East and North Hertfordshire NHS Trust

Trust Board Part I

Lister Education Centre, Lister Hospital, Stevenage, SG1 4AB

6 September 2017 14:00 - 6 September 2017 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. Draft mins 26 July 2017 - Pt I.pdf 5	Chair	
6	Matters Arising and Actions Log For information 06 Pt I Actions Log to September 2017.pdf 15 6.1 Appendix to Actions Log - Audit Committee Ann... 17	Chair	
7	Annual Cycle For information 07 Board Annual Cycle 2017-18.pdf 29	Company Secretary	

#	Description	Owner	Time
8	Chief Executive's Report For discussion 8. CE Board Report - September 2017.pdf 33	Chief Executive	
9	Finance and Performance		14.15
9.1	Finance Report - Month 4 For discussion 9.1 Month 4 Finance Report Board Part 1.pdf 37	Director of Finance	
9.2	Performance Report (to follow) For information 9.2 Performance Report Month 4.pdf 43	Director of Nursing	
9.3	Workforce Report For information. 9.3 Workforce Report.pdf 55	Chief People Officer	
9.4	Finance and Performance Committee - Annual Report & Terms of Reference For approval 9.4 FPC - Annual Report and Terms of Reference.p... 83	Company Secretary	
10	Risk and Quality		14:45
11	Report from Charity Trustee Committee (to follow after meeting on 4 Sept) For approval 11. CTC Executive Summary Report.pdf 95 11.1 Appendix to CTC Report - CTC Annual Report... 101	Chair	
12	Data pack For information 12. Data Pack.pdf 111	All Directors	

#	Description	Owner	Time
13	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.		15:30-18:00
13.1	Commercial-in-confidence		
13.2	Governance Matters		
13.3	Personnel Matters		
14	Date of next meeting: 1 November 2017 - Hertford County Hospital		

EAST AND NORTH HERTFORDSHIRE NHS TRUST

Minutes of the Trust Board meeting held in public on Wednesday 26 July 2017 at 2pm at the New QEII Hospital, Welwyn Garden City

Present:	Mrs Ellen Schroder	Chair of the Trust Board
	Mrs Alison Bexfield	Non-Executive Director, Trust Vice Chair
	Mr John Gilham	Non-Executive Director
	Ms Val Moore	Non-Executive Director
	Mr Bob Niven	Non-Executive Director
	Miss Jane McCue	Medical Director
	Ms Kate Lancaster	Director of Strategy
	Ms Liz Lees	Director of Nursing (Acting)
	Mr Nigel Kee	Chief Operating Officer
From the Trust:	Ms Jude Archer	Company Secretary
	Ms Crista Findell	Deputy Director of Finance (Acting)
	Mr Kevin O'Hart	PMO Director
	Ms Kerry Eldridge	Director of Workforce
	Mrs Jane Chapman	Board Committee Secretary (minutes)
In attendance:	Ms Kate Flavin	Final year Doctor in training
	Ms Harriet Aldridge	PWC
	Ms Emma Roberts	PWC
	Mr Stuart Norman	Independent Consultant
	Mr Mark Cohen	CYMRIO (CAPITA)

ACTION

17/120 CHAIR'S OPENING REMARKS

17/120.1 Mrs Schroder welcomed everyone to the meeting.

17/121 DECLARATIONS OF INTEREST

17/121.1 There were no declarations of interest.

17/122 QUESTIONS FROM THE PUBLIC

17/122.1 There were no questions from the public.

17/123 APOLOGIES FOR ABSENCE

17/123.1 Apologies for absence were received from Mr Nick Carver - Chief Executive, Mr Martin Armstrong - Director of Finance, Mr Julian Nicholls - Non-Executive Director and Mr Tom Simons - Chief People Officer.

17/124 MINUTES OF THE PREVIOUS MEETING

17/124.1 The Board reviewed the draft minutes of the previous meeting. The minutes were approved subject to the following changes:

- 17/088.5 – The Director of Workforce to make enquiries to NHS providers regarding the change to the levying from April. She confirmed this issue was raised at the regular Human

Resources Director Meeting and Mrs Schroder advised that she would also raise this at Chair meetings.

- Miss McCue confirmed her title as 'Miss'.

17/125 MATTERS ARISING AND ACTIONS LOG

17/125.1 The Board reviewed and noted the actions log. It was noted that all actions have been completed.

17/125.2 Mr Gilham requested that the Board is updated with regard to the Social Care Funding, particularly during the winter period. The Chief Operating Officer advised that a brief update is provided at each meeting in order to give assurance of winter bed numbers and reduction of DTOCs. **Chief Operating Officer**

17/126 ANNUAL CYCLE

17/126.1 The Board noted the annual cycle. Mrs Schroder requested that reports that were due during May's Major Incident are re-scheduled. The Company Secretary advised that these reports had now been included in the revised Annual Cycle.

17/127 CHIEF EXECUTIVE'S REPORT

17/127.1 The Board received the Chief Executive's report. This was delivered by the Medical Director on behalf of The Chief Executive. She began by highlighting the success of the 2018 AGM, stating that there was a very diverse range of attendees from both the public and staff.

17/127.2 Further highlights from the report included:

- There has been a significant improvement to the 4 hour Performance target. This has been possible due to the dramatic improvement of the ambulance hand-over time achieved through implementing new procedures together with staff engagement, seeing the Trust's service rise from consistently bottom of the league table to consistently top. This improvement has contributed to ED target compliance.
- The Trust's Research Team has been awarded a grant of £108k from National Institute for Health Research (NIHR).
- Mr Phillip Smith, the Trust's Associate Director of Research and Development, has been appointed as a visiting professor in the School of Health and Social Work.
- The Trust's Acute Stroke Therapy Team recently won the Excellence in Partnership Working Award at Hertfordshire Community NHS Trust's (HCT) Leading Lights Awards for 2017.

17/127.3 Ms Moore offered her congratulations to the AGM team for a very successful event. Mrs Schroder added a commendation for achieving the Research funding.

FINANCE AND PERFORMANCE

17/128 FPC Committee Report

17/128.1 The Deputy Director of Finance delivered the Finance and Performance Report covering Month 3 Finance Report, Performance, tPP and theatres. Key highlights included:

Month 3 Finance

17/128.2
- Delivery of a £9.6m year to date deficit against a planned deficit of £9.7m for 2017/18, giving an overall favourable variance of £0.1m against plan;
- Income continues to fall short of target in Month 3, £1.6m less than plan. This brings the year to date shortfall against plan to £5.7m;
- The Trust's CIP plan for 2017/18 totals £23.3m. The phased profile sees a significant increase in delivery as the year increased. The target at Month 3 was £2.3m and £2.9m was achieved, giving an overachievement to date of £0.6m.

17/128.3 Mrs Schroder asked that the Finance Report should be included in Part I, not just the summary in the FPC Report.

17/128.4 Mr Gilham enquired whether there was clear understanding of the changes that have affected activity levels. The Acting Deputy Director of Finance advised that the weekly information and Assurance Group assess the impact of service changes prior to them being implemented. Mr Gilham felt that it is important that activity levels are improved and enquired what impact Four Eyes Insight has had. The Deputy Director of Finance advis ed that good progress has been made with Four Eyes Insight with regard to theatres. Meetings are taking place on a daily/weekly basis to ensure that during August, activity is not compromised due to annual leave. The Chief Operating Officer advised that July showed improved activity. He advised that Orthopaedics have plateaued and the backlog is now being reduced and their income recovery plan is expected to deliver.

17/128.5 Ms Bexfield felt that the report was confusing and reflected on the past too much. Mrs Schroder suggested that the format should be reviewed.

17/128.6 Mrs Schroder raised concerns at the £5.7m reduction in income. She stated that there is a reduction of £1.3m on non-elective revenue. The Deputy Finance Director advised that coding could influence this and this is currently being reviewed.

17/128.7 Mr Niven enquired with regard to the value of the tPP legacy and whether tail-costs would be received. The Deputy Director of Finance advised that enquiries continue in relation to this but anticipates being able to provide more detail at the September Board meeting. Mrs Schroder advised that NHSI should be advised of the risk.

17/128.8 The Board approved the report.

17/129 Performance Report

17/129.1 The Chief Operating Officer delivered the Performance report. Key highlights included:

- RTT 18-week performance – Although June's performance has not been finalised the Trust does not expect to achieve the open pathway standard of 92% and is forecasting performance in the region of 88%. Areas of current focus for improvement are T&O and Audiology.
- 4 hour performance – Although the Trust did not achieve the standard for June, it continues to achieve against the STF

improvement trajectory, delivering 87.53% against a trajectory of 85.64%.

- Ambulance handover time – As reported in local media, ambulance handover performance at the Lister Hospital is now consistently the best in the region. The Trust is typically achieving c80% of patient handovers within 15 minutes.
- Cancer 62-day performance – The Trust did not achieve the standard for June or against the recovery trajectory, achieving 71% against a trajectory of 79.56%. Although performance has not recovered as per the trajectory, there is evidence that the Trust is treating more of the longer waiting patients.

17/129.2 The Chief Operating Officer advised that in recent days there had been considerable pressure within the Emergency Department. Mrs Schroder enquired whether this was due to increased activity within A&E, or whether this was due to shortage of beds. The Chief Operating Officer advised that it was due to exit block together with the volume of activity and caseloads. He advised that there is an unprecedented level of demand regionally for the season.

17/129.3 Ms Moore referred to RTT and enquired whether a plan is in place around Trauma & Orthopaedics for patients over 18 weeks. The Chief Operating Officer advised that work continues on data quality and he is confident in the 52 week harm review process; however, this is not required for 18-51 week patients but he assured the Board that any concerns raised by the patient or GP are picked up and reviewed. Mrs Schroder advised that it is important for specialists to have visibility in order to prioritise. The Chief Operating Officer advised that patients are treated in chronological order; however, this is overridden if there is change in a patient's circumstances. He also advised in relation to Cancer waits that the 62-99 day wait is reducing together with the 100+ day waiting list. Mr Nicholls suggested reflecting on the skills base of the team. The Chief Operating Officer advised that for a number of patients, time is crucial and therefore the service is being reviewed. The Oncology department has increased the number of sessions; however, there is scope for further change in order to accommodate the capacity required.

17/129.4 Mr Niven enquired of the Cancer Service standards at the Mount Vernon Cancer Centre. The Chief Operating Officer advised that:

- Brachytherapy requires review to increase capacity;
- Radiotherapy is performing to a good standard;
- The outpatient model requires further focus and this is priority.

17/129.5 Mr Niven enquired whether the failure to meet the 4 hour Stroke standard was viewed as an issue. The Chief Operating Officer advised that this was not an issue and the department continues to strive for improvements.

17/129.6 The Board approved the report.

17/130 Workforce Report

17/130.1 The Director of Workforce delivered the Workforce Report for Month 3. Key highlights included:

- The monthly agency ceiling target was achieved in Month 3 with agency spend under by £589k. Year to date the Trust is under

the ceiling target by £962k with further initiatives on track to reduce the agency usage.

- Agency expenditure is expected to remain below the ceiling throughout the year.
- Agency booked hours have reduced by 9% with the most significant reduction being Nursing (14%). Compared to the same period in 2016, agency hours booked have reduced by 56% across all staff groups.
- The new service for managing all medical temporary staff bookings internally is now live.
- The shared bank initiative across Hertfordshire is also live.
- All new doctors appointed will be automatically added to the new eRoster.

17/130.2 The Director of Workforce advised that the increased Visa fees have had an impact on staff recruitment and it is therefore vital to ensure the pipeline for delivery of these documents is timely. She advised that there are 20 overseas nurses being recruited; however, there is currently a delay in receiving their Certificates of Sponsorship that are required by the end of July 2017.

17/130.3 The Director of Workforce advised that retention is the key focus to recruitment at the current time, with reasons for staff relocating ranging from lack of flexibility to promotion. These areas are now under review.

17/130.4 The Director of Workforce also advised that:

- The number of Bands 7 and above staff has significantly increased due to more promotional opportunities being made available;
- An Apprenticeship scheme is being piloted within the Trust;
- LEND sessions have been oversubscribed during the summer period.

17/130.5 Mr Niven referred to appendix 4 of the report and suggested the challenge to improve leadership and career opportunities together with retention. The Director of Workforce advised that all levels and bands of staff are being reviewed in line with the financial climate.

17/130.6 Mr Nicholls enquired whether reports would be presented to the September Board in relation to savings in total pay. The Director of Workforce advised that changes continue with regard to the workforce and a timeframe will be presented to the September Board. This would include a projection of the cost of the workforce for the balance of this year. The Deputy Director of Finance advised that a 3 year model is required for the financial forecast. The Director of Nursing stated that age groups should also be considered and a succession plan should be included. **Director of Workforce**

17/130.7 The Board considered and approved the Workforce Race Equality Standard (WRES). The Director of Workforce advised that the annual report of the Equality and Diversity Scheme will be presented later in the year.

17/130.8 The Board approved the report.

RISK AND QUALITY

17/131 Risk and Quality Committee Report – Including Annual Safeguarding Report and Health & Safety Annual Report

17/131.1 Mr Gilham (Chair of Risk and Quality Committee) delivered the report. Key highlights were:

- The Committee approved the annual committee report and the Terms of Reference were approved following some minor changes. Results from the annual survey circulated to Committee members, highlighted areas to be developed within the structure of the meetings and the papers submitted;
- Safeguarding Children Annual Report and Health & Safety Annual Report were approved by the Committee.
- Nursing Establishment Review – recommendations supported.

17/131.2 Mr Gilham advised that, with regard to patient safety, the Committee agreed that a full action plan should be received on recent incidents that have taken place. The Director of Nursing advised that, following a recent serious incident of a vulnerable patient, an external specialist had been commissioned to provide an independent view of any additional actions that could be taken in addition to the comprehensive internal action plan. It was agreed that this is to be used as a case study as part of the training programme. She advised that rapid actions were taken to avoid repetition and changes are being implemented together with learning from the situation.

17/131.3 The Medical Director stated that the mortality report showed steady improvement and this was being sustained.

17/131.4 The Board approved the report including the RAQC Annual Report and Terms of Reference.

17/132 Nursing Establishment Review

17/132.1 The Director of Nursing delivered the Nursing Establishment Review. She advised that various metrics, methodologies and sources had been utilised in order to produce the report and benchmark the data. Data had been gathered daily throughout the year for consistency. This establishment review outlines the work undertaken since the last review six months ago, provides an update on any continuous or on-going initiatives and outlines any future options to be undertaken in relation to maintaining safe and productive nurse staffing levels. The results were used to view a number of areas.

The Director of Nursing advised of the following highlights;

- With regard to the reduction in staffing numbers, posts that were removed had been vacant following the reconfiguration, making a saving of c£1m.
- The Stroke unit is consistently staffed above the 'safe' level. Introduction of a 'whole service' approach to the stroke service is being considered.
- 8B, SSU and Ashwell Ward have received additional night support with the recruitment of an additional Care Worker to ensure patient safety.
- There was an increased level of sickness on SSU, this is now being monitored.
- Ashwell Ward has reduced beds from 28 to 24.
- Women & Children's has also seen savings in staffing numbers.

Consideration is also being given to:

- Update on Maternity staffing
- Skill mix change on ACU
- Skill mix change on ward 5A
- Skill mix change and staff reduction on Swift ward
- Implementation of Trainee Nurse Associates pilot
- Closely monitor ('Wait and watch') staffing, patient acuity and dependency on a continuous basis on the following wards:
    - SSU
    - Ashwell

17/132.2 The Director of Nursing advised that the NHSI Model Hospital Dashboard had been used to benchmark with neighbouring Trusts with regard to reductions in spending. She also advised that non-ward based nursing is to be focused on.

17/132.3 Mrs Schroder enquired whether there was any further benchmarking available. The Director of Nursing advised that there is a large amount available and informed the Board that this also indicates negative areas. Mrs Schroder advised that it is important to highlight both areas. The Director of Nursing advised that by using the Model Hospital benchmarking, it was demonstrated patient stay has been reduced by 2 days. Mrs Schroder stated that it would be useful to see comparison data in 6 months' time. **Director of Nursing**

17/132.4 The Board approved the recommendations.

17/133 Mortality Report

17/133.1 The Medical Director delivered the Mortality report. Key highlights were:

- The Trust is reporting its highest level of performance in the last 5 years;
- The Trust reported its second lowest level ever for Hospital Standardised Mortality Ratio figures in March that were "better than expected" - 94.35;
- SHMI – 'as expected' 102.31;
- The last 18 months have seen our ranking within the East of England improve significantly with our position moving from 17th out of 17 to 6th out of 16.

17/133.2 The Medical Director advised that a new Government policy, that is being released states that 50% of deaths should be reviewed. The Trust reviewed 88% of deaths during the past year.

17/133.3 The Medical Director stated that the introduction of the eObservation tool will have a positive impact on mortality due to swift escalation of any unexpected patient readings/data. The Director of Nursing stated that the increase of ward based staff has also contributed to this. It is expected that the roll out of Nervecentre will be completed on all wards in August.

17/133.4 The Medical Director advised that areas for assurance are:

- Cancer – The last 3 months have seen an increase of deaths; however, this has been largely patients from Michael Sobel Hospice together with other terminally ill patients.
- Gastroenterology – Following previously elevated mortality, this area has been closely monitored and latest figures indicate a

significant improvement and the Trust is in-line with its peers.

- Cardiology – Following recent alerts regarding AMI patients, which appeared to be results of genuine incorrect coding of cases, all AMI cases are now undergoing a coding review each month to ensure they have been correctly allocated.
- Areas for improvement – Sepsis and Acute Kidney Injury.

17/133.5 Discussions continue to identify and implement an additional four diagnostic care bundles over the next 12 months and to instigate annual audits to monitor the uptake of existing bundles.

17/133.6 With regard to the Seven Day Service Keogh standards, the Trust has been assigned to the second cohort to achieve compliance against the four prioritised standards by the end of March 2018 at a cost of £6.5m. CCG has been approach for support with the funding without success. The Medical Director will be renewing the application for support.

17/134 Audit Committee Report

17/134.1 Ms Bexfield (Chair of Audit Committee) presented the Audit Committee report noting the following items were recommended for final approval:

- Raising Concerns Policy – approved by Board. The Committee had also reviewed the Raising Concerns Log.
- Managing Conflicts of Interest Policy – approved by Board.
- Audit Committee Annual Report and Committee Terms of Reference – the terms of reference were approved by Board and one amendment was requested to the Annual report.

17/134.2 Mrs Schroder suggested the Managing Conflicts of Interest Register should be reviewed on an annual basis. She also enquired whether it should have an opt in option whereby a nil return is assured to stay current unless specifically advised by the individual. The Company Secretary advised against an opt in option since this was a live register which required review at least on an annual basis. Nil returns were encouraged. There would be the launch of a new policy in August increasing the scope to all budget holders. It was hoped to link this into the new starters' induction packs. The Board approved the policy. Ms Bexfield stated that it is important that people update the register on an annual basis.

17/134.3 Mrs Schroder referred to the Audit Committee report and compliance with the SFI's. She highlighted that the current Director of Finance had strengthened some financial and internal controls; however, these weaknesses could have been identified earlier by the Audit Committee and suggested this is reflected in the Annual Report. She suggested that focus should be given to the Board Assurance Framework and risk. Ms Bexfield suggested amendments to be made to the report and then re-presented at the next Board meeting. The Committee approved the terms of reference. The Company Secretary advised the Board that there would be a review of the strategic risk and risk appetite in December. **Company Secretary**

17/135 DATA PACK

17/135.1 The Board noted the data pack, which included the Annual Responsible Office Board Revalidation Report.

17/135.2 *There being no further business the Chair closed the meeting at 4.00pm.*

Ellen Schroder
Trust Chair, July 2017

	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 SEPTEMBER 2017

Meeting Date	Minute ref	Issue	Action	Update	Responsibility	Target Date
26 July 2017	17/125.2	Social Care Funding	Once each quarter provide a briefing to Board on the progress with workstreams regarding the additional H&SC funding as part of the Performance Report.		Chief Operating Officer	November 2017
26 July 2017	17/130.6	Workforce	To provide a report on the savings in total with regard to workforce pay.	**September 2017:** See Workforce Report	Director of Workforce	September 2017
26 July 2017	17/132.3	Nursing and Midwifery Establishment Review	Model Hospital benchmarking data to be included in the next Nursing Establishment Review.		Director of Nursing	January 2018
26 July 2017	17/134.3	Audit Committee	Amend Audit Committee annual review to reflect the gap in financial controls identified in 2016/17.	**September 2017:** Proposed wording circulated to AC members for consideration. Will append to actions log once confirmed.	Company Secretary	September 2017

Agenda Item: 6.1

TRUST BOARD PART I – 6 SEPTEMBER 2017

AUDIT COMMITTEE ANNUAL REVIEW 2016/17 – Final

PURPOSE	To present the 2016/17 updated annual review of the Audit committee – see highlighted section for the amendment.
PREVIOUSLY CONSIDERED BY	Audit Committee (17 July), Board July 2017 - approved the terms of reference but requested and update to the annual review to reflect the weakness identified in financial controls in early 2016/17.
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)	Key aspect of the Trust's assurance process
Healthcare/ National Policy (includes CQC/Monitor)	The production of an annual report is considered to be best practice and is in line with the recommendations made in the Audit Committee Handbook.
CRR/Board Assurance Framework *	[X] **Corporate Risk Register** [ ] **BAF**

ACTION REQUIRED *

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

DIRECTOR:	CHIEF EXECUTIVE
PRESENTED BY:	COMPANY SECRETARY
AUTHOR:	CORPORATE GOVERNANCE OFFICER / COMPANY SECRETARY
DATE:	SEPTEMBER 2017

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

***** tick applicable box

AUDIT COMMITTEE
ANNUAL REVIEW 2016/17

Executive Summary

The Audit Committee is a key assurance committee of the Trust Board. Its purpose is to provide an independent and objective review of the Trust's system of internal control, including its financial systems, financial information, assurance arrangements including clinical governance, approach to risk management and compliance with legislation.

This is the annual review of the Audit Committee which considers how it has met its duties under its Terms of Reference. In order for the Audit Committee to be effective it needed senior level support. A review of the Committee's minutes and its reports to the Board, the Annual Governance Statement 2016/17 and a review of the Trust's Standing Orders and Scheme of Delegation have been used to inform this report, together with a review of the assessment guidance from the Audit Committee Handbook. In addition committee members, Internal and External Auditors completed a questionnaire considering how the committee operated and how its operation could be improved.

As per the Audit Committee Handbook, the Company Secretary has completed the self-assessment checklist. The self-assessment evidenced a good level of compliance against best practice guidance and did not identify any material issues. The key matters to highlight from the assessment are:

- An Auditor Panel was established to tender for an External Auditor provider for 2017/18. This was awarded to BDO.
- Succession planning for the future NED Chairman of the Audit Committee is underway (the current Chairman will have served the maximum term in January 2018).
- RAQC remains the main assurance committee for risk.

A copy of the self-assessment checklist is appended to this report (Appendix 2).

This review concludes the Committee met its duties and continued to provide challenge, recognising the internal control environment could always be strengthened. The terms of reference have been reviewed and no changes are recommended.

To support the strengthening and effectiveness of the Committee the following recommendations are highlighted from the review:

- To consider inviting the relevant lead director for 'no assurance' / 'partial assurance' internal audits.
- To continue to support improvements to the quality of papers, in particular the executive summary section.
- To consider an increased linkage to the Trust's risk profile and BAF.

Summary of Key Findings

- **Meetings and Membership**

The Audit Committee met five times during 2016/17 and all meetings were quorate. There were no changes to the position of Chair. There were however a number of personnel changes amongst the Trust's executive directors during this period, including the Director of Finance. These changes are reflected within the Trust Annual Report. In line with good practice and requirements of the Audit Committee Handbook, the Committee met in private with the external auditors on two occasions and also with the internal auditors on two occasions. A review of the Committee's minutes demonstrated an appropriate level of scrutiny and challenge could be evidenced throughout its meetings.

The efficacy of the AC has been assessed by issuing a questionnaire to Committee members and others who regularly attend meetings. There were a total of 7 responses, 2 Non-Executive Directors, 3 attendees and a response from the Internal and External Auditors. The respondents were in agreement that the appropriate people were at the meetings, that there was sufficient time for discussion on individual agenda items and all respondents felt able to challenge the Trust at the meetings. The respondents also agreed that the papers provided appropriate briefing on the issues, though there were some suggestions that some executive summaries could be improved to make the key messages clearer. The majority of respondents agreed that the agenda covered the right items, though it was suggested more focus could be provided on the BAF and risk-related items (or that a report from RAQC could provide assurance on those items). It was considered that the quality of discussions were generally good, with suggestions for improvement including considering whether it would be beneficial to have the lead director present when an Internal Audit report is presented with an outcome of 'No assurance' / 'Partial assurance' and ensuring that discussion does not get drawn into points that are too detailed.

The respondents considered that the Committee had added value to the Trust's operations throughout the year in the following ways:

- Challenging the executive and auditors
- Supporting improvement through identifying key areas to challenge and use assurance resources
- Review and scrutiny of Trust control arrangements
- Maintaining an effective oversight of the quality of the accounts and the related process
- Counter fraud monitoring
- Reviewing accounting policy and practises
- Providing assurance to Board on a number of areas

On the whole, the responses received were positive regarding the efficacy of the Committee.

- **Areas for improvement highlighted in 2015/16 Annual Review**

The following table details the areas identified for improvement in the 2015/16 annual review and details how those recommendations have been addressed:

	Areas for improvement	Addressed by
1.	To continue to support further improvements to the papers and guidance offered to report writers – concise reports, preceded with clear executive summaries referencing relevant standards/management's preferred option/auditor's opinion, focusing on key issues for discussion and decision;	The reports and survey feedback indicate that this has improved. The findings of the committee survey suggest that there is perhaps some scope to make further improvements.
2.	To consider how the Committee could seek assurances around implementation of the IM&T strategy;	The CIO has attended meetings to be held to account and follow up on actions.
3.	To ensure that contentious items were brought to the committee earlier in the agenda cycle for discussion;	Agenda planning was on-going throughout the year. Internal Audit findings were taken early in the agenda
4.	To consider a deep dive of specific risks to gain assurance that the Executive is managing the risk sufficiently to provide the NED's with a greater understanding of the risk itself;	Considered with IA programme and assurance map in development.
5.	Consideration of member training.	No specific training undergone but members have access to training provided by NHS Providers and HFMA. Succession Planning in place for next Chair of Audit Committee.

The Committee can evidence that it has met its responsibilities as set out in the terms of reference in the following ways:

- **Governance, Risk Management and Internal Control**

It is the Audit Committee's responsibility to review the Trust's systems of governance, risk management and internal control. A key part of the AC's responsibility at the beginning of each year, is to review the Board Assurance Framework (BAF) to test robustness of the framework in terms of its structure and process, since this document was used by the Audit Committee to underpin the internal audit programme, and by the Risk and Quality Committee (RAQC) to provide assurance to the Board on management of key risks to the Trust's objectives. In May 2016 the Committee considered and approved a revised format for the BAF 2016/17, noting it had been reviewed in line with IA recommendations to ensure the framework remained fit for purpose. The AC also noted that changes to strategic risks had previously been considered by the Risk and Quality Committee.

The Audit Committee's review of the Trust's systems of governance, risk management and internal control culminated in its consideration of the Annual Governance Statement (AGS). In May 2016 the AC reviewed and endorsed the final draft of the Annual Governance Statement 2015/16 which was submitted to auditors on 2 June 2016 as part of the Trust's Annual Report and Accounts submission to NHSI. The overall opinion provided in the AGS was 'that no significant internal control issues have been identified that would impact on the delivery of the Trust's strategic and annual objectives'. The AGS concluded that the Trust had a generally sound system of internal control that supported the achievement of the organisation's

objectives, though acknowledged that the internal control environment could always be strengthened and this work would continue into 2016/17.

At the time the Annual Report and Accounts was being finalised the Audit Committee kept a close interest in the resolution of some weaknesses in financial control systems that emerged during the audit. The Committee was satisfied, through conversations with the external auditors, that these did not impact on the accounts which were approved and included in the Annual Report. Although the underlying weaknesses were escalated within Trust's management structure, with hindsight the Committee acknowledges that requesting an independent review by internal audit in this area might have been helpful in addressing the issues sooner.

As part of its governance responsibilities, the Audit Committee reviewed the declarations of interest and gifts and hospitality register for 2015/16 and received an update on declarations of interest received to date in 2016/17. The Committee supported a re-launch of the conflicts of interest policy and noted that the current policy would be reviewed in 2017 following the outcome of a national consultation on the matter.

Key policies/registers approved by the Audit Committee included:

- Losses and Special Payments Processes;
- Scheme and Limits of Delegation (endorsed by AC and referred to FPC for approval);

The AC were kept informed of potential emerging risks as they arose, such as regarding the change in legislation relating to the payroll treatment of individuals who provide services to the public sector through intermediary arrangements (AKA IR35).

At each meeting, the Committee reviewed the internal and external audit report log, monitoring implementation of recommendations made by Internal and External auditors and the Local Counter Fraud Specialist.

➢ **Internal Audit**

The Committee received regular progress reports from its internal auditors (RSM) on internal audit work during 2016/17 including a summary of reports issued.

In March 2017, the AC approved the Internal Audit Plan for 2017/18. In doing so, the AC noted the possible need for some further contingency days to be created for use in addressing specific challenges in the coming year.

Also in March 2017, the Committee approved the Internal Audit Strategy 2017-2020. Particular key audit areas included divisional reviews – performance management frameworks, Data Quality, Procurement, CIPS and Financial Forecasting and Control and Consultant Job Planning.

The AC regularly monitored performance indicators regarding whether audits commenced on time and were finalised within 6 weeks and scrutinised the time taken for management actions arising from audits. The AC requested a review of processes to ensure outstanding actions were escalated. It was agreed that a 'for action' database would be rolled out by IA to support greater visibility and ownership of actions. This will be rolled out once the software is available.

➢ **External Audit**

The AC received several reports providing updates on the 2016/17 accounting items and policy. This included discussion of accounting treatment for prior year errors, property valuations, consolidation of subsidiary and charity accounts as well as some technical accounting issues specific to the Trust.

The AC also receives a report from the External Auditors on the Quality Account each year. The AC are due to receive the report on the 2016/17 QA at the AC meeting in July 2017. The report has already been considered by the RAQC and provides an unqualified opinion based on the scope of the limited assurance review.

In May 2017 the AC received the Trust's annual accounts 2016/17 and EA report on the year-end accounts. The Committee noted the draft unqualified opinion on the accounts with an 'except for' conclusion on the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources. Subject to confirmation of the completion of the EA (which had been affected by the cyber-attack that affected a large number of NHS Trusts earlier in the month), the AC agreed to recommend the Trust's year-end accounts and letter of representation to Board for final approval. It was noted that the process was generally much improved on the previous year, even given the disruption caused by the cyber-attack.

- **Other Assurance Functions**

On a number of occasions during 2016/17 the Audit Committee sought assurance from other Board committees. In October 2016 the AC referred a matter to RAQC to provide assurance of the effectiveness of Trust policy to mitigate the risk of staff working too long and potentially impacting patient safety. In March 2017 the AC reviewed clinical audit assurances provided against the AC handbook measures and made a further referral to RAQC on clinical audit assurance and how this was provided. Both referrals were duly dealt with by the RAQC. Regarding Clinical Audit, the RAQC concluded that they were assured by the current clinical audit process and the further steps agreed at RAQC to be taken to ensure action plans arising from audits were completed.

In January 2017 the Committee received the latest report regarding Trust significant losses/special payments for the period April – September 2016. The AC was concerned at Pharmacy stock losses and requested further clarity of the summary of bad debts written off, including IT losses. The AC requested further information on drugs losses broken down by site and a further report was duly provided for the meeting in March 2017.

The FPC closely monitored the raising concerns (whistle-blowing) log, noting open cases, themes and actions being taken. The AC supported a policy review would be undertaken including engagement with the Trust Partnership to ensure it was in line with National guidance.

- **Counter Fraud**

The Audit Committee continued to monitor the work of the Local Counter Fraud Specialist (LCFS) throughout the year, a service provided by internal audit. In May 2016 the AC received the Local Counter Fraud Specialist Annual Report 2015/16 which provided a summary against NHS Protect's anti-fraud standards as agreed at AC in May 2015. The AC approved the LCFS plan for 2017/18 in outline at the meeting in March 2017, though requested that further assurance be provided on some specific areas through deep dives.

The AC received a regular LCFS progress report at its meetings throughout the year, detailing the work of the LCFS. This included details of local proactive exercises that were undertaken as well as details of counter fraud cases.

- **Management**

The Committee continued to monitor the adequacy and timeliness of management responses in relation to all reports received, and challenged these when necessary. The AC also continued its practice of requiring attendance by the relevant director or

senior manager whenever it considered a report provided less than adequate assurance.

- **Financial Reporting**

One of the key duties of the Audit Committee is to review the annual report and accounts before submission to the Board. In May 2016 the Committee endorsed the Trust's Annual Report and Accounts for publication on the Trust's website and final approval at Trust Board.

- **Reporting Arrangements**

The Audit Committee has reported key issues to the Board after each meeting, and continues the practice of producing an executive summary report to Board.

- **Conclusion**

This review demonstrates that the Audit Committee has discharged its duties under its terms of reference.

The terms of reference have been reviewed and no changes are recommended.

The Committee is asked to consider this Annual Review and approve the terms of reference (Appendix 1), subject to final approval by Board.

To support the strengthening and effectiveness of the Committee the following recommendations are highlighted from the review:

- To consider inviting the relevant lead director for 'no assurance' / 'partial assurance' internal audits.
- To continue to support improvements to the quality of papers, in particular the executive summary section.
- To consider an increased linkage to the Trust's risk profile and BAF.

Appendix 1

AUDIT COMMITTEE TERMS OF REFERENCE

Purpose

The purpose of the Audit Committee is to provide an independent and objective review of the Trust's system of internal control including its financial systems, financial information, assurance arrangements including clinical governance, approach to risk management and compliance with legislation.

Status and Authority

The Audit Committee is established as a formal committee of the Board. It is a non-executive committee and has no executive powers other than those specifically delegated in these terms of reference.

The Committee is authorised by the Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee. The Committee is also authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary.

Membership

Three Non-Executive Directors (excluding the Chair of the Trust Board), one of whom shall be appointed Chair by the Board.

Quorum

Any two members of the Committee are required to be present.

Attendance

The Director of Finance, the Company Secretary, and appropriate internal and external audit representatives shall normally attend meetings. At least once a year the Committee will meet privately with the external and internal auditors.

The Chief Executive should be invited to attend, at least annually, to discuss with the Audit Committee the process for assurance that supports the Annual Governance Statement (AGS). He or she should also attend when the Committee considers the draft internal audit plan and the annual accounts. Other executive directors should be invited to attend, particularly when the Committee is discussing the areas of risk or operation that are their responsibility. Other senior managers may be required to attend as needed.

Frequency of Meetings

The Committee will consider the appropriate frequency and timing of meetings to allow it to discharge all its responsibilities, but it will not meet less than five times during the year. The external auditors or Head of Internal Audit may request a meeting if they consider that one is necessary.

Duties

The duties of the Committee can be categorised as follows:

Governance, Risk Management and Internal Control

The Committee shall review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation's activities (both clinical and non-clinical), that supports the achievement of the organisation's objectives.

In particular, the Committee will review the adequacy of:

- all risk and control related disclosure statements (in particular the AGS), together with any accompanying Head of Internal Audit statement, external audit opinion or other appropriate independent assurances, prior to endorsement by the Board
- the underlying assurance processes that indicate the degree of the achievement of corporate objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements
- the policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements and related reporting and self-certification
- the policies and procedures for all work related to fraud and corruption as set out in Secretary of State Directions and as required by the NHS Counter Fraud and Security Management Service

In carrying out this work the Committee will primarily utilise the work of internal audit, external audit and other assurance functions to test the effectiveness of the framework, but will not be limited to these sources. It will also seek reports and assurances from directors and managers as appropriate, concentrating on the over-arching systems of integrated governance, risk management and internal control, together with indicators of their effectiveness.

This will be evidenced through the Committee's use of an effective Board Assurance Framework to guide its work and that of the audit and assurance functions that report to it.

Internal Audit

The Committee shall ensure that there is an effective internal audit function that meets mandatory Public Sector Internal Audit Standards and provides appropriate independent assurance to the Audit Committee, Chief Executive and Board. This will be achieved by:

- consideration of the provision of the internal audit service, the cost of the audit and any questions of resignation and dismissal
- review and approval of the internal audit strategy, operational plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the organisation as identified in the Board Assurance Framework
- consideration of the major findings of internal audit work (and management's response), and ensuring co-ordination between the internal and external auditors to optimise audit resources
- ensuring that the internal audit function is adequately resourced and has appropriate standing within the organisation
- an annual review of the effectiveness of internal audit

External Audit

The Committee shall review the work and findings of the external auditors and consider the implications and management's responses to their work. This will be achieved by:

- consideration of the appointment and performance of the external auditors, as far as the rules governing the appointment permit
- discussion and agreement with the external auditors, before the audit commences, of the nature and scope of the audit as set out in the annual plan, and ensuring co-ordination, as appropriate, with other external auditors in the local health economy
- discussion with the external auditors of their local evaluation of audit risks and assessment of the Trust and associated impact on the audit fee
- review of all external audit reports, including the report to those charged with governance, agreement of the annual audit letter before submission to the Board and any work undertaken outside the annual audit plan, together with the appropriateness of management responses.

Other Assurance Functions

The Audit Committee shall review the findings of other significant assurance functions, both internal and external to the organisation, and consider the implications for the governance of the organisation.

These will include, but will not be limited to, any reviews by Department of Health arm's length bodies or regulators/inspectors (eg the Care Quality Commission, etc) and professional bodies with responsibility for the performance of staff or functions (eg Royal Colleges, accreditation bodies, etc).

In addition, the Committee will review the work of other committees within the organisation, whose work can provide relevant assurance to the Audit Committee's own scope of work. In particular, this will include the Risk and Quality Committee (RAQC), the Finance and Performance Committee (FPC), and the Charity Trustee Committee (CTC).

In reviewing the work of the Risk and Quality Committee, and issues around clinical risk management, the Audit Committee will wish to satisfy itself on the assurance that can be gained from the clinical audit function.

Counter Fraud

The Committee shall satisfy itself that the organisation has adequate arrangements in place for countering fraud and shall review the outcomes of counter fraud work.

Management

The Committee shall request and review reports and positive assurances from directors and managers on the overall arrangements for governance, risk management and internal control.

The Committee may also request specific reports from individual functions within the organisation (eg clinical audit) as they may be appropriate to the overall arrangements.

Financial Reporting

The Audit Committee shall review the integrity of the financial statements of the Trust and any formal announcements relating to the Trust's financial performance. The Committee should ensure that the systems for financial reporting to the Board, including those of budgetary control, are subject to review as to completeness and accuracy of the information provided to the Board.

The Audit Committee shall review the annual report and financial statements before submission to the Board, focusing particularly on:

- the wording in the AGS and other disclosures relevant to the terms of reference of the Committee
- changes in, and compliance with, accounting policies, practices and estimation techniques
- unadjusted mis-statements in the financial statements
- significant judgements in preparation of the financial statements
- significant adjustments resulting from the audit
- letter of representation
- qualitative aspects of financial reporting.

