East and North Hertfordshire NHS Trust

East and North Hertfordshire NHS Trust

Trust Board Part I

New QEII Hospital, Welwyn Garden City, Herts

2 May 2018 14:00 - 2 May 2018 15:30

AGENDA

#	Description	Owner	Time
1	Chair's Opening Remarks	Chair	
2	Declaration of Interests		
3	Questions from the Public 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. 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. 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. 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 For approval 5. Minutes from 7 March 2018 Part I.pdf 7	Chair	
6	Matters Arising and Actions For information 6. Actions Log - Board Part 1.pdf 17	Chair	
7	Final version of Annual Cycle 2018/19 will be provided at the next meeting For information	Company Secretary	

#	Description	Owner	Time
8	Chief Executive's Report For discussion 8. Chief Executive's Board Report - April 2018.pdf 19	Chief Executive	
9	Finance and Performance Committee Report (no report this month due to Major Incident) For discussion	Chair of FPC	14.15
9.1	Finance Report - Month 12 For discussion 9.1 Finance Report Month 12.pdf 21	Director of Finance	
9.2	Performance Report For discussion 9.2 Performance Report Month 12.pdf 29	Chief Operating Officer	
9.3	Workforce Report For discussion 9.3 Workforce Report.pdf 39	Chief People Officer	
9.3.1	Guardian of Safe Working Quarterly Report For information 9.3.1 Guardian of Safe Working Quarterly Report.p... 65	Chief People Officer	
10	Risk and Quality Committee Report (including NHS Resolutions -Maternity Self Assessment and Risk Register Report) For discussion 10. RAQC Report to Board.pdf 77 10. Appendix 1 - NHS Resolutions Maternity Self A... 83 10. Appendix 1 VERSION 2 (updated following mee... 93 10. Appendix 2 - Update on Risk Review.pdf 103	Chair of RAQC	14:55
10.1	Learning From Deaths For discussion 10.1 Learning from Deaths Report.pdf 113	Medical Director	

#	Description	Owner	Time
11	**Audit Committee Report** For discussion [P] 11. Audit Committee Report.pdf 143	Chair of Audit Committee	15.15
12	**Board Assurance Framework** For discussion [P] 12. Board Assurance Framework.pdf 147	Company Secretary	
13	**Data pack** For information [P] 13. Data Pack.pdf 169	All Directors	
14	**Part II** 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
14.1	**Commercial-in-confidence**		
14.2	**Governance Matters**		
14.3	**Personnel Matters**		
15	**Date of next meeting:** Next full Trust Board Part 1 meeting: 4 July 2018 - New QEII		

EAST AND NORTH HERTFORDSHIRE NHS TRUST

Minutes of the Trust Board meeting held in public on Wednesday 7 March 2018 at 2.00pm at the Lister Education Centre, Lister Hospital, Stevenage

Present:	Mrs Ellen Schroder	Non-Executive Director (Chair)
	Mr Jonathan Silver	Non-Executive Director (Trust Vice Chair)
	Mr Bob Niven	Non-Executive Director
	Mr John Gilham	Non-Executive Director
	Ms Val Moore	Non-Executive Director
	Mr Nick Swift	Non-Executive Director
	Mr Nick Carver	Chief Executive Officer
	Mr Martin Armstrong	Director of Finance
	Mr Michael Chilvers	Medical Director
	Ms Rachael Corser	Director of Nursing
	Ms Bernie Bluhm	Interim Chief Operating Officer
In attendance from the Trust:	Ms Kate Lancaster	Director of Strategy
	Mr Tom Pounds	Deputy Director of Workforce
	Ms Jude Archer	Company Secretary
	Ms Katie Martin	Corporate Governance Assistant (minutes)
	Ms Jagdeep Kudhail	Divisional Director Cancer Services
In attendance external to the Trust:	Ms Lisa Nicholls	ENHT Anaesthetic ST7 Registrar
	Mr Martin Gray	Anaesthetic SPR

18/045 CHAIR'S OPENING REMARKS

18/045.1 Mrs Schroder welcomed Tom Pounds (Deputy Director of Workforce) who is standing in for the Chief People Officer.

18/046 DECLARATIONS OF INTEREST

18/046.1 There were no declarations of interest.

18/047 QUESTIONS FROM THE PUBLIC

18/047.1 Mrs Schroder reported that Mr Jewitt has raised a further question regarding the Trust's Cancer performance. It had been agreed that a meeting with the Chair, Interim Chief Operating Officer and Mr Jewitt would be beneficial in order to provide Mr Jewitt with a satisfactory answer.

18/048 APOLOGIES FOR ABSENCE

18/048.1 Apologies for absence were received from Mr Tom Simons – Chief People Officer.

18/049 MINUTES OF THE PREVIOUS MEETING

18/049.1 The Board reviewed the draft minutes of the previous meeting and approved with minor amendments.

18/050 MATTERS ARISING AND ACTIONS LOG

18/050.1 The Board reviewed and noted the actions log with the following comments:

- Social Care and Vascular Surgery – this has been completed and can be removed from the action log.

18/051 ANNUAL CYCLE

18/051.1 The Board noted the Annual Cycle.

18/052 CHIEF EXECUTIVE'S REPORT

18/052.1 The Chief Executive delivered the Chief Executive's Report, highlighting the following items:

- Winter Pressures- January and February have been busy as winter pressures continue. This increased demand has been incredibly challenging but the commitment of staff to ensure the safety of our patients has been inspiring- thanks must be given. Furthermore, there has been success within managing infection control as there have been no significant ward outbreaks and no ward closures have been required. Mrs Schroder also praised our strong culture of partnership working in the face of winter pressures.
- CQC Inspection Preparations- We have now received formal notification from the Care Quality Commission of their next inspection of our services. There will be an unannounced inspection of our core services across our sites, it is anticipated that this will occur during late March 2018. Awareness of this is high. This will be followed by an announced Well Led inspection which is scheduled to take place 23-25 April 2018. We are supporting our staff and encouraging the sharing of confident messages (what we are proud of, what we are doing and what quality improvements are planned.)
- Lorenzo Stabilisation- A stabilisation plan and stabilisation steering committees are in place to support this. Funding discussions are ongoing with NHSi, NHSe and NHS Digital. An external supplier (channel 3) has been commissioned to provide expertise on how to implement stabilisation swiftly.
- Our staff- Congratulations to individual staff within the Trust for their efforts and achievements. Also, well done to our Diabetic Screening Team - rated as one of the best performing services in England after taking part in Public Health England's annual national audit.

STRATEGIC

18/053 Trust Strategy and Objectives 2018/19

18/053.1 The Director of Strategy presented the achievements to date against the 2017/18 strategy and objectives and the final version of the Trust's plan. She also thanked the Board for its continuous input into the current strategy. The Board was asked to consider and approve the proposed measures for the 2018/19 strategy, and noted the commencement of engagement with Divisions for development of the Trust's new five year strategy.

18/053.2 Mr Niven considered whether the 18/19 plan and Board Assurance Framework work in parallel to one another. The Director of Strategy assured Mr Niven that the integration is seamless with the BAF changing to reflect the strategic aims.

18/053.3 Mr Gilham put forward the value in making an explicit statement in reducing variation and having standardised processes. The Director of Strategy communicated that this is implied in other priorities, but agreed with building this into the strategy going forward. Mrs Schroder asked where it would fit into the objectives to which Mr Gilham suggested a bullet point under improving patient outcomes. Mrs Schroder accepted this placing but underlined the importance of this being measurable.

18/053.4 Ms Moore recognised the potential for a bigger profile in terms of children's services in order to create a well-rounded reflection of services meeting the desired objectives. However, Mrs Schroder settled that isolating this means the profile of other services would also need to be isolated in turn which is problematic.

18/053.5 The Board formally approved the Trust Strategy and Objectives for 2018/19.

18/054 Mount Vernon Clinical Strategy

18/054.1 The Director of Strategy outlined the development of the Mount Vernon Cancer Centre clinical strategy. The development of a clinical and academic partnership has been agreed with University College London Hospital. Attention was given to the 4 strategic aims:

- Deliver innovative, high quality and efficient services
- With partners, transform how cancer care is provided
- Harness patient views and technology to transform the environment in which we deliver care
- Recruit and retain high quality staff

18/054.2 It was reported that a MV strategy delivery group is being established from April 2018 to support and drive the delivery of the strategy. The importance of engagement and activity was appreciated.

18/054.3 Mrs Schroder praised the great ambition of this, but brought awareness to the outstanding work to be done in terms of estates and non-clinical elements. She further expanded on the need to be specific about is going to be achieved in the short, mid and long term in order to be able to successfully monitor and review the framework. The Director of Strategy agreed, further articulating that the strategy will be shared with the Cancer Alliance Board and can involve wider stakeholders.

18/054.4 The Divisional Director of Cancer Services commented on the significance of being part of a network and gave formal recognition to the fact that this cannot be done without partner support. Mr Gilham challenged how things will look in a years' time. The Divisional Director of Cancer Services provided confidence that the Trust will have a clearer understanding of relationship with Hillingdon and academic partnership with UCLH will have been developed. She expanded that the Trust will be working towards a lease agreement

and formal engagement with other partners.

18/054.5 The Board approved the Mount Vernon Clinical Strategy.

18/055 Risk Management Strategy and Board Assurance Framework

18/055.1 The Director of Strategy presented the approach to Risk Management paper and made the following points:

- The Risk Management Strategy outlines key documents and how to support approach.
- The Risk Management strategy will be supported by a Risk Management procedure which aims to provide all staff with a step-by-step guide to the identification, escalation and management of risk on a daily basis.
- A key instrument in the effective management of risk (both clinical and non-clinical) will be the appointment of Risk and Quality leads within each Division.
- The refreshed Board Assurance Framework brings together in one place all of the relevant information on the risks to the delivery of the board's strategic objectives.

18/055.2 After explanation of the dynamic process that happens over a cycle, Mr Niven considered the relationship between the BAF and corporate risk register. He questioned to what extent the corporate risk register features in board and committees. The Director of Strategy clarified that the risk register features in instances and occasions where there is a need to know.

18/055.3 Mr Gilham focussed on the risk management activities and queried if the strategy will have a section on prevention. He further recognised the need for focus on best practice from individuals who will take on these roles. The Director of Strategy was of the view that risk management is everybody's business, but a training programme will both increase awareness on prevention, and achieve the focus on best practice from individuals within each division. Ms Moore commented on the usefulness of having a list of people in those current roles.

18/055.4 Mrs Schroder concluded that the Audit Committee would take the lead on this. The Board formally approved the Risk Management Strategy and Board Assurance Framework.

FINANCE AND PERFORMANCE

18/056 Finance and Performance Committee Report to Board

18/056.1 The Board received the report of the Finance and Performance Committee meeting held on 28 February 2018.

18/056.2 Mr Swift advised of the month 10 position and the significant pressures in terms of income. He informed the Board that we close this year at an exit run rate of £2million loss. Clearly, there is a need to bridge this gap.

18/056.3 Mr Swift reported that the Committee received a useful and comprehensive review on ED. It detailed the main challenges to ED performance, namely resource gaps as well as the main improvement plans for consideration. It can be summarised that

there is a broad resolution but more work still to do.

18/056.4 Mr Swift was clear that the Committee remain encouraged with regards to the Lorenzo Stabilisation plan and the respective partner chosen to implement stabilisation. It was noted that the Stabilisation Director is going to provide more detail on this through steering group meetings. Mrs Schroder recommended clearer milestones in order to see if the Trust is meeting expectations month by month.

18/057 Finance Report Month 10

18/057.1 The Director of Finance delivered the Month 10 Finance Report. Key points to be noted included:

- The Trust reported a £0.7m deficit in month, bringing the year to date position to a £23.8m deficit.
- In terms of SLA income, the Trust is significantly behind forecast for January. This is exacerbated in month because of reduction in elective activity due to operational pressures which required the re-focussing of resources, as well as the impact of system limitations.
- Non- pay costs constitute £1.4m but the vast majority of this is capitalisation of Lorenzo.
- Pay costs have risen by £400,000 month on month due to additional capacity required for winter pressures.
- In relation to CIP performance and delivery, the Trust is £2.7m adverse to plan thereby continuing to fall short of target.

18/057.2 Mrs Schroder challenged whether or not the £20million target is too high. The Director of Finance explained that the model hospital requires quantum of activity to deliver efficiency, but the disappointment on model hospital and headwinds from Lorenzo has influenced the successfulness of cost control and management. Mrs Schroder commented on the fact that we are approximately level year on year and in retrospect this plan was too ambitious. The Director of Finance disagreed with the optimisation bias, and further focussed on how despite national electives being down; our Trust has experienced distinct issues which have resulted in significant consequences.

18/057.3 Mr Niven brought the key question of whether the absolute limits have been reached in relation to CIP delivery to the fore. The Director of Finance articulated that all avenues have certainly not been exhausted, underpinning the crux of the issue to be the late intensity of CIP delivery and redesign.

18/057.4 Mr Silver considered the absolute pay levels and expenditure to challenge the £18m improvement identified. The Director of Finance provided assurance that for a large number of costs, normalising adjustments will occur. Mr Swift asked for non-recurring costs and inflation to be updated within this for the next FPC meeting.

18/058 Performance Report Month 10

18/058.1 The Interim Chief Operating Officer introduced the Month 10 Performance Report. Key points to note included:

- Following the migration to Lorenzo, the Trust remained

unable to report January's performance against the RTT standard. Following discussions with NHSI and further assessment of our current position, the Trust is unlikely to return to reporting for 6-9 months. It was highlighted that the 'new' PTL report will 'go live' in the second week of March.

- We are continuing to report breaches of the 52 week standard and keeping a log in relation to potential harm.
- The ED 4 hour performance was 82.03%, but the department has seen an increase in attendances at peak periods which has continued to impact upon delivery. As a result, there have been 2,400 breaches at Lister Hospital and just 10 breaches at QEII Hospital.
- With regards to Cancer Performance, January performance has not yet closed but we are still expecting to deliver the trajectory of 85%.
- We are continuing to perform well for stroke, although indicators have been impacted by delivery.

18/058.2 Mr Gilham alerted the Board to consider what learning has come out of delayed transfers of care. The Interim Chief Operating Officer articulated that work with the lead for the discharge team by way of tracking lists, as well as working with social care and community partners on sight has proved essential in limiting delayed transfers of care.

18/058.3 Mr Gilham further probed in relation to what should be done differently next year. The Interim Chief Operating Officer encapsulated that redesigning how we deliver the care by way of front door redesign, work around red to green and consultant involvement is key. The Medical Director reinforced this, commenting on how the change will turn the Trust around in terms of performance and finance.

18/058.4 Ms Moore questioned how the public have responded to winter pressures and whether there is an opportunity to put operational details on our website in a public friendly way. The Director of Strategy summarised the clear large public support and solidarity for the NHS. The Director of Strategy welcomed more information available to the public, noting the forum to be a powerful way of engagement.

18/058.5 Mr Niven brought attention to RTT stabilisation and the relevant urgency we can give to this. The Interim Chief Operating Officer explained that we are expecting to see a demand on operational and admin time, but alluded to the anticipated quick response for booking patients.

18/058.6 Finally, Mrs Schroder highlighted the importance of seeing what reporting looks like once PTL is active. It was agreed that internal reporting will begin at the end of March and this will be brought to the next Board meeting.

18/059 Workforce Report Month 10

18/059.1 The Deputy Director of Workforce delivered the Month 10 Workforce Report. Key highlights were:

- The monthly agency ceiling target continues to be achieved with agency spend under by £434k, continuing with positive

variance on control total

- The Trusts vacancy rate is 8.5%. However, there are still areas where we can do better and a robust improvement plan is in place to address this.
- Seasonal impact has meant sickness rate is quite high – a new policy and management has been released in respect of this.
- The staff survey results were disappointing; however, this has been acted upon quickly with online staff survey workshops and a crowd sourcing platform to make suggestions for change.
- Strong focus on organisation culture continues with LEND sessions for Spring 2018 launched and new 'Workforce Skills for Leaders' module to launch next month.
- The flu target of 70% has been achieved and since surpassed since January.

18/059.2 Ms Moore queried how the sickness policy has changed. The Deputy Director of Workforce submitted that the algorithm to measure sickness absence has been altered to enable managers to take much more of a proactive stance.

18/059.3 Mrs Schroder declared that these positive features must be driven through the organisation in order to combat negativity from the staff survey results. The Chief Executive supported communication of progress, but conveyed his concern of over pitching success as there are still many issues to address.

18/059.4 Mr Gilham recognised the need to better link together the staff survey results containing fundamental pressure points into the report. The Deputy Director of Workforce encapsulated how the report covers what was available to deliver the financial outcome but appreciated this clear necessity.

18/059.5 After receiving clarification that the survey was conducted during a difficult time for the organisation - implementing the Lorenzo system, Mrs Schroder asked whether this is limited to an annual occurrence. The Deputy Director of Workforce informed the Board that there are ways of doing pulse checks on a monthly basis which may prove highly beneficial.

18/059.6 A detailed look at the staff survey results and crowd sourcing information was requested for the next Board session.

RISK AND QUALITY

18/060 Risk and Quality Committee Report

18/060.1 Mr Gilham presented the RAQC Committee report. Key highlights included:

- Safer Staffing Report- the position regarding safe staffing was not significantly changed from the previous month. Assurance was provided that processes to manage this were in place and continuing to strengthen. Safer staffing as a key risk will form part of the refreshed BAF.
- Refreshment of Risk Management- Actions being taken included the introduction of risk clinics to support consistency in scoring and to support informed decision making of various

risks. Additional scrutiny requires assurance to be provided from the Interim Chief Operating Officer and Director of Nursing that actions are being reviewed. Work is taking place to finalise the Trust's new Risk Management Strategy. A new Risk report including detailing on incidents and clinical claims will be presented to the next RAQC meeting.

- Operating plan- the importance of ensuring that quality remained a core element of the plan and emphasising the message that patient safety and quality improvements could lead to financial benefits, helping to deliver the financial plan. The implementation of Getting it Right First Time (GIRFT) will be taken forward.

18/061 Learning from Deaths

18/061.1 The Medical Director presented the Learning from Deaths report, considering the Trusts current mortality performance. It was reported that crude mortality holds a decreasing trend, sitting at 1.57% for the 12 month period. HSMR has had a slight increase but is statistically as expected for the 12 month period (96.18). However, Lorenzo issues around depth of coding may mean that this is not a true representation of mortality. With regards to SHMI, the position is 102.14 for the 12 month period.

18/061.2 The Medical Director discussed the main risks that have been identified:

- Data submission/reporting: post Lorenzo issues
- Gastroenterology – operational issues/elevated HSMR for specialty of discharge
- Cardiology – elevation of AMI HSMR
- Slow progress with 7 day service
- Coding capability
- Reduced frequency of the Rolling Half Days to discuss mortality reviews
- Mortality Review Process – need for significant development of IT tool

18/061.3 Mrs Schroder stated that Sepsis is elevated. The Medical Director agreed that this is an area that requires a lot of attention as ultimately identifying sepsis is poor. He suggested that learning from other Trusts should improve our performance in terms of timely treatment and better management. The need to support staff and using systems to the maximum was emphasised. The Director of Nursing provided confidence that applying the work streams will get the right level of focus. Mrs Schroder requested a refresh in three months.

18/061.4 Mr Silver pointed out that re-admissions are in the red and questioned whether we should be doing something differently. The Medical Director clarified that this may be down to readmissions - either by incorrect recording or reduced length of stay having an impact on patient readmission. The Interim Chief Operating Officer was of the view that simplifying the pathway will ensure patients are in the right place and sitting with the right teams, limiting readmissions and therefore bring admissions into the green.

18/061.5 Mr Gilham highlighted that readmissions also occur if support from the community is not received which means we need to work more

succinctly with our partners. Mrs Schroder noted that as we are a national outlier on this, it would be worth picking up in RAQC.

18/062 **DATA PACK**

18/062.1 The Board noted the data pack.

There being no further business the Chair closed the meeting at 3.50pm.

Ellen Schroder
Trust Chair

March 2018

	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 MAY 2018 MEETING

Meeting Date	Minute ref	Issue	Action	Update	Responsibility	Target Date
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/West Hertfordshire. **May 2018:** Project currently under review. Action to close.	Director of Strategy	January 2018 * Review April 2018
7 March 2018	18/059.6	Staff Survey	To provide a detailed report of the staff survey results and crowd sourcing information.	Considered at Board Development on 4 April 2018	Chief People Officer	4 April 2018 (B Dev.)

East and North Hertfordshire NHS
NHS Trust

Chief Executive's Report

May 2018

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1. Corporate Update

Trust IT network incident

On Tuesday, 24 April 2018, the Trust's IT network developed a major fault that led to our staff reverting to paper-based systems at varying points throughout the rest of that week to ensure patients continued to receive safe and effective care. All of our staff worked together to keep patients safe and make sure they experienced as little disruption as possible.

The IT problems have been resolved, with colleagues from NHS Digital confirming that the Trust had taken all the right actions at the right times throughout this significant incident. I would also like to extend the Trust's gratitude to our colleagues from NHS Digital who provided technical support and neighbouring Trusts at Royal Papworth, Princess Alexandra, Luton & Dunstable, Addenbrookes and the East of England Ambulance Service who assisted with Diverts when required.

CQC Inspection

We undertook the well-led element of our CQC inspection during the latter end of April. It comprised three days of interviews with Directors, Senior Divisional leaders and other staff. The inspectors also had the unplanned opportunity to see how we reacted in a major incident situation. We have been advised that the report will be published with our new rating in the early summer.

New Lorenzo & Nervecentre Stabilisation Programme

To help further embed the new Lorenzo system (patient record system) the Digital Transformation Team have launched a new stabilisation programme. The aim is to make sure our processes and procedures work in line with the Lorenzo and Nervecentre systems so that staff feel more comfortable using them correctly and efficiently. The programme will be split into six different work streams covering: Access planning, contact centre and ERS, Emergency department, Outpatient, Inpatients, IT infrastructure, interfacing and support and bed management.

2. Our Staff

Urology Achievements

Mr Vasdev presented the Trust's data regarding Cytokine guided Robotic Prostatectomy at the recent European Association of Urology meeting held in Copenhagen. The presentation was recognised at the final plenary of the world's largest Urology meeting as amongst one of the best for innovation. Mr Vasdev has also secured £25,000 of commercial funding for the next stage of the multicentre study between Cambridge, Belgium and Sweden with the Lister leading the project.

Diabetic Screening Team Amongst the Best Performers in England

Our Diabetic Eye Screening Team has been rated as one of the best performing services in England after taking part in Public Health England's annual national audit. The audit looked at their performance between April 2016 and March 2017.

The service, which sees patients locally at a number of centres across east and north Hertfordshire, including in Stevenage, Welwyn Garden City and Hertford, was rated the best in the country for seeing patients with proliferative diabetic retinopathy within four weeks of receiving their positive screening results.

They also ranked second in England for the uptake of screening, with 91% of patients offered an appointment attending. The team was also recognised for giving 99.7% of patients their screening results within three weeks of their appointment.

Professional Midwifery Advocate (PMA)

Following the launch of the new Professional Midwifery Advocate (PMA) role at the Trust in January, staff in the Midwifery Team were asked to design a logo for it. Hannah Churms' logo was chosen and is now being used on all internal PMA documentation at the Trust. This logo was also chosen by NHS England to be used nationally on the first anniversary of the launch of the PMA role.

Orthopaedics Team Awarded Quality Data Provider Certificate by NJR

Our Orthopaedics Team has been awarded a Quality Data Provider certificate by the National Joint Registry (NJR), after successfully completing a national programme of local data audits. The audits looked at the accurate number of joint replacement procedures submitted to the registry compared to the number carried out and recorded in our patient administration system.

Agenda Item: 9.1

TRUST BOARD PART I – 2 MAY 2018

FINANCE REPORT MONTH 12

PURPOSE	To set out the Trust's financial position for Month 12.
PREVIOUSLY CONSIDERED BY	
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. ☐ 2. **Developing new services and ways of working** – delivered through working with our partner organisations ☐ **3. 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)	Financial risks are described in the main report
Healthcare/ National Policy (includes CQC/Monitor)	
CRR/Board Assurance Framework *	☐ **Corporate Risk Register** ☑ **BAF**

ACTION REQUIRED *

For approval	☐	For decision	☐
For discussion	☑	For information	☐

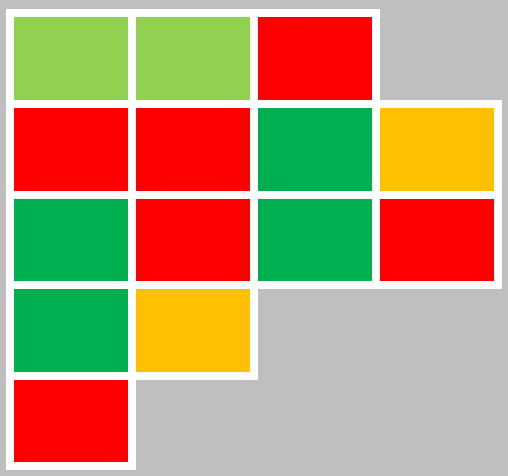
DIRECTOR:	Director of Finance
PRESENTED BY:	Director of Finance
AUTHOR:	Director of Finance
DATE:	27 April 2018

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 12 - 2017/18

Mth 12 - Finance Report - Commentary

EXECUTIVE SUMMARY

- The Trust pre accounts year end position reports a deficit of £27.3m, excluding impairment and inclusive of STF. This represents a adverse variance of £19.6m to Control Total Plan.
- Exclusive of STF the reported deficit is £28.6m. This represents an adverse variance to plan of £10.7m. This is the key measure that utilised by NHSI to monitor in year I&E performance achievement.
- Trust pre audit accounts are submitted to NHSI and DH on the 25th April 2018, and the External audit of these accounts commences on the 30th April 2018.
- Submission of audited accounts must take place by the 29th May 2018.

KEY MONTH 12 ISSUES

- Excluding impairments the Trust reported a £1.0m surplus in month, bringing the year to date position to a £27.3m deficit.
- As a result of the adverse year end variance, the Trust has assumed that it will not be eligible for STF funding after Q1.
- The month 12 and year end position was an improvement on the forecast position. The actual outturn of £28.6m exc STF compared with the forecast of £29.9m on a similar basis.
- This was redominately driven by stronger than anticipated activity throughput during March combined with a earlier than expected desclalatikon of unplanned winter pressure expenditure
- CIP performance during March was below plan, but was broadly in line with forecast.

EXCEPTIONAL ITEMS

- The normalised I & E run rate analysis within the report presents exceptional items.
- The M12 reported position assumes that the Trust will not receive any STF funding after quarter one.
- £0.7m of additional costs have been incurred in the month in relation to the stabilisation of Lorenzo. This has been partially offset by £0.25m transfer to capital in month to reflect costs incurred, above plan, for the stabilisation of the Lorenzo system.
- The pay position includes £265k of costs which have been incurred to open additional capacity, owing to winter pressures.

Mth 12 - Finance Report - Commentary

SLA INCOME PERFORMANCE

- The Trust continues to report significant under performance against its SLA plan. This year end adverse variance totalled £16.2m for the year to date at month 12. The material drivers of the shortfall are detailed below:

Reduced Elective Activity	*- 2.0m*
Non Elective Activity - reduced volume	*- 1.6m*
Outpatient Activity - reduced volume	*- 3.9m*
Maternity - reduced Ante natal	*- 3.0m*
Cyber Attack - reduced activity	*- 0.7m*
CQUIN Underachievement	*- 1.7m*
Fines & Challenges	*- 2.0m*

- Outpatient activity levels across the entire year have remained significantly belo w both plan and prior year levels.
- Day case throughput has continued to increase and is reported as £0.4m over plan in Month 11, this is offset by a under-recovery in Elective activity. Although the scale of the under recovery was reduced compared with previous months
- Non Elective inpatient activity saw significant increase in Month 12 compared with the previous month to levels similar to January.
- The acuity of non elective acivity continues to be consistent with winter patterns/
- 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, Clinical Support 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.
- All divisions with the exception of cancer services report material overspends in relation to pay budgets.

YEAR ON YEAR COMPARISON

- Income levels are now showing a £6.5m increase compared to the same period in 2016/17. This is mainly due to an increase in training and education income and also winter pressure funding.
- Elective activity is 12% down on previous year, although this is partially offset by an increase in day-case activity. Whilst Non elective activity is down 2%, year on year. This is atypical compared with other local providers and the national picture.
- Both Outpatient first and follow up attendances (6% lower), as well as outpatient procedures (12% lower), are significantly below volumes delivered last year.
- Pay expenditure in 17/18 is £1.6m lower than at the same period last year, when adjusting from normalising issues)eg. Pathology. This is despite the impact of the current year pay award.

Mth 12 Finance Report - Commentary

PAYBILL PERFORMANCE

- The Trust reported an over spend of £1.0m against its pay budget in March
- Pay budgets report an overspend of £2.9m across the full financial year.
- Pressues in respect of emergency services medical staffing cost have been particularly significant.
- Agency expenditure is £12.4m across the full year, which is below the NHSI agency ceiling target. This is £13.0m less than the agency bill in 2016/17.

CIP PERFORMANCE

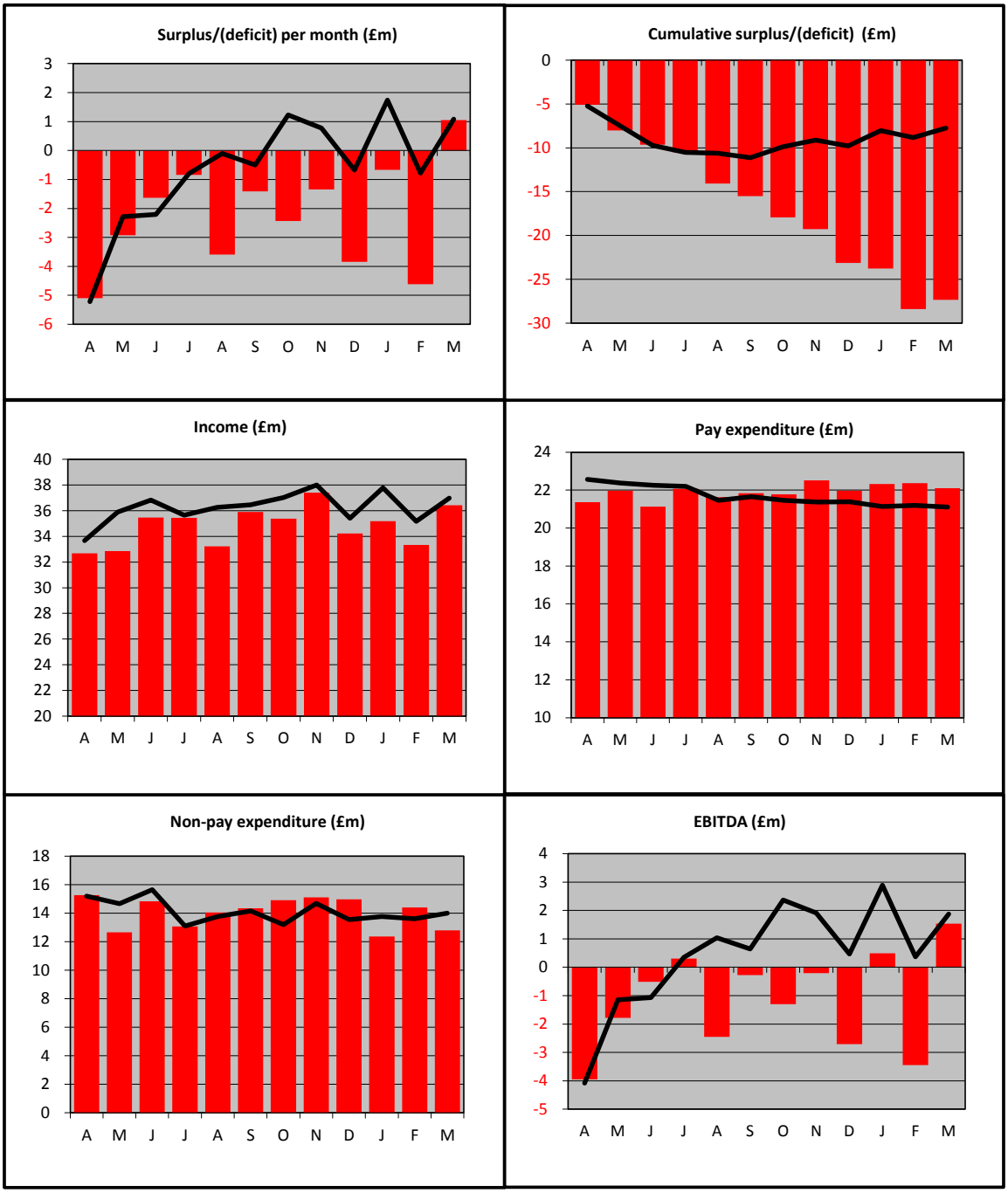
- The Trust has delivered £19.5 savings year to date against a full year plan of £23.3m. This represents an adverse variance to plan of £3.8m
- The overwhelming majority of the CIP overperformance is concentrated on this schemes within the 'model hospital' portfolio.
- The theatre and outpatient efficiency schemes, in particular, are not delivering to the scale anticipated, neither is the job planning scheme. There continues to be weekly information assurance meetings and CIP meetings, in an effort to secure anticipated savings for the remaining weeks of the financial year.

CASH, CAPITAL & BALANCE SHEET

- Non-achievement of planned levels of income and expenditure, including non-receipt of Strategic Transformation Fund monies has led to cash shortfalls, which have been, and continue to be, actively managed. The Trust has worked with NHSI on solutions to short-term borrowing requirements. However, there is a high focus on internal working capital management, including both debtor and creditor management.
- Whilst there is a requirement to restrict creditor payments to within available resources every effort will be made to reduce the risk suppliers withholding goods or services.
- The Board and FPC will continue to be apprised of the cash situation
- The Trust has obtained clearance from NHSI to capitalise a further £3.0m of appropriate Lorenzo stabilisation expenditure. This is reflected within the year end position.
- The Trust has delivered capital works within its agreed CRL.

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	424.9	35.8	36.4	0.6	424.9	416.2	-8.7
Pay	-260.1	-21.1	-22.1	-1.0	-260.1	-263.0	-2.9
Non Pay	-169.3	-14.0	-12.8	1.2	-169.3	-168.7	0.6
EBITDA	-4.6	0.7	1.5	0.8	-4.6	-15.6	-11.0
Financing Costs	-13.4	-0.8	-0.5	0.3	-13.4	-13.0	0.3
STF Monies	10.2	1.2	0.0	-1.2	10.2	1.3	-8.9
Deficit (excl impairment)	-7.7	1.1	1.1	-0.0	-7.7	-27.3	-19.6
Impairment	0.0	0.0	-3.9	-3.9	0.0	-3.9	-3.9
Deficit (incl impairment)	-7.7	1.1	-2.9	-4.0	-7.7	-31.3	-23.5



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	Dec	Jan	Feb	Mar						
Catering Income	1,153	90	93	81	80	32	122	103	116	98	120	97	148	96	148	51	1,153	1,182	29
NHS Non Patient Care Income	1,931	323	144	141	207	130	201	145	258	103	199	150	660	147	660	513	1,931	2,662	732
NHS Patient Care Income	385,202	28,969	29,160	31,494	31,586	30,781	31,896	32,051	33,125	29,089	31,630	29,528	30,920	32,442	30,920	-1,523	385,202	370,229	-14,973
Other Income Category C	20,682	1,414	1,412	1,477	1,474	312	1,150	899	1,621	2,871	1,016	1,230	2,156	2,036	2,156	120	20,682	17,032	-3,651
Other NHS Revenue	0	0	0	0	0	0	0	0	0	0	42	33	126	0	126	126	0	201	201
Other Patient Care Income	72	4	4	4	4	5	4	5	3	4	3	77	162	8	162	155	72	279	207
Private Patients	5,172	308	356	466	348	328	326	359	481	267	303	346	337	436	337	-99	5,172	4,225	-947
R&D Income	5,081	468	399	448	416	395	447	441	481	430	437	434	378	424	378	-45	5,081	5,172	91
RTA Income	1,173	-39	144	205	58	91	111	109	89	113	142	108	112	98	112	14	1,173	1,244	71
Training & Education Income	14,597	1,135	1,136	1,135	1,269	1,150	1,642	1,258	1,228	1,237	1,297	1,330	1,424	1,287	1,424	137	14,597	15,242	646
Income Total	**435,062**	**32,672**	**32,849**	**35,452**	**35,444**	**33,224**	**35,899**	**35,369**	**37,402**	**34,213**	**35,188**	**33,334**	**36,423**	**36,973**	**36,423**	**-550**	**435,062**	**417,468**	**-17,594**
Admin Staff	-36,078	-2,919	-3,021	-2,701	-2,990	-2,986	-2,994	-3,052	-3,213	-2,961	-2,980	-3,036	-3,033	-2,986	-3,033	-48	-36,078	-35,889	189
Ambulance Service Staff	10	16	-2	-2	-2	-2	-2	-2	-2	-2	-2	-2	-2	1	-2	-3	10	-4	-14
Ancillary Staff	-7,611	-669	-697	-668	-701	-693	-655	-651	-666	-677	-701	-672	-678	-625	-678	-53	-7,611	-8,130	-519
Clinical Support Staff	-15,587	-1,387	-1,349	-1,306	-1,392	-1,424	-1,349	-1,343	-1,368	-1,373	-1,413	-1,407	-1,406	-1,295	-1,406	-110	-15,587	-16,516	-929
Maintenance & Works Staff	-979	-70	-68	-68	-66	-69	-69	-69	-73	-68	-70	-75	-68	-81	-68	13	-979	-833	146
Medical Staff	-82,600	-6,889	-7,013	-6,799	-7,008	-6,941	-7,126	-7,109	-7,261	-7,142	-7,113	-7,337	-6,939	-6,808	-6,939	-130	-82,600	-84,675	-2,076
Nursing Staff	-81,125	-6,550	-6,672	-6,498	-6,692	-6,568	-6,563	-6,508	-6,728	-6,553	-6,837	-6,656	-6,668	-6,723	-6,668	54	-81,125	-79,494	1,631
Other Staff	43	-17	-6	-1	-20	-13	-6	-14	12	4	-3	-4	17	4	17	14	43	-50	-92
Pay Reserves	2,127	-197	-106	-24	-98	109	-82	-51	-83	-136	-92	-97	-285	619	-285	-904	2,127	-1,142	-3,270
Scientific Theraputic & Technical	-32,993	-2,283	-2,659	-2,665	-2,717	-2,650	-2,576	-2,539	-2,683	-2,619	-2,664	-2,653	-2,606	-2,765	-2,606	159	-32,993	-31,315	1,678
Senior Managers	-5,269	-387	-370	-394	-379	-388	-400	-427	-437	-429	-442	-425	-418	-439	-418	21	-5,269	-4,898	371
Social Care Staff	-84	-10	-9	-10	-11	-10	-10	-6	-7	-7	-7	-7	-7	-6	-7	-0	-84	-99	-15
Pay Total	**-260,145**	**-21,363**	**-21,973**	**-21,135**	**-22,077**	**-21,634**	**-21,830**	**-21,770**	**-22,511**	**-21,964**	**-22,323**	**-22,370**	**-22,094**	**-21,107**	**-22,094**	**-987**	**-260,145**	**-263,045**	**-2,900**
Admin Expenses	-26,579	-2,720	-3,048	-2,278	-2,131	-2,105	-2,027	-2,636	-2,059	-2,269	-2,286	-2,553	-2,020	-1,970	-2,020	-50	-26,579	-28,133	-1,554
Catering	-1,805	-169	-154	-166	-155	-189	-174	-148	-175	-148	-149	-159	-160	-149	-160	-11	-1,805	-1,944	-139
Commissioning Expenditure	-182	-5	-7	1	-10	-5	-44	-10	-19	-14	-75	56	-30	-17	-30	-13	-182	-164	18
Drugs, Blood & Lab Consumables	-46,489	-3,773	-3,558	-4,197	-3,215	-3,984	-4,008	-3,695	-4,992	-3,997	-4,603	-5,384	-4,209	-3,894	-4,209	-315	-46,489	-49,614	-3,125
Energy & Utilities	-2,287	-224	-196	-127	-189	-186	-93	-175	-215	-240	-275	-175	-137	-187	-137	50	-2,287	-2,231	56
IM&T Costs	-2,920	-248	-219	-303	-240	-228	-282	-236	-187	-194	-201	-155	-557	-209	-557	-348	-2,920	-3,050	-130
Internal Recharges	-30	-0	0	0	0	-0	0	0	0	0	0	0	0	-2	0	2	-30	0	30
Medical Consumables	-17,846	-1,341	-1,502	-1,448	-1,488	-1,494	-1,482	-1,540	-1,541	-1,545	-1,350	-1,521	-1,391	-1,485	-1,391	94	-17,846	-17,643	204
Non Pay Reserves	-3,718	-65	888	-293	17	-193	-376	-836	1,371	-256	-53	-21	-2,689	-1,272	-2,689	-1,417	-3,718	-2,504	1,214
P or L - Sale of Fixed Assets	700	0	0	0	0	0	0	0	0	0	0	0	0	700	0	-700	700	0	-700
Property Costs	-5,145	-429	-421	-418	-472	-415	-499	-430	-473	-446	-441	-449	-406	-402	-406	-3	-5,145	-5,299	-154
Purch & Maint of Equip - Medical	-16,623	-1,307	-1,339	-1,380	-1,364	-1,381	-1,353	-1,337	-1,597	-1,398	-1,264	-1,312	-1,475	-1,346	-1,475	-128	-16,623	-16,506	117
Purch & Maint of Equip - Non Medical	-1,677	-147	-125	-298	26	-69	-88	-136	-160	-5	-89	-87	-48	-138	-48	90	-1,677	-1,226	451
Purchase of Healthcare - Non NHS	-7,464	-553	-622	-561	-559	-607	-588	-601	-651	-814	-647	-598	-630	-603	-630	-27	-7,464	-7,430	34
Recharges In / Out	-1,594	-117	-154	-138	-174	-135	-144	-193	-146	-144	-175	-167	-163	-162	-163	-1	-1,594	-1,847	-254
Services from Other NHS bodies	-20,401	-2,769	-840	-1,574	-1,468	-1,422	-1,498	-1,305	-2,997	-1,700	-1,434	-611	822	-1,656	822	2,478	-20,401	-16,796	3,605
Site Support Services	-14,115	-1,342	-1,268	-1,582	-1,566	-1,584	-1,650	-1,575	-1,174	-1,726	742	-1,258	485	-1,051	485	1,537	-14,115	-13,499	616
Suspense Accounts	0	-1	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Training Costs	-1,134	-53	-97	-65	-67	-49	-41	-46	-82	-64	-68	-16	-192	-151	-192	-41	-1,134	-842	293
Non Pay Total	**-169,308**	**-15,260**	**-12,661**	**-14,826**	**-13,058**	**-14,045**	**-14,348**	**-14,899**	**-15,096**	**-14,959**	**-12,369**	**-14,408**	**-12,797**	**-13,994**	**-12,797**	**1,197**	**-169,308**	**-168,727**	**582**
Depreciation	-7,773	-648	-648	-538	-607	-607	-607	-604	-604	-604	-601	-601	-1,397	-648	-1,397	-749	-7,773	-8,065	-292
Dividend	-1,662	-168	-168	-168	-168	-168	-168	-168	-168	-168	-168	-168	1,368	182	1,368	1,186	-1,662	-476	1,186
Interest Payable	-3,944	-329	-329	-421	-378	-365	-364	-364	-364	-364	-397	-408	-451	-329	-451	-122	-3,944	-4,533	-589
Interest Receivable	25	3	2	2	2	2	2	2	0	8	4	5	0	2	0	-2	25	32	7
Financing Total	**-13,354**	**-1,141**	**-1,142**	**-1,124**	**-1,150**	**-1,138**	**-1,137**	**-1,134**	**-1,136**	**-1,128**	**-1,162**	**-1,171**	**-479**	**-792**	**-479**	**312**	**-13,354**	**-13,042**	**312**
Grand Total	**-7,745**	**-5,093**	**-2,927**	**-1,633**	**-841**	**-3,593**	**-1,415**	**-2,434**	**-1,340**	**-3,839**	**-666**	**-4,616**	**1,052**	**1,080**	**1,052**	**-28**	**-7,745**	**-27,346**	**-19,601**

East and North Hertfordshire NHS Trust

Agenda Item: 9.2

TRUST BOARD PART 1 – 2 MAY 2018
PERFORMANCE REPORT MONTH 12

PURPOSE	To update the Finance and Performance Committee on: • Progress against Operating Standards, Contractual standards and local performance measures.
PREVIOUSLY CONSIDERED BY	
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. ☐ 2. **Developing new services and ways of working** – delivered through working with our partner organisations ☐ **3. 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)	Delivery of financial, operational performance and strategic objectives, CQC ratings, Governance risk Rating, Contractual performance.
Healthcare/ National Policy (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:	20 April 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

PERFORMANCE REPORT

1. Executive Summary

The trust did not achieve the 4 hour A&E standard, delivering 80.21% against the national standard of 95%. Following publication of the technical guidance for the 18/19 acute contract, the trust is required to achieve a minimum of 90% by September 2018 and 95% by March 2019, against the A&E standard.

The trust did not have any breaches of the 12 hour trolley standard; across NHS England there were a total of 853 patients that exceeded this standard.

Cancer performance – The trust continued to deliver against the 2WW and 2WW breast symptoms standards and continues to make improvements against the 62 day standard; the trust delivered 84.4% against the 85% standard post breach sharing. The trust did not achieve against the 31 day standards.

RTT – the trust remains off national reporting since the implementation of Lorenzo; however the national performance against the open pathways standard was only 88.2% against the 92% standard.

Although the trust is off national reporting, there are a number of patients that have exceeded the 52 weeks wait for treatment from referral. At the most recent access board 80 patients had exceeded this standard, 45 had subsequently been treated with 35 still waiting treatment.

Diagnostics – the trust remains off national reporting against this standard, nationally performance was 98.4% against the 99% standard.

Stroke – stroke data is not currently available. The trust has transferred stroke data reporting to the national SSNAP reporting tool and is in the process of validating February and March data. It should also be noted that stroke benchmarking data is published four months retrospectively.

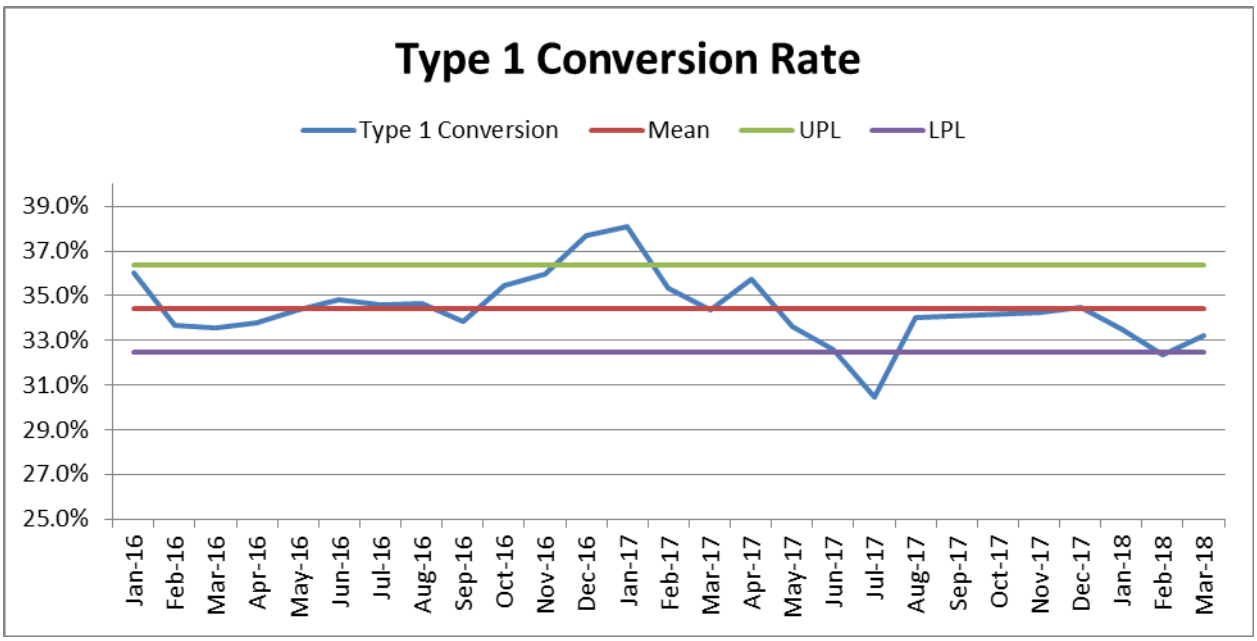
Summary Main KPI's					
Indicator	**Period**	**Standard**	**ENHT Perf**	**National Perf**	**Comment**
A&E					
4 Hr Standard	March	95.0%	80.21%	84.6%	2018/19 contact rq's 90% by Sept 18 and 95% by Mar 19
	Quarter 4 2017/18	95.0%	80.6%	85.0%	
	YTD 2017/18	95.0%	83.6%	-	National YTD not published
	April MTD	95.0%	82.0%	-	National MTD not published
12 Hr Trolley waits	March	Zero	Zero	853	853 total no. of pts >12 hours across NHSE
Cancer					
2WW GP Referral to 1st OPA]	February	93.0%	97.6%	95.2%	National average performance quoted
2WW Breast Symptoms	February	93.0%	100.0%	94.1%	National average performance quoted
31 day Diagnosis to 1st Definitive Treatment	February	96.0%	92.4%	97.6%	National average performance quoted
62 day Referral to Treatment - screening	February	90.0%	100.0%	88.0%	National average performance quoted
31 day Second or subsequent Treatment (drugs)	February	98.0%	97.0%	99.6%	National average performance quoted
31 day second or subsequent Treatment (radiotherapy)	February	94.0%	93.6%	97.7%	National average performance quoted
31 day Second or subsequent Treatment (surgery)	February	94.0%	92.3%	95.4%	National average performance quoted
62 day Urgent Referral to treatment all cancers					
Pre breach sharing	February	85.0%	80.3%	80.8%	National average performance quoted
Post breach sharing	February	85.0%	84.4%	80.8%	National average performance quoted
18 weeks RTT					
Open pathways	March	92.0%	Off reporting	88.2%	Lorenzo implementation
52 week Wait	March	Zero	Off reporting	1869	1869 total no. pt.'s >52 wks. across NHSE
Diagnostics					
DM01 <6 weeks	March	99.0%	Off reporting	98.4%	Feb data latest nationally published
Stroke					
Data not currently available					

2. ED Performance:

- March – 80.21% against the 95% standard, national performance across NHS England was 84.6%
- Quarter 4 2017/18 – 80.6%, national performance across NHS England was 85.06%
- YTD 2017/18 – 83.6%, no national performance has been published at this time
- April MTD – 82% at the time of writing

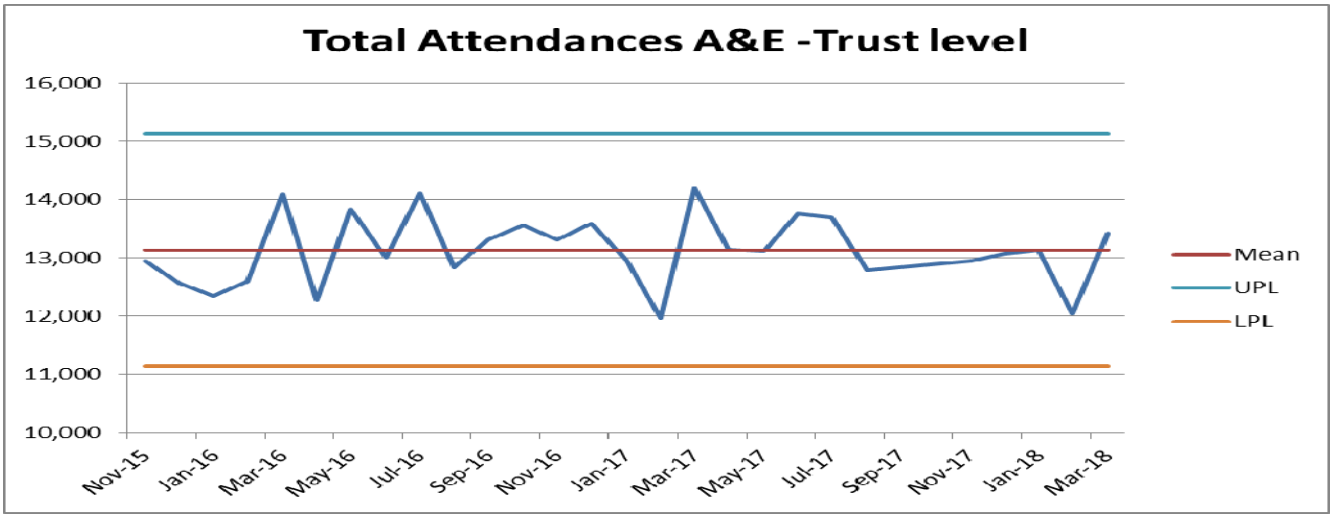
2.1 March Performance Breakdown

- QEII –achieved 99.66% with 12 patients exceeding the 4 hour standard. For quarter 4 QEII achieved 99.71% with 29 patients exceeding the standard
- Lister adult performance 59.19% with 2745 patients exceeding the standard
- Lister minors performance 82.12% with 2401 patients exceeding the standard
- Non admitted performance 89.8% with 1058 patients exceeding the standard
- 64.76% of patients were triaged within 15 minutes
- Admissions / conversation rate from Lister (type 1) was 33.2% and remains within normal variation, although March is the third consecutive month below the mean.