Reporting Arrangements

Following each meeting, the Audit Committee will submit a report to the Board, using the approved reporting form. The Chair of the Committee shall draw to the attention of the Board any issues that require disclosure to the full Board, or require executive action.

The Committee will report to the Board at least annually on its work in support of the AGS, specifically commenting on the fitness for purpose of the Board Assurance Framework, the completeness and embeddedness of risk management in the organisation, the integration of governance arrangements, the appropriateness of the evidence compiled to demonstrate fitness to register with the CQC and the robustness of the processes behind the Quality Account.

Process for Review

The Committee will complete an annual review of its terms of reference and conduct a self-assessment of its effectiveness on an annual basis, in line with the requirements of the Audit Committee Handbook 2013.

Support

The Company Secretary will ensure the Committee is supported administratively and advise the Committee on pertinent issues/areas.

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

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

Items	*Apr 17	May 17	*Jun 17	Jul 17	Aug 17	6th Sep 2017	4th Oct 2017*	1st Nov 2017	6th Dec 2017*	10th Jan 2018	7th Feb 2018*	7th Mar 2018
Standing Items												
CEO Report inc Floodlight Scorecard		x		x		x		x		x		x
Data Pack[i]		x		x		x		x		x		x
Patient Testimony (Part 2)		x		x		x		x		x		x
Suspensions (Part 2)		x		x		x		x		x		x
Committee Reports												
Audit Committee Report		x		x				x			x	
CTC Report *May 2017 meeting not held due to Major Incident		X*						x		x		
FPC Report [ii]	*x	x	*x	x			*x	x	*x	x	*x	x
RAQC Report	*x	x	*x	x			*x	x	*x	x	*x	x
Strategic												
Annual Operating Plan and objectives *(subject to change as dependant on national timeline)*								*x				*x
Strategic Review & Financial recovery Plan (TBC)			*x (draft recovery plan)	*x (final recovery plan)				*x (final recovery plan)				
Sustainability and Transformation Plan (STP) (Part 2 new standing item)				x		x		x		x		x

Board Annual Cycle 2017-18

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

Items	***Apr 17**	**May 17**	***Jun 17**	**Jul 17**	**Aug 17**	**6th Sep 2017**	**4th Oct 2017***	**1st Nov 2017**	**6th Dec 2017***	**10th Jan 2018**	**7th Feb 2018***	**7th Mar 2018**
Other Items												
Audit Committee												
Annual Audit Letter				x								
Annual Report and Accounts(Trust), Annual Governance Statement and External Auditor's Report		x										
Audit Committee TOR and Annual Report				x								
Quality Account and External Auditor's Report			x									
Raising Concerns at Work				x								x
Review of SO and SFI								x				
Charity Trust Committee												
Charity Annual Accounts and Report							x					
Charity Trust TOR and Annual Committee Review						x						
Finance and Performance Committee												
Draft Floodlight Indicators and KPIs				x								
Financial Plan inc CIPs and Capital Plan *(subject to change as dependant on national timeline)*							*x		*x			x
FPC TOR and Annual Report			x									
IM&T strategy review										x		
Market Report		x						x				x
Market Strategy Review (TBC)								x				
Risk and Quality Committee												
Adult Safeguarding and L.D. Annual Report		x										
Detailed Analysis of Staff Survey Results	x											

Board Annual Cycle 2017-18

- A Formal Board is held on alternate months.

Items	***Apr 17**	**May 17**	***Jun 17**	**Jul 17**	**Aug 17**	**6th Sep 2017**	**4th Oct 2017***	**1st Nov 2017**	**6th Dec 2017***	**10th Jan 2018**	**7th Feb 2018***	**7th Mar 2018**
Board Assurance Framework and review of delivery of objectives								x				x
Equality and Diversity Annual Report and WRES.				X (WRES)				X (Annual report)				
GMC National Training Survey *(subject to change as dependant on national release)*								x				
Health and Safety Strategy Review				x								
Improving Patient Outcomes Strategy				x								
Mortality	x			x				x				x
Nursing and Midwifery Strategy Review								x				
Nursing Establishment Review				x						x		
Patient Experience Strategy Review				X (RAQC/ Data Pack)								
Nursing - PQAF / Education report								x				
RAQC TOR and Annual Review				x								
Research and Development Annual Review			X (RAQC)									
Responsible Officer Annual Review				X (RAQC)								
Safeguarding Children Annual Review				x								
Serious Incidents Report (Part 2)				x				x		x		
University Status Annual Report										X (TBC)		
Shareholder / Formal Contracts												
ENH Pharma (Part 2) [iii]				x						x		
tPP (Part 2)	x	x	x	x		x		x		x		x

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

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

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

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

EAST AND NORTH HERTFORDSHIRE NHS TRUST

CHIEF EXECUTIVE'S REPORT

September 2017

1	**Angela Thompson takes on permanent role with NHS Improvement** The Trust's former director of nursing, Angela Thompson (who was seconded to NHS Improvement (NHSI) last November), has accepted a permanent role as its director of nursing and deputy regional chief nurse for NHSI London region. During her five years with the Trust, Angela championed improvements in both patient safety and experience, especially around the quality and consistency of services provided to people in our care. Areas where she and her colleagues had great impact have been reductions in inpatient falls, as well as hospital-acquired infections and pressure ulcers. Angela also placed great emphasis on developing the role of nursing within the Trust. I am sure that everyone will join me in wishing Angela every success in her new role. Liz Lees has been the Trust's acting director of nursing and patient experience since November 2016 – a role in which she will continue, pending the outcome of a formal recruitment process that will get under way shortly.
2	**Trust designated to create specialist vascular surgery hub for Hertfordshire and West Essex** On 1 August 2017, NHS England's Specialised Commissioners for the Midlands and East region wrote to the chief executives of the three NHS acute trusts in Hertfordshire and West Essex, as well as to the Hertfordshire and West Essex Sustainability and Transformation Partnership (STP), announcing that the Trust had been successful in its bid to develop a specialist vascular hub. The Specialised Commissioning team have agreed the designation of the East & North Hertfordshire NHS Trust (ENHT) as the Specialised Vascular Hub and Network lead with West Hertfordshire Hospital NHS Trust and The Princess Alexandra Hospital NHS Trust as integrated members of the network. This welcome announcement followed a lengthy commissioning review process undertaken by the specialised commissioning team. Work has now begun on establishing a Vascular Network Development Board, which will oversee the development of a business case for the new service. The Development Board will report into the Trusts' executive committees. The Development Board will also be reporting into the Hertfordshire and West Essex STP's planned care work stream. I would like to congratulate everyone who has been involved in this successful bid, which will see the Trust leading the development of the first specialist vascular surgery hub in Hertfordshire and West Essex.
3	**Lister's cellular pathology laboratories getting accredited** The cellular pathology laboratories at the Lister, which support the Trust's cancer services, has taken a major step in being accredited formally by the Government's new UK Accreditation Service - the national body with which all laboratories must gain accreditation by March 2018.

	Following a detailed two-stage inspection over the summer, the team learnt that it is being recommended for accreditation, pending action being taken to address successfully several minor points. The inspectors commented that it was clear that the team was providing a high quality service. When the inspectors come back in the Autumn to check on progress, it is likely that the remaining service at the Lister - blood sciences - will start its inspection process. This great news reflects the hard work that everyone in the pathology team has been undertaking since transferring across to the Trust earlier this year.
4	**Maternity team receive positive audit from the Twins and Multiple Births Association** During June 2017, TAMBA – the Twins and Multiple Births Association – carried out an audit of the services provided by the Trust's maternity unit for mothers who gave birth to more than one baby. The results, which were shared towards the end of July 2017, were excellent news for the Trust, with key highlights being: • Overall good service provided to multiples with a multi-disciplinary team, including a dedicated multiple pregnancy midwife • There were no still births or neonatal deaths for multiple births during the 12-month period in which the data was collected • Dating scan and combined screening promotes an informed choice for women however this appears to be compromising correct timing for chorionicity and amnionicity • Ultrasound department full capacity • A one-stop shop approach • Evidence of not assigning correct nomenclature to foetuses • Continuity would be enhanced by conducting a twin clinic on separate days The TAMBA report pointed to several innovations introduced by the maternity service at the Lister: • A *grow your own* approach to sonographers • Detailed and comprehensive sonography policy • Dedicated multiple sonography team • Training two midwives to be midwife sonographers to accommodate the increased need for scans due to GROW Although more work needs to be done to improve the service even further, this excellent audit outcome is a testament to the hard work of both the maternity service and its radiology colleagues.
5	**New patient administration system to be rolled out** Friday, 8 September 2017 sees the roll-out across the Trust of a new patient administration system called Lorenzo. The new system will allow staff to: • have access to real-time patient records • make clinical decisions quicker • record patient information better During the go-live period, some of the Trust's processes may take a little longer as staff get used to the new system following the training that has been taking place for some time now. Communications will be put in place to ensure that patients attending the Trust's hospitals during this period are made aware of what is happening. A more detailed update will be provided in my next chief executive's report.

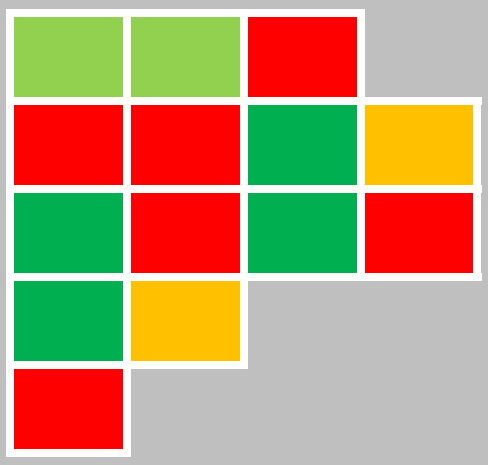
6	**Trust consultant received *Top Teacher* award from UCL Medical School** Recently I received a letter from the deputy director of UCL Medical School informing the Trust that one of its consultants – Dr Sagen Zac-Varghese, who is also one of our undergraduate tutors – had been nominated for a Top Teacher award. Throughout the academic year, students at the medical school are asked, via online evaluation questionnaires, to nominate teachers and administrators who have made an especially positive contribution to their learning and experience at UCL Medical School. During 2016/17, the school's students cast more than 2,000 votes, from which there were 48 winners – one of whom was Dr Zac-Varghese who is a consultant in diabetes and endocrinology. UCL Medical School also used the opportunity to thank the Trust for supporting undergraduate education. In doing so, it recognized the enormous amount of hard work needed to achieve what the deputy director described as "….such teaching and administrative excellence." I would like to congratulate Dr Zac-Varghese on this major achievement, as well as the wider medical education team for the excellent and often innovative service it provides for medical students and doctors in training.
7	**Trust in to top 50 NHS organisations in the country for research studies** According to the annual National Institute for Health Research (NIHR) Research Activity League Table, which was published on 2 August 2017, the Trust is now in the top 50 research-active hospital groups in the country. Research teams at the Trust carried out 122 studies and increased the number of participants recruited from 1,612 in 2015/16 to 2,295 in 2016/17. This is a 42% increase in the last year alone, offering more research opportunities to patients than ever. The Research Activity League Table is published by the NIHR Clinical Research Network (CRN) annually to detail research activity across all NHS trusts and CCGs in England. The table provides a picture of how much clinical research is happening in which NHS organisations, and involving how many patients. This is the first time that the Trust and its research team has featured in top 50 organisations in NIHR's annual Research Activity League Table.
8	**New renal peer support role is a first in the East of England** Renal patient Dom Willison has joined the Trust in a new role to provide one-to-one support for people going through dialysis treatment at the Trust's renal units. It is the first time that a renal patient has been recruited into this role in the East of England. The peer support facilitator role, which has been funded by the Lister Area Kidney Patient Association for two years, has been created in response to feedback from renal patients who felt that they would be better supported by somebody experiencing similar treatment. Dom will lead a team of trained volunteers who will be paired with patients from the start of their treatment, supporting them throughout and highlighting any issues or concerns to the renal multi-disciplinary team.
9	**New volunteer role helps patients requiring extra support at cancer centre** A new *buddy* volunteer support role has launched at the Mount Vernon Cancer Centre to assist patients who require extra support with attending their appointments or cancer treatments.

	They will act as a host for visitors to the cancer centre, providing guidance and support in a number of different ways, including by: • meeting patients when they arrive • helping them locate departments • bringing them drinks and refreshments • keeping them company. Each volunteer has had extra training that will aid them with supporting patients with additional needs, such as those with sight or hearing problems.
10	**World urological robotic surgery experts visits the Lister** Dr Karel Decaestecker, a world expert in robotic bladder cancer surgery, visited the Lister last week to share his skills and expertise with Trust consultant Nikhil Vasdev and the urology team. Together they performed two cystectomies and advanced urinary reconstruction techniques robotically on bladder cancer patients. Dr Decaestecker is the head of clinic for the department of urology at Ghent University hospital in Belgium. In 2012, he became a fellow for the European Board of Urology and has performed over 500 robotic procedures, mostly on bladder cancer patients.

Chief Executive
September 2017

East and North Hertfordshire NHS
NHS Trust

Finance Report



Month 4 - 2017/18

Mth 4 Finance Report - Commentary

KEY BOARD MESSAGES

- The Cyber attack impact upon the Trust financial position was significant - £0.7m.
- Pay and Non Pay remains at reduced run rates and below budget plan
- Agency expenditure has reduced materially compared with the 16/17 run rate
- Continued focus upon improving substantive recruitment to reduce temporary spend.
- Activity levels across the YTD are significantly below 16/17 and 17/18 plan levels.
- Poor utilisation of planned capacity is a significant issue that requires immediate redress.
- Reductions in emergency activity levels and also reduced case-mix are also a significant risk.
- Significant progress continues to be made in implementing and delivering CIP schemes.

SUMMARY

- The Trust reported a month four breakeven position against plan, bringing the year to date position to £10.5m deficit.
- The overall income position rallied in month four to record a £0.1m favourable variance to plan in month. However, the year to date position on income remains a shortfall of £5.3m against plan.
- The income shortfall for the year to date is offset by underspends against plan on both pay and non-pay but the pay spend for month four was the highest for the year to date. It needs to be remembered that the CIP trajectory anticipates the run rate (spend) for these areas will decrease as the financial year progresses.

EXCEPTIONAL ITEMS

- The normalised I&E run rate analysis presents exceptional items.
- The month 4 reported income position assumes a reduced level of receipt of 'Sustainability and Transformation' Funding, £1,882k year to date. This funding is potentially available throughout 2017/18 but is dependent on the Trust meeting its financial control total and A&E target trajectory. 70% of the funding relates to delivery of the financial control total but 30% relates to delivery of two A&E targets and is split - 15% for each target:-
- 15% for A&E 4 hour performance
- 15% for GP streaming
- As the Trust has failed to meet the national A&E national target for the year to date it has forfeit entitlement to the 15% of the STF monies dependent on its achievement.
- There is also a tranche of costs related to the consultancy expenses related to the Financial Recovery plan.

SLA ACTIVITY & INCOME PERFORMANCE

- The Trust continues to report significant under performance against its SLA plan. This adverse variance now totals £5.9m for YTD M4. The material drivers of the shortfall are detailed below:

Issue	Impact
Reduced Elective Activity - DC & EL	£1.9m
Non-elective - reduced volume & casemix	£0.9m
Outpatient activity below plan	£1.6m
Reduced Maternity Antenatal bookings	£0.4m
Cyber Attack - reduced activity	£0.7m

- 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.
- The recovery plan initiated by the surgical division has started to produce results with a notable increase in activity and income for both T&O and ENT on Elective/Day case activity.
- Investigations continue into the reduction in emergency admissions and the matching drop in average case-mix, as this is a continuing trend in month 4.

Mth 4 Finance Report - Commentary

DIVISIONAL FINANCIAL PERFORMANCE

- The Medicine and Surgery Divisions have both reported an adverse variance to plan on spend in month four. The Medical Division reports an adverse variance of £0.9m bringing their year to date position to £1.5m adverse to plan. A significant increase has been experienced in medical staffing pay in the month, most of which relates to the Emergency Department. The Surgery Division has also reported an increase in medical staffing spend.

YEAR ON YEAR COMPARISON

- Income levels are now showing a £7m reduction compared to the same period in 16/17. However it needs to be remembered that at this period in the last financial year the Trust was assuming circa £3m worth of income that was later found not to be due and payable.
- Elective activity is down by 344 and both outpatient follow ups and outpatient procedures are significantly lower than at the same period last year.
- Work is ongoing by the Information Assurance Group to understand the drivers behind this change in activity delivery.
- Once the impact of the TUPE transfer of TPP staff has been taken into account the pay position is showing a reduction in overall terms when compared to last year. Whilst agency spend has significantly reduced between years the Trust needs to continue the emphasis on reducing temporary staffing rates, in addition to changing the employment route of staff.

PAYBILL METRICS

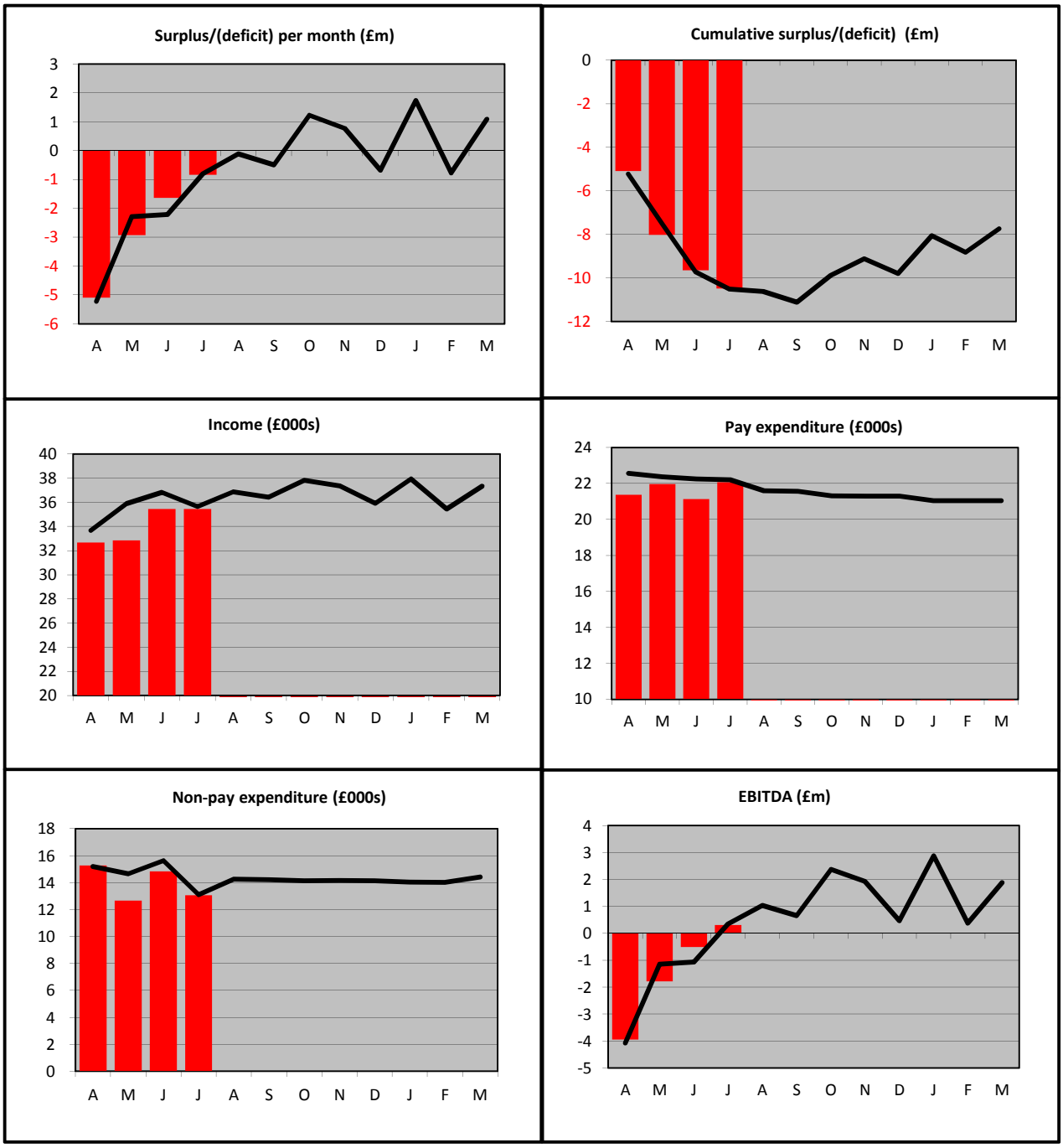
- The overall pay bill for the Trust saw a significant increase in month four when compared to month three.
- A large increase was reported in medical staffing costs, particularly in the Emergency Department. Some of the increase in costs arose from the duplicate running during the changeover in medical staff rotations.
- The Trust also experienced a rise in Nursing pay costs, partially owing to a supernumerary element for new starters in the period.
- Administration and Senior Managers pay costs have risen in the month. This is mainly owing to increases in expenditure in the Information and PMO teams.

CIP PERFORMANCE METRICS

- The Trust CIP plan for the year to date was delivery of £3.8m worth of savings. The figure actually achieved exceeded this sum, totalling £4.4m.
- Whilst the over achievement to month four is positive the Trust is falling behind target in terms of the theatre efficiency scheme. The recovery plans that the Trust has put in place to optimise activity delivery, including the 'daily drumbeat' sessions, should realise greater savings in this area going forward.

Summary Financial Performance - Trust

	Annual Plan £m	Budget Mth £m	Actual Mth £m	Variance mth £m	Budget YTD £m	Actual YTD £m	Variance YTD £m
Income	426.9	35.0	35.1	0.1	139.8	134.5	-5.3
Pay	-259.6	-22.2	-22.1	0.1	-89.4	-86.5	2.8
Non Pay	-171.9	-13.1	-13.1	0.0	-58.6	-55.8	2.8
EBITDA	-4.6	-0.3	-0.0	0.3	-8.2	-7.8	0.3
Financing Costs	-13.4	-1.1	-1.1	-0.0	-4.6	-4.6	0.0
STF Monies	10.2	0.7	0.3	-0.3	2.2	1.9	-0.3
Retained Deficit	-7.7	-0.8	-0.8	-0.0	-10.5	-10.5	0.0



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						
Catering Income	1,153	90	93	81	80			96	80	-16	382	345	-37
NHS Non Patient Care Income	1,889	323	144	141	207			144	207	64	751	816	65
NHS Patient Care Income	389,433	28,969	29,160	31,494	31,586			31,829	31,586	-243	127,140	121,209	-5,931
Other Income Category C	20,343	1,414	1,412	1,477	1,474			1,528	1,474	-55	5,613	5,777	165
Other Patient Care Income	63	4	4	4	4			5	4	-1	21	16	-5
Private Patients	5,069	308	356	466	348			422	348	-74	1,666	1,477	-189
R&D Income	5,077	468	399	448	416			423	416	-7	1,692	1,731	39
RTA Income	1,173	-39	144	205	58			98	58	-40	391	369	-22
Training & Education Income	12,919	1,135	1,136	1,135	1,269			1,098	1,269	170	4,369	4,675	307
Income Total	**437,120**	**32,672**	**32,849**	**35,452**	**35,444**	**0**	**0**	**35,644**	**35,444**	**-201**	**142,025**	**136,416**	**-5,609**
Admin Staff	-35,736	-2,919	-3,021	-2,701	-2,990			-3,099	-2,990	109	-12,087	-11,632	455
Ambulance Service Staff	10	16	-2	-2	-2			1	-2	-2	3	10	7
Ancillary Staff	-7,514	-669	-697	-668	-701			-625	-701	-76	-2,537	-2,735	-198
Clinical Support Staff	-15,418	-1,387	-1,349	-1,306	-1,392			-1,310	-1,392	-81	-5,191	-5,434	-243
Maintenance & Works Staff	-979	-70	-68	-68	-66			-81	-66	15	-330	-273	57
Medical Staff	-82,255	-6,889	-7,013	-6,799	-7,008			-6,874	-7,008	-135	-27,645	-27,709	-64
Nursing Staff	-81,262	-6,550	-6,672	-6,498	-6,692			-6,780	-6,692	88	-27,382	-26,412	970
Other Staff	43	-17	-6	-1	-20			4	-20	-24	14	-44	-58
Pay Reserves	2,151	-197	-106	-24	-98			-159	-98	61	-1,519	-426	1,094
Scientific Theraputic & Technical	-33,259	-2,283	-2,659	-2,665	-2,717			-2,804	-2,717	86	-10,930	-10,324	606
Senior Managers	-5,270	-387	-370	-394	-379			-467	-379	88	-1,756	-1,530	226
Social Care Staff	-84	-10	-9	-10	-11			-6	-11	-5	-33	-40	-7
Pay Total	**-259,574**	**-21,363**	**-21,973**	**-21,135**	**-22,077**	**0**	**0**	**-22,202**	**-22,077**	**124**	**-89,393**	**-86,548**	**2,845**
Admin Expenses	-26,855	-2,720	-3,048	-2,278	-2,131			-2,031	-2,131	-100	-10,748	-10,177	572
Catering	-1,803	-169	-154	-166	-155			-166	-155	11	-613	-644	-31
Commissioning Expenditure	-73	-5	-7	1	-10			-6	-10	-4	-24	-21	3
Drugs, Blood & Lab Consumables	-50,527	-3,773	-3,558	-4,197	-3,215			-3,154	-3,215	-62	-14,646	-14,742	-97
Energy & Utilities	-2,287	-224	-196	-127	-189			-195	-189	6	-780	-735	44
IM&T Costs	-2,978	-248	-219	-303	-240			-264	-240	24	-1,062	-1,010	52
Internal Recharges	-30	-0	0	0	0			-2	0	2	-10	0	10
Medical Consumables	-17,740	-1,341	-1,502	-1,448	-1,488			-1,470	-1,488	-18	-5,932	-5,779	153
Non Pay Reserves	-4,869	-65	888	-293	17			-260	17	278	-1,811	548	2,360
P or L - Sale of Fixed Assets	700	0	0	0	0			0	0	0	0	0	0
Property Costs	-5,139	-429	-421	-418	-472			-431	-472	-42	-1,723	-1,740	-17
Purch & Maint of Equip - Medical	-15,869	-1,307	-1,339	-1,380	-1,364			-1,328	-1,364	-35	-5,494	-5,390	104
Purch & Maint of Equip - Non Medical	-1,674	-147	-125	-298	26			-141	26	167	-566	-544	22
Purchase of Healthcare - Non NHS	-6,891	-553	-622	-561	-559			-580	-559	21	-2,351	-2,295	56
Recharges In / Out	-1,222	-117	-154	-138	-174			-147	-174	-27	-499	-582	-83
Services from Other NHS bodies	-18,857	-2,769	-840	-1,574	-1,468			-1,520	-1,468	51	-6,676	-6,652	24
Site Support Services	-14,750	-1,342	-1,268	-1,582	-1,566			-1,319	-1,566	-247	-5,285	-5,758	-473
Suspense Accounts	0	-1	1	0	0			0	0	0	0	0	0
Training Costs	-1,072	-53	-97	-65	-67			-83	-67	16	-363	-283	80
Non Pay Total	**-171,937**	**-15,260**	**-12,661**	**-14,826**	**-13,058**	**0**	**0**	**-13,099**	**-13,058**	**41**	**-58,583**	**-55,805**	**2,778**
Depreciation	-7,773	-648	-648	-538	-607			-648	-607	41	-2,591	-2,441	150
Dividend	-1,662	-168	-168	-168	-168			-168	-168	0	-671	-671	0
Interest Payable	-3,944	-329	-329	-421	-378			-329	-378	-49	-1,315	-1,456	-141
Interest Receivable	25	3	2	2	2			2	2	0	8	9	1
Financing Total	**-13,354**	**-1,141**	**-1,142**	**-1,124**	**-1,150**	**0**	**0**	**-1,142**	**-1,150**	**-8**	**-4,568**	**-4,558**	**10**
Grand Total	**-7,745**	**-5,093**	**-2,927**	**-1,633**	**-841**	**0**	**0**	**-798**	**-841**	**-43**	**-10,519**	**-10,495**	**24**

Agenda Item:9.2

TRUST BOARD – 6 SEPTEMBER 2017
PERFORMANCE REPORT MONTH 4

PURPOSE	To update the Finance and Performance Committee on: • Progress against NHSI Oversight framework, 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, FT application, CQC ratings, Governance risk Rating, Contractual performance.
Healthcare/ National Policy (includes CQC/Monitor)	Achievement of NHSI Oversight framework, CQC, 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:	Director of Nursing (Acting)
PRESENTED BY:	Director of Nursing (Acting)
AUTHOR:	Company Secretary/Divisional Directors
DATE:	August 2017

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

***** tick applicable box

PERFORMANCE REPORT

1. Key Headlines

This report provides the latest position against the key performance indicators. In summary:

- The Trust failed to meet the referral to treatment 92% standard in July 2017 which was due to the increasing number of pathways over 18 weeks. However there were no 52 week breaches reported.
- The Trust did not achieve the 4 hour ED standard in July but continued to achieve against the STF improvement trajectory, delivering 87.77% against a trajectory of 87.10%. Performance in August has been challenging.
- The Trust failed to meet the 62 day cancer standard. Performance was 66.4% in June. With increased focus on tertiary referrals it is anticipated that the number of breaches that the Trust can avoid taking will increase and as a result overall performance should improve. Awaiting publication of the July performance, an update should be available at Board.

2. RTT – 18 weeks

2.1 RTT performance

The following table shows the last 5 months reported RTT position.

RTT Trust Aggregated Performance			
Month	Non Admitted (95%)	Admitted (90%)	Open Pathways (92%)
Mar-17	90.00%	77.20%	92.00%
Apr-17	87.20%	74.80%	92.10%
May -17	85.99%	79.44%	90.49%
Jun – 17	88.63%	73.56%	88.93%
Jul - 17	83.12%	67.81%	87.43%

The Trust failed to meet the 92% standard in July 2017 which was due to the increasing number of pathways over 18 weeks. The backlog increased by 949 from the end of June 2017 to the end of July 2017. There were increases across all specialities (except Cardiology which remained similar).

At a speciality level 13 out of the 18 Unify reportable bandings did not meet the standard compared to 10 last month with Oral Surgery, Cardiothoracic Surgery and Geriatric Medicine not meeting the standard this month.

2.2 52 week breaches

The following table shows the Trust's 52 week trajectory and the reported position.

Month	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17
Plan	6	5	5	5	3	2	2	1
Actual	1	2	0					

RTT 52 week in no longer an STF trajectory for 17/18, however the Trust remained committed to reducing the number of patients waiting over 52 weeks to zero. The work continues to be below the predicted number of 52 week breaches with none reportable for July 2017 and the introduction of a robust validation process for any pathway over 40 weeks is increasing the confidence in the PTL.

2.3 RTT Recovery

Operational Performance will continue to work with Divisions to understand and recover 18 week performance including development and sharing of a 13 week performance prediction tool, waiting list profile analysis and breach analysis. More details will be given as each aspect is developed.

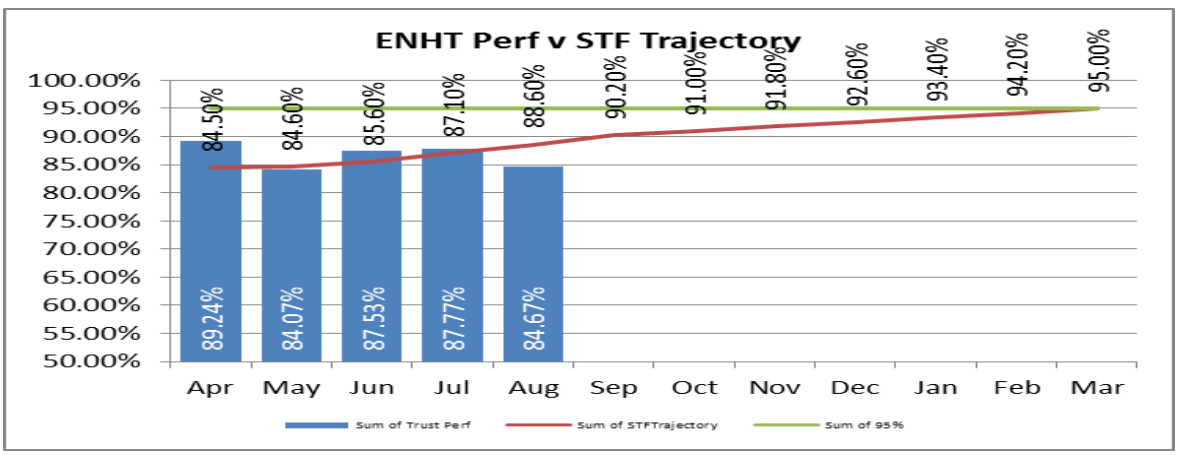
Improvement actions in place include:

- Daily 'drum beat' meetings ensuring clinics and theatre slots are fully utilised
- RTT e learning module developed and being implemented – focuses on the correct application of national RTT codes
- Enhanced oversight via weekly Access Meeting continues
- Data Quality / validation work continues

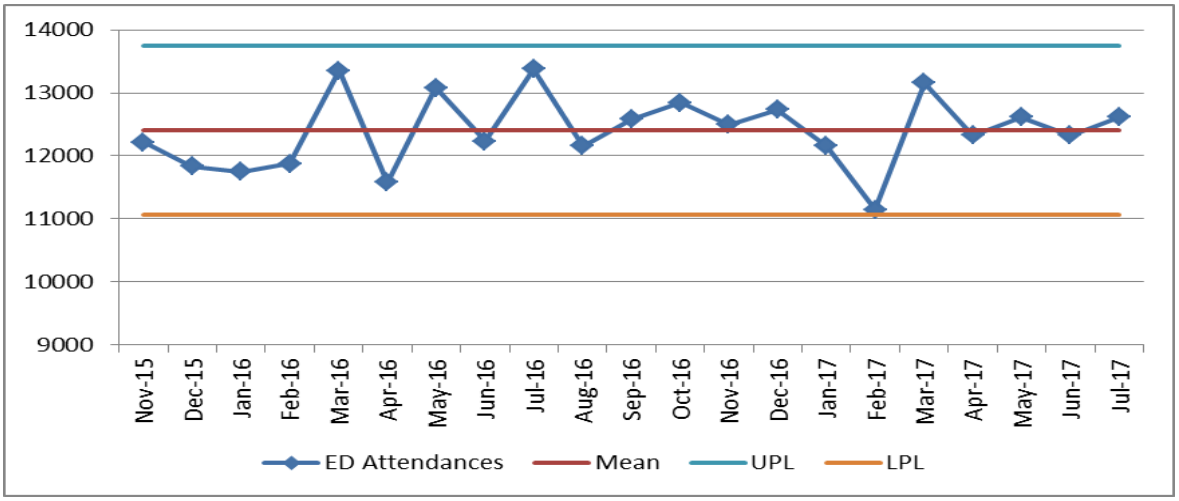
3. 4 Hour Performance

The Trust did not achieve the 4 hour standard in July but continued to achieve against the STF improvement trajectory, delivering 87.77% against a trajectory of 87.10%. August performance has been challenging with bed and flow issues. Further improvement actions being taken include:

- Working with ECIST and Four Eyes Insight on delivery of improvement plan and trajectory
- New Streaming model to be implemented in September 2017.
- New Capital build starting in September 2017.
- Re-focus Red to Green days and SAFER being pushed throughout Trust.



ED Attendances

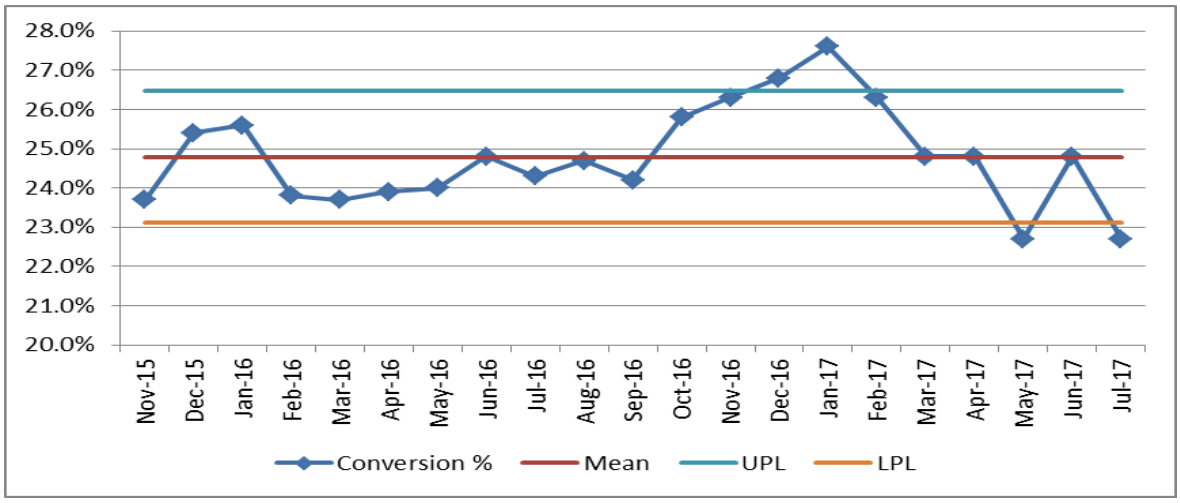


Post Our Changing Hospitals attendance volumes at the Trust have remained within 2 standard deviations. During March – August volumes fluctuated with some broad ranges i.e. March had 1478 more attendances than February.

Q3 was characterised by a more consistent activity, albeit above the mean through the whole quarter March 2017 – third highest number of attendances since November 2015.

Q1 2017 – attendances have remained around the mean average

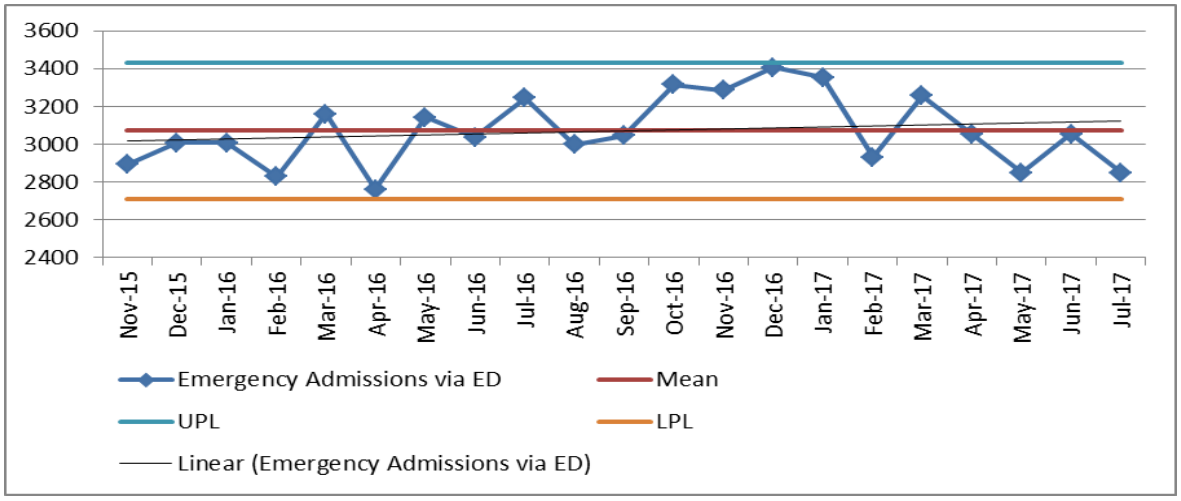
Admissions



The Trust's mean conversion to admission is 24.9%, which is within the expected range for an acute organisation, however between October and February there has been an increase in the percentage of patients admitted with November, December and January exceeding normal variation.

During February, the conversion rate decreased to within normal variation albeit at the upper control limit

May & July 2017 has seen the % conversion drop below the LPL



Admissions via ED have remained within normal variation (2 standard deviations) post Our Changing Hospitals

Quarter 3 was characterised by high volumes of admissions.

During February there was a fall in the number of admissions from ED, however they subsequently increased above the mean average the following month.

Since Quarter 1 admission volume have decreased, currently below the mean average for the 4th consecutive month.

3.1 Ambulance Handover

As reported in the local media ambulance handover performance at the Lister Hospital is now consistently the best in the region. The trust is typically achieving 80% of patient handovers within 15 minutes. The changes previously reported have been tested during a number of extremely busy periods and on the whole the process has proven to be sustainable and produce consistent performance.

4. Cancer

4.1 Cancer 62 day Trajectories

Cancer performance is reported retrospectively. The following table shows the Trust's position against the 62 day trajectories for the last 3 closed months.

Tumour Site		Apr-17			May-17			Jun-17		
62 Day (85%)		Plan	Actual	Variance	Plan	Actual	Variance	Plan	Actual	Variance
Breast	Numerator	15	14	-1.0	15	19.5	4.5	14.5	17.5	3.0
	Denominator	18	15	-3.0	17	25	8.0	15.5	18.5	3.0
	%	83.3%	93.3%	10.0%	88.2%	78.0%	-10.2%	93.5%	94.6%	1.0%
Gynaecology	Numerator	4	2.5	-1.5	6	4	-2.0	6	4.5	-1.5
	Denominator	7	2.5	-4.5	8	6	-2.0	7	5	-2.0
	%	57.1%	100.0%	42.9%	75.0%	66.7%	-8.3%	85.7%	90.0%	4.3%
Haematology	Numerator	4	3	-1.0	4	1.5	-2.5	5	6	1.0
	Denominator	8	7	-1.0	5	1.5	-3.5	6	10	4.0
	%	50.0%	42.9%	-7.1%	80.0%	100.0%	20.0%	83.3%	60.0%	-23.3%
Head & Neck	Numerator	3	2	-1.0	5	3	-2.0	6	4.5	-1.5
	Denominator	4	6.5	2.5	6	5	-1.0	7	6	-1.0
	%	75.0%	30.8%	-44.2%	83.3%	60.0%	-23.3%	85.7%	75.0%	-10.7%
Lower GI	Numerator	5	2.5	-2.5	5	9	4.0	7	4.5	-2.5
	Denominator	10	6	-4.0	8	12	4.0	8	10.5	2.5
	%	50.0%	41.7%	-8.3%	62.5%	75.0%	12.5%	87.5%	42.9%	-44.6%
Lung	Numerator	6	4	-2.0	6	5	-1.0	7	12.5	5.5
	Denominator	11	8	-3.0	10	13	3.0	10	19.5	9.5
	%	54.5%	50.0%	-4.5%	60.0%	38.5%	-21.5%	70.0%	0.0%	-70.0%
Other	Numerator	1	1	0.0	2	0	-2.0	0	0	0.0
	Denominator	1	1	0.0	2	0	-2.0	0	0	0.0
	%	100.0%	100.0%	0.0%	100.0%					
Sarcoma	Numerator	0	1	1.0	0	1	1.0	0	1	1.0
	Denominator	0	1	1.0	0	1	1.0	0	1.5	1.5
	%		100.0%			100.0%			66.7%	
Skin	Numerator	16	20	4.0	18	16.5	-1.5	16	12	-4.0
	Denominator	18	20	2.0	20	18.5	-1.5	17	13	-4.0
	%	88.9%	100.0%	11.1%	90.0%	89.2%	-0.8%	94.1%	92.3%	-1.8%
Upper GI	Numerator	7	8.5	1.5	5	5	0.0	6	4	-2.0
	Denominator	9.5	9.5	0.0	7	8.5	1.5	7	8	1.0
	%	73.7%	89.5%	15.8%	71.4%	58.8%	-12.6%	85.7%	50.0%	-35.7%
Urology	Numerator	16	19.5	3.5	18	14	-4.0	20	9	-11.0
	Denominator	31	27.5	-3.5	32	21	-11.0	25	25	0.0
	%	51.6%	70.9%	19.3%	56.3%	66.7%	10.4%	80.0%	36.0%	-44.0%
TRUST TOTAL	Numerator	77	78	1.0	84	78.5	-5.5	87.5	75.5	-12.0
	Denominator	117.5	104	-13.5	115	111.5	-3.5	102.5	117	14.5
	%	65.5%	75.0%	9.5%	73.0%	70.4%	-2.6%	85.4%	64.5%	-20.8%

The Cancer Performance for July 2017 will be uploaded on Friday 1st September and published on Monday 4th September.

The performance for June 2017 against the 62 day standard is 64.5% prior to breach sharing. This is 20.8% below the trajectory but was an expected result. Considerable progress has been made in reducing the number of patients waiting over 62 days for treatment. As the long waiters are treated performance naturally drops. It is expected that a shift change will occur during July and August as the number of pathways to treat over 62 days reduces.

Through correct application of the breach sharing agreement the Trust performance post-sharing is 66.4%. With increased focus on tertiary referrals it is anticipated that the number of breaches that the Trust can avoid taking will increase and as a result overall performance should improve.

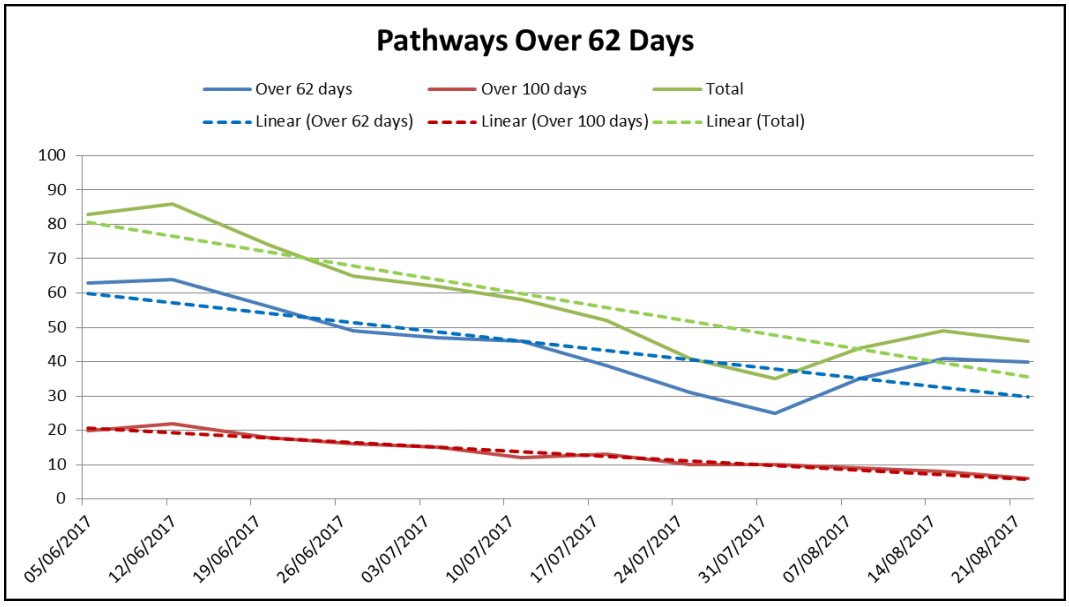
4.2 Cancer Waiting List Profiles

The following table shows the overall profile of the 62 day Cancer PTL.

Trust Overview	29-43 days on pathway	44-62 days on pathway	63 -99 days on pathway	100+ days on pathway
Current Cancer PTL Profile	171	95	43	6
Last Week Cancer PTL Profile	181	69	35	8

There has been a reducing number of pathways over 100 days for the past 6 weeks. The tumour sites with 100 day pathways are: Haematological x 2, Gynaecological x 1, Lung x 1 and Urology x 2.

The following graph shows the trend in the number of pathways over the 62 day standard on the PTL.



There is a downward trend in the number of pathways breaching the standard. Significant progress has been made since 13th June where the numbers of pathways over 62 days decreased rapidly. During August the number breaching the standard has increased slightly which is normal for this time of year when patients are exercising choice about not attending diagnostic and treatment appointments during late July and August. In previous years the increase has been rebalanced during September. This situation will be closely monitored and managed during September and October. Key points:

- The proportion of pathways that have exceeded 62 days has decreased from 6.9% of the total waiting list (05/06/17) to 2.8% (15/08/17)
- 6 patients remain over 100 days (2 are tertiary referrals out of the Trust), each patient is closely tracked and plans are in place. These long waiters have complex pathways or associated medical conditions which have extended a normal pathway.
- All patients over 62 days are discussed in detail at the new Trust wide weekly PTL meeting and the Trust Access meeting.

4.3 Cancer Performance Recovery

The Cancer Board meeting was held on Monday 14th August at which the following table was presented showing the final performance for June, the unvalidated position in July (validation ongoing before upload on 1st September) plus the performance in August for the first 13 days of the month.

Target	Performance Measure	Target	Month	July Unvalidated	August Unvalidated
Target Referrals					
Cancer Referral to 1st Outpatient Appointment	< 14 Days	93.0%	98.7%	97.7%	96.9%
Referrals with Breast Symptoms (wef January 2010)	< 14 Days	93.0%	93.4%	96.5%	91.5%
Cancer Treatments					
Decision to Treat to 1st Definitive Treatment for all Cancers	< 31 Days	96.0%	90.7%	93.6%	96.3%
Referral to Treatment from Consultant Upgrade	<62 days	90.0%	50.0%	69.2%	80.0%
Referral to Treatment from Screening (62 Day)	< 62 Days	90.0%	58.8%	50.0%	100.0%
Second or Subsequent Treatment (Anti Cancer Drug Treatments)	< 31 Days	98.0%	96.3%	94.8%	96.6%
Second or subsequent treatment (Radiotherapy Treatments)	< 31 Days	94.0%	87.2%	89.5%	95.9%
Second or subsequent treatment (Surgery)	< 31 Days	94.0%	82.2%	81.0%	75.0%
Urgent Referral to Treatment of All Cancers	< 62 Days	85.0%	64.5%	68.7%	
Urgent Referral to Treatment of All Cancers (following breach reallocation)	< 62 Days	85.0%	66.4%	-	72.1% *

* Month End Predicted

The following points should be noted:

- **Decision to treat to first definitive treatment – 31 days.**
  - The Trust undertook to deliver this standard in August. The micro-management of the 62 day pathways has led to an increase in the number of pathways meeting the 31 day standard. IN June the position was 90.7% and as at 14th August is tracking at 96.3%. With the continued intervention in the management of the 62 day pathways the 31 day standard is highly likely to be delivered in August.

- **Referral to Treatment from Consultant Upgrade**
  - The Trust reports relatively low numbers via Consultant Upgrade and performance can be volatile as a result. After migration to Lorenzo the functionality for Consultant Upgrades is vastly improved and it is expected that higher volumes will be captured in this standard.

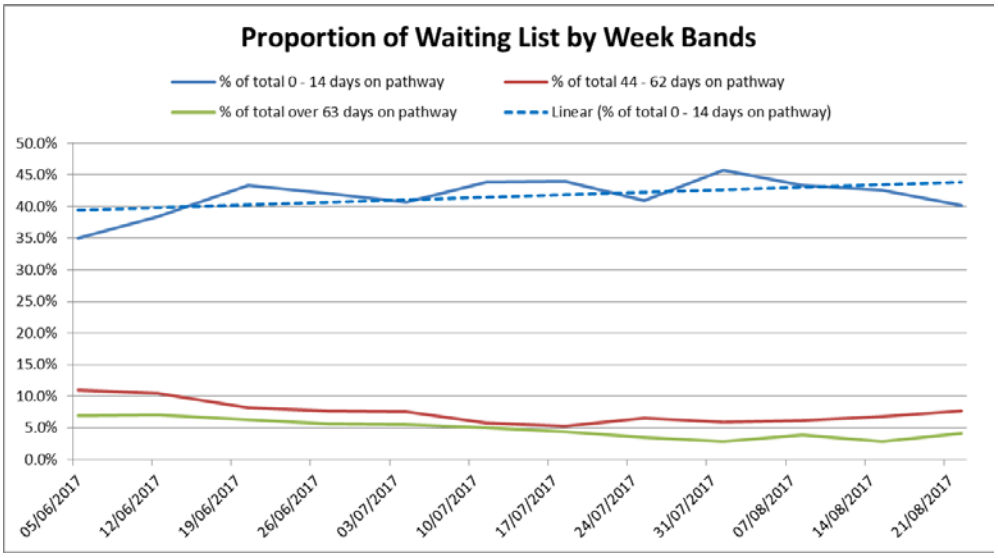
- **Referral to Treatment from Screening - 62 days**
  - Although no specific intervention has been put in place to improve performance the impact of closely monitoring and reporting other 62 day pathways has led to an increase in this measure. It is anticipated that this standard will be met for August

- **Second and Subsequent Treatment (radiotherapy)**
  - Closer tracking of the 62 day pathways has led to an increased focus on booking radiotherapy dates to meet the 31 day standard. It is anticipated that this standard will be deliver for August

- **Urgent Referral to treatment all cancers – 62 day standard**
  - With closer management and scrutiny of the 62 day pathways an increase in performance has been achieved. For August it is predicted that the Trust performance will be 72.1%. Utilising a

new predictive tool this forecast is monitored and updated each day. It is encouraging when analysing the treatment booked at the Lister site for the rest of the month that 85% will be within 62 days. However at the Mount Vernon site this is only 42% so there is increased focus on pathways managed at Mount Vernon to improve performance and pathway management.

4.3 Waiting List Profile



- 72.0% of the total waiting list size are waiting under 28 days compared with 7.7% waiting in the 44-62 day period

- A sustainable waiting list profile has more patients waiting in the earlier part of the pathway, therefore suggesting that the Trust's cancer waiting list profile has progressed to a more sustainable position

4.4 Reporting

Following a joint correspondence from NHSI & NHSE trusts are required to routinely report numbers of patients waiting over 62 and 104 days to the public board, along with outcomes and learning themes from RCA's and harm reviews.

ENHT has routinely reported the volume of patient waiting over 62 and 100 days (see graph, 'Pathways Over 62 Days'). The national measure and acute contract requires patients to be tracked at 100 days therefore ENHT will continue to report as per national standards, this will also by default include those patients that are at 104 days plus.

An enhanced RCA and harm review process has been established jointly with the local CCG and it is the expectation that themes and learning will be shared in subsequent performance reports. The process includes a final joint review by the CCG and clinical lead.

5 Stroke

Improvements across the board and being sustained ('A' rating awarded).

July '17 Stroke performance

Metrics	July '16	Aug '16	Sep '16	Oct' 16	Nov' 16	Dec '16	Jan' 17	Feb '17	Mar '17	Apr ' 17	May' 17	June' 17	July '17
Trust SSNAP Grade	B	B	B	B	B	A	A	A	A				
Stroke Discharged with AF on anticoagulants (ASI 1)	86.7%	83.3%	80%	88.9%	75%	86.7%	72.2%	88.2%	91.7%	54.5%	90%	92.3%	62.5%
Stroke – 4 hours direct to stroke unit (ASI 2)	77.8%	91%	75.4%	80.9%	76.1%	76.6%	71.8%	76.4%	73.4%	82.5%	76.6%	77.6%	78.6%
Stroke – 80% of patients spent 90% of time on the stroke unit (ASI 3)	74.3%	91%	91.4%	93%	84.3%	85.7%	86.9%	83.3%	92.5%	88.9%	91.4%	88.5%	88%
Stroke – 60 min to scan 9ASI 4a)	60%	58.8%	56.9%	51.9%	40.9%	47.6%	51.2%	46.2%	51.3%	52.4%	55.1%	57.5%	70%
Stroke 60 mins to scan urgent only	91.1%	89.5%	93.8%	100%	91.3%	86.1%	91.7%	90%	89.2%	95.2%	91.7%	90%	96.2%
Stroke – scanned within 24 hrs (ASI 4b)	98.6%	100%	100%	98%	100%	98.8%	100%	98.7%	100%	100%	98.6%	100%	100%
Total Thrombolysis Rate	4.6%	6.6%	14.9%	8.2%	3.4%	9.9%	17.1%	7.5%	13.6%	16.2%	11.5%	13.4%	14.3%
Stroke thrombolysed within 3hrs-4.5hrs	4.6%	3.3%	14.9%	6.1%	3.45%	7.1%	12%	6%	9.1%	10.8%	6.6%	9%	7.1%
Stroke – discharged with JCP (ASI 7)	97.3%	92.3%	94.4%	94.1%	90.5%	79.2%	95.8%	100%	100%	100%	100%	100%	100%
Stroke –discharged with ESD (ASI 9B)	37.5%	31.1%	33.3%	27.5%	39.6%	36.5%	42.1%	42.4%	40%	54.5%	26.5%	48.1%	50%
TIA – high risk, not admitted, tx within 24hrs	68%	63.3%	66.7%	75%	70.8%	73.2%	68.4%	66.7%	63.3%	91.7%	57.9%	60%	73.7%
TIA – high risk tx within 24hrs	68%	63.3%	66.7%	75%	70.8%	71.4%	68.4%	66.7%	63.3%	91.7%	57.9%	60%	73.7%
TIA – low risk, treated within 7 days from first contact	66.7%	88.9%	100%	81.5%	88.9%	94.4%	90.9%	93.3%	88.9%	88%	81.3%	79.3%	86.7%
TIA – low risk, treated within 7 days from onset	44.4%	48.1%	100%	40.7%	72.2%	44.4%	72.7%	53.3%	48.1%	60%	56.3%	48.3%	53.3%

6 Other Areas

Six week diagnostics has been delivered consistently except for July 2017 when the impact of Audiology delays has been evident in performance. Recovery plans have been enacted and good progress has been achieved. Forecasting August will improve but may still be below the standard with a return in September.

Demand continues to be elevated for MRI – Mobile MRI van continues to be utilised Ultra sound demand also increasing necessitating additional sessions using agency sonographers

DM01	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17
Standard	99%	99%	99%	99%	99%	99%	99%	99%	99%	99%	99%	99%
Actual	99.52%	99.62%	99.68%	99.61%	99.23%	99.90%	99.68%	99.82%	99.72%	99.00%	99.55%	96.65%

As reported previously there is ongoing work regarding the capture of data and the reporting of the DM01 (diagnostic standard). Historically the specialities have reported their own data which the information team have collated into a monthly submission, the review of this process continues and as a result a number of issues have been identified that require further investigation, any potential impact is not yet known until this work has progressed.

7 Pathology Performance – July

Indicators	Data to	Trend	n	Target	May	Jun	Jul	FYtD
A&E Basket of Tests (1 Hour)								
Sodium	Jan	⇩	4127	97%	97.95%	97.83%	97.46%	97.91%
Troponin	Jan	⇩	1203	97%	95.74%	97.35%	96.67%	96.85%
D Dimer	Jan	⇧	413	97%	97.46%	97.21%	97.34%	97.00%
Full Blood Count	Jan	⇩	4022	97%	97.52%	98.20%	97.29%	97.64%
Acute Basket of Tests								
Sodium (4 Hours)	Jan	⇩	9211	95%	95.77%	98.24%	94.93%	96.13%
Full Blood Count (4 Hours)	Jan	⇧	9821	95%	99.38%	99.10%	99.24%	99.18%
Blood Group & Screen (24 hours)	Jan	⇧	2735	99.5%	99.38%	99.58%	99.82%	99.59%
Feto-maternal Haemorrhage	Jan	⇩	83	95%	100.00%	100.00%	98.80%	99.61%
Antenatal Blood Group & Screen	Jan	⇔	1012	95%	100.00%	100.00%	100.00%	100.00%
Transfusion Antibody Investigation	Jan	⇔	241	95%	100.00%	100.00%	100.00%	100.00%
Histology								
Lab 3 day TAT	Jan	⇧		80%	74.08%	71.09%	82.71%	75.54%
Total 7 day TAT	Jan	⇧	2366	80%	76.54%	73.03%	91.38%	79.21%
Total 10 day TAT	Jan	⇩		95%	92.52%	92.52%		71.07%
Total 21 day TAT	Jan	⇔		95%	99.76%			48.80%
Total Activity								
Total Activity (Acute)	Jan	⇩	38048		37927	38725	38048	150453
Critical results communication (acu	Jan	⇧	750	97%	99.80%	99.04%	100.00%	99.57%

Blood Sciences: - All KPI for July were met with the exception of the AE Troponin and Sodium within the acute baskets of tests. The reason for this was due to network issues which impacted on pathology IT systems causing the system to auto restart. Breaches also occurred as a result of operator error, this has been addressed. KPI's are being monitored daily which reassure we are back on track.

Histology:- At the time of writing this paper only the 3 and 10 day KPI data is available, we have met this target. This is as a result of changing processes, however we have also received lower number of requests.

Agenda Item: 9.3

TRUST BOARD PART 1 – 6 SEPTEMBER 2017

Workforce & OD Board Report – Month 4

PURPOSE	To present an update to the Trust Board on Workforce and OD 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	[ ]

DIRECTOR:	Chief People Officer
PRESENTED BY:	Chief People Officer
AUTHOR:	Deputy Director of Workforce
DATE:	1st September 2017

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

* tick applicable box

Workforce Report

JULY 2017

BASED ON MONTH 4 DATA

Executive Summary

The trends for the Trust workforce report for month 4:

Key Headlines

Vacancy Rate:
The Trust's vacancy rate at the end of July 2017 was 8.56% compared to 9.62% in June, although a proportion of this drop was due to new junior doctors joining, the underlying vacancy rate was still down. This is the 15th month of continued improvement.

Retention:
Plans are progressing to reduce attrition and improve staff engagement and reduce the number of leavers. In July, the turnover rate was 12.89% compared to 13.2% in June.

Agency spend:
The monthly agency ceiling target was achieved in month 4, with agency spend under by £142k. Year to date, the Trust is under the ceiling target by £1,104k. There are more initiatives on track to reduce the agency usage and it is expected the agency expenditure will remain below the ceiling throughout the year. The reduction in agency hours has been delivered through a comprehensive action plan focusing on key areas including agency controls, bank recruitment, regional collaboration, demand management and staff engagement.

Benchmarking:
The Trust's vacancy rate, turnover rate and agency rate are the lowest amongst other healthcare providers in the geographical area*.

Friends and Family Test:
National results were released on 24th August indicating a drop in the Trust results away from the national average for recommending the Trust for work. Analysis of themes is being carried out to identify key issues and communicate action plans.

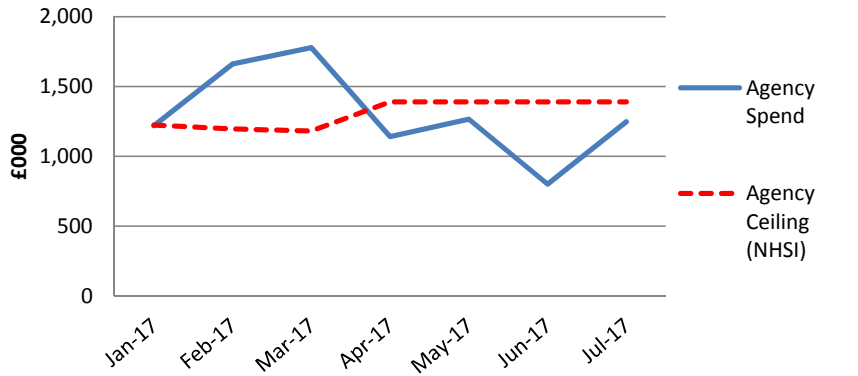
*(*benchmarking data provided in appendix 6)*

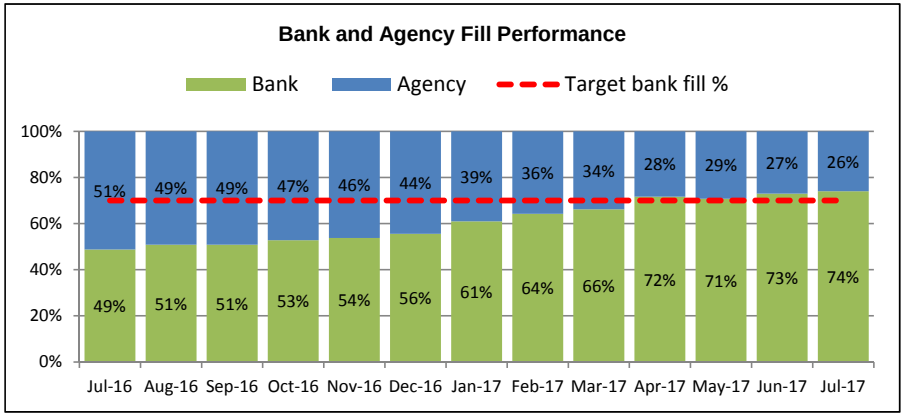
Workforce Board Report

Index

1. Temporary Staffing

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





Headlines:

The monthly agency ceiling target was achieved in month 4, with agency spend under by £142k. The Trust is under the ceiling target by £1,104k, year to date, and there are more initiatives on track to reduce the agency usage. It is expected that the agency expenditure will remain below the ceiling throughout the year. In month 3, part of the reduction in agency spend related to adjustments made for bank and agency accruals and re-categorisation of consultant spend for IM&T projects to the amount of £150k. There was also a further reduction of £173k due to a data feed error by NHS Professionals, which is now represented in the spend for month 4.

Spend in relation to hours booked in month 4 increased for bank (7%) and agency (4%). The increases were fairly evenly distributed across all divisions and staff groups. Indicative figures for August show a reduction in bank spend (approx.10%) and agency returning to the month 3 spend total. Compared to month 4 the previous year agency booked hours have reduced by 60% and bank hours have increase by 20%.

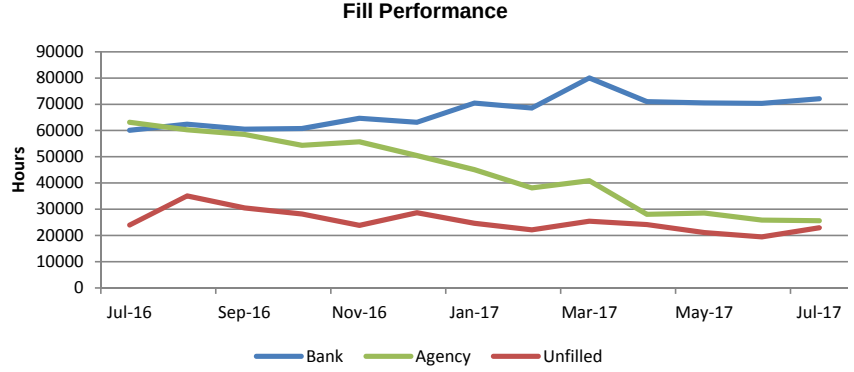
The reduction in agency hours has been delivered through a comprehensive action plan focusing on key areas including agency controls, bank recruitment, regional collaboration, demand management and staff engagement.

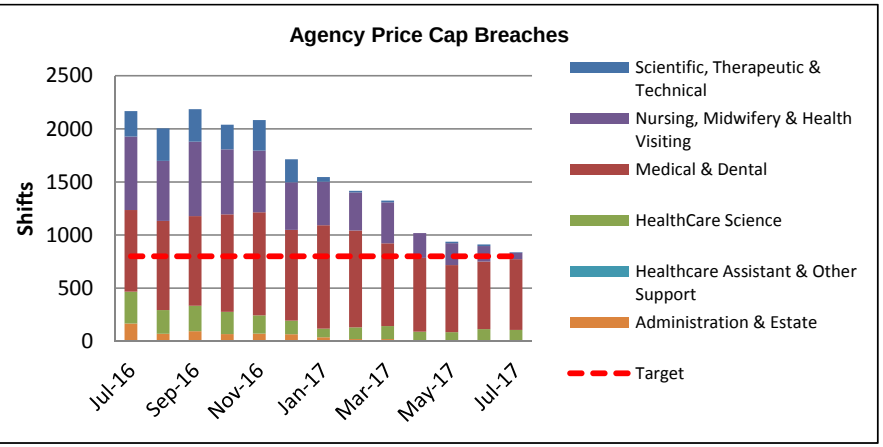
Shared bank:

The shared bank initiative across Hertfordshire went live at the end of July. This has enabled multi-trust working for staff working bank and prevents NHS staff working with agencies in partner Trusts. Known as 'The Bank Network', the shared bank has been marketed around the Trust. Data showing uptake will be available in early August to enable Trusts to assess benefits.

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:

Set up of internal Temporary Staffing Office, Doctors (TSOD):

The new service for managing all medical temporary staffing bookings is now fully embedded. Benefits are already being realised with the improvement of control processes around requesting and approving agency and enhanced agency management. The team are now working on reducing the unit cost of agency through increased negotiation and by maintaining the regional ceiling charge rate. Changes to IR35 legislation has made this difficult by creating a reduction of available locums in the market and impacted the worker's expectation of gross pay. Bank recruitment is very positive with a large number of workers in the pipeline wanting to work for TSOD.

Agency restrictions/agency free zones:

'Padlocks', restricting agency, are now automatically applied to all shifts for nursing and midwifery and are only removed with approval from the Director of Nursing. Direct booking of agency has been switched off meaning all shifts are filled through the agency cascade.

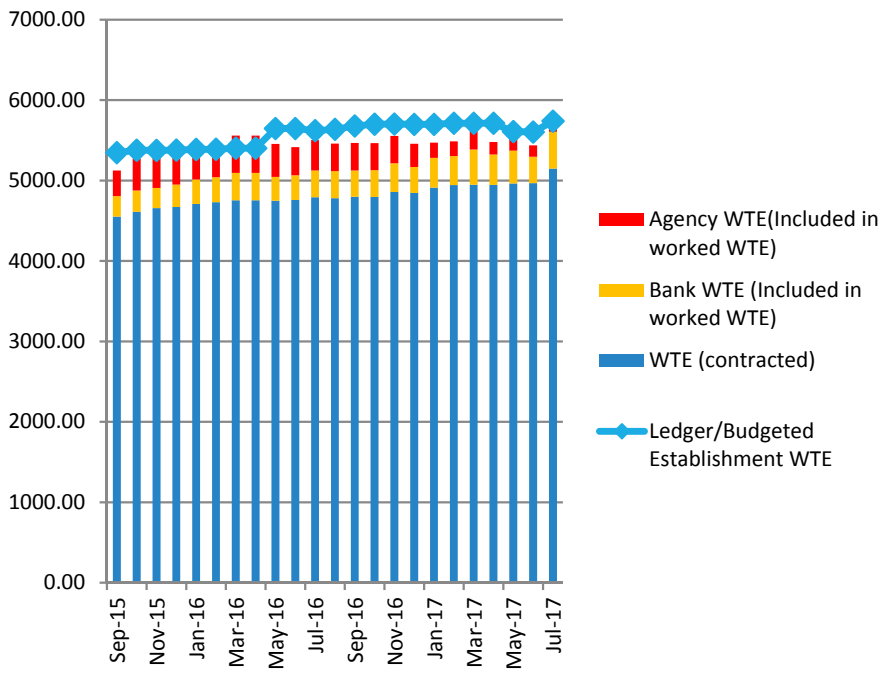
A recognition scheme has been set up to identify departments that have removed all agency, gaining 'Agency Free Zone' status. The first departments received their award in July following three months being agency free. The plan is to increase the agency free zones across the Trust.

Agency unit cost and price management:

Rates were renegotiated for agencies supplying to critical areas resulting in no critical care nursing breaches from July due to agencies either being removed or reducing rates. The only nursing area now breaching is oncology.

2. Resourcing - Non-Medical

Strategy: To reduce the vacancy rate to 5% in order to support the trust's People Strategy and the Safer Staffing agenda. The achievement of this strategy is reliant on new, innovative attraction, recruitment and retention projects.



Headlines:

Performance: The vacancy rate at the end of July 2017 was 8.56% compared to 9.62% in June, although a proportion of this drop was due to new junior doctors joining, the underlying vacancy rate was still down. There are currently 313 wte external candidates undergoing pre-employment checks or waiting to start with the Trust.

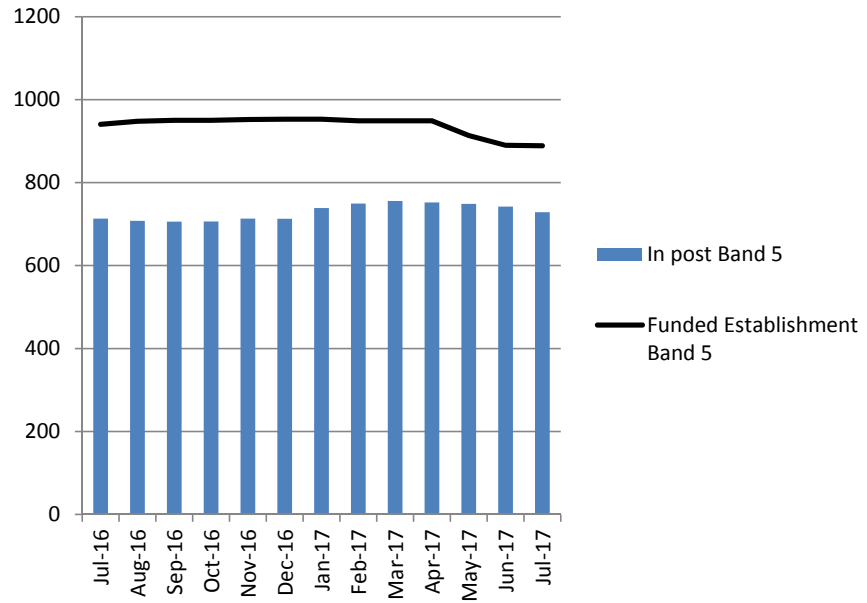
There were 264wte new starters reported in July 2017, compared to 62wte in June 2017. The significant increase in the number of new starters can be attributed to the transfer of 139 wte TPP staff to the organisation, plus the intake of 54 wte Junior Doctors.

There is significant work being conducted to enhance the reporting on Time to Hire across the Trust. The changes in reporting is to understand any blockages in the recruitment process, plus to highlight areas of good practice. There is continued work being undertaken by each Division to drive down the overall Time to Hire across the Trust. Changes in how recruitment data is presented and shared to the Divisions is supporting the drive to reduce process time and understand blockages in the recruitment timeline. Focused work on reducing the time lapse between a member of staff resigning to authorising the vacancy is proving positive in reducing the overall Time to Hire.

Candidate Attraction: Work is underway to enhance the branding of the Trust and Recruitment function by utilising a range of digital media options. Plans are currently being devised with each Division to enhance recruitment channels, attraction to the Trust and in particular hard to recruit posts.

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

Strategy: To reduce the vacancy rate to 5% 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:

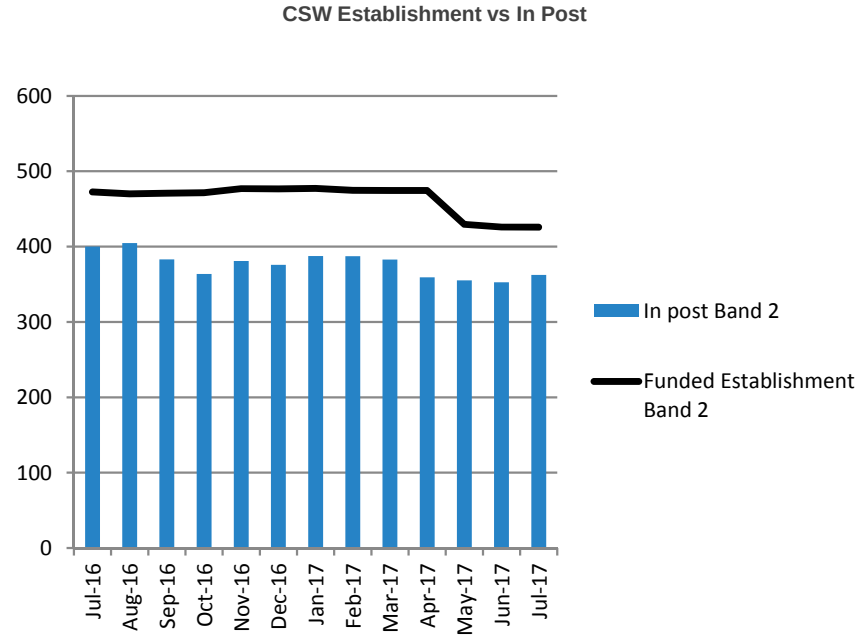
The Trust's vacant posts for band 5 registered nurses at the end of July 2017 was 160 wte, this equates to an 18.04% vacancy rate. The forward view recruitment trajectory for band 5 registered nurses, predicts a decrease in the vacancy rate to circa 12.0% by December 2017.

There are currently 218 wte external band 5 qualified nurse candidates undergoing pre-employment checks or awaiting to start with the Trust.

Acknowledging the current attrition rate for Band 5 nurses at an average of 10 wte per month; the Trust requires an additional 5 wte starters per month in order to be on target. In order to meet the demand of recruiting to Band 5 vacancies each Division has confirmed recruitment plans. There are a number of bespoke recruitment events planned from September 2017 until the end of March 2018. Each recruitment event has ben designed to display the opportunities available within the Division with a focus on hard to recruit posts, training opportunities and rotational posts.

2c. Resourcing - Non-Medical CSW

Strategy: To reduce the vacancy rate to 5% 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:

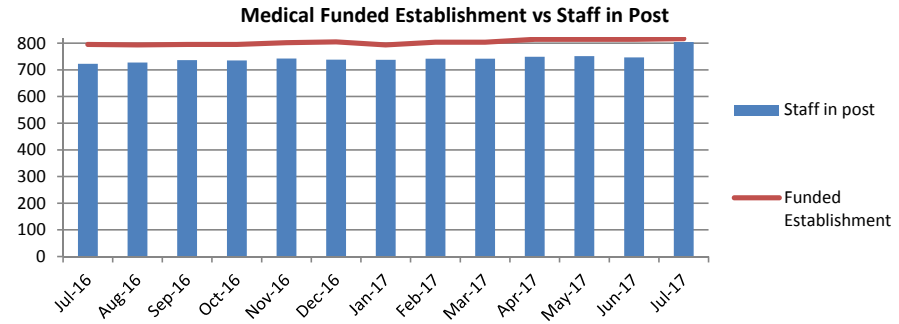
The Trust's number of vacant posts for band 2 Clinical Support Workers (CSWs) at the end of July 2017 was 63 wte, equating to an overall vacancy rate of 14.85% for CSWs.