N.B. Sept & Oct 2017 data has been excluded

- Overall attendances were 13426 for March 1384 more than in February. However when February's data is 'normalised' to the same number of days as March the attendance activity is comparable. Activity was down by 782 attendances when compared with the same period in 2017. However as demonstrated below attendance volumes remain within normal variation.



N.B. Sept & Oct 2017 data has been excluded

2.2 ED Interventions / Recovery Actions:

- Improving Minors / non admitted breach performance at Lister – Target >90% daily by July 2018

The physical building work at the front of the department is almost complete. It is expected that by 23rd April the trust will be able to fully utilise the new facilities providing greatly enhanced streaming and assessment at the front of the department.

Patients presenting to the ED will be streamed on arrival by a senior nurse or doctor to a range of options, including ambulatory care, 'hot' clinics, a GP or the assessment units.

Further work is required to ensure that the minor's stream is protected at night to ensure rapid turnaround and avoid this group of patients merging into majors. Changes to the ENP working times are needed to support this.

- Earlier senior clinical decision making

A rapid assessment and treatment model has been implemented (DART) to ensure earlier senior decision making is in place. This process has been trialled within the department and has recently been used during periods of escalation, however the intention is to make this more business as usual over the coming weeks provided staffing levels are suitable.

From the 23rd April, once the new streaming facilities 'come online' there will also be additional space and resources to rapidly assess and treat more minor category patients using the GP streaming model. It is anticipated that this development will improve the performance for the non-admitted patients.

- Nervecentre improvements

Further work is required to optimise Nervecentre and provide an effective operational / flow management function that supports the ED staff to identify delays in the patient's pathways and escalate as identified. This is being managed through the Lorenzo stabilisation work programme.

2.3 Key Risks to Delivery:

- Recruitment to senior medical posts in the ED, there are currently 4 consultant posts vacant and being advertised
- Whilst the Red to Green / SAFER initiative have shown some promising early improvements and length of stay reductions on the pilot wards, sustaining those benefits is challenging and requires a relentless focus and senior oversight. To prevent exit block from the ED and assessment areas it is vital that improvement in this area continues and becomes part of the trusts 'normal' business activities
- Nursing workforce gaps continue to be challenging, during periods of reduced staffing there is often a reduction in compliance with SAFER & Red to Green escalations
- Whilst the senior decision making model (DART) has been implemented there is differences in the level of clinical commitment to the model that results in an inconsistent approach depending on the staff on duty
- Whilst professional responsive standards have been implemented there are still relatively lengthy delays in some areas where another speciality is asked to assess the patient in the ED. The current systems do not easily allow for the reporting of compliance against these internal standards and work is ongoing with Nerve Centre to enable more visibility of these standards.

3. Cancer

Cancer performance is reported retrospectively, February's finalised position is shown below.

Performance February 2018

Target	Goal	Threshold	Month	Quarter 4	Year 17/18	Nat Average (Feb)	Nat Average Qtr (Q3)
Target Referrals							
Cancer Referral to 1st Outpatient Appointment	< 14 Days	93.0%	97.6% ▲	97.5% ▲	97.7% ▲	95.2%	94.9%
Referrals with Breast Symptoms (wef January 2010)	< 14 Days	93.0%	100.0% ▲	97.6% ▲	94.0% ▼	94.1%	95.1%
Cancer Treatments							
Decision to Treat to 1st Definitive Treatment for all Cancers	< 31 Days	96.0%	92.4% ▼	94.0% ▼	92.7% ▲	97.6%	97.7%
Referral to Treatment from Consultant Upgrade	< 62 Days	90.0%	81.0% ▲	78.4% ▲	72.6% ▼	87.0%	88.4%
Referral to Treatment from Screening (62 Day)	< 62 Days	90.0%	100.0% ▲	68.0% ▼	68.8% ▼	88.0%	90.7%
Second or Subsequent Treatment (Anti Cancer Drug Treatments)	< 31 Days	98.0%	97.0% ▲	93.9% ▼	95.7% ▲	99.6%	99.5%
Second or subsequent treatment (Radiotherapy Treatments)	< 31 Days	94.0%	93.6% ▲	90.6% ▼	89.7% ▼	97.7%	97.5%
Second or subsequent treatment (Surgery)	< 31 Days	94.0%	92.3% ▲	87.2% ▲	86.1% ▲	95.4%	95.6%
Urgent Referral to Treatment of All Cancers	< 62 Days	85.0%	80.3% ▲	75.3% ▼	73.1% ▲	80.8%	82.9%
Urgent Referral to Treatment of All Cancers (following breach reallocation)	< 62 Days	85.0%	- ◀	- ◀	- ▲	-	-

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

Target	Goal	Threshold	Month	Quarter 4	Year 17/18	Nat Average (Feb)	Nat Average Qtr (Q3)
By Tumour Group							
Breast Cancer							
Decision to Treat to 1st Definitive Treatment for Breast Cancer	< 31Days	96.0%	100.0%	100.0%	98.6%	98.2%	98.7%
Urgent Referral to Treatment of Breast Cancer	< 62 Days	85.0%	100.0%	100.0%	90.8%	91.2%	94.7%
Colorectal Cancer							
Decision to Treat to 1st Definitive Treatment for Colorectal Cancer	< 31Days	96.0%	83.3%	90.4%	92.7%	97.5%	98.0%
Urgent Referral to Treatment of Colorectal Cancer	< 62 Days	85.0%	75.0%	61.9%	59.2%	73.6%	73.5%
Gynae Cancer							
Decision to Treat to 1st Definitive Treatment for Gynae Cancer	< 31Days	96.0%	92.9%	96.0%	98.5%	97.0%	97.1%
Urgent Referral to Treatment of Gynae Cancer	< 62 Days	85.0%	46.2%	33.3%	71.3%	75.4%	79.4%
Haematology Cancer							
Decision to Treat to 1st Definitive Treatment for Haematology Cancer	< 31Days	96.0%	90.0%	89.3%	96.5%	99.4%	99.6%
Urgent Referral to Treatment of Haematology Cancer	< 62 Days	85.0%	100.0%	67.9%	66.9%	76.9%	80.5%
Head and Neck Cancer							
Decision to Treat to 1st Definitive Treatment for Head and Neck Cancer	< 31Days	96.0%	100.0%	93.8%	92.7%	94.9%	94.5%
Urgent Referral to Treatment of Head and Neck Cancer	< 62 Days	85.0%	28.6%	37.5%	57.6%	94.8%	65.5%
Lung Cancer							
Decision to Treat to 1st Definitive Treatment for Lung Cancer	< 31Days	96.0%	100.0%	98.1%	96.5%	98.1%	98.1%
Urgent Referral to Treatment of Lung Cancer	< 62 Days	85.0%	73.7%	67.4%	59.0%	72.4%	72.7%
Sarcoma, Brain & Other Cancer							
Decision to Treat to 1st Definitive Treatment for Sarcoma, Brain & Other Cancer	< 31Days	96.0%	100.0%	100.0%	98.0%	100.0%	98.3%
Urgent Referral to Treatment of Sarcoma, Brain & Other Cancer	< 62 Days	85.0%	NIL	100.0%	59.7%	NIL	71.1%
Skin Cancer							
Decision to Treat to 1st Definitive Treatment for Skin Cancer	< 31Days	96.0%	100.0%	100.0%	97.9%	98.6%	97.5%
Urgent Referral to Treatment of Skin Cancer	< 62 Days	85.0%	94.9%	92.9%	94.6%	95.9%	95.3%
UpperGI Cancer							
Decision to Treat to 1st Definitive Treatment for UpperGI Cancer	< 31Days	96.0%	100.0%	100.0%	96.2%	98.6%	98.8%
Urgent Referral to Treatment of UpperGI Cancer	< 62 Days	85.0%	60.0%	59.5%	67.8%	72.5%	74.8%
Urology Cancer							
Decision to Treat to 1st Definitive Treatment for Urology Cancer	< 31Days	96.0%	79.6%	84.5%	78.3%	96.0%	96.3%
Urgent Referral to Treatment of Urology Cancer	< 62 Days	85.0%	75.5%	75.0%	63.6%	76.3%	79.5%

The Trust did not achieve against the 62 day national standard but did achieve against the recovery trajectory and missed the national standard by 0.6% after breach sharing. See table below for trajectory.

	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
	Finalised									
Trajectory Pre Sharing							70.6%	75.2%	78.5%	81.0%
Pre-breach sharing actual	65.0%	71.0%	69.5%	73.2%	76.8%	75.5%	79.9%	71.4%	80.3%	
Trajectory Post Sharing							74.90%	78.30%	82.50%	85.00%
Post-breach sharing actual	66.4%	74.9%	72.2%	78.8%	79.1%	80.3%	80.5%	76.6%	84.4%	

3.1 Cancer Key Actions:

Significant senior management oversight continues regarding performance with additional enhancements having been implemented ensuring senior divisional ownership. Commencing this month, April, each tumour site will complete an assurance overview summary for discussion at the main trust level access board detailing issues, actions and mitigations.

Furthermore the second stage review of the trusts three tier PTL reviews has been altered to reflect the changes to the PTL profile over recent months. The second tier review, which is chaired by the access manager with the general managers focus' on breach avoidance and checking compliance with waiting time rules and standards, flagging any patients that need to have their appointment dates brought forward.

There is significant work from within the informatics department, the Lorenzo stabilisation team and the main performance team to try and understand some of the recent changes to the total size of the cancer PTL. This is probably the single most important issue at this time as the current level of growth in the PTL size is significant and not currently fully understood.

Additional non-recurrent funding was made available in late summer last year for a small number of projects aimed at supporting the recovery of the 62 day standard. The trust commissioned an external party to build a capacity and demand model that could be used going forwards to ensure that capacity was sufficient to achieve the cancer standards. Whilst the model has been slightly delayed from the original completion timeline of the end of March, a version is now available and is being tested by the division, it is anticipated the model will be completed by the end of April and could be used to inform capacity discussion on an ongoing basis.

3.2 Cancer Key Risks

The current cancer and performance manager has left the organisation and there is no immediate succession plan. Recruitment into the post will be commenced following a review of the current structure and banding of this role.

Additional temporary workforce has been deployed within the cancer performance team to try and stabilise the current tracking processes. The team had been subjected to a restructure prior to being moved to the operational performance team and team members are challenging the viability of current structures. It is probable that additional changes will be required in the short term and potentially a subsequent large scale change in coming months.

The operational cancer performance team requires considerable development and support; the team has not had consistent leadership for many years with multiple changes in management and direction. The team dynamics are not ideal and some of the functions of the roles have become blurred over time, adding to issues and performance challenges.

The team is currently being line managed by the interim access and stabilisation lead who is an experienced manager. With support from Steve Andrews a longer term team development plan is also being developed with the aim to establish an improved team dynamic with much improved relationships within the team.

4. RTT

4.1 RTT – 18 weeks

Following the migration to Lorenzo the trust is unable to report performance against the RTT standard. The trust continues to work towards returning to national reporting in November reporting October's performance, subject to the ongoing stabilisation program.

Following release of the technical guidance for operational and activity plans 2018/19 trust are expected that during 2018/19 their respective RTT open pathway performance does not drop to below the level reported in March 2018, and that the number of patients waiting more than 52 weeks for treatment should be halved by March 2019. As the trust has not returned to national reporting, the trust is unable to benchmark its current March 2018 position, therefore following further discussion with NHS Improvement trust that are not reporting nationally have been given the following advice:

- Total waiting list trajectory not required as part of planning round
    - In advance of providers re-entering national reporting, a total waiting list trajectory will need to be developed and agreed – with expectation of 'stay still' from point of re-entry to year-end (allowing for seasonality)
- No requirement for submission of 52 week wait trajectory during planning round
    - In advance of providers re-entering national reporting, a 52 week wait improvement trajectory will need to be developed and agreed – with expectation of at least 50% reduction by end of FY 18/19

4.2 RTT Stabilisation

4.2.1 PTL Development

The first of the Superview PTL (OP New) went live on 22nd March. Go live followed rigorous user testing and training which undoubtedly contributed to the very low level of reported post go-live user problems. Overall it has been very well received by users.

- Superview FU PTL will go live on 19th April
- All remaining PTL including the RTT incomplete PTL will go live on 11th May

Effective user testing and training has been a key enabler in the roll out of the first PTL, this will be strengthened further in future planned roll outs by including Lorenzo / RTT re-fresher training alongside PTL sessions in the run up to 11th May.

4.2.2 Validation Update

The validation strategy continues to strike a balance between the validation of "live" incomplete pathways and closed pathways where there is a risk of user error removing patients incorrectly.

Open Pathways

- All active RTT patients > 18 weeks are validated
- 12K active RTT patients < 18 weeks are validated

Validated clock stops for patients attending in next 2 weeks	3,892
Clocks closed in error and re-opened	137
Error rate	4%
Error rate reported Feb 2018	23%

This is a very encouraging improvement and is a function of the intensive validation program and greater scrutiny and intervention at operational level.

Note:

Retrospective validation of clock stops in high risk specialties continues to show concerning levels of incorrect clock stops. Causal factors will be described and measured and will inform our immediate training strategy.

4.2.3 Clinical Harm Review

All patients who trigger a clinical harm review are logged by the Divisions on a central tracker maintained by the Trust data quality team.

52 week breaches

There are currently 80 patients being tracked through the clinical harm process.

- 11 have been completed and no harm reported
- 69 are in progress

Non 52 week breaches

Over March and April 2 SIs and 2 IRIs have been brought to the bi-weekly SI panel relating to cancellation or delays in appointments

SI/IRI	Division	Category	Level of Harm
SI	Cancer	Capacity	Moderate
SI	Cancer	Care related	Minor
IRI	Women & Children's	Care related	Minor
IRI	Women & Children's	Care related	Moderate

4.2.4 Patient tracking

There has been a marked improvement in the numbers of patients dated at the FU and Admitted stages of treatment. Whilst this is encouraging, the numbers of patients overall waiting more than 40 weeks for treatment continues to rise. Tracking of long waiters within Divisions will be strengthened to mitigate the risk of increasing 52 week waiters.

Comparing the numbers of patients dated at each stage of RTT treatment

	28 Feb	Current	% Change
1st OP	13,339	12,928	-3
FU	3,795	4,778	+26
Admitted	764	1,587	+108

4.3 52 week Standard

Using the incomplete PTL from 11th April the trust has now confirmed that a total of 80 patients have waited over 52 weeks from referral for their first definitive treatment. At the time of writing, 45 of the patients have subsequently been treated or their pathways closed, 35 patients remain waiting treatment.

Given the scale of the data quality and technical issues it is probable that more patients will exceed 52 weeks until the position has stabilised further and the confidence level in the PTL's has increased.

5. Diagnostic Standard (DM01)

The trust has not been able to report the DM01 performance in March as a consequence of moving to the new PAS (Lorenzo). The trust is working towards returning to national reporting in November reporting October's data.

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	
Dec-17	No submission	
Jan-18	No submission	
Feb-18	No submission	
Mar-18	No submission	

Stroke

January's stroke performance data was presented to the committee last month, no further validated performance data is currently available at this time.

The trust was previously reporting stroke data using a separate system, Network records, however this was creating duplication of work as the information was also required to complete the SSNAP reporting, furthermore it transpires that SSNAP records patients that suffer a stroke as an inpatient differently to that being recorded on Network records. As SSNAP is the main national registry for stroke data the decision was made by the division to report from SSNAP only. February and March's data is currently being validated and finalised and is therefore not available at this time.

It is anticipated that reporting via SSNAP will show a deterioration in the performance metric that measures how quickly patients are transferred to the stroke unit due to the recording of patients that suffer from a stroke whilst already an inpatient within the hospital.

Full details will be provided in next month's report.

** End of document **

Agenda Item: 9.3

FINANCE AND PERRFORMANCE COMMITTEE – 2 MAY 2018

Workforce & OD Board Report – Month 12

PURPOSE	To present an update to the Trust Board on Workforce and OD key work streams and issues.
PREVIOUSLY CONSIDERED BY	Monthly standing item
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. [ ] 2. **Developing new services and ways of working** – delivered through working with our partner organisations [ ] **3. 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)	Financial: increased workforce costs HR: failure to meet agreed standards Legal: failure to meet CQC and other national standards Patient Safety: failure to maintain appropriately trained workforce
Healthcare/ National Policy (includes CQC/Monitor)	
CRR/Board Assurance Framework *	[√] **Corporate Risk Register** [ ] **BAF**

ACTION REQUIRED *

For approval	[ ]	For decision	[ ]
For discussion	[ ]	For information	[x]

DIRECTOR:	Chief People Officer
PRESENTED BY:	Chief People Officer
AUTHOR:	Deputy Director of Workforce
DATE:	27 April 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

APRIL 2018

BASED ON MONTH 12 DATA

Key Headlines

Executive Summary

Trust workforce report for month 12:

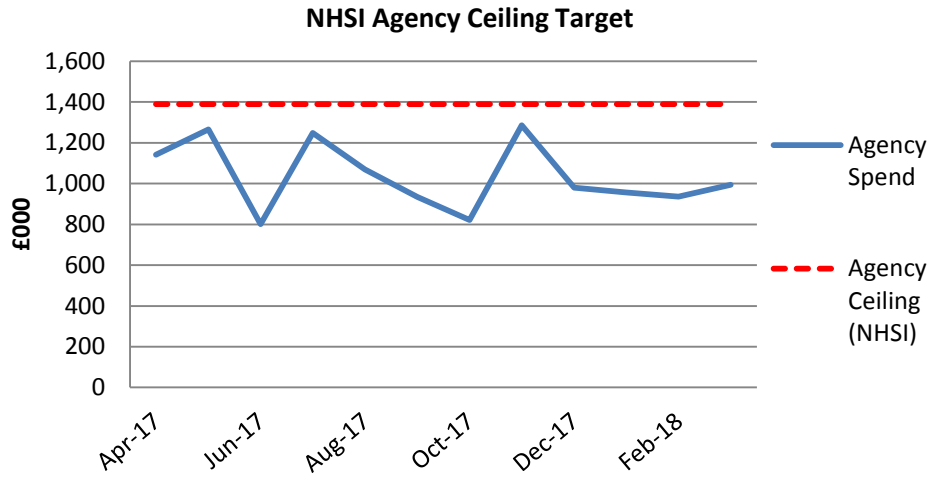
- The Trust ended the year £12,424k expenditure on agency which was £4,256k under the agency ceiling target for the year (positive variance of 26%)
- The vacancy rate at the end of March 2018 was 8.4% (469.7 WTE) and indicates positive improvement from the start of the financial year (11.9%)
- A detailed Sickness Absence Action Plan has been developed, including the launch of the revised policy. The new policy, which provides a more consistent and robust framework for managing sickness absence, was launched on 26th March. The implementation is being supported by a high number of training sessions targeted at all managers who have a responsibility for managing sickness absence.
- A Staff Survey Action Group has been formed to respond to the 2017 Staff Survey and the ‘online staff survey staff workshops’. Staff identified themes will be progressed by executive sponsors.

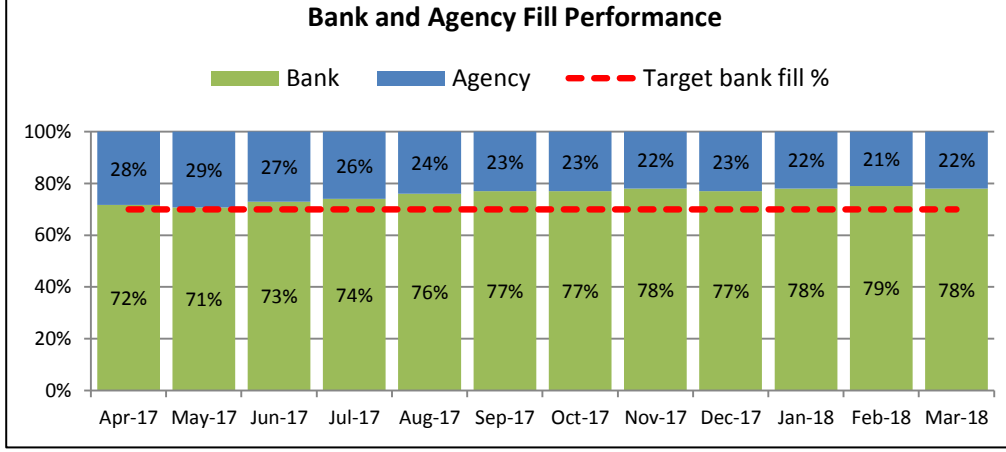
Workforce Board Report

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 Trust ended the year with £12,424k expenditure on agency which was £4,256k under the agency ceiling target for the year (positive variance of 26%). The 18/19 agency ceiling is £12.4m and the Trust is already in a strong position to achieve this and expects a positive variance to target again.

Month 12 spend was below plan for Medical and Other Clinical and significantly lower when looking at year to date for all groups. However, Nursing and Non-Clinical overspent against the plan, both with increases in agency. Nursing increases relate to improved fill in March to meet extra demand for winter pressures. Non-Clinical costs have increased greatly in month, some of which relates to a correction of M11 reported figures within IM+T Department.

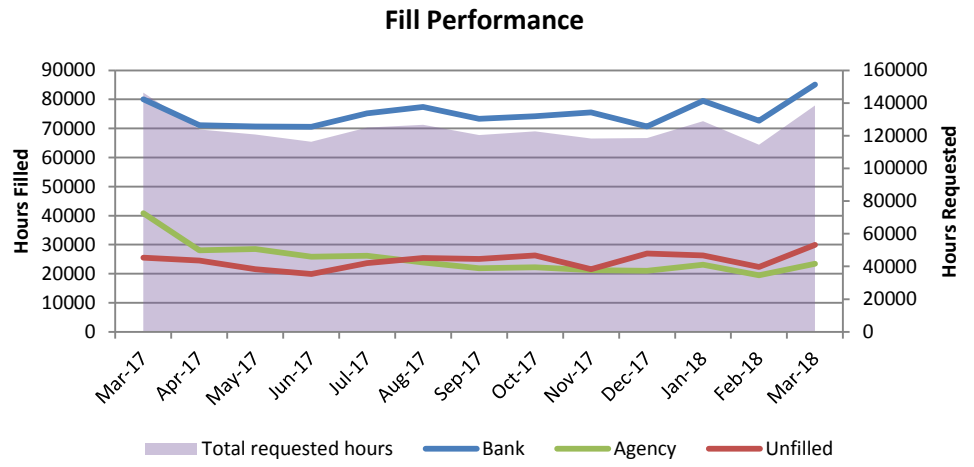
Medical Staff costs have reduced in month mostly within CSS. Within Pathology Microbiology Lab the provision for missing NHSP shifts has been dropped resulting in a reduction in month.

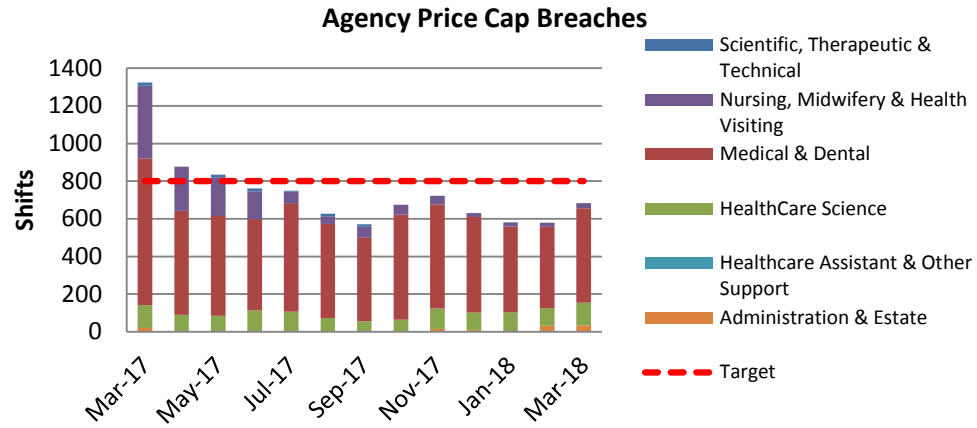
Year on year comparison shows an overall reduction of 21% in temporary staffing expenditure. Agency costs have reduced by 53% and bank has increased by 19%. This transition has been delivered through a comprehensive action plan focusing on key areas including agency controls, bank recruitment, regional collaboration, demand management and staff engagement.

Shared bank: With The Bank Network now embedded with three Hertfordshire Trusts, the Trust is now reviewing how this could be expanded further including a review of the software available to facilitate this. Department of Health Bank Flexible Working Pilot has been approved in principle which is set to significantly enhance bank offer.

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:

Fill rate improvement initiatives: The team of 'Rapid Response' staff was increased to enable short notice deployment of staff to 'red' wards. A CSW working group has been in place for one month to look at the 'end to end' experience for a bank CSW with a proposal to be submitted shortly to improve the Bank pay rate. A project is underway which is aimed at increasing the proportion of Trust employed staff who are active on the bank. In March there was a significant increase in bank shifts filled and work needs to be undertaken in how to maintain the rate.

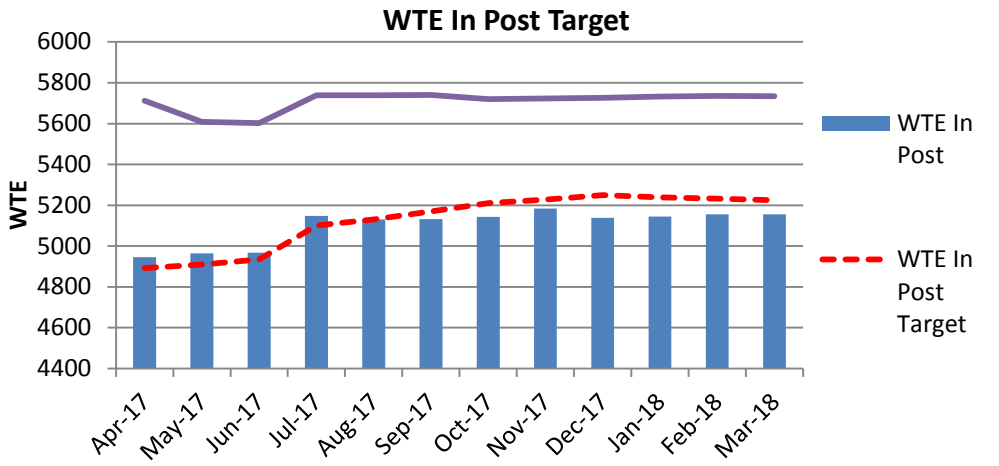
Internal Temporary Staffing Office, Doctors (TSOD): Work is ongoing with the pan London procurement group to review the Hertfordshire ceiling rates with their rates for Doctors. Benchmarking data shows that Hertfordshire are paying higher agency rates on average than London therefore further work is required to achieve alignment. A meeting has taken place with Trusts across the East of England to plan how this is taken forward. ED has now moved onto the rostering platform and is settling well aligning with TSOD – further divisions expected to follow in May

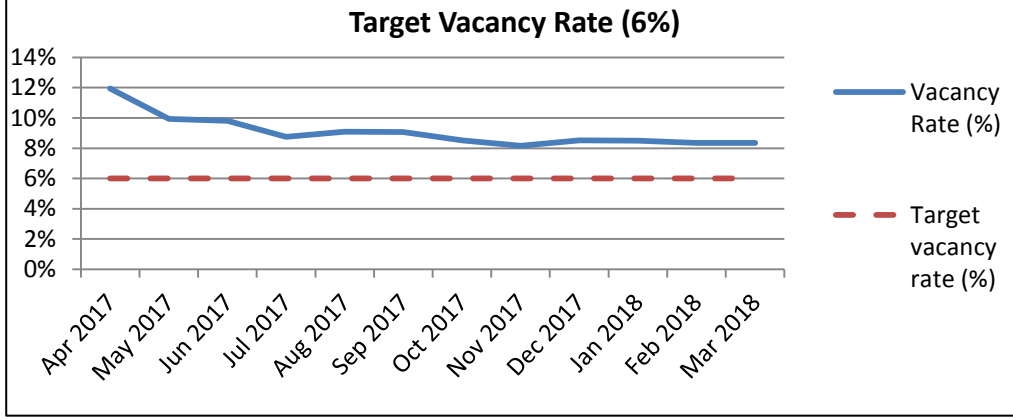
Agency Breaches: Priorities remain on reducing Medical breaches, March's slight increase in A&C is due to additional staff in Finance. Exploring Medical bank pay rates as part of EoE consortium, workshops to be held 16th/17th April which will focus on a programme to reduce agency pay rates. The only nursing breaches are for chemotherapy staff, however the number of shifts are reducing.

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 applied to this through Grip and Control.

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:

Total WTE in post in month 12 decreased by 1.1 WTE to 5154.7 WTE compared to month 11. There was a total of 69.6 WTE starters in March against 77.6 WTE leavers giving a net decrease of – 8 WTE.

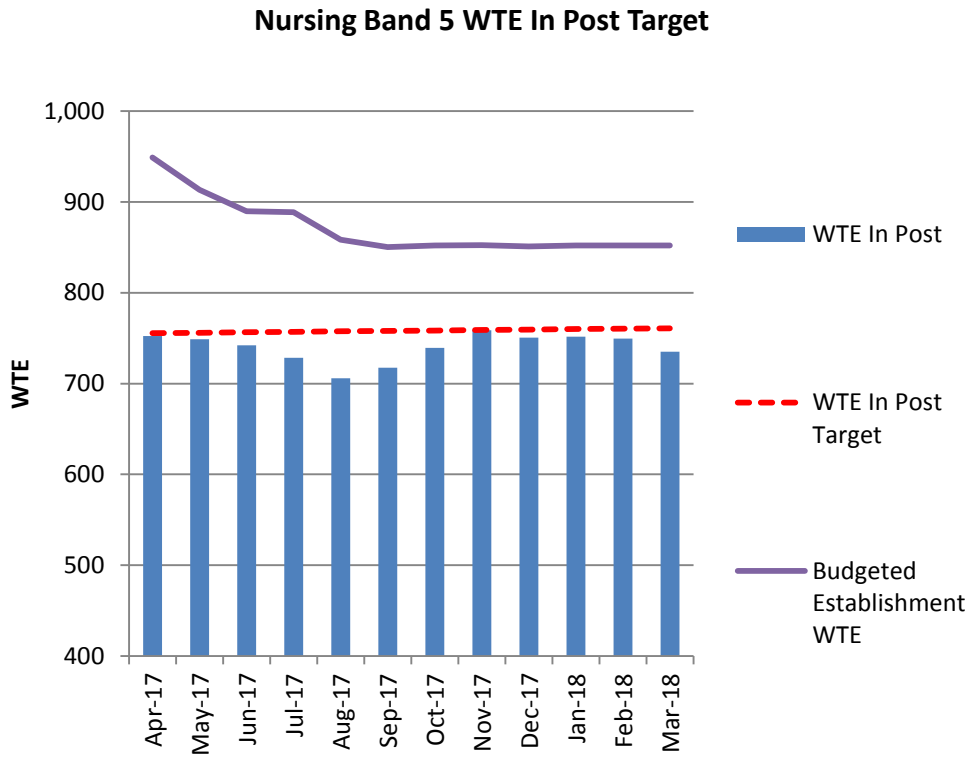
Month 12 reported figures were 70.5 WTE below the in-month and end of year recruitment target. There are currently 247.8 WTE external candidates undergoing pre-employment checks or waiting to start with the Trust. There will be an increase of new employees compared to March's new starter figures in April 2018; with a projection of 41 WTE new starters across all staff groups.

The vacancy rate at the end of March 2018 was 8.4% (469.7 WTE) and indicates positive improvement from the start of the financial year (11.9%). The vacancy rate is based on the posts actively being recruited, excluding bank and agency lines. Based on regional benchmarking of 12 organisations the Trust has the second lowest vacancy rate (appendix 1).

New recruitment targets are being set up in partnership with the divisions targeting areas of high agency spend. The re-set of recruitment targets will be supplemented by a Trust-wide Recruitment Strategy to provide the organisation with the strategic direction in which the Trust will work towards recruiting and retaining a highly skilled and dedicated workforce.

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:

Band 5 nurses in post decreased by 14.3 WTE in March taking the total number of Band 5 nurses to 735 WTE. A total of 19.5 WTE nurses commenced employment in March, however 29.4 nurses left in month. This meant the Trust was 25.8 WTE away from the in-month and end of year target.

The Trust's vacant posts for Band 5 registered nurses at the end of March was 116 WTE, this equates to a vacancy rate of 13.7%.

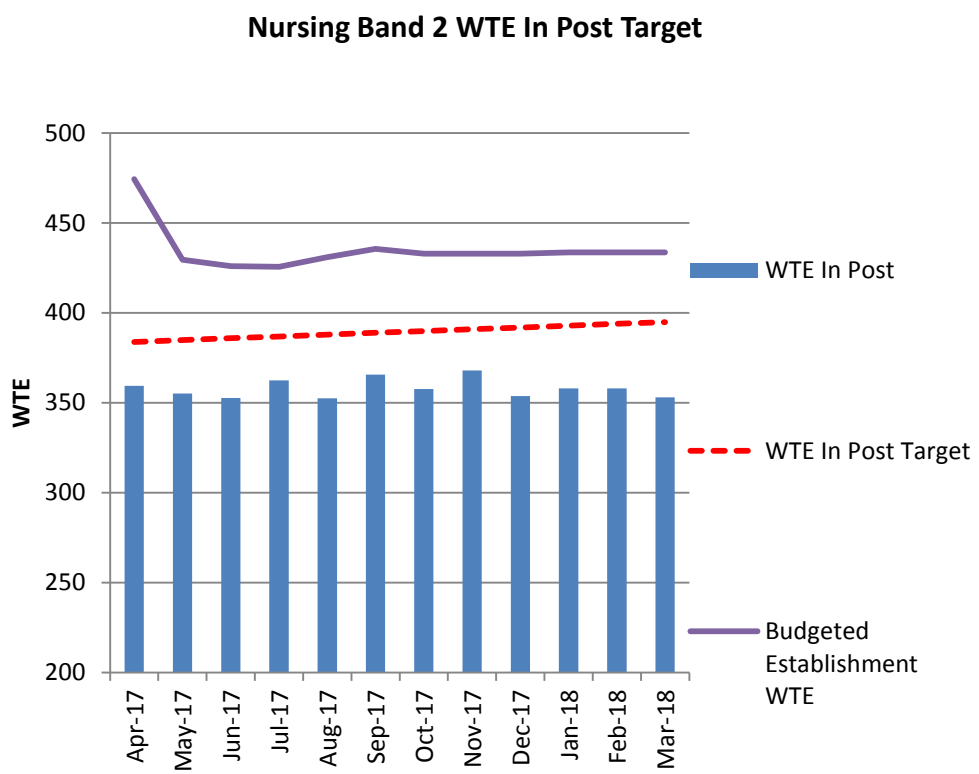
There are currently 170 WTE external band 5 qualified nurse candidates undergoing pre-employment checks or awaiting to start with the Trust. The Band 5 nurse trajectory has 10 WTE new starters for April 2018 with a cohort of 5 nurses from the Philippines.

The Trust is taking an active lead on the STP Recruitment & Attraction Workstream. Current work underway is a joint Band 5 Recruitment Open Day to be held in May 2018. The campaign will target nurses who live within the STP but commute into London for work using radio, newspaper and social media to promote the Recruitment event.

The Trust is expanding the network of suppliers for international recruits and is actively pursuing new way to increase the number of the international cohort.

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 decreased slightly by 4 WTE from February to March with the total number of 353 WTE in post. This meant the Trust was 41 WTE away from the in- month and end of year target.

The number of vacant posts for Band 2 CSWs at the end of March was 80 WTE, equating to an overall vacancy rate of 18.6% for CSWs. There are currently 15 WTE CSW candidates going through pre-employment checks and a cohort of 40 candidates shortlisted for the forthcoming assessment and interview round. It is projected 7 WTE CSWs will commence employment in April 2018.

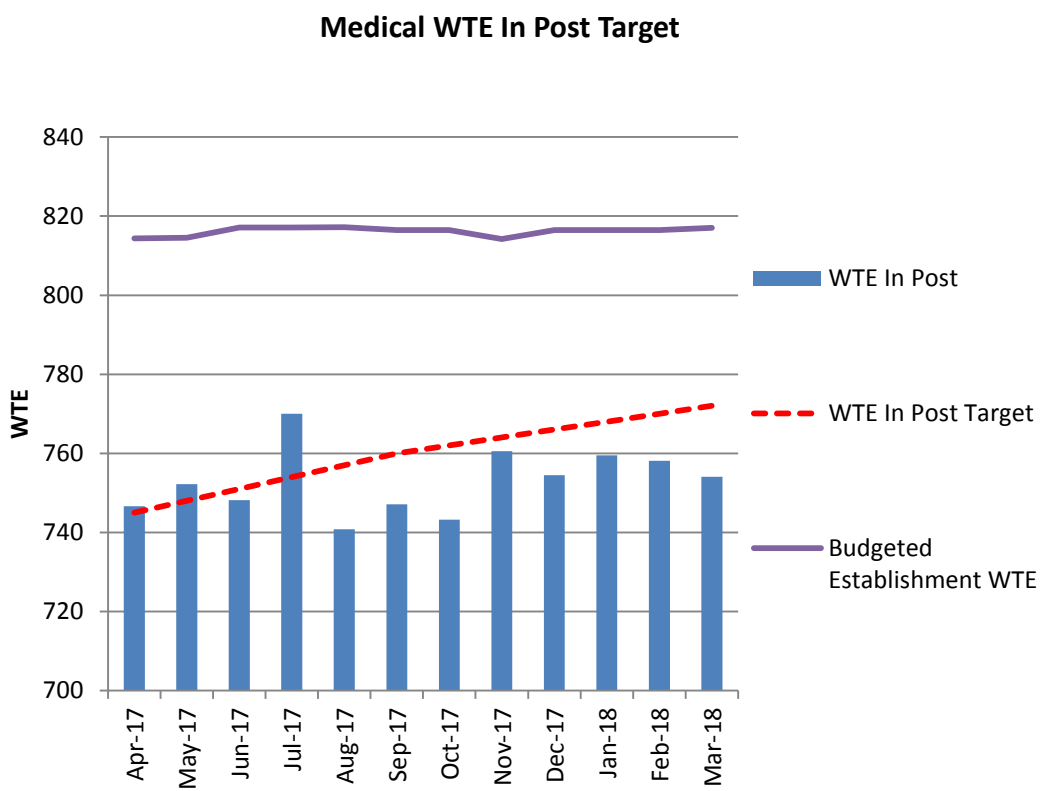
There are further assessment and recruitment events planned until the end of the calendar year with employment start dates in line with the Preparation to Practice Course which is now being scheduled every month as opposed to every 2 months.

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.

The CSW Working Group continues to meet and collaborate with Nursing and Temporary Staffing teams to improve attraction and retention and to 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:

For all non-training grades there were 8 WTE Medical staff were appointed in March 2018 and 5 WTE leavers; resulting in a net increase of 3 WTE for the month, overall there was a reduction of 4 WTE. April is projected to have 11 WTE starters in the pipeline and 7 WTE scheduled to leave. There are a total of 23 new starters in the pipeline, 17 with agreed start dates.

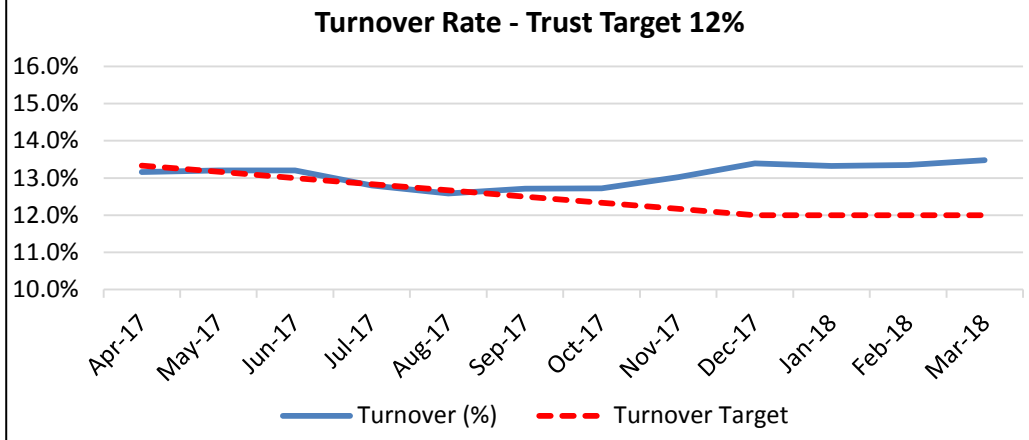
The trust has developed an efficient and pro-active Resourcing team working closely with the divisions on recruitment plans and expediting recruitment processes. New staff are made to feel welcomed upon joining the Trust. International recruits have support from a relocation company who help with airport pickups, finding schools and accommodation in the local area.

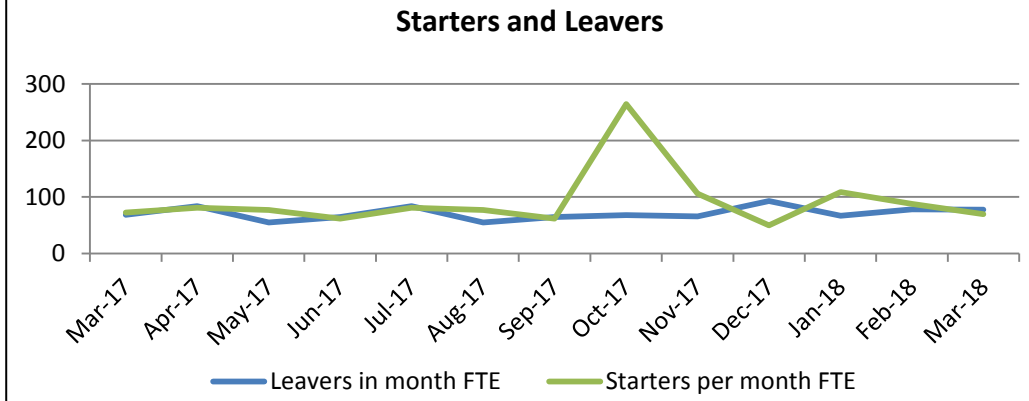
There is ongoing work on retention following feedback gathered from new starters and leavers. Focus on on-boarding is required for new starters, specifically from overseas during the first three months of starting. Staff listening events have are held for Plastic Surgery and Emergency Medicine so that doctors can be given the opportunity to provide their views on their experiences in the job roles to avoid potential staff turnover.

Consultant adverts are being looked at so that when they go into the BMJ they are a lot more succinct and attractive to potential candidates. A process is being drawn up to ensure the sign off for external adverts within the Division is timely.

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.





Headlines:

Turnover rate in month 12 was 13.48% (increase of 0.13%), leaving the Trust 1.48% above in month and end of year target. In month 12 the number of leavers reduced slightly from 78.4 to 77.6.

The Trust retention plan for 18/19 aims to reduce turnover to 12% for all staff groups and 10.5% for nursing and midwifery staff. The plan covers the four key areas as follows:

Improved experience of staffing levels – Continued focus on Re-set Tuesday to ensure staff movements on the day are kept to a minimum. The initiative now needs to be developed further to ensure it can be sustained and potentially developed further. The retention steering group continues to influence and support development of the recruitment strategy, with particular focus on CSW recruits.

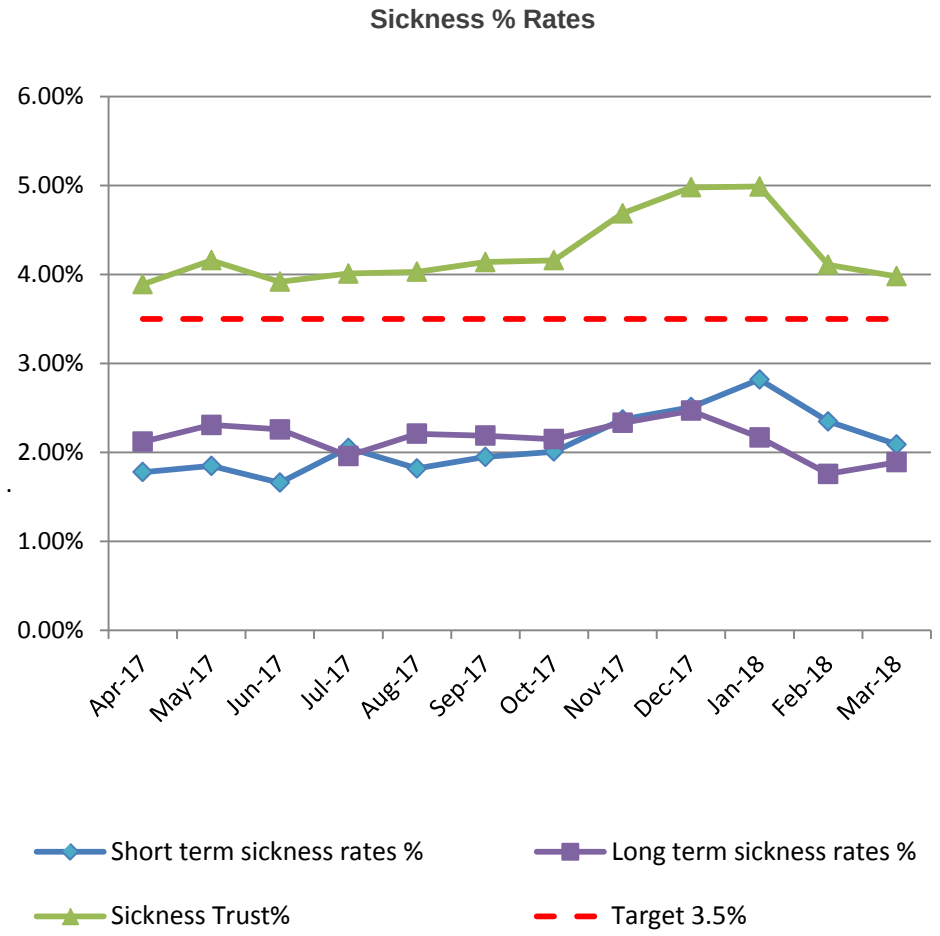
Improved clinical management and team development - An area of focus has been Acute Paeds and Neo-natal where work is being undertaken improve team dynamics creating a high performing team. Also support has been provided working with managers in Cancer Services.

Enhanced employment offer and staff benefits - Flexible working opportunities remains one of our core offering to staff and self-lead rostering promoted in all e-rostered departments. The workforce team will be in the next phase of the roll-out. Review of technology is underway to introduce an app-based service which promotes trust benefits.

The group are undergoing a data review to identify key groups of staff and hot spot areas to target. The will lead to more local based initiatives to improve retention.

4. ER Sickness Management

Strategy: To reduce and maintain an in-month sickness absence rate below which is Trust target of 3.5% in 2018/19. 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:

The in-month sickness absence rate decreased from 4.11% in February 2018 to 3.98% in March 2018; this is mainly as a result of the short term sickness absence rate reducing from 2.35% in February to 2.09% in March 2018. The overall number of WTE days lost due to sickness absence increased to 6354 which is an increase on the previous month of 423 – this is a result of an increased LTS cases. At month end there were 99 individuals absent due to ongoing long term sickness.

A detailed Sickness Absence Action Plan has been developed, including the launch of the revised policy. The new policy which provides a more consistent and robust framework for managing sickness absence was launched on 26th March; supported by a high number of training sessions targeted at all managers who have a responsibility for managing sickness absence. Sessions have been well attended to date and FAQ's have been regularly updated taking into account any key queries or issues arising from the launch of the policy.

In accordance with the revised policy – all stages of the procedure for managing short term sickness are considered formal and ERAS has seen an increased number of cases referred to us during April for support, guidance and attendance at formal meetings. The next stages of implementation are as follows;

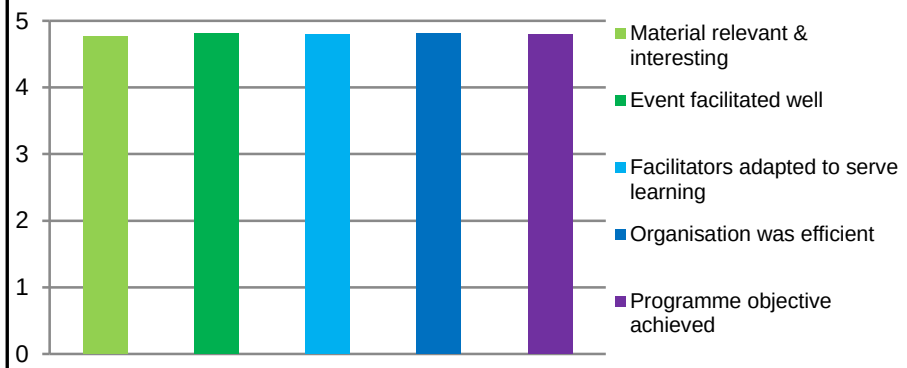
- To identify any supervisors / managers who have not attended a policy update session and liaise direct to ensure attendance.
- To develop the Bradford Score reporting and link with Qlikview to ensure Divisional oversight of cases that are being proactively managed; to support the Divisions in targeting areas where a high number of individuals have reached or exceeded formal trigger points.
- To develop Divisional action plans for addressing sickness absence: focusing on early intervention, key themes and causes for concern and proactive management during 2018/19.

5. Organisational Development

Purpose : To develop the capability and capacity of our workforce and systems in order to influence and inspire a culture in which compassion and effectiveness are the ethos that drives continual improvement.

Division	Number of LMCDP places used April 2016 - March 2018
Cancer	135
CSS	116
Medicine	254
NCS	242
Surgery	240
W&C	132
Total	**1119**

LMCDP Delegate evaluation
February 2018



Headlines:

The LMCDP (Leadership, Management and Coaching Development Pathway) was launched in 2016. In the two years 1119 places were filled by our staff.

Evaluation of the programmes remain excellent both on the day feedback and through 3 post course surveys.

CPD accreditation for all the programmes is almost complete. Submission of our learning outcomes, curriculum and course materials to external bodies has proved a valuable experience and the feedback has been of a high level.

The internal ‘Faculty of Leadership Development’ is growing with colleagues now contributing more than ever before to delivering on our internal programmes.

The Accelerated Director Development Scheme (ADDS) selected Palmer Winstanley (DD Women and Children’s) for development this year.

The ‘On Boarding’ programme has proved to be a great success. As well as being supportive to staff it has improved retention and is now admired by our local partners and is short listed for a HSJ Award.

5b. Organisational Development

Purpose : To develop the capability and capacity of our workforce and systems in order to influence and inspire a culture in which compassion and effectiveness are the ethos that drives continual improvement.

Headlines:

To respond to the 2017 Staff Survey and the 'online staff survey staff workshops' a Staff Survey Action Group has been formed. Staff identified themes will be progressed by executive sponsors.

The NHSi culture toolkit will be deployed in May for the next few months. This is phase 1 of the culture intervention. From this work a set of cultural indicators will be developed and form part of the Trusts accountability framework.

Progress is being made to use the Apprentice Levy to fund BSc and MSc programmes with the Business School at the University of Hertfordshire. Our aim to secure at least 4 places on each.

There has been an increase in bespoke team interventions across the organisation with work in IT, Maternity, Cancer. The use of the organisational values and behaviours provide a consistent approach to all work undertaken

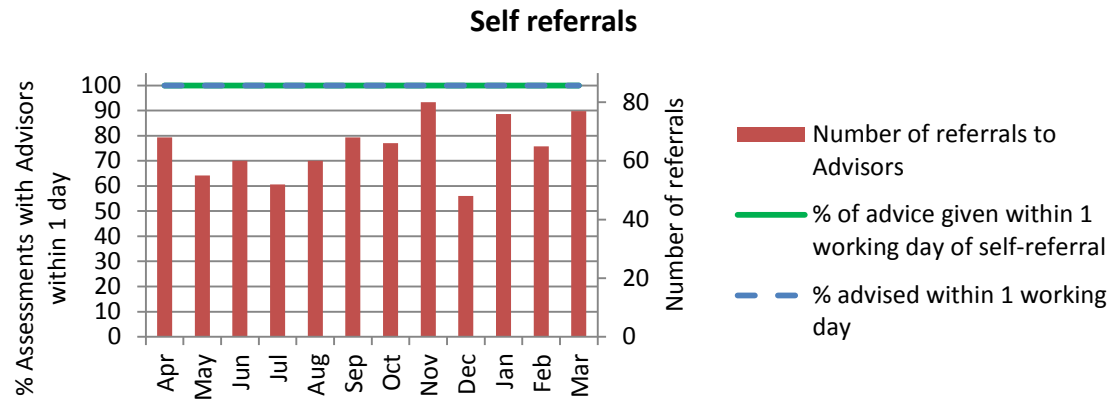
FOR HEALTHCARE LEADERS HSJ VALUE IN HEALTHCARE AWARDS FINALIST

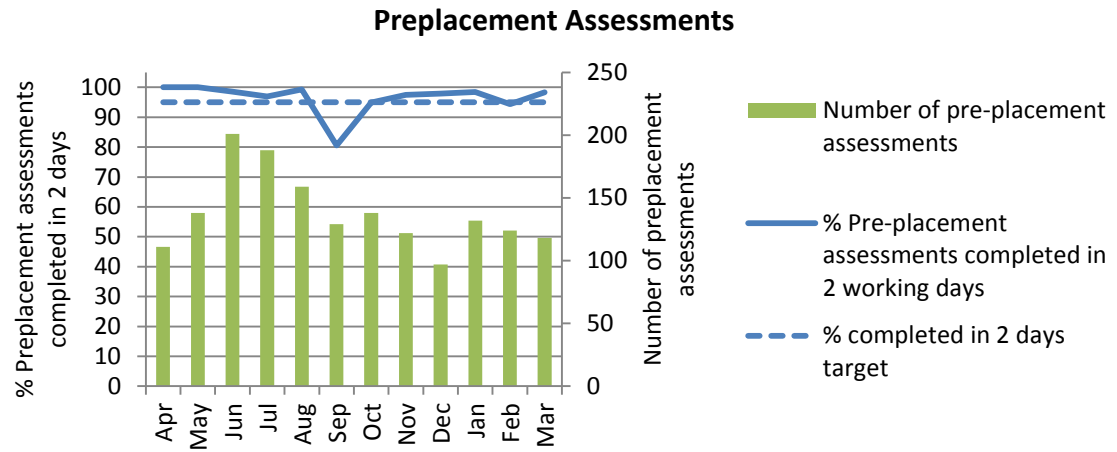
NHS Improvement

University of Hertfordshire UH

6. 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.