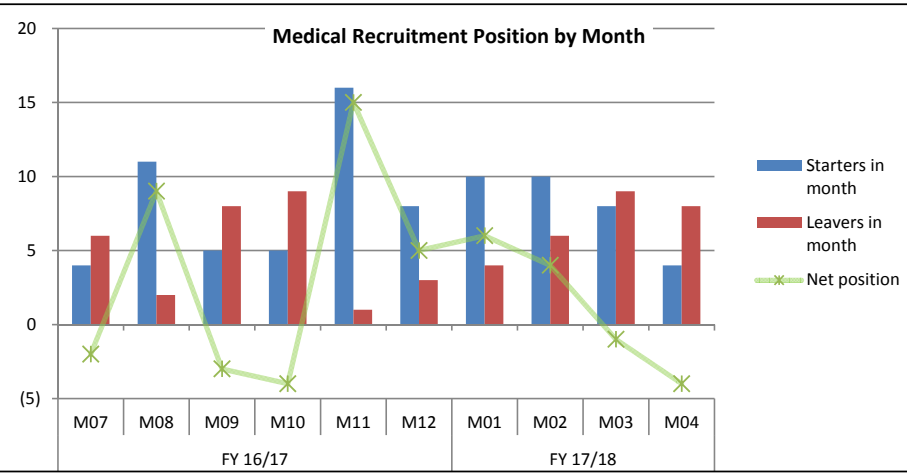
There are 362 wte of Clinical Support Workers in post. There are currently 44 wte Clinical Support Workers undergoing pre-employment checks. Attraction to the CSW role is challenging, however the increase in CSW in the reported recruitment pipeline can in part be attributed to the change in the contract from fixed term to permanent and the changes in the way the Apprenticeship course is taught and assessed.

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.

3. 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:

Four new medical staff were appointed and in post in month 4. However, 8 staff left, giving a net position of -4. The drop in recruitment numbers is typical this time of year and was expected. However, the new starter figures for August are more positive indicating a return to planned levels of staff in post. The increase to staff in post numbers in July was due to 54 WTE working shadow period (staff due to commence foundation training as per mandate).

The additional recruitment activity which took place in July and August involved the junior doctor rotation with 153 leavers processed and 169 new starters recruited. Plans are ongoing to increase the number of substantively employed medical staff, with a number of key actions as part of the recruitment strategy.

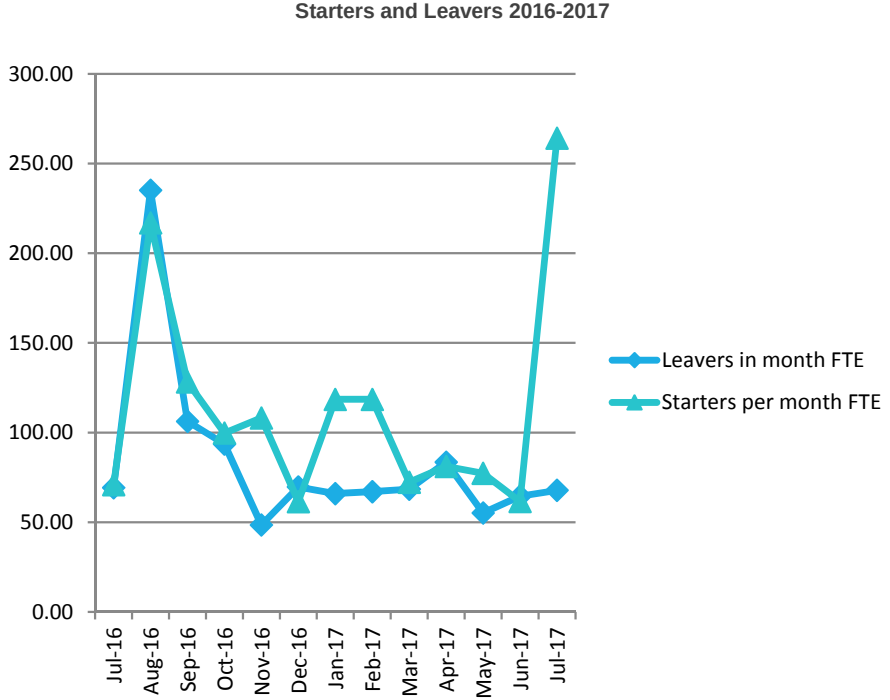
Retention of staff: The first group of survey results have been returned by the international applicants appointed in the last 6 months. This highlighted positives with the recruitment and welcome process, but there is more work to be done with the settling in and induction process. The team will formulate plans with departments to address this. A comprehensive introduction has been set up including welcome packs, temporary on-site accommodation and use of specialist relocation companies.

Recruitment partners: The Trust is working with a specialist recruitment agency to support sourcing candidates for hard to recruit areas.

Candidate attraction: A promotional event is planned to be held at the AGM exhibition, using the newly developed promotional material and video.

4. 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:

In July, there were 59 individuals who voluntarily resigned from their posts, other leavers were in fixed term contracts or their contracts were terminated. The most common reasons for leaving were retirement, relocation, better reward package and seeking better opportunities for flexible working. The significant increase in new starters is attributed to the transfer of 138.68 wte TPP staff and 54 junior doctor show offers in month 4.

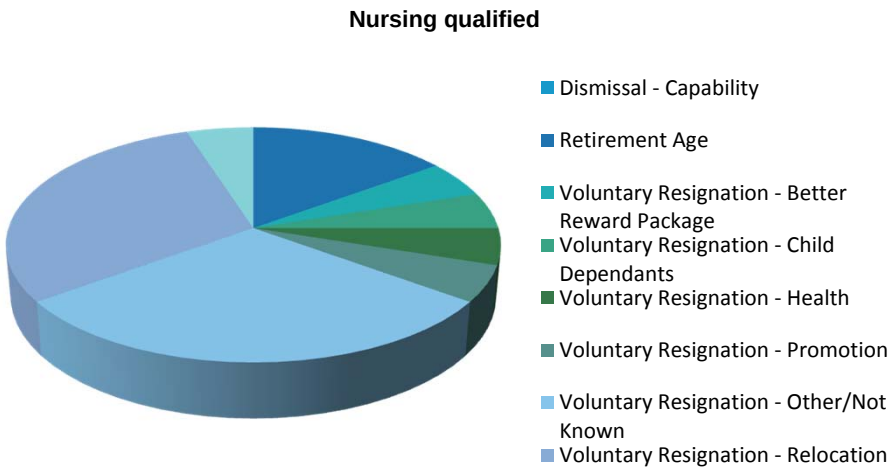
Key Retention Actions:

- Completed 6 month Flexible Working Project focusing on direct engagement; with the aim of increasing awareness of FW options and giving staff opportunity to apply.
- Since the project commenced, the team received 163 FW Requests; 80% of which were fully or partially approved.
- With the project complete; the team will embed some of the good practice adopted during the project.
- As a result of the direct engagement project; use of Employee Online (EOL) for the making of requests increased.
- Reviewing the format of the Exit Interview Questionnaire in partnership with staff side colleagues to ensure feedback useful in feedback to the divisions.
- Bullying and Harassment Steering Group launched with effect from 15th August 2017.
- Joint Staff Feedback Sessions - dates to be shared in September 2017 for the rest of the financial year; key focus being bullying and harassment and retention.

4b. 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.

Top reasons for Nurses leaving 2016-2017 were:



Month 4 Qualified nurse reasons for leaving: the top 3 reasons for leaving were retirement, relocation or not known

Headlines:

Retention plans are progressing to reduce attrition and improve staff engagement and a lower number of leavers. In July, the turnover rate was 12.89% compared to 13.2% in June. There were a total of 67.80 wte leavers compared to 64.57 wte in July. The total number of new staff joining the Trust in July was 264.16 wte, a net increase of 202.59 wte. The significant increase in new starters is attributed to the transfer of 138.68 wte TPP staff in month 4.

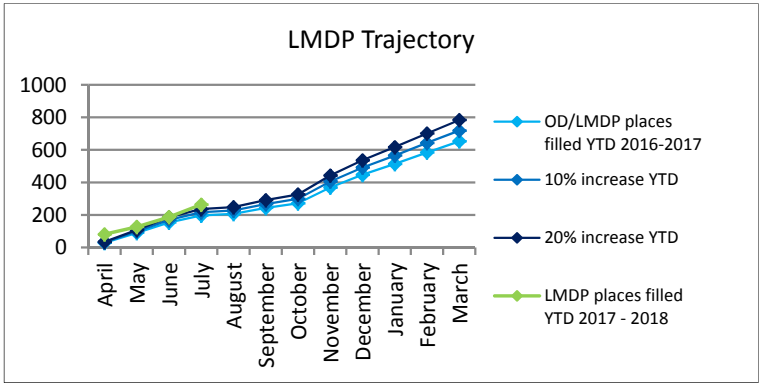
Future plans:

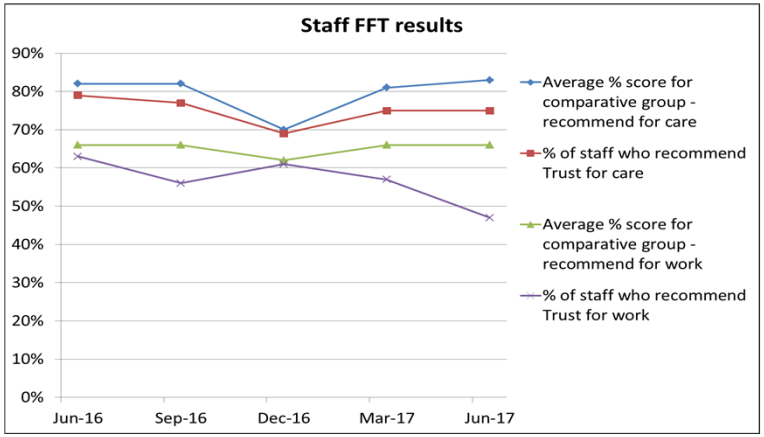
There are a variety of plans across the Trust to improve retention. Which include:

- Identification and maximising of training & development opportunities for Radiology staff
- Development of a Radiology Lecturer Practitioner role with the University of Herts
- Focus groups for nursing to identify reasons for leaving and mitigate risks
- HR early intervention clinics
- H@W early intervention initiatives
- Training offering and career fast-track
- Divisional recognition initiatives
- Rotational posts and transfer register

5. Capability of leaders

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





Headlines:

The LMDP pathway programmes have been well attended and exceed attendance at the same point in 2016-2017. A new edition of the Leadership & Management Development Pathway will be published in September. Delegate evaluation of the programmes remains very good overall, with an average of 4.85 out of 5 against the evaluation measures. The *Skills Development Group* has now been established to take forward the incorporation of the competencies identified by PwC and Foureyes into Trust development programmes. The next meeting scheduled for 8 September.

The Summer LEND sessions concluded in early August. The dates for the Winter LEND sessions have now been confirmed and will be communicated shortly.

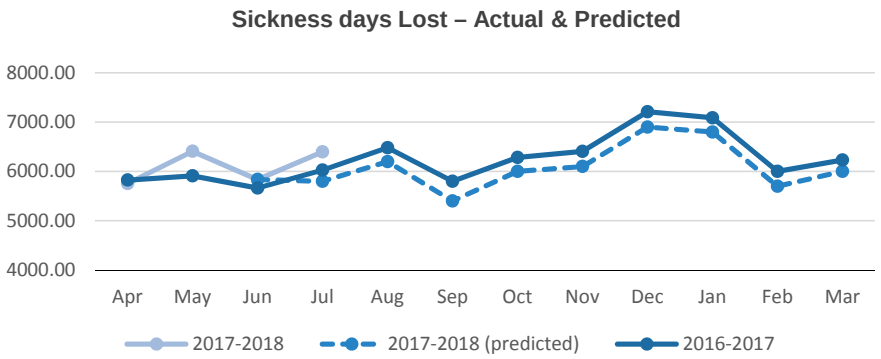
Preparation is underway for the 2017 NHS National Staff Survey, which will be launched in early October. Following the higher response rate in 2016 for online surveys compared to paper surveys, the Trust intends to move to an all-online survey this year.

This year's Celebration of Excellence event is taking place in December, with nominations opening on mid-September - this is later than usual to accommodate the Lorenzo launch. While the event continues to recognise the contribution of award winners and long service staff, it has been scaled back to a smaller, more informal event to reflect current Trust circumstances.

The Q1 national Staff FFT results have now been published - graph 2 shows the Trust's performance against the acute Trust national average. National results were released on 24th August indicating a drop in the Trust results away from the national average for recommending the Trust for work. Analysis of themes is being carried out to identify key issues and communicate action plans.

6. ER Sickness Management

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



Future Actions to reduce sickness absence:

- Finalise and launch revised policy with a number of drop-in sessions available to line managers.
- Monitor compliance in relation to streamlined process.
- Mandate the completion of Return to Work Interviews and report monthly on completion.
- Continue to focus on hotspot areas and develop action plans for all individuals having reached formal trigger stage.
- Case Conferences to be held between ERAS and Health at Work to ensure timely resolution of LTS cases.
- Full review of Absence Assist Service.

Headlines:

Reduction in Sickness Absence: The aim over the 2017/18 financial year is to reduce the annualised sickness absence rate from 3.64% to 3.30% by the end of March 2018. This sickness reduction equates to 200 less sickness days per month.

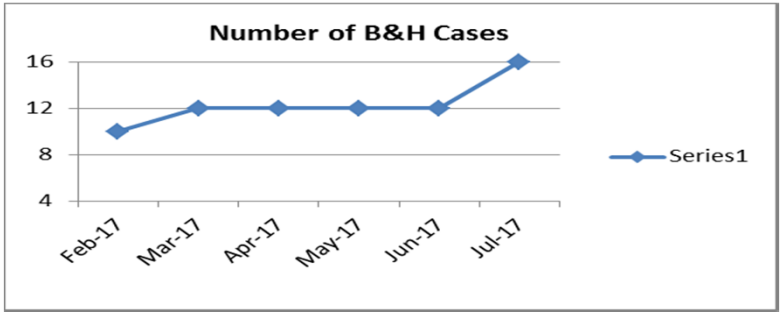
It is estimated that this reduction would support the Divisions in achieving cost savings equivalent to £250k, as a result of the reduced need for temporary staffing cover. Whilst there has been an increased number of days lost due to sickness absence in July 2017; the annualised sickness absence rate was 3.45% which is an improvement from the July 2016 position of 3.61%.

The key actions that have commenced in respect of this sickness absence cost saving plan are;

- Review of policy with operational colleagues. The policy update is required to ensure proactive and consistent management of sickness absence. This update will include a streamlined process.
- Auto-enrolment of LTS cases.
- Focus on hotspot areas.
- Early intervention by Health at Work in respect of musculoskeletal and stress related sickness.
- Direct communications with individuals reaching informal triggers in respect of STS absence.

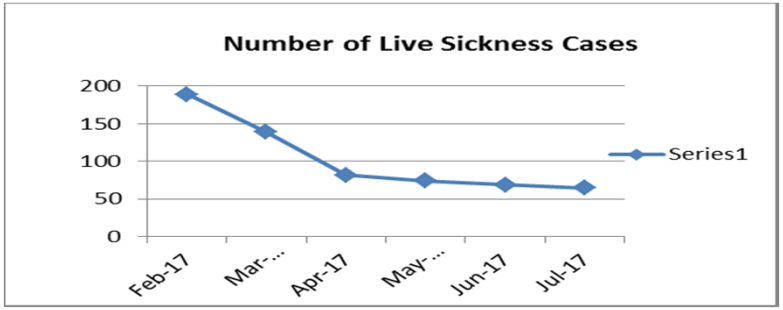
7. Employee Relations

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



Headlines:

- In July, the percentage of employee relations cases within the Trust was 2.23% and within the target range.
- The overall number of live employee relations cases increased from 121 in June to 132 in July 2017 (excluding flexible working requests made as part of direct engagement project)
- There has been an increase of 4 cases in B&H, with 12 ongoing cases as at month end. A Bullying and Harassment Steering Group has now been established with the first meeting taking place on 15th August 2017. We are looking to launch open feedback sessions / forums with effect from September 2017 to increase awareness of bullying and harassment and the support available to staff and managers.
- The team are currently reviewing the Speak in Confidence Service; the contract is due for renewal September 2017.



Management of Sickness Absence:

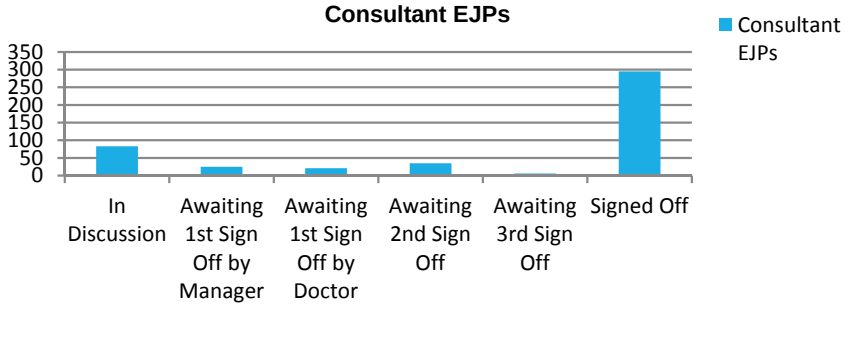
- The number of active cases has reduced due to the manner in which STS cases are being recorded at present.
- All LTS cases over 6 Months are automatically registered with ERAS.
- For STS the ERAS team with HRBPs are targeting hotspots areas using metrics for the highest number of staff reaching the formal triggers.
- The number of ongoing long term cases reduced from 108 in June to 100 in July 2017.; this is a reduction in the overall number of cases for the 2nd consecutive month.

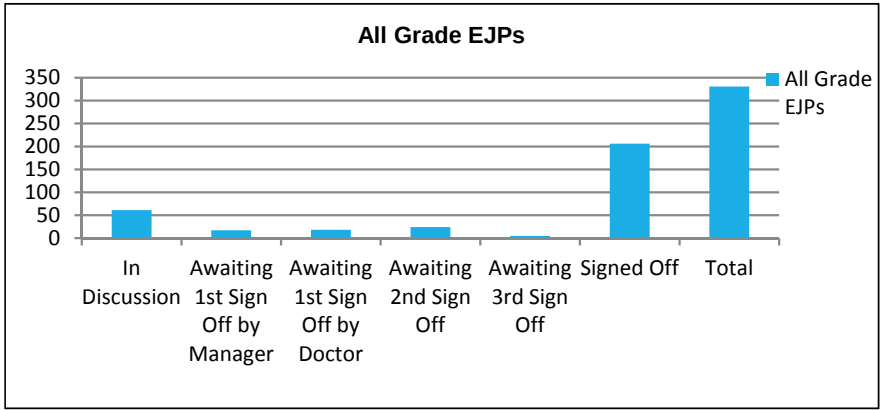
Policy Update

- Review of the sickness absence policy is underway to ensure a more consistent and robust approach. The ERAS Team are currently exploring trigger information and benchmarking against other NHS Trusts.
- Trust Policy for Raising Concerns / Whistleblowing signed off at Trust Partnership in July 2017.
- Amended Work life Balance Policy signed off at Trust Partnership July 2017.
- Review of Dignity and Respect at Work and Disciplinary Policy ongoing – reviewing comments following staff side review.

8. Medical HR: Electronic Job Planning

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





Headlines:
There was a total of 294 Consultant Electronic Job Plans which needed updating and sign off in the 2017/18 Financial Year. There were 37 Electronic Job Plans which require sign of for SAS Grade Doctors. All EJPs were published April 2017 and the timeframe for sign off had been extended to the end of July 2017. The steering group continues to meet weekly to review sign-off progress; chaired by the Medical Director.

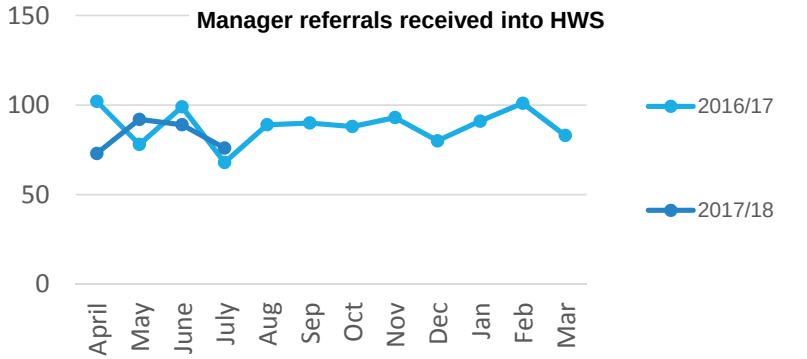
Consultant EJPs:
In July 2017, a significant number have progressed in terms of sign off; significantly reducing the number which had not been reviewed or were at discussion stage. The % that have been fully signed off has increased from 23% as at the end of June to 61% as of 18th August 2017.

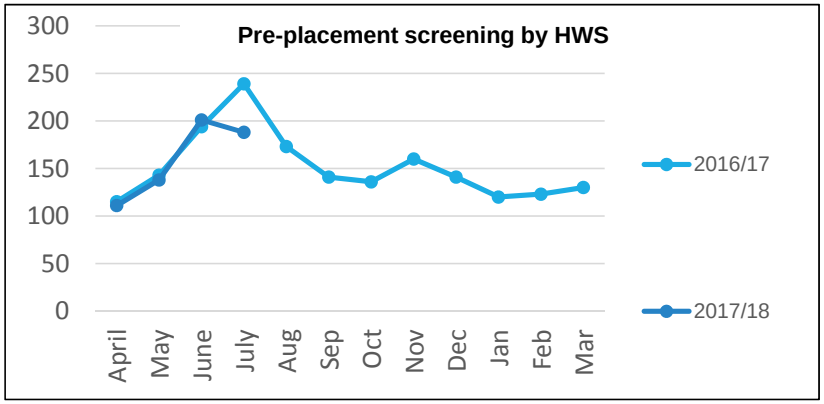
SAS Grade:
The % of SAS Grade EJPs fully signed off has increased from 18.42% as at the end of June 2017 to 42% as of 18th August 2017. There is a reduced number now at discussion stage and an increased number awaiting sign off and manager sign off. It is expected these will progress to formal sign off during August 2017. The EJP Team are continuing to provide additional training in respect of new system and policy and will target any areas where EJP's have not been accessed.

Guardian for Safe working:
Provides quarterly board reports regarding exception reporting, for further information see Appendix 2

9. 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:

Referrals to the Health at Work Service

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

- 76 referrals were received from managers, following attendance in clinic 97.7% of reports were issued within the 2 day target delivery time an improvement of month 3 reports issues within 94.1%.

- 52 employees telephoned the Health at Work Advice line to self-refer to the Health at Work Service, all these staff were offered advice about strategies to optimise their health at work within 1 day of the call.

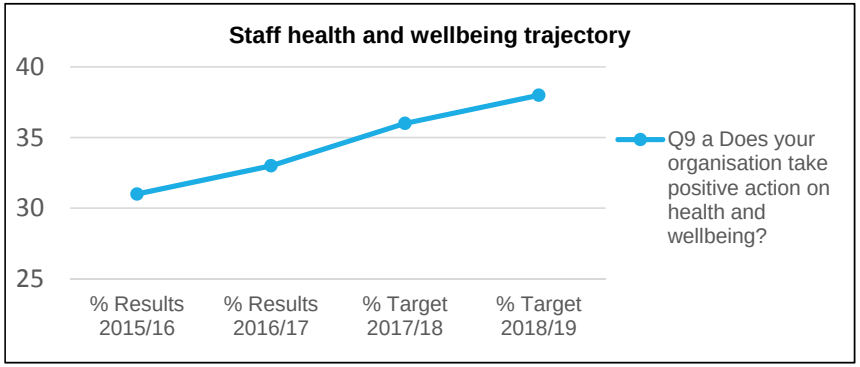
Pre-placement health advice

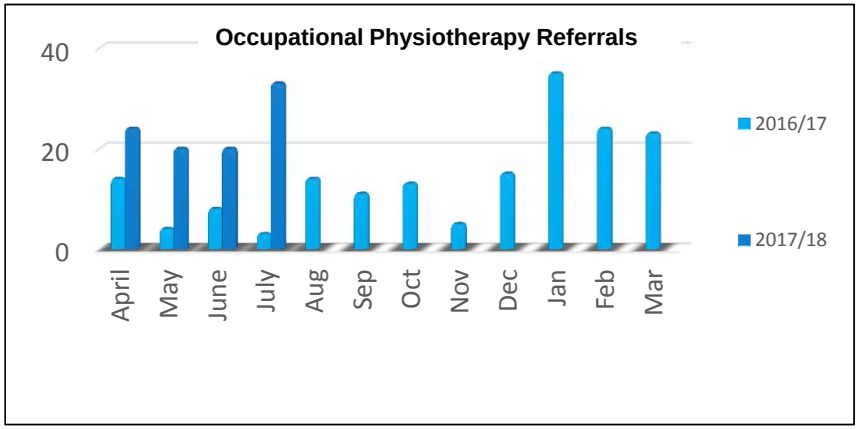
The Health at Work Service (H@W) provides the Trust with fitness for work advice on all new employees following an offer of a post.

188 Preplacement health questionnaires were received in July, 96.2% of pre-placement health clearances were sent within 2 working days .

9b. Staff Health and Well-being

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





Headlines:

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

Trajectory -To achieve a 5% improvement in two of the three NHS annual staff survey questions on health and wellbeing.

Performance:

- SEQOHS (Safe Effective Quality Occupational Health Service) re-accreditation was achieved following assessment visit on 6 July.
- A stand was displayed and attended at the Trust AGM, reflexology and head massages were available as well as information on mental health and wellbeing. On 24th July a ONE YOU event was held at Lister supported by Odyssey Health Club.
- In July, 99 employees experiencing musculoskeletal issues and 25 employees with stress or mental health problems were telephoned by the Health at Work Service on their first day of sickness absence to provide early advice.
- 33 employees were referred for fast track occupational physiotherapy in July.
- In July, 18 employees have telephoned the Trust Employee Assistance Programme, a further 7 have accessed help from the Workplace Options web site.

10. 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.

Fig 1. Workstream Organisation structure

Headlines:

As part of the Trust's Transformation programme and to support the Model hospital agenda and develop a leaner Trust organisation structure, a workforce efficiency programme will develop an organisational design to align the demand, capacity and income of the Trust with more efficient workforce models, within a reduced pay envelope to deliver financial stability and high quality patient care.

Performance:

- The programme involves seven workstreams as detailed in the diagrammatic Fig 1, the full year savings is £4.62 million, the validation by Finance of savings to date is £3.2million
- The programme includes an estimated reduction of substantive posts of 166 wte, the strategy to limit any potential redundancy is the active management of vacancies, fixed term contracts and turnover to reduce the risk to substantive staff; the Executive agreed a MARS programme in August and the WF modelling identified a staff reduction through MARS or redundancy of 30 posts
- The A&C clinical pathway will deliver co-located pods of staff supporting clinical delivery, the full year effect for savings is £1.6million
- The A&C workforce efficiencies programme targets a 10% reduction of staff in scope, the full year effect for savings is £3.02 million
- The establishment of a workstream organisation structure to lead the deliver of improved models and cost improvement and a QIA process, which is reviewed at Programme Board to provide assurance regarding the quality and safety of the plans and savings
- The e-job planning will support improved Medical capacity, this includes the delivery of the 42 week tracker to manage Medic PA capacity and performance

11. Appendices

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1. ERAS Data
2. Medical Staffing Data
3. H@W Scorecard
4. Appraisal Data
5. Training Data
6. Benchmarking

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1. ERAS Data

Source: ERAS	Total Live Cases as at 30-Jun-17	Total Live Cases as at 31-Jul-17	Surgery	Medicine	CSS	Women & Children	Cancer (inc R & D)	corporate
Headcount	5697	5907	1364	1465	924	759	664	731
Number of Disciplinary Cases (excluding medical cases) % = no of cases as % of headcount	16 (0.3%)	20 (0.3%)	5 (0.4%)	6 (0.4%)	2 (0.2%)	2 (0.3%)	4 (0.6%)	1 (0.1%)
Number of Grievances	6	7	0	4	1	0	1	1
Number of Capability cases	3	5	2	2	0	0	1	0
Number of B&H, discrimination and victimisation cases	12	16	2	2	2	1	3	6
Number of formal short term sickness cases including cases under monitoring	13	13	4	2	3	2	1	1
Number of formal long term sickness cases	56	52	15	19	5	5	4	4
Number of *MHPS cases (Medical cases)	1	2	0	2	0	0	0	0
Total number of cases in progress	107	115	28	37	13	10	14	13
Number of suspensions/medical exclusions (inclusive of over six months)	0	0	0	0	0	0	0	0
Number of suspensions lasting 6 months or longer	0	0	0	0	0	0	0	0
Number of appeals	6	10	3	1	0	0	6	0

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2. Medical HR

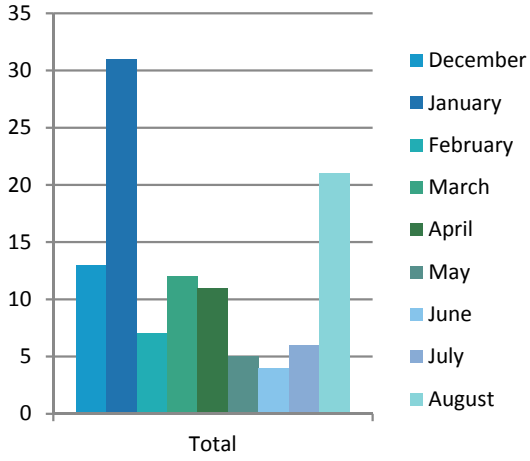
Transition to the 2016 terms and conditions continues, in accordance with the nationally set timetable. As of August 2017, r 80% of the Trust's doctor in training workforce is contracted to the new 2016 terms and conditions. Revising rotas to be 'mixed economy' continues with two rotas under finalisation for October 2017. transition as per the schedule table below.

Rota Revision Schedule Table

Finalised by:	Rota numbers
Dec-16	6
Feb-17	6
Mar-17	3
Apr-17	5
Aug-17	17
Sep-17	2
Oct-17	2
Total	41

Exception Reports

The Guardian of Safe Working Hours last quarterly report was issued in July 2017. Exception report numbers had lessened but August has seen an increase with the higher proportion of doctors on the new contract.



11. Appendices

3. H@W scorecard

		Avg last yr	Last month	This month
Activity	**Trust**			
	Pre placement screened	**151**	201	188
	Manager Referrals received	**89**	89	76
	Immunisations and blood tests given	**365**	370	414
	Health surveillance	**67**	106	97
	Blood borne virus incident (sharps) reported	**13**	7	12
	Phased return to work plan implemented	**24**	50	46
	Self referrals	**20**	60	52
	Manager referrals			
	Cancer	**10**	5	7
	Clinical Support Services	**14**	16	18
	Medicine	**22**	22	19
	Surgery	**20**	20	11
	W&C	**14**	15	14
	Corporate	**8**	11	6
	Total 'live cases' as at 01/08/2017		135	127
	External			
	Pre-placement	**84**	100	59
	Manager referrals	**44**	31	52
	Immunisations and blood tests	**152**	137	135
	Health surveillance	**8**	1	3
	Blood borne virus incident (sharps)	**4**	3	4

Management Referrals		Avg last yr	Last Month	This Month
Staff Satisfaction	Overall % of client satisfaction of HWS	**95.3%**	**96.20%**	**93.21%**
Manager Satisfaction	Overall % of manager satisfaction of HWS	**84.6%**	**90.39%**	**89.51%**

		Last year	Last month	This month
Health & Wellbeing	**Early Intervention - Mental Health (S10)**			
	Episodes of sickness reported to Absence Assist		23	36
	Phone advice offered, manager informed		8	12
	Recently advised following self referral		0	2
	Recently advised following manager referral		1	2
	Unable to contact, manager informed		11	7
	Incorrectly coded/not appropriate		2	2
	Early Intervention - Musculo-skeletal (S11/12/28)			
	Episodes of sickness reported to Absence Assist		98	108
	Phone advice offered, manager informed		40	42
	Recently advised following self referral		3	7
	Recently advised following manager referral		1	4
	Unable to contact, manager informed		19	24
	Incorrectly coded/not appropriate		24	22
	Number of physiotherapy referrals		20	33
	Employee Assistance Programme (EAP) calls			
	Calls to EAP		12	18
	EAP Web hits		25	7
	Influenza vaccination for frontline staff	**63.8% (2927)**		

11. Appendices

3.b H@W scorecard

		Avg last yr	Last month	This month
Performance	**Trust**			
	Pre placement health screening processed within 2 working days of receipt	92%	98.5% 198/201	96.85% 182/188
	HWS advisor appointment within 6 working days following receipt of fully completed manager referral	90%	91.7% 67/73	98.5% 68/69
	HWS Physician appointment within 12 working days following receipt of a fully completed manager referral	84%	60% 6/10	33% 1/3
	Medical report sent within 2 working days of HWS appointment	97%	94.1% 48/51	97.7% 69/71
	External			
	Pre placement health screening processed within 3 working days of receipt	86%	100% 100/100	100% 59/59
	HWS advisor appointment within 6 working days following receipt of fully completed manager referral	80%	88% 24/27	76.5% 36/47
	HWS Physician appointment within 12 working days following receipt of a fully completed manager referral	70%	100% 1/1	0% 0/3
	Medical report sent within 3 working days of HWS appointment	97%	100% 13/13	100% 46/46

11. Appendices

4. Appraisals

Appraisal compliance

Compliance	Done	Not Done	Not due but require review*	Grand Total	Completion Rate % November
Cancer Services	381	28	81	490	**93.15%**
Clinical Support Services	506	75	282	863	**87.09%**
Medicine	729	152	254	1135	**82.75%**
Corporate	455	72	160	687	**86.34%**
Research & Development	53	15	18	86	**77.94%**
Surgery	680	201	145	1026	**77.19%**
Women's and Children's	458	64	90	612	**87.74%**
Grand Total	**3262**	**607**	**1030**	**4899**	**84.31%**

Appraisal by Payband Data

Band	**Done**	**Not Done**	**Not Due But require review**	**Grand Total**	**Completion rate%**
Band 1	101	14	24	139	**87.83%**
Band 2	534	88	237	859	**85.85%**
Band 3	455	73	154	682	**86.17%**
Band 4	312	75	94	481	**80.62%**
Band 5	659	130	237	1026	**83.52%**
Band 6	627	100	140	867	**86.24%**
Band 7	391	65	75	531	**85.75%**
Band 8A	104	31	27	162	**77.04%**
Band 8B	39	12	8	59	**76.47%**
Band 8C	18	4	14	36	**81.82%**
Band 8D	9	5	7	21	**64.29%**
Band 9	2	3	4	9	**40.00%**
SMP	10	7	4	21	**58.82%**
Tupe	1		5	6	**100.00%**
Grand Total	**3262**	**607**	**1030**	**4899**	**84.31%**

11. Appendices

5. Training

Source: ESR	Trust MTH	Surgery	Medicine	CSS	W & C	Cancer	R and D	Corporate
Statutory and mandatory training full compliance (Incl M&D)	64.11%	59.91%	55.04%	71.31%	67.76%	73.47%	72.22%	70.44%
Statutory and mandatory training average compliance (Incl M&D)	87.34%	84.83%	84.31%	90.57%	90.15%	89.02%	91.44%	90.68%

11. Appendices

6. Benchmarking

Trust	Mandatory Training Rate Jun 17	Appraisal Rate Jun 17	Turnover Jun 17	Vacancy Rate Jun 17	In mth Sickness Jun 17	Agency Jun 17
Bedford Hospital	82%	81%	14.45%	8.90%	2.80%	5.90%
Herts Community	90%	85%	14.50%	11.70%	3.80%	8.90%
WHHT	92%	90%	16.10%	13.00%	2.90%	8.00%
East & North Herts	92%	84%	13.20%	9.60%	3.92%	3.80%
Luton & Dunstable	80%	78%	16.22%	13.10%	2.88%	8.50%
HPFT	84%	86%	13.60%	13.70%	4.27%	5.90%
ELF Bedford	84%	75%	16.16%	16.60%	6.75%	12.00%
ELF Luton	84%	86%	17.40%	18.40%	6.49%	7.30%
Princess Alexandra	75%	68%	16.60%	11.10%	3.45%	11.10%
CNWL FT	96%	91%	17.70%	14.70%	3.56%	4.40%
Milton Keynes UFT	91%	87%	13.10%	15.70%	3.89%	8.70%
Average	86%	83%	15.37%	13%	4.06%	7.68%

East and North Hertfordshire NHS Trust

Agenda Item: 9.4

TRUST BOARD PART 1 – 6 SEPTEMBER 2017
Finance and Performance Committee Annual Report 2016/17

PURPOSE	To present the FPC Annual Report for 2016/17 and terms of reference for approval. The report is designed to provide an overview of the Committee's operation, demonstrating the extent to which it has met its terms of reference.
PREVIOUSLY CONSIDERED BY	Finance and Performance Committee (19 July)
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. [X] 2. **Developing new services and ways of working** – delivered through working with our partner organisations [X] **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 element of the Trust's governance and assurance processes.
Healthcare/ National Policy (includes CQC/Monitor)	The production of an annual report is in line with best practice in corporate governance.
CRR/Board Assurance Framework	[ ] **Corporate Risk Register** [ ] **BAF**

ACTION REQUIRED

For approval	✓	For decision	
For information		For discussion	

DIRECTOR:	Chief Executive
PRESENTED BY:	Company Secretary
AUTHOR:	Board Committee Secretary / Company Secretary
DATE:	September 2017

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

Finance and Performance Committee
Annual Review 2016/17

Executive Summary

The Finance and Performance Committee is a key assurance committee of the Trust Board. As set out in its terms of reference, the purpose of the Finance and Performance Committee (FPC) is to support the further development of the financial strategy of the Trust, to review the strategy as appropriate and monitor progress against it to ensure achievement of financial targets, business objectives and the financial stability of the Trust. The Committee reviews and monitors financial plans and their link to operational performance, oversees financial risk management, provides scrutiny and approval of business cases and the capital programme and maintains oversight of the finance function, key financial policies and other financial issues that may arise. The Committee also oversees the IM&T strategy transformation programme which has a focus toward improving data quality and hospital efficiency to ensure the Trust is prepared for the major financial challenges facing the NHS.

This is the annual review of the FPC which considers how it has met its duties under its terms of reference. A review of the Committee's minutes, its reports to Board, a review of the Trust's Standing Orders and Scheme of Delegation and a self-assessment survey of the effectiveness of the FPC was completed by Committee members and attendees and were used to inform this report.

This review concludes the Committee has met its duties and continues to provide challenge, recognising that in considering overall financial performance, in quarter 3 and 4 the Committee moved to a focus on financial recovery and it should strengthen its reporting and consideration on strategic financial risk in 2017/18. Appendix 1 sets out the revised FPC Terms of Reference for consideration by the Committee (the changes are highlighted for ease of reference).

To support the strengthening and effectiveness of the Committee the following recommendations are highlighted from the review:

- Enable greater focus on financial strategic risk and more time to ensure effective scrutiny of performance and data quality and IM&T.

  To support this explore if the presentation of reports could be more succinct to enable greater discussion on the key areas of risk/for focus. The Board and Board Committee cycle has recently been reviewed to support and enable a greater level of data analytics and analysis within the papers; this will be implemented in September 2017.

- Consider how greater discussion could leverage Non-Executive Directors and Executive skills for supporting improvement.

The Committee is asked to:

- Discuss the findings of the effectiveness review and consider any further actions
- Recommend the amended terms of reference and approve this annual review for submission to the Board.

Summary of Key Findings

Meetings and Membership
The FPC met monthly during 2016/17, with the exceptions of August when no Board committees were routinely scheduled. All meetings were quorate under current terms of reference. During 2016/17 there was no change to the position of Chair. Vijay Patel, Non-Executive Director (Designate) retired from the Committee and Trust at the end of January 2017.