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.

In March 77 employees self-referred to Health at Work, all these staff were offered advice about strategies to optimise their health at work within 1 day of the call. The Health at Work Service have consistently been able to offer 100% of employees advice within the same day of a telephone request.

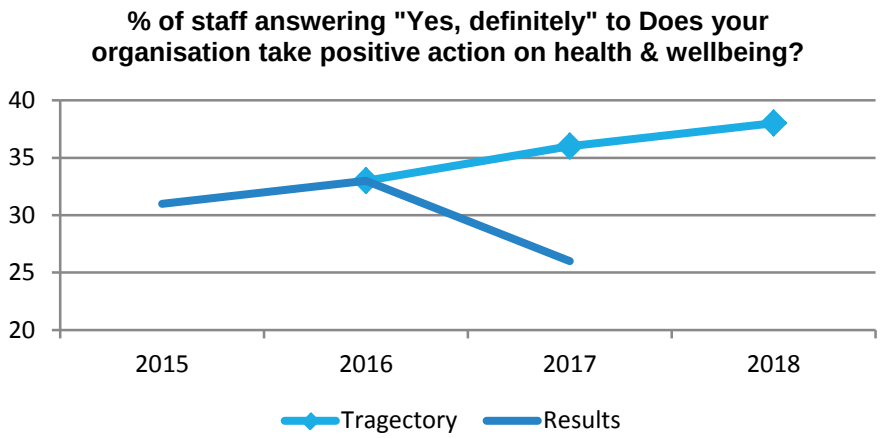
In March 67 referrals were received from managers, 81.8% of employees were assessed by an Advisor within 6 days of referral. Of the 12 employees were not offered an assessment within 6 days, 9 were within 8 days, 2 within 9 and 1 waited 11 days. 100% of advice reports were sent within 2 days.

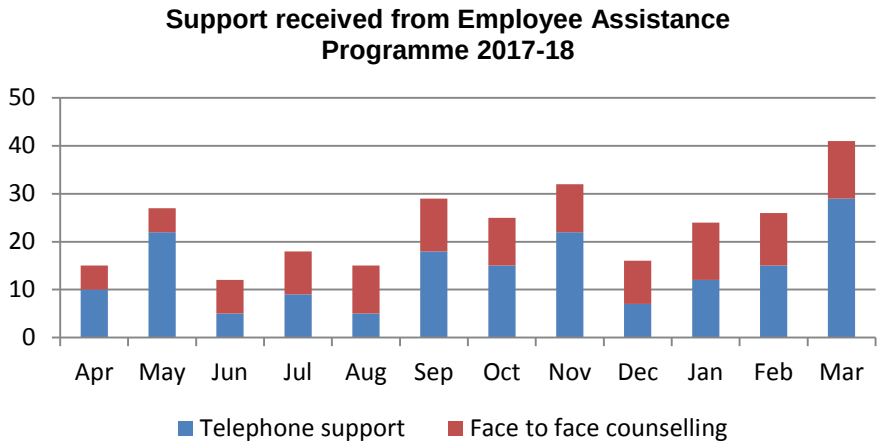
Pre-placement health advice: The Health at Work Service provides the Trust with fitness for work advice on all new employees following an offer of a post.

118 Preplacement health questionnaires were received in March 98.3% of pre-placement health clearances were sent within 2 working days.

6b. 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 Trust targeted a 5% improvement in 17/18 in two of the three NHS annual staff survey questions on health and wellbeing. The actual result showed a decline (7%) although in one of the results (staff experiencing musculoskeletal problems at work) the was an improvement. The decline was representative of the overall decline in staff survey results however the Trust is committed to making the improvement this year and plans are in place to enhance wellbeing services.

An early advice service has been introduced to support staff on the first day of sickness absence due to stress, mental health and musculoskeletal issues.

A fast-track physiotherapy service has been introduced, 191 employees have received fast-track physiotherapy in 2017-18.

Mental health first aid training has been delivered to 112 leaders. Use of the Employee Assistance Programme, which provides free access to confidential advice and counselling, has increased throughout the year.

A network of staff wellbeing champions has been supported to promote and publicise initiatives. The number of champions has increased from 24 to 39.

Staff wellbeing events have been held every month to encourage staff to make healthy lifestyle choices. Events have included, free cholesterol testing, exercise promotion, stress management advice, weight management, onsite exercise classes and mental health promotion.

The Target to vaccinate 70% of frontline staff against flu has been exceeded.

7. 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, informed by the unwarranted variance in the Model Hospital benchmarking and other comparison information.

Workforce Efficiency	Exec Sponsor	Workstream detail	Implementation Timeline	Savings (FYE)	Net savings (pye)	Savings (PYE)
Admin & Clerical	Bernie Bluhm	1. A&C Redesign	August to October	£900,000	£325,000	£450,000
		2. Operational Management	June to July	£500,000	£78,000	£450,000
Nursing & AHP	Rachael Corser	3. NWBN	full year	£174,000	£174,000	£174,000
		4. Nurse Management	June to July	£151,000	£55,500	£75,500
		5. AHP's	August to October	£30,000	£25,000	£30,000
		6. Therapies Review	April to October	£343,000	£340,000	£340,000
Consolidation & Efficiencies	Tom Simons	7. Consolidation of Services	August to October	£150,000	£122,500	£150,000
		8. Grip & Control Function	full year	£3,000,000	£1,750,000	£1,750,000
Corporate Back Office Functions	Rachael Corser	9. Back Office Functions	June to October	£3,000,000	£458,000	£1,308,000
Total Savings				£8,248,000	£3,328,000	£4,727,500

Headlines:

The Workforce Efficiency programme savings was agreed at Programme Board by the Executives and an additional workstream to deliver improved retention of staff, a reduced vacancy rate to 6% and an annualised sickness rate equivalent to the 'best in class'. This new workstreams plan includes £3m gross savings. The revised opportunity for savings in 18-19 year is £8.2m (fye). The Programme includes nine work streams with the changes delivered from April through to October 18.

The overview:

1. There will be a phased approach to savings across the work streams to mitigate risk for Lorenzo stabilisation
2. The Model Hospital benchmarking is informing the savings opportunity with Trust senior leaders input
3. A staff engagement and communication plan will be in place to inform and support managers and staff
4. The work streams for Nursing management, consolidation of Trust teams, e.g. IM&T, Estate and Facilities and the Therapies service review are already under way.
5. The additional work stream which will encompass retention strategy, sickness and vacancy reduction to support staff utilisation on wards and departments. This workstream includes an investment of £1.26m (core expenditure being international recruitment campaign). The saving is driven from a reduction in temporary staffing expenditure with focus on areas with high cost agency and bank.

A short term project resource has been agreed to ensure staff consultations are thorough and supports the workforce redesign, communication with staff and leaders and the delivery of savings within planned timescales. A five step gateway process led by the Chief People Officer, will ensure work streams are on track and reduce the risks and barriers to delivery of savings timeline

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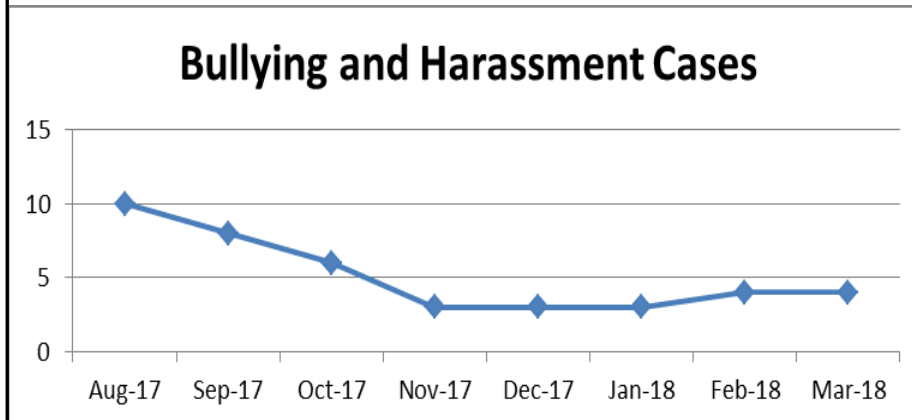
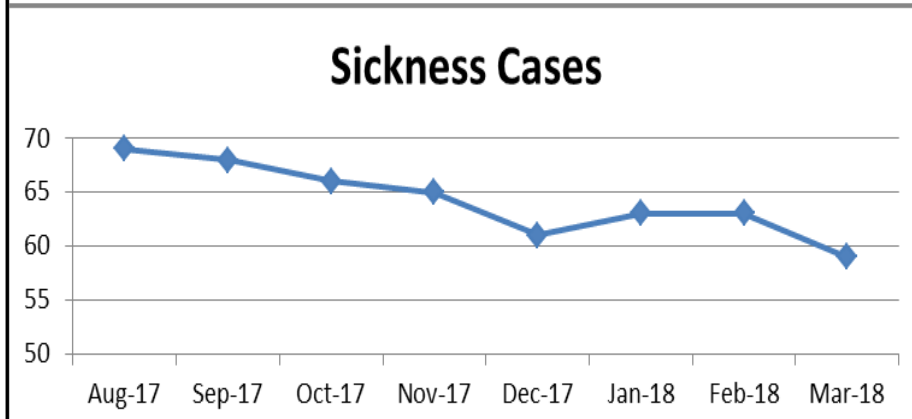
2. ERAS Data

Source: ERAS	Total Live Cases as at 31 March 2018	Total Live Cases as at 28 Feb 2018	Surgery	Medicine	CSS	Women & Children	Cancer (inc R & D)	corporate
Headcount	5906	5907	1383	1424	921	787	656	735
Number of Disciplinary Cases (excluding medical cases) % = no of cases as % of headcount	17 (0.3%)	18 (0.3%)	3 (0.2%)	3 (0.2%)	1 (0.1%)	3 (0.4%)	4 (0.6%)	3 (0.4%)
Number of Grievances	4	4	1	2	1	0	0	0
Number of Capability cases	3	3	0	1	0	0	2	0
Number of B&H, discrimination and victimisation cases	4	3	1	0	0	0	1	2
Number of formal short term sickness cases including cases under monitoring	18	18	7	2	4	1	1	3
Number of formal long term sickness cases	41	45	11	10	6	6	1	7
Number of *MHPS cases (Medical cases)	2	2	1	1	0	0	0	0
Total number of cases in progress	99	106	24	19	12	10	9	15
Number of suspensions/medical exclusions (inclusive of over six months)	2	4						
Number of suspensions lasting 6 months or longer	1	2	1	0	0	0	0	1
Number of appeals	2	1	0	0	0	1	0	1

3. ERAS Data Cont.



- In March, the percentage of employee relations cases based on headcount within the Trust was 1.7% which sits within the expected range of between 1% and 3%. There were 99 open cases at month end including; Sickness Absence , Grievance, Disciplinary, Capability and Appeals.
- There was 1 new case opened in relation to Dignity and Respect at Work.
- Work is continuing to address bullying and harassment concerns and dates are being finalised for future drop-in sessions at each of the Trust sites.
- Increased communications will commence in April 2018 in relation to the Trusts' Speak in Confidence Service; to notify staff of key changes to the service and increase overall awareness.



- The number of sickness absence cases registered with ERAS for active support remained stable in month 12; we have however seen an increased number of STS cases being referred following the recent policy launch.
- It is anticipated that approximately 800 staff members will have reached the formal trigger of 192; a review of all cases will take place commencing April 2018.
- In accordance with the Trusts plans for reducing short term sickness absence; the ERAS team with HRBPs will be targeting hotspots areas using metrics for the highest number of staff reaching the formal trigger point. This will ensure increased awareness of the policy and will develop the HR capabilities of managers dealing with sickness absence.
- Long term sickness cases continue to be monitored and auto-enrolled with ERAS to ensure timely and consistent management action.

Policy Update:

- Focus is currently placed on updating the Trusts Dignity and Respect at Work Policy.
- The Trusts Disciplinary, Sickness Absence and Change Management Policy have all now been signed off.

8. Appendices

4. Medical HR

Exception Report Division Summary Since August 2017 Changeover (As at end of Month 11 awaiting further information)

	No. submitted exception reports	Total Additional Hours	Paid Enhanced Hours	Paid Basic Hours	Total Pay	Total TOIL Hours
Medicine Total	**76**	**119**	**0.5**	**65.5**	**£969.19**	**27.25**
Complete	56	94.25	0.5	59.5	£880.55	27.25
Pending	15	17.75	0	2	£29.54	0
Unresolved	5	7	0	4	£59.09	0
Surgery Total	**41**	**158.5**	**3.25**	**44.25**	**£640.81**	**47.75**
Complete	23	95.25	3.25	44.25	£640.81	47.75
Pending	17	61.25	0	0	£0.00	0
Waiting For Doctor Agreement	1	2	0	0	£0.00	0
W&C Total	**3**	**2.75**	**0**	**1.25**	**£21.86**	**1.5**
Complete	3	2.75	0	1.25	£21.86	1.5
Grand Total	**120**	**280.25**	**3.75**	**111**	**£1,631.86**	**76.5**

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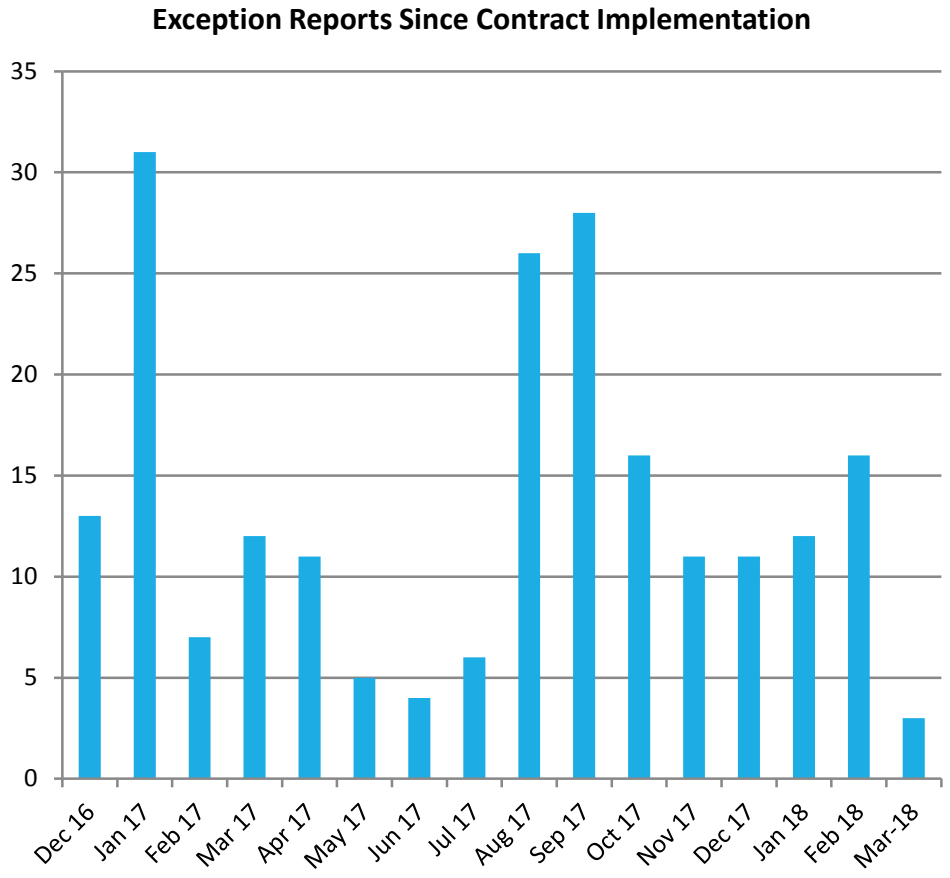
5. Medical HR data cont..



Headlines

Electronic Job Planning

At present the intention is not to re-publish job plans for 2018/9 round as previously planned before April 2018 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. The exception is those who have job plan changes since 2017/18 sign off who are now able to have job plans published for updating or those who have joined the Trust recently and require a job plan in place

Exception Reporting

After a decrease towards the end of 2017, there is a small upturn in exception reporting since the start of 2018. It is speculated that there might be a steady increase in exception reporting further to the findings in the Dr Bawa-Garba case. The Guardian levied the first fine in the Trust in February 2018 which was for a breach of the average hours limit by a trainee working on the Surgery Urology F1 rota. The hours were exceeded by 15 mins resulting in a fine of £12.76.

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6. Appraisals

Appraisal compliance

Compliance	Done	Not Done	Not due but require review*	Grand Total	Completion Rate % October
Cancer Services	372	39	74	485	90.51%
Clinical Support Services	546	63	276	885	89.66%
Medicine	737	177	221	1135	80.63%
Corporate	460	131	111	702	77.83%
Research & Development	47	18	28	93	72.31%
Surgery	737	186	151	1074	79.85%
Women's and Children's	444	88	99	631	83.46%
Grand Total	**3343**	**702**	**960**	**5005**	**82.65%**

Appraisal by Payband Data

Band	Done	Not Done	Not Due But require review	Grand Total	Completion rate%
Band 1	109	12	25	146	90.08%
Band 2	533	80	242	855	86.95%
Band 3	488	84	132	704	85.31%
Band 4	329	81	94	504	80.24%
Band 5	675	159	233	1067	80.94%
Band 6	643	108	125	876	85.62%
Band 7	381	96	60	537	79.87%
Band 8A	102	41	23	166	71.33%
Band 8B	35	16	9	60	68.63%
Band 8C	22	8	7	37	73.33%
Band 8D	10	5	4	19	66.67%
Band 9	1	5	4	10	16.67%
SMP	10	7	2	19	58.82%
Tupe	5			5	100.00%
Grand Total	**3343**	**702**	**960**	**5005**	**82.65%**

8. Appendices

7. Training

Source: ESR	Trust MTH	Surgery	Medicine	CSS	W & C	Cancer	R and D	Corporate
Statutory and mandatory training full compliance (Incl M&D)	66.15%	64.84%	61.77%	61.79%	64.73%	76.05%	71.28%	75.80%
Statutory and mandatory training average compliance (Incl M&D)	87.41%	86.48%	86.51%	82.88%	90.19%	91.13%	92.44%	89.92%

8. Appendices

8. Benchmarking

Trust	Mandatory Training Rate Dec 17	Appraisal Rate Dec 17	Turnover Rate Dec 17	Vacancy Rate Dec 17	Sickness Rate Dec 17	Agency Rate Dec 17
Bedford Hospital	85%	75%	14.51%	8.1%	3.91%	8.30%
Herts Community	89%	90%	14.32%	11.5%	4.35%	
WHHT	87%	85%	16.40%	11.3%	3.49%	7.30%
East & North Herts	88%	83%	13.40%	8.5%	4.98%	4.50%
Luton & Dunstable FT	82%	82%	15.47%	9.7%	3.67%	8.00%
HPFT	81%	87%	13.27%	13.4%	4.51%	5.80%
ELF Bedford	83%	86%	21.30%	20.0%	5.11%	15.30%
ELF Luton	86%	96%	19.10%	19.8%	5.26%	11.10%
Princess Alexandra	84%	86%	15.04%	10.0%	3.85%	6.00%
Herts Valleys CCG	94%	85%	20.80%	18.4%	4.22%	
Milton Keynes UFT	90%	83%	12.19%	11.8%	4.49%	6.40%
Central North West London FT	95%	83%	19.30%	14.8%	3.58%	3.50%
East & North Herts CCG	86%	85%	17.2%	15.7%	2.54%	
Luton CCG	91%	99%	20.40%	13.8%	2.10%	
Bedford CCG	88%	82%	17.86%	16.0%	3.53%	
Average	**87%**	**86%**	**16.70%**	**13.5%**	**4.0%**	**7.6%**

8. Appendices

6. Independent Contractors Quarterly Report for the period 1 January 2018 to 31 March 2018

Department	Duties	Contract Arrangement
Workforce & OD	ADDS Consultant	Contract to 31/03/2018
Workforce & OD	Coaching & Leadership Consultant	Contract to 31/03/2018
Workforce & OD	Midlands and East Talent Management Programme	Contract to 31/03/2018
Workforce & OD	Interim Director of Operations	Contract to 31/03/2018
Workforce & OD	Interim Manager (Cancer)	Contract ended on 24/03/2018
Workforce & OD	Interim Manager (Cancer)	Contract was to 24/03/2018 and has been extended.
Workforce & OD	Job Planning Consultant	Contract from 26/03/2018 to 13/07/2018
Operations	Systems Stabilisation Consultant	Contract from 15/01/2018 to 27/04/2018
Estates	Strategic Development	Contract terms requested from Department
Estates	Estates Health & Safety Advisor	Contract terms requested from Department
Finance	Senior Contract Manager	Contract ended 28/02/2018
Medicine	Renal IT Systems Development	Contract ended 23/03/2018
Medicine	Professional Supervision	Occasional Service Provision
Medicine	Neurophysiology Service	Occasional Service Provision
Medicine	Neurophysiology Service	Occasional Service Provision

TRUST BOARD PART I – 2 MAY 2018
Guardian of Safe Working Quarterly Report

PURPOSE	To provide information on standard monthly metrics and Trust wide issues relating to management of the workforce
PREVIOUSLY CONSIDERED BY	**NIL**
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. ☑ 2. **Developing new services and ways of working** – delivered through working with our partner organisations ☐ **3. 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)	Financial: increased workforce costs HR: failure to meet agreed standards Legal: failure to meet CQC and other national standards Patient Safety: failure to maintain appropriately trained workforce
Healthcare/ National Policy (includes CQC/Monitor)	CQC 13 and 14 NHSLA
CRR/Board Assurance Framework *	☑ **Corporate Risk Register** ☐ **BAF**

ACTION REQUIRED *

For approval	☐	For decision	☐
For discussion	☐	For information	☑

DIRECTOR:	Director of Workforce
PRESENTED BY:	Chief People Officer
AUTHOR:	Guardian of Safe Working
DATE:	27 April 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

QUARTERLY REPORT ON SAFE WORKING HOURS - DOCTORS IN TRAINING

April 2018 Report (Period covered 01 January to 31 March 2018) (except for cumulative numbers)

1.0 Executive summary

1.1 This is the sixth report.

For the period of this report there were 38 Exception Reports submitted, the majority relating to working extra hours. 1 report cited immediate patient safety concerns which related to a weekend when the medical team were short staffed and a junior doctor had to carry multiple bleeps including a senior (Registrar) bleep.

Most reports refer to a theme of very busy routine daytime workloads, and the extra difficulties dealing with this when there are unplanned shortages of medical staff. Note that most specialties continue to have vacancies in their Junior Dr rotas. Particular Foundation Year rotas continue to contribute to the majority of Exception Reports – namely Gen Medicine FY1/CT and Surgery /Urology FY1 rotas.

There were no patient safety reports relating to unsafe hours in the period reported on.

One breach of working hours necessitating a fine was confirmed from the previous reporting period (Oct – Dec 2017) and is detailed later in this report.

A few Educational Supervisors are still taking a significant time to meet and agree exception report outcomes with their trainees.

2.0 Background

2.1 The new junior doctors contract was introduced from August 2016 with the requirement for all Trust's to have a Guardian of Safe Working in place who is required to:

- provide assurance to the Trust Board that doctors are safely rostered and are working hours that are safe and in compliance with the TCS.
- prepare, no less than quarterly, a report for the Trust Board, which summarises all exception reports, work schedule reviews and rota gaps, and provides assurance on compliance with safe working hours by both the employer and doctors in approved training programmes.

2.2 Dr Stephen Bates was appointed as Guardian and commenced in post on 26th July 2016. Interim administrative support has been put in place from the Medical HR Team, and Dr Bates is working closely with Dr Shahid Khan, Director of Medical Education; the postgraduate medical centre and Medical HR to ensure full support of the 2016 contract.

2.3 Presentations outlining the guardian role are made to junior doctor induction meetings, the medical education committee and the educational supervisors.

2.4 From October 2017 all Junior Doctors in training will be on the 2016 Junior Doctors Contract.

2.5 Generic work schedules outlining working pattern; a breakdown of pay; training opportunities; and key contacts whilst in post are issued 8 weeks' prior to Junior Drs start dates in line with the code of practice. The doctors with their educational supervisors will personalise generic work schedules outlining both service and educational activity. The work schedule along with the rota should accurately reflect the actual activities of the doctors working time including, education, handovers, breaks and rest periods.

2.6 Exception reporting is the mechanism for all doctors employed on the 2016 Junior Doctors Contract to inform the trust when their day to day work varies significantly and/or regularly from the agreed work schedule. The reports are raised electronically using the 'Allocate' e-rostering system.

The educational / clinical supervisor receiving the exception report will review the content and then discuss it with the doctor to agree what action is necessary to address the issue. The supervisor will set out the agreed outcome of the exception report, including any agreed actions, in an electronic response to the doctor (and copied to either the DME or guardian of safe working, depending on whether the issue is educational or safety related, or both).

3.0 Introduction

3.1 This sixth report is based on the period from 1st January to 31st March 2018.

The report looks at the number and qualitative aspects of Exception Reports submitted by Junior Doctors. It attempts to analyse the underlying reasons for the reports, how they link to staff shortages. It attempts to link these to specialties and grades of doctor. It will report on any patient safety issues which are related to working hours or working patterns. Finally details the payments that are made including fines generated by any breaches of working hours of the new contract.

3.2 High level data

Number of doctors in training (total): **359**

Number of doctors in training on 2016 TCS (to October 2017): **359**

Amount of time available in job plan for guardian to do the role: 2 PAs / 8 hours per week

Admin support provided to the guardian (if any): No specific admin support currently in post.

Current support from Medical HR team.

Amount of job-planned time for Foundation Educational Supervisors: 0.25 PAs per trainee

Amount of job planed time for Non-Foundation Educational Supervisors: 0.25 PAs per trainee

3.3 Exception reports

(From e-exception system)

Exception reports by department and rota				
Specialty	No. exceptions carried over from last report	No. exceptions raised (01 Jan to 31 Mar)	No. exceptions closed (total)	No. exceptions outstanding (from total)
T&O				
T&O FY1	14	0	10	4
T&O ST	2	0	0	2
General Medicine				
Resp/Cardiology FY1	34	20	47	7
Elderly/Stroke FY1	73	4	76	1
Community (CT)	1	1	2	0
Gen Med ST3+	0	1	0	1
Renal Med F2	0	1	1	0
RenalMed CMT	0	1	1	0
Gen Surg/Urol	60	8	64	4

FY1				
Gen Surg/Urology F2/CST	0	1	0	1
Surgery (ST3/SCF)	1	0	1	0
Plastics ST3	2	0	2	0
Obs & Gynae F2/ST1-2	3	1	2	1
Total	190	38	207	21
Exception reports by department – Cumulative Dec 2016 to 30 Sept 2017				
Specialty	No. exceptions carried over from last report	No. exceptions raised (01 Jan to 31 Mar 2018)	No. exceptions closed	No. exceptions outstanding
T&O	16	0	10	6
Medicine (incld Renal)	108	28	127	9
Gen Surg & Urol	61	9	65	5
Plastics ST	2	0	2	0
Obs & Gynae	3	1	2	1
Total	190	38	207	21

Exception reports by grade – Cumulative Dec 2016 to March 2018				
Specialty	No. exceptions carried over from last report	No. exceptions raised	No. exceptions closed	No. exceptions outstanding
F1	181	32	197	16
F2	3	3	4	2
CT1-2 / ST1-2	1	2	3	0
ST3	5	1	3	3
Total	190	38	207	21

Exception reports (response time*) – Dec 2016 to 31 Mar 2018				
Addressed 48 hours or less	Addressed 3 to 7 days	Addressed 8 to 30 days	Addressed more than 30 days	Still open
37	58	61	51	25

**Response time – from report submitted to initial meeting by ES*

3.4 Hours Monitoring Exercise Report (Dr's on 2002 contract) – not relevent

3.5 Work schedule reviews

No personalized or generic work schedule review was conducted in this report.
Cumulative work schedule reviews

Work schedule and work place reviews by grade (cumulative to end Mar 2018)	
F1	6

F2	1
CT1-2 / ST1-2	0
ST3+	0

Work schedule and work place reviews by department (cumulative to end Mar 2018)	
Gen Medicine (Elderly Care)	3
T&O (1 for allocation CS + 2 other)	3
Surgery & Urology	1

3.6 Locum bookings (information from Business Intelligence/Qlikview)

Summary of Junior Dr Locum shifts in the Trust
(Information from Knowledge Centre/Applications/Business Intelligence/Qlikview – to be verified by Temporary Staffing Manager) (new numbers below exclude Cons, Associate Specialists, Specialty Doctor and Staff Grade Dr shifts (includes Clinical Fellow shifts))

Jan 2018

Agency Filled shifts - 196
Bank Filled shifts - 478
Unfilled shifts - 55
Total – 729 shifts

Feb 2018

Agency Filled shifts - 198
Bank Filled shifts - 359
Unfilled shifts - 47
Total – 604 shifts

Mar 2018

Agency Filled shifts - 202
Bank Filled shifts - 496
Unfilled shifts - 180
Total – 878 shifts

3.7 Shifts by Grade

Jan-18			Feb-18			Mar-18		
Agency	Sen Reg	2	Agency	Sen Reg	0	Agency	Sen Reg	
	Reg	43		Reg	154		Reg	160
	ST 1 - 3	114		ST 1 - 3	0		ST 1 - 3	0
	SHO	37		SHO	44		SHO	42
	FY2			FY2	0		FY2	0
	FY1			FY1	0		FY1	0
	CF			CF	0		CF	0

	Total	196		Total	198		Total	202
Bank	Sen Reg	2	**Bank**	Sen Reg	3	**Bank**	Sen Reg	0
	Reg	243		Reg	141		Reg	189
	ST 1 - 3	15		ST 1 - 4	13		ST 1 - 3	15
	SHO	185		SHO	179		SHO	252
	FY2	2		FY2	1		FY2	23
	FY1	29		FY1	21		FY1	16
	CF	2		CF	1		CF	1
	Total	478		Total	359		Total	496
Unfilled	Sen Reg	10	**Unfilled**	Sen Reg	0	**Unfilled**	Sen Reg	0
	Reg	9		Reg	36		Reg	114
	ST 1 - 3	3		ST 1 - 3	0		ST 1 - 3	0
	SHO	2		SHO	10		SHO	66
	FY2	2		FY2	0		FY2	0
	FY1	29		FY1	1		FY1	0
	CF	0		CF	0		CF	0
	Total	55		Total	47		Total	180

No data on specialty by grade of shifts available.

3.10 Locum work carried out by trainees

No information available at the time of this report. Currently no mechanism available to capture this information.

3.11 Vacancies/Rota Gaps

(provided by Med HR)

Vacancies by Month (Jan, Feb, Mar 2018)

Specialty	Grade	Rota Name	Jan-18	Feb-18	Mar-18	Total Gaps (average)
Anaesthetics	ST3+	Anaesthetics Obstetrics ST3+/SD (1:7)	0	0	0	0.00
Anaesthetics	ST3+	Anaesthetics ITU ST3+ (1:8)	0	0	0	0.00

Anaesthetics	CT1 - CT2	Anaesthetics CT1-2/ACCS (1:6)	0	0	0	0.00
Anaesthetics	CT1 - CT2	Anaesthetics CT1-2/ACCS (1:8)	0	0	0	0.00
Anaesthetics	ST3+	Anaesthetics Snr Reg	0	0	0	0.00
Cardiology	SCF	Cardiology ST3+	2	1	1	1.33
Chemical Pathology	ST3+	Chemical Pathology ST3+	0	0	0	0.00
Emergency Department	ST1 - ST2	ED ACCS/GP/JCF	1	1	1	1.00
Emergency Department	F2	ED F2	1	1	1	1.00
Emergency Department	ST3+	ED ST3+	0	1	1	0.67
Emergency Department	SCF	ED ST3+	7	7	7	7.00
ENT	JCF	ENT CST/STGP/JCF	0	0	0	0.00
ENT	ST3+	ENT ST3+	0	0	0	0.00
Respiratory	F1	GM Inc AM,Resp,Cardio,D&E Rota A	1	1	0	0.67
Acute Medicine	JCF	GM Inc AM,Resp,Cardio,D&E Rota B	1	1	0	0.67
Respiratory	ST1-ST2	GM Inc AM,Resp,Cardio,D&E Rota B	1	1	1	1.00
Stroke Medicine	ST1 - ST2	GM Inc Eld,Stroke,Outliers,Gastro Rota A	1	1	1	1.00
Care of the Elderly	ST1- ST2	GM Inc Eld,Stroke,Outliers,Gastro Rota B	0	0	0	0.00
Care of the Elderly	F2	GM Inc Eld,Stroke,Outliers,Gastro Rota B	0	0	0	0.00
Gastroenterology	CT1-CT2	GM Inc Eld,Stroke,Outliers,Gastro Rota B	0	0	0	0.00
Gastroenterology	F1	GM Inc Eld,Stroke,Outliers,Gastro Rota B	0	0	0	0.00
Acute Medicine	ST3+	General Medicine ST3+	5	4	4	4.33
Care of the Elderly	ST3+	General Medicine ST3+	1	1	1	1.00
Gastroenterology	ST3+	General Medicine ST3+	0	0	1	0.33
Respiratory	ST3+	General Medicine ST3+	0	1	1	0.67
Stroke Medicine	JCF	1 in 5 GIM	1	1	1	1.00
Clinical Oncology MVCC	ST1 - ST2	MVCC ST1-2	0	0	0	0.00
Clinical Oncology MVCC	ST3+	MVCC ST3+	0	0	0	0.00
Obstetrics & Gynaecology	ST1 - ST2	O&G ST1-2	0	0	0	0.00
Obstetrics & Gynaecology	ST3+	O&G ST3+	0	0	0	0.00
Ophthalmology	SD	Ophthalmology ST3+	1	2	2	1.67

Paediatrics	ST1 - ST3	General Paeds ST1-3	0	0	0	0.00
Paediatrics	ST1 - ST3	Neonates Paeds ST1 -3	0	0	0	0.00
Paediatrics	ST4+	Paediatrics ST4+	0	0	0	0.00
Palliative Medicine	STGP	Garden House Hospice GP	0	0	0	0.00
Palliative Medicine	ST3+	Garden House Hospice ST3+	0	0	0	0.00
Palliative Medicine	F2	Isabel Hospice F2	0	0	0	0.00
Palliative Medicine	GP	Isabel Hospice GP	1	1	1	1.00
Plastic & Reconstructive Surgery	JCF	Plastics CST/JCF	0	0	0	0.00
Plastic & Reconstructive Surgery	ST3+	Plastics ST3+	0	0	0	0.00
Radiology	ST1-5	Radiology ST	1	1	0	0.67
Renal Medicine	CMT	Renal CMT	0	0	0	0.00
Renal Medicine	F2	Renal F2	0	0	0	0.00
Renal Medicine	ST3+	Renal ST3+	0	0	0	0.00
General Surgery	ST3+/SCF	Surgery Senior Rota - Part 1	0	0	0	0.00
General Surgery	AS	Surgery Senior Rota - Part 2	0	0	0	0.00
Trauma & Orthopaedics	JCF	T&O F2 /CST/ JCF	1	1	1	1.00
Trauma & Orthopaedics	F2	T&O F2/CST / JCF	1	1	1	1.00
Trauma & Orthopaedics	JCF	T&O F1	1	1	1	1.00
Trauma & Orthopaedics	SCF	T&O 1:13	1	1	1	1.00
Trauma & Orthopaedics	ST3+	T&O 1:13	1	1	1	1.00
General Surgery / Urology	JCF	Surgery Urology F1	0	1	1	0.67
General Surgery / Urology	F2/CT1 - CT2	Surgery Urology F2/CST	0	0	0	0.00
Urology	CT2	Urology CT2/ST3+/SCF	0	0	0	0.00
Total			30	32	30	30.67

Notes;

4.0 Payments and Fines

1 breach of a 48 hour average working week has been confirmed which would generate a penalty fine. The breach related to an excess of approximately 15 minutes above the maximum allowed hours. This episode was a one off and has not recurred. The breach occurred due to busy daytime working hours and was

partially contributed by the delay in engagement with the trainees Educational Supervisor. This breach occurred in August 2017.
This has been presented to the relevant department, and a response is being awaited before the fine is actioned.

4.1 Payments to date

Total Payments to date (excluding fines & penalties)		
Payments made previously	Payments made this report	Cumulative payments
£2573.84	£1122.55	£3696.39

Payments by Rota (Payments in this period – 01 Jan to 31 Mar 2018)	
Rota	Payments Made
T&O FY1	£23.86
Gen Surgery & Urology FY1	£672.26
Gen Med – COE Rota A FY1	£125.55
Gen Med – COE Rota B FY1	£207.66
Gen Med – AM/Resp Rota A FY1	£0
Gen Med – AM/Resp Rota B FY1	£0
Plastics CT1-2	£71.37
O&G ST2	£21.85
Total	£1122.55

Payments by department (Payments in this period – 01 Jan to 31 Mar 2018)	
Rota & Department	Payments Made
T&O FY1	£23.86
Gen Surgery & Urology FY1	£672.26
COE FY1	£207.66
AM	£0
Rheumatology	£125.55
Gastro	£0
Respiratory	£0
Cardiology	£0
Diabetes & Endocrine	£0
Plastics	£71.37
O&G	£21.85
Total	£1122.55

4.2 Fines to date

4.3 Hours compensated this report

Hours Compensated by Rota by Rota (01 Jan to 31 Mar 2018)	
Total Hours Extra this period	69.5
Hours Compensated by TOIL	
Rota	Hours
Renal CMT	1.5
Gen Med – AM Resp Cardio Rota B FY1	1.5

5.0 Qualitative information

5.1 Patient Safety reports – In this period there was 1 report citing immediate patient safety concerns. The narrative of this report indicates a significant safety concern at the time. This “service support” report was

by a junior doctor who had to carry multiple bleeps and act up to Registrar level over a weekend when there were medical staff shortages. These concerns were appropriately escalated by the trainee to their Consultant and the hospital manager at the time. Unfortunately the trainee is yet to meet with their Educational Supervisor so no outcome has yet been agreed.

5.2 More than 80% of Exception Reports in this period (01 Jan to 31 Mar) were from Foundation Year 1 doctors. There have been uncorroborated verbal reports of trainees being discouraged from Exception reporting. This will be monitored, but steps have been taken to make information more accessible to trainees and Educational Supervisors. The Guardian for SWH will conduct further talks with trainees and Educational Supervisors to highlight the benefits of Exception Reporting. There continue to be time delays in meeting with their Educational Supervisors, but hopefully with time this will improve.

5.3 As in the previous reports the General Medicine and FY1 Surgery and Urology rota continue to be busy rotas with busy daytime work. The theme continues to be of extremely busy day time routine work, which takes much longer when there are unplanned shortages of medical staff. During the busy working day, other events such as deteriorating patients, family conversations, additional administrative work can easily cause the doctors to stay later than planned. These rotas continue to be addressed by rota coordinators and College Tutors. Some small changes can result in significant differences in support for junior doctors. The large number of monthly temporary shifts which need to be filled (tabulated above and which exclude Consultant and Specialty Doctor shifts) reflects the vacancies in the Junior Doctor rotas. These vacancies can make taking compensatory TOIL for extra work unrealistic.

5.4 This period saw a few reports relating to lack of service support. With rota gaps and teams being short staffed junior doctors are often required to cover for missing colleagues, increasing their burden and responsibility of work. Junior doctors need to be encouraged to let their seniors know when this occurs.

5.5 There continue to be almost no reports relating to missed breaks despite the reported busy work schedules. While the narrative of reports reflect that Junior Drs don't seem to be getting their breaks, almost no reports cite this as a specific reason for an Exception Report. It is thus difficult to quantify missed breaks at this time.

5.6 Educational Supervisors were given another update on the new contract requirements at a Educational Supervisors Update half day organised by the Education Department.

6.0 Issues arising

6.1 Junior doctors have reported a lack of knowledge with Exception Reporting. Induction sessions clearly do not provide enough time for the information provided to be assimilated. Links on the Trust Knowledge Center will hopefully make information easier to access.

6.2 There continue to be a small number of Educational Supervisors who have difficulty engaging with their trainees following an Exception Report, resulting in delays to achieving an outcome.

6.3 Exception reports of lack of service support by trainees, whilst not an hours problem, does indicate the increasing burden of junior doctors having to take on extra roles when there are staff shortages.

7.0 Actions taken to resolve issues

7.1 Training doctors continue to be reminded of the requirements around submitting Exception Reports in a timely fashion, the need to notify seniors of immediate patient safety concerns and also to endeavor to meet with their Educational Supervisors in a timely fashion. These messages are emphasized at the Induction meetings and Junior Dr Forum meetings. Access to information has been made easier on the Trust Knowledge Centre.

7.2 Both Junior Dr and Educational Supervisors will be encouraged to provide a proper narrative of the Exception Reports and the ensuing outcome. Educational Supervisors continue to be encouraged by the Guardian and Medical HR to support their work in the Exception Reporting process.

7.3 Improved ways of providing information and guidance to Junior Doctors continue to be sought to enable Exception Reporting. Junior Doctors to be encouraged to engage with the process via their Junior Doctor Forum and other forms of communication. Guardian to investigate giving departmental talks to small groups n order to clarify the process.

7.4 Educational and Clinical Supervisors need to be encouraged to engage with the process to make local departmental changes which will improve the working conditions for their trainees.

8.0 Summary

8.1 Exception reporting seems to be at a consistent level though informal, uncorroborated reports of junior doctors being discouraged from reporting is concerning and is being monitored. A recent Trust Training Doctors Survey may hopefully shed more light on this.

8.2 A few reports citing lack of service support have been submitted, one of which had patient safety concerns when a shortage of staff meant a junior doctor was carrying multiple bleeps and having to act up in a more senior position.

8.3 A breach of average working hours necessitating a fine to the relevant department has been confirmed. A combination of busy daytime work and rota gaps continue to necessitate junior doctors to work extra hours. A combination of staff shortages and time to resolve these hours result in a majority of financial compensation for the extra hours.

8.4 Junior Drs. need to be aware of the requirements around Exception Reporting and ways of providing this information continue to be sought.

8.5 Educational Supervisors need to be given further support to encourage engagement with the Exception Reporting process.

9.0 Questions for consideration – none

Next report due in July 2018

Dr Stephen Bates

Consultant Anesthetist and Guardian of Safe Working Hours

Our vision: "To be amongst the best"

East and North Hertfordshire NHS Trust

Agenda Item: 10

TRUST BOARD PART 1 – 2 MAY 2018

RISK AND QUALITY COMMITTEE – MEETING HELD ON 24 APRIL 2018
EXECUTIVE SUMMARY REPORT

PURPOSE	To present to the Board the report from the RAQC meeting of 24 April 2018.
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. ☐ **2. Developing new services and ways of working** – delivered through working with our partner organisations ☐ **3. 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)	Key assurance committee reporting to the Board Financial risks as outlined in paper
Healthcare/National Policy (includes CQC/Monitor)	Potential risk to CQC outcomes 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:	APRIL 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 24 APRIL 2018

SUMMARY REPORT TO TRUST BOARD – 2 MAY 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:
Bernie Bluhm, Nick Carver, Michael Chilvers and Rachael Corser

The following points are specifically highlighted to the Trust Board:

Safer Staffing Report

The Committee reviewed the latest safe staffing report. The Unify submission for registered fill % decreased in March with the average day fill % for registered nurses decreasing from 95.2% in February to 93.5% in March. It was reported that March had been a challenging month for staffing, though it was considered that the position was now improving and this should be seen in the April data. The Director of Nursing's opinion was that the processes for ensuring safe staffing remained robust.

The Committee discussed the increase in shifts that triggered red and remained red in month. It was explained that this was in part due to a change in the way that the threshold at which a red shift would be triggered was applied. It was agreed that it was important to be consistent in the application of the threshold from this point onwards and it was noted that historical comparisons against the position prior to the threshold changing would result in the current position appearing worse. The Director of Nursing explained that where a decision was taken to leave a shift red, she was comfortable that the patients were safe for that shift. The other issues discussed by the Committee included the impact of annual leave on staffing and plans for the closure of the escalation beds.

NHS Resolution Maternity Self-Assessment

The Committee received a report regarding the new Clinical Negligence Scheme for Trusts' Incentive Scheme for Maternity Services from NHS Resolution. Trusts were required to provide a report to Board demonstrating the required progress against 10 actions in order to qualify for a minimum rebate of their contribution to the incentive fund (calculated as 10% of their maternity premia). Completed reports would need to be signed off by the Board, discussed with commissioners and then submitted to NHS Resolution by Friday 29 June for review, with the results confirmed by end July 2018. The Trust was already fully compliant with 8 of the actions (although further clarity was being sought in relation to two of the actions) and partially compliant with the remaining two actions, but it was anticipated that the Trust would be compliant with all actions by the time of submission. The actions would also be included in the maternity dashboard in future. The Committee noted the self- assessment was shortly to be discussed with the CCG and congratulated the maternity services team on the work they had been doing.
Please see Appendix 1 for the latest version of the Maternity Self-Assessment for approval.

Learning from Deaths Report

The Medical Director presented the Learning from Deaths report. It was reported that there was a possibility that the crude mortality position would worsen as the latest rolling data was picked up by the metric. It was also noted that the impact on coding from the introduction of the new PAS could have a negative impact on the mortality indicators, although some assurance could be taken from the latest data update which had begun to cover the period of the Lorenzo implementation and had not significantly impacted the indicators yet.

Other issues discussed included an improvement in the respiratory service, readmissions and 7 day services. It was also noted that a review of HSMR for sepsis was being undertaken.

Infection Prevention Control Monthly Report
The Committee received the latest IPC report and were informed that root cause analysis of the 2017/18 cases of C.difficile was being undertaken, with two Trust allocated C.diff cases in March being investigated as an SI as part of a probable outbreak. The Committee discussed actions taking place to improve cleanliness on the ward and NHSI had been invited to do a further review of standards and compliance on the ward. It was also reported that there had been 4 further cases of C.diff reported in month against the Trust's target of 10 for the year. The Director of Nursing added that that the IPC Committee had been reviewed and updated. The Committee noted the report.

Outcomes:

Quality Transformation Programme Verbal Update
The Director of Nursing provided an update on the Quality Transformation programme. The Committee discussed the proposed implementation of governance leads within the divisional teams to support the programme. There was also some discussion regarding the five proposed work streams of the programme.

Clinical Harm Reviews Monthly Update
The Committee received the latest update on the clinical harm review process, which included a list of the investigations underway. The Committee noted the update.

Management of Incidents Update
The Committee were provided with an update regarding the developments in process and practice in the management of incidents. The developments included the establishment of an SI panel and the production of a daily incident report on all patient safety and organisational safety incidents. The processes in place had started to reduce the total number of incidents outstanding for review and sign off. It was the intention to improve timeliness further. The Committee discussed the importance of providing feedback to the individual staff members who logged the incidents as well as summarised feedback.

Safeguarding Adults and Children Verbal Update
The Committee were informed that there had been a move towards greater integration between the Adult Safeguarding and Children Safeguarding teams. There was now one joint Safeguarding Committee and it was the intention to produce a joint annual report. The Committee were informed that the Trust had achieved compliance with the Section 11 requirements having recently been assessed by the CCG. Recent feedback from an adult safeguarding visit had also been positive.

Complaints, PALS and Patient Experience Report
The Director of Nursing presented the Complaints, PALS and Patient Experience Report which provided an update on the Trust's position with regard to the Q4 complaints and PALS activity and patient experience feedback. The report highlighted the trends in volume, timeframe for response and subject of complaints. Communication was highlighted as one of the most frequent subjects of PALS concerns. The report also included FFT data and it was noted that this was an area where the Trust generally scored highly. The Committee also discussed the possibility of sharing more positive feedback from the surveys with staff. The Committee noted the details of the complaint regarding delays in phlebotomy and requested an update from the Clinical Support Services at the next meeting.

LD Update
The Committee received the latest update in relation to the completion of actions arising from the investigation into an SI involving a patient with Learning Disabilities. The majority of actions arising had been completed and the remainder were due to be completed the by end of June. The Committee noted the importance of ensuring that assurance could be provided that the completed actions were effective and embedded.

Clinical Audit Report
The Committee received the Clinical Audit report which summarised the 2017/18 clinical audit performance developments and current risks. In 2017/18 there had been 718 'forward plan' audits and 82 'in year' audits. The developments included an improved audit registration process and better monitoring had continued to help reduce the number of abandoned/ withdrawn audits. Other developments included greater focus and monitoring of audit actions and an increase in the number of audits on schedule by division. The Committee noted the report and suggested that in future more information on improvements made following the clinical audit process should be provided.

Update on Risk Review
The Committee received an update on the implementation of the Risk Management Policy and Procedure, the ongoing updating of the risk register and projects on some key risks. One significant development was the establishment of risk clinics. It was noted that the new divisional governance lead role would help support the divisions with managing their risks.
Please see Appendix 2 for a copy of the report.

BAF Discussion
The Committee discussed the BAF risk that the Trust is not always able to consistently embed culture of safety and evidence of continuous quality improvement and patient experience. The Committee considered whether all key controls had been identified and also discussed the scoring of the risk. It was suggested that the risk level should reduce relatively quickly due to the extent of the actions currently underway. It was agreed that the risk would be updated further for the next meeting.

The following reports were noted by the Committee:

1. **Cyber Security Update**
   The Committee received an update on Cyber Security. It was agreed that an update on two actions would be requested to be circulated by email.

2. **Emergency Preparedness Monthly Update**
   The Committee noted the latest Emergency Preparedness report which provided an update on progress against the EPRR work programme.

3. **Clinical Governance Strategy Committee Report**
   The Committee noted the latest Clinical Governance Strategy Committee report which informed the RAQC of matters escalated from the CGSC.

4. **GDPR Update**
   The Committee noted the GDPR update report which provided an update on the Trust's preparations for the new General Data Protection Regulation and confirmed the final outcome of the Information Governance Toolkit submission 31 March 2018.

5. **Quality Account**
   The Committee noted the latest position regarding the 2017/18 Quality Account, including detail of the priorities for 2018/19 that were approved by the Divisional Executive committee on 29 March 2018.

6. **CQC Updates and Insight Briefing**
   The Committee noted the CQC Insight dashboard report. The report provided details of the March release of the dashboard as the April report had not yet been published.

7. **Maternity Dashboard**
   The Committee noted the Maternity Dashboard and cover report.

8. **Floodlight Scorecard**
   The Committee noted the Month 12 Floodlight Scorecard.

John Gilham
April 2018

East and North Hertfordshire NHS Trust

Agenda Item: 10 (Appendix 1)

TRUST BOARD PART 1 – 2 MAY 2018

NHS Resolutions

PURPOSE	To Inform the Board of the new Clinical Negligence Scheme for Trust (CNST) Incentive Scheme for Maternity Services from NHS Resolution (Previously NHS Litigation Authority)
PREVIOUSLY CONSIDERED BY	**Head of Midwifery and Gynaecology, Clinical Director, Governance Lead Midwife for Maternity, Divisional Chair RAQC**
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. [ ] 2. **Developing new services and ways of working** – delivered through working with our partner organisations [ ] **3. 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)	That the Maternity Services do not meet the Safety Requirements as outlined and do not therefore qualify for the incentives That verification of the evidence by NHS Resolution does not demonstrate compliance
Healthcare/ National Policy (includes CQC/Monitor)	NHS Resolution previously known as the NHS Litigation Authority
CRR/Board Assurance Framework *	[ ] **Corporate Risk Register** [ ] **BAF**

ACTION REQUIRED *

For approval	[X]	For decision	[ ]
For discussion	[ ]	For information	[ ]

DIRECTOR:	Director of Nursing
PRESENTED BY:	Director of Nursing
AUTHOR:	Head of Midwifery and Gynaecology
DATE:	27th April 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

Purpose

- To provide the Board with the information on the new incentive Scheme for Maternity Services

- To inform the Board of the Maternity Services position against the 10 required actions in order to qualify for a minimum rebate of their contribution to the incentive fund (calculated at 10% of their maternity premia)

Executive Summary

The Maternity Safety Strategy set out the Department of Health's ambition to reward those who have taken action to improve maternity safety. NHS Resolution are supporting this ambition by trialling the CNST incentive scheme for 2018/19.

The scheme is discretionary and subject to available funds. Using CNST to incentivise safer care received strong support from respondents to the 2016 CNST consultation where 93% of respondents wanted incentives under CNST to fund safety initiatives. This is also directly aligned to the Intervention objective in the Five year strategy: Delivering fair resolution and learning from harm.

Maternity safety is an important issue for all CNST members as obstetric claims represent the scheme's biggest area of spend (c£500m in 2016/17). Of the clinical negligence claims notified in 2016/17, obstetric claims represented 10% of the volume and 50% of the value. These figures do not take into account the recent change to the Personal Injury Discount Rate. Trusts that improve their maternity safety will be saving the NHS money, allowing more money to be made available for frontline care.

The expectation is that trusts will be able to demonstrate the required progress against all 10 of the actions in order to qualify for a minimum rebate of their contribution to the incentive fund (calculated at 10% of their maternity premia).