Although the NED membership has remained consistent, there have been a number of changes to the executive team and therefore changes at the Committee with four of the key core attendees - Director of Finance, Chief Operating Officer, Director of Nursing and Director of Strategy. Two of these have changed on more than one occasion as Interim support was secured during the substantive recruitment. These are reflected within the Trust annual report.

The efficacy of the FPC has been assessed this year by sending a questionnaire to Committee members and others who regularly attend meetings. Invites to complete the survey were sent to the 15 members of the Committee and regular attendees. Responses were received from 8 people. Key findings were:

- Improvements from the previous year with the quality of reports – in particular with the executive summaries and the finance and workforce papers, allowing more time for discussion.
- Good level of scrutiny on workforce, finance and business cases.
- There has been an improvement on the level of discussion but this could be improved further by encouraging more open discussions with other Committee members other than those members presenting; could leverage Non-Executive Directors and Executive skills for supporting improvement
- There has been limited discussion on the medium and long term financial strategy and strategic financial risk
- A number reflected that more time should be allocated to discussion and scrutiny of performance, IM&T and data quality.

Following the 2016/17 survey and comparing to results from the 2015/16 survey, five areas have been reviewed and developed and identified to support the strengthening and effectiveness of the Committee:

- Improved scrutiny and approval of business cases and oversight of the capital programme
- Improved reviewing and monitoring of the workforce
- Appropriate items are being covered in agendas
- The Committee is listening to members voices
- Discussions are appropriately summarised with clear conclusions

The Committee can evidence that it has met its responsibilities as set out in the terms of reference in the following ways:

Key Financial Areas

Finance Planning
The Trust continued to experience significant financial challenges in 2016/17 delivering a year end deficit of £37.2million against a revised forecast deficit of £24.2m, mainly due to procurement and agency/locum staffing. Despite an incredibly challenging year, the Trust delivered £12.9m CIPs against a plan of £15.5m. Key financial activities monitored throughout 2016/17 included:

<u>Financial reporting</u>

The FPC monitored monthly variances to forecast for income, pay and non-pay expenditure. Throughout the year month-end forecasts were reviewed on a daily basis and the FPC continued to receive monthly updates on the 2016/17 year-end forecast including financial risks. The FPC closely monitored the Trust's monthly cashflow and capital positions.

The Women and Children's division were held to account by the Committee as they had not delivered against plan. The divisional leadership attended the Committee in March 2016 and reported that the three key areas attributing to this underperformance were under performance in CIPs income, maternity income plan assumptions and, changes in activity/lead provider and challenges from neighbouring Trusts in relation to cross charging. It was established that an improved number of short stay patients, use of Grip & Control together with planning realistic budgets, would see improvements during 2017/18.

Financial Planning 2016/17 and 2017/18

The FPC considered and approved the final budget of the financial plan 2016/17. In Month 3 the FPC recognised the requirement for an overall financial recovery plan for 2016/17. The FPC continued to vigorously monitor monthly updates on the financial plan for 2016/17. As activity and income were not aligned, the financial recovery plan was put into place. During the same period, the Trust identified it had been wrongly advised and mistakenly over-claimed VAT in the region of £3.4m. This was rectified and self-reported to HMRC; however, the risk remained and the Trust could still incur a penalty in the region of £1m. This did not materialise. The FPC supported appointing an external consultancy in order to help improve theatre utilisation/efficiencies. The FPC supported further refinement to the format of the financial report, allowing for informative analysis in a number of key areas, prior to the 2017/18 financial reporting. In March 2016, the Trust reported a £29.5m delivering the year end forecast agreed with NHSI. The 2017/18 and 2018/19 financial plan has been discussed with NHSI.

Floodlight scorecard

The FPC continued to monitor the Trust's monthly floodlight scorecard in detail. From Month 1 the FPC requested a revised dashboard enabling targets and monthly accumulative trajectories in order to provide greater detailed information. Due to a number of competing priorities and changes in the information team this had not been completed in full, although a business intelligence model has progressed. Developing a new integrated performance report is a focus for 2017/18.

Agency expenditure

The FPC continued to undertake a robust scrutiny of monthly agency expenditure.
Throughout the year, agency expenditure has continued to reduce as in-house bank recruitment has continued to grow and internal control measures have taken effect. The Trust now has a central control desk with Executive sign off prior to agency staff being appointed. A pilot recruitment drive for staff from India and the utilisation of Philipino agencies has taken place since month 4 with success. There has been a significant number of agency to bank migrations. The Trust has also focused on enhanced flexible working.

Income recovery

The FPC continued to receive regular updates on the income assurance plan for revenue capture and recognition. Income recovery would continue to be a key area of scrutiny in 2017/18 with Grip & Control being key.

The Pathology Partnership (TPP)

The FPC undertook rigorous monthly observation of TPP performance discussing accounting, treatment and workforce management. The clinical risks were reviewed by RAQC. The FPC noted an immediate improvement in KPI performance whilst delivering an improved service. Month 3, the Trust received formal notification of Cambridge University Hospital withdrawing from tPP as the host shareholder in July 2017. The FPC have overseen the transition plans, seeking advice from lawyers on legal aspects of the contents and proposals.

IM&T Strategy/Lorenzo

The FPC continued to monitor development of the Trust's IM&T Strategy together with possible risks. Following a major incident in May 2017, the deployment date of Lorenzo was delayed once again, due to a major incident, until 8 September. In February 2017, the Chief Information Officer replaced the Head of Information as project lead. All risks have actions to mitigate the risks and a successful pilot has taken place on Bluebell to implement Nervecentre. Further pilots have taken place in ED. A dress rehearsal will take place prior to deployment together with a training programme taking place across the organisation.

Procurement
The FPC continued to monitor progress against savings targets, tender waivers and key strategic tenders. The introduction of the Grip and Control programme has seen cash savings. Divisions are identifying where changes can be made and taking action. Department of Health initiatives, tender waivers and key strategic tenders were aligned with recommendations of the Lord Carter Review and a Carter Procurement plan was submitted in October 2016.

Lord Carter Review
In April 2016 a programme board was established to monitor 15 recommendations for bi-monthly scrutiny via a strategic project with good progress being made across all recommendations.

Lister Hospital Pharmacy Transformation Plan
The FPC approved the plan to transform the Pharmacy enabling an improved service to patients, including safer working practice. There will be a focused on ward based staff providing a face-to-face service.

Further key financial areas of scrutiny included:

- Regular meetings with NHSI to ensure that an effective recovery programme is in place and being actioned;
- Continued monthly progress reports on data quality;
- The Trust's Cost-Improvement Programme 2016/17.

Performance
The FPC scrutinised performance data during 2016/17. Key headlines included*:*

- ED Performance
  A&E attendance showed a sharp rise from February to March 2017, with no obvious reason. Admissions showed a 22% rise in March 2016. At 2016/17 year end, although ED Performance indicated small improvements, it continued to under achieve the 4 hour targets and failed the STF improvement trajectory. With the review of the ED pathway and continued work within the divisions, this is expected to improve for 2017/18.

- RTT performance
  Ambulance handover time was down to 15 minutes, the highest achiever nationally. A review of the RTT open pathway plan and validation programme took place and upward trajectories have been seen. During March 2017, the Trust migrated to a new PTL for RTT in preparation for the Lorenzo change over in September 2017. During this transition data quality has been significantly improved which will allow for an improved streamlined pathway in September 2017.

- Stroke performance continued to improve across a range of indicators
  The Trust failed to meet the, 4 hour direct to stroke unit targets for the majority of the year. The stroke service is becoming an increasingly busy service with taking patients from PAH and is moving towards nurses having authority to request CT scans to improve the pathway process. Performance against standards has improved and SSNAP category A rating achieved.

- Cancer targets were met with the exception of the 62-day wait from referral to first definitive treatment
  In September 2016 the commissioners endorsed the implementation of the 62-day Cancer Referral to Treatment Cancer Action Plan. Challenges to Cancer performance were exacerbated by the high volume of backlog patients. In January 2017, the Patients' Tracking List (PTL) system was rebuilt enabling greater oversight of the patient pathway.

- Theatre usage
  Following the engagement of Four Eyes Insight external consultants, a review of theatre usage and pathway has seen a significant improvement in performance in 2016/17.

Data Quality Metrics
From April 2016 reports have been presented to the FPC each month in a new format giving accuracy of data, service delivery and patient flow. An improved depth of coding indicates that the Trust has out-performed the national average. There has been an improvement programme in place focusing on ED, W&C and Clinical Coding. Key areas have been BIMS to PAS and Maternity service data capture. In January 2017 an external review was provided by Deloitte consultants that reported that both significant activity and tariff increases were highly likely due to an improvement in activity capture, coding and/or patient case mix changes. The report also gave recommendations on improving completeness and accuracy of data quality, this lead to the Chief Information Officer developing a Data Quality Improvement Plan that is being built into the Lorenzo Transformation Programme. This will be monitored through 2017/18.

Workforce

The FPC scrutinised workforce data during 2016/17. Key areas of focus included:

- Temporary staffing, including continued challenges to deliver reduced temporary and agency staffing usage, the Trust's approach to implementation of the agency price caps by the NHSI and conversion of agency to bank staff through incentivising bank shifts and automatic transfer to bank when staff either left the Trust or required flexible working patterns.
- Staff retention to mitigate high turnover rates;
- Reducing vacancy rates/staff turnover;
- Overseas staff recruitment from the Philippines and India including implementation of a re-settlement package;
- Initiatives to reassure and support staff to raise concerns including the 'Freedom to Speak' and 'Zero Tolerance to Bullying and Harassment' schemes;
- Increased focus on staff development and leadership/coaching;
- Improved internal communications;
- Working with colleagues from UCLH to launch the 'Never Lose a Nurse' campaign.

The Trust's Q4 2016/17 'Staff, Friends and Family' test results proved to be the most positive since the scheme commenced in April 2013, moving the Trust out of the bottom quartile. 339 responses were received with 75% of staff stating that they would recommend the Trust for care or treatment and 57% of staff would recommend the Trust as a place work.

In November 2016, the Trust was rated, by the British Medical Association, as one of the best in the region for keeping junior doctors updated with information.

Other duties

Market Report
The Committee received quarterly market reports providing a summary of the Trust's market and competitive position, including: indicating increased GP referrals and, the financial positions of the majority of neighbouring acute Trusts and CCGs, continues to deteriorate.

Sustainability

The Trust gave approval for a Salix Finance bid to replace steam traps on the Lister site in June 2016, in order to save over the next 10 years and reduce emissions.

Strategic Projects

The FPC continued to monitor the Trust's Strategic Projects throughout 2016/17 and endorsed a revised format for monitoring in March 2017.

Reporting Arrangements

The committee considered financial, performance and workforce information through the individual reports at each meeting. The Committee Executive Summary reports to Trust Board demonstrated that it had reported key areas, including risks to the Board after each meeting.

The FPC actions log provided a clear audit trail of agreed actions as well as closure of those actions. It was monitored by the Committee at each meeting. Actions referred to FPC by Trust Board and the Audit Committee were added to the FPC actions log and monitored through to completion by the Committee.

A number of items have moved from completion for their original timeline this last year, potential reasons for the delays have been competing priorities and a number of significant changes to the executive team.

Conclusion

The overall conclusion was that the Committee had discharged its duties under its terms of reference during the year 2016/17 but recognises it should strengthen its reporting and consideration on strategic financial risk in 2017/18 and enable balance of time across all agenda items. The FPC terms of reference were last reviewed and approved in June 2016 and have been updated to reflect this.

The minutes demonstrated clear challenge and questioning to gain assurance. Progress throughout the year was well documented and discussed at Trust Board and Finance and Performance Committee meetings.

To support the strengthening and effectiveness of the Committee the following recommendations are highlighted from the review:

- Enable greater focus on financial strategic risk and more time to ensure effective scrutiny of performance and data quality and IM&T.

  To support this explore if the presentation of reports could be more succinct to enable greater discussion on the key areas of risk/for focus. The Board and Board Committee cycle has recently been reviewed to support and enable a greater level of data analytics and analysis within the papers; this will be implemented in September 2017.

- Consider how greater discussion could leverage Non-Executive Directors and Executive skills for supporting improvement.

The Committee is asked to note the Annual Report and consider the revised terms of reference (Appendix 1) prior to approval by Trust Board.

FINANCE AND PERFORMANCE COMMITTEE

TERMS OF REFERENCE

1. Purpose

The purpose of the Finance and Performance Committee is to support the further development of the financial strategy of the Trust, to review the strategy as appropriate and monitor progress against it to ensure the achievement of financial targets and business objectives and the financial stability of the Trust.

This will include:

- overseeing the development and maintenance of the Trust's medium and long term financial strategy;
- reviewing and monitoring financial plans and their link to operational performance;
- overseeing financial risk management;
- scrutiny and approval of business cases and oversight of the capital programme;
- maintaining oversight of the finance function, key financial policies and other financial issues that may arise.

The Committee will also oversee aspects of the underpinning activity performance of the Trust, along with responsibility for the IM&T strategy transformation programme to improve data quality and hospital efficiency to ensure the Trust is prepared for forthcoming major financial challenges facing the NHS.

2. Status & Authority

The Committee is constituted as a formal committee of the Trust Board and is authorised by the Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the committee.

3. Membership

Three Non-Executive Directors, one of whom will be nominated as Chair

Core Attendees:

Chief Executive
Director of Finance
Chief Operating Officer
Director of Strategy
Chief People Officer
Director of Nursing
Company Secretary

Attendees:

Director of Workforce
Deputy Medical Director
Chief Information Officer

All other Non-Executive Directors/Directors are welcome to attend

Other staff will be invited to attend to present an item to the Committee or to support their personal development with the prior agreement of the Committee Chair.

If a conflict of interests is established, the above member/attendee concerned should declare this and withdraw from the meeting and play no part in the relevant discussion or decision.

4. Quorum

Two Non-Executive Directors and two core attendees one of whom should be either:

- Director of Finance or in their absence
- Chief Executive and a designated Finance representative

5. Frequency of meetings

The Committee will meet every month and prior to Trust Board meeting. The Chair of the Committee may convene additional meetings if required to consider business that requires urgent attention.

6. Duties

6.1 Financial Planning

Act as an Assurance Committee of the Trust's business and finance risks through the following activities

To determine or approve:

- the Trust's Marketing strategy and review and monitor progress against this
- Individual investment decisions including a review of Outline and Full Business Cases between £500k and £1 million

To recommend to the Board:

- the Trust's ~~5 year~~ Integrated Business Plan, develop and approve a financial framework to support the delivery of the Trust's strategic objectives;
- the Medium Term Financial Strategy including the Long Term Financial Model and recommend its adoption to the Board;
- Approve proposals for the reinvestment of any surpluses generated by the Trust in undertaking its operational activities and recommend to the Board;
- Receive the annual plan and budgets for revenue and capital and recommend adoption by the Board;
- For investment decisions or schemes in excess of £1 million, the Committee will make a recommendation to the Trust Board, who will ultimately make a decision on the proposal;
- Recommend the Cost Improvement Programme to the Board and refer any potential concerns on quality to the Risk and Quality Committee for scrutiny.

To monitor and review:

- Enabling strategies and their impact on the Medium Term Financial Strategy including the Long Term Financial Model;
- The capital programme and work of the Investment Scrutiny Committee;
- The development of the annual Cost Improvement Programme and oversee development of the rolling programme that is to be incorporated into the Long Term Financial Model and monitor in year delivery;
- Value for money and efficiency issues as required to ensure problem areas are addressed and action taken as appropriate;
- The further development of service line reporting within the Trust;
- Progress against the System Transformation Plan

- The development of financial forecasts and measures taken to promote financial sustainability.

6.2 Investments

To recommend to the Board:
- A Treasury Management Policy including delegated arrangements and recommend its adoption by the Board;

To monitor and review:
- Reports as appropriate from the Director of Finance on transactions undertaken on behalf of the Trust.

6.3 Performance

Regularly review the performance of the Trust against financial performance targets as described in the NHS Performance Management Framework (NHS Trust). This review should include:

To determine or approve:
- In conjunction with the Audit Committee agree the timetable for the Annual Accounts and receive the External Auditors report and review and monitor the associated action plan.

To recommend to the Board:
- the application of contingency funding where appropriate;
- To recommend to the Board Review the performance of the Trust against the NHS Improvement (NHSI) Performance Framework, Monitor Risk Assessment Framework and Department of Health Outcomes Framework and local priority measures on the Trust's Floodlight Scorecard;

To monitor and review:
- Financial performance in relation to both the capital and revenue budgets;
- Financial performance in relation to activity and Service Level Agreements;
- Financial performance in relation to sensitivity analysis and the risk environment;
- To commission and receive the results of in depth reviews of key financial issues affecting the Trust;
- To monitor the progress of the Trust's strategic projects.;
- To monitor the benefits realisation of major projects;.

6.4 Other duties

To determine or approve:
- The data quality matrix and monitor delivery against the indicators;
- the Trust's Sustainability Development Management Strategy and plan and monitor progress to ensure national requirements are met

To recommend to the Board:
- the Information Management and Technology Strategy and monitor the implementation against the implementation plan;

To monitor and review:
- The workforce strategy and key indicators in relations to finance and performance
- Procurement activities, progress against savings targets, tender waivers and key strategic tenders.

6.4 Financial Risk Reporting

The Committee will regularly receive financial risk register reports for review and consider with the appropriate escalation to the Trust Board and for incorporation within the Board Assurance Framework

7. Reporting arrangements

The Committee will identify and report the key issues requiring Board consideration to the Trust Board after each meeting.

It will make recommendations to the Board, Executive Team and Executive Directors for these groups/individuals to take appropriate action.

8. Process for review of Committee's work including compliance with terms of reference

The committee will monitor and review its compliance through the following:

- The Committee report to Trust Board;
- FPC annual evaluation and review of its terms of reference.

9. Support

The Company Secretary will ensure the committee is supported administratively and advise the Committee on pertinent areas.

Reviewed July 2017.

East and North Hertfordshire NHS Trust

Agenda Item:11

TRUST BOARD PART I – 6 SEPTEMBER 2017

CHARITY TRUST COMMITTEE – 4 SEPTEMBER 2017
EXECUTIVE SUMMARY REPORT

PURPOSE	To present to the Trust Board the report from the Charity Trust Committee meeting of 4 September 2017
PREVIOUSLY CONSIDERED BY	N/A
Objective(s) to which issue relates *	[x] 1. **Keeping our promises about quality and value** – embedding the changes resulting from delivery of Our Changing Hospitals Programme. [x] 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 CTC
PRESENTED BY:	Chairman of CTC
AUTHOR:	Corporate Governance Officer/Company Secretary
DATE:	September 2017

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

CHARITY TRUSTEE COMMITTEE MEETING HELD 4 SEPTEMBER 2017

SUMMARY REPORT TO BOARD – 6 SEPTEMBER 2017

The following members were present: Bob Niven (Committee Chairman), Kate Lancaster (Director of Strategy), Martin Armstrong (Director of Finance), Carolyn Fowler (on behalf of Director of Nursing)

Key Decisions made under delegated authority:

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

Cancer Services Reports:

1. **Voluntary Services and Community Engagement at MVCC Charitable Funds Report**

The CTC received a report which summarised the activity of the Community Engagement Department at Mount Vernon Cancer Centre over the past 14 months and provided a review of the activities against the objectives set out in the last report to CTC in May 2016. The report also detailed plans for the next seven months until 31st March 2018 and included an application for charitable funds for a continuation of funding beyond March 2018 (including staffing costs and the reimbursement of volunteer expenses). There was some discussion regarding how performance against objectives would be measured. The Committee also discussed the importance of ensuring there was an effective link with the trust-wide engagement team. The CTC approved the proposal, subject to the funding coming from the MVCC general fund and to a commitment to continue to ensure the continuation of close working between the community engagement department at Mount Vernon with the Trust wide team and the production of a short report on formalising that process being provided for the next meeting.

2. **John Bush Legacy Proposal**

The CTC received 3 proposals for funding for the John Bush Legacy. These had been identified by staff at MVCC. The proposals were:

1. Clinical Research Posts (application total expenditure: £500,000)

The proposal was to improve patient access to clinical research by funding members of staff to expand and promote the portfolio of available clinical trials for cancer patients. The application stated that a research-active culture can bring a host of benefits for patients, driving innovation, giving rise to better and more cost-effective treatments and creating opportunities for the development of better patient outcomes overall.

2. Ambulatory Care Unit (application total expenditure: £150,000 John Bush Legacy and £150,000 to be fundraised for)

The proposal was to form an ambulatory care unit on the current Marie Curie Ward. This would allow some conditions to be treated without the need for an overnight stay in hospital. There would be a number of positive impacts on patient experience.

3. John Bush Research Suite MVCC (application total expenditure: £50,000)

The monies would be spent to support the refurbishment of a clinical research area on ward 10 at MVCC. Research patients were currently seen within the standard clinic as there was no dedicated research space to see them. This had a negative impact on patient experience due to a lack of clinical room availability, resulting in longer waiting times.

A fourth application (not in relation to the John Bush Legacy) was also received:

4. Application for the purchase of a laser system for the new Siemens MRI scanner (£36,450) donated by the Paul Strickland Scanner Centre
The proposal had previously been considered by the CTC but a lower cost had now been secured.

The CTC discussed whether these proposals were deemed to be of greatest need and whether using the funding for capital expenditure had also been considered. The CTC supported the proposal for clinical research posts on the basis that a strategy was developed for the remainder of the MVCC funds, giving consideration to the possibility of their use for capital expenditure. This proposal would be referred to Trust Board (as Corporate Trustee) for final approval on account of the sum requested.

Regarding proposal 2 (Ambulatory Care Unit), it was agreed that a business case should first be scrutinised by the Business Development Committee and reconsidered at the next CTC meeting following that process.

Proposals 3 (John Bush Research Suite) and 4 (purchase of a laser system for the new MRI scanner) were approved.

Capital Approvals for expenditure over £5,000
The CTC received a report detailing four significant bids for support for capital expenditure. The subject of the bids had been considered as part of the Trust's capital planning process. Although there had been compelling cases for each scheme in terms of benefits for patients and overall benefit to the services provided by the Trust, the availability of internally funded capital resources was such that only schemes with the highest risk to patient safety or service delivery could be carried forward. The bids were for:

SPE-CT at Lister (capital cost £675,000)
Hertford X-Ray room (capital cost £260,000)
Emergency department portable ultrasound machine (capital cost £35,000)
Labour ward portable ultrasound machine (capital cost £15,623)

It was confirmed that all four bids met the tests for public benefit and were in line with the Charity objectives. The CTC noted that the paperwork supporting these applications was incomplete in places. They supported the applications on the basis that the paperwork was retrospectively completed. The application regarding the SPE-CT was referred to Trust Board for approval on account of the sum involved.

The CTC also considered the following application for expenditure:
Extended Pharmacy Education and Training to support the Hospital Pharmacy Transformation Plan (£17,250).
The funding would accelerate the transformation programme which would otherwise take longer to deliver efficiencies and improvement in patient experience. The Committee supported the proposal but considered it would be beneficial to undertake a piece of work to establish a framework at the start of each financial year to establish what the funding priorities would be for the Charity for that year. The application was approved.

Other outcomes:

Investment Portfolio Update
The CTC received an update from the investment advisors (Rathbones). From 13 July 2016 to 31 July 2017, the portfolio had returned 13.5% compared to the benchmark which had returned 12.8%.

CSS Divisional Fund Management Report
This report was not received. The item was deferred to the next meeting.

Charity Management Team Update
The Head of Engagement presented the Charity Management Team Update. The report included details of the revised approvals process, updates regarding risks relating to the charity and work that was taking place to ensure the Charity would be fully compliant with the new General Data Protection Regulation (GDPR) that was due to come into effect in May 2018. The Committee were also informed that, following a thorough recruitment and selection process, an offer of employment had been made to appoint a new Head of Charity. It was anticipated that the new Head of Charity would take up post in November.

Charity Finance Report
The CTC received a report regarding the financial performance of the Charity to 30th June 2017 (Month 3) and a verbal update for Month 4. It was agreed that the quality of the finance reports was much improved on previous versions. The Committee noted the report.

Draft Charity Annual Report and Accounts 2016/17 and External Auditor's Report
The Committee received the draft Charity Annual Report and Accounts 2016/17 and draft External Auditor report. External Audit had identified one material misstatement which had been corrected in the financial statements and was in relation to legacy income being recorded in the incorrect financial year. The legacy had been received in July 2017. The Annual Report and Accounts would need to be updated to the audit opinion of the treatment of the legacy. The audit work in respect of the financial statements for the year that ended 31 March 2017 had been substantially completed and the External Auditors anticipated issuing an unqualified audit opinion on the financial statements.

The Committee approved the Charity Annual Report and Accounts for 2016/17 subject to the final amendments referred to above. The final versions would be presented to the Board for approval once the amendments had been made.

2017/18 Financial Plan
The CTC received the 2017/18 Financial Plan. The paper outlined the Charity's income and expenditure plans for 2017/18 which would be used to formulate the Charity's budgets for the year. It was noted that the plan would need to be updated regarding legacies. The Committee noted the report.

CTC Annual Review and Review of Terms of Reference
The Company Secretary presented the CTC Annual Review and review of the Committee's Terms of Reference. The Committee noted the findings of the report, including areas highlighted for consideration to further strengthen the Committee's performance. The Committee agreed that an upper limit of £500,000 for approvals of charitable funds schemes should be added to the Committee's Terms of Reference.

Above this level approval from Trust Board would be required. Subject to this amendment, the CTC recommended the report to Trust Board for approval.

A copy of the report is attached.

Charity Structure / Strategy Annual Review
The Committee received the draft Strategy for the Charity for 2017-2020. This had been developed following a strategy away day in April. The strategy aimed to further develop the Charity into a high performing operation providing the best support to the Trust's patients and hospitals. The strategy was a high-level statement of intent and would be supported by a more detailed three year action plan. It was the intention for the final proposed strategy to be considered at the Board Development meeting in October, reflecting any comments received from CTC members and others in the intervening period. The CTC supported the draft strategy.

Bob Niven
CTC Chair

September 2017

Agenda Item: 11.1

TRUST BOARD – 6 SEPTEMBER 2017

Charity Trustee Committee Annual Report and Review of Terms of Reference

PURPOSE	To present the 2016/17 annual review of the Charity Trustee Committee
PREVIOUSLY CONSIDERED BY	CTC 4 September 2017 - Annual report endorsed with the inclusion of an upper limit for authorisation of funds.
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)	Key aspect of the Trust's assurance process
Healthcare/ National Policy (includes CQC/Monitor)	The production of an annual report is considered to be best practice and is in line with the recommendations made in the Charity Trustee Committee Handbook.
CRR/Board Assurance Framework *	[X] **Corporate Risk Register** [ ] **BAF**

ACTION REQUIRED *

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

DIRECTOR:	CHIEF EXECUTIVE
PRESENTED BY:	COMPANY SECRETARY
AUTHOR:	BOARD COMMITTEE SECRETARY / COMPANY SECRETARY
DATE:	AUGUST 2017

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

***** tick applicable box

Charity Trustee Committee
Annual Review 2016/17

EXECUTIVE SUMMARY

As set out in the terms of reference the Charity Trustee Committee (CTC) is a committee of the Board in its role of Corporate Trustee and with responsibility:

- to ensure a robust strategy for the delivery of the Charity aims and objectives;
- to champion the Charity and its development, providing leadership both within the Trust and externally;
- to provide stewardship of charitable resources and ensure compliance with relevant legislation, guidance and Trust policies.

This is a delegated duty carried out on behalf of the East and North Hertfordshire NHS Trust, which is the sole *Corporate Trustee* of East & North Herts Hospitals Charity (registered charity no. 1053338).

This is the annual review of the CTC which considers how the Committee has met its duties under its terms of reference. A review of the minutes and reports to Board, and a review of the Trust's Standing Orders and Financial Instructions have been used to inform this report.

The efficacy of the CTC has been assessed this year by sending a questionnaire to Committee members and others who regularly attend meetings. Key findings were:

Strengths:

- All respondents felt able to challenge the Trust at meetings and felt that there are enough open discussions with other Committee members other than those presenting;
- The majority of the time respondents felt that discussions are summarised and the conclusion is clear.

Areas to consider:

- Although recent improvements in the reports submitted to the Committee were acknowledged it was felt that there could be a higher degree of focus to the executive summary and continued development of the financial reports;
- Promote and champion the charity both internally and externally, this would also support delivery of the strategy and strengthen internal governance at a divisional fund management level and consideration for future fundraising;
- Enable more time to the development and delivery of the charity's strategy. *The new strategy is due to be considered and approved at CTC September 2017.The awaydays to support the development of the strategy were commended.*

The overall conclusion of this annual review is that the Committee has discharged its duties under its terms of reference during 2016/17. The CTC continues to champion and raise awareness of the Charity and its development, both externally and within the Trust, provides stewardship of charitable resources and ensures compliance with relevant legislation, guidance and Trust policies.

The Committee and team are committed to continue to strengthen the Charity through implementation of the strategy, and further developing reporting and governance arrangements during 2017/18.

The Board as Corporate Trustee is asked to note the report and approve the revised terms of reference which have been reviewed and an upper authorisation limit of £500,000 has been set of the Committee, (appendix 1 attached).

SUMMARY OF KEY FINDINGS

Meetings and Membership

The CTC met four times during 2016/17 and all meetings were quorate under current terms of reference. The position of Head of Hospital Charities has remained vacant since the sudden departure of the previous post holder in November 2016. The Head of Engagement has taken on the role during this interim period until such time the post is filled (recruitment in progress). Membership attendance was recorded in the Trust Annual Report; no issues were identified. The minutes demonstrated where scrutiny and appropriate challenge had been presented during meetings.

The Committee can evidence that it has met its responsibilities as set out in the terms of reference in the following ways:

Strategic

Charity Governance
The CTC ensured policies and procedures were in place to allow the effective day-to-day management of The Charity and its funds.

In May 2016 the Committee approved the draft Charity Strategy 2016/17 for submission to Trust Board in September. The Charity Strategy 2016/17 outlined the key financial objective to achieve a gross annual income of £1.2M by March 2017 against a spend of £1.2M.

In September 2016 changes took place regarding the staff structure so that the Head of Charity is now line manager for each fundraiser. Due to reduced management capacity following the unexpected departure of the Head of Charity, the priority for delivering the 2016/17 strategy was the achievement of the headline financial targets:

- To induct and support the new Head of Charity and Lister-based Fundraiser to ensure both are prepared to increase income as soon as possible.
- To revise the staff structure from 1 April 2016 to ensure all Charity staff, with the exception of the Charitable Funds Accountant, are responsible to the Head of Charity.
- To strengthen the profile of the Charity both internally and externally. This involved re-branding the Charity, creating a new website and improving the Charity's social media presence.
- To improve donor data capture at the point of donation so donors can be promptly and accurately thanked
- To implement the new Harlequin database system, ensuring all staff are utilising it in order to capture donor details and increase the Charity's opportunities to secure repeat gifts.
- To clarify the situation around other Charities fundraising on the Lister hospital site.

The financial plan for 2016/17, giving priority for the development of the Charity moving forward were:

- appoint a head of fundraising with responsibility for delivering a site specific fundraising strategy focussing on trust applications and legacies as the more cost-effective methods of fundraising;

- delivering improved marketing for the Charity to make fundraising easier

- revised charity strategy

Charitable Management Team (CMT) Meetings

The CTC received regular updates on activities of the Charity Management Team (CMT) meetings, which take place once a month to ensure the Charity's strategic key performance indicators (KPIs) are being met. In May 2016 the interim Head of Charity departed and a new fund raiser was appointed at Lister Hospital. They had approved funding for Micro MOSFET detectors for brachytherapy and funding for the development of a Trust Staff Choir.

In May 2016, the budgeted expenditure on raising funds was £400k out of a budgeted £1.2m income. This equates to 33p in the £1, a ratio of 1:3 or 33%. The Committee agreed to an annual key performance indicator (KPI) of 'expenditure on raising funds' of no more than 25p in the £1; a ratio of 1:4. This meant that the annual charitable overheads should be no more than 25% of annual income. This could then be sustained and further improved upon in 2017/18.

The Committee were informed that a legacy of £240k had been bequeathed to Hillingdon Hospitals Charity and a quarter to 'Mount Vernon Hospital', the Mount Vernon Hospital share being for the purposes of treating leukaemia.

Divisional Fund Management Reports

Throughout 2016/17 the CTC received divisional fund management updates on charitable activities from Surgery, Women & Children, Clinical Support Services and Medicine. The reports provided the Committee with information on what divisions were delivering well in terms of use of charitable funding and what was proving more challenging with reasons and next steps. The Charity supported consolidation of small funds and recognised there is further work to do in engaging fund managers to use the donations and with Divisions to seek further fundraising opportunities.

Annual Report and Accounts 2015/16 and 2016/17

In May 2016 the CTC approved the Annual Report and Accounts for 2015/16.

The targets for 2016-17 continued to be ambitious and challenging:

• To raise at least £1.2m
• To recruit and induct a new Head of Charity and Hospital Charity Fundraiser
• To continue the Magic of Play Appeal
• To continue the Forget Me Not appeal to support more patients with dementia
• To develop a number of smaller projects at MVCC for which supporters could fundraise
• To deliver a robust strategy enabling the Charity to develop a robust income base for the future.

The Trust received payments for recharges to the end of September 2016 with quarterly payments thereafter in the sum of £396,580.11.

At the time of writing the Annual Report had not been considered by the CTC. The external audit of the Annual Report and Accounts is scheduled to commence 21 August 2017.

Investment Policy and Portfolio

A tender process was held in 2016 to review the Trust's investment advisors and Rathbones were successful in this regard. At the end of June, the Trust closed the account with investment advisors, 'Investec Wealth and Management' and an account with Rathbones was opened on 1

July. The full transfer of the portfolio was completed by September 2016. The CTC received quarterly updates from the Trust's investment adviser on the Charity's portfolio.
In March 2017 the Committee were advised that the Charity Accountant reported a lower than expected dividend had been received last month. At this time, the Charity had chosen the pooled fund option for investment. Following discussions on the Charity's current financial position it was agreed that no draw-down would be necessary at this time.

Operational

Charity development
The minutes and papers demonstrate a range of fundraising activities for campaigns such as the ongoing Forget-Me-Not Appeal, a fund raising campaign to improve the Trust's care for patients with dementia, and the Butterfly project which provides one to one compassionate listening, comfort and companionship for patients in the last few days and hours of life, particularly for those with few or no visitors who would otherwise be alone.

Income activity
The CTC received regular updates on top line income activity and progress of the Charity to meet the income plan 2016/17.

Although a challenging year for operational management the final income target was surpassed at £1.2m

Activities during 2016/17 included:

- Trust Patient Wi-Fi went live on 24 May 2016;
- community-led fundraising with Rotary and Lions clubs;
- Bruce Springsteen tribute concert;
- 'Fairies in the Garden' family festival;
- community golf day.

Corporate successes included opportunities with Sainsburys, law firm Debenhams Ottaway and the Hertfordshire Festival of Music.

Approvals of Expenditure Over £5k
During 2016/17 the CTC reviewed and endorsed funding requests for the following from charitable funds:

- £120,242 - (subject to clarification of employment of the posts with HR) Macmillan Education Project
- £22,758 - Butterfly Project
- £16,758 - an emergency alert system within the Radiotherapy Department
- £20,835 - an MRI Overlay for the new Siemens MRI scanner in the Radiotherapy Department
- £50,000 - payment to the Trust for the balance of the Renal Intervention and Treatment Area RITA project

Further requests were deferred to allow for a review of the application process to ensure that all requests go through the correct internal governance procedure prior to final consideration by CTC. The Committee agreed that the Mount Vernon Community Engagement Project would be funded by the Charity to March 2018 at a cost of £96,314 and that £9k would be allocated for the payment of associated volunteers' expenses.

Reporting to Board

The Committee has reported to the Trust Board as Corporate Trustee following each meeting and the CTC actions log provides a clear audit trail of actions agreed through to closure.

CONCLUSION

The overall conclusion of this annual review is that the Committee has discharged its duties under its terms of reference during 2016/17. The CTC continues to champion and raise awareness of the Charity and its development, both externally and within the Trust, provides stewardship of charitable resources and ensures compliance with relevant legislation, guidance and Trust policies.

The Committee and team are committed to continue to strengthen the Charity through implementation of the strategy, and further developing reporting and governance arrangements during 2017/18.

The Board as Corporate Trustee is asked to note the report and approve the revised terms of reference which have been reviewed and an upper authorisation limit of £500,000 has been set of the Committee, (appendix 1 attached).

Appendix 1

CHARITY TRUSTEE COMMITTEE
TERMS OF REFERENCE

1. Purpose & Authority

The purpose of the Charity Trustee Committee is:

- To ensure a robust strategy for the delivery of the Charity aims and objectives.
- To champion the charity and its development, providing leadership both within the Trust and externally
- To provide stewardship of charitable resources and ensure compliance with relevant legislation, guidance and Trust policies

This is a delegated duty carried out on behalf of the East and North Hertfordshire NHS Trust, which is the sole *Corporate Trustee* of the Charity, East and North Herts Hospitals Charity (registered charity no 1053338).

2. Authority

The Charitable Trustee Committee is authorised:

- to investigate any activity within its Terms of Reference.
- to obtain reasonable external legal or other independent professional advice and to secure the attendance of outsiders with relevant experience or expertise, if it considers this to be necessary.

3. Membership of the Committee

Membership (with voting rights):

- two Non-Executive Directors
- Director of Finance
- Director of Strategy
- Director of Nursing/representative

In attendance:

- Head of Charity
- Charity Financial Accountant
- Company Secretary
- Head of Engagement
- additional attendees selected by the Committee as deemed necessary to fulfil its function, including the Charity Independent Investment Advisor at least annually, Trust Financial Controller and Director of Business Development and Partnerships.

The Chair of the Committee shall be one of the Non-Executive Directors selected by the Board. In their absence, meetings shall be chaired by the other Non-Executive Director.

If a conflict of interests is established, the member/attendee concerned should declare this and withdraw from the meeting and play no part in the relevant discussion or decision.

4. Quorum

A minimum of two members must be present, of which one must be a Non-Executive Director and one must be an Executive Director.

5. Meetings

The Charitable Trustee Committee will meet at least four times a year (as near as practical to quarter ends). The Chair of the Committee may convene additional meetings if required to consider business that requires urgent attention.

6. Key duties and responsibilities

a. To ensure a robust strategy for the delivery of The Charity aims and objectives including:

- To approve and monitor The Charity and Strategy and Charity Management Team Annual Plan and Priorities.

b. To provide stewardship of charitable resources and ensure compliance with relevant legislation, guidance and Trust policies

- Ensuring policies and procedures are in place that allow the effective day to day management of the charity and its funds
- Ensuring The Charity satisfies all regulatory, legal and NHS compliance requirements
- Ensuring funding provides added value to patients and staff, above those afforded by Exchequer Funds
- Ensuring expenditure is in line with donors' expectations of an NHS Charity
- Ensuring effective systems are in place to manage budget holders and ensuring they demonstrate adherence to charitable objectives in spending charitable monies
- To recommend the appointment of Investment Managers to provide investment advice and manage the Trusts investment portfolio through an agreed Investment Policy, so as to safeguard the charity's future while maximising income.
- Ensuring The Charity's financial dealings are systematically accounted for
- To ensure appropriate mechanisms are in place to manage restricted and designated monies, and to use monies as agreed with the donor or negotiate alternative arrangements
- Receive and provide scrutiny to The Charity's Annual Report and Accounts, prior to final approval by the Corporate Trustee,
- Encouraging a culture of expending expendable income unless there is a clear reason to accumulate
- Establishing a Reserves Policy and monitoring its implementation
- Providing assurance updates to the Audit Committee regarding the governance and risk management of the charitable funds
- Reviewing and approving the Fundraising and Communications Strategies and the resources required to implement them
- Monitoring performance against financial and other key performance targets
- Setting a clear framework for prioritising charitable expenditure, and establishing appropriate approval processes for agreeing new campaigns and spending existing charitable monies
- To ensure appropriate delegation of charitable expenditure
- To authorise the establishment of any new funds
- For charitable funds' schemes with a value of £5,000 and £500,000:
    - Reviewing and, if appropriate, authorising
    - Ensuring that the Business Development Committee, and where appropriate the Executive Committee, reviews and monitors the application and implementation of charitable funds schemes.

c. To champion The Charity and its development, both externally and within the Trust to include:

- Providing inspiring, reflective and visible leadership of the charity, clearly communicated to all stakeholders
- Growing the reputation and profile of the Charity (and by association, the Trust)
- Advocating and being ambassadors for charitable giving to the Charity within the community
- Developing through high donor activities a network of seriously influential stakeholders who see themselves as business partners in the Trust's future, and personally cultivating and stewarding these relationships
- Leading and encouraging the Board in achieving similar and appropriate support for the Charity.

7. Reporting arrangements

The Committee will report to the Trust Board, as Corporate Trustee, following each meeting.

8. Support

The Company Secretary will advise the Committee on pertinent governance issues and ensure it is supported administratively, including:

- Agreement of agenda with Chairman and attendees and collation of papers
- Taking the minutes
- Keeping a record of matters arising and issues to be carried forward

9. Review

The Terms of Reference of the Committee shall be reviewed by the Trust Board (Corporate Trustee) annually.

DATA PACK

Contents

1. Data & Exception Reports:

FFT

Health & Safety Indicators

Friends and Family Test - July 2017

Appendix 1

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	95.74	0.00	22	23	2	0	0	0	47	71	66.20
5B	100.00	0.00	15	2	0	0	0	0	17	43	39.53
7B	100.00	0.00	58	26	0	0	0	0	84	172	48.84
8A	94.52	2.74	49	20	2	2	0	0	73	108	67.59
8B	91.46	3.66	42	33	4	1	2	0	82	152	53.95
11B	92.31	0.00	21	15	3	0	0	0	39	140	27.86
Swift	98.32	0.00	89	28	1	0	0	1	119	203	58.62
ITU/HDU	100.00	0.00	6	1	0	0	0	0	7	20	35.00
Day Surgery Centre, Lister	98.78	0.30	252	72	3	1	0	0	328	492	66.67
Day Surgery Treatment Centre	97.42	0.86	194	33	4	2	0	0	233	587	39.69
Endoscopy, Lister	99.30	0.00	267	16	2	0	0	0	285	714	39.92
Endoscopy, QEII	98.92	0.00	86	6	0	0	0	1	93	229	40.61
SURGERY TOTAL	97.80	0.57	**1101**	**275**	**21**	**6**	**2**	**2**	**1407**	**2931**	48.00
SSU	100.00	0.00	22	8	0	0	0	0	30	109	27.52
AMU	94.12	0.00	37	11	3	0	0	0	51	124	41.13
Pirton	96.67	0.00	47	11	2	0	0	0	60	77	77.92
Barley	100.00	0.00	16	1	0	0	0	0	17	30	56.67
6A	90.63	3.13	21	8	1	0	1	1	32	72	44.44
6B	100.00	0.00	31	9	0	0	0	0	40	64	62.50
11A	100.00	0.00	75	27	0	0	0	0	102	102	100.00
ACU	90.00	5.00	14	4	0	0	1	1	20	91	21.98
10B	89.47	5.26	9	8	0	0	1	1	19	46	41.30
Ashwell	94.12	0.00	29	3	2	0	0	0	34	51	66.67
9B	100.00	0.00	34	12	0	0	0	0	46	46	100.00
9A	100.00	0.00	35	4	0	0	0	0	39	39	100.00
Cardiac Suite	100.00	0.00	50	5	0	0	0	0	55	112	49.11
MEDICINE TOTAL	97.43	0.55	**420**	**111**	**8**	**0**	**3**	**3**	**545**	**963**	56.59
10AN Gynae	93.42	3.95	52	19	2	2	1	0	76	111	68.47
Bluebell ward	95.08	0.00	37	21	1	0	0	2	61	195	31.28
Bluebell day case	100.00	0.00	4	2	0	0	0	0	6	6	100.00
Neonatal Unit	100.00	0.00	15	0	0	0	0	0	15	21	71.43
WOMEN'S/CHILDREN TOTAL	94.94	1.90	**108**	**42**	**3**	**2**	**1**	**2**	**158**	**333**	47.45
Michael Sobell House	100.00	0.00	34	0	0	0	0	0	34	55	61.82
11	96.55	3.45	27	1	0	1	0	0	29	143	20.28
CANCER TOTAL	98.41	1.59	**61**	**1**	**0**	**1**	**0**	**0**	**63**	**198**	31.82
TOTAL TRUST	97.51	0.69	**1690**	**429**	**32**	**9**	**6**	**7**	**2173**	**4425**	49.11

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	97.42	0.69	1543	422	32	8	6	6	2017	3998	50.45
QEII	98.92	0.00	86	6	0	0	0	1	93	229	40.61
Mount Vernon	98.41	1.59	61	1	0	1	0	0	63	198	31.82
TOTAL TRUST	**97.51**	**0.69**	**1690**	**429**	**32**	**9**	**6**	**7**	**2173**	**4425**	**49.11**

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	91.46	2.74	198	102	17	5	4	2	328	8505	3.86
QEII UCC	95.38	1.54	45	17	1	0	1	1	65	4068	1.60
A&E TOTAL	**92.11**	**2.54**	**243**	**119**	**18**	**5**	**5**	**3**	**393**	**12573**	**3.13**

Maternity	% Would recommend	% Would not recommend	Extremely Likely	Likely	Neither Likely/ Unlikely	Unlikely	Extremely Unlikely	Don't Know	Total responses	No. of Discharges	Total % response rate
Antenatal	100.00	0.00	9	1	0	0	0	0	10	515	**1.94**
Birth	95.69	0.00	162	60	3	0	0	7	232	466	**49.79**
Postnatal	89.66	3.02	126	82	12	6	1	5	232	466	**49.79**
Community Midwifery	100.00	0.00	4	0	0	0	0	0	4	606	**0.66**
MATERNITY TOTAL	**92.89**	**1.46**	**301**	**143**	**15**	**6**	**1**	**12**	**478**	**2053**	**23.28**

Outpatients	% Would recommend	% Would not recommend	Extremely Likely	Likely	Neither Likely/ Unlikely	Unlikely	Extremely Unlikely	Don't Know	Total responses
Lister	95.10	1.51	775	235	27	4	12	9	1062
QEII	95.64	1.42	798	278	24	8	8	9	1125
Hertford County	96.23	1.03	204	77	6	1	2	2	292
Mount Vernon CC	97.73	0.00	109	20	0	0	0	3	132
Satellite Dialysis	97.44	0.00	56	20	1	0	0	1	78
OUTPATIENTS TOTAL	**95.65**	**1.30**	**1942**	**630**	**58**	**13**	**22**	**24**	**2689**

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
	H&S public liability claims	0	0	0	0									0
	Slips, Trips & Falls (not including inpatient falls)	0	0	0	0									0
	Physical assault	0	0	0	1									1
Visitor Incidents	RIDDOR incidents	0	0	0	0									0
	H&S public liability claims	1	0	0	1									2
	Slips, Trips & Falls	2	2	4	3									11
The Workforce (Including Contractors) Incidents	RIDDOR incidents	2	2	5	3									12
	Slips, Trips & Falls	1	5	7	6									19
	Employer liability claims	0	2	1	1									4
	Sharps incidents	11	7	12	12									42
	Workplace stress	6	2	1	3									12
	Contact dermatitis/latex	0	0	0	0									0
	Musculoskeletal injuries	5	3	8	3									19
	Physical assault	4	0	10	9									23
	H & S training (Compliance) (YTD = Latest Available Position)	89%	88%	88%	87%									352%
	Significant workplace fires	1	0	0	0									1
	Total Staff	5514	5529	5532	5574									22149

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	2	5	3	0	0	0	0	0	0	0	0	12
RATE %	Red < 0.36 Amber 0.36-0.33 Green > 0.33	0.363	0.362	0.904	0.538	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.542
Slips, Trips and Falls		1	5	7	6	0	0	0	0	0	0	0	0	19
RATE %	Red <0.86 Amber 0.86 - 0.78 Green >0.78	0.181	0.904	1.265	1.076	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.858
Sharps Injuries		11	7	12	12	0	0	0	0	0	0	0	0	42
RATE %	Red < 2.56 Amber 2.56-2.33 Green > 2.33	1.995	1.266	2.169	2.153	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	1.896
Mgr Referrals to OH for Stress		6	2	1	3	0	0	0	0	0	0	0	0	12
RATE %	Red < 0.96 Amber 0.96-0.87 Green > 0.87	1.088	0.362	0.181	0.538	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.542
Work related Musculosketal Injuries		5	3	8	3	0	0	0	0	0	0	0	0	19
RATE %	Red < 1.11 Amber 1.11-1.01 Green > 1.01	0.907	0.543	1.446	0.538	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.858
Physical Assault		4	0	10	9	0	0	0	0	0	0	0	0	23
RATE %	Red < 1.45 Amber 1.45-1.32 Green > 1.32	0.725	0.000	1.808	1.615	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	1.038
Total Staff		5514	5529	5532	5574	0	0	0	0	0	0	0	0	22149

2. Performance Data:

CQC Outcomes Summary

Floodlight Scorecard

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 is due to be released at the end of July 17.

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.**

East and North Hertfordshire NHS
NHS Trust

TRUST FLOODLIGHT

DASHBOARD AND SCORECARD 2017/18

July 17 - Month 04

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

East and North Hertfordshire NHS
NHS Trust

GUIDANCE

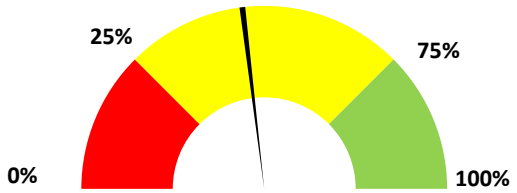
Executive Summary	• Overview of the Trusts performance when compared to targets and historical performance
Dashboard	• High-level visualisation of the Key Performance Indicator Themes grouped to give an indication of overall performance
All KPI's by Theme	•Second level of detail of agree Key Performance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

Executive Summary July 2017

East and North Hertfordshire NHS Trust

Trust Overall

Percentage of KPIs met



KPI Performance					
Improved		No Change		Declined	
	40		11		30

Highlights:

Lowlights:

Key Findings:

Executive Summary

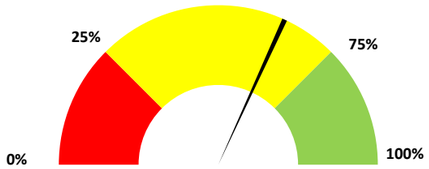
2.2 SHMI & 2.3 SHMI Palliative Care Adjustment
RAG Ratings Amended for July onwards

5.3 Friends & Family Recommended Place of Care & 6.5 Friends & Family Recommended Place of Work
RAG Ratings Amended for April onwards. Both indicators to be Quarterly.

Trust Floodlights Dashboard
July 2017 (M04)

1 - Safe

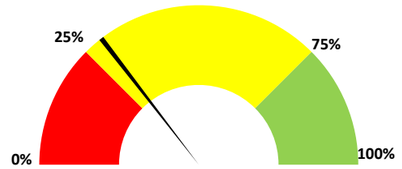
Percentage of KPIs met



KPI Performance					
Improved		No Change		Declined	
	10		1		8

2- Effective

Percentage of KPIs met



KPI Performance					
Improved		No Change		Declined	
	3		2		2

3 - Responsive - Efficiency

Percentage of KPIs met

KPI Performance					
Improved		No Change		Declined	
	2		1		3

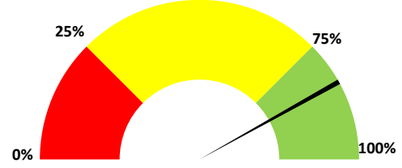
4 - Responsive - Key Targets

Percentage of KPIs met

KPI Performance					
Improved		No Change		Declined	
	9		0		6

5 - Caring

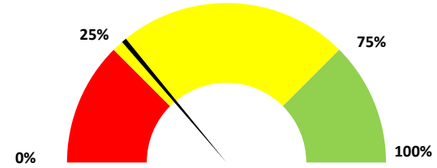
Percentage of KPIs met



KPI Performance					
Improved		No Change		Declined	
	4		1		1

6 - Well-Led

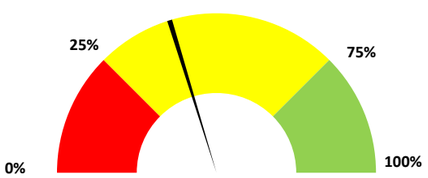
Percentage of KPIs met



KPI Performance					
Improved		No Change		Declined	
	5		2		4

7 - Financial Performance

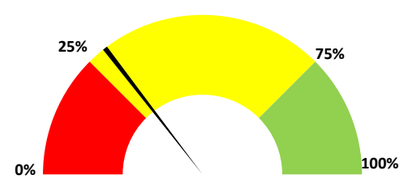
Percentage of KPIs met



KPI Performance					
Improved		No Change		Declined	
	4		4		2

8 - Sustainability

Percentage of KPIs met



KPI Performance					
Improved		No Change		Declined	
	3		0		4

Trust Floodlights Dashboard
July 2017 (M04)

Monthly Information,
Performance and RAG Rating

SAFE

Patient Safety

ID	Indicator (YTD)	Month Change
1.1	Never Events 1	▬
1.2	Safety Thermometer Patients with Harm 98	▲
1.3	Clostridium Difficile Cases 11	▼
1.4	MRSA Post 48 hours Cases 1	▲
1.5	Hospital Acquired Pressure Ulcers Grade 2 or higher 0.07	▲
1.6	Inpatient Falls 2.86	▼
1.7	Ambulance Handovers > 30 mins 180	▲
1.8	Fill Rate RNs (%) 95.6	▼
1.9	Fill Rate RNs Unreg (%) 96.0	▲

Training

ID	Indicator (YTD)	Month Change
1.10	Statutory Mandatory Training 87.34	▼
1.11	Safeguarding Adults Training 88.2	▼
1.12	Safeguarding Children Training 88.8	▼
1.13	Competancy Coverage 64.1	▼

Health & Safety

ID	Indicator (YTD)	Month Change
1.14	RIDDOR Incidents 0.50	▲
1.15	Musculosketal Injuries Reported 0.86	▲
1.16	Physical Assault Incidents 1.04	▲
1.17	Manager Referrals to OH for Stress 0.54	▼
1.18	Staff Slips, Trips & Falls 0.86	▲
1.19	Staff Sharps Injuries 1.90	▲

EFFECTIVE

Mortality

ID	Indicator (YTD)	Month Change
2.1	HSMR 93.7	▲
2.2	SHMI 102.31	▬
2.3	SHMI (Palliative Care Adjustment) 92.9	▬

Admissions

ID	Indicator (YTD)	Month Change
2.4	Medical & Surgical Patient Outliers 108	▼
2.5	Number of Patients with LOS > 14 days 116	▲
2.6	LOS - Non Elective 3.8	▲
2.7	Readmissions 8.1	▼

FINANCIAL PERFORMANCE

Single Oversight Framework - Finance and Use of Resources Metrics

ID	Indicator (YTD)	Month Change
7.1	Capital Servicing Capacity 4	▬
7.2	Liquidity Ratio (days) 3	▬
7.3	I&E Margin 4	▬
7.4	Distance from financial plan 2	▼
7.5	Agency spend variance from ceiling 1	▬
7.6	Overall Finance Metric 3	▬

Other Financial Metrics

7.7	Pay Spend 100.0	▼
7.8	Capital Plan Trajectory 84	▼
7.9	CIP Plan delivered 102	▼
7.10	Cash Plan 124.2	▼

RESPONSIVE-EFFICIENCY

ID	Indicator (YTD)	Month Change
3.1	New to Follow-Up Ratio 2.15	▲
3.2	Overnight Bed Occupancy Rate 87.3	▬
3.3	Pre OP bed days (elective) 3.3	▼
3.4	Delayed Transfer of Care 18	▼
3.5	Post Acute Transfer Delays	
3.6	Ward Discharges before Midday 14	▼
3.7	Cancelled Ops - on Day 371	▼
3.8	Number of Discharges from Discharge Lounge	

RESPONSIVE-KEY TARGETS

ID	Indicator (YTD)	Month Change
4.1	A&E 4 hour Target 87.2	▲
4.2	RTT Admitted 73.7	▼
4.3	RTT Non Admitted 86.2	▼
4.4	RTT - Open Pathways 87.4	▼
4.5	RTT Patients Waiting > 18 weeks 4140	▼
4.6	Diagnostic Waits < 6 weeks 99.4	▲
4.7	Cancer 2week Ref to Appt 98.4	▲
4.8	Cancer 31day : Diag 90.0	▲
4.9	Cancer 62day : Urgent RTT inc ITP transfers 72.2	▼
4.10	TIA: High Risk treatment within 24 hrs 67.8	▲
4.11	TIA: Low Risk treatment within 7 days from 1st contact 86.2	▲
4.12	4 hrs direct to Stroke Unit 78.6	▲
4.13	90% of time on the Stroke Unit 87.3	▼
4.14	60 minutes to scan 92.7	▲
4.15	Thrombolysed within 3 hrs 6.1	▲

CARING

ID	Indicator (YTD)	Month Change
5.1	Inpatient FFT % of patients would recommend 97.5	▲
5.2	FFT Response Rate % 49.1	▲
5.3	Friends & Family Recommend Place of Care 75.0	
5.4	Complaints - % received telephone call 100.0	▬
5.5	% of Complaints concluded within agreed timeframe 65.5	▼
5.6	GP Enquiries Response Rate - Routine 86.0	
5.7	GP Enquiries Response Rate - Urgent 100.0	

SUSTAINABILITY

ID	Indicator (YTD)	Month Change
8.1	GP referrals Received - 2WW 2925	▲
8.2	GP referrals Received - non 2WW 32544	▼
8.3	A&E Attendances 50744	▲
8.4	Elective Spells (PBR) 13132	▲
8.5	NonElective Spells 15094	▼
8.6	OP Attendances/Procs (Total) 157932	▼
8.7	Outpatient DNA Rate 7.5	▲
8.8	Theatre Utilisation	

WELL-LED

ID	Indicator (YTD)	Month Change
6.1	Continuity of Services Risk Rating	
6.2	Risk register	▲
6.3	CQC Outcomes	▬
6.4	NHSI Governance Risk Rating 3	▬
6.5	Friends & Family Recommend Place of Work 46.6	▼
6.6	Vacancy Rate % 9.6	▼
6.7	Vacancy rate (Baseline) 8.1	▲
6.8	Bank Staff Usage 10.22	▼
6.9	Agency Staff Usage 5.68	▼
6.10	Sickness % 3.46	▲
6.11	Substantive Staff Turnover 12.8	▲
6.12	Appraisal Rate 84.2	▲

Trust Floodlights Dashboard
July 2017 (M04)

Monthly Information, Performance and RAG Rating

1 - SAFE

ID	Indicator	Target 17-18	Target YTD	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position
1.1	Never Events	0		1	0			
1.2	Safety Thermometer Patients with Harm	336	112	98	20			
1.3	Clostridium Difficile Cases	11	4	11	4			
1.4	MRSA Post 48 hours Cases	0		1	0			
1.5	Hospital Acquired Pressure Ulcers Grade 2 or higher	0.16		0.07	0.00			
1.6	Inpatient Falls	3.17		2.86	3.27			
1.7	Ambulance Handovers > 30 mins	2604	868	180	44			
1.8	Fill Rate RNs (%)	90		95.6	94.1			
1.9	Fill Rate RNs Unreg (%)	90		96.0	93.3			
1.10	Statutory Mandatory Training	90		87.3	87.3			
1.11	Safeguarding Adults Training	90		88.2	88.2			
1.12	Safeguarding Children Training	90		88.8	88.8			
1.13	Competancy Coverage	85		64.1	64.1			
1.14	RIDDOR Incidents	0.56		0.50	0.36			
1.15	Musculosketal Injuries Reported	1.09		0.86	0.54			
1.16	Physical Assault Incidents	1.13		1.04	1.61			
1.17	Manager Referrals to OH for Stress	0.57		0.54	0.54			
1.18	Staff Slips, Trips & Falls	1.18		0.86	1.08			
1.19	Staff Sharps Injuries	2.00		1.90	2.15			

2 - EFFECTIVE

ID	Indicator	Target 17-18	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position
2.1	HSMR	95	93.7				
2.2	SHMI	100	102.3				
2.3	SHMI (Palliative Care Adjustment)	95	92.9				
2.4	Medical & Surgical Patient Outliers	50	108				
2.5	Number of Patients with LOS > 14 days	100	116				
2.6	LOS - Non Elective	3.5	3.8	3.6			
2.7	Readmissions	7.75	8.1	7.7			

3 - RESPONSIVE - EFFICIENCY

ID	Indicator	Target 17-18	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position
3.1	New to Follow-Up Ratio	2	2.15	2.15			
3.2	Overnight Bed Occupancy Rate	85	87.3	88.4			
3.3	Pre OP bed days (elective)	6	3.3	4.5			
3.4	Delayed Transfer of Care	8	18	10			
3.5	Post Acute Transfer-Total Avg beds blocked	Method of Data Collection and Definition to be confirmed					
3.6	Ward Discharges before Midday	13	13.7	13.0			
3.7	Cancelled Ops - on Day	504	371	97			
3.8	Number of Discharges from Discharge Lounge	Method of Data Collection to be confirmed					

4 - RESPONSIVE - KEY TARGETS

ID	Indicator	Target 17-18	Target YTD	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position
4.1	A&E 4 hour Target	95		87.2	87.8			
4.2	RTT Admitted	0		73.7	67.8			
4.3	RTT Non Admitted	0		86.2	83.1			
4.4	RTT - Open Pathways	92		87.4	87.4			
4.5	RTT Patients Waiting > 18 weeks	1231		4140	4140			
4.6	Diagnostic Waits < 6 weeks	99		99.4	99.6			
4.7	Cancer 2week Ref to Appt	93		98.4	98.7			
4.8	Cancer 31day : Diag	96		90.0	90.7			
4.9	Cancer 62day : Urgent RTT inc ITP transfers	85		72.2	66.4			
4.10	TIA: High Risk treatment within 24 hrs	62.5		67.8	73.7			
4.11	TIA: Low Risk treatment within 7 days from 1st contact	85		86.2	86.7			
4.12	4 hrs direct to Stroke Unit	90		78.6	78.6			
4.13	90% of time on the Stroke Unit	80		87.3	88.0			
4.14	60 minutes to scan	90		92.7	96.2			
4.15	Thrombolysed within 3 hrs	12		6.1	14.3			

5 - CARING

ID	Indicator	Target 17-18	Target YTD	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position
5.1	Inpatient FFT % of patients would recommend	95		97.5	97.5			
5.2	FFT Response Rate %	40		49.1	49.1			
5.3	Friends & Family Recommend Place of Care	76		75.0	75.0			
5.4	Complaints - % received telephone call	85		100.0	100.0			
5.5	% of Complaints concluded within agreed timeframe	75		65.5	53.0			
5.6	GP Enquiries Response Rate - Routine	80		86.0	86.0			
5.7	GP Enquiries Response Rate - Urgent	95		100.0	100.0			

6 - WELL-LED

ID	Indicator	Target 17-18	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position
6.1	Continuity of Services Risk Rating	0	0	0			
6.2	Risk register	1	3	0			
6.3	CQC Outcomes	1	2	0			
6.4	NHSI Governance Risk Rating	4	3	0			
6.5	Friends & Family Recommend Place of Work	61	46.6	46.6			
6.6	Vacancy Rate %	10	9.63	9.63			
6.7	Vacancy rate (Baseline)	5	8.09	8.09			
6.8	Bank Staff Usage	9	10.22	10.22			
6.9	Agency Staff Usage	7	5.68	5.68			
6.10	Sickness %	3.5	3.46	3.46			
6.11	Substantive Staff Turnover	11	12.8	12.8			
6.12	Appraisal Rate	85	84.2	84.2			

7 - FINANCIAL PERFORMANCE

ID	Indicator	Target 17-18	Target YTD	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position
7.1	Capital Servicing Capacity	1		4.0	4.0			
7.2	Liquidity Ratio (days)	1		3.0	3.0			
7.3	I&E Margin	1		4.0	4.0			
7.4	Distance from financial plan	1		2.0	2.0			
7.5	Agency spend variance from ceiling	1		1.0	1.0			
7.6	Overall Finance Metric	1		3.0	3.0			
7.7	Pay Spend	100		100.0	100.0			
7.8	Capital Plan Trajectory	90		84.0	84.0			
7.9	CIP Plan delivered	100		102.0	102.0			
7.10	Cash Plan	90		124.2	124.2			

8 - SUSTAINABILITY

ID	Indicator	Target 17-18	Target YTD	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position
8.1	GP referrals Received - 2WW			2925	893			
8.2	GP referrals Received - non 2WW			32544	7991			
8.3	A&E Attendances	147144	49163	50744	12849			
8.4	Elective Spells (PBR)	37060	12353	13132	3553			
8.5	NonElective Spells	46703	15229	15094	3780			
8.6	OP Attendances/Procs (Total)	471770	157257	157932	39670			
8.7	Outpatient DNA Rate	8		7.525183	7.302136			
8.8	Theatre Utilisation	Method of Data Collection and Definition to be confirmed						

Key: Monthly Change

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

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

Trust Floodlights Dashboard
July 2017 (M04)

Monthly Information, Performance and RAG Rating

1 - SAFE

ID	Indicator	Target 17-18	Target YTD	Actual YTD	Actual Month	Month Performance	Monthly Change	YTD Position	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12
1.1	Never Events	0		1	0		▬		0	1	0	0								
1.2	Safety Thermometer Patients with Harm	336	112	98	20		▲		20	24	34	20								
1.3	Clostridium Difficile Cases	11	4	11	4		▼		2	2	3	4								
1.4	MRSA Post 48 hours Cases	0		1	0		▲		0	0	1	0								
1.5	Hospital Acquired Pressure Ulcers Grade 2 or higher	0.16		0.07	0.00		▲		0.000	0.189	0.100	0.000								
1.6	Inpatient Falls	3.17		2.86	3.27		▼		2.70	2.41	3.10	3.27								
1.7	Ambulance Handovers > 30 mins	2604	868	180	44		▲		42	94	44	One month in arrears								
1.8	Fill Rate RNs (%)	90		96	94		▼		96.1	96.3	95.7	94.1								
1.9	Fill Rate RNs Unreg (%)	90		96	93		▲		104.3	94.8	91.5	93.3								
1.10	Statutory Mandatory Training	90		87.3	87.3		▼		89.3	87.8	88.3	87.3								
1.11	Safeguarding Adults Training	90		88.2	88.2		▼		90.5	89.2	89.5	88.2								
1.12	Safeguarding Children Training	90		88.8	88.8		▼		91.1	89.6	90.0	88.8								
1.13	Competancy Coverage	85		64.1	64.1		▼		66.4	64.0	64.8	64.1								
1.14	RIDDOR Incidents	0.56		0.50	0.36		▲		0.36	0.36	0.90	0.36								
1.15	Musculosketal Injuries Reported	1.09		0.86	0.54		▲		0.91	0.54	1.45	0.54								
1.16	Physical Assault Incidents	1.13		1.04	1.61		▲		0.73	0.00	1.81	1.61								
1.17	Manager Referrals to OH for Stress	0.57		0.54	0.54		▼		1.09	0.36	0.18	0.54								
1.18	Staff Slips, Trips & Falls	1.18		0.86	1.08		▲		0.18	0.90	1.27	1.08								
1.19	Staff Sharps Injuries	2.00		1.90	2.15		▲		1.99	1.27	2.17	2.15								

2 - EFFECTIVE

ID	Indicator	Target 17-18	Target YTD	Actual YTD	Actual Month	Month Performance	Monthly Change	YTD Position	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12
2.1	HSMR	95.0		93.7			▲		95.03	95.03	94.35	93.68								
2.2	SHMI	100		102.3			▬		105.6	105.6	102.3	102.3								
2.3	SHMI (Palliative Care Adjustment)	95.0		92.9			▬		95.37	95.37	92.94	92.9								
2.4	Medical & Surgical Patient Outliers	50		108			▼		91	91	88	108								
2.5	Number of Patients with LOS > 14 days	100		116			▲		172	148	129	116								
2.6	LOS - Non Elective	3.5		3.8	3.6		▲		3.8	4.0	3.8	3.6								
2.7	Readmissions	7.75		8.06	7.7		▼		8.7	8.1	7.7	7.7								

3 - RESPONSIVE - EFFICIENCY

ID	Indicator	Target 17-18	Target YTD	Actual YTD	Actual Month	Month Performance	Monthly Change	YTD Position	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12
3.1	New to Follow-Up Ratio	2.0		2.15	2.15		▲		2.19	2.18	2.16	2.15								
3.2	Overnight Bed Occupancy Rate	85		87.30	88.44		▬		84.8	87.5	88.4	88.4								
3.3	Pre OP bed days (elective)	6		3.30	4.5		▼		4.1	2.1	2.5	4.5								
3.4	Delayed Transfer of Care	8		18	10		▼		5	0	3	10								
3.5	Post Acute Transfer-Total Avg beds blocked	Method of Data Collection and Definition to be confirmed																		
3.6	Ward Discharges before Midday	13.0		13.7	13.0		▼		14.5	14.0	13.2	13.0								
3.7	Cancelled Ops - on Day	504	168	371	97		▲		46	71	157	97								
3.8	Number of Discharges from Discharge Lounge	Method of Data Collection to be confirmed																		

4 - RESPONSIVE - KEY TARGETS

ID	Indicator	Target 17-18	Target YTD	Actual YTD	Actual Month	Month Performance	Monthly Change	YTD Position	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12
4.1	A&E 4 hour Target	95		87.2	87.8		▲		89.23	84.07	87.53	87.77								
4.2	RTT Admitted	0		73.7	67.8		▼		74.8	78.8	73.6	67.8								
4.3	RTT Non Admitted	0		86.2	83.1		▼		87.2	86.0	88.6	83.1								
4.4	RTT - Open Pathways	92		87.4	87.4		▼		92.2	90.5	88.9	87.4								
4.5	RTT Patients Waiting > 18 weeks	1231		4140	4140		▼		2022	2436	3191	4140								
4.6	Diagnostic Waits < 6 weeks	99		99.4	99.6		▲		99.72	99.00	99.55	One month in arrears								
4.7	Cancer 2week Ref to Appt	93		98.4	98.7		▲		98.6	98.3	98.2	98.7								
4.8	Cancer 31day : Diag	96		90.0	90.7		▲		93.0	86.3	90.3	90.7								
4.9	Cancer 62day : Urgent RTT inc ITP transfers	85		72.2	66.4		▼		73.5	77.9	71.0	66.4								
4.10	TIA: High Risk treatment within 24 hrs	62.5		67.8	73.7		▲		91.7	57.9	60.0	73.7								
4.11	TIA: Low Risk treatment within 7 days from 1st contact	85		86.2	86.7		▲		88.0	81.3	79.3	86.7								
4.12	4 hrs direct to Stroke Unit	90		78.6	78.6		▲		82.5	76.6	77.6	78.6								
4.13	90% of time on the Stroke Unit	80		87.3	88.0		▼		88.9	91.4	88.5	88.0								
4.14	60 minutes to scan	90		92.7	96.2		▲		95.2	91.7	87.8	96.2								
4.15	Thrombolysed within 3 hrs	12		6.1	14.3		▲		10.8	6.6	9.0	14.3								

5 - CARING

ID	Indicator	Target 17-18	Target YTD	Actual YTD	Actual Month	Month Performance	Monthly Change	YTD Position	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12
5.1	Inpatient FFT % of patients would recommend	95		97.5	97.5		▲		96.6	97.0	97.2	97.5								
5.2	FFT Response Rate %	40		49.1	49.1		▲		52.84	51.45	44.06	49.11								
5.3	Friends & Family Recommend Place of Care	76.0		75.0	75.0				75.0											
5.4	Complaints - % received telephone call	85		100.0	100		▬		100	100	100	100								
5.5	% of Complaints concluded within agreed timeframe	75		65.5	53		▼		68	74	67	53								
5.6	GP Enquiries Response Rate - Routine	80		86.0	86.0		▲		58	74	86	One month in arrears								
5.7	GP Enquiries Response Rate - Urgent	95		100.0	100.0		▲		100	80	100	One month in arrears								

6 - WELL-LED

ID	Indicator	Target 17-18	Target YTD	Actual YTD	Actual Month	Month Performance	Monthly Change	YTD Position	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12
6.1	Continuity of Services Risk Rating								Metric removed in September 2016.											
6.2	Risk register	1		3			▼		3	3	2	3								
6.3	CQC Outcomes	1		2			▬		2	2	2	2								
6.4	NHSI Governance Risk Rating	4		3			▬		3	3	3	3								
6.5	Friends & Family Recommend Place of Work	61		46.6	46.6		▼		46.60											
6.6	Vacancy Rate %	10		9.6	9.6		▲		12.13	9.66	10.71	9.63								
6.7	Vacancy rate (Baseline)	5.0		8.1	8.1		▲		5.48	9.02	9.07	8.09								
6.8	Bank Staff Usage	9		10.2	10.2		▼		5.9	8.23	5.90	10.22								
6.9	Agency Staff Usage	7		5.7	5.7		▼		5.4	5.7	5.34	5.68								
6.10	Sickness %	3.5		3.5	3.5		▲		3.64	3.62	3.58	3.46								
6.11	Substantive Staff Turnover	11.0		12.8	12.8		▲		13.2	13.2	13.2	12.8								
6.12	Appraisal Rate	85		84.2	84.2		▲		81.9	82.7	83.7	84.2								

7 - FINANCIAL PERFORMANCE

ID	Indicator	Target 17-18	Target YTD	Actual YTD	Actual Month	Month Performance	Monthly Change	YTD Position	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12
7.1	Capital Servicing Capacity	1		4	4		▬		4	4	4	4								
7.2	Liquidity Ratio (days)	1		3	3		▬		3	3	3	3								
7.3	I&E Margin	1		4	4		▬		4	4	4	4								
7.4	Distance from financial plan	1		2	2		▼		2	4	1	2								
7.5	Agency spend variance from ceiling	1		1	1		▬		1	1	1	1								
7.6	Overall Finance Metric	1		3	3		▬		3	3	3	3								
7.7	Pay Spend	100		100	100.0		▼		97.0	98.0	96.0	100.0								
7.8	Capital Plan Trajectory	90		84	84.0		▼		13	108.2	149	84								
7.9	CIP Plan delivered	100		102	102.0		▼		122	107	120	102								
7.10	Cash Plan	90		124	124.2		▼		146.5	131.0	135.6	124.2								

8 - SUSTAINABILITY

ID	Indicator	Target 17-18	Target YTD	Actual YTD	Actual Month	Month Performance	Monthly Change	YTD Position	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12
8.1	GP referrals Received - 2WW			2925	893		▲		542	666	824	893								
8.2	GP referrals Received - non 2WW			32544	7991		▼		7656	8516	8381	7991								
8.3	A&E Attendances	147144	49163	50744	12849		▲		12354	12706	12835	12849								
8.4	Elective Spells (PBR)	37060	12353	13132	3553		▲		2947	3285	3347	3553								
8.5	NonElective Spells	46703	15229	15094	3780		▼		3691	3747	3876	3780								
8.6	OP Attendances/Procs (Total)	471770	157257	157932	39670		▼		33886	41380	42996	39670								
8.7	Outpatient DNA Rate	8		7.5	7.30		▼		7.21	8.07	7.52	7.30								
8.8	Theatre Utilisation	Method of Data Collection and Definition to be confirmed																		

3. Risk and Quality Committee Reports:

Safer Staffing

Infection Control Data

PALS and Complaints Monthly Report

East and North Hertfordshire NHS Trust

Safe Nurse Staffing Levels

July 2017

Executive Summary

The purpose of this report is:

1. To provide an assurance with regard to the management of safe nursing and midwifery staffing for the month of July 2017.
2. To provide context for the Trust Board on the UNIFY safer staffing submission for the month of July 2017.

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

No	Topic	Measure	Summary	RAG
1.	**Patient safety is delivered though consistent, appropriate staffing levels for the service.**	Unify RN fill rate	The Unify submission for registered fill % decreased in July with the average day fill % for registered nurses falling from 95.7% in June to 94.1% in July.	
		Care hours per Patient Day - CHPPD	Overall CHPPD decreased slightly from 7.3 in June to 7.2 in July.	
2.	**Staff are supported in their decision making by effective reporting.**	% of Red triggered shifts	Increase in % of Red Triggered shifts from 6.51% to 8.24%	
		% of shifts that remained partially mitigated	6 of the 276 (0.18%) shifts that initially triggered red in July remained only partially mitigated. This is an increase in the number of partially mitigated shifts from 3 in June.	
3.	**Staffing risks are effectively escalated to an appropriate person**	Red flag reportable events and DATIX report	Red flags continue to be used to escalate staffing issues in the organisation. The Safer staffing team have reworded the NICE red flags to make them more user friendly and meaningful to the nursing teams. These are being piloted for 3 months until the end of August.	
4.	**The Board are assured of safe staffing for nursing**	Board reports and discussion covering overview of safe staffing levels	The overall RN fill rate decreased slightly due to an increase in sickness and decrease in temporary staffing RN fill. The CHPPD delivered in July has decreased slightly from June for the above reasons.	

1. Patient safety is 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 July. 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 (%)
94.1%	93.3%	94.8%	112.2%

The Unify submission for registered fill % decreased in July with the average day fill % for registered nurses falling from 95.7% in June to 94.1% in July.

Factors affecting Planned vs. Actual staffing

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

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

- **Ward 11** – The wards at Mount Vernon were merged in April following a review of the service model for these wards. The combined Oncology ward will be known as Ward 11 for the purposes of this report. Ward 11 ran below their planned patient numbers in July, therefore although their fill rate is below 90% the CHPPD delivered meets the required level of care.
- **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.
- **5A, 5B, 8B, 9A, 9B, ACU, AMU-W, Ashwell, Barley and SSU** – Had a high number of patients requiring enhanced care which resulted in increased Clinical Support Worker (CSW) fill.
- **Acute Cardiac Unit** - Continues to support the reactive opening of the Cardiac Cath Lab as an escalation area when required. To ensure this increased activity is supported most efficiently additional temporary staffing is only resourced when current staffing levels cannot support activity. No additional staff resource was required in July for the opening of escalation beds. Registered Nurse (RN) day fill was 87.7% in July, the average bed occupancy was however 86.07%. CHPPD was 6.90 which is above the planned service model.
- **Swift** – RN day fill is recorded as 79.2% in July, the average bed occupancy was however 68.9% as at the 23:59 census period. Staffing levels were managed appropriately to the occupancy. CHPPD is 7.07 which is above the planned service model therefore we are assured that staffing is maintained appropriately. Due to lower planned staffing levels at night there is less flexibility to reduce staffing at night in line with occupancy.
- **Surgical Assessment Unit (SAU)** - Since the relocation of SAU in November 2016 the service adjusted staffing to meet service need as activity is lower in the early part of the day, but remained higher into the evening and night. The new service plan has been approved and was implemented on the 15 June. SAU aligned to their new service model for the month of July. RN fill was low during the day as the fourth RN shift was often unfilled as they recruit into this vacancy.