A Steering group will be responsible for confirming the final results as well as evaluating the scheme itself and confirming the approach for 2019/20 by end July 2018

Trusts will be expected to provide a report to their Board demonstrating progress (with evidence) against each of the 10 actions using the template Board report for result submission. (Appendix 1)

Completed reports need to be signed off by the Board, discussed with commissioners and then submitted to NHS Resolution (with all relevant supporting documentation) by Friday 29 June 2018 for review by the National Maternity Safety Champions and the Steering group.

National Maternity Safety Champions and Steering group will confirm final results by end July 2018

NHS Resolution to confirm and pay discounts by end Aug 2018

It is expected that Trust Boards will self-certify declarations following consideration of the evidence provided. Where subsequent verification checks demonstrate an incorrect declaration has been made, this may indicate a failure of Board governance which the steering group will escalate within the system for further exploration. We will also take steps to recover in full any incentive payment that has been made under the scheme.

If the service is unable to demonstrate the required progress against all of the 10 actions, the Board report should set out a detailed plan for how the trust intends to achieve the required progress and over what time period. Where possible, this should also include an estimate of the

additional costs of delivering this. The National Maternity Safety Champions and Steering group will review these details and NHS Resolution, at its absolute discretion, will agree whether any reimbursement of CNST contributions is to be made to the trust. Any such payments would be at a much lower level than for those trusts able to demonstrate the required progress against the 10 actions and the 10% of the maternity contribution used to create the fund. If made, any such reimbursement must be used by the trust for making progress against one or more of the 10actions.

Background

The 10 actions were agreed by the National Maternity Safety Champions as reflecting best practice in maternity safety improvement which could be evidenced to demonstrate progress against them. Implementing these actions should deliver a qualitative difference in trusts' performance on improving maternity safety and by doing this, trusts would be expected to reduce incidents of harm that lead to clinical negligence claims. The scheme will therefore reward those trusts who are have implemented the 10 maternity safety actions.

The National Maternity Safety Champions were advised by a group of system experts including representatives from:

- NHS England
- NHS Improvement
- NHS Digital
- MBRRACE UK
- Royal College of Obstetricians and Gynaecologists
- Royal College of Midwives
- Care Quality Commission
- Department of Health
- NHS Resolution
- Clinical obstetric, midwifery and neonatal staff

ENHT Maternity Services Benchmarking Against the 10 Safety Actions (Appendix 1&2)

Fully Compliant (8)

Safety Action 1
The service uses the National Perinatal Mortality Review Tool to review perinatal deaths

Safety Action 2
The Service submits data to the Maternity Services Data Set (MSDS) to the required Standard

Safety Action 3
Transitional care facilities are in place and operational to support the implementation of the ATAIN Programme

Safety Action 4
The service is able to demonstrate an effective system of medical workforce planning

Safety Action 5
The service can demonstrate an effective system of midwifery workforce planning but need to support with evidence

Standard 2: Trust policy demonstrating that, as standard, midwifery labour ward shifts are rostered in a way that allows the labour ward coordinator to have supernumerary status (defined as having no case load of their own during that shift)

Action: There is a Supernumerary Labour ward coordinator for each shift needs to evidenced and added to the Trust Staffing Policy and Supernumerary shift to be evidenced on E Roster System

Safety Action 6
The service is compliant with all four elements of the Saving Babies' Lives care bundle

Safety Action 9
The service can demonstrate that the trust safety champions (obstetrician and midwife) are meeting bi-monthly with Board level champions to escalate locally identified issues

Action: The Trust Maternity Safety Committee will meet Bi-Monthly and be chaired by the Non-Executive Director for Women's Services

Safety Action 10
The service have reported 100% of qualifying 2017/18 incidents under NHS Resolution's Early Notification scheme?

Partially Compliant (2)

Safety Action 7
Can you demonstrate that you have a patient feedback mechanism for maternity services, such as the Maternity Voices Partnership Forum and that you regularly action feedback

We do not currently have a Maternity Voices Partnership Forum as the last Chair of our MSLC stood down

Action: This Partnership is led by the CCG and work is ongoing to recruit a chair

Safety Action 8
Can you evidence that 90% of each maternity unit staff group have attended an 'inhouse' Multi-professional maternity emergencies training session within the last training year?

100% of midwives are trained, 71% of Doctors.

Action: Identify reasons for the gap and formulate an action plan of how compliance will be met by June 2018

Scheme Evaluation

The scheme will be evaluated to understand whether it has been successful in incentivising sustainable improvement(s) in maternity safety.

We will make a short online survey available in June to capture feedback on key points, such as:

- Whether the scheme has had a positive impact on your ability to deliver safer maternity care?
- Whether the scheme has supported discussions with Commissioners around the delivery of safer maternity care?
- What other areas do you think it would be useful to incentivise through CNST contributions?
- Whether there have been any unintended consequences as a result of the process?
- How the scheme could be improved in future years – e.g. improvements to the verification process?
- Any other thoughts/comments on the scheme

The National Maternity Safety Champions and the Steering group will use this feedback, as well as third party data sources to review whether the scheme has been successful. If so, we will look at how the scheme could be extended and developed in future years to continue to drive improvements in safety. Future developments could include things like specific neonatal workforce measures or other suggestions put forward during the evaluation process.

Next Steps

1. Undertake all actions to demonstrate compliance
2. Meet with the CQC 30th April 2018 to present current status and progress
3. Present to the Board in May with all the evidence for sign off
4. Submission to NHS Resolutions on or before the 29th June 2018

Board report on East and North Hertfordshire NHS Trust progress against the Clinical Negligence Scheme for Trusts (CNST) incentive scheme maternity safety actions

Date: 27th March 2018

[ADD USUAL BOARD TEMPLATE HEADINGS – e.g. Introduction, Background etc.]

SECTION A: Evidence of Trust's progress against 10 safety actions:
Please note that trusts with multiple sites will need to provide evidence of each individual site's performance against the required standard.

Safety action – please see the guidance for the detail required for each action	Evidence of Trust's progress	Action met? (Y/N)
1). Are you using the National Perinatal Mortality Review Tool (NPMRT) to review perinatal deaths?	*Please refer/ append all relevant evidence to demonstrate the Trust's progress against this action as per the guidance document.* **Screen shots of PMRT form for 6 cases between January and March 2018** *NHS Resolution will also use data from MBRRACE to verify the Trust's progress against this action.*	**Y**
2). Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?	*Please refer/ append all relevant evidence to demonstrate the Trust's progress against this action as per the guidance document.* **ENHT have been submitting the required Data since launch June 2015** **The January 18 Data has been submitted** **The table attached summarises the number of criteria met for the MSDS submissions for October 2017 - January 2018. This information is provided so that trusts can review the number of criteria met for those months to inform their work to improve data quality leading up to the March 2018 data submitted by the end of May 2018.** **ENHT have met all 10 criteria for each month submitted** *NHS Resolution will also use data from NHS Digital to verify the Trust's progress against this action.*	**Y**
3). Can you demonstrate that you have transitional care facilities that are in place and	*Please refer/ append all relevant evidence to demonstrate the Trust's progress against this action as per the guidance document.* **Transitional care is provided in a six bedded bay on the postnatal ward.**	**Y**

operational to support the implementation of the ATAIN Programme?	**This is mostly for babies equal to or more than 34 weeks gestation who are receiving IV antibiotics (but asymptomatic). Those with nasogastric tubes and no medical concerns infants at risk of withdrawal symptoms from maternal substance abuse but symptoms do not require treatment. Care by the neonatal team in partnership with the midwives and parents. This is supported by a departmental policy for Transitional Care. Babies requiring Transitional care are recorded on to the Neonatal Badgernet data system and are included in the Network and unit reports generated.** *NHS Resolution will cross-check trusts' self-reporting with Neonatal Operational Delivery Networks to verify the Trust's progress against this action.*	
4). Can you demonstrate an effective system of medical workforce planning?	*Please refer/ append all relevant evidence to demonstrate the Trust's progress against this action as per the guidance document. This should include reference to the Royal College of Obstetricians and Gynaecologists (RCOG) workforce monitoring tool template* **We are compliant with the RCOG workforce monitoring tool template. We provide 122 hrs Consultant presence on the delivery suite. We run a 1 tier middle grade rota from 8:30 to 13:00 and a two tier 13:00 - 20:00 Monday to Friday. From 20:30 to 8:30 Monday to Thurs resident Consultant with 1 middle grade. On weekends 2 middle grades for 24 hours and Bank holidays. Middle grades work 1:7 for daytime and 1:7 for weekends. 1:7 for weekdays and 1:14 for week nights. 7 trainees and 9 clinical fellows. Rota gaps for sickness or leave are covered by regular locums who know the unit. If new to the unit they must be paired with a senior middle grade known to the unit or Consultant.** **It is very rare for Consultants to cover for registrars. Only I night shift in the 4 week period a resident Consultant acted as a registrar as the locum did not turn up due to a mix up with the booking and no registrar was available.** **Appendices and rota templates attached from 5th March -1st April**	**Y**

5). Can you demonstrate an effective system of midwifery workforce planning?	*Please refer/ append all relevant evidence to demonstrate the Trust's progress against this action as per the guidance slides.* **Established to 1:29 with skill mixing 90/10 split** **Workforce Paper presented to Board Biannually** **Birthrate Plus desktop undertaken quarterly** **Workforce predictor for next 4 months based on predicted births** **Monthly workforce analysis undertaken based on actual activity and workforce (attached)** **Supernumerary Labour Ward Co-Ordinator in place** **Neonatal Unit Workforce Tool utilised benchmarked against BAPM standards**	**Y**
6). Can you demonstrate compliance with all 4 elements of the Saving Babies' Lives (SBL) care bundle?	*Please refer/ append all relevant evidence to demonstrate the Trust's progress against this action as per the guidance document.* **We are compliant with all four elements of Saving Babies Lives care bundle as evidences in the GAAP analysis and the presentation to the CG Rolling Half Day Audit meeting.** *NHS Resolution will cross-check trusts' self-reporting with NHS England.*	**Y**
7). Can you demonstrate that you have a patient feedback mechanism for maternity services, such as the Maternity Voices Partnership Forum, and that you regularly act on feedback?	*Please refer/ append all relevant evidence to demonstrate the Trust's progress against this action as per the guidance document.* **Friends and Family test results which are collected monthly and action plan formulated each month to address feedback; birth options and birth afterthoughts meetings offered to women to provide individualised plans and listen to feedback, stakeholder events organised for women and their families to attend and provide feedback. Maternity Voices is currently being organised in collaboration with the CCG.**	**Partial**
8). Can you evidence that 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training	*Please refer/ append all relevant evidence to demonstrate the Trust's progress against this action as per the guidance document. This should include completion of a local training record form.* **100% of midwives** **81% of CWS**	**Partial**

session within the last training year?	**71% of doctors**	
9). Can you demonstrate that the trust safety champions (obstetrician and midwife) are meeting bi-monthly with Board level champions to escalate locally identified issues?	*Please refer/ append all relevant evidence to demonstrate the Trust's progress against this action as per the guidance document.* **To Set up a Trust Maternity Safety Committee Chaired by a Non-Executive**	**Y**
10). Have you reported 100% of qualifying 2017/18 incidents under NHS Resolution's Early Notification scheme?	*Please refer/ append all relevant evidence to demonstrate the Trust's progress against this action as per the guidance document.* **Submit all incidents to Each Baby Counts** **Only one case in 2017 and one so far in 2018** *NHS Resolution will also use data from the National Neonatal Research Database to verify the Trust's progress against this action.*	**Y**

SECTION B: Further action required:
If the Trust is unable to demonstrate the required progress against any of the 10 actions, please use this section to set out a detailed plan for how the Trust intends to achieve the required progress and over what time period. Where possible, please also include an estimate of the additional costs of delivering this.
The National Maternity Safety Champions and Steering group will review these details and NHS Resolution, at its absolute discretion, will agree whether any reimbursement of CNST contributions is to be made to the Trust. Any such payments would be at a much lower level than for those trusts able to demonstrate the required progress against the 10 actions and the 10% of the maternity contribution used to create the fund. If made, any such reimbursement must be used by the Trust for making progress against one or more of the 10 actions.

SECTION C: Sign-off
……..
For and on behalf of the Board of [INSERT TRUST NAME] confirming that:

- **The Board are satisfied that the evidence provided to demonstrate compliance with/achievement of the maternity safety actions meets the required standards and that the self-certification is accurate.**
- **The content of this report has been shared with the commissioner(s) of the Trust's maternity services**
- **If applicable, the Board agrees that any reimbursement of CNST funds will be used to deliver the action(s) referred to in Section B**

Position: ……..
Date: ……..
We expect trust Boards to self-certify the Trust's declarations following consideration of the evidence provided. Where subsequent verification checks demonstrate an incorrect declaration has been made, this may indicate a failure of board governance which the Steering group escalate to the appropriate arm's length body/NHS System leader.

……..

East and North Hertfordshire NHS Trust

Agenda Item: 10 (Appendix 1) VERSION 2

TRUST BOARD PART 1 – 2 MAY 2018

NHS Resolutions

PURPOSE	To Inform the Board of the new Clinical Negligence Scheme for Trust (CNST) Incentive Scheme for Maternity Services from NHS Resolution (Previously NHS Litigation Authority)
PREVIOUSLY CONSIDERED BY	**Head of Midwifery and Gynaecology, Clinical Director, Governance Lead Midwife for Maternity, Divisional Chair RAQC**
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. [ ] 2. **Developing new services and ways of working** – delivered through working with our partner organisations [ ] **3. 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)	That the Maternity Services do not meet the Safety Requirements as outlined and do not therefore qualify for the incentives That verification of the evidence by NHS Resolution does not demonstrate compliance
Healthcare/ National Policy (includes CQC/Monitor)	NHS Resolution previously known as the NHS Litigation Authority
CRR/Board Assurance Framework *	[ ] **Corporate Risk Register** [ ] **BAF**

ACTION REQUIRED *

For approval	√	For decision	
For discussion		For information	

DIRECTOR:	Director of Nursing
PRESENTED BY:	Director of Nursing
AUTHOR:	Head of Midwifery and Gynaecology
DATE:	May 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 improvemen

Purpose

- To provide the Board with the information on the new incentive Scheme for Maternity Services

- To inform the Board of the Maternity Services position against the 10 required actions in order to qualify for a minimum rebate of their contribution to the incentive fund (calculated at 10% of their maternity premia)

Executive Summary

The Maternity Safety Strategy set out the Department of Health's ambition to reward those who have taken action to improve maternity safety. NHS Resolution are supporting this ambition by trialling the CNST incentive scheme for 2018/19.

The scheme is discretionary and subject to available funds. Using CNST to incentivise safer care received strong support from respondents to the 2016 CNST consultation where 93% of respondents wanted incentives under CNST to fund safety initiatives. This is also directly aligned to the Intervention objective in the Five year strategy: Delivering fair resolution and learning from harm.

Maternity safety is an important issue for all CNST members as obstetric claims represent the scheme's biggest area of spend (c£500m in 2016/17). Of the clinical negligence claims notified in 2016/17, obstetric claims represented 10% of the volume and 50% of the value. These figures do not take into account the recent change to the Personal Injury Discount Rate.
Trusts that improve their maternity safety will be saving the NHS money, allowing more money to be made available for frontline care.

The expectation is that trusts will be able to demonstrate the required progress against all 10 of the actions in order to qualify for a minimum rebate of their contribution to the incentive fund (calculated at 10% of their maternity premia).

A Steering group will be responsible for confirming the final results as well as evaluating the scheme itself and confirming the approach for 2019/20 by end July 2018

Trusts will be expected to provide a report to their Board demonstrating progress (with evidence) against each of the 10 actions using the template Board report for result submission. (Appendix 1)

Completed reports need to be signed off by the Board, discussed with commissioners and then submitted to NHS Resolution (with all relevant supporting documentation) by Friday 29 June 2018 for review by the National Maternity Safety Champions and the Steering group.

National Maternity Safety Champions and Steering group will confirm final results by end July 2018

NHS Resolution to confirm and pay discounts by end Aug 2018

It is expected that Trust Boards will self-certify declarations following consideration of the evidence provided. Where subsequent verification checks demonstrate an incorrect declaration has been made, this may indicate a failure of Board governance which the

steering group will escalate within the system for further exploration. We will also take steps to recover in full any incentive payment that has been made under the scheme.

If the service is unable to demonstrate the required progress against all of the 10 actions, the Board report should set out a detailed plan for how the trust intends to achieve the required progress and over what time period. Where possible, this should also include an estimate of the additional costs of delivering this. The National Maternity Safety Champions and Steering group will review these details and NHS Resolution, at its absolute discretion, will agree whether any reimbursement of CNST contributions is to be made to the trust. Any such payments would be at a much lower level than for those trusts able to demonstrate the required progress against the 10 actions and the 10% of the maternity contribution used to create the fund. If made, any such reimbursement must be used by the trust for making progress against one or more of the 10actions.

Background

The 10 actions were agreed by the National Maternity Safety Champions as reflecting best practice in maternity safety improvement which could be evidenced to demonstrate progress against them. Implementing these actions should deliver a qualitative difference in trusts' performance on improving maternity safety and by doing this, trusts would be expected to reduce incidents of harm that lead to clinical negligence claims. The scheme will therefore reward those trusts who are have implemented the 10 maternity safety actions.

The National Maternity Safety Champions were advised by a group of system experts including representatives from:

- NHS England
- NHS Improvement
- NHS Digital
- MBRRACE UK
- Royal College of Obstetricians and Gynaecologists
- Royal College of Midwives
- Care Quality Commission
- Department of Health
- NHS Resolution
- Clinical obstetric, midwifery and neonatal staff

ENHT Maternity Services Benchmarking Against the 10 Safety Actions (Appendix 1&2)

Fully Compliant (7)

Safety Action 1
The service uses the National Perinatal Mortality Review Tool to review perinatal deaths

Safety Action 2
The Service submits data to the Maternity Services Data Set (MSDS) to the required Standard

Safety Action 3

Transitional care facilities are in place and operational to support the implementation of the ATAIN Programme

Safety Action 4
The service is able to demonstrate an effective system of medical workforce planning

Safety Action 5
The service can demonstrate an effective system of midwifery workforce planning but need to support with evidence

Standard 2: Trust policy demonstrating that, as standard, midwifery labour ward shifts are rostered in a way that allows the labour ward coordinator to have supernumerary status (defined as having no case load of their own during that shift)

Action: There is a Supernumerary Labour ward coordinator for each shift needs to evidenced and added to the Trust Staffing Policy and Supernumerary shift to be evidenced on E Roster System

Safety Action 6
The service is compliant with all four elements of the Saving Babies' Lives care bundle and meets the required standards of >75% compliance

Safety Action 10
The service have reported 100% of qualifying 2017/18 incidents under NHS Resolution's Early Notification scheme?

Partially Compliant (3)

Safety Action 7
Can you demonstrate that you have a patient feedback mechanism for maternity services, such as the Maternity Voices Partnership Forum and that you regularly action feedback

We do not currently have a Maternity Voices Partnership Forum as the last Chair of our MSLC stood down

Action: This Partnership is led by the CCG and members have been identified. It is anticipated that the date for the first meeting will be agreed prior to submission on the 29th June 2018

Safety Action 8
Can you evidence that 90% of each maternity unit staff group have attended an 'inhouse' Multi-professional maternity emergencies training session within the last training year?

100% of midwives are trained, 71% of Doctors.

Action: Gaps have been identified and compliance will be met by the submission date

Safety Action 9
The service can demonstrate that the trust safety champions (obstetrician and midwife) are meeting bi-monthly with Board level champions to escalate locally identified issues

Action: The Trust Maternity Safety Committee will meet Bi-Monthly and be chaired by the Non-Executive Director for Women's Services

Draft Terms of reference developed including membership. Date for meeting May 2018 TBC and the Action will be met by the submission date of the 29th June 2018

Scheme Evaluation

The scheme will be evaluated to understand whether it has been successful in incentivising sustainable improvement(s) in maternity safety.

We will make a short online survey available in June to capture feedback on key points, such as:

- Whether the scheme has had a positive impact on your ability to deliver safer maternity care?
- Whether the scheme has supported discussions with Commissioners around the delivery of safer maternity care?
- What other areas do you think it would be useful to incentivise through CNST contributions?
- Whether there have been any unintended consequences as a result of the process?
- How the scheme could be improved in future years – e.g. improvements to the verification process?
- Any other thoughts/comments on the scheme

The National Maternity Safety Champions and the Steering group will use this feedback, as well as third party data sources to review whether the scheme has been successful. If so, we will look at how the scheme could be extended and developed in future years to continue to drive improvements in safety. Future developments could include things like specific neonatal workforce measures or other suggestions put forward during the evaluation process.

Next Steps

1. Undertake all actions to demonstrate compliance

2. Meet with the CQC 30th April 2018 to present current status and progress- COMPLETED

3. Present to the Board in May with all the evidence for sign off

4. Submission to NHS Resolutions on or before the 29th June 2018

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Board report on East and North Hertfordshire NHS Trust progress against the Clinical Negligence Scheme for Trusts (CNST) incentive scheme maternity safety actions

Date: 27th March 2018

[ADD USUAL BOARD TEMPLATE HEADINGS – e.g. Introduction, Background etc.]

SECTION A: Evidence of Trust's progress against 10 safety actions:
Please note that trusts with multiple sites will need to provide evidence of each individual site's performance against the required standard.

Safety action – please see the guidance for the detail required for each action	Evidence of Trust's progress	Action met? (Y/N)
1). Are you using the National Perinatal Mortality Review Tool (NPMRT) to review perinatal deaths?	*Please refer/ append all relevant evidence to demonstrate the Trust's progress against this action as per the guidance document.* **Screen shots of PMRT form for 6 cases between January and March 2018** *NHS Resolution will also use data from MBRRACE to verify the Trust's progress against this action.*	**Y**
2). Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?	*Please refer/ append all relevant evidence to demonstrate the Trust's progress against this action as per the guidance document.* **ENHT have been submitting the required Data since launch June 2015** **The January 18 Data has been submitted** **The table attached summarises the number of criteria met for the MSDS submissions for October 2017 - January 2018. This information is provided so that trusts can review the number of criteria met for those months to inform their work to improve data quality leading up to the March 2018 data submitted by the end of May 2018.** **ENHT have met all 10 criteria for each month submitted** *NHS Resolution will also use data from NHS Digital to verify the Trust's progress against this action.*	**Y**
3). Can you demonstrate that you have transitional care facilities that are in place and	*Please refer/ append all relevant evidence to demonstrate the Trust's progress against this action as per the guidance document.* **Transitional care is provided in a six bedded bay on the postnatal ward.**	**Y**

operational to support the implementation of the ATAIN Programme?	**This is mostly for babies equal to or more than 34 weeks gestation who are receiving IV antibiotics (but asymptomatic). Those with nasogastric tubes and no medical concerns infants at risk of withdrawal symptoms from maternal substance abuse but symptoms do not require treatment. Care by the neonatal team in partnership with the midwives and parents. This is supported by a departmental policy for Transitional Care. Babies requiring Transitional care are recorded on to the Neonatal Badgernet data system and are included in the Network and unit reports generated.** *NHS Resolution will cross-check trusts' self-reporting with Neonatal Operational Delivery Networks to verify the Trust's progress against this action.*	
4). Can you demonstrate an effective system of medical workforce planning?	*Please refer/ append all relevant evidence to demonstrate the Trust's progress against this action as per the guidance document. This should include reference to the Royal College of Obstetricians and Gynaecologists (RCOG) workforce monitoring tool template* **We are compliant with the RCOG workforce monitoring tool template. We provide 122 hrs Consultant presence on the delivery suite. We run a 1 tier middle grade rota from 8:30 to 13:00 and a two tier 13:00 - 20:00 Monday to Friday. From 20:30 to 8:30 Monday to Thurs resident Consultant with 1 middle grade. On weekends 2 middle grades for 24 hours and Bank holidays. Middle grades work 1:7 for daytime and 1:7 for weekends. 1:7 for weekdays and 1:14 for week nights. 7 trainees and 9 clinical fellows. Rota gaps for sickness or leave are covered by regular locums who know the unit. If new to the unit they must be paired with a senior middle grade known to the unit or Consultant.** **It is very rare for Consultants to cover for registrars. Only I night shift in the 4 week period a resident Consultant acted as a registrar as the locum did not turn up due to a mix up with the booking and no registrar was available.** **Appendices and rota templates attached from 5th March -1st April**	**Y**

5). Can you demonstrate an effective system of midwifery workforce planning?	*Please refer/ append all relevant evidence to demonstrate the Trust's progress against this action as per the guidance slides.* **Established to 1:29 with skill mixing 90/10 split** **Workforce Paper presented to Board Biannually** **Birthrate Plus desktop undertaken quarterly** **Workforce predictor for next 4 months based on predicted births** **Monthly workforce analysis undertaken based on actual activity and workforce (attached)** **Supernumerary Labour Ward Co-Ordinator in place** **Neonatal Unit Workforce Tool utilised benchmarked against BAPM standards**	**Y**
6). Can you demonstrate compliance with all 4 elements of the Saving Babies' Lives (SBL) care bundle?	*Please refer/ append all relevant evidence to demonstrate the Trust's progress against this action as per the guidance document.* **We are compliant with all four elements of Saving Babies Lives care bundle as evidences in the GAAP analysis and the presentation to the CG Rolling Half Day Audit meeting.** *NHS Resolution will cross-check trusts' self-reporting with NHS England.*	**Y**
7). Can you demonstrate that you have a patient feedback mechanism for maternity services, such as the Maternity Voices Partnership Forum, and that you regularly act on feedback?	*Please refer/ append all relevant evidence to demonstrate the Trust's progress against this action as per the guidance document.* **Friends and Family test results which are collected monthly and action plan formulated each month to address feedback; birth options and birth afterthoughts meetings offered to women to provide individualised plans and listen to feedback, stakeholder events organised for women and their families to attend and provide feedback. Maternity Voices is currently being organised in collaboration with the CCG.**	**Partial**
8). Can you evidence that 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training	*Please refer/ append all relevant evidence to demonstrate the Trust's progress against this action as per the guidance document. This should include completion of a local training record form.* **100% of midwives** **81% of CWS**	**Partial**

session within the last training year?	**71% of doctors** **Plan in place to achieve compliancy by submission date**	
9). Can you demonstrate that the trust safety champions (obstetrician and midwife) are meeting bi-monthly with Board level champions to escalate locally identified issues?	*Please refer/ append all relevant evidence to demonstrate the Trust's progress against this action as per the guidance document.* **Trust Maternity Safety Committee Chaired by a Non-Executive has been agreed with DRAFT Terms of reference and membership. First meeting date to be agreed for May 2018**	**Partial**
10). Have you reported 100% of qualifying 2017/18 incidents under NHS Resolution's Early Notification scheme?	*Please refer/ append all relevant evidence to demonstrate the Trust's progress against this action as per the guidance document.* **Submit all incidents to Each Baby Counts** **Only one case in 2017 and two so far in 2018** *NHS Resolution will also use data from the National Neonatal Research Database to verify the Trust's progress against this action.*	**Y**

SECTION B: Further action required:
If the Trust is unable to demonstrate the required progress against any of the 10 actions, please use this section to set out a detailed plan for how the Trust intends to achieve the required progress and over what time period. Where possible, please also include an estimate of the additional costs of delivering this.
The National Maternity Safety Champions and Steering group will review these details and NHS Resolution, at its absolute discretion, will agree whether any reimbursement of CNST contributions is to be made to the Trust. Any such payments would be at a much lower level than for those trusts able to demonstrate the required progress against the 10 actions and the 10% of the maternity contribution used to create the fund. If made, any such reimbursement must be used by the Trust for making progress against one or more of the 10 actions.

SECTION C: Sign-off
……..
For and on behalf of the Board of [INSERT TRUST NAME] confirming that:

- **The Board are satisfied that the evidence provided to demonstrate compliance with/achievement of the maternity safety actions meets the required standards and that the self-certification is accurate.**
- **The content of this report has been shared with the commissioner(s) of the Trust's maternity services**
- **If applicable, the Board agrees that any reimbursement of CNST funds will be used to deliver the action(s) referred to in Section B**

Position: ……..
Date: ……..
We expect trust Boards to self-certify the Trust's declarations following consideration of the evidence provided. Where subsequent verification checks demonstrate an incorrect declaration has been made, this may indicate a failure of board governance which the Steering group escalate to the appropriate arm's length body/NHS System leader.

……..

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East and North Hertfordshire NHS Trust

Agenda Item: 10 (Appendix 2)

TRUST BOARD PART 1 – 2 MAY 2018

Risk Register Update

PURPOSE	To update the RAQC on the planning for implementation of the Risk Management Policy and Procedure, ongoing updating of the risk register and projects on some key risks.
PREVIOUSLY CONSIDERED BY	Risks routinely reviewed by the Clinical Governance Strategy Committee RAQC
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. ☑ 2. **Developing new services and ways of working** – delivered through working with our partner organisations ☐ **3. 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)	Potential risk to patient safety, staff and organisation if risks are not identified and reviewed appropriately or adequately controlled
Healthcare/ National Policy (includes CQC/Monitor)	Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 - Regulation 17 'Good Governance'
CRR/Board Assurance Framework *	☑ **Corporate Risk Register** ☑ **BAF**

ACTION REQUIRED *

For approval	☐	For decision	☐
For discussion	☐	For information	☑

DIRECTOR:	Medical Director
PRESENTED BY:	Medical Director
AUTHOR:	Interim Head of Risk
DATE:	24 April 2018

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We strive for excellence and continuous improvement

***** tick applicable box

1. PURPOSE

The purpose of this paper is to provide a summary update on the development of the Trust-wide risk implementation plan, as part of the Quality Transformation Programme.

The status of the risk register is described with arrangements made for completion of the reviews of all divisional risk registers by end of May 2018.

Key risks arising from the Never Events have been included in the risk register.

2. BACKGROUND

The Trust-wide Risk Implementation Plan will implement the recently approved Risk Management Strategy and Procedure.

Further risk register clinics with the Director of Nursing, Medical Director and Interim Head of Risk are booked in May. Thereafter, regular routine facilitation of the divisional risk registers and risks by the Interim Head of Risk working with divisions.

3. CURRENT STATUS

Following the risk clinics in March, the Trust has reduced its high scoring risks.
There are 524 open risks on the risk register on 31.03.2018.
137 risks scored >14 (representing 26% of the total open risks). Of these, 40 risks scored >19 (representing 7.5% of the total open risks).

34 risks scoring >20 are approved, a reduction from 36 since the last report.
There are 6 still awaiting approval.

The risk scoring 25 remains - Risk of compromised patient safety due to insufficient inpatient emergency capacity.

A Summary of the Top 5 Corporate Risks is attached at Appendix 1. This summary provides a picture of the risks scoring >14, and will be updated monthly for this report.

4. DEVELOPMENTS

4.1 Risk register cleanse

The Director of Nursing, Medical Director and Interim Head of Risk are completing the initial risk register cleanse with divisions by the end of May. The focus will continue to be on divisions reviewing their risks and ensuring their scoring methodology adheres to national and Trust policy.

4.2 Risk Implementation plan

A Trust-wide risk procedure implementation plan is being developed to reflect the recently updated risk management strategy and risk management procedure; this

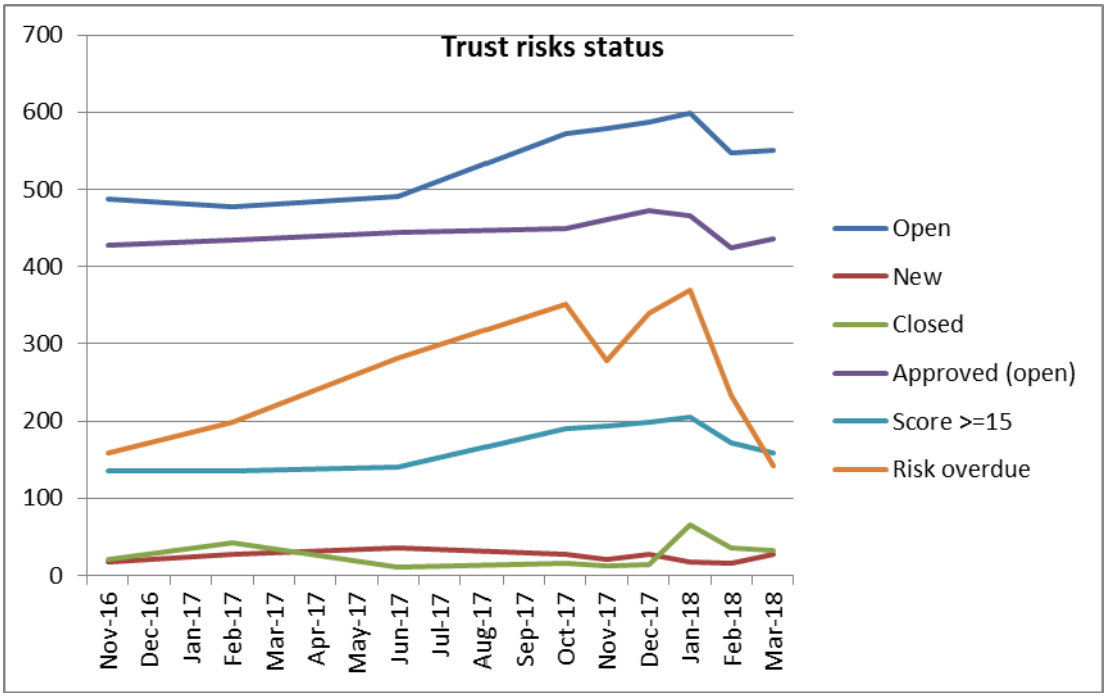
has been done with the involvement of key Trust staff and divisions The plan will be available for the May RAQC, and discussed in detail at the Clinical Governance Strategy Committee.

4.3 Risk status monitoring

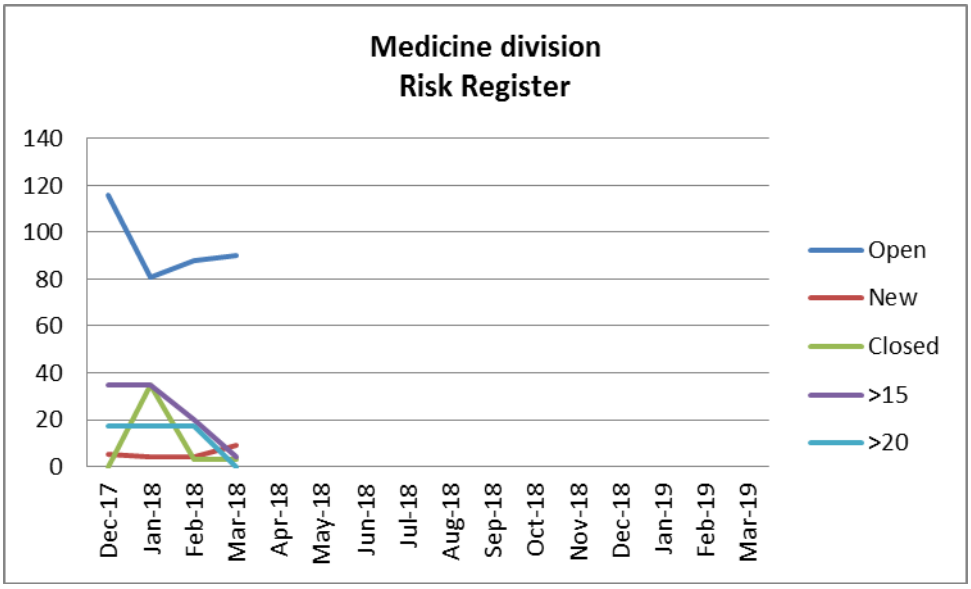
Open, approved, new and closed risks are shown in the graphs below with the newly developed risk monitoring tool.

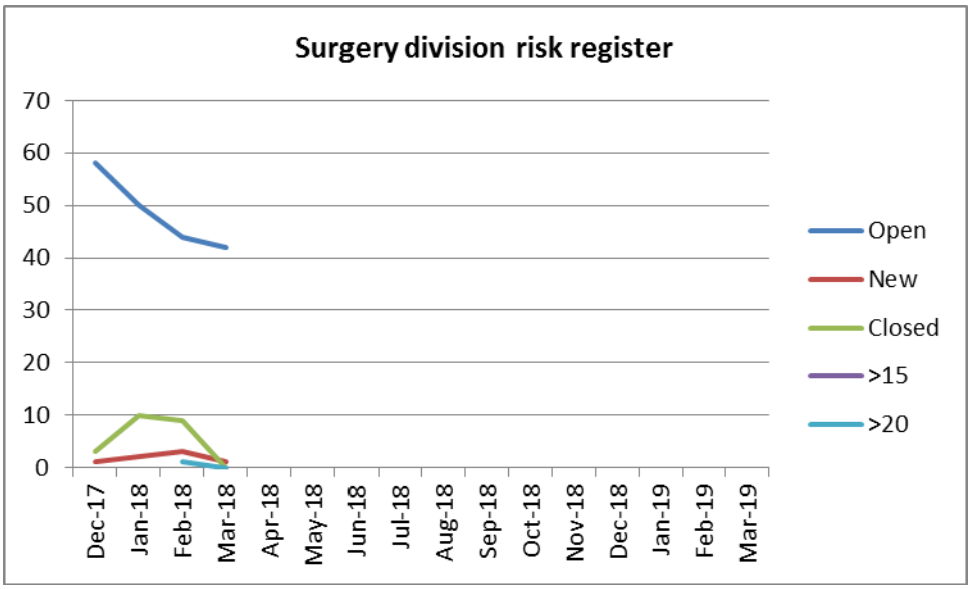
There is a marked reduction in risks with overdue review dates. This is because divisions are reviewing their risks. Overdue risks reduced from 233 (28 Feb) to 142 (31 Mar).

The impact of the risk clinics held in March is shown with risk scores >14 reducing from 172 (28 Feb) to 159 (31 Mar). Those relating to score >19 remain the same at 40.

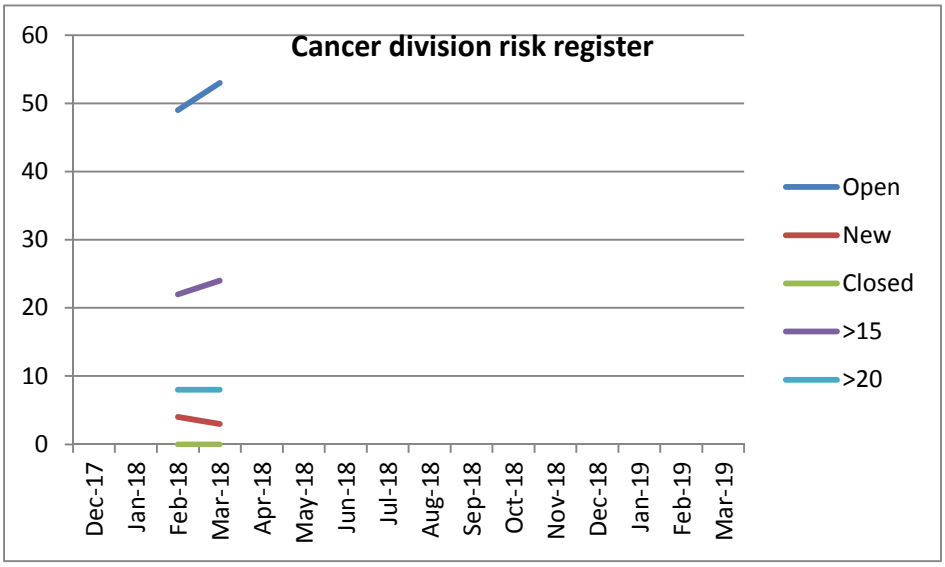


Divisional risk register status is shown below, mirroring the effects above.





Cancer, CSSS and W&C divisional risk registers are included below showing datea only since February 2018.


Cancer division risk register
60
50
40
30
20
10
0
Dec-17
Jan-18
Feb-18
Mar-18
Apr-18
May-18
Jun-18
Jul-18
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Open
New
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>15
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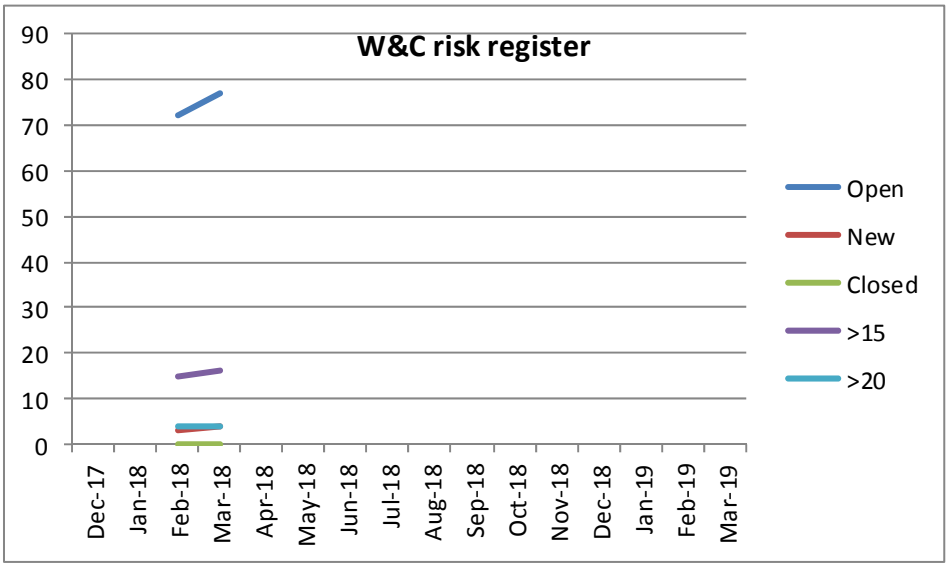
W&C risk register
90
80
70
60
50
40
30
20
10
0
Dec-17
Jan-18
Feb-18
Mar-18
Apr-18
May-18
Jun-18
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Open
New
Closed
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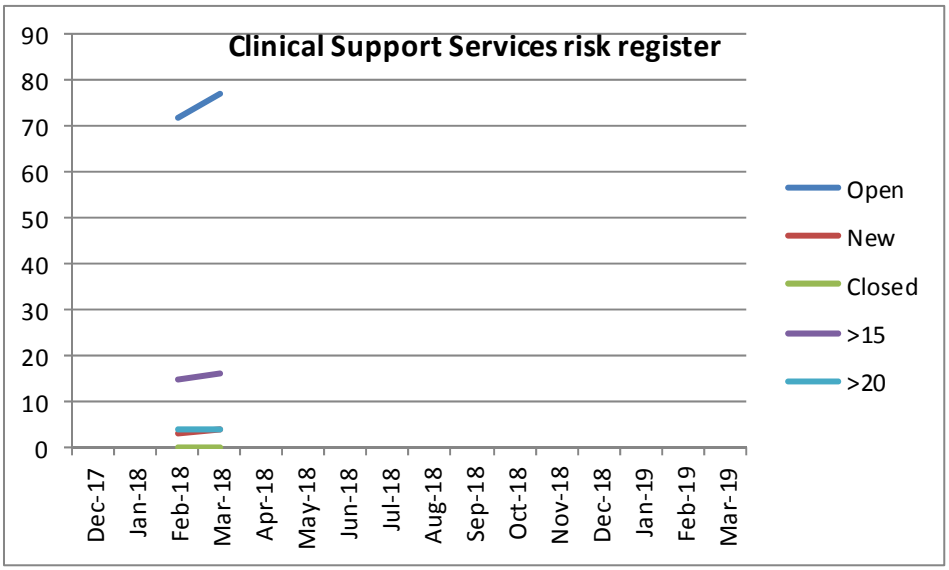
Clinical Support Services risk register
90
80
70
60
50
40
30
20
10
0
Dec-17
Jan-18
Feb-18
Mar-18
Apr-18
May-18
Jun-18
Jul-18
Aug-18
Sep-18
Oct-18
Nov-18
Dec-18
Jan-19
Feb-19
Mar-19
Open
New
Closed
>15
>20

Risk reviews involving the risk leads of the non-clinical support services division (Human Resources, Trust Management etc) will be completed before the end of June 2018. At that point, we expect to have completed the initial cleanse to provide a comprehensive and accurate risk register.

5. RECOMMENDATION

The RAQC is asked to note the developments and the early indications of improvement.

Appendix 1 - Summary of Top 5 Corporate risks – 18.04.2018

There are 153 risks >14 on the risk register. The 5 top risk types (amounting to 124 risks), identified by their frequency, have been analysed and thematicised below to give a picture of the top 5 risk types.
Top 5 risk types are:

- Clinical risks (71)
- Corporate and strategic (18)
- IM&T (17)
- Financial (11)
- Clinical targets (7)

A summary of what these risks are is described below:

1. CLINICAL RISKS

Lack of staff with appropriate expertise

The most frequent cause of clinical risk (16 risks) was lack of staff/expertise. Services affected included vascular surgery (6029), phlebotomy (5984), colposcopy administrative staff (5976), both chemotherapy units (5819), skin cancer CNS (5796 & 5794) Cancer of Unknown Primary MDT (5766), Consultant gynaecologists (5674 & 5673), children with mental illness (5652), middle grade ED doctors (5580), nuclear medicine (5544), midwives (5128), acute medicine consultants (4565), nurses and locum doctors (4431) and ED nursing establishment when over capacity (3895).

Capacity

The next most frequent cause of clinical risk (11 risks) was lack of capacity. Services affected included emergency inpatients (5884), ECG monitor analysis backlog (5722), social care packages (5670), OPD capacity (5640), MRI service (5626), therapists (5567), ED triage at Lister (5513), Critical Care (5460), serial scanning for foetuses (5173), ENT follow up (4690) and access to surgical lists, interventional radiology and nephrological clinics resulting in excessive central lines (1580).
The next most frequent cause of clinical risk was Lorenzo and equipment requiring upgrade/replacement at 8 risks each.

Lorenzo

8 risks were due to Lorenzo. Issues raised included clinicians typing free text in referrals (5989), IT shortfalls (5975), discharge summaries not sent and no IM reports (5925), clinicians not following the quick reference guide (5898), reliability, efficiency and user issues (5883), lack of an interface between Lorenzo and Nerve Centre (5863), clinic productivity (5767) and data quality (5755).

Equipment requiring upgrade/replacement

8 risks were due to equipment needing replacement. These included: pathology (5983), old mobile image intensifiers (5941), crash bleeps (5899), pharmacy hoist (5744), cardiac catheterisation lab 2 (5688), ITU incubators (5647), emergency buzzers in CLU/MLU (5598) and imaging in MV nuclear medicine (4609).

The next most frequent cause of clinical risk was lack of system/process and compliance with standards with both having 5 risks each.

Lack of system/process

Risks included lack of a unified system for recording and monitoring competencies (6022), lack of system for verifying final copies of medical correspondence (5183), disparate filing systems for health records (5182), lack of visibility of OPD follow up appointments and missed xrays (2124).

Compliance with standards

Risks included the number of Never Events reported (6041), risk of oxygen tubing being connected to air flowmeters (6033), Fit testing (5872), 50% usage of the ICP for dying patients (5733) and EPR record keeping by clinicians concerning safeguarding children (5412).

The remaining clinical risks were due to:

- Lack of training/skills - 4 risks – 5980 (new doctors Nerve Centre training), 5825 (EOL care training no longer mandatory), 5649 (untrained agency staff glucometers), 5323 (care of high dependency children)
- IM&T issues - 4 risks – 6011 (ACC/MDU lack Lorenzo interface), 5888 (Lister ED department lack of Systm 1 access), 5729 (RTT access database - PTLs), 5420 (incompatible OCT investigations)
- Lack of equipment - 4 risks – 6036 (imaging eyes), 6032 (T34 pumps EOL), 5965 (PCA analgesia), 5945 (SCBU incubators)
- Replacement of ageing equipment - 3 risks – 5999 (PPCI communications service), 5978 (ARIA system), 5943 (cardiac CT scanner)
- Estates fabric/layout - 2 risks – 5328 (MVCC fabric), 4351 (ED overcrowding)
- Lack of treatment escalation plan – 1 risk 6023 (EOL)

2. CORPORATE AND STRATEGIC RISKS

Partnership risks – mainly L&D renal dialysis service

There are 5 partnership risks, 4 of these are due to the renal dialysis services L&D Hospital. These are 5889 (possible loss of service), 5538 (notice to vacate), 5459 (135 renal patients need relocating), 5622 (insufficient decommissioning budget). 6030 relates to lack of MVCC lease. A further capacity risk is 5552 (insufficient inpatient beds at Lister for renal patients from L&D).

Reputation and negative media risks

3 specific reputational risks include: 5560 (insufficient engagement with GPs), 5559 (delayed responses to GP Helpline queries), and 5993 (negative media).

Inadequate estate risks

2 risks include 4872 (radio-pharmacy windows), 5891 (water plant/estate L&D Hospital renal services).

Compliance risks

2 risks are compliance related: 5813 (nuclear medicine; radioactive waste stores, ward 11, patient toilet MVCC), 5187 (DoLs Supervising Authority delays).

Project risks

2 risks include: 5822 (no suitable site), 5801 (funding lack for satellite radiotherapy).

Other risks

The following risk categories had 1 risk each:

- Ageing equipment -5602 (SSD washer disinfector and sterilisers)
- Emergency preparedness -5799 (under-resourcing threatens standards)
- External competition -3160 (unplanned changes in demand)

3. IM&T RISKS

Lorenzo

Of 17 IM&T risks, the greatest number (5 risks) was due to Lorenzo – 6009 (pulling list errors from IFit/Feed from Lorenzo), 5905 (time/resources risk from multiple access plans), 5892 (data quality issues post Go-live), 5890 (information and reporting issues), 5865 (LD alert search not on Lorenzo).

Not meeting service needs

3 risks included: 5959 (Palliative care – Infoflex IT system), 5812 (Pathology laboratory information management system – failure risk), 4688 (Renal Plus IT system – provider ceasing operation).

Confidentiality

2 risks included: 5465 (patient data not encrypted between L&D and St Albans and N3 link), 5456 (letters sent to patients' temporary address).

Lack of back up in event of failure

2 risks included 6025 (switchboard), 5519 (lack of network diagnostic tools).

Software compatibility

2 risks included 6034 (Cisco IOS, IOS XE software), 5646 (CFM monitor – health records).

Old IM&T equipment/infrastructure

2 risks included: 5789 (old wireless access points), 5437 (60 microsoft servers pre 2003 versions).

4. FINANCIAL RISKS

11 financial risks include:

- 5851 (failure to develop robust CIP plan)
- 5850 (non-achievement 17/18 SLA income plan)
- 5847 (exceeding expenditure budgets)
- 5843 (non-payment SLA activity delivered)
- 5842 (aged debtors/creditors management)
- 5841 (cash flow)
- 5953 (risk of mis-match accounting reconciliation)
- 5956 (no POCT HbAIc analysers – diabetic OPD Hertford)
- 5922 (1 particle counter -PAQC monitoring)
- 5830 (risk to service from Radiation Protection Advisor/Radiation Waste Advisor)
- 5251 (infoflex licensing costs)

5. CLINICAL TARGET RISKS

Of the 7 clinical target risks, 2 risks related to ageing equipment - 5935 (dialysis equipment), 5190 (Lister 1.5T MRI scanner); 2 risks related to staffing - 5921 (cancer diagnosis delay), 5201 (Children's Unscheduled Care). There are 2 capacity risks including - 3852 (respiratory clinic OPD), 5797 (scheduled care acute and community paediatrics).

East and North Hertfordshire NHS Trust

Agenda Item: 10.1

TRUST BOARD PART 1 – 2 MAY 2018
Learning from Deaths Report

PURPOSE	To provide the Board with an update on mortality
PREVIOUSLY CONSIDERED BY	Elements considered by the Trust Mortality Surveillance Group (Clinical Governance Committee) RAQC
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. ☑ 2. **Developing new services and ways of working** – delivered through working with our partner organisations ☐ **3. 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)	As identified in the report
Healthcare/ National Policy (includes CQC/Monitor)	CQC Compliance
CRR/Board Assurance Framework *	☐ **Corporate Risk Register** ☑ **BAF**

ACTION REQUIRED *

For approval	☐	For decision	☐
For discussion	☑	For information	☐

DIRECTOR:	Medical Director
PRESENTED BY:	Medical Director
AUTHOR:	Clinical Improvement Lead / Medical Director
DATE:	April 2018

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1. BACKGROUND

Reducing mortality is one of the Trust's key objectives for 2017 to 2019. This quarterly report summarises the results of mortality improvement work including the regular monitoring of mortality rates and outputs from our learning from deaths work that are continual, on-going processes throughout the Trust.

Schemes to reduce mortality form an important part of the *Improving Patient Outcomes Strategy 2015-2018 (IPOS)* and link closely with other clinical quality initiatives such as Clinical Effectiveness, Patient Safety and Patient Experience all of which are regularly reported to the Risk and Quality Committee (RAQC).

The full learning from deaths report with further information on the key metrics, developments and current risks summarised on this page can be found in Appendices 1-3.

2. KEY METRICS

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

Metric	Result
Crude mortality	Crude mortality is 1.54% for the 12 month period to February 2018 compared to 1.62% for the latest 3 years.
HSMR (data period Jan 17 – Dec 17)	HSMR for the 12 month period is **99.41** and is statistically **'as expected'.**
SHMI (data period Oct16 - Sep17)	SHMI for the 12 month period is 102.91: **'as expected band 2'.**
HSMR – Peer comparison	E&NH is ranked 7th (out of 16) in the East of England Peer group compared to 6th out of 16 in the last report.

3. DEVELOPMENTS

- SHMI has remained stable within the 'as expected band'
- Third report of information and data mandated by the National Guidance on Learning from Deaths published by the National Quality Board in March 2017
- Learning from Deaths information included in annual Quality Account
- Participation in Learning from Death Regional Forum
- Consideration of Clarity Informatics Mortality Review Tool.