- **Michael Sobell House** - RN day fill is recorded as 80.4% in July. The average bed occupancy for July was 76.41% as at the 23:59 census period. Staffing levels were flexed to reflect bed occupancy. This is demonstrated by 7.92 CHPPD which is above the planned service model therefore we are assured that safe staffing levels are maintained appropriately. Due to lower planned staffing levels at night there is less flexibility to reduce staffing at night in line with bed occupancy.
- **Pirton –** RN day fill is recorded as 89.2% in July. The average bed occupancy for July was 86.98% as at the 23:59 census period. Staffing levels were managed appropriately to reflect the bed occupancy as the delivered CHPPD of 7.21 is above the planned service model. It has also been noted that the Stroke wards tend to have reduced bed occupancy during the day; therefore CHPPD is greater during the day. In addition to the planned ward staff, the Stroke wards have support from the specialist Stoke Nurses which is not currently reflected in the Unify return. Work is on-going to capture the care hours provided by the Stroke Nurses and Therapists on this ward.
- **Bluebell –** RN day fill is recorded as 88.3%. The average bed occupancy was 66.73% in July (11 patient average) based on their 16 bed shift plan. Bluebell flexed their staff in July across the Paediatric service with additional support from the senior nursing team to ensure they delivered safe and quality care.

The Enhanced Nursing Care Team (ENCT)

The Enhanced Nursing Care Team (Specialling team) continues to mitigate the risk and reduce the need to cover those patients requiring enhanced care with temporary staff. This provides a higher skilled workforce for less cost. The team is currently recruiting for band 4 team leaders which it is hoped will bring the team up to full establishment by the end of September. The impact in terms of how care hours delivered by the ENCT has reduced reliance on agency staff can be seen in Chart 1 below.

Chart 1

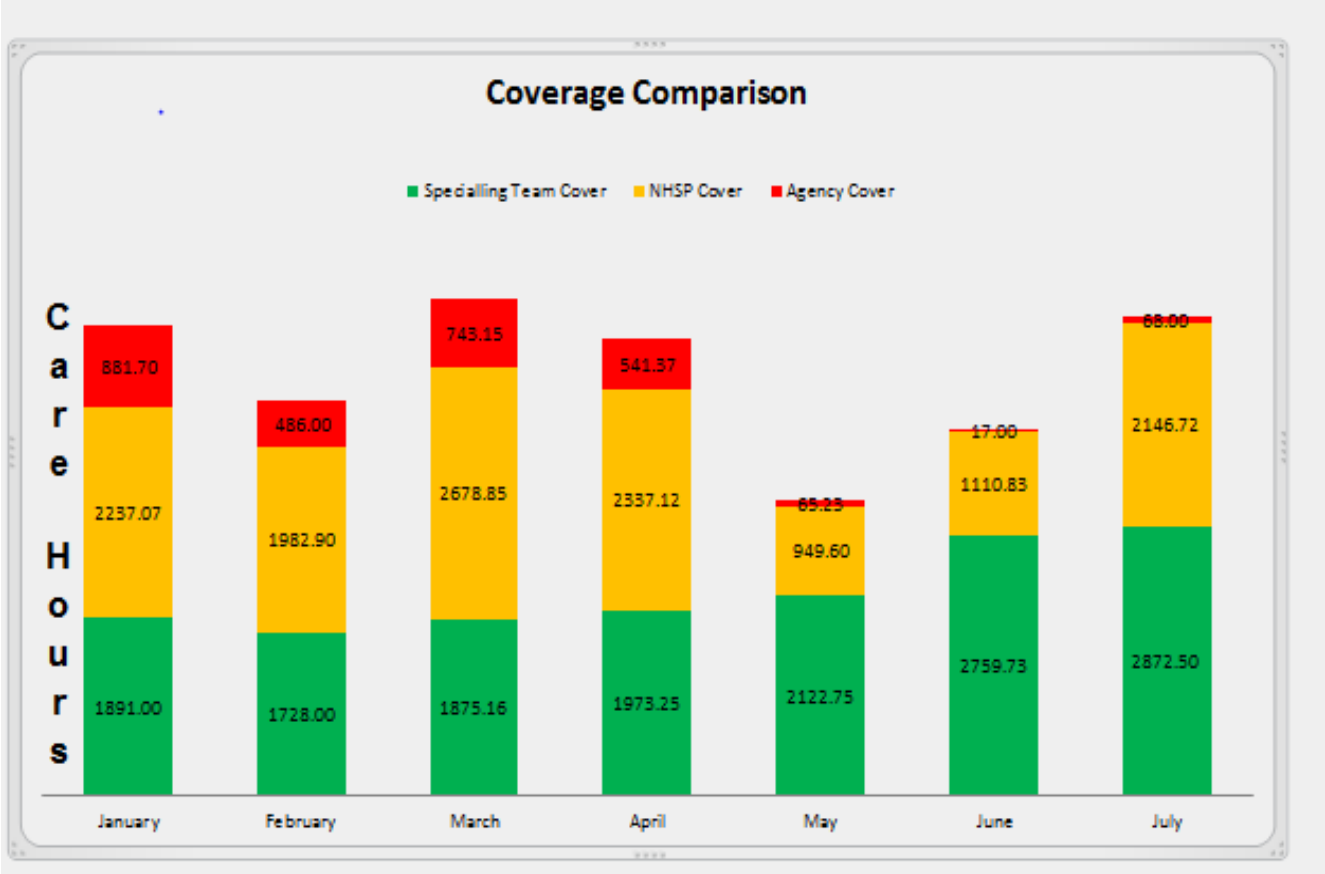
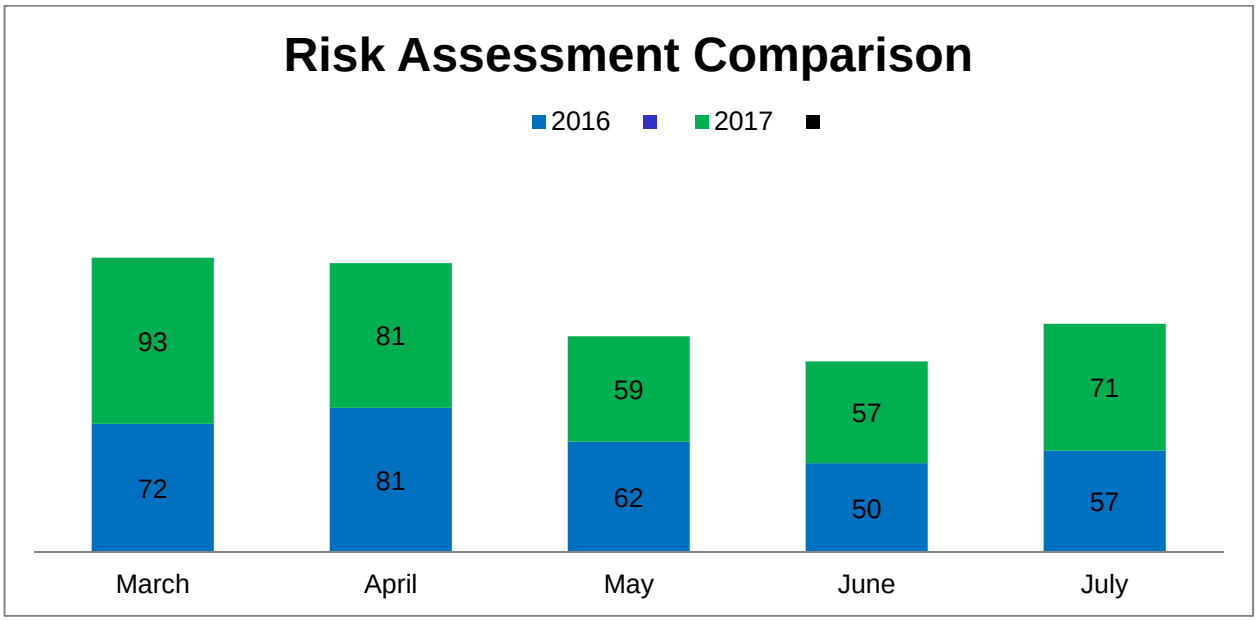


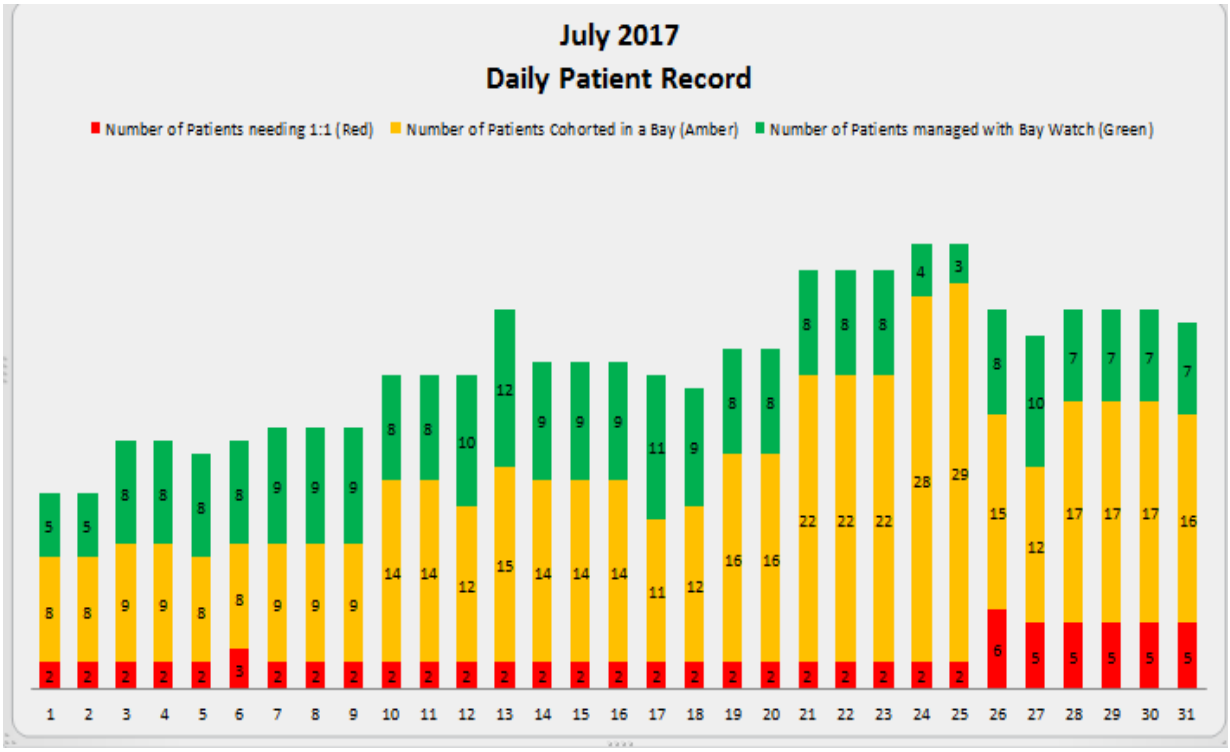
Chart 2 shows that demand for enhanced care has increased for the month of July with 14 more risk assessments received for enhanced care needs from the previous month. It also shows that demand for enhanced care needs has increased compared to the same period in 2016.

Chart 2



Daily ward rounds are conducted by a senior member of the team for all patients identified as requiring enhanced care, through documented risk assessments. These ward rounds determine the level of support required by each patient and ensures that a consistent approach is applied. Chart 3 demonstrates the number of patients, per day, in July needing enhanced care and the level of support they required. The last week in July shows a significant spike in the number of patients requiring 1:1 care (n=5-6 against an average of n=1-3). This spike in activity was matched by a significant demand for additional support for cohorted patients who could not be managed with Baywatch and normal ward establishments (n=12-17).

Chart 3



1.2 UNIFY Care Hours Per Patient Day (CHPPD)

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

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

This is a standard calculation indicating the number of care hours provided to each patient over a 24 hour period. The table below shows the CHPPD for July, this indicates overall CHPPD decreased slightly from 7.3 in June to 7.2 in July.

Table 2 – Average Care Hours Per Patient Day

Trust-wide	Care Hours Per Patient Day (CHPPD)		
	Registered midwives/ nurses	Care Staff	Overall
Total	**4.6**	**2.6**	**7.2**

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

Additional analysis of how the organisation uses CHPPD to inform productive and effective use of staffing is on-going and was included in the Trust's Nursing Establishment review in December 2016. The NHS Improvement Model Hospital Portal includes the CHPPD metric and will be used to Benchmark CHPPD against other Trusts for the April Establishment Review.

2. Staff are supported in their decision making by effective reporting

2.1 Daily process to support operational staffing

Three daily staffing meetings and twice weekly look-ahead meetings continue to support the organisation in balancing staffing risk across the Trust. Each ward is rated as red, amber or green for each of the early, late and night shifts. This record is held electronically in the Staffing Hub which provides a central point to access the E-Roster and NHS Professional 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 211 shifts in June to 276 in July. The percentage of Red Triggered shifts increased from 6.51% in June to 8.24% July. Table 3 below shows the % of shifts that triggered red in month.

Table 3 – % of shifts triggering red

Month	% of shifts that triggered red in Month
Jul-16	4.42%
Aug-16	8.57%
Sep-16	7.72%
Oct-16	5.14%
Nov-16	4.35%
Dec-16	6.02%
Jan-17	5.32%
Feb-17	6.40%
Mar-17	7.44%
Apr-17	5.91%
May-17	6.13%
Jun-17	6.51%
Jul-17	8.24%

Comparison of red triggered shifts between July 2016 and July 2017 shows an increase of 3.82% in the number of shifts triggering red in month.

Out of the shifts triggering red in July, 6 of the 276 that initially triggered red (0.18%) remained only partially mitigated. This is an increase in the number of partially mitigated shifts from 3 in June. Shifts triggering red, and those that remained a challenge to mitigate, are explored below.

Chart 4 below shows the % of shifts triggering red in month. Following the spike in August 2016 the % shifts triggering red has shown a linear increase in the following months. This is multifactorial, these reasons include sustained levels of vacancies and sickness and controlled use of agency and are discussed in section 2.3. It is worth noting however that the trend on shifts remaining red has declined.

Chart 4

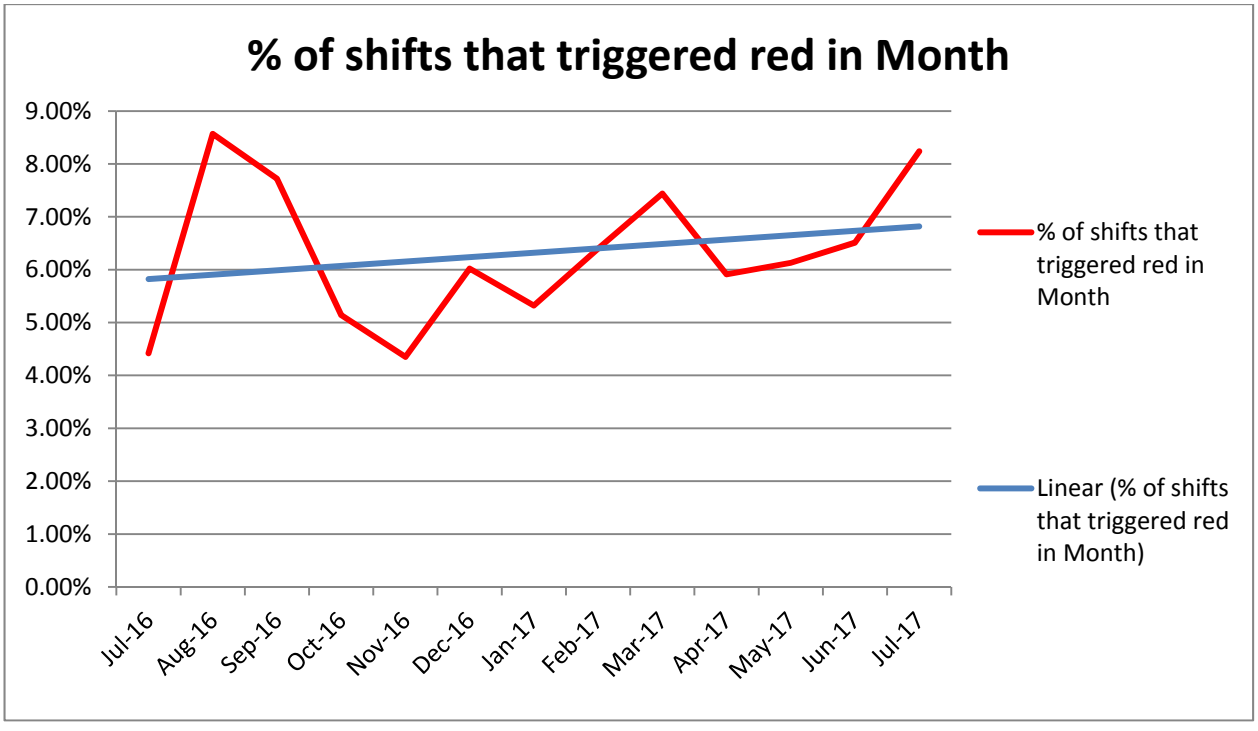
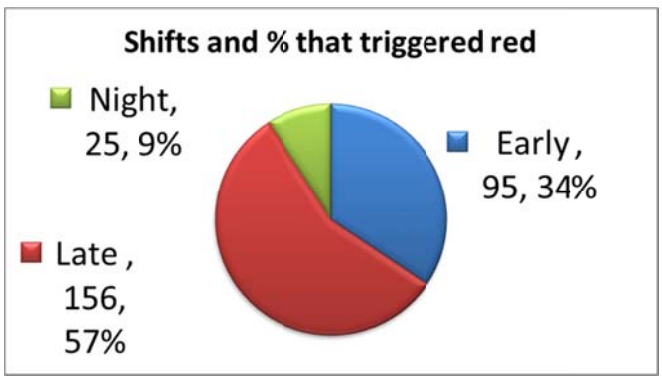
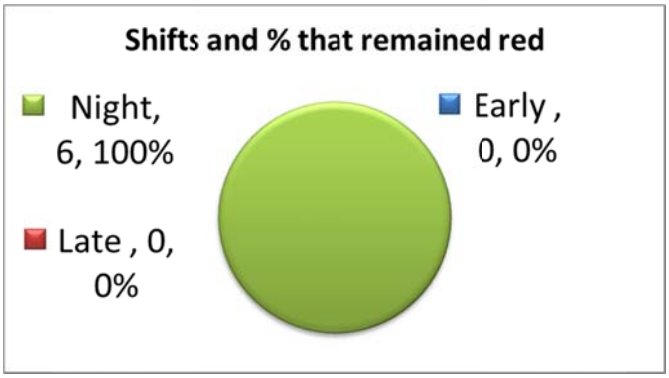


Chart 5 below shows the number and % distribution of red triggered shifts and those shifts that remained red after mitigating action was taken.

Chart 5 – Shifts initially triggering red & remained red





A list of all the shifts triggering red can be found in Appendix 3. 14 wards triggered red on 10% or more of the shifts in month which is an increase from June where 11 wards triggered red on 10% or more of shifts.

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

Table 4 – Wards triggering high number of red shifts

	INITIAL REDS				
Ward	**Early**	**Late**	**Night**	**Number of shifts where staffing initially fell below agreed levels**	**% of shifts where staffing fell below agreed levels and triggered a Red rating**
Barley	5	5	0	10	10.75
6A	4	4	2	10	10.75
10B	6	4	1	11	11.83
11A	6	7	1	14	15.05
ACU	4	9	4	17	18.28
AMU-A	4	13	2	19	20.43
SSU	4	9	1	14	15.05
Ashwell	5	7	2	14	15.05
8B	5	6	3	14	15.05
SAU	4	7	0	11	11.83
11B	2	7	1	10	10.75
5B	15	19	0	34	36.56
10A Gynae	4	7	3	14	15.05
Child A&E	4	8	2	14	15.05

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

2.3 Summary of factors affecting red triggering shifts

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

- Temporary Staffing Fill – Temporary staffing demand increased in July, agency usage decreased by 1.61% and bank filled hours increased by 0.01%. The percentage of unfilled hours increased from 19.1% in June to 20.7% in July. Overall fill rate in temporary staffing dropped by 1.6%; therefore there was an increase in red triggered shifts.
- Sickness – Sickness rate decreased from 6.7% in June to 5.7% in July (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.

3. Staffing risks are 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 the 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.

The Safer Staffing team have re-worded the NICE red flags and developed new flags which are user-friendly and meaningful to the nursing teams. These are being piloted for 3 months, and commenced in May. Red flag notification is sent to a centralised staffing e-mail address and escalated at each of the 3 daily staffing meetings with feedback required prior to each meeting. 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 new red flags much more appropriate to the staffing challenges they need to escalate on a shift.

Chart 6 below shows the distribution of red flags by type. This shows that the shortfall in care hours was the most common flag raised. Matrons are expected to visit any ward that has raised a red flag within an hour to ensure any risk is mitigated.

Chart 6 – Red Flags raised by Type

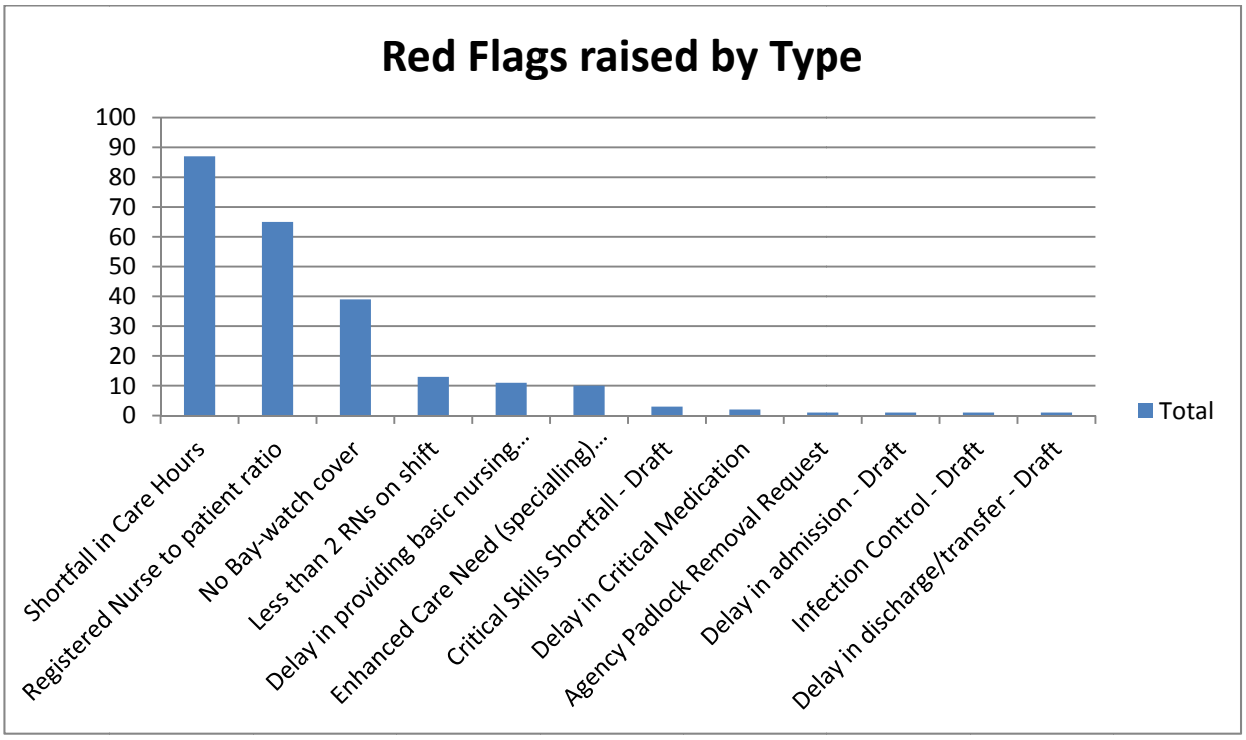
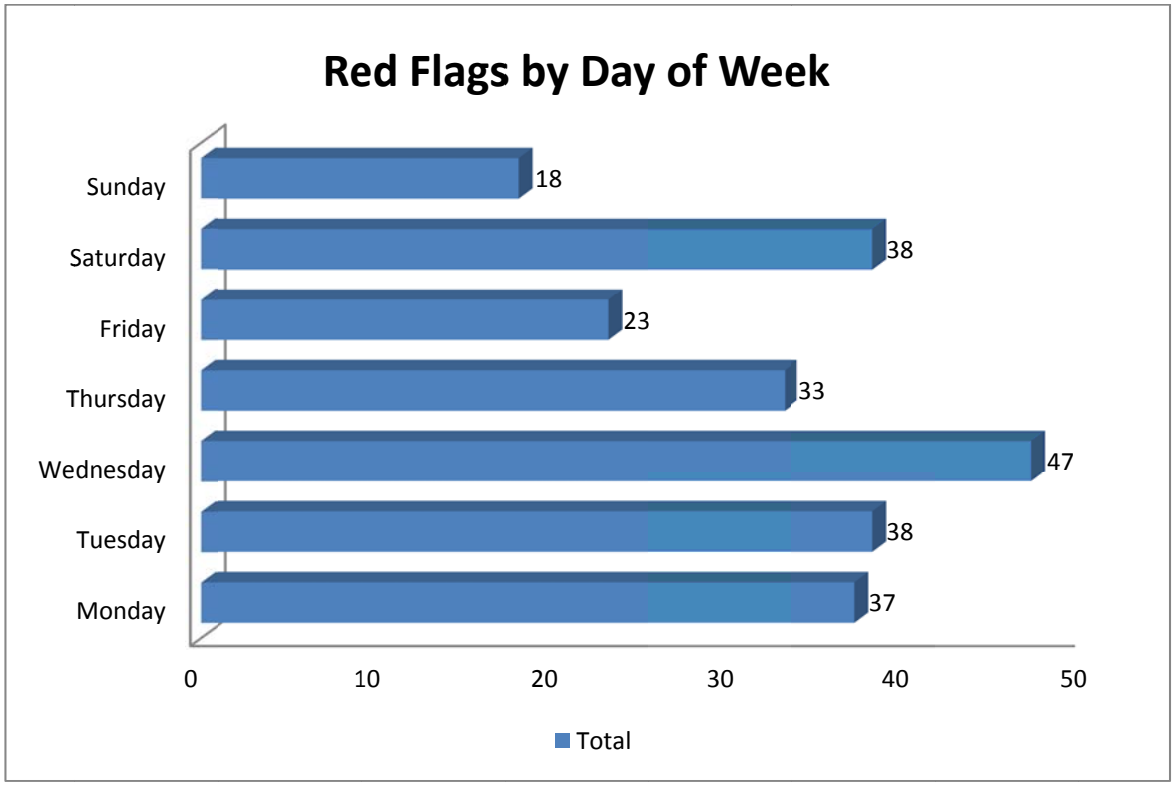


Chart 7 indicates the red flags by day of the week; this shows that Wednesdays had the highest number of red flags raised in July. This data is being interrogated over a period of time in relation to what might affect staffing on particular days of the week.

Chart 7 - Red Flags Day of Week



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

The overall RN fill rate decreased slightly due to a decrease in temporary staffing RN fill. The CHPPD delivered in July also decreased slightly. The maintenance of safe staffing levels on wards in July was supported by:

- Continued daily monitoring and ward RAG rating of staffing levels across inpatient wards
- Matrons review and response to red flag events at the three daily staffing meetings with mitigations fed back to the wards via SafeCare in real time
- Regular patient acuity audits completed by Matrons
- Working with cap compliant agencies
- Working with agencies to identify long line agencies to support areas with high vacancies
- Controlled release of unfilled shifts to agencies
- Additional support provided by e-Roster, NHSP and Temporary Staffing management to assist wards with staffing challenges
- Active management by the Divisional / Duty Matron and support from Matrons and Heads of Nursing within the Divisions to review staffing requirements on a daily basis for identified wards
- Divisional Heads of Nursing, Matrons, Specialist Nurses and the Education Team working clinically where needed
- The introduction of the e-Roster operational support service in the evening to cover the handover of the night shift and support the Duty Matron with the mitigation of red shifts at night
- The e-Roster team visiting 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	91.2%	94.7%	92.6%	107.7%
11A	91.1%	90.4%	96.4%	100.9%
11B	90.2%	93.4%	100.0%	100.0%
5A	94.1%	84.9%	96.8%	148.7%
5B	92.9%	91.7%	93.6%	128.1%
6A	96.3%	88.2%	97.7%	96.5%
6B	99.4%	80.5%	102.3%	101.5%
10A Gynae	100.0%	101.6%	97.5%	104.9%
7B	99.7%	82.5%	96.1%	96.8%
8A	98.5%	93.0%	100.0%	103.2%
8B	90.2%	126.2%	93.0%	230.5%
9A	101.1%	110.1%	93.9%	150.7%
9B	95.8%	114.4%	100.0%	145.1%
ACU	87.7%	82.9%	82.5%	145.7%
AMU-A	91.9%	91.9%	91.0%	103.1%
AMU-W	99.7%	98.0%	97.9%	116.1%
Ashwell	100.1%	107.9%	98.8%	134.0%
Barley	96.2%	98.2%	100.0%	131.3%
Bluebell	88.3%	91.1%	95.1%	#DIV/0!
Critical Care 1	100.0%	100.0%	100.0%	100.0%
Dacre	101.1%	89.7%	97.8%	#DIV/0!
Gloucester	100.2%	88.8%	97.1%	85.6%
CLU	98.4%	89.4%	102.0%	94.2%
Mat MLU	106.4%	102.7%	100.9%	90.4%
Michael Sobell House	80.4%	90.6%	100.7%	103.2%
Pirton	82.1%	100.5%	95.9%	92.9%
SAU	82.6%	91.4%	100.3%	100.0%
SSU	100.1%	113.5%	92.1%	149.3%
Swift	79.2%	88.6%	83.6%	90.8%
Ward 11	89.8%	44.4%	60.8%	10.0%
Total	**94.1%**	**93.3%**	**94.8%**	**112.2%**

Appendix 2

Ward name	Care Hours Per Patient Day (CHPPD)		
	Registered midwives/ nurses	Care Staff	Overall
10B	2.83	2.44	5.27
11A	4.13	1.76	5.89
11B	3.87	2.90	6.77
5A	3.24	1.86	5.09
5B	3.23	2.67	5.90
6A	3.07	2.26	5.33
6B	4.04	2.52	6.56
10A Gynae	5.24	2.74	7.98
7B	3.29	1.60	4.89
8A	3.14	2.13	5.27
8B	3.32	2.59	5.90
9A	3.00	2.86	5.86
9B	3.22	2.70	5.92
ACU	5.05	1.85	6.90
AMU-A	7.97	5.06	13.03
AMU-W	4.05	3.33	7.38
Ashwell	2.89	2.89	5.78
Barley	3.64	2.76	6.40
Bluebell	7.81	1.96	9.77
Critical Care 1	16.76	2.72	19.48
Dacre	6.03	0.92	6.95
Gloucester	3.19	2.57	5.76
CLU	30.07	6.32	36.39
Mat MLU	22.82	7.09	29.91
Michael Sobell House	4.77	3.15	7.92
Pirton	4.64	2.57	7.21
SAU	6.34	2.94	9.28
SSU	3.45	3.01	6.46
Swift	3.80	3.26	7.07
Ward 11	6.80	1.61	8.41
Total	**4.6**	**2.6**	**7.2**

Appendix 3

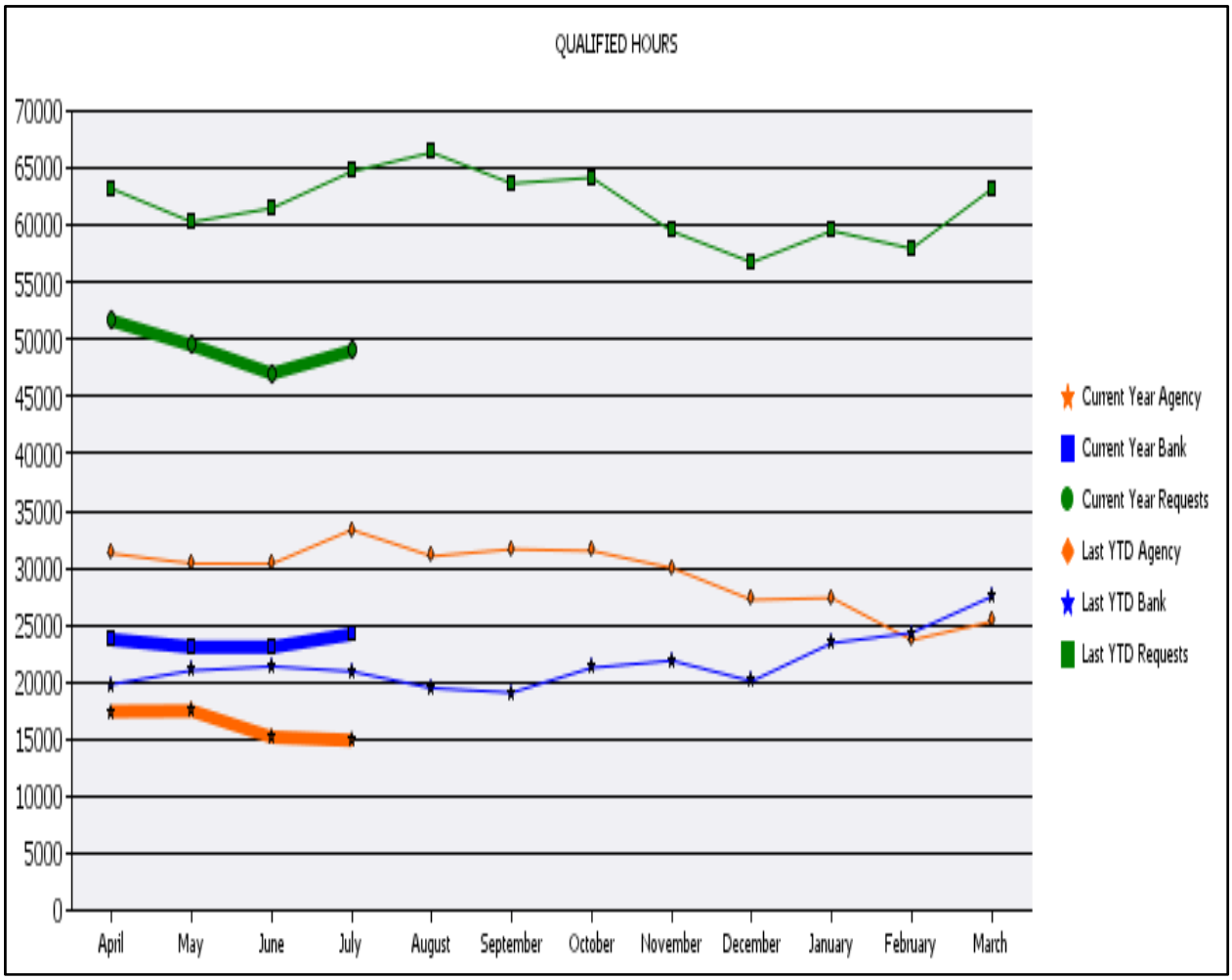
Speciality	Ward	INITIAL REDS				
		Early	Late	Night	Number of shifts where staffing initially fell below agreed levels	% of shifts where staffing fell below agreed levels and triggered a Red rating
Care of the Elderly	9A	3	3	0	6	6.45
	9B	3	3	0	6	6.45
Stroke	Barley	5	5	0	10	10.75
	Pirton	0	1	0	1	1.08
General	6A	4	4	2	10	10.75
	10B	6	4	1	11	11.83
Respiratory	11A	6	7	1	14	15.05
	7AN	0	0	0	0	0.00
Cardiology	ACU	4	9	4	17	18.28
Acute	AMU-A	4	13	2	19	20.43
	SSU	4	9	1	14	15.05
	AMU-W	0	0	0	0	0.00
Renal	6B	1	7	0	8	8.60
DTOC / gastro	Ashwell	5	7	2	14	15.05
ED	A&E	2	3	2	7	7.53
	UCC	0	0	0	0	0.00
		47	**75**	**15**	**137**	**9.21**
General	8A	0	2	0	2	2.15
	8B	5	6	3	14	15.05
	SAU	4	7	0	11	11.83
Surgical Spec	11B	2	7	1	10	10.75
	7B	4	4	0	8	8.60
T&O	5A	2	2	0	4	4.30
	5B	15	19	0	34	36.56
	Swift	0	6	1	7	7.53
ATCC	Critical Care 1	0	0	0	0	0.00
	ASCU	0	0	0	0	0.00
		32	**53**	**5**	**90**	**9.68**
Gynae	10A Gynae	4	7	3	14	15.05
Paeds	Bluebell	2	4	0	6	6.45
	Child A&E	4	8	2	14	15.05
	NICU	0	0	0	0	0.00
Maternity	Dacre	1	0	0	1	1.08
	Gloucester	0	2	0	2	2.15
	Mat MLU	1	2	0	3	3.23
	Mat CLU 1	4	3	0	7	7.53
		16	**26**	**5**	**47**	**6.32**
Inpatient	Ward 10	0	1	0	1	1.08
	Michael Sobell House	0	1	0	1	1.08
		0	**2**	**0**	**2**	**1.08**
	TRUST TOTAL	**95**	**156**	**25**	**276**	**8.24**

Appendix 4

Speciality	Ward	FINAL REDS				
		Early	Late	Night	Number of shifts where staffing initially fell below agreed levels	% of shifts where staffing fell below agreed levels and triggered a Red rating
Care of the Elderly	9A	0	0	0	0	0.00
	9B	0	0	0	0	0.00
Stroke	Barley	0	0	0	0	0.00
	Pirton	0	0	0	0	0.00
General	6A	0	0	0	0	0.00
	10B	0	0	0	0	0.00
Respiratory	11A	0	0	0	0	0.00
	7AN	0	0	0	0	0.00
Cardiology	ACU	0	0	2	2	2.15
Acute	AMU-A	0	0	2	2	2.15
	SSU	0	0	0	0	0.00
	AMU-W	0	0	0	0	0.00
Renal	6B	0	0	0	0	0.00
DTOC / gastro	Ashwell	0	0	0	0	0.00
ED	A&E	0	0	1	1	1.08
	UCC	0	0	0	0	0.00
		0	**0**	**5**	**5**	**0.34**
General	8A	0	0	0	0	0.00
	8B	0	0	0	0	0.00
	SAU	0	0	0	0	0.00
Surgical Spec	11B	0	0	0	0	0.00
	7B	0	0	1	1	1.08
T&O	5A	0	0	0	0	0.00
	5B	0	0	0	0	0.00
	Swift	0	0	0	0	0.00
ATCC	Critical Care 1	0	0	0	0	0.00
	ASCU	0	0	0	0	0.00
		0	**0**	**1**	**1**	**0.11**
Gynae	10A Gynae	0	0	0	0	0.00
Paeds	Bluebell	0	0	0	0	0.00
	Child A&E	0	0	0	0	0.00
	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
		0	**0**	**0**	**0**	**0.00**
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	**0**	**0**	**6**	**6**	**0.18**