4. CURRENT RISKS

Table 2 below summaries key risks identified:

Risks	Report ref (Mitigation)
Acumen tool – Deaths in hospital and ED Deaths reports still in UAT	1.3
Sepsis performance	1.43/1.6.4
Slow progress with 7 day service & current lack of 7DS Lead	1.8.2
Coding capability	1.9
Data Quality issues	1.3/1.10
Mortality management - capacity	1.11
Mortality Review Process – need for significant development of IT tool	1.11/1.11.2

Appendix 1

LEARNING FROM DEATHS – DETAILED UPDATE APRIL 2018

1.1 Introduction

Reducing mortality is one of the Trust's key objectives for 2017 to 2019. This quarterly report summarises the results of mortality improvement work including the regular monitoring of mortality rates together with outputs from our learning from deaths work that are continual on-going processes throughout the Trust.

Schemes to reduce mortality form an important part of the *Improving Patient Outcomes Strategy 2015-2018* (IPOS) and link closely with other clinical quality initiatives such as Clinical Effectiveness, Patient Safety and Patient Experience all of which are regularly reported to the Risk and Quality Committee (RAQC). Patient safety indicators, as well as other Trust wide and clinical pathway mortality data, are included on the Mortality Improvement dashboard and can be seen in Appendix 2.

The National Guidance on Learning from Deaths published by the National Quality Board in March 2017 placed new requirements on Trusts regarding their approach to learning from deaths. Mandated data and information is contained later in this report.

The Trust also works in tandem with the CCG on specific mortality reduction initiatives via the Mortality Review Group. This forum provides our external partners with the opportunity to discuss and review all of the Trust's activities aimed at reducing mortality and to make requests and recommendations as appropriate. Worthy of note is the fact that the frequency of meetings has been reduced as a direct consequence of the increased confidence of our Commissioners in our mortality performance.

1.2 Mortality indicators

There are three main types of mortality indicator. Crude mortality is a simple analysis of the percentage of patients who died in hospital against the total number of discharges from hospital and makes no adjustment for patient acuity. The Hospital Standardised Mortality Ratio (HSMR) is a logistical regression calculation developed by Dr Foster to measure in-hospital mortality for 80% of the most common diagnosis categories resulting in patient deaths. It includes case-mix adjustment for a range of factors including patient age and patient acuity and for the delivery of palliative care.

The Summary Hospital Mortality Indicator (SHMI) is also based on a logistical regression model and measures hospital mortality outcomes for all diagnosis groups along with deaths in the community up to 30 days after discharge. This measure is published by NHS Digital. In additional to the different scope of this measure, the case-mix adjustment varies from HSMR in a number of ways with a key difference being that SHMI does not make an adjustment for palliative care.

Crude mortality is available within one day following the end of the month. HSMR is 3 months in arrears and SHMI 7-9 months in arrears.

1.3 Crude Mortality

Crude mortality is most useful in monitoring the performance of a defined clinical unit where the case-mix is expected to remain stable over time. It is less useful for comparing the performance of clinical units with differing case-mix where mortality varies. Following the implementation of Lorenzo, the Acumen tool for daily mortality

data remains unavailable due to continuing data quality issues. Provisional UAT data (User Acceptance Testing) for September 2017 to February 2018 has been used in the preparation of this report.

Dr Foster is now comparing performance of crude mortality and reports that the average national crude inpatient mortality (for ordinary admissions excluding day cases) is 1.4% and 1.5% within the region. This compares to 1.6% within ENHT.

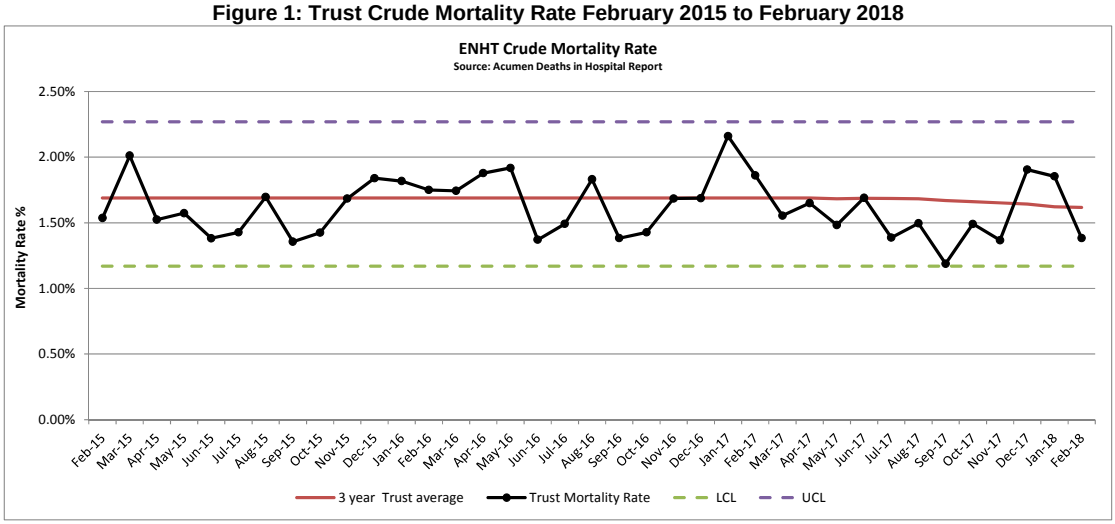
Dr Foster's Mortality Comparator also provides the ability to benchmark the Trust's performance against other non-specialist acute providers. The latest available information is provided below.

Table 1: Crude Mortality rate by where patient died for ENHT vs all non-specialist acute providers in July 2016 to June 2017

	ENHT	Non-specialist acute providers
All deaths	3.53	3.28
In-hospital deaths	2.47	2.33
Post discharge deaths	1.07	0.95

Figure 1 shows the Trust's local crude mortality rate for the last four years along with the long-term mean over this period. This local crude mortality includes all the activity that happened at the Trust and is a simple calculation of deaths against the number of spells. For information, provisional data for September 2017 to February 2018 has been included as noted above.

Figure 1: Trust Crude Mortality Rate February 2015 to February 2018



The 3 year average rate for crude mortality shown in figure 1 above is 1.62%.

Table 2 below provides the data for deaths, discharges and the crude mortality rate for the latest rolling year from March 2017 to February 2018 (1.54%) together with the current financial year 'YTD' position.

Table 2: Trust Crude Mortality February 2017 to February 2018

	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	YTD 17/18
Trust Deaths	152	137	126	122	142	124	142	120	156	149	183	198	135	1598
Trust Discharges	8170	8814	7635	8227	8401	8939	9493	10098	10459	10746	9606	10733	9756	104093
Trust Mortality Rate	1.86%	1.55%	1.65%	1.48%	1.69%	1.39%	1.50%	1.19%	1.49%	1.39%	1.91%	1.85%	1.38%	1.54%

Within these figures there can be considerable variation especially at site level and when there are changes in clinical pathways. Increased management of patients via ambulatory routes such as “hot’ clinics, may result in rising crude mortality.

There is normally strong seasonal variation in crude mortality across England but last year the usual sharp winter spike was replaced by a far less pronounced but protracted elevated trajectory which did not settle until June. While January 2017 did see a spike in mortality this did not compare to 2015. Since that point the Trust’s crude mortality rate continued on a downward trend. While December 2017-January 2018 did see a winter spike, this did not even compare to last year’s elevation with February 2018 seeing a significant decrease.

1.4 Hospital Standardised Mortality Ratio (HSMR)

The HSMR is a powerful measure of performance compared to crude mortality as it effectively benchmarks the performance of a trust against all English acute non-specialist hospital Trusts. It is at its most effective as a comparator when viewed at Trust level and for a twelve month rolling period to reduce the seasonal variation.

The view of Dr Richard Wilson NHSI’s Director of Quality Intelligence & Insight is that it is very common for depth of coding to decrease following the introduction of any Patient Administration System, such as the Trust’s implementation of Lorenzo in September 2017. One effect of this is an increase in HSMR and SHMI, due to the apparent reduction in the risk of mortality for patients who appear to have fewer co-morbidities.

The Trust’s HSMR position for the last twelve months to December 2017 was **99.41.** The Trust’s position relative to its East of England peers is 7th (out of 16) and can be viewed in Appendix 3. Over the last 12 months the Trust’s in-month HSMR has been on an upward trend. As depth of coding returns to pre-Lorenzo levels HSMR will continue to be monitored to assess if there are additional underlying factors contributing to this trend.

1.4.1 HSMR Performance

One of the strengths of the HSMR model is the ability to review the calculations for individual months and for units of analysis within a Trust. HSMR at the Trust is reviewed at both Trust level and for each Division against appropriate thresholds and reported on the Trust Board Performance Report showing rolling 12 month performance. Table 3 shows Trust and Divisional monthly HSMR performance RAG rated against internal targets. The Rolling 12 month positions for Cancer Services and Medicine are both showing marginal red ratings with figures of 101.8 and 100.1 respectively.

1.4.2 HSMR Trends

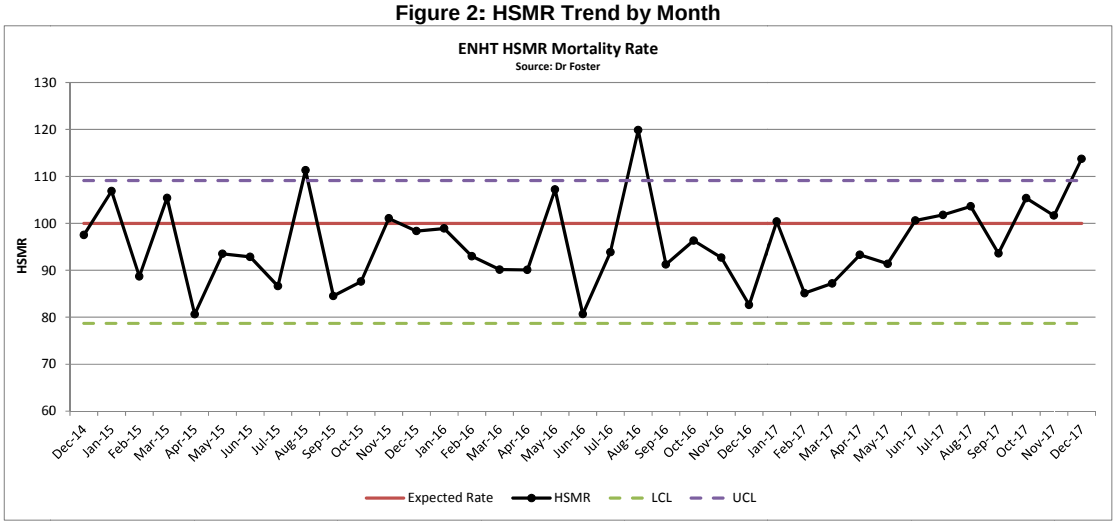
Table 3: Monthly Trust and Divisional HSMR Jan17-Dec17

	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Rolling 12M
Cancer	84.9	145.5	124.3	104.4	115.7	92.0	83.9	64.0	118.6	130.2	103.2	88.9	75.0	101.8
CSS	0.0	135.3	0.0	0.0	0.0	0.0	0.0	0.0	0.0	118.8	0.0	0.0	0.0	42.9
Medicine	81.0	99.2	88.4	91.1	91.3	95.3	105.2	107.7	103.6	99.5	108.9	95.6	119.0	100.2
Surgery	152.8	123.2	108.3	52.3	104.4	72.3	126.1	145.0	97.0	62.9	120.1	50.2	99.2	96.6
Women & Children	128.2	235.6	0.0	0.0	0.0	0.0	0.0	0.0	157.2	0.0	0.0	0.0	0.0	38.5
Trust	88.9	106.2	92.6	88.1	94.4	91.4	103.4	103.0	104.9	98.3	107.9	89.5	113.7	99.4

Source: Dr Foster Healthcare Intelligence Portal

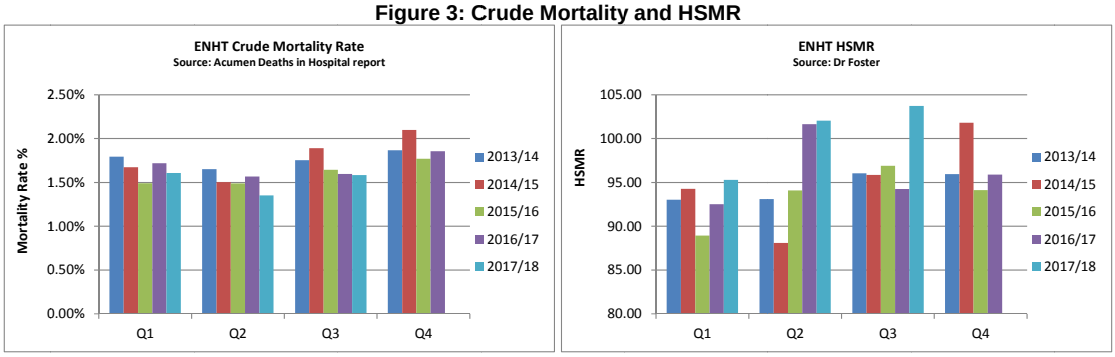
The monthly Trust-level HSMR is shown in Figure 2.

Figure 2: HSMR Trend by Month



The observed number of deaths within the risk model for HSMR is the greatest factor determining the overall score for an organisation. The relationship between the levels of crude mortality and HSMR can be seen in figure 3 below. Crude mortality can be used as a useful predictor of coming HSMR performance.

Figure 3: Crude Mortality and HSMR



1.4.3 HSMR Outliers

With regard to HSMR for the latest rolling year to December 2017, there are currently two diagnostic groups attracting significantly higher than expected deaths at the 95% confidence level for relative risk where 6 or more deaths are observed.

Table 4: HSMR Negative Outlier January 2017 to December 2017

	Relative Risk	Observed Deaths	Expected Deaths	"Excess" Deaths
Septicaemia (except in labour)	133.8	209	156	53
Pulmonary heart disease	186.3	15	8	7

Source: Dr Foster Healthcare Intelligence Portal

Recent changes to Sepsis Coding guidelines came into effect on 1 April 2017. Prior to this the Trust's HSMR for Septicaemia stood at 97. Since this point it has steadily increased, rising to 133.8 at the latest Dr Foster release for the 12 months to December 2017. Since the November release (Sep-16 to Aug-17) it has been significantly elevated. The Dr Foster Unit of Imperial College London has advised that it has now alerted the CQC to this continuing elevation.

Following detailed discussion at April's Clinical Governance Strategy Committee meeting it was agreed that an in-depth review of 2017 cases involving deaths coded to sepsis should be conducted. This will involve a multidisciplinary team led by the Sepsis Lead Nurse and will include coding and microbiology input.

Further information regarding ongoing Sepsis management work is detailed in 1.6.4.

The verbal debrief following the Invited Service Review by the Royal College of Physicians indicated that there were no concerns regarding cardiology mortality. The draft report has now been received and is in the process of review for factual accuracy.

1.4.4 CQC CUSUM Alerts

There have been no new CQC CUSUM alerts since October 2013.

1.4.5 Key Quality Measures

It is important to triangulate mortality data with other quality measures to give a balanced perspective on quality of care provided by the Trust. Table 5 shows the index based on observed over expected values for HSMR, Length of Stay and Re-admission for the rolling year up to December 2017.

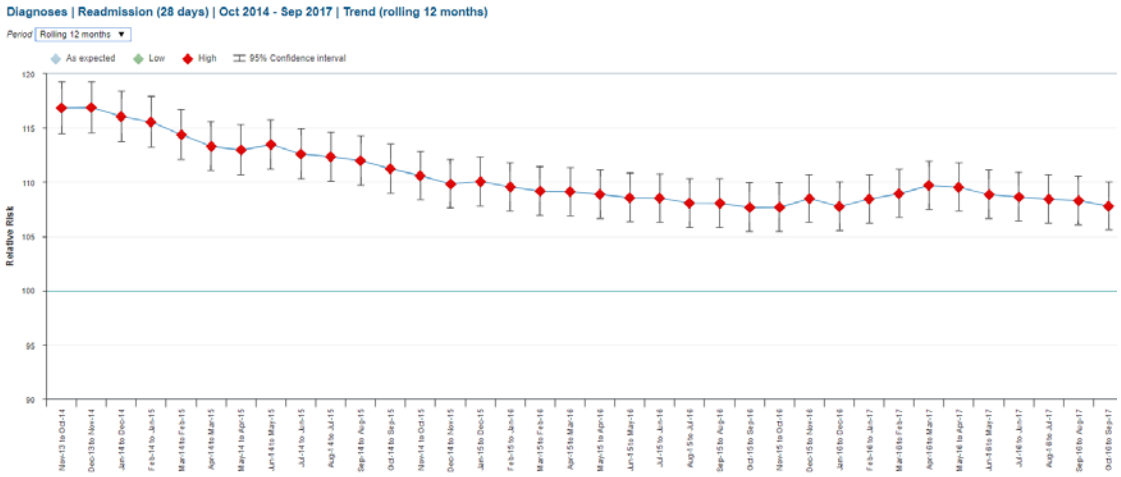
Table 5: Key Quality Measures January 2017 – December 2017

	Trust Total	Elective	Non-Elective
HSMR	99.4	109.6	99.2
Length of Stay	90.7	84.7	91.7
Readmissions within 28 days	107.8	108.7	107.5

Source: Dr Foster Healthcare Intelligence Portal

HSMR mortality remains within the 'as expected' band, and length of stay has remained consistently below the expected levels, meaning that overall we discharge patients sooner than expected for our case mix. Readmissions, while continuing to be above the national average, has shown a gradual decrease over the last three years as demonstrated by the chart below.

Figure 4: Readmissions (28 days): Rolling 12 month Trend: October 2014 – September 2017

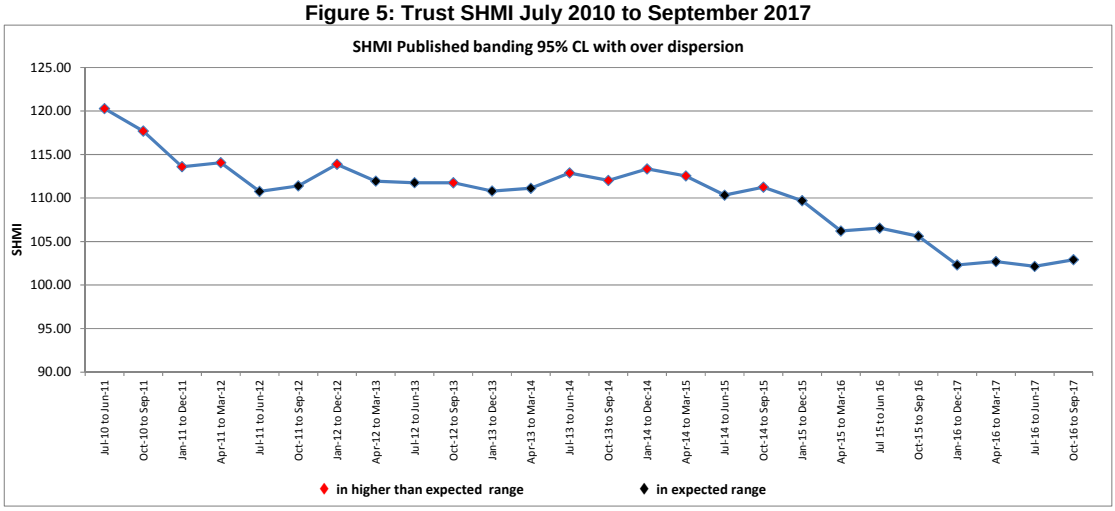


1.5. Summary Hospital Mortality Indicator (SHMI)

SHMI alongside HSMR can be a powerful benchmarking tool. Historically the methodological differences between these two models have provided challenges for the Trust. However, over the last 3 years the difference between these 2 indicators has gradually narrowed, now standing at less than 4 points. The remaining discrepancy is partly accounted for by 7-day provision of palliative care services and in addition the Trust remains in a small minority that include a hospice.

Following consistent improvements in SHMI, the latest rolling 12 month period to September 2017 has shown the Trust's position remaining relatively stable with a small increase from 102.1 to 102.9. As figure 5 demonstrates this represents a 17.3 point reduction since our first SHMI was reported for the period July 2010 to June 2011.

Figure 5: Trust SHMI July 2010 to September 2017



1.5.1 SHMI Mortality Triangulation

We use two approaches to identify areas for investigation into potential mortality problems: diagnosis groups with the highest number of deaths, as small improvements in care could benefit a large number of patients, and diagnosis groups with high 'excess' deaths.

The five diagnoses resulting in the highest number of deaths during this period are Pneumonia, Acute Cerebrovascular Disease (which includes stroke), Septicaemia

(except in labour) and Shock, Congestive Heart Failure and Urinary Tract Infections, Congestive Heart Failure.

Table 6: SHMI Diagnosis Groups with highest death rate Oct16-Sep17

CCS Group	Spells	Observed Deaths	Expected Deaths	SHMI	SHMI Performance Change
Pneumonia	1831	366	320.6	114.2	▼
Acute cerebrovascular disease	901	174	159.0	109.4	▼
Septicaemia (except in labour), Shock	828	171	147.7	115.8	▼
Congestive heart failure, nonhypertensive	583	96	85.6	112.1	▲
Urinary tract infections	1535	78	82.3	94.8	▼

Source: NHS Digital

Table 7 shows the five diagnoses with the highest number of "excess" deaths. Excess deaths are the actual number of deaths over the expected number for our population that have been calculated within the SHMI case-mix adjustment.

Table 7: SHMI Diagnosis Groups with highest excess Oct16-Sep17

Diagnosis group	Spells	Excess Deaths	Latest SHMI (Oct16-Sep17)	Previous SHMI (Jul16-Jun17)	SHMI Performance Change
Pneumonia	1831	45	114.2	110.1	▼
Septicaemia (except in labour), Shock	828	23	115.8	105.1	▼
Acute cerebrovascular disease	901	15	109.4	100.3	▼
Acute myocardial infarction	616	14	134.5	137.7	▲
Chronic obstructive pulmonary disease and bronchiectasis	903	12	120.6	128.5	▲

Source: NHS Digital

Measures in train to reduce deaths in these areas are explained in more detail in 1.6.

1.6 Specific Actions to Address High Mortality Conditions

1.6.1 Pneumonia, Acute Bronchitis & Chronic Obstructive Pulmonary Disease (COPD)

We continue to build on the many improvements implemented since 2012 and the focus continues with improving coordination with Primary Care. Details of current initiatives and updates are provided below:

- The Integrated Community Respiratory Service has been fully established since May 2017. It works closely with Acute Chest Team to prevent admission and support early discharge. The Community team continues to work with GPs to highlight frequent attenders and support early discharge from hospital
- Fortnightly Consultant input into target days at GP practices continue to work well
- While uptake of the use of the e-mail advice line for GPs and practice nurses (which replaced the telephone advice line) was initially slow, this is now being used and links with the HOT clinics for rapid assessment
- The Trust continues to do well with the National COPD audit, being one of the top performers among participating trusts. Further external audit participation is scheduled with start of the national Asthma audit in November.
- The team continues to monitor HSMR and SHMI closely at monthly meetings, investigating any concerns that arise.

Despite the Respiratory team remaining one consultant short, the service continues to be maintained with cross cover.

Following previously reported improvements in SHMI levels, the latest release has shown further improvements in four of the seven respiratory diagnosis groups, with significant decreases for Acute Bronchitis and Respiratory Failure. The challenges associated with accurate coding of a number of respiratory conditions including Pneumonia and Respiratory Failure continue and work remains ongoing in this regard.

Table 8: Respiratory Service SHMI Data

Diagnosis group	Observed Deaths	Excess Deaths	Latest SHMI (Oct16-Sep17)	Previous SHMI (Jul16-Jun17)	SHMI Performance Change
Pneumonia	366	321	114.2	110.1	▼
Chronic obstructive pulmonary disease and bronchiectasis	71	59	120.6	128.5	▲
Aspiration pneumonitis, food/vomitus	63	70	89.5	87.7	▼
Acute bronchitis	24	39	61.0	80.1	▲
Respiratory failure, insufficiency, arrest (adult)	18	22	83.4	117.3	▲
Pleurisy, pneumothorax, pulmonary collapse	11	16	67.8	76.4	▲
Other upper respiratory infections…	7	12	59.9	48.6	▼

Source: NHS Digital

1.6.2 Acute Chest Team (Post CQUIN)

Now well embedded, the Acute Chest Team (ACT) has been operational as a 7 Day Service since April 2015. In additional to holding 3 'Hot' clinics a week it provides an excellent consultant led daily service from 8.30am-5.30pm with respiratory input being given to acutely admitted patients on ED, AMU and SSU. Following conclusion of the CQUIN, the ACT service continues to collect data for internal audit purposes as part of the on-going assessment of the Trust's respiratory service.

1.6.2.1 Seven Day Respiratory Service

We look at mortality indicators relating to the specific respiratory diagnosis groups within the respiratory basket to try to assess the impact of moving to a seven day service.

Table 9 below shows that while HSMR has remained in the "as expected" range, further significant reductions have been achieved in the majority of respiratory diagnosis groups compared to the previous 12 month period. While this improvement had been expected, it took time to materialise. These levels now better reflect the persistent hard work of the Respiratory team and the findings of the RCP Invited Service Review of August 2015.

Table 9: Respiratory Service HSMR Data

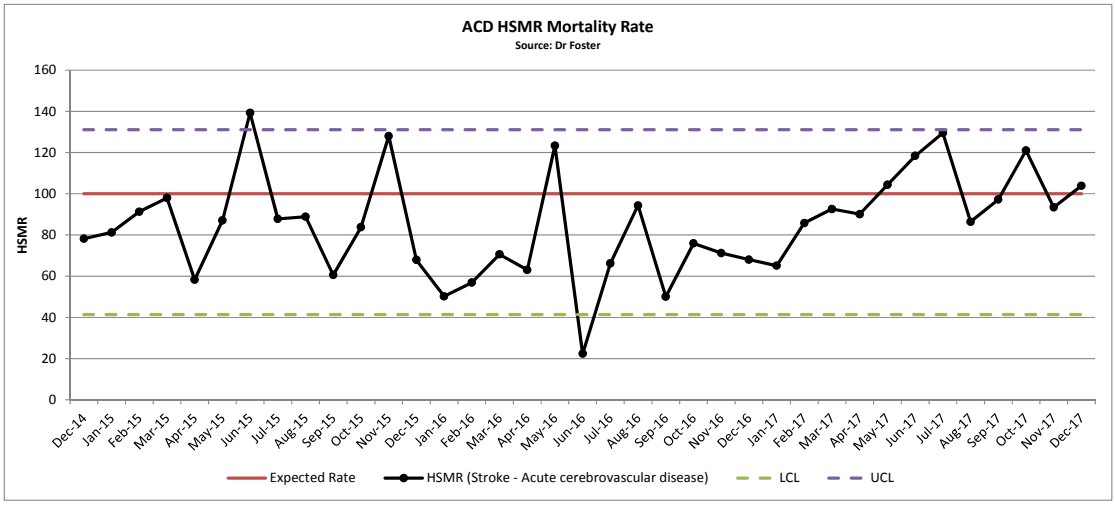
Diagnosis group	Jan-16 to Dec-16 HSMR	Jan-17 to Dec-17 HSMR	HSMR Performance Change
All	104.6	98.8	▲
Acute bronchitis	98.4	58.8	▲
Aspiration pneumonitis food/vomitus	88.4	81.6	▲
Chronic obstructive pulmonary disease and bronchiectasis	114.4	99.1	▲
Other lower respiratory disease	81.1	90.7	▼
Other upper respiratory disease	106.3	70.8	▲
Pleurisy pneumothorax pulmonary collapse	110.8	47.7	▲
Pneumonia	105.6	109.7	▼
Respiratory failure insufficiency arrest (adult)	137.7	84.0	▲

Source: Dr Foster (Benchmark month: Jun 2017)

1.6.3 Acute Cerebrovascular Disease (Stroke)

Stroke SHMI had been a cause for concern, rising to 124.08 for the period January 2015 to December 2015. However, SHMI releases in September and December 2016 saw significant falls in SHMI to 101.67 and 85.3 respectively. Although the latest release to September 2017 has seen an increase to 109.4 (from July 2016-June 2017 100.3), this is still an improvement on the 2015 position. As Dr Foster's Mortality Comparator has yet to refresh with the September 2017 release, it is not yet known whether this is within the 'as expected' range. For the 12 months to August 2017, HSMR was 87.05. While for the 12 months to December 2017 this has risen to 97.3, it remains within the 'as expected' range.

Figure 6: Acute Cerebrovascular Disease HSMR by Month



Recent reports to this Committee have outlined a variety of improvements that have taken place in Stroke care to improve outcomes for patients. While there have been few recent developments the following remain relevant:

- In February the Trust again retained its A rating in the SSNAP audit report produced by the Royal College of Physicians, representing an excellent level of performance
- NHS England has commissioned the Thrombectomy service as a specialist service. The Service is currently working on a SLA with Charring Cross Hospital for referrals
- Two consultant positions have remained covered by Locums (2 out of 6). While there appears to be a national problem recruiting to substantive posts, the Service continues in its efforts to fill these positions
- The 24/7 HASU service continues (in the absence of a full substantive team, certain aspects have to be covered with the help of external bodies)
- Following agreement of the Thrombolysis in-hospital pathway and action plan, CCGs continue to work on the pre-hospital pathway with feedback from our consultants regarding telemedicine.

1.6.4 Sepsis

1.6.4.1 Sepsis CQUIN

Sepsis continued as a national CQUIN for 2017-18 with some changes to the targets, including new requirements regarding reduction in antibiotic usage.

Table 10: Sepsis Key CQUIN Data 2017-2018

CQUIN Requirement	Target	Q4*	Q3	Q2	Q1
Timely identification of sepsis in emergency departments and acute inpatient settings					
Adult ED patients who needed screening for sepsis were screened	90%	98%	86%	95%	96%
Child ED patients who needed screening for sepsis were screened	90%	March data awaited	80%		
In-patients who needed screening for sepsis, were screened	90%	93%	91%	95%	97%
Timely treatment of sepsis in emergency departments and acute inpatient settings					
Emergency department adult patients received IVABs within 1 hour of meeting Red flag criteria	90%	78%	57%	63%	59%
Emergency department child patients received IVABs within 1 hour of meeting Red flag criteria	90%	Feb/March data awaited	62.5%		
In–patients received IVABs within 1 hour of meeting Red Flag criteria	90%	33%	47%	59%	50%

*The final CQUIN report has not yet been finalised for Q4 so the figures provided above are provisional. Initial indications regarding inpatient results are extremely disappointing. The Sepsis Lead reported that many of those referred by CCOT to the sepsis team were not eligible for the inpatient audit. At the time of writing, further sets of notes were awaited which may improve the figures.

ED screening for adults has shown marked improvement following the introduction of NerveCentre and the change in position of the Sepsis proforma (now placed at the front of the paperwork 'bundle' nurses must complete for each patient). It should be noted that March ED audit work was hampered by the lack of provision of the ED admissions report from Informatics together with reduced access to prescription records & front sheets in ED due to reception building work during March. This resulted in the need for randomisation of available notes for the assessment of both screening and treatment of sepsis.

Currently inpatient wards & Children's areas are using a different version of NerveCentre which does not prompt the user to screen for sepsis when the PEWS or NEWS triggers. The required update to align these services with the ED system was expected to be in use by Q4, but unfortunately a “go live” date is still awaited. It is anticipated that improvements seen in ED will be mirrored in inpatients/Children’s following this system update. Additionally the children's department are in the process of redesigning their Paediatric assessment form to better support good practice and evidence appropriate screening.

Prior to the introduction of NerveCentre ward sisters conducted a monthly NEWS chart audit, which has since ceased (as it was due to be done electronically). The current concern is that inpatient screening is potentially positively biased as all the patients audited had been referred to Sepsis audit by CCOT, which meant that all had been screened. From April, the Sepsis team will audit a random sample of 50 inpatients every month to assess whether they should have been screened for sepsis.

While treatment times in ED have shown a degree of recovery in Q4, they are still significantly below the 90% target. Review of cases of patients not treated within 1

hour, usually shows a delay in either escalation by nurses or response from doctors or sometimes a delay in decision to act on red flags.

The focus has remained on providing sepsis training and continuing to raise awareness of the vital importance of appropriate and timely action regarding the identification and management of sepsis, the following being relevant examples:

- Enhanced care team targeted to encourage them to consider sepsis in patients who have additional needs
- Proactive approach to monitoring the NEWS scores of people with learning disabilities with early intervention when these patients deteriorate, to remind staff to screen for sepsis & urge prompt treatment
- From April, individual feedback to the staff concerned in sepsis treatment delays is planned
- Training for FY 1/2's and AMU doctors
- RHD reminder by Medical Director regarding urgency of treatment of patients with suspected red flag sepsis
- Sepsis included in CCOT run alert course
- Planned training for 2018 includes 6 Sepsis Update training sessions for ED staff (April-June); a care of the acutely ill ward patient study day (April); 3 sepsis updates for MVCC staff and SIM training on elderly wards using scenarios based on real patients.

Unfortunately it has been noticed that fewer nurses have been available to attend teaching over the recent months, with those attending usually doing so after working a night shift or on their days off.

1.6.5 Gastroenterology

HSMR for Gastroenterology had continued to rise over the winter period. The Specialty continued to believe that incorrect coding of General Medical cases to Gastroenterology was a significant factor in this increase. A recent exercise with Coding was undertaken to ensure that Gastroenterology consultants have both Gastroenterology and General medical profiles under their names allowing for correct allocation of cases. Subsequently HSMR for Gastroenterology as the speciality of discharge has shown a significant improvement since my last report, falling from 158.2 (above expected range) down to 138.2 (within the 'as expected' range) for the rolling year to December 2017. Further refreshes should show whether the errors in coding were responsible for the elevated mortality rate.

Discussions have continued regarding the management of GI bleeds. Currently these are overseen by Gastroenterology and General Surgery. Consideration is being given as to whether it will be more effective for one of the Specialties to assume sole responsibility.

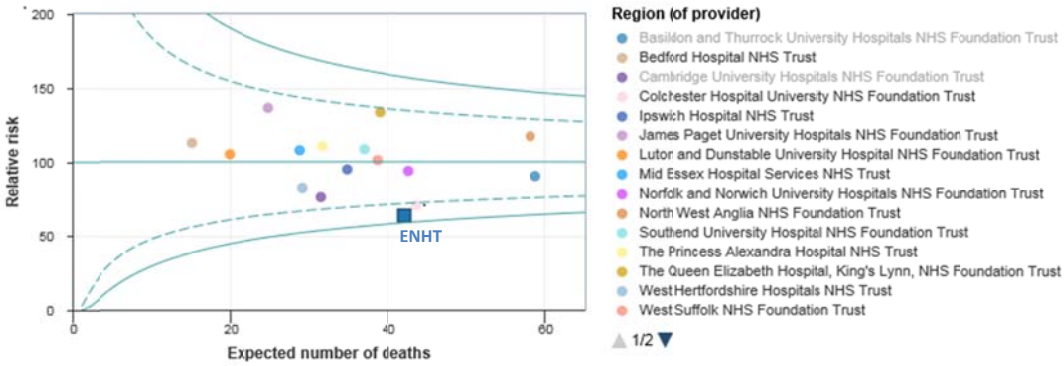
1.6.6 Acute Kidney Injury

After a long period of uncertainty the AKI team has finally be granted funding for a substantive post for its AKI specialist nurse. The quality of care and innovation she has demonstrated has already helped the service to achieve a reduction in AKI related mortality and she will now be dedicated to achieving further long term sustainable improvements.

The AKI team continues to promote AKI awareness and best care both within the hospital and wider community. Key points of note include:

- For the 12 months ending February 2017, HSMR for acute unspecified renal failure had reduced to 92.5. This represented a marked improvement to the years prior to the inception of the AKI team in February 2016. April to August 2017 saw HSMR rise significantly. Subsequent work with the Head of Coding identified a coding issue which was corrected
- HSMR has now recovered and continued to improve reflecting the Specialty's preventative clinical model and close liaison with coding to improve accuracy of reporting to Dr Foster. It now stands at 64.1, falling within the 'lower than expected' range. Additionally the Trust now has the lowest HSMR for acute and unspecified renal failure in our East of England peer group

Figure 7: Acute Unspecified Renal Failure HSMR (Jan-17 to Dec17) EoE Peer Comparison



- A key priority for the service remains the establishment of links between LIMS and NerveCentre/Lorenzo to enable AKI data to be submitted to the Renal registry for a mandated national comparative audit. Most other acute trusts are already submitting data and ENHT remains an outlier
- The team remains committed to maximising the use of data to enhance the quality of patient care. In the last two years 9 accepted abstracts from the service have been presented by a multidisciplinary team at national and international levels. This year their data regarding in-hospital AKI and Gentamicin has been accepted for publication in a renal journal. The continuing data based culture of the team has allowed them to understand the Trust's AKI and create a safer environment for patients.

1.6.7 Cardiology

At the time of my last report HSMR for AMI was significantly elevated at 143.9 for the rolling 12 months to August 2017. This has now seen a significant reduction to 125.2 for the 12 months to December 2017 and sits within the 'as expected range'. HSMR for Cardiology as the Specialty of Discharge has remained steady at 116.1 for the year to December 2017 which is in "as expected" range. Work has remained on-going to ensure correct/consistent coding of these patients, including external liaison with the Classifications Department regarding clarification of appropriate protocols.

Of note is that verbal feedback following the October Invited Service Review by the Royal College of Physicians contained no concerns regarding mortality rates. The draft report has now been received from the RCP and is in the process of being reviewed for factual accuracy.

1.7 Update on Strategically Important Pathways

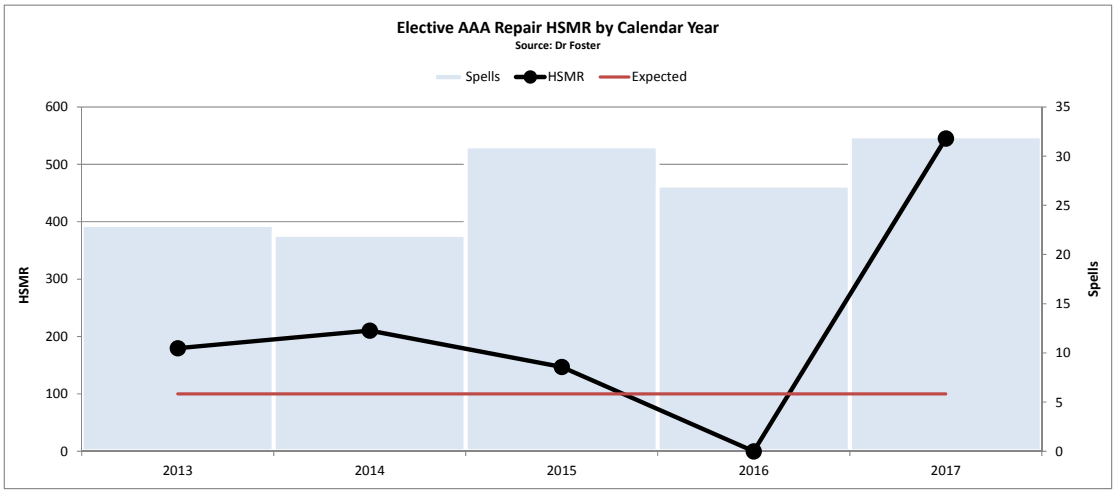
1.7.1 Elective Abdominal Aortic Aneurysm Repair (AAA)

Following the Trust's recent successful bid for the creation of a Vascular hub at Lister servicing the whole of Hertfordshire and West Essex, the future is now looking more secure for the Service. Work continues regarding the development of the business case for the vascular hub at Lister Hospital.

Validation of the activity and cost assumptions from the bid and development of clinical pathways have taken longer than anticipated. Therefore, development of Outline Business Case (OBC) for Phases 1 and 2 has been delayed beyond April 2018.

The chart below shows the annual relative risk trend for elective AAA procedures along with the total number of elective operations carried out (on the right). The relatively small numbers involved create more uncertainty in the indicative accuracy of the HSMR value.

Figure 8: Elective AAA Repair by Year



Note: data for 2017 is for the full year Jan-Dec 2017

The spike in HSMR for the period Jan-Dec 2017 is the result of two deaths. The first was detailed in my last report. It was comprehensively reviewed via the Trust's mortality review process and Specialty Clinical Governance forum prior to final consideration by the Clinical Governance Strategy Committee. The Committee concluded that this was major surgery with known risks, performed by a highly experienced vascular surgeon. All appropriate consenting had been carried out and no failings in care were identified. It was agreed that this was an unfortunate but unavoidable death. The second death has also been appropriately reviewed and discussed. It was concluded that this procedure was extremely high risk. The patient was fully aware and had refused all other options. Again it was agreed that this was an unfortunate but unavoidable death.

1.7.2 Deteriorating Patient Plan

Deteriorating Patient Plan (DPP) working group now forms part of the Patient Safety Committee. Current updates include:

- NerveCentre e-Obs is now in place at MVCC
- New Cardiac arrest root cause analyses process has been introduced. This process feeds into both the Serious Incident and mortality review processes and has already proved valuable in identifying cases deserving further investigation and opportunities to learn and improve patient care
- Monthly critical medication audits have shown encouraging results compared with the baseline (Dec: 6.15%; Jan: 5.41%; Feb: 2.31%; Mar: 5%)
- A re-scoping of the sepsis workstream has been completed with the aim of resolving practical challenges.

1.8 Other Trust-wide reducing mortality initiatives

1.8.1 Improving Patient Outcomes Strategy 2015-18

The Improving Patient Outcomes Strategy 2015-18 (IPOS) which combines a strategy for clinical effectiveness and patient safety is in its final year. Indications in the mid-year were positive and compared favourably with last year's position. The final end of year report is due to be presented to the Risk and Quality Committee in June 2018.

1.8.2 Seven Day Services

The Trust continues to work towards 7 day working and fully achieving the Keogh standards set out in the report NHS Services, Seven Days A Week. ENHT was confirmed as being in the tranche of trusts tasked with achieving compliance against the four prioritised standards by the end of March 2018. These four prioritised standards are:

- Standard 2: Time to Consultant Review
- Standard 5: Access to Diagnostics
- Standard 6: Access to Consultant-directed Interventions
- Standard 8: On-going Review.

When the Medical Director attended the Seven Day services day provided by NHS I in Cambridge in September it was obvious that many other Trusts, like ENHT, were struggling to make progress towards achievement of the required standards. The Trust's endeavours have been further hampered by the departure of our Seven Day Services Lead. The target of compliance with the four prioritised standards by the end of March 2018 has not been achieved.

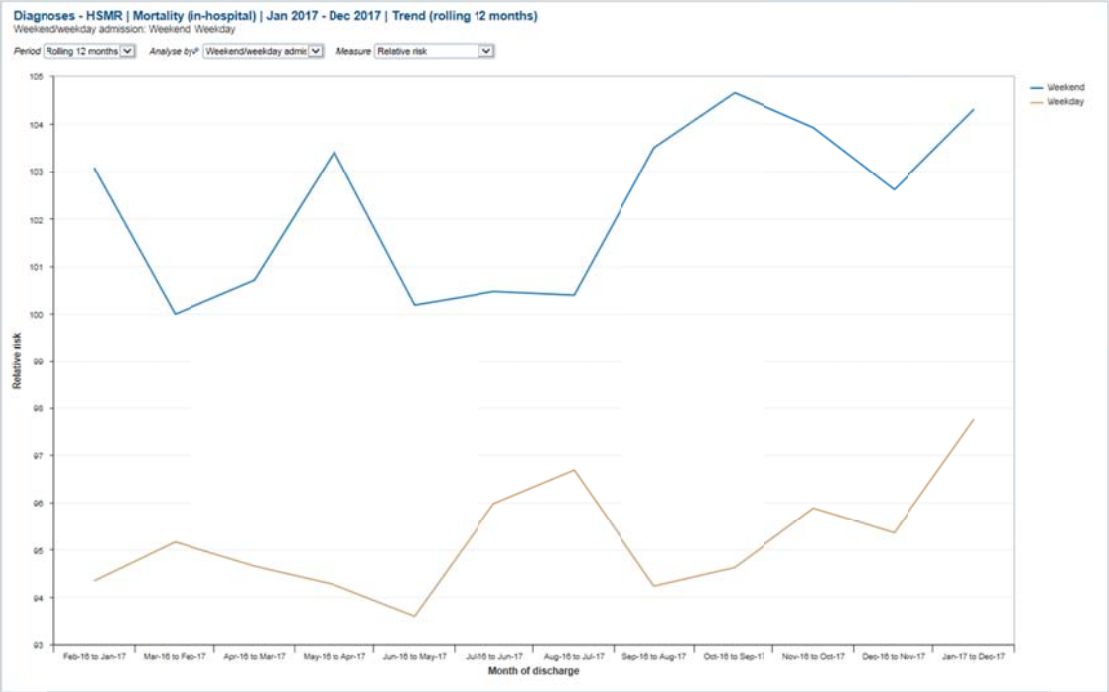
Following the full audit of the four standards in March 2017 a mini audit of Standard 2 was conducted in September 2017. Table 11 provides headline detail of the outcome. The results were extremely disappointing. The next full audit is due to commence at the end of April, the results of which will be reported in due course.

Table 11: 7 Day Services September 2017 Standard 2 Audit Summary

Standard	Requirement	ENHT Outcome	
Standard 2	Patients should be seen by a consultant within 14 hours of admission	The overall proportion of patients seen and assessed by a suitable consultant within 14 hours of admission	48%

Figure 9 below shows that following intermittent widening divergences between weekday and weekend HSMR levels, the latest data release shows a parallel rise in HSMR. The reasons for these variances are not fully understood and will continue to be monitored.

Figure 9: HSMR by Weekend/weekday admission: rolling 12 months Jan17 to Dec17



1.8.3 Care Bundles

As part of the Improving Patient Outcomes Strategy the Trust was committed to the implementation of ten care bundles by the end of 2017-18. The following Care Bundles, either standalone or as part of an Integrated Care Plan, have been identified as being in active use:

- Acute Myocardial Infarction
- AKI
- Congestive cardiac failure
- COPD (admission)
- COPD (discharge)
- Decompensated cirrhosis
- Pneumonia
- Saving Babies Lives
- Sepsis
- Stroke.

Audits are in progress to gain baseline information regarding awareness and use of the care bundles to inform future plans to improve uptake of the bundles in clinical practice.

Work remains ongoing to develop a more standardised format for care bundles together with appropriate guidance regarding their creation and use. Subsequent to this a Trust-wide awareness campaign is planned. The ultimate aim is to transfer to an electronic format. This work is strongly supported by the CCG via the Mortality Review Group.

1.9 Coding

The Head of Coding has continued to implement changes to improve the service. Recent developments have included:

- Provision of support to the Lorenzo implementation
- Continued work to clear the coding backlog as a consequence of Lorenzo implementation Data Quality Issues. Coding backlog now reduced to 86% at flex dates
- "The importance of coding" training and awareness to FY2 completed on 21 November 17 and FY1 on 23 January 2018
- Focus on creating greater Clinician/Coder engagement and clinical coding audits
- Continued focus on training to improve coding staff capability. This has included a Clinical Coding refresher course for all coders completed January 2018 (the assessment carries an 85% pass mark)
- IGT Audit completed March 2018 (Level 3 achieved)
- Validation of coded data and review of all UZ HRG from 1 April 2017
- April - September 2017 refresh of coded data to SUS completed.

1.10 Data Quality

Following the implementation of Lorenzo a number of data quality issues relevant to mortality have arisen. The first, alluded to in 1.3 above, relates to the continued unavailability of the Deaths in hospital and ED Deaths Acumen reports, which allow daily monitoring of hospital mortality data. The new reports created post Lorenzo have not yet been published due to ongoing data quality issues.

Additionally the transition to Lorenzo resulted in some patients being allocated more than one hospital number. Anomalies have been identified regarding the deceased status of a number of patients, and subsequently the total number of patients being picked up by the mortality audit tool. Following the appointment of a new Data Quality Lead, further updates will be provided regarding progress made to address these issues.

1.11 Learning from Deaths National Requirements

In December 2016 the CQC published its report 'Learning, Candour and Accountability: A review of the way NHS Trusts review and investigate the deaths of patients in England'. Commissioned by the Secretary of State for Health in response to the very low number of investigations and reviews of deaths at Southern Health NHS Foundation Trust, it concluded that opportunities to improve care for future patients were being missed due to insufficient consideration being paid to learning from deaths in the NHS.

The Secretary of State accepted the report's recommendations, asking the National Quality Board (NQB) to translate the recommendations into a framework for implementation across the NHS. In March 2017 the first step in this programme was published in the form of the National Guidance on Learning from Deaths.

As stipulated in the last report to Committee, the fact that the guidance is detailed, in places open to interpretation and impacts on multiple Trust processes and policies,

means that work will remain ongoing over the coming months to ensure we take full account of all the recommendations, not only to guarantee compliance, but also to gain maximum benefit from the quality improvement recommendations.

Our mortality management and administrative resource capacity over the last 12 months has become increasingly stretched. As it has become clear that the increased demand is due not only to short term development requirements, but to the longer term, ongoing requirements of compliance with national guidance, a review is currently underway to assess what level of resource is now needed and whether a case for additional investment needs to be made.

The national guidance contained four key requirement milestones. These are detailed below together with an indication of our current compliance:

Table 12: Learning from Deaths: Compliance Summary

Guidance Requirement	Current Compliance Status
From April 2017 Collection of quarterly information relating to deaths, reviews, investigations and resulting quality improvement	**Compliant** Corresponding detail provided in this report at 1.11.3 below.
By the end of September 2017 Publish an updated policy detailing how the Trust responds to and learns from the deaths of patients in its care	**Compliant** Policy drafted by 30 September; ratified by the Clinical Governance Strategy Committee on 4 October and published on Trust website on 5 October.
From Q3 2017 Publish information on deaths, reviews and investigations via a quarterly agenda item and paper to its public board meeting	**Compliant** First report to Board took place on 1 November 2017, with papers subsequently published on the Trust website. This is now the third report to RAQC/Board.
From June 2018 Publish an annual overview of the relevant information in the Trust's Quality Account, including a more detailed narrative account of the learning from deaths reviews/investigations, actions taken in the preceding year, an assessment of their impact and actions planned for the next year.	**On track for compliance** Relevant detail has been drafted for inclusion in the Trust's Quality Account.

As detailed in my last report, attendance at several external events provided opportunities for discussion with other Trusts, Regulators and the Public. They also confirmed the complexity and diversity of challenges involved in the implementation of the framework across the healthcare system, the diversity of approaches being adopted by different organisations and the fact that there is a great deal of variation in how far advanced organisations are on the road to full implementation and compliance with the framework.

In view of this we will continue to find opportunities for discussion with other trusts, especially those in our region. The Eastern Academic Health Science Network is setting up a 'Learning from Deaths' Regional Forum, and we will attend the first event in May.

While we believe that our Trust is well placed in terms of compliance with the key initial requirements for the national guidance, significant ongoing development is now required both to our existing mortality review system and regarding the adoption of new processes to further enhance our learning from deaths.

1.11.1 Learning from Deaths Policy

The new national guidance required trusts to have published a Learning from Deaths Policy on their websites, compliant with the guidance, by the end of September. Our policy was developed within this timeframe and published on the Trust's website. As further development of our Learning from Deaths framework takes place over the coming months our policy will continue to be revisited and shaped.

1.11.2 Mortality Case Record Review Process and Methodology

As indicated in the last report, following detailed consideration, including consultation with our Mortality Reviewers, a decision was made that the Trust would not adopt the Standardised Mortality Review Methodology which has been developed by the Royal College of Physicians. Instead the decision was made to develop our existing tool, taking into account the best of both the RCP and PRISM methodologies.

Prior to the start of this work we have been approached by an IT development company which, in collaboration with a group of northern trusts, has developed a review tool which appears to have greater flexibility regarding content than the RCP tool and has also been developed with the capability for a number of trusts to group together to reduce costs/facilitate collaboration. A demonstration has been arranged in May, with invitations extended to PAH and WHHT, to assess the value/viability of the product.

We now have 35 trained mortality reviewers in place from across medical and surgical specialties. For the time being, Areas of Concern (ACONs) raised following Stage 1 reviews continue to be forwarded to relevant Specialties for Stage 2 review and discussion at Directorate RHDs, with final Stage 3 consideration, including a decision regarding the avoidability of death, conducted by the Clinical Governance Strategy Committee. A review of the effectiveness of the current Stage 2 format of the process remains a priority.

1.11.3 Mandated Mortality Information

The Learning from Deaths framework states that trusts must collect and publish (from Q3 2017-18), via a quarterly public board paper, certain key data and information regarding deaths in their care. This is the third report to Board to include this information, the detail of which follows below.

1.11.3.1 Learning from Deaths Dashboard

The National Quality Board provided a suggested dashboard for the reporting of core mandated information which we are currently trialling. This is attached at Appendix 4. As this dashboard does not cover all the data that the national guidance requires, once the new reporting regime becomes embedded, a bespoke report detailing all the required information may be developed. In the meantime further detail is provided below.

In addition, for cases where Areas of Concern are raised, the current lapse in time between the death and completion of Stages 1, 2 and 3 of the review process, means that the avoidability of death score is often not being decided in the same review year. This should be borne in mind when viewing the data contained in the dashboard at Appendix 4, which only includes the conclusion details for 2017-18 deaths. In particular it should be noted that in Q3 three ACONs were concluded relating to deaths in 2016-17 where an avoidability of death score of ≤3 was decided (one with a score of 2 and two with a score of 3).

1.11.3.2 Learning Disability Deaths

A Learning Disability mortality review process has been established in the Trust in line with the requirements of the new LeDeR national programme.

Work to embed the process internally is continuing. While confirmation of cases has still been achieved via reference to cases reported to the national programme, Lorenzo flag, and inclusion of an LD question on the mortuary checklist, the weekly report based on coding remains unavailable following the implementation of Lorenzo.

Reports from the wider healthcare community have confirmed that the requirements of the external review process are challenging, being both complex and time consuming. Internally our decision has remained to review learning disability deaths using our standard review process, with outputs provided to the national programme.

In Q3 two learning disability deaths have been reported.

Table 13: Q3 Learning Disability Deaths

	Oct-17	Nov-17	Dec-17
Learning Disability deaths	1	1	0

Both deaths have been reviewed internally and the detail provided to the national LeDeR programme.

The first death has been investigated as a Serious Incident. This was a complex case with significant safeguarding concerns raised in relation to care in the community, and certain aspects of post admission care including delay in admission to ICU. The approved investigation report was sent to the CCG on 6 April 2018. The report included detailed recommendations and action plan. The full report will be provided to key personnel across the Trust with summary learning points shared via RHDs and the Patient Safety Matters newsletter. Final consideration of the case by the Clinical Governance Strategy Committee including assessment of the avoidability of death is scheduled for May.

The second death was of a 64 year old patient who was admitted suffering from DVT, constipation and sepsis. The patient was reviewed by both the Sepsis and Learning Disability teams. Sadly despite being treated appropriately for sepsis the patient died two weeks later. The reviewer did not find failings in care and concluded that the death was unavoidable.

1.11.3.3 Severe Mental Illness Deaths

The learning from deaths guidance stipulates that Trusts must have systems in place to flag patients with severe mental health needs so that if they die in an Acute Trust setting their care can be reviewed and reported on. As indicated in our previous reports, when this requirement was discussed with our Rapid Assessment, Interface and Discharge mental health team (RAID) they felt the inclusion of a mental health flag on the Trust's patient administration system ran counter to moves to change attitudes towards mental health by the removal of such labelling. Additionally no clear indication was given in the national guidance regarding what definition should be attached to the term 'severe mental illness' and internal discussions continue regarding how best to comply with the guidance.

In the meantime our mortality reviews have identified 2 patients suffering from some form of mental illness. The first death occurred in Q2 in August and the second in Q3 in December. Both of these cases gave rise to some areas of concern and are being subjected to further review via the Trust's ACON process.

1.11.3.4 Stillbirth, Children and Maternity Deaths

While the national guidance acknowledges that these deaths will be subject to special consideration, it requires that trusts include detail of relevant deaths in the quarterly reports and include reference to the associated processes in their Learning from Deaths Policy.

Our Policy includes the relevant detail and Q3 statistics are provided below:

Table 14: Q3 Stillbirth, Children and Maternity Deaths

	Oct-17	Nov-17	Dec-17
Stillbirth	1	1	0
Children	1	1	0
Maternity	0	0	0

Child deaths are rigorously reviewed via the Child Death Overview Panel and the Rapid Response Framework, both managed locally by the Hertfordshire Safeguarding Children Board. Learning is agreed and disseminated by the local Steering Group, attended by representatives from the Trust's Safeguarding team, with information cascaded to relevant Trust teams.

Maternal deaths, which are extremely rare, are all subject to investigation under the Trust's Serious Investigation (SI) framework with learning shared across the Trust via the formal SI process. In addition, all maternal deaths are reported to the national MBRRACE-UK programme which investigates maternal deaths and publishes an annual report which includes general learning which is used to inform the Trust's internal quality improvement work.

With regard to perinatal deaths, all intra-uterine deaths are reviewed by the MDT at the time of loss and subsequently by the Bereavement Group with discussion at the Clinical Governance Rolling Half Day (RHD). Lessons learnt are shared with the appropriate multi-disciplinary team. If themes are identified action plans are formulated and monitored at subsequent RHD meetings.

Additionally, feedback from bereaved parents from Local Support Groups and national guidance from organisations such as the Miscarriage Association and the Stillbirth and Neonatal Death charity provide learning and best practice to inform our standards of care.

1.11.3.5 Serious Incidents involving Deaths

The 2017 learning from deaths guidance requires that the number of Serious Incidents which have involved the death of a patient are included in the quarterly Board report. The relevant detail is provided below.

Table 15: Q3 Serious Incidents Involving a Patient Death

Serious Incidents involving the death of a patient	Oct-17	Nov-17	Dec-17
Serious Incidents reported	0	1	1
Serious Incidents – final report approved*	2	1	2

** the reports approved do not necessarily relate to the incidents reported*

Key learning from the above five Serious Incidents closed during this quarter:

- Roles of Ward Registrar and CNS team were not clear. These have been reviewed to include competencies and responsibilities and this information has been shared within the Division

- Ongoing SEPSIS training including escalation and appropriate and timely use of antibiotics
- Both nursing and medical staff need to ensure that the patient is aware of the very rare risk of DPD deficiency when giving patients verbal and written information
- Inadequate preoperative anaesthetic review and poor documentation led to decision to perform surgery. Preoperative checks and documentation must be completed fully
- Diagnostic error brought about by reassuring symptoms. Staff to be aware of human factors, in particular cognitive errors such as the 'framing effect' when assessing patients.

Following conclusion of investigations, learning and feedback is provided to relevant Specialty Rolling Half Day clinical governance meetings for discussion and adoption of agreed actions. Inclusion of information in the Patient Safety Matters newsletter is also used to promote Trust-wide sharing of important learning and developments. The Patient Safety Committee is responsible for ensuring that key learning and themes inform the Trust's quality improvement initiatives. A detailed Serious Incident Report is provided to the Risk and Quality Committee on a quarterly basis.

1.11.3.6 Learning from Complaints
Since compilation of the Learning from Deaths data for Q1, it has been decided there is also merit in this report detailing information regarding the number of complaints received that relate to a patient who has died. Q3 data is provided below.

Table 16: Q3 Complaints Involving a Patient Death

	Oct-17	Nov-17	Dec-17
Complaints received relating to an in-hospital death	3	3	0

No patterns were identified regarding specialty, ward or patient cohort of these cases. However, most involved elements of poor communication with, or provision of information to, the patient or their family. In most case the shortfall was not in clinical care, but in human interaction. One case has been escalated and is being investigated as a Serious Incident.

1.11.3.7 Learning from Inquests
In addition to a number of types of death that must be reported to the Coroner, Doctors must report any death where, for any reason, they are unable to determine the cause of death. The Coroner's jurisdiction is limited to determining who the deceased was and how, when and where they came by their death. When the death is suspected to have been either sudden with unknown cause, violent, or unnatural, the coroner decides whether to hold a post-mortem examination and, if necessary, an inquest.

While it is not part of the Coroner's remit to indicate general learning points regarding care of the patient prior to their death, on extremely rare occasions, if significant failings in care are identified, the Coroner will issue a Regulation 28: Report to Prevent Future Deaths (PFD). Should such a report be issued, the Trust is duty bound to provide a response within 56 days with detail of actions taken/proposed. These reports are addressed to the Chief Executive and copied to the CQC. Due to their extremely serious nature, both the identification of appropriate remedial measures and dissemination of these across the Trust would be prioritised.

Table 17: Q3 Inquests into a Patient Death

	Oct-17	Nov-17	Dec-17
Requests for a Report to the Coroner	3	6	6
Regulation 28: Report to Prevent Future Deaths	0	0	0

1.11.3.8 Key Issues and Themes from Mortality Reviews

Central to the topics covered at clinical governance Rolling Half Days are cases raised as Areas of Concern (ACONs) as a consequence of mortality case record reviews. The RHD meetings provide a forum for discussion, learning and the creation of appropriate Specialty-specific action plans and represent a key element of the Trust's learning from deaths framework.

Key themes arising from the ACONs which were concluded in Q3 are detailed below. In order to ensure all important themes and learning are made available to the Board, the detail below relates to all ACONs concluded in Q3, whether the patient's death occurred in the current year or 2016-17. Throughout the year emerging themes will be monitored and will be used to inform quality improvement initiatives.

- Value of the mortality review process in promoting the adoption of new guidelines and development of new processes, and for highlighting areas requiring review (examples in this quarter being: adoption of new Standard Operating Procedure for PEG insertion; the need for consideration regarding the feasibility of an inpatient Haematology service and adequacy of the Trust's current version of ICE)#
- Vital importance of Specialty to Specialty communication and liaison regarding patient management, particularly in complex cases
- The need for a more holistic approach by Specialties to avoid the dangers of tunnel vision in the management of patients
- Importance of all relevant information being fully documented#
- The need for all staff to adhere to escalation protocols#
- Importance of appropriate communication with patients and family including the provision of relevant/sufficient information
- The need for clarity regarding responsibilities for documentation of requests, tracking, considering of, and acting on, test results
- Importance of communication between teams, in particular at handover
- The need for careful thought regarding the timing of transfers out of ITU and for the tightening of out of hours referrals to Critical Care
- The importance of close monitoring of the continued appropriateness of prescribed antibiotics.

Additionally, the importance of the following clinical requirements was highlighted:

- ED patients must have a CT scan before admission to the Stroke ward
- The need for vigorous monitoring of renal function when ACE inhibitors are started in patients with CKD
- The need for early consideration of PTC where ERCP has been unsuccessful.

1.12 Summary of Key Mortality Issues

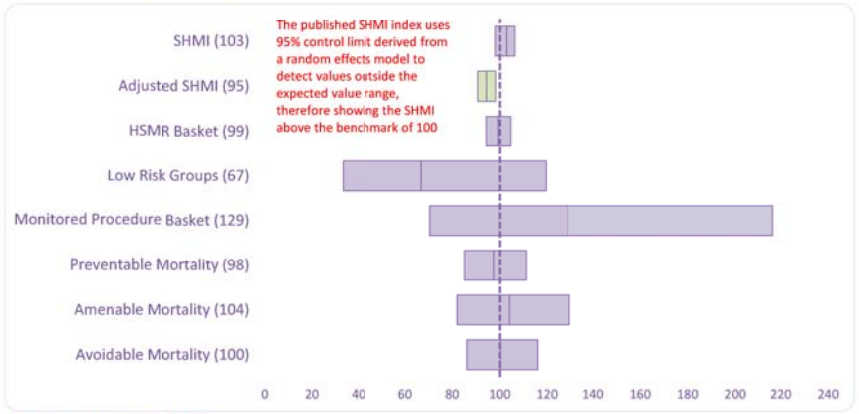
- Crude mortality is 1.54% for the latest rolling year to February 2018
- At 99.41 HSMR remains within the 'as expected' range, with the Trust's overall position within the region remaining strong at 7th out of 16 trusts in East of England
- The SHMI has remained stable at 102.9
- Numerous mortality improvement initiatives as detailed in the *Improving Outcome Strategy 2015-18 (IPOS)* are in train
- Current report incorporates new national Learning from Deaths requirements
- Following publication of the new Trust Learning from Deaths Policy the focus is now on additional associated development work required to support the Learning from Deaths framework (including the development of the Trust's Mortality Case Record Review methodology/process and database)
- Mortality monitoring is on-going with regular reporting to DEC, RAQC, Board, and CCG
- Regular joint meetings are held with ENH CCG to improve mortality rates.

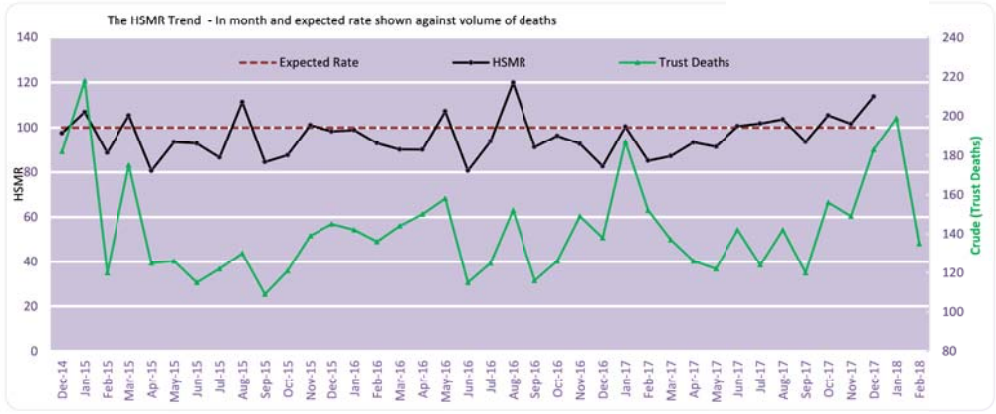
Appendix 2: Mortality Improvement Plan

Mortality Improvement Plan March 2018 update

This dashboard reports on the twelve month rolling period ending February 2018 for Crude Mortality, December 2017 for HSMR and June 2017 for SHMI (with the exception of the headline SHMI which is September 2017).

The Trust will improve mortality and deliver HSMR and SHMI with the 'as expected' range or better





Patient Safety Indicators

Period: 12 months (Jan 17 to Dec 17)

Indicator	Volume	Observed	Expected	Obs rate/k	Exp rate/k	Relative risk
Accidental puncture or laceration	79317	61	102.3	0.8	1.3	59.6
Deaths after surgery	525	57	49.9	108.6	95.0	114.2
Deaths in low-risk diagnosis groups	33039	11	16.5	0.3	0.5	66.9
Decubitus ulcer	9319	306	457.0	32.8	49.0	67.0
Infections associated with central line	16686	0	0.7	0	0.0	0.0
Obstetric trauma - caesarean delivery	1377	3	5.8	2.2	4.2	52.1
Obstetric trauma - vaginal delivery with instrument	716	33	51.7	46.1	72.3	63.8
Obstetric trauma - vaginal delivery without instrument	2832	55	88.5	19.4	31.3	62.1
Postoperative haemorrhage or haematoma	23795	13	10.2	0.5	0.4	127.7
Postoperative hip fracture	29907	3	1.6	0.1	0.1	182.4
Postoperative physiologic and metabolic derangement	19870	3	2.1	0.2	0.1	139.8
Postoperative pulmonary embolism or deep vein thrombosis	24103	56	58.9	2.3	2.4	95.1
Postoperative respiratory failure	17630	10	15.0	0.6	0.8	66.7
Postoperative sepsis	539	2	6.8	3.7	12.5	29.6
Postoperative wound dehiscence	941	1	0.8	1.1	0.9	120.4

Note: SHMI figures quoted from Dr Foster Mortality Comparator

HSMR Performance (1=lowest HSMR 16=highest HSMR)	Latest rolling period	Previous rolling period	Performance
EoE Ranking Acute providers only (Jan17-Dec17, Dr Foster)	7	7	–

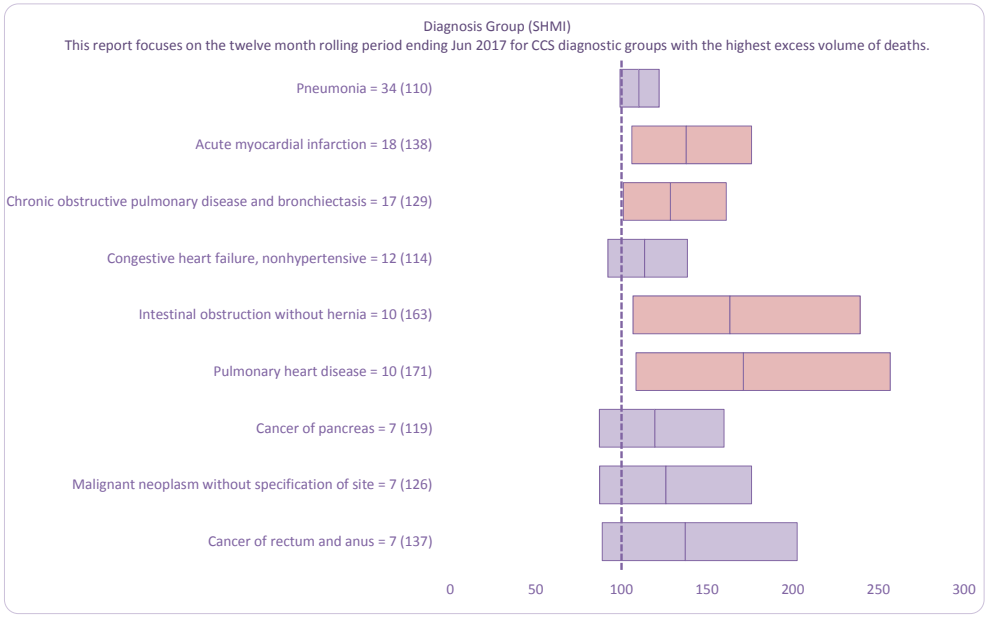
Leading Quality Indicators	Latest rolling period	Previous rolling period	Performance
Deaths in Residual Code Group (Jan17-Dec17, Dr Foster)	9	10	▲
Crude Mortality Rate (Mar17-Feb18, UAT)	1.54%	1.57%	▲
Depth of Coding vs Upper Quartile YTD (Jan17-Dec17, Dr Foster Heathcare Intelligence Portal)	1.14	1.37	▼
Charlson rate as index of national 2017/18	93	92	▲
Palliative Care Coding vs National FYTD	1.39	1.40	

Note 2: Number of Trust Deaths for Sep17 to Feb18, Crude Mortality Rate for Feb17-Jan18 & Mar17-Feb18 are from the UAT version of Deaths in Hospital report
Note 3: Trust deaths for Oct17 has been manually increased by 1 and Dec17 by 3 due to DQ issues identified. Other DQ issues are being investigated.
Note 4: Source for Depth of Coding, Charlson rate and Palliative Care coding is now Dr Foster Healthcare Intelligence Portal
Note 5: Preventable, Amenable and Avoidable Mortality data has not yet been updated due to data issues, data shown is for Dec16-Nov17.

Mortality Improvement Plan March 2018 - v1_1

Appendix 2 (cont)

Selected Diagnosis HSMR / SHMI Report March 2018 update



Diagnosis Groups with elevated SHMI (data shown for the latest 7 quarters rolling year) and HSMR (data shown for the last 7 months rolling year)

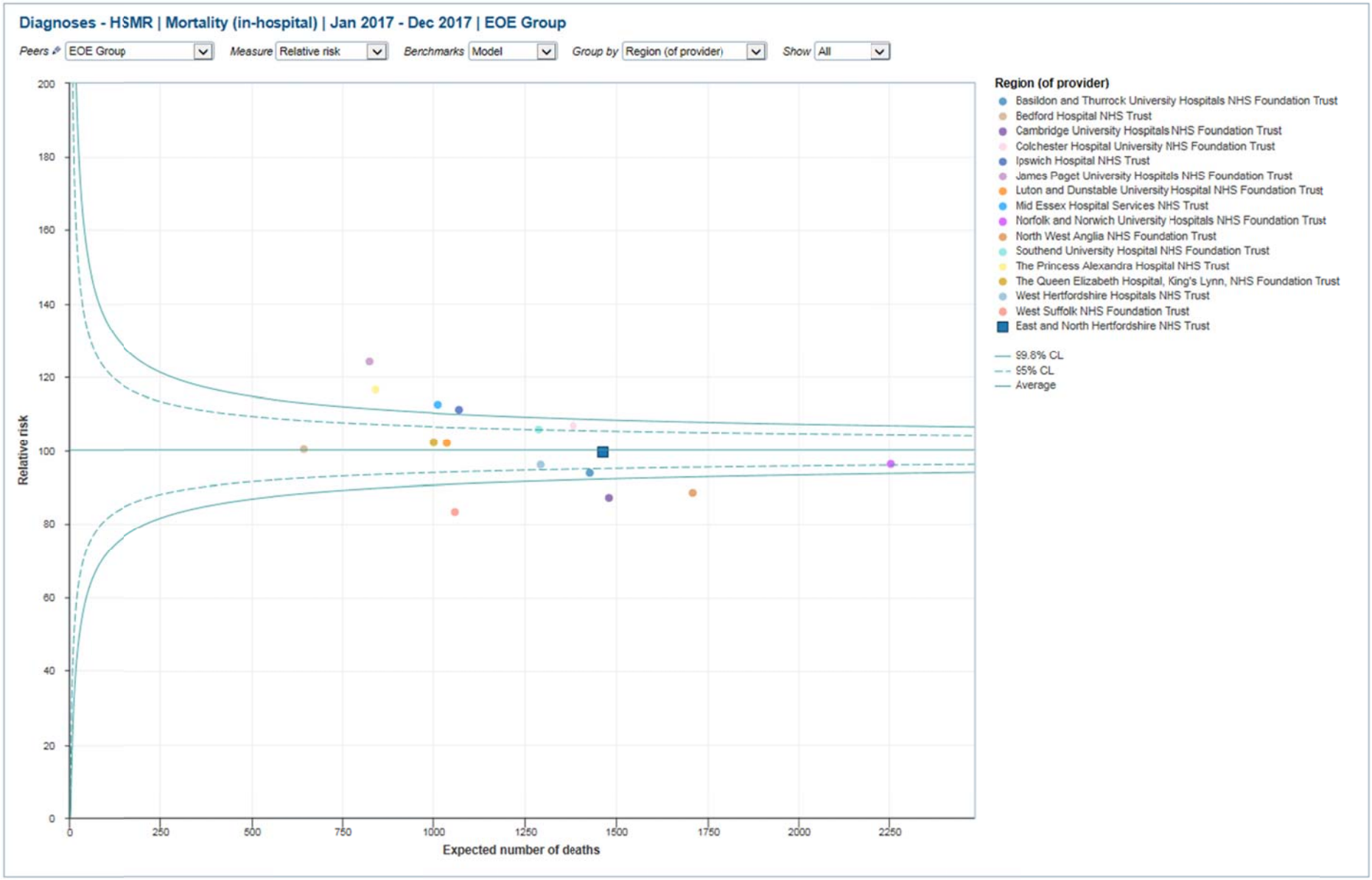
Elevated SHMI reported in Jul16-Jun17	RY x 7 qtrs
ENHT Trust	
Acute myocardial infarction	
Chronic obstructive pulmonary disease and bronchiectasis	
Intestinal obstruction without hernia	
Pulmonary heart disease	

Elevated HSMR reported in Jan17-Dec17	RY x 7 mths
ENHT Trust	
Pulmonary heart disease	
Septicemia (except in labour)	

Note: SHMI figures quoted from Dr Foster Mortality Comparator

Appendix 3

HSMR by East of England Trusts: Funnel Plot
Period: January 2017 to December 2017



East and North Hertfordshire NHS Trust: Learning from Deaths Dashboard - December 2017-18

Department of Health

Description:

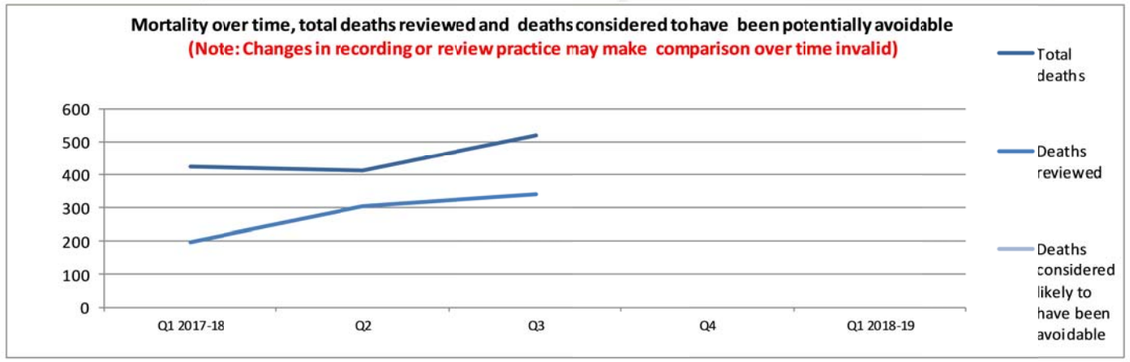
This dashboard is a tool to aid the systematic recording of deaths and learning from the care provided by East and North Hertfordshire NHS Trust and is based on the dashboard suggested by the National Quality Board in its Learning from Deaths Guidance published in March 2017. Its purpose is to record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

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

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

Total Number of Deaths in Scope		Total Deaths Reviewed		Total Number of deaths considered to have been potentially avoidable (RCP<=3)	
This Month	Last Month	This Month	Last Month	This Month	Last Month
194	158	122	86	0	0
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
517	413	339	304	0	0
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
1352	0	841	0	0	0

Time Series: Start date 2017-18 Q1 — End date 2018-19 Q1



Total Deaths Reviewed by RCP Methodology Score

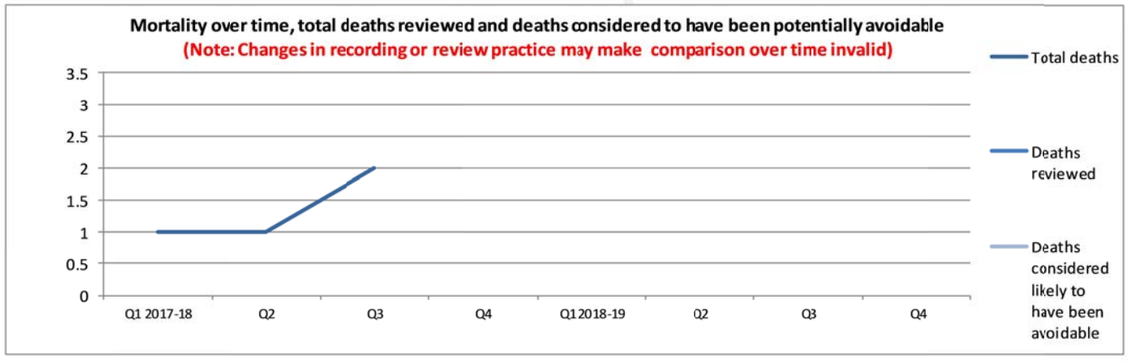
Score 1 Definitely avoidable			Score 2 Strong evidence of avoidability			Score 3 Probably avoidable (more than 50:50)			Score 4 Probably avoidable but not very likely			Score 5 Slight evidence of avoidability			Score 6 Definitely not avoidable		
This Month	0	0.0%	This Month	0	0.0%	This Month	0	0.0%	This Month	1	0.8%	This Month	0	0.0%	This Month	118	99.2%
This Quarter (QTD)	0	0.0%	This Quarter (QTD)	0	0.0%	This Quarter (QTD)	0	0.0%	This Quarter (QTD)	2	0.6%	This Quarter (QTD)	1	0.3%	This Quarter (QTI	325	99.1%
This Year (YTD)	0	0.0%	This Year (YTD)	0	0.0%	This Year (YTD)	0	0.0%	This Year (YTD)	3	0.4%	This Year (YTD)	5	0.6%	This Year (YTD)	798	99.0%

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

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

Total Number of Deaths in scope		Total Deaths Reviewed Through the LeDeR Methodology (or equivalent)		Total Number of deaths considered to have been potentially avoidable	
This Month	Last Month	This Month	Last Month	This Month	Last Month
0	1	1	2	0	0
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
2	1	3	0	0	0
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
4	0	3	0	0	0

Time Series: Start date 2017-18 Q1 — End date 2018-19 Q4



TRUST BOARD PART 1 – 2 MAY 2018

AUDIT COMMITTEE REPORT TO BOARD

PURPOSE	To inform the Trust Board of the decisions taken by the Audit Committee, and other outcomes, at its meeting of 26 March 2018.
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. ☑ **2. Developing new services and ways of working** – delivered through working with our partner organisations ☑ **3. 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)	Key assurance committee reporting to the Board
Healthcare/ National Policy (includes CQC/Monitor)	In line with Standing Orders and best practice in corporate governance
CRR/Board Assurance Framework *	☑ **Corporate Risk Register** ☑ **BAF**

ACTION REQUIRED *

For approval	☑	For decision	☐
For discussion	☐	For information	☐

DIRECTOR:	CHAIR OF AUDIT COMMITTEE
PRESENTED BY:	CHAIR OF AUDIT COMMITTEE
AUTHOR:	CORPORATE GOVERNANCE OFFICER/COMPANY SECRETARY
DATE:	APRIL 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

AUDIT COMMITTEE – MEETING HELD ON 26 MARCH 2018

SUMMARY REPORT TO TRUST BOARD – 2 MAY 2018

The following members were present: Jonathan Silver (Chair), Bob Niven and Nick Swift

MATTERS REFERRED TO BOARD

There were no matters referred to Trust Board for approval.

OTHER

Cyber Security Update
The Associate Director of IT presented a paper which updated the Committee on the Trust's cyber security position. The report included an update on the actions arising from the various reports and audits that had been undertaken. It was reported that the Trust had recently been successful in a bid for £1.2m of funding from NHSD. This money would allow the replacement of infrastructure items ensuring a much higher level of security and prevention. It was agreed that an update report would be provided for the next meeting.

Internal Audit Progress Report
The Committee received the latest Internal Audit Progress Report. Since the last Audit Committee meeting three final reports had been issued, two of which had received reasonable assurance opinions whilst the other had received a substantial assurance opinion. There was some discussion regarding timeliness of report finalisation and how this could be improved.

Draft Internal Audit Annual Report and Head of Internal Audit Opinion
The AC received the draft Head of Internal Audit opinion. The draft opinion was:

'The organisation has an adequate and effective framework for risk management, governance and internal control.
However, our work has identified further enhancements to the framework of risk management, governance and internal control to ensure that it remains adequate and effective.'

The final opinion would be presented to the AC in May and form part of the AGS.

Internal Audit Plan for 2018/19
The AC reviewed and noted the final draft of the IA plan for 2018/19 which took into account the changes requested at the previous meeting.

Local Counter Fraud Specialist Progress Report and Plan for 2018/19
The Committee received the LCFS progress report and draft plan for 2018/19. There was some discussion regarding the NHS-wide fraud level estimate and also regarding engagement with staff in relation to the LCFS survey.

External Audit Update Report
The AC reviewed and noted the latest version of the External Audit Update report which took into account the changes requested at the previous meeting. The timelines for the finalisation of the Annual Report were noted.

Draft AGS Update
The Company Secretary advised the Committee that this report would be circulated outside of the meeting.

IFRS Changes
The AC received a report regarding changes to the International Financial Reporting Standards that impact upon disclosure requirements that the Trust would need to make in the 17/18 accounts and would require changes in accounting treatment during 18-19 to prepare for revised reporting requirements for the 18-19 year and future reporting periods. The Committee noted the report.

Annual Accounts Preparation
The AC received an update on issues relating to the preparation of the financial statements for the Trust, ENH Pharma, its wholly-owned subsidiary and its associated Charity. The report also considered the processes to be used when considering the accounting treatments for specific 'unusual' transactions as well as 'business as usual' financial transactions. The Committee noted the report.

Risk Management Strategy and BAF
The Committee noted the Risk Management Strategy and latest Board Assurance Framework which had been considered and approved through the Extraordinary Audit Committee and by the Trust Board on 7 March 2018.

Internal Audit Tracking Report
The Committee noted the latest IA tracking report. It was discussed that a significant number of actions were overdue. The Committee discussed how this position could be improved and it was agreed that there was a need to ensure that actions were properly handed over when there were changes at senior management level.

Jonathan Silver
Non-Executive Director

April 2018

Agenda Item: 12

TRUST BOARD PART 1 - 2 MAY 2018
BOARD ASSURANCE FRAMEWORK

PURPOSE	To present the latest version of the Board Assurance Framework for information only this month due to the shortened meeting. This has been updated by the Executive Leads. There have not been any changes to the levels of risk this month. All key updates are in green text for ease of reference.
PREVIOUSLY CONSIDERED BY	**RAQC (24 April)**
Objective(s) to which issue relates *	[v] 1. **Keeping our promises about quality and value** – embedding the changes resulting from delivery of Our Changing Hospitals Programme. [v] 2. **Developing new services and ways of working** – delivered through working with our partner organisations [ ] **3. 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)	• The Trust's risks in relation to the delivery of services and care to patients are minimised, that the wellbeing of patients, staff and visitors is optimised and that the assets, business systems and income of the Trust are protected • The implementation and ongoing management of a comprehensive, integrated Trust-wide approach to the management of risk is based upon the support and leadership offered by the Trust Board
Healthcare/ National Policy (includes CQC/NHSI)	CQC Well Led Domain Single Oversight framework
CRR/Board Assurance Framework *	[ ] **Corporate Risk Register** [ ] **BAF**

ACTION REQUIRED *

For approval	[ ]	For decision	[ ]
For discussion	[ ]	For information	[x]

DIRECTOR:	Chief Executive
PRESENTED BY:	Company Secretary
AUTHOR:	Executive Team
DATE:	April 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 Scoring Guide

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

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

Trust risk scoring matrix and grading

	Likelihood				
Impact	**1 Rare**	**2 Unlikely**	**3 Possible**	**4 Likely**	**5 Almost certain**
Catastrophic 5	5	10	15	20	25
Major 4	4	8	12	16	20
Moderate 3	3	6	9	12	15
Minor 2	2	4	6	8	10
Negligible 1	1	2	3	4	5

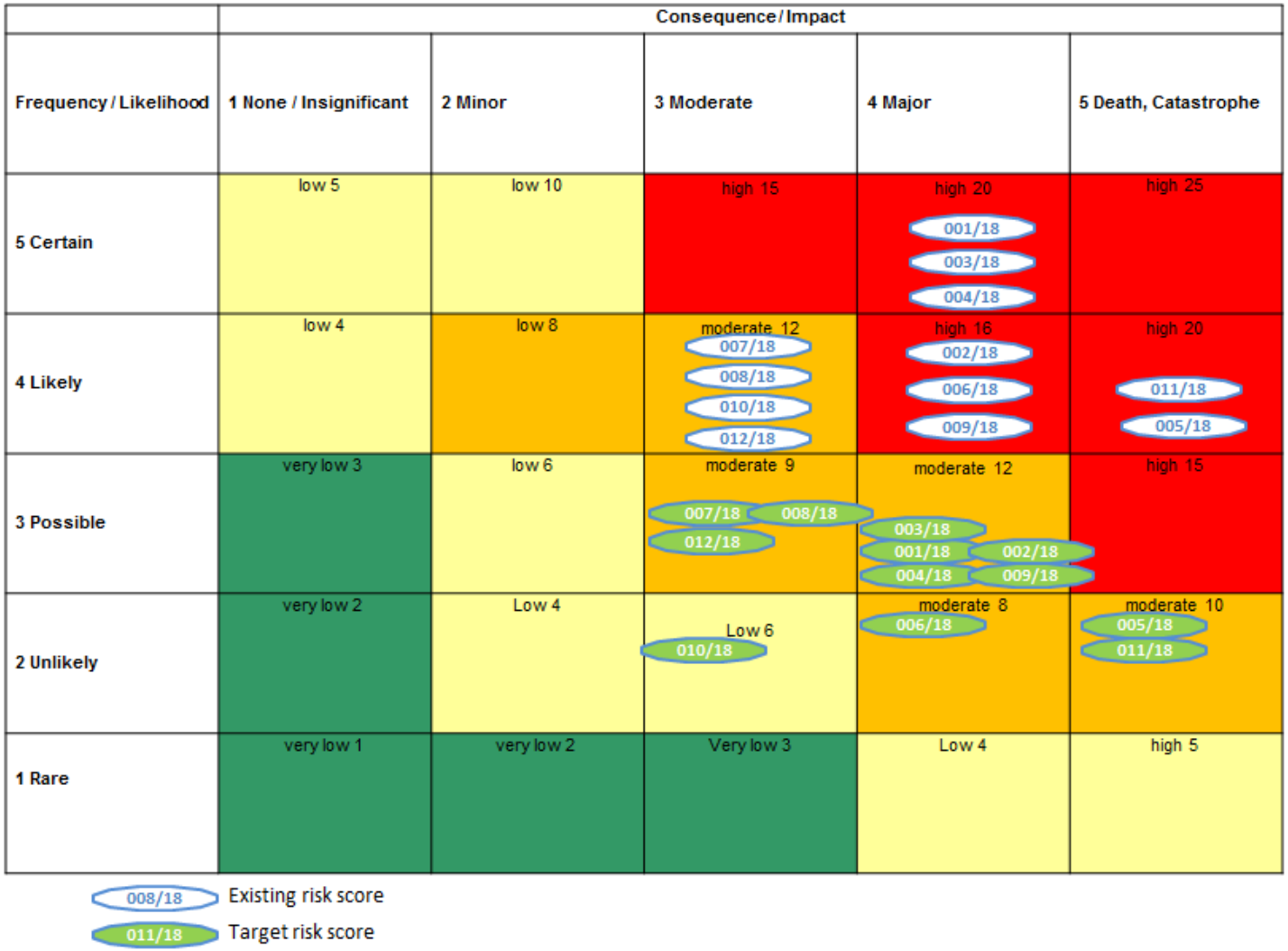
Risk Assessment	Grading
15 – 25	**Extreme**
8 – 12	**High**
4 – 6	**Medium**
1 – 3	**Low**

BOARD ASSURANCE FRAMEWORK OVERVIEW

Risk Ref	Risk Description	Lead Executive	Committee	Current Risk	Target Score	Last Month	3 months ago	6 months ago	Date added
Corporate Objective 1: Delivering our promise on value and quality									
001/18	There is a risk that within the context of the Healthcare Economy the Trust has insufficient capacity to sustain timely and effective patient flow through the system which impacts the delivery of the 62day cancer, RTT and the A&E 4-hour standards	Chief Operating Officer	FPC	20	12	20			01-03-18
002/18	There is a risk to the availability of appropriate staff to fill establishment for nursing and medical staff.	Chief Nurse/Medical Director/Chief People Officer	RAQC	16	12	16			01-03-18
003/18	There is a risk that the Trust is unable to achieve financial performance in 17/18 as a result of not securing the required efficiency improvement within its cost improvement plan and its income.	Director of Finance	FPC	20	12	16	16	16	01-04-17
004/18	There is a risk that the Trust is unable to deliver target levels of patient activity and achieve reimbursement from commissioners for activity in 17/18	Director of Finance	FPC	20	12	20	20	12	01-04-17
005/18	There is a risk that the Trust's IT systems are not sufficiently embedded/stabilised to ensure the hospital is run in a safe and effective way	Director of Finance/ Chief Operating Officer	RAQC	20	10	20	20	16	01-04-17
006/18	There is a risk that there is insufficient capital funding to address all estates backlog maintenance, including fire estates work, and funding for medical equipment	Director of Finance	FPC	16	8	16			01-03-18
007/18	There is a risk that the governance structures in the Trust do not facilitate visibility from board to ward and appropriate performance monitoring and management to achieve the Board's objectives	Chief Executive	Board of Directors	12	9	12			01-03-18
008/18	There is a risk that the Trust is not adequately prepared to deal with a major incident or emergency	Director of Strategy	RAQC	12	9	12			01-03-18
Corporate Objective 2: New ways of caring									
009/18	There is a risk that the culture and context of the organisation leaves the workforce insufficiently empowered, impacting on the Trust's ability to deliver the required improvements and transformation	Chief People Officer	FPC & RAQC	16	12	16			01-03-18
010/18	There is a risk that the Healthcare Economy does not work effectively to redesign new models of care, which impacts on the hospital's ability to manage demand for services	Director of Strategy	FPC	12	6	12			01-03-18
011/18	There is a risk that the Trust is not always able to consistently embed of a safety culture and evidence of continuous quality improvement and patient experience	Chief Nurse/Medical Director	RAQC	20	10	20			01-03-18
Corporate Objective 3: Develop the Mount Vernon Cancer Centre									
012/18	There is a risk that the Trust is not able to secure the long-term future of the MVCC	Director of Strategy	FPC	12	9	12			01-03-18

APRIL 2018: THERE HAVE NOT BEEN AND CHANGES TO THE RISK SCORE THIS MONTH

OVERVIEW OF BOARD ASSURANCE FRAMEWORK RISKS



Key to assurance on controls

- Level 1 (Management) L1
- Level 2 (Oversight functions) L2
- Level 3 Independent (Audits / Reviews/ Inspections etc.) L3

April 2018 – No movement to the heat map.

BOARD ASSURANCE FRAMEWORK: APRIL 2018

BAF risk	001/18	**There is a risk that within the context of the Healthcare Economy the Trust has insufficient capacity to sustain timely and effective patient flow through the system which impacts the delivery of the 62day cancer, RTT and the A&E 4-hour standards**

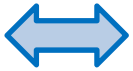
20

Strategic aim	**Delivering our promise on value and quality**
Latest review date	April 2018

Lead Executive	Chief Operating Officer
Board monitoring committee	FPC

Risk rating	**Impact**	**Likelihood**	**Total**
Initial (Feb 18)	4	5	20
Current (April 18)	4	5	20
Target (Feb 19)	4	3	12

Change since last month



Related BAF & Corporate Risk Register entries

ID	**Score**	**Summary risk description**
002/18	16	Risk to patient care & safety due to lack of nursing &medical staffing

Key controls

- ED Patient flow improvement steering group
- Three times weekly workstream meetings including Red to Green
- Weekly ED Team/COO meeting
- Length of Stay consultant led reviews
- Daily system telephone conference
- Weekly access meeting chaired by COO
- Three tier cancer tracking meeting; Divisional PRMs
- Trust representation on A&E delivery Board/ Cancer Board/ STP
- Integrated Care Team engagement
- Additional management resource secured to support delivery of cancer timed pathway programme

Assurance on controls

- A&E Delivery Board (L1)
- System Resilience Group (L2)
- Reports to FPC and Board of Directors (L3)
- Floodlights scorecard (L1)
- NHSI PRM(L3)
- Cancer Board (L2)

Gaps in control	**Gaps in assurance**	**Actions to address gaps in controls and assurances**	**Due date**
Limited evidence of schemes reducing emergency demand – Trust and system Consistency in implementation of	• Accountability Framework arrangements • Impact of local Hospitals on Trust activity	• Implementation of the accountability framework • Develop the floodlights score card • Implementation of ED patient flow improvement programme	March 2018 (Implementation date now May) May 2018 October 2018

Risk score	**Feb 2018**	**March 2018**	**April 2018**	**May 2018**	**June 2018**	**July 2018**	**August 2018**

20	20	20	20				

BAF risk	002/18	There is a risk to the availability of appropriate staff to fill establishment for nursing and medical staff.

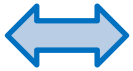
16

Strategic aim	Delivering our promise on value and quality
Latest review date	April 2018

Lead Executive	Chief Nurse/Medical Director/Chief People Officer
Board monitoring committee	RAQC

Risk rating	Impact	Likelihood	Total
Initial (Feb 18)	4	4	16
Current (April 18)	4	4	16
Target (March 19)	4	3	12

Change since last month



Related BAF & Corporate Risk Register entries

ID	Score	Summary risk description
001/18	20	Insufficient capacity for timely patient flow
003/18	20	The Trust is unable to achieve financial performance
008/18	12	Governance arrangements do not facilitate delivery

Key controls

- Monthly nursing and midwifery workforce steering group
- Safe care – 3 times daily staffing reviews
- University of Hertfordshire recruitment
- Rotation of band 5 nurses to aid retention
- NHSI Wave 2 retention programme
- Eroster
- Scheduled regular monthly updates of staffing data to NHSP, to ensure staffing lists as accurate as they can be.

Assurance on controls

- Report to RAQC on medical staffing (L2)
- Report to Board of Directors via RAQC on safer staffing (L2)
- Workforce report to FPC (L2)
- Eroster reports (L2)
- Temporary Staff -Nursing and CSWs
  72 CSWs joined bank in last quarter.26 band 5 nurses joined in last quarter NHS Professionals continuously recruiting to midwifery band 2 and band 5 roles.
- Permanent staff Trust has gained 67 WTE more qualified nursing new starters than leavers since Feb 2017. Development of joint recruitment and attraction strategy with STP. Launch of retention strategy focussing on band 5 nurses

Gaps in control	Gaps in assurance
• 40,000 nurses short across the country • Camb/London recruitment/weighting • Capacity to balance quality, money and operational pressure. • Embedding Accountability Framework	• Data consistency and quality

Actions to address gaps in controls and assurances	Due date
• Hertfordshire wide recruitment and retention programme for temporary workers, e.g. Bank Network	Ongoing
• Daily review of patient safety concerns	April 2018
• Twice weekly learning reviews with MD and DoN for any potential Sis	February 2018
• Senior matron support out of hours to support clinical teams with maintaining patient safety and early escalation of patient safety concerns	On going

		• Trust wide recruitment plans and targets	On going

Risk score	Feb 2018	March 2018	April 2018	May 2018	June 2018	July 2018	August 2018
16	16	16	16				

BAF risk	003/18	There is a risk that the Trust is unable to achieve financial performance in 17/18 as a result of not securing the required efficiency improvement within its cost improvement plan and its income.

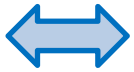
20

Strategic aim	Delivering our promise on value and quality
Latest review date	31st March 2018

Lead Executive	Director of Finance
Board monitoring committee	FPC

Risk rating	Impact	Likelihood	Total
Initial (Feb 18)	4	5	20
Current (April 18)	4	5	20
Target (March 19)	4	3	12

Change since last month



Related BAF & Corporate Risk Register entries		
ID	Score	Summary risk description
FIN9	20	CIP Plan Non Delivery
FIN1	20	Effective Management of Trust Cash Flow

Key controls

- Establishment of PMO function approved by the Board in Dec-16. At full establishment from Q2 17/18.
- Weekly workforce Grip and Control review sessions in place
- Weekly divisional CIP development and monitoring sessions
- Industry standard CIP development methodology deployed in Q1 17/18
- Weekly cash flow management meetings in place with DoF
- Appropriate senior approval of all payment runs
- Cash Diagnostic Report undertaken by PWC with supporting action plan
- Cash reporting schedules to FPC and Trust Board each month
- Development of Qlikview Debtors and Creditors reports

Assurance on controls

- Weekly Financial Recovery Programme Board in place attended by all execs(L1)
- Monthly CIP / Financial Recovery updates provided to Finance Committee and NHSI (L1)
- CIP tracker in place to monitor delivery achievement (L1)
- Submission and approval of WC load required to agreed timetables (L1)
- Monthly cash reporting to FPC / Trust Board and NHSI(L2)

Gaps in control	Gaps in assurance
• Underperformance against Model Hospital schemes in 17/18. Significant slippage against Theatres / Outpatients and Job Planning schemes. • Delay in development and enhancement of Qlikview reports	• Lack of progress in respect of the pace of development of the 18/19 CIP / savings quantum.