Appendix 5

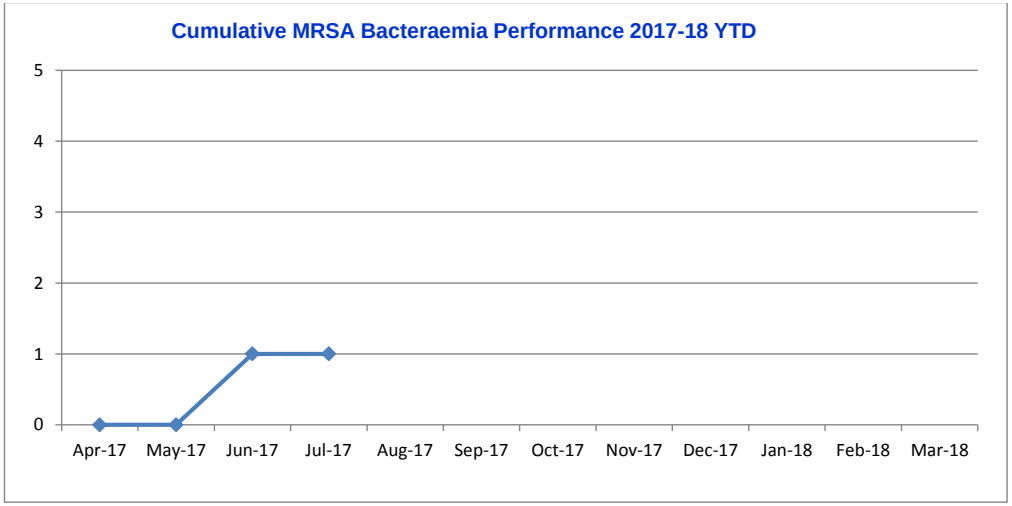
NHSP hours YTD report

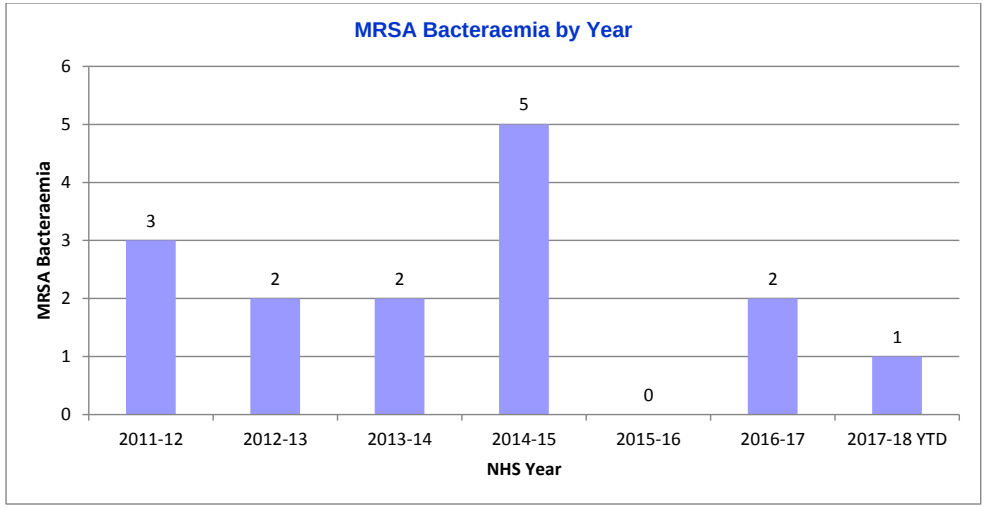


Infection Prevention and Control Board Report Objectives & Outcomes: July 2017

HCAI SURVEILLANCE	MRSA bacteraemias	0 hospital associated MRSA bacteraemia in July Year to date position is 1 case, (target 0 cases to year end)	Red
	C.difficile	4 hospital allocated *C.difficile* cases in July. Year to date position 11 cases (ceiling target of 11 cases to year end). 6 of the 11 cases to date have been provisionally accepted by the CCG Appeals Panel for exemption against financial sanctions as there are no identified gaps in practice.	Amber
	MSSA bacteraemias	3 hospital associated MSSA bacteraemia in July Year to date position is 8 cases (no target set)	Green
	E.*coli* bacteraemias	There were 3 hospital associated E.*coli* bacteraemias in July Year to date position is 17 cases (no target set)	Green
		A new Quality Premium was introduced in July for a 10% reduction in *E.coli* bacteraemias attributed to each CCG, measured against 2016 performance data. This is part of a national requirement for a 50% reduction in gram negative bacteraemias by the beginning of 2021. The strategy is now being developed in partnership with the CCG and other Hertfordshire stakeholders.	TBC
	Klebsiella species *Pseudomonas aeruginosa*	Surveillance and reporting of these two organisms became mandatory from 01 July 2017, backdated to April 2017, as part of the gram negative bacteraemia reduction programme.	TBC
	Carbapenemase-producing Enterobacteriaceae(CPE)	1 new inpatient case identified in July, in a patient transferred from another hospital. 0 new outpatient cases. Year to date position is 5 inpatient cases and 1 outpatient case (no target set)	Green
	Outbreaks / Periods of Increased Incidence	No outbreaks or periods of increased incidence were identified in July.	Green
	Surgical Site Infection	The Trust was identified as a high outlier for 2014-15 in all 3 categories monitored. Figures for 2015-17 to date indicate overall improvement, but the Trust remains a high outlier for Knee Replacement and Hip Replacement.	Amber
CQUINs	Antimicrobial stewardship	8% increase* to end July in total antibiotic consumption (target 2% reduction). 54% reduction* to end July in piperacillin-tazobactam (target 2% reduction) 21.9% reduction to end June in carbapenems (target 2% reduction) * Figures influenced by national shortage of piperacillin/tazobactam	Amber
		Review of sepsis patients on antibiotics who are still inpatients at 72 hrs. Q1: 75% of cases reviewed within 72 hrs to end Q1 (target 25%). Q2: Will be reported at end September	Green
AUDITS	High Impact Interventions (HII)	HII audit scores in July were above 95% with the exception of Hand Hygiene, Intravascular Devices Continuing Care and Renal Environment.	Amber
ISSUES / EVENTS	ICNet	Potential solutions to resolve ongoing ICNet/TPP interface issue were presented to the IM&T Strategy Board in December 2016 and an outline business case for the reinstatement of the ICNet system will be presented in September. On Risk Register.	Red
	Infection in Critical Care Quality Improvement Programme (ICCQIP)	CCU are participating in the voluntary national surveillance programme which commenced in 2017 for blood stream infections in intensive care units, with the aim of reducing the number of such infections.	Green

MRSA BACTERAEMIA – POST 48 HRS





MRSA Bacteraemia by Division

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

MRSA – PHE Benchmarking Data (July 2017)

Public Health England

MRSA

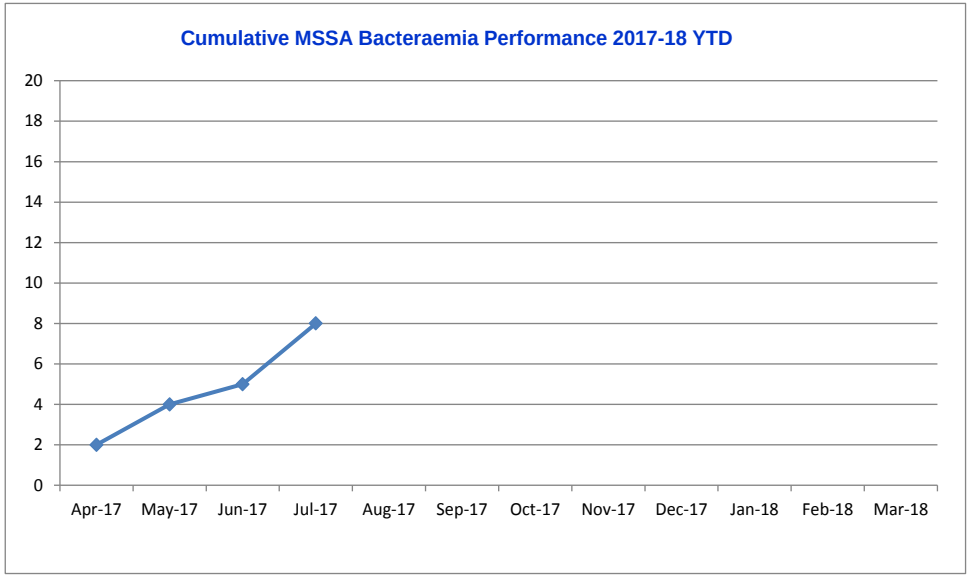
Count of trust PIR assigned cases per month

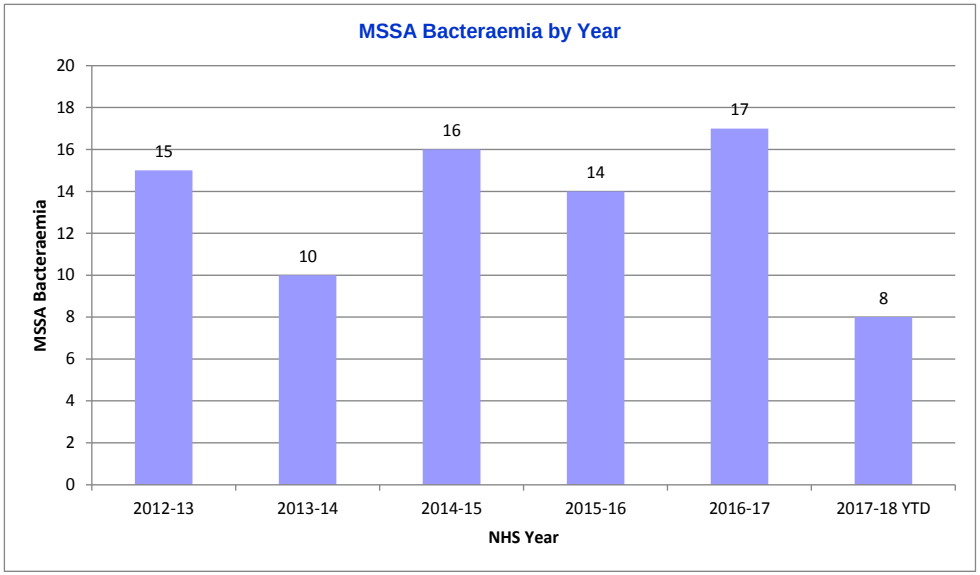
Trust Code	Acute Trust Name	Trajectory	2017									2018			Total
			April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	
RDD	Basildon & Thurrock University Hospitals NHS Foundation Trust	N/A	0	0	0	1									1
RC1	Bedford Hospitals NHS Trust	N/A	0	0	0	0									0
RGT	Cambridge University Hospitals NHS Foundation Trust	N/A	0	0	0	0									0
RDE	Colchester Hospitals University NHS Foundation Trust	N/A	0	0	0	0									0
RWH	East & North Hertfordshire NHS Trust	N/A	0	0	1	0									1
RGQ	Ipswich Hospital NHS Trust	N/A	0	1	0	0									1
RGP	James Paget University Hospitals NHS Foundation Trust	N/A	0	0	0	0									0
RC9	Luton & Dunstable Hospital NHS Foundation Trust	N/A	0	0	0	0									0
RQ8	Mid Essex Hospital Services NHS Trust	N/A	2	0	0	0									2
RD8	Milton Keynes Hospital NHS Foundation Trust	N/A	0	0	1	0									1
RM1	Norfolk & Norwich University Hospitals NHS Foundation Trust	N/A	0	0	0	0									0
RGN	North West Anglia NHS Foundation Trust	N/A	1	0	0	0									1
RGM	Papworth Hospital NHS Foundation Trust	N/A	0	0	0	0									0
RQW	Princess Alexandra Hospital NHS Trust	N/A	0	0	0	0									0
RAJ	Southend University Hospital NHS Foundation Trust	N/A	1	0	0	1									2
RCX	The Queen Elizabeth Hospital King's Lynn NHS Trust	N/A	0	0	0	0									0
RWG	West Hertfordshire Hospitals NHS Trust	N/A	0	0	0	1									1
RGR	West Suffolk Hospitals NHS Trust	N/A	0	0	0	0									0
	East of England Total	**N/A**	**4**	**1**	**2**	**3**									**10**
	England Total	**N/A**	**32**	**29**	**23**	**20**									**104**

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	5.22									1.33
RC1	Bedford Hospitals NHS Trust	N/A	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
RDE	Colchester Hospitals University NHS Foundation Trust	N/A	0.00	0.00	0.00	0.00									0.00
RWH	East & North Hertfordshire NHS Trust	N/A	0.00	0.00	6.01	0.00									1.48
RGQ	Ipswich Hospital NHS Trust	N/A	0.00	5.89	0.00	0.00									1.50
RGP	James Paget University Hospitals NHS Foundation Trust	N/A	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
RQ8	Mid Essex Hospital Services NHS Trust	N/A	14.07	0.00	0.00	0.00									3.46
RD8	Milton Keynes Hospital NHS Foundation Trust	N/A	0.00	0.00	7.95	0.00									1.95
RM1	Norfolk & Norwich University Hospitals NHS Foundation Trust	N/A	0.00	0.00	0.00	0.00									0.00
RGN	North West Anglia NHS Foundation Trust	N/A	4.90	0.00	0.00	0.00									1.21
RGM	Papworth Hospital NHS Foundation Trust	N/A	0.00	0.00	0.00	0.00									0.00
RQW	Princess Alexandra Hospital NHS Trust	N/A	0.00	0.00	0.00	0.00									0.00
RAJ	Southend University Hospital NHS Foundation Trust	N/A	7.17	0.00	0.00	6.94									3.53
RCX	The Queen Elizabeth Hospital King's Lynn NHS Trust	N/A	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									1.31
RGR	West Suffolk Hospitals NHS Trust	N/A	0.00	0.00	0.00	0.00									0.00
	East of England Total	**N/A**	**1.43**	**0.35**	**0.71**	**1.04**									**0.88**
	England Total	**N/A**	**0.91**	**0.82**	**0.65**	**0.57**									**0.74**

MSSA BACTERAEMIA - POST 48 HRS





Hospital acquired MSSA Bacteraemia by Division

Division	2016-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	2017-18 YTD
Cancer	0	0	0	0	0									0
Medicine	10	0	1	0	1									2
Surgical	5	0	1	0	1									2
Women & Children	1	1	0	0	1									2
MVCC	1	1	0	1	0									2
Grand Total	17	2	2	1	3									8

MSSA – PHE Benchmarking Data (July 2017)

Public Health England

MSSA

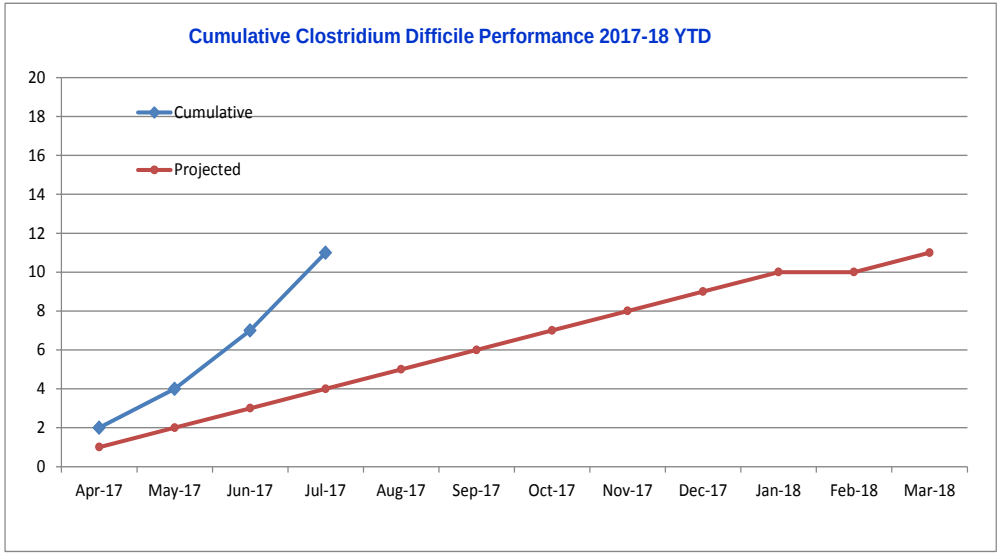
Count of all cases identified by acute trust per month

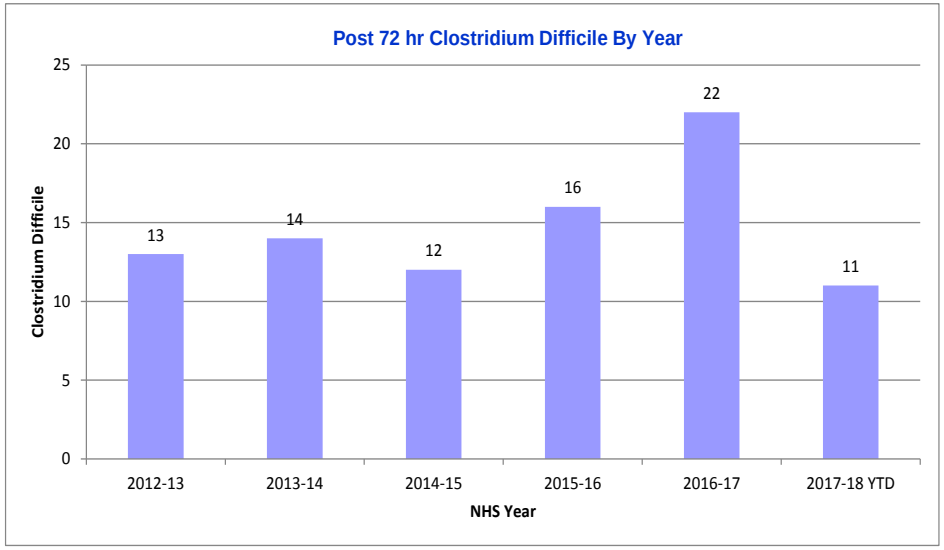
Trust Code	Acute Trust Name	Trajectory	2017 April	May	June	July	Aug	Sept	Oct	Nov	Dec	2018 Jan	Feb	Mar	Total
RDD	Basildon & Thurrock University Hospitals NHS Foundation Trust	N/A	1	2	4	1									8
RC1	Bedford Hospitals NHS Trust	N/A	0	0	1	1									2
RGT	Cambridge University Hospitals NHS Foundation Trust	N/A	2	0	1	0									3
RDE	Colchester Hospitals University NHS Foundation Trust	N/A	1	2	2	2									7
RWH	East & North Hertfordshire NHS Trust	N/A	2	2	1	3									8
RGQ	Ipswich Hospital NHS Trust	N/A	1	0	1	0									2
RGP	James Paget University Hospitals NHS Foundation Trust	N/A	3	0	3	0									6
RC9	Luton & Dunstable Hospital NHS Foundation Trust	N/A	0	0	0	1									1
RQ8	Mid Essex Hospital Services NHS Trust	N/A	1	1	2	2									6
RD8	Milton Keynes Hospital NHS Foundation Trust	N/A	2	2	1	2									7
RM1	Norfolk & Norwich University Hospitals NHS Foundation Trust	N/A	3	1	3	4									11
RGN	North West Anglia NHS Foundation Trust	N/A	0	1	1	2									4
RGM	Papworth Hospital NHS Foundation Trust	N/A	1	2	0	0									3
RQW	Princess Alexandra Hospital NHS Trust	N/A	0	0	1	0									1
RAJ	Southend University Hospital NHS Foundation Trust	N/A	1	2	0	1									4
RCX	The Queen Elizabeth Hospital King's Lynn NHS Trust	N/A	0	1	2	1									4
RWG	West Hertfordshire Hospitals NHS Trust	N/A	3	3	1	1									8
RGR	West Suffolk Hospitals NHS Trust	N/A	0	1	1	0									2
	East of England Total	**N/A**	**21**	**20**	**25**	**21**									**87**
	England Total	**N/A**	**255**	**295**	**264**	**248**									**1062**

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

Trust Code	Acute Trust Name	Trajectory	2017 April	May	June	July	Aug	Sept	Oct	Nov	Dec	2018 Jan	Feb	Mar	Total
RDD	Basildon & Thurrock University Hospitals NHS Foundation Trust	N/A	5.39	10.44	21.58	5.22									10.61
RC1	Bedford Hospitals NHS Trust	N/A	0.00	0.00	9.11	8.82									4.48
RGT	Cambridge University Hospitals NHS Foundation Trust	N/A	7.78	0.00	3.89	0.00									2.87
RDE	Colchester Hospitals University NHS Foundation Trust	N/A	6.47	12.53	12.95	12.53									11.14
RWH	East & North Hertfordshire NHS Trust	N/A	12.02	11.63	6.01	17.44									11.82
RGQ	Ipswich Hospital NHS Trust	N/A	6.09	0.00	6.09	0.00									2.99
RGP	James Paget University Hospitals NHS Foundation Trust	N/A	27.99	0.00	27.99	0.00									13.76
RC9	Luton & Dunstable Hospital NHS Foundation Trust	N/A	0.00	0.00	0.00	5.79									1.47
RQ8	Mid Essex Hospital Services NHS Trust	N/A	7.03	6.81	14.07	13.62									10.38
RD8	Milton Keynes Hospital NHS Foundation Trust	N/A	15.89	15.38	7.95	15.38									13.68
RM1	Norfolk & Norwich University Hospitals NHS Foundation Trust	N/A	11.09	3.58	11.09	14.31									10.00
RGN	North West Anglia NHS Foundation Trust	N/A	0.00	4.74	4.90	9.49									4.82
RGM	Papworth Hospital NHS Foundation Trust	N/A	18.96	36.70	0.00	0.00									13.99
RQW	Princess Alexandra Hospital NHS Trust	N/A	0.00	0.00	7.65	0.00									1.88
RAJ	Southend University Hospital NHS Foundation Trust	N/A	7.17	13.88	0.00	6.94									7.06
RCX	The Queen Elizabeth Hospital King's Lynn NHS Trust	N/A	0.00	8.46	17.48	8.46									8.60
RWG	West Hertfordshire Hospitals NHS Trust	N/A	15.99	15.47	5.33	5.16									10.48
RGR	West Suffolk Hospitals NHS Trust	N/A	0.00	8.16	8.43	0.00									4.15
	East of England Total	**N/A**	**7.51**	**6.92**	**8.94**	**7.26**									**7.65**
	England Total	**N/A**	**7.21**	**8.35**	**7.47**	**7.02**									**7.51**

CLOSTRIDIUM DIFFICILE – HOSPITAL ACQUIRED





Post 72 hr Clostridium Difficile by Division

Division	2016-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	2017-18 YTD
Cancer	0	0	0	0	0									0
Medicine	14	2	1	3	3									9
Surgical	8	0	1	0	1									2
Women & Children	0	0	0	0	0									0
MVCC	0	0	0	0	0									0
Grand Total	22	2	2	3	4									11

Findings from the 11 cases to end July:

- 6 cases have been provisionally accepted by the Appeals Panel for exemption from financial sanctions as there were no identifiable gaps in practice.
- 1 further case to date will be submitted to the October Appeals Panel
- 4 cases to date had an avoidable delay in sending a stool sample and will not be appealed
- In 1 of the above cases antibiotics were inappropriately prescribed

C.DIFFICILE – PHE Benchmarking Data (July 2017)

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									9
RC1	Bedford Hospitals NHS Trust	10	0	1	1	0									2
RGT	Cambridge University Hospitals NHS Foundation Trust	49	1	11	4	7									23
RDE	Colchester Hospitals University NHS Foundation Trust	18	0	3	3	1									7
RWH	East & North Hertfordshire NHS Trust	11	2	2	2*	4									10*
RGQ	Ipswich Hospital NHS Trust	18	1	3	1	8									13
RGP	James Paget University Hospitals NHS Foundation Trust	17	0	2	3	3									8
RC9	Luton & Dunstable Hospital NHS Foundation Trust	6	1	2	1	1									5
RQ8	Mid Essex Hospital Services NHS Trust	13	8	3	2	5									18
RD8	Milton Keynes Hospital NHS Foundation Trust	39	1	0	0	1									2
RM1	Norfolk & Norwich University Hospitals NHS Foundation Trust	49	2	1	6	3									12
RGN	North West Anglia NHS Foundation Trust	40	7	4	4	4									19
RGM	Papworth Hospital NHS Foundation Trust	5	0	0	0	0									0
RQW	Princess Alexandra Hospital NHS Trust	10	1	0	1	4									6
RAJ	Southend University Hospital NHS Foundation Trust	30	5	2	4	1									12
RCX	The Queen Elizabeth Hospital King's Lynn NHS Trust	53	2	3	4	5									14
RWG	West Hertfordshire Hospitals NHS Trust	23	1	1	4	0									6
RGR	West Suffolk Hospitals NHS Trust	16	3	0	0	1									4
	East of England Total	**413**	**40**	**39**	**42**	**49**									**170**
	England Total	**4483**	**346**	**371**	**411**	**463**									**1591**

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

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

Trust Code	Acute Trust Name	Trajectory	2017									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									11.94
RC1	Bedford Hospitals NHS Trust	8.30	0.00	8.82	9.11	0.00									4.48
RGT	Cambridge University Hospitals NHS Foundation Trust	15.60	3.89	41.40	15.56	26.34									21.99
RDE	Colchester Hospitals University NHS Foundation Trust	9.10	0.00	18.80	19.42	6.27									11.14
RWH	East & North Hertfordshire NHS Trust	4.90	12.02	11.63	12.02*	23.26									14.78*
RGQ	Ipswich Hospital NHS Trust	15.60	6.09	17.67	6.09	47.11									19.45
RGP	James Paget University Hospitals NHS Foundation Trust	9.40	0.00	18.06	27.99	27.09									18.35
RC9	Luton & Dunstable Hospital NHS Foundation Trust	13.10	5.99	11.59	5.99	5.79									7.36
RQ8	Mid Essex Hospital Services NHS Trust	3.10	56.28	20.42	14.07	34.04									31.14
RD8	Milton Keynes Hospital NHS Foundation Trust	7.30	7.95	0.00	0.00	7.69									3.91
RM1	Norfolk & Norwich University Hospitals NHS Foundation Trust	25.80	7.39	3.58	22.18	10.73									10.91
RGN	North West Anglia NHS Foundation Trust	15.10	34.32	18.98	19.61	18.98									22.91
RGM	Papworth Hospital NHS Foundation Trust	7.00	0.00	0.00	0.00	0.00									0.00
RQW	Princess Alexandra Hospital NHS Trust	14.40	7.65	0.00	7.65	29.62									11.29
RAJ	Southend University Hospital NHS Foundation Trust	6.50	35.87	13.88	28.70	6.94									21.17
RCX	The Queen Elizabeth Hospital King's Lynn NHS Trust	17.30	17.48	25.37	34.96	42.29									30.09
RWG	West Hertfordshire Hospitals NHS Trust	38.00	5.33	5.16	21.31	0.00									7.86
RGR	West Suffolk Hospitals NHS Trust	10.90	25.30	0.00	0.00	8.16									8.29
	East of England Total	**13.70**	**14.30**	**13.49**	**15.01**	**16.95**									**14.94**
	England Total	**13.13**	**9.79**	**10.50**	**11.63**	**13.10**									**11.25**

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

CARBAPENEMASE-PRODUCING ENTEROBACTERIACEAE

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 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.

Carbapenemase-Producing Organisms - 2017-18

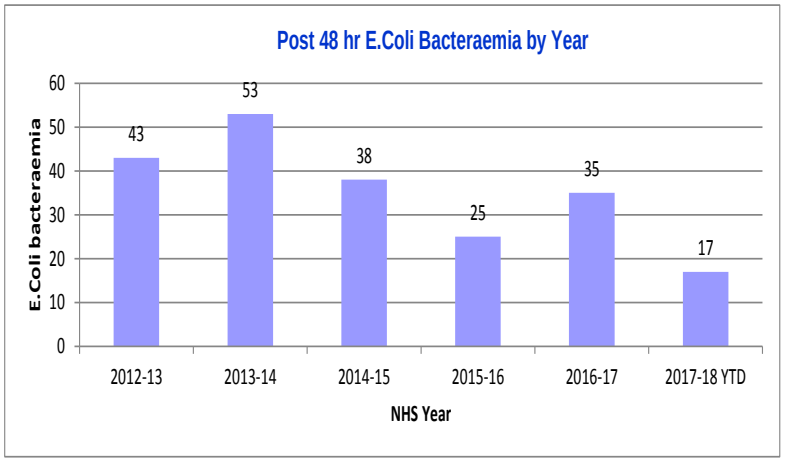
Division/Dept		2016-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	YTD 2017-18
INPATIENTS	Renal Ward - Lister	3	0	0	1	0									1
	Medicine	3	0	1	0	0									1
	Surgery	7	1	0	0	0									1
	W&C	0	0	0	0	1									1
	MVCC	0	0	0	0	0									0
RENAL DIALYSIS UNITS	Lister	1	0	0	0	0									0
	L&D	0	0	0	0	0									0
	Harlow	0	0	0	0	0									0
	St Albans	0	0	0	0	0									0
	Bedford	0	0	0	0	0									0
OUTPATIENTS	Lister	0	0	1	0	0									1
	QEII	1	0	0	0	0									0
	HCH	0	0	0	0	0									0
	MVCC	0	0	0	0	0									0
TOTAL		15	1	2	1	1									5

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

E.COLI BACTERAEMIA – POST 48 HRS

Hospital acquired E.Coli Bacteraemia by Division

Division	2016-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	2017-18 YTD
Cancer	0	0	0	0	0									0
Medicine	16	3	3	2	2									10
Surgical	16	1	2	1	1									5
Women & Children	1	0	2	0	0									2
MVCC	2	0	0	0	0									0
Grand Total	35	4	7	3	3	0	0	0	0	0	0	0	0	17



E.COLI – PHE Benchmarking Data (July 2017)

Public Health England

Escherichia coli

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

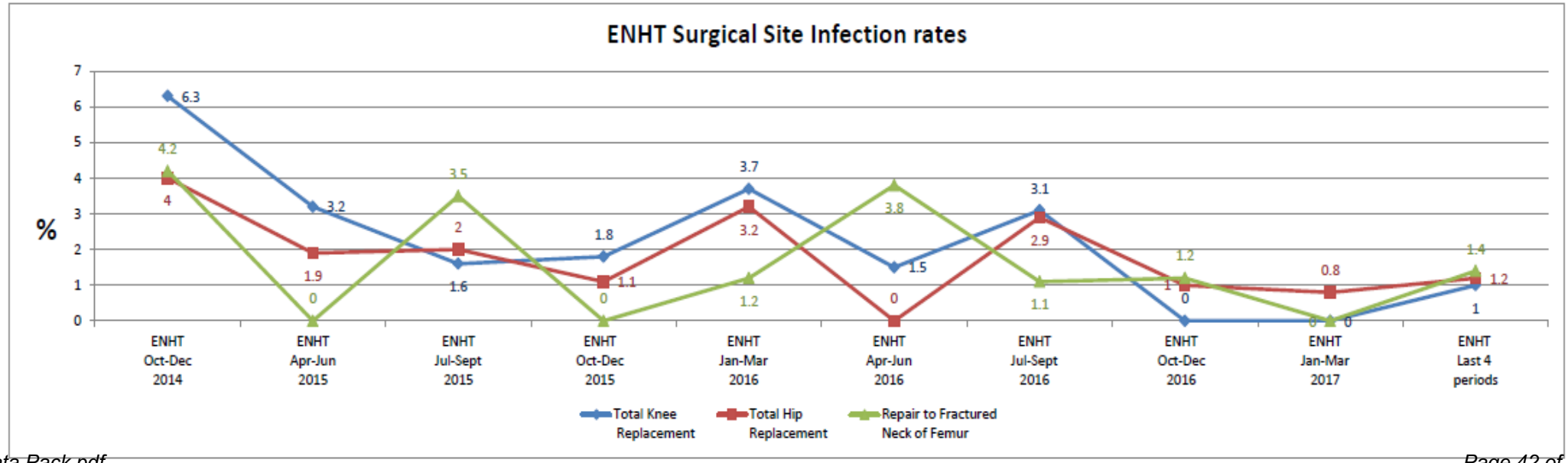
Trust Code	Acute Trust Name	Trajectory	2017 April	May	June	July	Aug	Sept	Oct	Nov	Dec	2018 Jan	Feb	Mar	Total
RDD	Basildon & Thurrock University Hospitals NHS Foundation Trust	N/A	18	22	19	16									75
RC1	Bedford Hospitals NHS Trust	N/A	12	12	12	13									49
RGT	Cambridge University Hospitals NHS Foundation Trust	N/A	32	22	33	32									119
RDE	Colchester Hospitals University NHS Foundation Trust	N/A	16	25	27	26									94
RWH	East & North Hertfordshire NHS Trust	N/A	23	27	18	24									92
RGQ	Ipswich Hospital NHS Trust	N/A	27	21	23	12									83
RGP	James Paget University Hospitals NHS Foundation Trust	N/A	19	23	20	11									73
RC9	Luton & Dunstable Hospital NHS Foundation Trust	N/A	13	12	22	12									59
RQ8	Mid Essex Hospital Services NHS Trust	N/A	16	17	18	21									72
RD8	Milton Keynes Hospital NHS Foundation Trust	N/A	21	13	12	27									73
RM1	Norfolk & Norwich University Hospitals NHS Foundation Trust	N/A	29	24	36	27									116
RGN	North West Anglia NHS Foundation Trust	N/A	25	25	25	36									111
RGM	Papworth Hospital NHS Foundation Trust	N/A	0	1	0	2									3
RQW	Princess Alexandra Hospital NHS Trust	N/A	13	10	13	11									47
RAJ	Southend University Hospital NHS Foundation Trust	N/A	19	21	23	26									89
RCX	The Queen Elizabeth Hospital King's Lynn NHS Trust	N/A	18	18	20	17									73
RWG	West Hertfordshire Hospitals NHS Trust	N/A	18	14	26	28									86
RGR	West Suffolk Hospitals NHS Trust	N/A	12	11	16	15									54
	East of England Total	**N/A**	**331**	**318**	**363**	**356**									**1368**
	England Total	**N/A**	**3290**	**3390**	**3503**	**3690**									**13873**

Surgical Site Infection Rates

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

Category / Quarter	Oct-Dec 14 ENHT	Apr-Jun 15 ENHT	Jul-Sept 15 ENHT	Oct-Dec 15 ENHT	Jan-Mar 16 ENHT	Apr-Jun 16 ENHT	Jul-Sept 16 ENHT	Oct-Dec 16 ENHT	Jan-Mar 17 ENHT	* 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%**	**0%**	**0%**	**1%**	**0.6%**
TKR infections/ops	5 / 80	2 / 63	1 / 64	1 / 57	2 / 54	1 / 66	2 / 65	0 / 85	0 / 77	3 / 293	
Total Hip Replacement	**4%**	**1.9%**	**2%**	**1.11%**	**3.2%**	**0%**	**2.9%**	**1%**	**0.8%**	**1.2%**	**0.7%**
THR infections/ops	4 / 101	2 / 103	2 / 100	1 / 89	3 / 94	0 / 94	3 / 105	1 / 99	1 / 129	5 / 427	
Repair Fractured Neck of Femur	**4.2%**	**0%**	**3.5%**	**0%**	**1.2%**	**3.8%**	**1.1%**	**1.2%**	**0%**	**1.4%**	**1.3%**
#NOF infections/ops	5 / 118	0 / 93	3 / 86	0 / 99	1 / 81	3 / 80	1 / 87	1 / 82	0 / 116	5 / 365	

* 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



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%									95.52%	▼
Surgical Site Observation	93.13%	94.57%	96.46%	97.87%	97.49%									96.69%	▼
Intravascular Devices (Insertion)	93.58%	95.44%	96.16%	95.16%	96.05%									95.71%	▲
Intravascular Devices (Continuing Care)	91.65%	93.29%	94.26%	95.27%	94.42%									94.28%	▼
Urinary Catheter (Insertion)	96.39%	94.26%	99.31%	96.60%	97.14%									96.93%	▲
Urinary Catheter (Continuing Care)	93.82%	88.00%	98.63%	93.92%	97.83%									94.79%	▲
Renal Dialysis (Continuing Care)	96.70%	100.00%	100.00%	100.00%	100.00%									100.00%	◆
Ventilator (Continuing Care)	97.00%	100.00%	81.48%	100.00%	100.00%									94.25%	◆
Environment (Inpatients)	96.70%	96.54%	97.25%	96.74%	96.46%									96.76%	▼
Environment (Outpatients)	97.17%	96.96%	96.50%	97.62%	96.85%									96.99%	▼
Environment (Renal Dialysis)	89.24%	91.18%	93.56%	91.07%	90.39%									91.43%	▼
MRSA Screening Compliance	96.42%	90.25%	97.09%	95.61%	98.03%									95.23%	▲

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

PALS and Complaints Monthly Position Report July 2017

Purpose

This report has been prepared to provide an indication of the Trust's position on Complaints and PALS Concerns data for July 2017. The Quarterly report will expand on the data provided, looking in depth at themes and actions arising. This will include a breakdown on the numbers and subject of complaints for all sites.

Number of Complaints

The Trust received 87 complaints in July. In comparison 67 complaints were received in July 2016. The number of complaints received within the Medicine Division has significantly increased. The increase is attributed to delay in treatment or appointments, the quality of care received and communication. The quarterly report will provide an in depth analysis of the complaints paying particular attention to the location and staff groups that the complaints relate to.

Table 1 - Complaints by Division July 2016 - July 2017

	July 2016	July 2017
Surgery	34	31
Medicine	15	32
Women's & Children's	8	10
Clinical Support	9	8
Cancer	0	4
Operations	1	2

Table 2 - PALS Concerns by Division July 2016 – July 2017

There were 295 PALS concerns for July 2017 compared to 275 in July 2016.

	July 2016	July 2017
Surgery	135	166
Medicine	56	58
Women's & Children's	33	31
Clinical Support	41	22
Cancer	7	18
Operations	3	0

Compliance

The National mandatory timeframe of acknowledging receipt of a formal complaint within 3 working days was achieved in July with 100% of complaints acknowledged within the timeframe.

The Trust has set a target of 80% of all open complaints across the division being responded to within the agreed timescale per month. In July 2017 53% of all the open complaints that were closed across all the divisions were responded to within the agreed timescale.
The reduction in the timeframe for response was highlighted in the Q1 report. An improvement is anticipated for Q2 as the complaints team will be back to full establishment by the end of August. In addition the introduction of a designated DGM to support the complaints team when an investigation needs to be escalated is proving to be very successful. Prior to this, the investigations were escalated to the senior staff within the speciality the complaint related to. This was a pilot but this will now form part of the escalation process on an ongoing basis.

Table 4 – Response timeframe for June 2017 to July 2017

Division	June 2017	July 2017
Surgery	35%	28%
Medicine	63%	65%
Women's & Children's	50%	69%
Clinical Support	100	100
Cancer	67%	50%

Parliamentary and Health Service Ombudsman (PHSO)

There were no requests for papers from the Ombudsman in July.