Actions to address gaps in controls and assurances	Due date
• PMO development of opportunity packs for divisions and specialties	Complete
• Escalation / Progress reports to FPC and DEC	Feb-18
• Briefing reports to weekly PMB meetings in respect of actions to improve Model Hospital Scheme delivery	Ongoing
• Expanded debtor management meetings to be introduced	8th March 18

Risk score	Feb 2018	March 2018	April 2018	May 2018	June 2018	July 2018	August 2018
20	20	20					

BAF risk	004/18	There is a risk that the Trust is unable to deliver target levels of patient activity and achieve reimbursement from commissioners for activity in 17/18

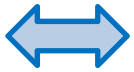
20

Strategic aim	Delivering our promise on value and quality
Latest review date	31st March 2018

Lead Executive	Director of Finance
Board monitoring committee	FPC

Risk rating	Impact	Likelihood	Total
Initial (Feb 18)	4	5	20
Current (March 18)	4	5	20
Target (March 19)	4	3	12

Change since last month



Related BAF & Corporate Risk Register entries		
ID	Score	Summary risk description
FIN2	20	Non Payment of SLA
FIN 3	20	Delivery of SLA Activity

Key controls

- Qlikview SLA income and activity application developed and in place
- Monthly SLA income reports to FPC / DEC and Divisions
- Weekly Information Assurance Group (IAG) in place to review deliver
- Monthly CQUIN meetings to review progress in place
- Contract monitoring meetings in place with all commissioners
- Weekly IAG meeting attended by appropriate Executives, Corporate and Divisional Officers to review weekly activity delivery and agree appropriate remedial action where required.
- Key monitoring metrics reflected in new divisional PRM dashboards
- New CQUIN framework

Assurance on controls

- Independent reviews of coding and counting practice undertaken in 17/18 (L3)
- Actions plans to address findings in place and reviewed at IAG(L1)
- Regular Data quality and Clinical Coding updates to IAG and FPC (L2)

Gaps in control	Gaps in assurance
• The implementation of the Lorenzo PAS has limited the Trust ability to deliver activity at planned levels • Implementation of pathway change and the understanding of financial impact	Delivery of CQUIN targets

Actions to address gaps in controls and assurances	Due date
• Set up of weekly IAG meeting attended by appropriate Executives, Corporate and Divisional Officers to review weekly activity delivery and agree appropriate remedial action where required.	Ongoing
• The IAG also reviews the impact of recommended pathway change	Ongoing
• New CQUIN governance framework agreed for implementation	April 2018

Risk score	Feb 2018	March 2018	April 2018	May 2018	June 2018	July 2018	August 2018
20	20	20					

BAF risk	005/18	The Trust's IT systems are not sufficiently embedded/stabilised to ensure the hospital is run in a safe and effective way

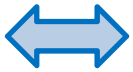
20

Strategic aim	Delivering our promise on value and quality
Latest review date	April 2018

Lead Executive	Director of Finance/ Chief Operating Officer
Board monitoring committee	RAQC

Risk rating	Impact	Likelihood	Total
Initial (Feb 18)	5	4	20
Current (April 18)	5	4	20
Target (March 19)	5	2	10

Change since last month



Related BAF & Corporate Risk Register entries

ID	Score	Summary risk description
003/18	20	The Trust is unable to achieve financial performance
004/18	20	The Trust is unable to deliver target levels of patient activity

Key controls

- The Trust has put in place twice weekly Lorenzo meetings
- The Trust has developed a Lorenzo Stabilisation plan
- The Stabilisation plan is monitored and co-ordinated through a bi-weekly Stabilisation Committee
- Monthly progress reports are provided to the Trust Board and FPC
- The Trust has appointed a stabilisation director to co-ordinate activity
- External support secured to facilitate stabilisation actions
- Dedicated project lead appointed to manage operational recovery
- Central data point for tracking of all potential harm

Assurance on controls

- The Trust was reviewed its Stabilisation plan with regulators (inc NHSI, NHSD)(L3)
- Regulators are included within the Stabilisation Committee membership (L2)
- Monitoring of key safety and quality indicators through PRM's (L2)
- Reports to Executive Committee, FPC and Board (L2)

Gaps in control	Gaps in assurance
• Tracker in respect of key stabilisation activities to allow performance management • Validated and reviewed PTL's	Development of DQ dashboard to track stabilisation activity progress

Actions to address gaps in controls and assurances	Due date
• Activity tracker to be monitored at future stabilisation committee meeting	8th March
• Super view PTL reports to be in place Delayed until end May 18	March 2018
• Validation support in place to support review of records	Ongoing
• Implementation of Lorenzo Stabilisation Plan	03/18 – 09/18

Risk score	Feb 2018	March 2018	April 2018	May 2018	June 2018	July 2018	August 2018
20	20	20	20				

BAF risk	006/18	There is a risk that there is insufficient capital funding to address all estates backlog maintenance, including fire estates work, and funding for medical equipment

16

Strategic aim	Delivering our promise on value and quality
Latest review date	31 March 2018

Lead Executive	Director of Finance/Chief Medical Officer
Board monitoring committee	FPC

Risk rating	Impact	Likelihood	Total
Initial (Feb 18)	4	4	16
Current (March 18)	4	4	16
Target (March 19)	4	2	8

Change since last month
⟺

Related BAF & Corporate Risk Register entries		
ID	Score	Summary risk description
003/18	20	The Trust is unable to achieve financial performance

Key controls
• Six Facet survey undertaken in 17/18 • Capital review Group meets monthly • Prioritising areas for limited capital spend through capital plan • Fire policy and risk assessments in place • Major incident plan • Mandatory training • Equipment Maintenance contracts

Assurance on controls
• Report on Fire Safety to Executive Committee (L2) • Report on Fire and Backlog maintenance to RAQC(L2) • Reports to Health and Safety Committee (L2) • Capital plan report to FPC (L2) • Annual Fire report (L3) • PLACE reviews (L3)

Gaps in control	Gaps in assurance
• Not fully compliant with all Fire regulations and design • 1960s buildings difficult to maintain • No formalised equipment replacement plan	Availability of capital

Actions to address gaps in controls and assurances	Due date
• Estates strategy to support the five-year trust strategy	Dec 2018
• Review, risk assess and prioritise equipment replacement for 2018/19	March 2018
• Review ongoing risks through RM processes / structures	Ongoing
• Develop capital equipment replacement plan	(TBC)

Risk score	Feb 2018	March 2018	April 2018	May 2018	June 2018	July 2018	August 2018
16	16	16					

BOARD ASSURANCE FRAMEWORK: APRIL 2018

BAF risk	007/18	**There is a risk that the governance structures in the Trust do not facilitate visibility from board to ward and appropriate performance monitoring and management to achieve the Board's objectives**

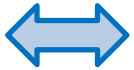
12

Strategic aim	**Delivering our promise on value and quality**
Latest review date	April 2018

Lead Executive	Chief Executive
Board monitoring committee	Board of Directors

Risk rating	**Impact**	**Likelihood**	**Total**
Initial (Feb 18)	3	4	12
Current (April 18)	3	4	12
Target (March 19)	3	3	9

Change since last month



Related BAF & Corporate Risk Register entries

ID	**Score**	**Summary risk description**
003/18	20	The Trust is unable to achieve financial performance

Key controls

- Monthly Board meeting/Board Development Session/ Board Committees
- Annual Internal Audit Programme/ LCFS service and annual plan
- Standing Financial Instructions and Standing Financial Orders
- Each NED linked to a Division (from January 2018)
- Commissioned external reviews – PwC Governance Review September 2017
- Review of external benchmarks including model hospital , CQC Insight and stethoscope – reports to FPC and RAQC

Assurance on controls

- Visibility of Corporate risks and BAF as Board Committees and Board (L2)
- Internal Audits delivered against plan, outcomes report to Audit Committee
- Annual review of SFI/SFOs (L3)
- Annual review of board committee effectiveness and terms of reference (May-July) (L3)
- PwC Governance review (included well led assessment) (L3)
- Annual governance statement (L3)
- Counter fraud annual assessment and plan (L3)
- Annual self-assessment on monitor licence conditions FT4 (L3)

Gaps in control	Gaps in assurance
• Limited visibility and challenge of corporate risks and BAF through Board committee • Development of an integrated performance report • Limitations of current performance monitoring and management forums and frameworks • Performance Management Framework/Accountability Framework	• Embedded risk management - CRR and BAF • Integrated performance report

Actions to address gaps in controls and assurances	Due date
• Implementation of revised Risk Management Strategy and BAF	7 March 2018 completed
• Follow up on actions from Internal Audits	Monthly
• Follow up on actions from other external audits (PwC governance action plan)	Monthly
• Review of Divisional Board and PMF/PRM Terms of reference	March 2018
• Development of an integrated performance report	Q1 2018/19
• Development and implementation of a Performance Management Framework/Accountability Framework	
• Annual review of effectiveness of Board Committee in line with governance review and new Committee Chairs	June/July 2018

Risk score	Feb 2018	March 2018	April 2018	May 2018	June 2018	July 2018	August 2018
12	12	12	12				

BOARD ASSURANCE FRAMEWORK: APRIL 2018

BAF risk	008/18	There is a risk that the Trust is not adequately prepared to deal with a major incident or emergency

12

Strategic aim	Delivering our promise on value and quality
Latest review date	April 2018

Lead Executive	Director of Strategy
Board monitoring committee	RAQC

Risk rating	Impact	Likelihood	Total
Initial (Feb 18)	3	4	12
Current (April 18)	3	4	12
Target (March 19)	3	3	9

Change since last month: ⟺

Related BAF & Corporate Risk Register entries		
ID	Score	Summary risk description
005/18	15	The Trust's IT systems are not sufficiently embedded/stabilised

Key controls
• EPRR Plan in place to gain compliance with the Core Standards • Business Impact Assessment process underway with Divisions • CBRN plan and equipment in place • Support in place by EPRR manager from Basildon NHS Trust • Cyber security – firewall, testing, antivirus – internal and external testing on controls

Assurance on controls
• EPRR Committee Chaired by AEO (Director of Strategy) (L2) • Regular reports on progress against EPRR plan to RAQC(L2) • Annual EPRR Core Standards Assurance process including external visit by NHSE(L3) • Regular Attendance at LHRP(L2) • Internal and external review of Cyber security (L3) • Reports to audit committee, RAQC and Board (cyber) (L2) • Organisational response to cyber incident (L1)

Gaps in control	Gaps in assurance
• Currently partially compliant with NHSE Core standards • Full training and awareness programme to be developed • Testing programme to be developed • Ability to implement all cyber security requirements • Full time EPRR officer not in post	Availability in capital to invest in cyber security

Actions to address gaps in controls and assurances	Due date
• Recruitment of full time EPRR Officer	Feb 2018 (now May 2018)
• Delivery of action plan in full	Sept 2018
• Training for Gold, Silver and Bronze commanders	May 2018
• Business Continuity plans in place for critical services	April 2018
• Review of Major incident plan	Oct 2018
• Monitor and review of cyber security actions and explore funding options	Ongoing review
• Trust wide Business continuity plan	April 2018 June 2018

Risk score	Feb 2018	March 2018	April 2018	May 2018	June 2018	July 2018	August 2018
12	12	12	12				

BOARD ASSURANCE FRAMEWORK: APRIL 2018

BAF risk	009/18	There is a risk that the culture and context of the organisation leaves the workforce insufficiently empowered impacting on the Trust's ability to deliver the required improvements and transformation

16

Strategic aim	New ways of caring
Latest review date	April 2018

Lead Executive	Chief People Officer
Board monitoring committee	FPC and RAQC

Risk rating	Impact	Likelihood	Total
Initial (Feb 18)	4	4	16
Current (April 18)	4	4	16
Target (March 19)	4	3	12

Change since last month
⟺

Related BAF & Corporate Risk Register entries		
ID	Score	Summary risk description
002/18	16	There is a risk to patient care and safety as a result of nursing and medical staffing capacity
003/18	20	The Trust is unable to achieve financial performance

Key controls

- Leadership and Development Programme
- LEND Programme
- Trust Values / Leadership Behaviours
- Health and Well Being Strategy
- Dedicated Associate Director of Leadership and Change
- HR Policies including Raising Concerns Policy
- ERAS teams and Freedom to Speak Up Guardian
- People Strategy
- Leadership Strategy

Assurance on controls

- Workforce reports (includes culture) to RAQC, FPC, Board (L2)
- LEND sessions quarterly (L1)
- FFT (L1)
- Raising Concerns report to Audit Committee and Board (L2)
- Workshops – face to face and online (L1)
- Review of Insight and Model Hospital
- Board Development session April 2018

Gaps in control	Gaps in assurance
• Culture change program using NHSI culture tool kit • Talent management lead • Senior leadership training	

Actions to address gaps in controls and assurances	Due date
• Review of LEND and leadership behaviours in a challenging environment	May 18
• Increased visibility of Senior Leadership Team (Divisional, Executive and Board)	Mar 18- Completed
• Development of innovative online workshop for use as crowd sourcing platform	May 18
• Develop and implement action plan following staff survey feedback – Executive sponsors to core issues and suggestions from staff	Apr 18
• Recruit talent management lead	Apr 18
• Senior leadership programme developed for 2018 following ADDS	Jul 18

		• Undertake culture change programme using NHSI culture toolkit • Board Development session held to discuss staff survey, underlying causes and actions.	Apr 18

Risk score	Feb 2018	March 2018	April 2018	May 2018	June 2018	July 2018	August 2018
16	16	16	16				

BOARD ASSURANCE FRAMEWORK: APRIL 2018

BAF risk	010/18	There is a risk that the Healthcare Economy does not work effectively to redesign new models of care, which impacts on the hospital's ability to manage demand for services

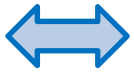
12

Strategic aim	New ways of caring
Latest review date	April 2018

Lead Executive	Director of Strategy
Board monitoring committee	FPC

Risk rating	Impact	Likelihood	Total
Initial (Feb 18)	3	4	12
Current (Feb 18)	3	4	12
Target (March 19)	3	2	6

Change since last month



Related BAF & Corporate Risk Register entries		
ID	Score	Summary risk description
001/18	20	The trust has insufficient capacity to sustain patient flow

Key controls
• Participation in STP work streams including Planned care, urgent and emergency care, frailty and cancer • STP CEO bi-weekly meeting • Early work in place to work with PAH on fragile and back office services • Vascular Hub project with West Herts and PAH • Cancer work stream of STP and representing STP Cancer Alliance • Model Hospital redesign work • Integrated discharge team

Assurance on controls
• Reports to Board regarding progress on STP(L2) • Regular oversight by NHSI and NHSE (L2) • Monthly A&E delivery Board (L2) • Transformation Board of the CCG(L2) • Reports of Model Hospital work streams to Programme Board (L2) • NHSE Deep-dive into cancer work stream (L3)

Gaps in control	Gaps in assurance
• Scope for accelerated development of STP and its governance arrangements • Need for external resource to develop STP to ICS	

Actions to address gaps in controls and assurances	Due date
• Work programme of external partner to support development of STP	June 2018

Risk score	Feb 2018	March 2018	April 2018	May 2018	June 2018	July 2018	August 2018
12	12	12	12				

BOARD ASSURANCE FRAMEWORK: APRIL 2018

BAF risk	011/18	There is a risk that the Trust is not always able to consistently embed a safety culture and evidence of continuous quality improvement and patient experience

20

Strategic aim	New ways of caring
Latest review date	April 2018

Lead Executive	Chief Nurse/Medical Director
Board monitoring committee	RAQC

Risk rating	Impact	Likelihood	Total
Initial (Feb 18)	5	4	20
Current (April 18)	5	4	20
Target (March 19)	5	2	10

Change since last month: ⟺

Related BAF & Corporate Risk Register entries		
ID	Score	Summary risk description
002/18	16	There is a risk to patient care and safety as a result of nursing and medical staffing capacity

Key controls
• Clinical governance strategy group • Patient Safety Committee • Quality Improvement Board • Accountability Framework • CQC Engagement meeting • Increased Director presence in clinical areas • SI's and Learning from death investigations

Assurance on controls
• Reports to RAQC (L2) • Quality review meetings with CCG (L2) • Divisional Performance Meetings (L2) • Clinical Governance Strategy Committee(L2) • Monitoring of new to follow up ratios through OPD steering group and access meetings(L2) • Peer Reviews (L3) • Audit Programme (internal and external) (L3) • Quality Transformation Programme – framework presented to RAQC, March 18 (L2)

Gaps in control	Gaps in assurance
• National guidance and GIRFT Gap analysis identifies areas for improvement • Consistency with procurement and engagement with clinicians • Patient safety team capacity	• Constituency in following care bundles • Implementation of action plans • Embedding of learning from SI's/Learning from Deaths • Data quality

Actions to address gaps in controls and assurances	Due date
• Review and relaunch of care bundles	July 2018
• Complete Gap analysis on GIRFT reports and develop and monitor action plans	June 2018
• Revised Clinical Governance structures	July 2018
• Divisional Clinical Governance facilitators	July 2018
• Establishment of quality transformation programme	March 2018
• Bi-weekly Quality Transformation Steering Group in place	April 2018
• Monthly patient safety newsletter	March 2018

Risk score	Feb 2018	March 2018	April 2018	May 2018	June 2018	July 2018	August 2018
20	20	20	20				

BOARD ASSURANCE FRAMEWORK: APRIL 2018

BAF risk	012/18	There is a risk that the Trust is not able to secure the long-term future of the MVCC

12

Strategic aim	Develop the Mount Vernon Cancer Centre
Latest review date	April 2018

Lead Executive	Director of Strategy
Board monitoring committee	FPC

Risk rating	Impact	Likelihood	Total
Initial (Feb 18)	3	4	12
Current (April 18)	3	4	12
Target (March 19)	3	3	9

Change since last month: ⇔

Related BAF & Corporate Risk Register entries		
ID	Score	Summary risk description
003/18	20	The Trust is unable to achieve financial performance

Key controls
• Monthly meetings with CEOs and Chairs of ENHT and Hillingdon NHS FT • Clinical strategy for MVCC • Development of a five-year strategy for the Trust • Development of SLAs with MVCC • Clinical and Academic Partnership in place with UCLH and MVCC, Board Established and has met to develop work plan

Assurance on controls
• Regular reports to FPC and the Board of Directors (L2) • Regular reporting into the strategy Board (L2) • Reporting to the Board of Directors on the progress of the UCLH/MVCC partnership (L2)

Gaps in control	Gaps in assurance
• Hillingdon has no long-term plan for the MVCC site	

Actions to address gaps in controls and assurances	Due date
• SLA for Estates and Facilities at MVCC with Hillingdon	April 2018 (now June 2018)
• MOU with Hillingdon for sale of the MV site	July 2018
• Development of a lease with Hillingdon for MVCC	May 2018
• Sign off of UCLH/MVCC Partnership work plan by Board of Directors	June 2018
• First meeting of MVCC strategy implementation group	May 2018

Risk score	Feb 2018	March 2018	April 2018	May 2018	June 2018	July 2018	August 2018
12	12	12	12				

DATA PACK

Contents

1. Data & Exception Reports:

FFT

Health & Safety Indicators

Friends and Family Test - March 2018

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	87.23	0.00	21	20	5	0	0	1	47	85	55.29
5B	100.00	0.00	11	13	0	0	0	0	24	47	51.06
7AN	87.76	1.02	57	29	9	0	1	2	98	138	71.01
7B	98.55	1.45	36	32	0	1	0	0	69	156	44.23
8A	94.00	4.00	26	21	1	2	0	0	50	95	52.63
8B	98.89	0.00	55	34	1	0	0	0	90	112	80.36
11B	93.75	0.00	29	16	2	0	0	1	48	114	42.11
Swift	97.26	0.00	52	19	2	0	0	0	73	191	38.22
ITU/HDU	100.00	0.00	3	1	0	0	0	0	4	9	44.44
Day Surgery Centre, Lister	97.89	0.00	139	47	4	0	0	0	190	338	56.21
Day Surgery Treatment Centre	99.55	0.00	199	22	1	0	0	0	222	549	40.44
Endoscopy, Lister	100.00	0.00	192	21	0	0	0	0	213	920	23.15
Endoscopy, QEII	98.92	0.00	89	3	0	0	0	1	93	273	34.07
SURGERY TOTAL	97.22	0.33	**909**	**278**	**25**	**3**	**1**	**5**	**1221**	**3027**	40.34
SSU	89.13	0.00	31	10	4	0	0	1	46	178	25.84
AMU	95.12	0.00	33	6	2	0	0	0	41	47	87.23
Pirton	90.00	10.00	6	3	0	1	0	0	10	71	14.08
Barley	100.00	0.00	15	6	0	0	0	0	21	30	70.00
6A	90.70	0.00	27	12	2	0	0	2	43	86	50.00
6B	95.24	4.76	27	13	0	0	2	0	42	61	68.85
7AS	100.00	0.00	5	3	0	0	0	0	8	62	12.90
11A	100.00	0.00	59	18	0	0	0	0	77	80	96.25
ACU	100.00	0.00	8	2	0	0	0	0	10	120	8.33
10B	88.89	0.00	12	4	1	0	0	1	18	85	21.18
Ashwell	100.00	0.00	21	7	0	0	0	0	28	60	46.67
9B	95.52	0.00	43	21	3	0	0	0	67	74	90.54
9A	100.00	0.00	44	0	0	0	0	0	44	46	95.65
Cardiac Suite	100.00	0.00	32	10	0	0	0	0	42	103	40.78
MEDICINE TOTAL	96.18	0.60	**363**	**115**	**12**	**1**	**2**	**4**	**497**	**1103**	45.06
10AN Gynae	95.83	0.00	48	21	2	0	0	1	72	99	72.73
Bluebell ward	84.78	4.35	20	19	3	1	1	2	46	194	23.71
Bluebell day case	NP	NP	0	0	0	0	0	0	0	6	0.00
Neonatal Unit	96.15	0.00	24	1	1	0	0	0	26	51	50.98
WOMEN'S/CHILDREN TOTAL	92.36	1.39	**92**	**41**	**6**	**1**	**1**	**3**	**144**	**350**	41.14
Michael Sobell House	100.00	0.00	36	0	0	0	0	0	36	38	94.74
11	100.00	0.00	19	2	0	0	0	0	21	105	20.00
CANCER TOTAL	100.00	0.00	**55**	**2**	**0**	**0**	**0**	**0**	**57**	**143**	39.86
TOTAL TRUST	96.66	0.47	**1419**	**436**	**43**	**5**	**4**	**12**	**1919**	**4623**	41.51

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	96.44	0.51	1275	431	43	5	4	11	1769	4207	42.05
QEII	98.92	0.00	89	3	0	0	0	1	93	273	34.07
Mount Vernon	100.00	0.00	55	2	0	0	0	0	57	143	39.86
TOTAL TRUST	**96.66**	**0.47**	**1419**	**436**	**43**	**5**	**4**	**12**	**1919**	**4623**	**41.51**

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	88.21	1.50	289	242	52	4	5	10	602	10025	6.00
QEII UCC	97.37	0.00	30	7	1	0	0	0	38	3506	1.08
A&E TOTAL	**88.75**	**1.41**	**319**	**249**	**53**	**4**	**5**	**10**	**640**	**13531**	**4.73**

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	95.74	4.26	23	22	0	1	1	0	47	478	**9.83**
Birth	99.03	0.00	161	43	1	0	0	1	206	447	**46.09**
Postnatal	92.72	1.46	134	57	7	3	0	5	206	447	**46.09**
Community Midwifery	100.00	0.00	5	2	0	0	0	0	7	569	**1.23**
MATERNITY TOTAL	**95.92**	**1.07**	**323**	**124**	**8**	**4**	**1**	**6**	**466**	**1941**	**24.01**

Outpatients	% Would recommend	% Would not recommend	Extremely Likely	Likely	Neither Likely/ Unlikely	Unlikely	Extremely Unlikely	Don't Know	Total responses
Lister	96.22	1.20	359	124	10	2	4	3	502
QEII	94.01	1.50	422	143	20	6	3	7	601
Hertford County	94.08	0.59	111	48	5	1	0	4	169
Mount Vernon CC	96.07	0.56	146	25	5	1	0	1	178
Satellite Dialysis	97.56	1.22	63	17	1	1	0	0	82
OUTPATIENTS TOTAL	**95.17**	**1.17**	**1101**	**357**	**41**	**11**	**7**	**15**	**1532**

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	0	0	0
	H&S public liability claims	0	0	0	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	0	0	0	2
	Physical assault	0	0	0	1	0	1	0	0	0	2	0	0	4
Visitor Incidents	RIDDOR incidents	0	0	0	0	0	0	0	0	0	0	0	0	0
	H&S public liability claims	1	0	0	1	0	0	0	0	2	0	0	0	4
	Slips, Trips & Falls	2	2	4	3	4	0	2	0	3	2	1	0	23
The Workforce (Including Contractors) Incidents	RIDDOR incidents	2	3	5	4	4	2	3	2	8	3	1	2	39
	Slips, Trips & Falls	1	5	7	6	5	5	8	2	12	6	3	6	66
	Employer liability claims	0	2	1	1	0	0	1	0	2	1	1	1	10
	Sharps incidents	11	7	12	12	15	13	9	24	13	12	5	16	149
	Workplace stress	6	2	1	3	7	3	4	4	2	4	5	4	45
	Contact dermatitis/latex	0	0	0	0	0	0	0	0	0	0	0	0	0
	Musculoskeletal injuries	5	3	8	3	8	5	8	3	0	4	8	4	59
	Physical assault	4	0	10	9	12	9	6	15	11	7	5	6	94
	H & S training (Compliance) (YTD = Latest Available Position)	89%	88%	88%	87%	88%	86%	91%	91%	91%	89%	91%	90%	91%
	Significant workplace fires	1	0	0	0	1	0	0	0	0	0	0	0	2
	Total Staff	5514	5529	5532	5574	5562	5881	5895	5940	5893	5907	5908	5906	69041

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	8	3	1	2	39
RATE %	Red < 0.36 Amber 0.36-0.33 Green > 0.33	0.363	0.543	0.904	0.718	0.719	0.340	0.509	0.337	1.358	0.508	0.169	0.339	0.565
Slips, Trips and Falls		1	5	7	6	5	5	8	2	12	6	3	6	66
RATE %	Red <0.86 Amber 0.86 - 0.78 Green >0.78	0.181	0.904	1.265	1.076	0.899	0.850	1.357	0.337	2.036	1.016	0.508	1.016	0.956
Sharps Injuries		11	7	12	12	15	13	9	24	13	12	5	16	149
RATE %	Red < 2.56 Amber 2.56-2.33 Green > 2.33	1.995	1.266	2.169	2.153	2.697	2.211	1.527	4.040	2.206	2.031	0.846	2.709	2.158
Mgr Referrals to OH for Stress		6	2	1	3	7	3	4	4	2	4	5	4	45
RATE %	Red < 0.96 Amber 0.96-0.87 Green > 0.87	1.088	0.362	0.181	0.538	1.259	0.510	0.679	0.673	0.339	0.677	0.846	0.677	0.652
Work related Musculosketal Injuries		5	3	8	3	8	5	8	3	0	4	8	4	59
RATE %	Red < 1.11 Amber 1.11-1.01 Green > 1.01	0.907	0.543	1.446	0.538	1.438	0.850	1.357	0.505	0.000	0.677	1.354	0.677	0.855
Physical Assault		4	0	10	9	12	9	6	15	11	7	5	6	94
RATE %	Red < 1.45 Amber 1.45-1.32 Green > 1.32	0.725	0.000	1.808	1.615	2.157	1.530	1.018	2.525	1.867	1.185	0.846	1.016	1.362
Total Staff		5514	5529	5532	5574	5562	5881	5895	5940	5893	5907	5908	5906	69041

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

March 2018

Executive Summary

For the month of March the trust saw a reduction in the % of planned vs actual hours for the inpatient wards for the unify return. Despite the decrease in planned vs actual, the care hours per patient day remained static. Extreme weather conditions, sustained levels of vacancies, sickness, controlled use of agency and unfilled temporary staffing shifts and additional capacity beds being opened over March, both planned and unplanned have impacted our fill rates and red triggered shifts.

The number of shifts initially triggering red increased from 392 in February to 538 in March. The percentage of Red Triggered shifts increased from 12.28% in February to 15.22% in March.

The number of patients requiring enhanced nursing care increased from 80 risk assessed patients in February to 83 patients in March. There was also an increase in the care hours required for mental health patients, from 122.5 care hours in February to 248.5 care hours in March.

There were 79 patient falls recorded in the trust for the month of March. This is 1 less than recorded in February. 1 of these falls resulted in a severe harm injury and is currently under investigation.

For the month of March 2018, the Trust had a slight increase in avoidable hospital acquired ulcer grade 2-4.

Purpose of Report:
1. To provide an assurance with regard to the management of safe nurse and midwifery staffing for the month of March 2018. **2.** To provide a summary report of quality metrics for the month of March 2018 as indicators of patient safety. **3.** To provide context for the Trust Board on the UNIFY safer staffing submission for the month of March 2018.

Assessment parameters and criteria
To assess that ward staffing levels are safe the following parameters will be assessed: The Thresholds will be agreed at the Nursing Workforce committee. 1. Patient safety was delivered through consistent, appropriate, staffing levels for the service. Criteria: Unify RN fill rate, Unify CHPPD and staff to patient ratio's Threshold: 2. Staff were supported in their decision making by effective reporting. Criteria: Percentage of red triggering shifts and percentage of shifts that remained

partially mitigated.
Threshold:

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

   Criteria: Red Flag reportable events and DATIX report
   Threshold:

4. The Board are assured of safe staffing for nursing and midwifery

   Criteria: Board reports and discussion covering overview of safe staffing levels
   Threshold:

Performance Assessment for month of March 2018

1. **Patient safety was delivered through consistent, appropriate, staffing levels for the service.**

   Performance: RN day fill rate greater than 95% and has a RAG rating of red.
   Benchmarking threshold to be agreed for CHPPD

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

   Performance: % of shifts triggered red in month and has a RAG rating of red.

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

   Performance of red flags were escalated in month and has a RAG rating of green

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.

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 has been submitted to Unify for March 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. 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 (%)
93.5%	85.3%	94.1%	108.2%

The Unify submission for registered fill % decreased in March with the average day fill % for registered nurses decreasing from 95.2% in February to 93.5% in March.

Factors affecting Planned vs. Actual staffing

Due to increased demand, the trust has opened escalation beds in line with the escalation policy. These beds have required additional staff to support safe patient care. An overview of this can be seen below:

Escalation

- Ashwell is established as a 28 bedded Frailty ward. Staffing for additional capacity beds on Ashwell Annex (5 beds) was required for 2/31 days in March when the ward was bedded above 28 patients. Staffing was flexed based on patient acuity and additional capacity beds. This has resulted in RN fill above planned levels (28 beds).
- A new winter pressures ward (7AN) was opened on the 3rd December. The ward was planned to be a 14 bed Surgical 23 hour stay ward, with the ward being open Monday to Saturday afternoon. The requirement for additional capacity beds led to the ward being opened 7 days a week. The planned hours for this ward are reflective of 7 day a week opening in March.

- 6B was open to 26 patients (planned 25 beds) on 1 occasion in March. Staffing was flexed at night to support additional capacity.
- Ward 11 flex their RN requirement at night in line with patient numbers above their planned 22 beds.

There are a number of other contributory factors which affect the fill rate for March. 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, 5A, 5B, 7B, 8A, 8B, 9A, 9B, ACU, Barley, Pirton and SSU** – Had an increased demand for patients requiring enhanced care which resulted in an increased CSW fill in these areas. In excess of 2090 hours of care were provided by the enhanced care team, 1730 hours by bank CSWs and 389 hours by agency CSWs.
- **10B, 11B, 7B, 7AN, 8B, ACU, AMU-A and SAU –** RN day and/or night fill fell below 90% in March; this is due to the increased staffing requirements for the trust as a result of the opening of escalation areas above the winter plan. This has depleted the overall staffing pool, and risk was balanced across the service to mitigate risk to patient safety.
- **6B –** RN Day fill is recorded as 84.9% in March, this is due to part closure in month as a result of beds closed due to infection control. Occupancy was down to 82.63%.
- **Pirton –** RN day fill is recorded as 79.2% in March with an average occupancy of 86.07% as at the 23:59 census period. The CHPPD for the service was 6. 34 compared to the service target of 6.18; this would suggest staffing was appropriate for acuity and dependency of patients on the ward. Stroke specialist nurses have also provided support for the inpatient ward to ensure patient safety.
- **Swift** – RN day fill is recorded as 83.8% in March with average bed occupancy of 73.82% as at the 23:59 census period. The CHPPD for the service was 5.52 compared to the service target of 5.02; this would suggest staffing was appropriate for acuity and dependency of patients on the ward. Due to lower planned staffing levels at night there is less flexibility to reduce staffing at night in line with occupancy.

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 March, this indicates overall CHPPD remained static at 6.9 in February and March.

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 March 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**	**2.4**	**6.9**

The following shows the actual gaps in care hours v's the required gaps in care hours by clinical areas, table 3. Work is ongoing to triangulate this information with red flags and staffing related incidents by clinical area

Table 3

Unit	Avarge of Daily Required CHPPD	Avarge of Daily Actual CHPPD	Variance Required vs Actual
10A Gynae	5.35	7.19	1.84
10B	7.04	5.42	-1.62
11A	6.64	5.64	-1
11B	5.74	5.59	-0.15
5A	5.82	4.9	-0.92
5B	6.75	5.76	-0.99
6A	6.3	5.27	-1.03
6B	5.67	6.22	0.55
7AN	4.78	5.6	0.82
7AS	7.31	6.53	-0.78
7B	5.56	4.58	-0.98
8A	5.96	5.01	-0.95
8B	5.82	5.02	-0.8
9A	6.69	5.48	-1.21
9B	6.77	5.48	-1.29
ACU	7.22	6.42	-0.8
AMU-A	8.8	7.95	-0.85
AMU-W	7.93	6.98	-0.95
Ashwell	6.94	5.67	-1.27
Barley	7.37	5.89	-1.48
Bluebell	9.01	7.5	-1.51
Critical Care 1	18.26	16.66	-1.6
Michael Sobell Ho	7.97	7.35	-0.62
Pirton	6.85	6.4	-0.45
SAU	6.27	6.3	0.03
SSU	6.65	6.06	-0.59
Swift	5.21	5.29	0.08
Ward 10	4.86	6.48	1.62
Grand Total	**6.98**	**6.38**	**-0.60**

1.2 Patient to staff ratios:

Staff to patient ratio (registered) data is shown on the roster dashboard as per Table 4. The Trust adheres to national guidance and has an average staff to patient ratio in surgery of 1:6.8 and medicine of 1:6.4 once speciality areas have been removed, for the month of March. This is an improved picture from last month with nurses having less patients to care for on average.

Table 4

Units	Nurses to Patient Ratio (Registered)	Units	Nurses to Patient Ratio (Registered)
Critical Care 1	**1:1.35**	7AN	**1:6.42**
Bluebell	**1:3.67**	SSU	**1:6.60**
10A Gynae	**1:4.19**	Barley	**1:6.77**
AMU-A	**1:4.41**	5B	**1:6.94**
Ward 11	**1:4.52**	5A	**1:7.03**
Michael Sobell House	**1:5.02**	6A	**1:7.23**
11A	**1:5.41**	7B	**1:7.32**
Pirton	**1:5.44**	8B	**1:7.43**
AMU-W	**1:5.46**	9A	**1:7.45**
ACU	**1:5.54**	8A	**1:7.52**
6B	**1:5.82**	9B	**1:7.55**
Swift	**1:5.99**	Ashwell	**1:7.66**
SAU	**1:6.16**	10B	**1:7.79**
11B	**1:6.37**		

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. These meetings feed into the operations centre to ensure that risk is being balanced throughout the day and night. 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 increased from 392 in February to 538 in March. The

percentage of Red Triggered shifts increased from 12.28% in February to 15.22% in March. Table 5 below shows the % of shifts that triggered red in month.

Table 5 – % of shifts triggering red and remained red

Month	% of shifts that triggered red in Month	% of shifts that remained triggered red
Mar-17	7.44%	0.23%
Apr-17	5.91%	0.12%
May-17	6.13%	0.09%
Jun-17	6.51%	0.09%
Jul-17	8.24%	0.18%
Aug-17	8.90%	0.24%
Sep-17	10.62%	0.34%
Oct-17	12.16%	0.84%
Nov-17	9.07%	0.18%
Dec-17	12.51%	0.51%
Jan-18	16.21%	0.20%
Feb-18	12.28%	0.22%
Mar-18	15.22%	2.15%

Comparison of red triggered shifts between March 2017 and March 2018 shows an increase of 7.78% in the number of shifts triggering red in month.

Out of the shifts triggering red, 76 of the 538 that initially triggered red (2.15%) remained only partially mitigated. This is a significant increase in the number of partially mitigated shifts compared to February. Shifts triggering red, and those that remained a challenge to mitigate, are explored below.

Due to the opening of escalation areas occupancy remains above planned. This contributed to the high number of shifts triggering red as additional staff resource was required for the additional capacity beds.

Chart 1 below shows the % of shifts triggering red in month and the % of shifts that remained triggered red; the % shifts triggering red has shown a linear increase. This is multifactorial and the reasons include extreme weather conditions, sustained levels of vacancies, sickness, controlled use of agency and unfilled temporary staffing shifts and additional capacity beds being opened over March, both planned and unplanned. These are discussed in section 2.3.

Chart 1

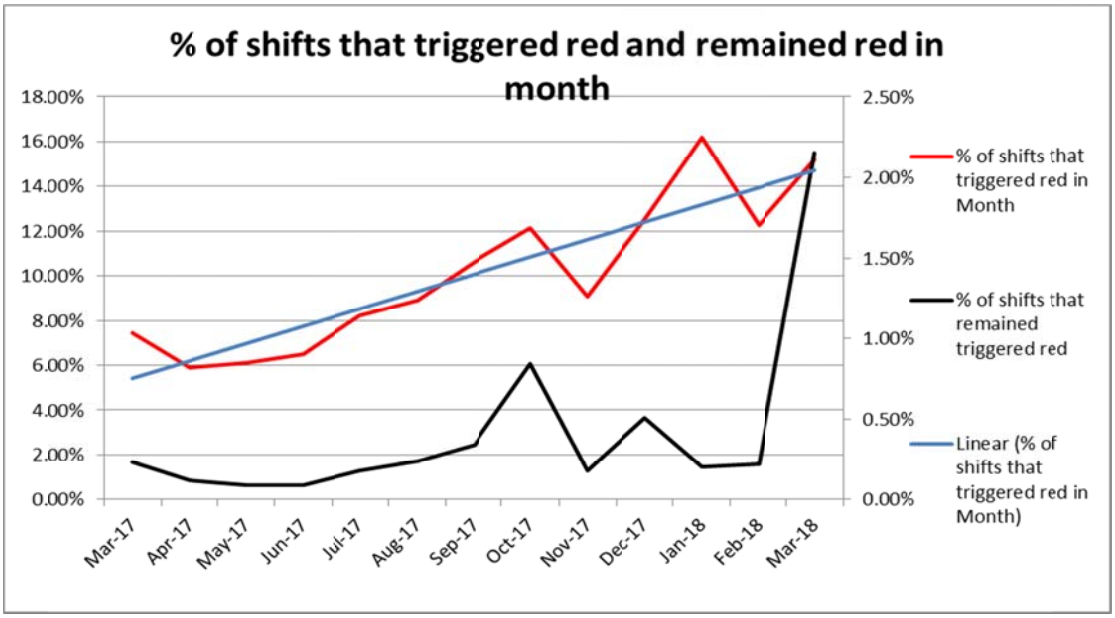
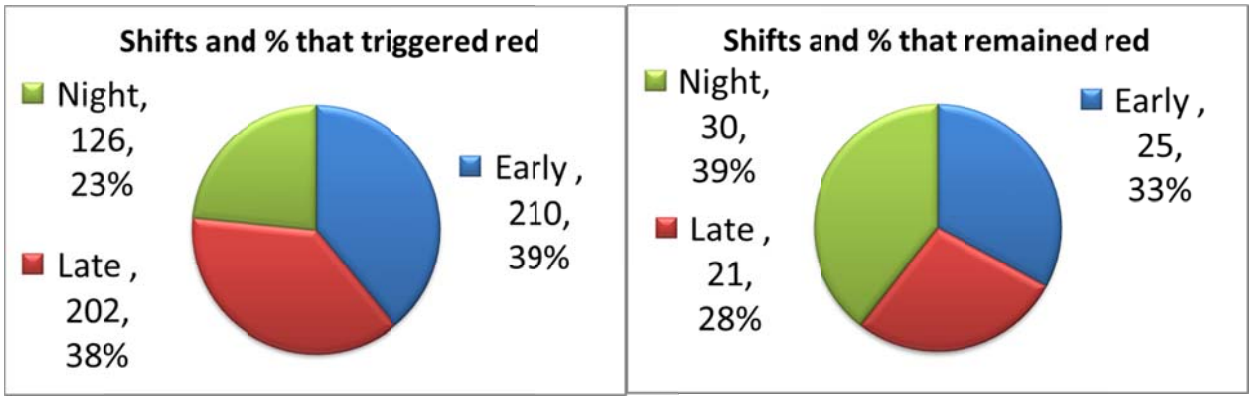


Chart 2 below shows the number and % distribution of red triggered shifts and those shifts that remained red after mitigating action was taken.

Chart 2 – Shifts initially triggering red & remained red



A list of all the shifts triggering red can be found in Appendix 3. Twenty-two wards triggered red on 10% or more of the shifts in March which is a slight increase from 21 wards in February.

Generally, red shifts are mitigated by moving staff between wards to balance staff numbers and skill mix. Table 5 below shows the shift breakdown for each of these wards.

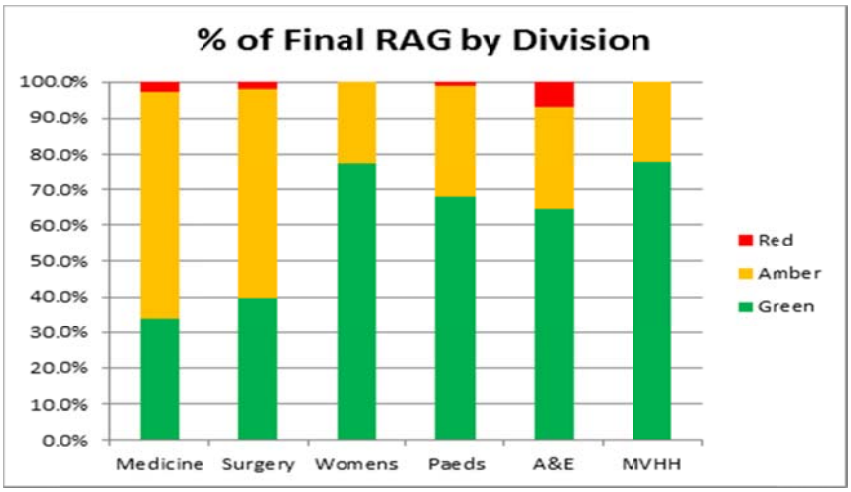
Table 5 – Wards triggering high number of red shifts

	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
5B	18	16	3	37	39.78
10B	14	14	7	35	37.63
9A	17	11	5	33	35.48
Barley	18	7	5	30	32.26
ACU	10	12	7	29	31.18
7AS	7	15	2	24	25.81
7AN	6	11	7	24	25.81
8A	10	11	2	23	24.73
8B	8	8	7	23	24.73
Swift	4	10	8	22	23.66
7B	7	5	9	21	22.58
11A	8	8	4	20	21.51
Ashwell	7	5	8	20	21.51
A&E	7	9	4	20	21.51
9B	11	6	2	19	20.43
6A	9	5	3	17	18.28
SAU	3	8	6	17	18.28
SSU	8	6	1	15	16.13
AMU-W	7	4	3	14	15.05
5A	5	2	7	14	15.05
AMU-A	3	5	5	13	13.98
Pirton	4	4	2	10	10.75

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.

Chart 3 shows the% of the final RAG shift status by Division for March. As supported by the data already presented the majority of final red and amber shifts are within medicine and surgery divisions, with A&E having the largest number of final red shifts during March. The reasons for this are presented in 2.3 below.

Chart3 - % of final RAG shifts by division



2.3 Summary of factors affecting red triggering shifts

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

- Temporary Staffing Fill – Overall fill rate for temporary staffing decreased by 2.8% from 74.3% in February to 71.5% in March, demand has however increased slightly when factoring in the differing number of days in month. The decrease in fill resulted in 25,180 unfilled hours (28.5% of demand unfilled). This is an increase from 19,300 unfilled hours in February (25.7% unfilled). See Appendix 5.
- Sickness – The sickness rate decreased from 7.7% in February to 6.3% in March (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 from the first week in January 7AS was opened as a 14 bed unplanned winter pressures ward. This is not included in the Unify return as it is a temporary ward. Substantive staffs have been moved from other areas to support the temporary opening and additional temporary staffing requested to support this ward.
- The 18 long line agency nurses continued to be booked throughout March. The majority of nurses are working the required shift volume agreed at the start of the placements. The agencies have been contacted regarding those nurses working below the number of shifts agreed to encourage further fill going forward.

2.4 The Enhanced Nursing care team (ENCT)

The Enhanced Nursing care team continue to streamline the service for patients requiring enhanced care (specialling) and have been recognised by NHSI as a best practice team to support our most vulnerable high risk patients. For the month of March there has been an increase of 3 patients referred to the team compared to February. March has also seen an increase in mental health enhanced care hours. The team continue to streamline the service and improve patient care and outcomes.

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

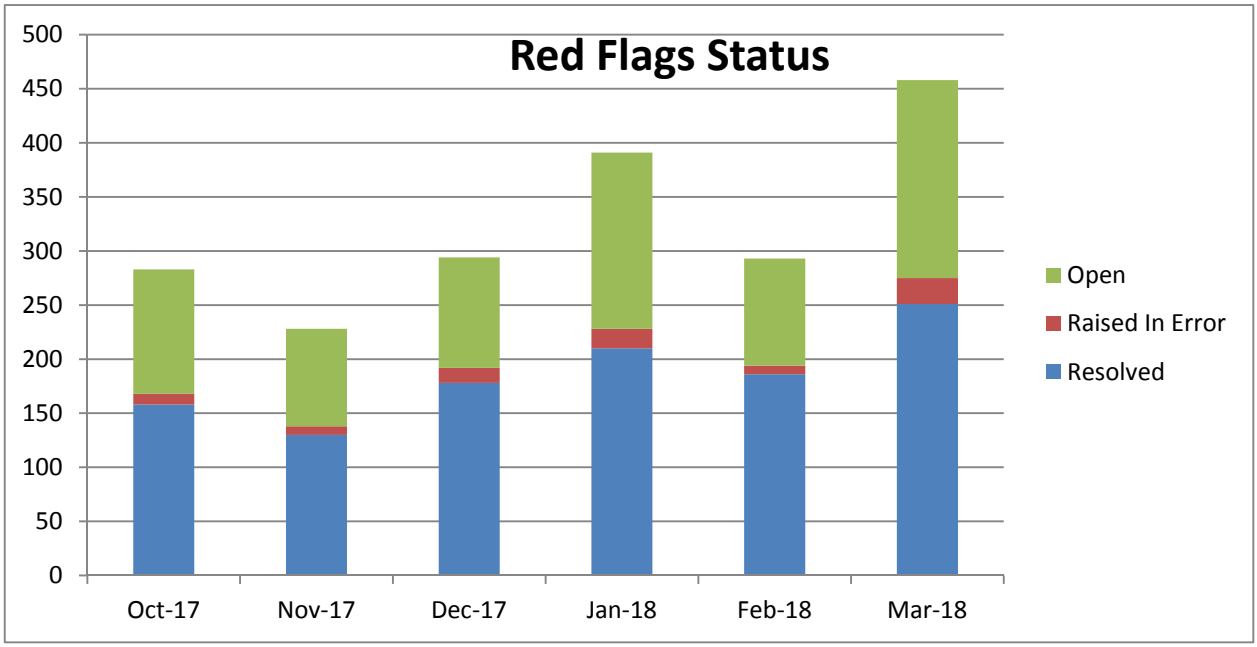
Red flags are NICE recommended nationally reportable events that require an immediate response from the Senior Nurse Team. “Red flag events” signal to the Senior Nurse Team an urgent need for review of the numbers of staff, skill mix and patient acuity and numbers. These events are considered as indicators 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 are appropriate to the staffing challenges they need to escalate on a shift.

There is ongoing development to resolve red flags at the staffing meetings to identify where staffing levels have impacted the quality of care on the wards. When a ward raises a red flag the matron must visit the ward to assess the challenges and risk the ward is facing and put measures in place to support this area appropriately. Chart 4 below shows the number of red flags raised each month over the last 6 months and their status.

Chart 4



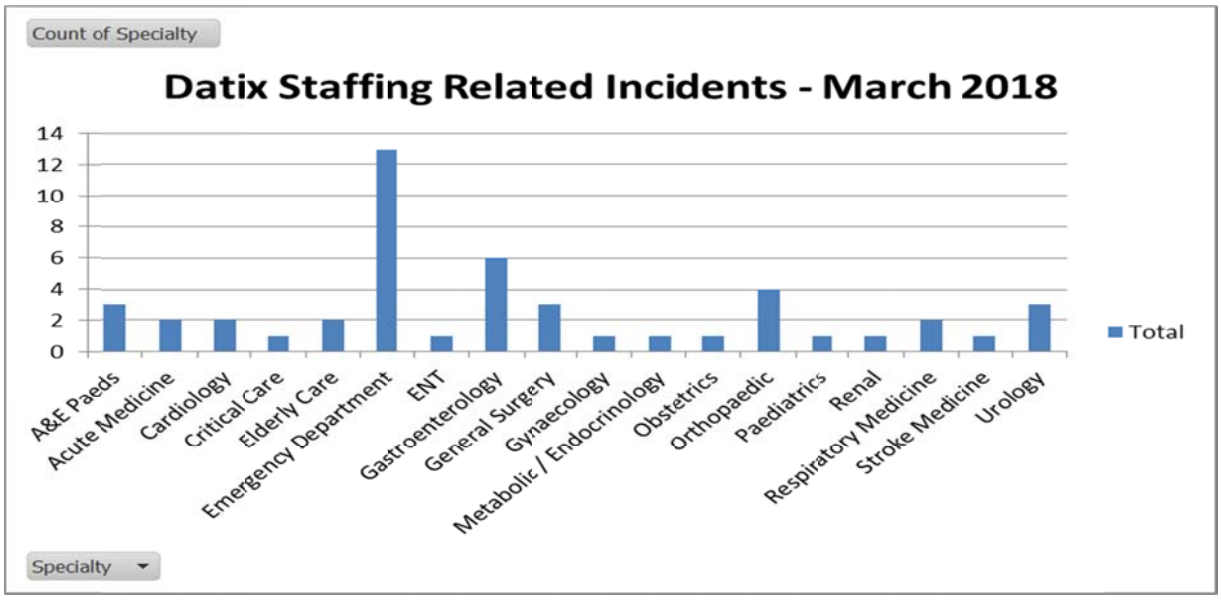
4. Datix

Chart 5 below shows the number of staffing related Datix incidents logged in March by speciality.

There was an increase in Datix reported incidents related to staffing in March, with an increase in clinical areas reporting incidents but the emergency department continuing to report the greatest number.

All staffing related incidents are reviewed by the Safer Staffing Matron and DoN and actioned as appropriate.

Chart 5



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

The overall RN day fill rate decreased by 1.7% due to the actual care being greater than planned as a result of escalation staffing, although CSW day fill rate increased by 1%. There has been a slight increase in temporary staffing fill, sickness rates remain high. The CHPPD delivered in March has however remained static. The maintenance of safe staffing levels on wards in March 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
- Monthly patient acuity audits completed by Matrons. If Acuity is in question the matron will visit the ward and review the Acuity scoring for that shift. This data is recorded on meridian and reported in the E Roster monthly report.
- 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
- All controls off for the top 5 wards with the highest operational shortfall
- Additional support provided by e-Roster, NHSP and Temporary Staffing management to assist wards with staffing challenges
- The non-ward based nursing project continues to review roles and activities of non-ward based nurses, and allows for a more objective approach to meeting the clinical and organisational demands.
- 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 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	88.7%	91.8%	90.0%	129.6%
11A	91.4%	79.6%	94.4%	98.0%
11B	88.3%	62.8%	99.1%	100.4%
5A	96.4%	81.6%	93.4%	130.9%
5B	92.1%	84.3%	92.7%	132.4%
6A	97.8%	78.3%	96.1%	97.9%
6B	84.9%	72.9%	100.3%	89.5%
10A Gynae	103.2%	64.4%	101.3%	70.7%
7B	97.2%	85.3%	86.3%	142.3%
7AN	98.6%	72.1%	76.5%	97.6%
8A	94.4%	84.4%	89.6%	106.7%
8B	86.6%	96.9%	85.4%	113.2%
9A	97.4%	93.1%	92.1%	132.2%
9B	94.5%	96.0%	93.1%	125.0%
ACU	88.1%	111.1%	84.6%	119.4%
AMU-A	86.6%	92.1%	85.6%	98.8%
AMU-W	96.7%	84.5%	89.9%	104.3%
Ashwell	98.0%	92.6%	100.3%	103.1%
Barley	98.0%	100.2%	93.6%	142.0%
Bluebell	93.9%	92.9%	94.4%	#DIV/0!
Critical Care 1	100.0%	100.0%	100.0%	100.0%
Dacre	101.8%	72.9%	96.8%	#DIV/0!
Gloucester	105.6%	88.6%	91.5%	87.3%
CLU	96.8%	71.7%	99.7%	93.1%
Mat MLU	104.8%	83.4%	100.7%	91.5%
Michael Sobell House	90.5%	87.8%	103.7%	97.4%
Pirton	79.2%	85.2%	92.5%	111.4%
SAU	80.4%	82.9%	100.6%	97.3%
SSU	99.5%	97.0%	93.6%	123.9%
Swift	83.8%	67.3%	77.5%	98.0%
Ward 11	87.2%	67.5%	118.0%	85.8%
Total	**93.5%**	**85.3%**	**94.1%**	**108.2%**

Appendix 2

Ward name	Care Hours Per Patient Day (CHPPD)		
	Registered midwives/ nurses	Care Staff	Overall
10B	2.81	2.62	5.43
11A	3.94	1.56	5.50
11B	3.48	2.05	5.53
5A	3.06	1.89	4.95
5B	3.12	2.51	5.62
6A	3.12	2.13	5.24
6B	3.80	2.36	6.15
10A Gynae	5.38	1.78	7.16
7B	2.91	1.72	4.64
7AN	3.24	2.24	5.48
8A	3.01	2.11	5.12
8B	2.85	2.01	4.85
9A	2.93	2.47	5.41
9B	2.99	2.21	5.20
ACU	3.94	2.63	6.57
AMU-A	5.19	3.43	8.62
AMU-W	3.83	3.02	6.85
Ashwell	2.99	3.09	6.08
Barley	3.28	2.65	5.92
Bluebell	6.61	1.77	8.38
Critical Care 1	16.13	2.06	18.19
Dacre	8.40	1.05	9.44
Gloucester	5.06	4.08	9.14
CLU	35.22	6.58	41.81
Mat MLU	30.28	8.60	38.88
Michael Sobell House	4.50	2.93	7.42
Pirton	4.00	2.34	6.34
SAU	5.93	2.62	8.55
SSU	3.51	2.57	6.08
Swift	3.35	2.17	5.52
Ward 11	5.52	1.96	7.48
Total	**4.5**	**2.4**	**6.9**

Appendix 3

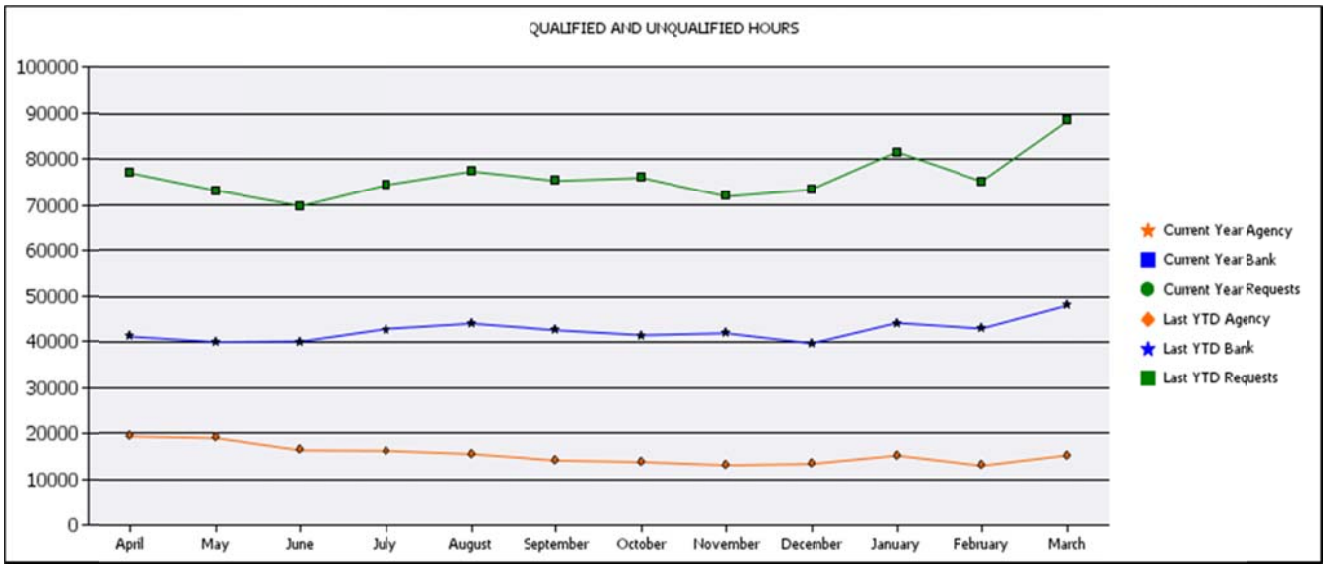
Speciality	Ward	INITIAL REDS				
		Early	Late	Night	Number of shifts where staffing initially fell below agreed levels	% of shifts where staffing fell below agreed levels and triggered a Red rating
Care of the Elderly	9A	17	11	5	33	35.48
	9B	11	6	2	19	20.43
Stroke	Barley	18	7	5	30	32.26
	Pirton	4	4	2	10	10.75
General	6A	9	5	3	17	18.28
	7AS	7	15	2	24	25.81
	10B	14	14	7	35	37.63
Respiratory	11A	8	8	4	20	21.51
Cardiology	ACU	10	12	7	29	31.18
Acute	AMU-A	3	5	5	13	13.98
	SSU	8	6	1	15	16.13
	AMU-W	7	4	3	14	15.05
Renal	6B	2	2	5	9	9.68
DTOC / gastro	Ashwell	7	5	8	20	21.51
ED	A&E	7	9	4	20	21.51
	CDU	3	3	2	8	8.60
	UCC	1	1	0	2	2.15
		136	**117**	**65**	**318**	**20.11**
General	7AN	6	11	7	24	25.81
	8A	10	11	2	23	24.73
	8B	8	8	7	23	24.73
	SAU	3	8	6	17	18.28
Surgical Spec	11B	1	3	2	6	6.45
	7B	7	5	9	21	22.58
T&O	5A	5	2	7	14	15.05
	5B	18	16	3	37	39.78
	Swift	4	10	8	22	23.66
ATCC	Critical Care 1	1	0	2	3	3.23
	ASCU	0	0	0	0	0.00
		63	**74**	**53**	**190**	**18.57**
Gynae	10A Gynae	2	2	2	6	6.45
Paeds	Bluebell	3	3	2	8	8.60
	Child A&E	3	2	1	6	6.45
	NICU	0	0	0	0	0.00
Maternity	Dacre	0	0	0	0	0.00
	Gloucester	0	1	0	1	1.08
	Mat MLU	2	2	0	4	4.30
	Mat CLU 1	1	1	0	2	2.15
		11	**11**	**5**	**27**	**3.63**
Inpatient	Ward 10	0	0	0	0	0.00
	Michael Sobell House	0	0	3	3	3.23
		0	**0**	**3**	**3**	**1.61**
	TRUST TOTAL	**210**	**202**	**126**	**538**	**15.22**

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	1	1	0	2	2.15
	9B	0	0	0	0	0.00
Stroke	Barley	1	1	1	3	3.23
	Pirton	1	0	1	2	2.15
General	6A	1	1	2	4	4.30
	7AS	0	0	0	0	0.00
	10B	1	3	2	6	6.45
Respiratory	11A	1	0	2	3	3.23
Cardiology	ACU	1	1	2	4	4.30
Acute	AMU-A	1	1	1	3	3.23
	SSU	0	1	1	2	2.15
	AMU-W	1	0	1	2	2.15
Renal	6B	0	0	0	0	0.00
DTOC / gastro	Ashwell	1	2	2	5	5.38
ED	A&E	5	4	4	13	13.98
	CDU	1	1	2	4	4.30
	UCC	1	1	0	2	2.15
		17	**17**	**21**	**55**	**3.48**
General	7AN	0	0	1	1	1.08
	8A	2	1	0	3	3.23
	8B	2	1	2	5	5.38
	SAU	1	0	0	1	1.08
Surgical Spec	11B	0	0	0	0	0.00
	7B	0	0	1	1	1.08
T&O	5A	0	1	0	1	1.08
	5B	1	0	0	1	1.08
	Swift	1	0	2	3	3.23
ATCC	Critical Care 1	0	0	2	2	2.15
	ASCU	0	0	0	0	0.00
		7	**3**	**8**	**18**	**1.76**
Gynae	10A Gynae	0	0	0	0	0.00
Paeds	Bluebell	1	1	0	2	2.15
	Child A&E	0	0	1	1	1.08
	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	0	0	0.00
		1	**1**	**1**	**3**	**0.40**
Inpatient	Ward 10	0	0	0	0	0.00
	Michael Sobell House	0	0	0	0	0.00
		0	**0**	**0**	**0**	**0.00**
	TRUST TOTAL	**25**	**21**	**30**	**76**	**2.15**

Appendix 5

NHSP hours YTD report



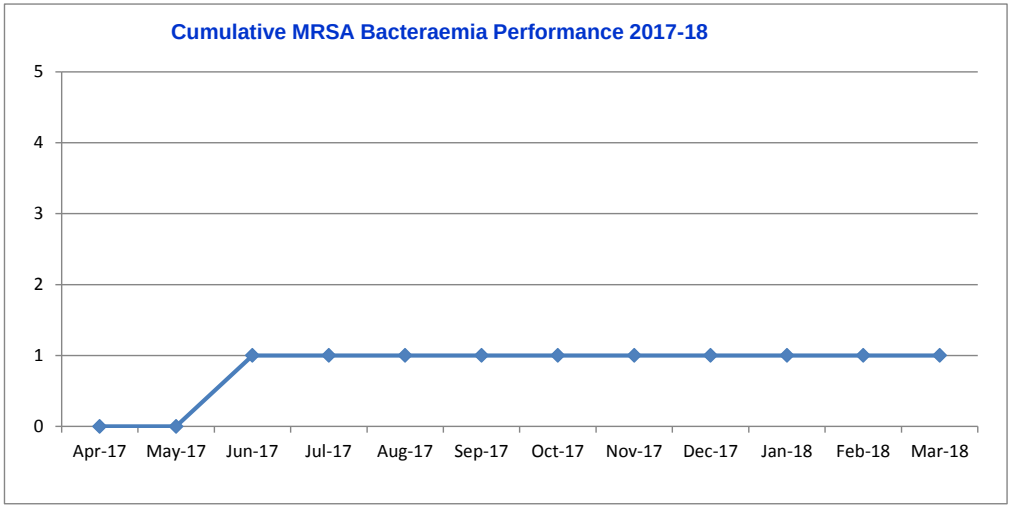
Infection Prevention and Control Board Report Objectives & Outcomes: March 2018

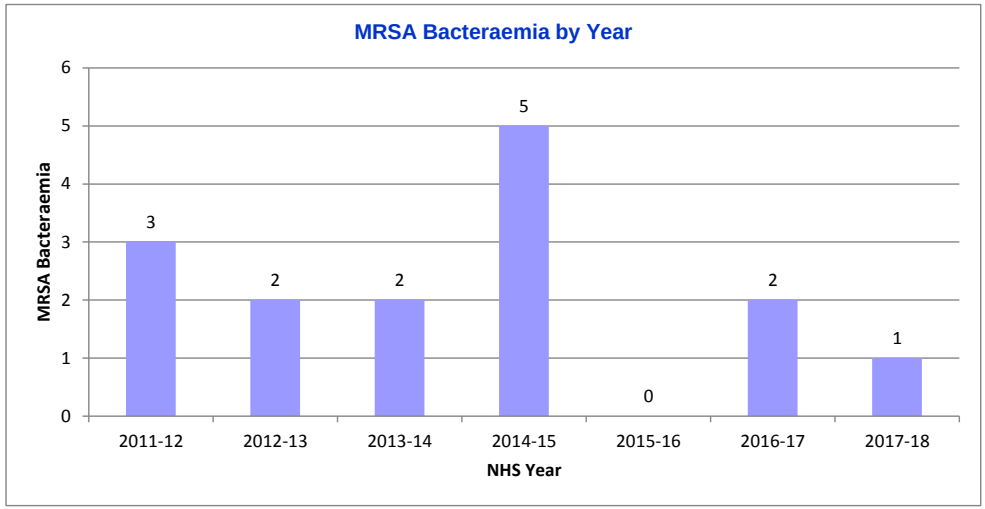
Note: RAG ratings are based on performance against set targets, previous year's performance or PHE benchmarking data, as specified.

HCAI SURVEILLANCE	MRSA bacteraemias	0 hospital associated MRSA bacteraemias in March. Year end position is 1 Trust allocated case (target 0 cases to year end). Trust rate is 0.49 cases per 100,000 bed days against EoE average of 1.0 cases (data to end March 2018)	Red
	C.difficile	2 Trust allocated *C.difficile* cases in March, being investigated as an SI as part of a probable outbreak. Year end position is 28 reported cases, of which 12 have been accepted by the CCG Appeals Panel for exemption against financial sanctions. The Trust is 5 cases over the ceiling of 11 cases for the purpose of potential financial sanctions. The 2018-19 ceilings have been reduced by 1 case for each Trust, therefore ENHT's ceiling is 10 cases. RAG rating is based on current position for the purpose of potential financial sanctions. Recorded cases in the Trust have increased since 2016 – see September report for further details.	Red
	MSSA bacteraemias	3 Trust allocated MSSA bacteraemia in March Year end position is 21 cases (no target set). RAG rating based on Trust rate of 10.34 cases per 100,000 bed days against EoE average of 8.55 cases (data to end March 2018).	Amber
	Gram negative bacteraemia: National monitoring and reduction programme for E.*coli, Pseudomonas aeruginosa, Klebsiella species*.	3 Trust associated E.*coli* bacteraemias in March. Year end position is 36 cases (no target set). RAG rating based on Trust rate of 17.73 cases per 100,000 bed days against EoE average of 20.54 cases (data to end March 2018).	Green
		1 Trust associated *Pseudomonas aeruginosa* bacteraemia in March. Year end position is 2 cases (no target set). RAG rating based on Trust rate of 0.99 cases per 100,000 bed days against EoE average of 3.99 cases (data to end March 2018).	Green
		0 Trust associated *Klebsiella species* bacteraemias in March. Year end position is 8 cases (no target set). RAG rating based on Trust rate of 3.94 cases per 100,000 bed days against EoE average of 7.23 cases (data to end March 2018).	Green
	Carbapenemase Producing Organisms (CPO)	1 new inpatient case identified in March. Year end position is 10 inpatient cases and 7 outpatient cases (no target set). RAG rating based on 15 cases in 2016-17 and likely cross-transmission incident.	Amber

	Outbreaks / Periods of Increased Incidence	**Influenza –** 73 inpatient cases of influenza had been identified by the end of March, 10 of whom required a stay in CCU. **Viral gastroenteritis –** In March, 49 bed days were lost due to confirmed or suspected viral gastroenteritis. Some bay closures were implemented on Ashwell, SSU, 11AN and 6B, and 6B was fully closed for several days except for renal emergency admissions. A daily report is circulated to PHE and within the Trust detailing numbers of confirmed influenza cases and specifying any area closures due to gastroenteritis. The IP&C Team liaise several times per day with the bed management and operations teams to facilitate safe and efficient use of beds. ***C.difficile*** An outbreak of *C.difficile* involving at least 4 patients is being investigated as an SI. RAG rating based on several bed/ward closures and transmission of viral gastroenteritis and *C.difficile*.	Amber
	Surgical Site Infection	The Trust was identified as a high outlier for 2014-15 in all 3 orthopaedic categories monitored. Figures for 2015-17 to date indicate overall improvement and are now in line with national benchmarks – see page 12 for detailed figures. RAG rating based on reduced infection rates although further work needed to sustain reductions.	Amber
CQUINs	Antimicrobial stewardship	10% reduction (Apr 17-Mar 18) in total antibiotic consumption (target 2% reduction on baseline data Jan-Dec 2016). RAG rating based on target of 2% reduction. 47.5% reduction (Apr 17-Mar 18) (supply shortage May-Oct) in piperacillin-tazobactam (target 2% reduction on baseline data Jan-Dec 2016). RAG rating based on target of 2% reduction. 40.6% reduction (Apr 17-Mar 18) in carbapenems (target 2% reduction on baseline data Jan-Dec 2016). RAG rating based on target of 2% reduction.	Green
		Review of sepsis patients on antibiotics who are still inpatients at 72 hrs. Q1: 75% reviewed within 72 hrs (target 25%) Q2: 78% reviewed within 72 hrs (target 50%) Q3: 93% reviewed within 72 hrs (target 75%) Q4: 95% reviewed within 72 hrs (target 90%). RAG rating based on quarterly targets.	Green
AUDITS	High Impact Interventions (HII)	HII audit scores in March were above 95% with the exception of Intravascular Devices Insertion and Renal Environment. RAG rating based on scores exceeding 95% in 10 out of 12 categories monitored.	Green
SURVEILLANCE PROCESSES	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 was presented at the January TIPCC and will be presented quarterly by the CCU Team.	Target TBC

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
Cancer	0	0	0	0	0	0	0	0	0	0	0	0	0	**0**
Medicine	2	0	0	1	0	0	0	0	0	0	0	0	0	**1**
Surgical	0	0	0	0	0	0	0	0	0	0	0	0	0	**0**
Women & Children	0	0	0	0	0	0	0	0	0	0	0	0	0	**0**
Grand Total	**2**	**0**	**0**	**1**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**1**

1 community-allocated (pre-48 hrs) MRSA bacteraemia was identified in March and the Trust is participating in the Post Investigation Review.

The hospital-allocated bacteraemia in June 2017 was deemed to be a contaminant and unavoidable as the patient's peripheral veins were inaccessible.

MRSA – PHE Benchmarking Data (March 2018)

Public Health England

MRSA

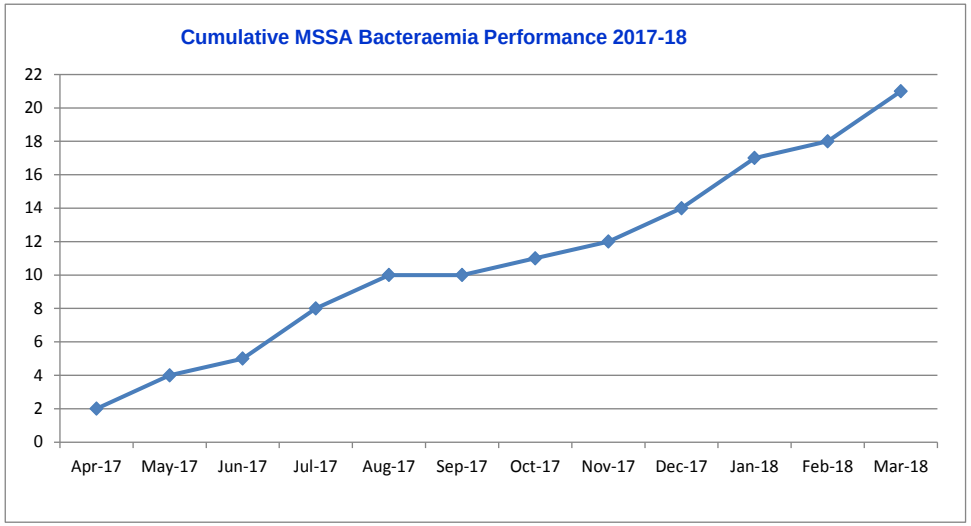
Count of trust PIR assigned cases per month

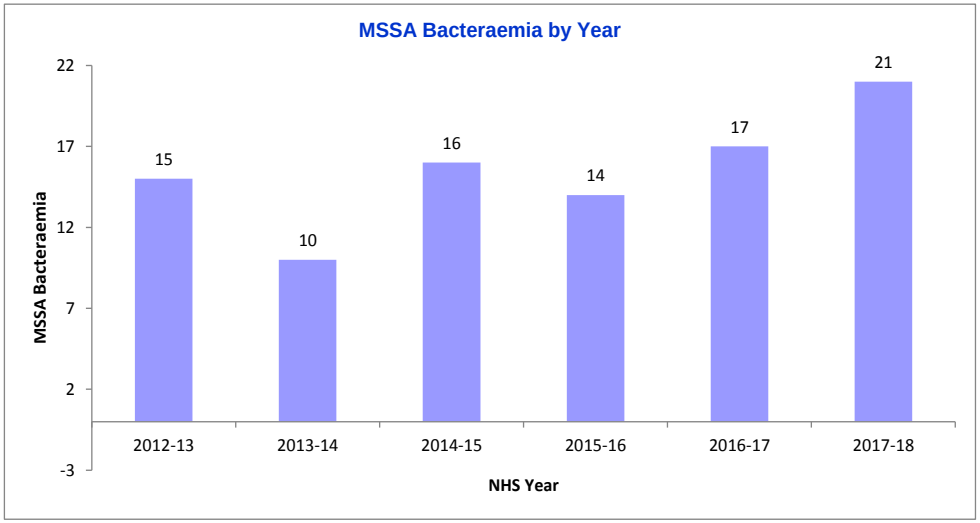
Trust Code	Acute Trust Name	Trajectory	2017									2018			Total
			April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	
RDD	Basildon & Thurrock University Hospitals NHS Foundation Trust	N/A	0	0	0	2	2	0	0	1	0	0	0	1	**6**
RC1	Bedford Hospitals NHS Trust	N/A	0	0	0	0	0	0	0	0	0	0	0	0	**0**
RGT	Cambridge University Hospitals NHS Foundation Trust	N/A	0	0	0	0	0	0	0	0	0	0	0	0	**0**
RDE	Colchester Hospitals University NHS Foundation Trust	N/A	0	0	0	0	0	0	0	0	2	0	0	0	**2**
RWH	East & North Hertfordshire NHS Trust	N/A	0	0	1	0	0	0	0	0	0	0	0	0	**1**
RGQ	Ipswich Hospital NHS Trust	N/A	0	1	0	0	0	0	0	0	0	0	0	0	**1**
RGP	James Paget University Hospitals NHS Foundation Trust	N/A	0	0	0	0	0	0	0	0	0	0	0	0	**0**
RC9	Luton & Dunstable Hospital NHS Foundation Trust	N/A	0	0	0	0	0	0	0	1	0	0	0	0	**1**
RQ8	Mid Essex Hospital Services NHS Trust	N/A	2	0	0	0	0	0	0	0	2	2	1	0	**7**
RD8	Milton Keynes Hospital NHS Foundation Trust	N/A	0	0	1	0	1	0	0	0	0	0	0	0	**2**
RM1	Norfolk & Norwich University Hospitals NHS Foundation Trust	N/A	0	0	0	0	0	0	0	0	0	0	0	0	**0**
RGN	North West Anglia NHS Foundation Trust	N/A	1	0	0	0	0	0	0	0	0	0	0	0	**1**
RGM	Papworth Hospital NHS Foundation Trust	N/A	0	0	0	0	0	1	1	0	0	0	0	0	**2**
RQW	Princess Alexandra Hospital NHS Trust	N/A	0	0	0	0	0	0	0	0	0	0	0	0	**0**
RAJ	Southend University Hospital NHS Foundation Trust	N/A	1	0	0	1	2	0	0	0	0	1	1	0	**6**
RCX	The Queen Elizabeth Hospital King's Lynn NHS Trust	N/A	0	0	0	0	0	0	0	0	0	0	0	0	**0**
RWG	West Hertfordshire Hospitals NHS Trust	N/A	0	0	0	1	0	0	0	0	0	0	0	0	**1**
RGR	West Suffolk Hospitals NHS Trust	N/A	0	0	0	0	0	0	0	0	0	0	1	0	**1**
	East of England Total	**N/A**	**4**	**1**	**2**	**4**	**5**	**1**	**1**	**2**	**4**	**3**	**3**	**1**	**31**
	England Total	**N/A**	**32**	**29**	**25**	**23**	**27**	**19**	**23**	**27**	**18**	**33**	**20**	**17**	**293**

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	5.39	0.00	0.00	0.00	5.22	**2.66**
RC1	Bedford Hospitals NHS Trust	N/A	0.00	0.00	0.00	0.00	0.00	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	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	12.53	0.00	0.00	0.00	**1.06**
RWH	East & North Hertfordshire NHS Trust	N/A	0.00	0.00	6.01	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	**0.49**
RGQ	Ipswich Hospital NHS Trust	N/A	0.00	5.89	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	**0.50**
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	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	5.99	0.00	0.00	0.00	0.00	**0.49**
RQ8	Mid Essex Hospital Services NHS Trust	N/A	13.62	0.00	0.00	0.00	0.00	0.00	0.00	0.00	13.62	13.62	7.54	0.00	**4.04**
RD8	Milton Keynes Hospital NHS Foundation Trust	N/A	0.00	0.00	7.95	0.00	7.69	0.00	0.00	0.00	0.00	0.00	0.00	0.00	**1.30**
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	0.00	0.00	0.00	0.00	**0.00**
RGN	North West Anglia NHS Foundation Trust	N/A	4.74	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	**0.40**
RGM	Papworth Hospital NHS Foundation Trust	N/A	0.00	0.00	0.00	0.00	0.00	18.96	18.35	0.00	0.00	0.00	0.00	0.00	**3.11**
RQW	Princess Alexandra Hospital NHS Trust	N/A	0.00	0.00	0.00	0.00	0.00	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	6.94	0.00	0.00	6.94	13.88	0.00	0.00	0.00	0.00	6.94	7.69	0.00	**3.53**
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	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	0.00	0.00	0.00	0.00	0.00	**0.44**
RGR	West Suffolk Hospitals NHS Trust	N/A	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	9.04	0.00	**0.69**
	East of England Total	**N/A**	**1.44**	**0.35**	**0.72**	**1.44**	**1.81**	**0.36**	**0.35**	**0.71**	**1.38**	**1.04**	**1.15**	**tbc**	**1.00**
	England Total	**N/A**	**1.13**	**0.99**	**0.88**	**0.79**	**0.93**	**0.68**	**0.79**	**0.96**	**0.62**	**1.14**	**0.76**	**tbc**	**0.93**

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
Cancer	0	0	0	0	0	0	0	0	0	0	0	0	0	**0**
Medicine	10	0	1	0	1	0	0	1	0	0	0	1	1	**5**
Surgical	5	0	1	0	1	2	0	0	1	1	3	0	2	**11**
Women & Children	1	1	0	0	1	0	0	0	0	1	0	0	0	**3**
MVCC	1	1	0	1	0	0	0	0	0	0	0	0	0	**2**
Grand Total	**17**	**2**	**2**	**1**	**3**	**2**	**0**	**1**	**1**	**2**	**3**	**1**	**3**	**21**

Note: 2 of the 3 cases in March relate to the same patient but count as separate cases as samples were taken more than 14 days apart. The case in Medicine is the later sample for this patient.

MSSA – PHE Benchmarking Data (March 2018)

Public Health England

MSSA

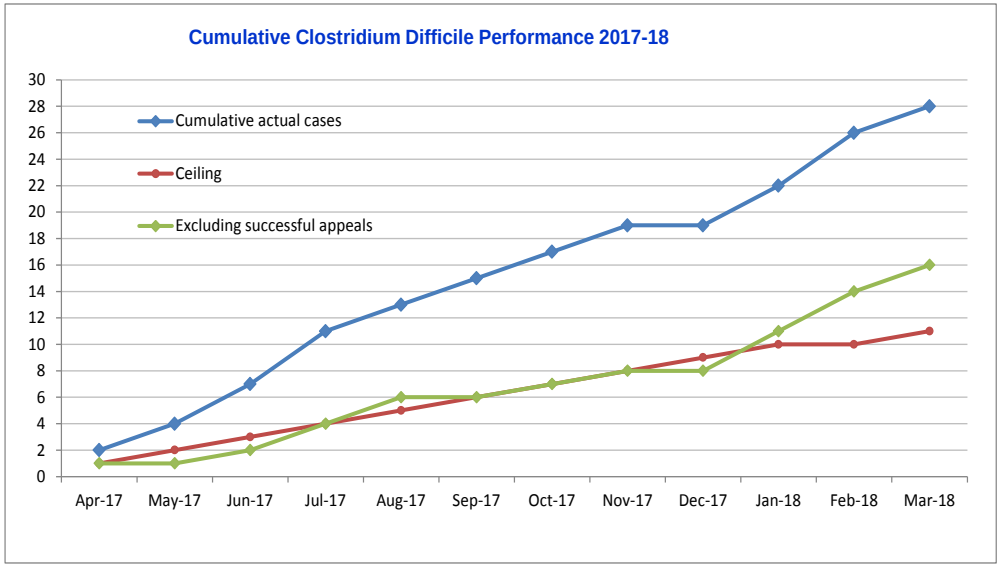
Count of all cases identified by acute trust per month

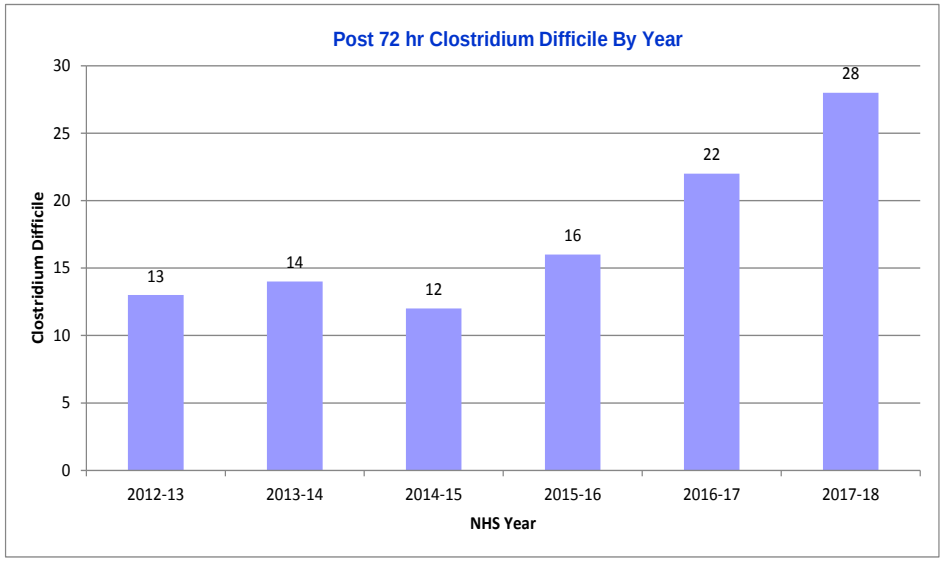
Trust Code	Acute Trust Name	Trajectory	2017									2018			Total
			April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	
RDD	Basildon & Thurrock University Hospitals NHS Foundation Trust	N/A	1	2	4	1	1	1	2	1	1	2	1	1	**18**
RC1	Bedford Hospitals NHS Trust	N/A	0	0	1	1	0	1	0	0	1	0	0	1	**5**
RGT	Cambridge University Hospitals NHS Foundation Trust	N/A	2	0	1	0	1	5	2	3	2	3	3	3	**25**
RDE	Colchester Hospitals University NHS Foundation Trust	N/A	1	2	2	2	2	1	0	0	2	1	1	0	**14**
RWH	East & North Hertfordshire NHS Trust	N/A	2	2	1	3	2	0	1	1	2	3	1	3	**21**
RGQ	Ipswich Hospital NHS Trust	N/A	1	0	1	0	3	1	1	0	2	4	1	3	**17**
RGP	James Paget University Hospitals NHS Foundation Trust	N/A	3	0	3	0	0	1	3	1	2	1	1	2	**17**
RC9	Luton & Dunstable Hospital NHS Foundation Trust	N/A	0	0	0	1	2	1	0	1	2	0	0	3	**10**
RQ8	Mid Essex Hospital Services NHS Trust	N/A	1	1	2	2	0	3	2	1	0	3	1	1	**17**
RD8	Milton Keynes Hospital NHS Foundation Trust	N/A	2	2	1	2	2	4	4	0	0	2	4	2	**25**
RM1	Norfolk & Norwich University Hospitals NHS Foundation Trust	N/A	3	1	3	4	1	0	2	0	1	0	2	1	**18**
RGN	North West Anglia NHS Foundation Trust	N/A	0	1	1	2	1	2	2	0	1	1	0	1	**12**
RGM	Papworth Hospital NHS Foundation Trust	N/A	1	2	0	0	1	2	1	1	0	0	0	3	**11**
RQW	Princess Alexandra Hospital NHS Trust	N/A	0	0	1	0	0	0	0	1	1	0	1	0	**4**
RAJ	Southend University Hospital NHS Foundation Trust	N/A	1	2	0	1	1	1	1	0	1	1	0	2	**11**
RCX	The Queen Elizabeth Hospital King's Lynn NHS Trust	N/A	0	1	2	1	2	1	1	1	1	1	2	1	**14**
RWG	West Hertfordshire Hospitals NHS Trust	N/A	3	3	1	1	1	1	1	1	1	1	0	2	**16**
RGR	West Suffolk Hospitals NHS Trust	N/A	0	1	1	0	1	1	0	1	3	1	0	0	**9**
	East of England Total	**N/A**	**21**	**20**	**25**	**21**	**21**	**26**	**23**	**13**	**23**	**24**	**18**	**29**	**264**
	England Total	**N/A**	**255**	**295**	**264**	**249**	**269**	**256**	**290**	**255**	**267**	**253**	**232**	**270**	**3155**

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	5.39	5.22	10.44	5.78	5.22	**7.98**
RC1	Bedford Hospitals NHS Trust	N/A	0.00	0.00	9.11	8.82	0.00	9.11	0.00	0.00	8.82	0.00	0.00	8.82	**3.73**
RGT	Cambridge University Hospitals NHS Foundation Trust	N/A	7.53	0.00	3.89	0.00	3.76	19.44	7.53	11.67	7.53	11.29	12.50	11.29	**7.97**
RDE	Colchester Hospitals University NHS Foundation Trust	N/A	6.27	12.53	12.95	12.53	12.53	6.47	0.00	0.00	12.53	6.27	6.94	0.00	**7.43**
RWH	East & North Hertfordshire NHS Trust	N/A	11.63	11.63	6.01	17.44	11.63	0.00	5.81	6.01	11.63	17.44	6.44	17.44	**10.34**
RGQ	Ipswich Hospital NHS Trust	N/A	5.89	0.00	6.09	0.00	17.67	6.09	5.89	0.00	11.78	23.56	6.52	17.67	**8.48**
RGP	James Paget University Hospitals NHS Foundation Trust	N/A	27.09	0.00	27.99	0.00	0.00	9.33	27.09	9.33	18.06	9.03	10.00	18.06	**13.00**
RC9	Luton & Dunstable Hospital NHS Foundation Trust	N/A	0.00	0.00	0.00	5.79	11.59	5.99	0.00	5.99	11.59	0.00	0.00	17.38	**4.91**
RQ8	Mid Essex Hospital Services NHS Trust	N/A	6.81	6.81	14.07	13.62	0.00	21.10	13.62	7.03	0.00	20.42	7.54	6.81	**9.80**
RD8	Milton Keynes Hospital NHS Foundation Trust	N/A	15.38	15.38	7.95	15.38	15.38	31.79	30.76	0.00	0.00	15.38	34.06	15.38	**16.29**
RM1	Norfolk & Norwich University Hospitals NHS Foundation Trust	N/A	10.73	3.58	11.09	14.31	3.58	0.00	7.15	0.00	3.58	0.00	7.92	3.58	**5.45**
RGN	North West Anglia NHS Foundation Trust	N/A	0.00	4.74	4.90	9.49	4.74	9.81	9.49	0.00	4.74	4.74	0.00	4.74	**4.82**
RGM	Papworth Hospital NHS Foundation Trust	N/A	18.35	36.70	0.00	0.00	18.35	37.92	18.35	18.96	0.00	0.00	0.00	55.05	**17.10**
RQW	Princess Alexandra Hospital NHS Trust	N/A	0.00	0.00	7.65	0.00	0.00	0.00	0.00	7.65	7.41	0.00	8.20	0.00	**2.51**
RAJ	Southend University Hospital NHS Foundation Trust	N/A	6.94	13.88	0.00	6.94	6.94	7.17	6.94	0.00	6.94	6.94	0.00	13.88	**6.47**
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	8.74	8.46	8.46	18.73	8.46	**10.03**
RWG	West Hertfordshire Hospitals NHS Trust	N/A	15.47	15.47	5.33	5.16	5.16	5.33	5.16	5.33	5.16	5.16	0.00	10.31	**6.99**
RGR	West Suffolk Hospitals NHS Trust	N/A	0.00	8.16	8.43	0.00	8.16	8.43	0.00	8.43	24.48	8.16	0.00	0.00	**6.22**
	East of England Total	**N/A**	**7.54**	**6.95**	**8.98**	**7.59**	**7.59**	**9.29**	**7.96**	**4.65**	**7.96**	**8.30**	**6.89**	**#N/A**	**8.55**
	England Total	**N/A**	**9.00**	**10.08**	**9.32**	**8.57**	**9.26**	**9.11**	**9.99**	**9.07**	**9.19**	**8.71**	**8.85**	**#N/A**	**10.06**

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
Cancer	0	0	0	0	0	0	0	0	0	0	0	0	0	**0**
Medicine	14	2	1	3	3	0	2	1	0	0	3	3	2	**20**
Surgical	8	0	1	0	1	2	0	1	1	0	0	1	0	**7**
Women & Children	0	0	0	0	0	0	0	0	0	0	0	0	0	**0**
MVCC	0	0	0	0	0	0	0	0	1	0	0	0	0	**1**
Grand Total	**22**	**2**	**2**	**3**	**4**	**2**	**2**	**2**	**2**	**0**	**3**	**4**	**2**	**28**

Summary of reviews of the 26 Trust allocated cases to end February 2018:

- 12 cases were accepted by the Appeals Panel for exemption from financial sanctions as there were no identified gaps in practice.
- 16 cases were not appealed or were rejected due to avoidable delay in sending a sample (4 cases), inappropriate antibiotics (4 cases), no documented review of antibiotics after 72 hrs (3 cases), incomplete documentation eg stool chart (2 cases) or poor documentation of assessment of cause of diarrhoea (1 case).
- The 2 cases identified in March are being investigated as a Serious Incident in the context of a probable outbreak involving 4 patients.

C.DIFFICILE – PHE Benchmarking Data (March 2018)

Public Health England

Clostridium difficile

Count of acute trust apportioned 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	31	5	1	2	1	1	2	1	1	5	2	4	3	28
RC1	Bedford Hospitals NHS Trust	10	0	1	1	0	1	2	0	1	1	2	0	2	11
RGT	Cambridge University Hospitals NHS Foundation Trust	49	1	11	4	7	5	8	5	4	6	2	8	6	67
RDE	Colchester Hospitals University NHS Foundation Trust	18	0	3	3	1	1	2	0	1	4	3	0	0	18
RWH	East & North Hertfordshire NHS Trust	11	2	2	2*	4	2	2	1*	2	0	3	4	2	26*
RGQ	Ipswich Hospital NHS Trust	18	1	3	1	8	2	1	1	1	0	0	2	3	23
RGP	James Paget University Hospitals NHS Foundation Trust	17	0	2	3	3	1	0	2	2	0	1	1	1	16
RC9	Luton & Dunstable Hospital NHS Foundation Trust	6	1	2	1	1	1	1	1	0	1	0	0	0	9
RQ8	Mid Essex Hospital Services NHS Trust	13	8	3	2	5	7	3	2	4	5	5	3	8	55
RD8	Milton Keynes Hospital NHS Foundation Trust	39	1	0	0	1	3	0	1	0	1	3	2	0	12
RM1	Norfolk & Norwich University Hospitals NHS Foundation Trust	49	2	1	6	3	3	3	4	4	2	3	3	1	35
RGN	North West Anglia NHS Foundation Trust	40	7	4	4	4	3	8	3	6	2	1	5	12	59
RGM	Papworth Hospital NHS Foundation Trust	5	0	0	0	0	0	0	2	0	0	0	1	2	5
RQW	Princess Alexandra Hospital NHS Trust	10	1	0	1	4	0	3	0	1	0	2	0	2	14
RAJ	Southend University Hospital NHS Foundation Trust	30	5	2	4	1	3	1	1	4	7	2	3	0	33
RCX	The Queen Elizabeth Hospital King's Lynn NHS Trust	53	2	3	4	5	3	5	7	4	1	3	5	6	48
RWG	West Hertfordshire Hospitals NHS Trust	23	1	1	4	0	0	0	3	5	1	6	6	1	28
RGR	West Suffolk Hospitals NHS Trust	16	3	0	0	1	0	2	6	4	0	1	0	2	19
	East of England Total	**438**	**40**	**39**	**42**	**49**	**36**	**43**	**40**	**44**	**36**	**39**	**47**	**51**	**506**
	England Total	**2945**	**345**	**372**	**412**	**464**	**399**	**407**	**408**	**389**	**352**	**384**	**380**	**426**	**4738**

*** Figures shown for ENHT exclude 1 case in June which does not meet PHE criteria for inclusion but which is Trust associated, and also 1 case in October which is not yet shown due to a data error**

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	13.60	26.97	5.22	10.79	5.22	5.22	10.79	5.22	5.39	26.10	10.44	23.12	15.66	12.42
RC1	Bedford Hospitals NHS Trust	8.30	0.00	8.82	9.11	0.00	8.82	18.22	0.00	9.11	8.82	17.63	0.00	17.63	8.21
RGT	Cambridge University Hospitals NHS Foundation Trust	15.60	3.76	41.40	15.56	26.34	18.82	31.11	18.82	15.56	22.58	7.53	33.33	22.58	21.36
RDE	Colchester Hospitals University NHS Foundation Trust	9.10	0.00	18.80	19.42	6.27	6.27	12.95	0.00	6.47	25.06	18.80	0.00	0.00	9.55
RWH	East & North Hertfordshire NHS Trust	4.90	11.63	11.63	12.02*	23.26	11.63	12.02	5.81*	12.02	0.00	17.44	25.75	11.63	12.81*
RGQ	Ipswich Hospital NHS Trust	9.40	5.89	17.67	6.09	47.11	11.78	6.09	5.89	6.09	0.00	0.00	13.04	17.67	11.47
RGP	James Paget University Hospitals NHS Foundation Trust	13.10	0.00	18.06	27.99	27.09	9.03	0.00	18.06	18.66	0.00	9.03	10.00	9.03	12.24
RC9	Luton & Dunstable Hospital NHS Foundation Trust	3.10	5.79	11.59	5.99	5.79	5.79	5.99	5.79	0.00	5.79	0.00	0.00	0.00	4.42
RQ8	Mid Essex Hospital Services NHS Trust	7.30	54.46	20.42	14.07	34.04	47.65	21.10	13.62	28.14	34.04	34.04	22.61	54.46	31.71
RD8	Milton Keynes Hospital NHS Foundation Trust	25.80	7.69	0.00	0.00	7.69	23.07	0.00	7.69	0.00	7.69	23.07	17.03	0.00	7.82
RM1	Norfolk & Norwich University Hospitals NHS Foundation Trust	15.10	7.15	3.58	22.18	10.73	10.73	11.09	14.31	14.79	7.15	10.73	11.88	3.58	10.60
RGN	North West Anglia NHS Foundation Trust	tbc	33.21	18.98	19.61	18.98	14.23	39.23	14.23	29.42	9.49	4.74	26.27	56.94	23.71
RGM	Papworth Hospital NHS Foundation Trust	7.00	0.00	0.00	0.00	0.00	0.00	0.00	36.70	0.00	0.00	0.00	20.32	36.70	7.77
RQW	Princess Alexandra Hospital NHS Trust	6.50	7.41	0.00	7.65	29.62	0.00	22.96	0.00	7.65	0.00	14.81	0.00	14.81	8.78
RAJ	Southend University Hospital NHS Foundation Trust	17.30	34.71	13.88	28.70	6.94	20.83	7.17	6.94	28.70	48.60	13.88	23.06	0.00	19.40
RCX	The Queen Elizabeth Hospital King's Lynn NHS Trust	38.00	16.92	25.37	34.96	42.29	25.37	43.70	59.21	34.96	8.46	25.37	46.82	50.75	34.39
RWG	West Hertfordshire Hospitals NHS Trust	10.90	5.16	5.16	21.31	0.00	0.00	0.00	15.47	26.64	5.16	30.94	34.25	5.16	12.23
RGR	West Suffolk Hospitals NHS Trust	12.50	24.48	0.00	0.00	8.16	0.00	16.87	48.97	33.73	0.00	8.16	0.00	16.32	13.13
	East of England Total	**13.70**	**14.36**	**13.55**	**15.08**	**17.70**	**13.00**	**15.37**	**13.84**	**15.73**	**12.45**	**13.49**	**18.00**	**tbc**	**16.39**
	England Total	**13.13**	**12.18**	**12.71**	**14.55**	**15.98**	**13.74**	**14.48**	**14.05**	**13.84**	**12.12**	**13.22**	**14.49**	**tbc**	**15.11**

*** Figures shown for ENHT exclude 1 case in June which does not meet PHE criteria for inclusion but which is Trust associated, and also 1 case in October which is not yet shown due to a data error**

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.

The 2 cases identified in December and the outpatient case identified in February are being investigated due to probable cross-transmission of infection. All 3 cases have a near-identical profile, and the patients had previously attended the same clinic on the same day. Practices are being reviewed and the department has implemented a number of changes.

1 inpatient case identified in March, on the Renal ward. The patient was isolated from admission, but all patients on the ward have been screened as a precautionary measure and no further positives identified.

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	2017-18
INPATIENTS	Renal Ward - Lister	3	0	0	1	0	0	0	0	0	0	0	0	1	2
	Medicine	3	0	1	0	0	0	0	0	0	0	0	0	0	1
	Surgery	7	1	0	0	0	1	1	1	0	1	0	1	0	6
	W&C	0	0	0	0	1	0	0	0	0	0	0	0	0	1
	MVCC	0	0	0	0	0	0	0	0	0	0	0	0	0	0
RENAL DIALYSIS UNITS	Lister	1	0	0	0	0	0	0	0	0	0	0	0	0	0
	L&D	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Harlow	0	0	0	0	0	0	0	0	0	0	1	0	0	1
	St Albans	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Bedford	0	0	0	0	0	0	0	0	0	0	0	0	0	0
OUTPATIENTS	Lister	0	0	1	0	0	0	1	0	0	1	1	1	0	5
	QEII	1	0	0	0	0	0	0	0	0	0	0	0	0	0
	HCH	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	MVCC	0	0	0	0	0	0	0	1	0	0	0	0	0	1
TOTAL (TRUST PATIENTS)		15	1	2	1	1	1	2	2	0	2	2	2	1	17

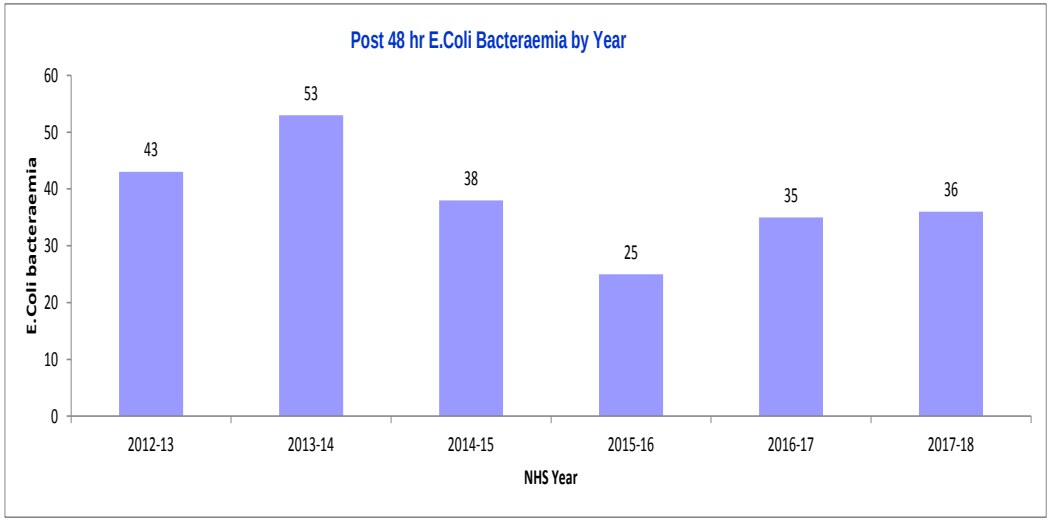
Note: The MVCC case in October and 2 cases in January were identified from samples taken at differents hospital, but included here as patients are regular attenders at ENHT.

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	0	0	0	0	2

E.COLI BACTERAEMIA – POST 48 HRS

A new Quality Premium was introduced in July 2017 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
Cancer	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Medicine	16	3	3	2	2	2	2	2	0	0	2	0	1	19
Surgical	16	1	2	1	1	0	2	1	0	0	0	3	1	12
Women & Children	1	0	2	0	0	0	0	0	1	0	0	0	0	3
MVCC	2	0	0	0	0	0	0	0	0	0	0	1	1	2
Grand Total	35	4	7	3	3	2	4	3	1	0	2	4	3	36

E.COLI – PHE Benchmarking Data (March 2018)

Public Health England

Escherichia coli

Hospital onset cases per month (sample taken later than day following admission)

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	3	3	2	4	3	7	5	5	8	2	4	5	**51**
RC1	Bedford Hospitals NHS Trust	N/A	1	3	1	0	3	0	1	2	2	1	1	2	**17**
RGT	Cambridge University Hospitals NHS Foundation Trust	N/A	13	8	7	8	11	6	10	11	3	10	5	5	**97**
RDE	Colchester Hospitals University NHS Foundation Trust	N/A	5	5	1	2	4	0	2	7	2	2	2	4	**36**
RWH	East & North Hertfordshire NHS Trust	N/A	4	7	3	3	2	4	3	1	0	2	4	3	**36**
RGQ	Ipswich Hospital NHS Trust	N/A	4	3	3	2	3	1	1	5	1	0	1	1	**25**
RGP	James Paget University Hospitals NHS Foundation Trust	N/A	1	4	3	3	1	2	2	0	3	5	6	4	**34**
RC9	Luton & Dunstable Hospital NHS Foundation Trust	N/A	2	2	3	3	0	3	3	0	2	2	2	1	**23**
RQ8	Mid Essex Hospital Services NHS Trust	N/A	2	5	5	1	1	2	5	4	4	0	1	0	**30**
RD8	Milton Keynes Hospital NHS Foundation Trust	N/A	2	2	4	4	1	1	4	1	4	2	3	3	**31**
RM1	Norfolk & Norwich University Hospitals NHS Foundation Trust	N/A	1	4	6	5	4	5	11	9	3	4	1	3	**56**
RGN	North West Anglia NHS Foundation Trust	N/A	2	4	1	4	5	5	3	4	4	6	1	3	**42**
RGM	Papworth Hospital NHS Foundation Trust	N/A	0	1	0	1	0	1	1	1	2	1	0	0	**8**
RQW	Princess Alexandra Hospital NHS Trust	N/A	2	1	2	0	2	3	4	2	1	2	0	1	**20**
RAJ	Southend University Hospital NHS Foundation Trust	N/A	3	1	2	3	2	5	3	4	4	0	1	2	**30**
RCX	The Queen Elizabeth Hospital King's Lynn NHS Trust	N/A	4	4	2	3	0	4	2	5	4	2	3	1	**34**
RWG	West Hertfordshire Hospitals NHS Trust	N/A	1	1	5	8	3	2	4	4	2	2	8	3	**43**
RGR	West Suffolk Hospitals NHS Trust	N/A	2	0	2	3	1	2	1	2	3	2	0	3	**21**
	East of England Total	**N/A**	**52**	**58**	**52**	**57**	**46**	**53**	**65**	**67**	**52**	**45**	**43**	**44**	**634**
	England Total	**N/A**	**610**	**687**	**681**	**664**	**645**	**676**	**667**	**664**	**582**	**646**	**572**	**610**	**7704**

Monthly rate per 100,000 occupied bed days (hospital onset 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	16.18	15.66	10.79	20.88	15.66	37.76	26.10	26.97	41.77	10.44	23.12	26.10	**22.61**
RC1	Bedford Hospitals NHS Trust	N/A	8.82	26.45	9.11	0.00	26.45	0.00	8.82	18.22	17.63	8.82	9.76	17.63	**12.69**
RGT	Cambridge University Hospitals NHS Foundation Trust	N/A	48.92	30.11	27.22	30.11	41.40	23.33	37.63	42.78	11.29	37.63	20.83	18.82	**30.92**
RDE	Colchester Hospitals University NHS Foundation Trust	N/A	31.33	31.33	6.47	12.53	25.06	0.00	12.53	45.32	12.53	12.53	13.87	25.06	**19.10**
RWH	East & North Hertfordshire NHS Trust	N/A	23.26	40.70	18.03	17.44	11.63	24.03	17.44	6.01	0.00	11.63	25.75	17.44	**17.73**
RGQ	Ipswich Hospital NHS Trust	N/A	23.56	17.67	18.26	11.78	17.67	6.09	5.89	30.43	5.89	0.00	6.52	5.89	**12.47**
RGP	James Paget University Hospitals NHS Foundation Trust	N/A	9.03	36.11	27.99	27.09	9.03	18.66	18.06	0.00	27.09	45.14	59.98	36.11	**26.00**
RC9	Luton & Dunstable Hospital NHS Foundation Trust	N/A	11.59	11.59	17.96	17.38	0.00	17.96	17.38	0.00	11.59	11.59	12.83	5.79	**11.29**
RQ8	Mid Essex Hospital Services NHS Trust	N/A	13.62	34.04	35.17	6.81	6.81	14.07	34.04	28.14	27.23	0.00	7.54	0.00	**17.30**
RD8	Milton Keynes Hospital NHS Foundation Trust	N/A	15.38	15.38	31.79	30.76	7.69	7.95	30.76	7.95	30.76	15.38	25.54	23.07	**20.19**
RM1	Norfolk & Norwich University Hospitals NHS Foundation Trust	N/A	3.58	14.31	22.18	17.89	14.31	18.48	39.35	33.27	10.73	14.31	3.96	10.73	**16.97**
RGN	North West Anglia NHS Foundation Trust	N/A	9.49	18.98	4.90	18.98	23.72	24.52	14.23	19.61	18.98	28.47	5.25	14.23	**16.88**
RGM	Papworth Hospital NHS Foundation Trust	N/A	0.00	18.35	0.00	18.35	0.00	18.96	18.35	18.96	36.70	18.35	0.00	0.00	**12.43**
RQW	Princess Alexandra Hospital NHS Trust	N/A	14.81	7.41	15.31	0.00	14.81	22.96	29.62	15.31	7.41	14.81	0.00	7.41	**12.55**
RAJ	Southend University Hospital NHS Foundation Trust	N/A	20.83	6.94	14.35	20.83	13.88	35.87	20.83	28.70	27.77	0.00	7.69	13.88	**17.64**
RCX	The Queen Elizabeth Hospital King's Lynn NHS Trust	N/A	33.83	33.83	17.48	25.37	0.00	34.96	16.92	43.70	33.83	16.92	28.09	8.46	**24.36**
RWG	West Hertfordshire Hospitals NHS Trust	N/A	5.16	5.16	26.64	41.25	15.47	10.66	20.63	21.31	10.31	10.31	45.67	15.47	**18.78**
RGR	West Suffolk Hospitals NHS Trust	N/A	16.32	0.00	16.87	24.48	8.16	16.87	8.16	16.87	24.48	16.32	0.00	24.48	**14.52**
	East of England Total	**N/A**	**18.67**	**20.15**	**18.67**	**20.59**	**16.62**	**18.94**	**22.48**	**23.95**	**17.99**	**15.57**	**16.47**	**tbc**	**20.54**
	England Total	**N/A**	**21.54**	**23.47**	**24.04**	**22.87**	**22.21**	**24.05**	**22.97**	**23.63**	**20.04**	**22.25**	**21.81**	**tbc**	**24.57**

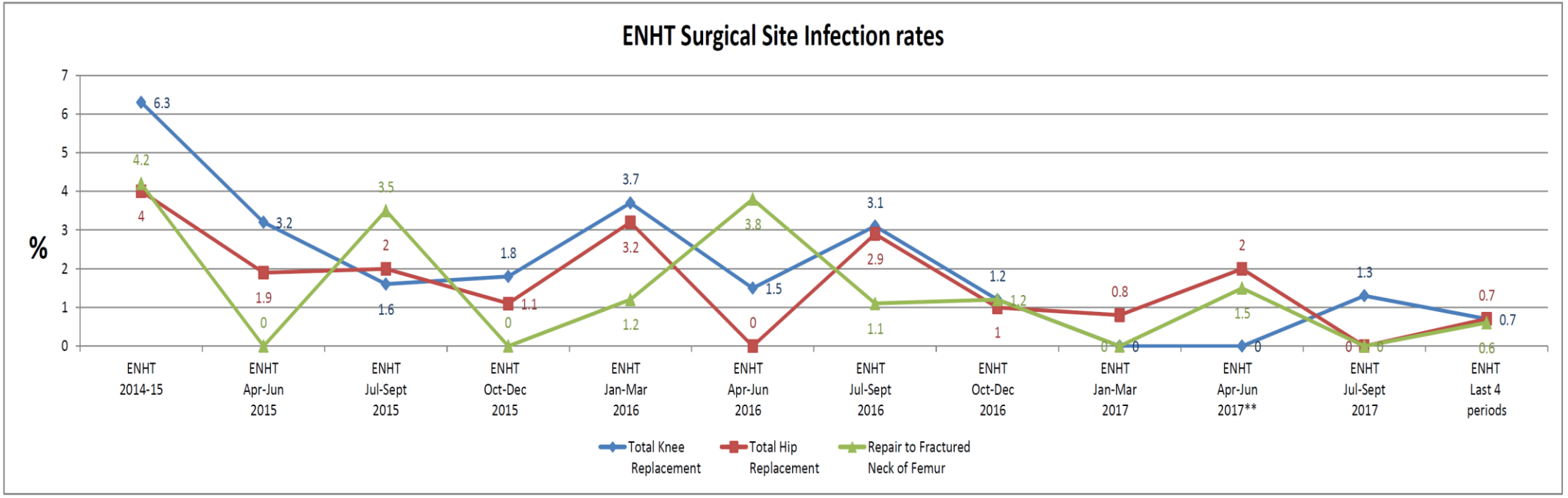
Surgical Site Infection Rates

SSI figures over the last 4 periods (Oct 2016 – Sept 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. 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	Jul-Sept 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%**	**1.3%**	**0.7%**	**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	1 / 76	2 / 298	
Total Hip Replacement	**4%**	**1.9%**	**2%**	**1.1%**	**3.2%**	**0%**	**2.9%**	**1%**	**0.8%**	**2%**	**0%**	**0.7%**	**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	0 / 111	3 / 437	
Repair Fractured Neck of Femur	**4.2%**	**0%**	**3.5%**	**0%**	**1.2%**	**3.8%**	**1.1%**	**1.2%**	**0%**	**1.5%**	**0%**	**0.6%**	**1.2%**
#NOF infections/ops	5 / 118	0 / 93	3 / 86	0 / 99	1 / 81	3 / 80	1 / 87	1 / 82	0 / 116	1 / 68	0 / 80	2 / 346	

* 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%	93.81%	96.24%	96.81%	97.61%	95.55%	▲
Surgical Site Observation	93.13%	94.57%	96.46%	97.87%	97.49%	96.57%	95.85%	95.74%	96.68%	96.79%	96.41%	97.70%	95.01%	96.47%	▼
Intravascular Devices (Insertion)	93.58%	95.44%	96.16%	95.16%	96.05%	93.93%	94.63%	95.38%	95.00%	94.19%	94.38%	94.80%	94.03%	94.93%	▼
Intravascular Devices (Continuing Care)	91.65%	93.29%	94.26%	95.27%	94.42%	95.04%	95.97%	95.37%	96.23%	96.12%	95.00%	95.21%	95.84%	95.15%	▲
Urinary Catheter (Insertion)	96.39%	94.26%	99.31%	96.60%	97.14%	95.86%	96.85%	95.56%	95.04%	95.92%	93.98%	98.64%	98.10%	96.45%	▼
Urinary Catheter (Continuing Care)	93.82%	88.00%	98.63%	93.92%	97.83%	98.57%	97.56%	97.79%	95.71%	97.93%	93.90%	97.10%	97.50%	96.24%	▲
Renal Dialysis (Continuing Care)	96.70%	100.00%	100.00%	100.00%	100.00%	100.00%	99.67%	100.00%	100.00%	98.58%	97.62%	97.60%	100.00%	99.48%	▲
Ventilator (Continuing Care)	97.00%	100.00%	81.48%	100.00%	100.00%	100.00%	100.00%	100.00%	96.77%	100.00%	97.14%	100.00%	100.00%	97.47%	◆
Environment (Inpatients)	96.70%	96.54%	97.25%	96.74%	96.46%	95.63%	95.63%	97.04%	95.97%	96.52%	95.73%	95.72%	95.91%	96.27%	▲
Environment (Outpatients)	97.17%	96.96%	96.50%	97.62%	96.85%	96.29%	96.32%	95.98%	96.79%	97.94%	95.96%	97.40%	97.00%	96.77%	▼
Environment (Renal Dialysis)	89.24%	91.18%	93.56%	91.07%	90.39%	85.60%	86.81%	89.96%	90.84%	89.30%	89.92%	88.43%	87.32%	89.49%	▼
MRSA Screening Compliance	96.42%	90.25%	97.09%	95.61%	98.03%	95.69%	93.93%	97.78%	96.94%	96.09%	93.57%	95.74%	97.18%	95.61%	▲

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