East and North Hertfordshire NHS Trust

Trust Board Part I

Mount Vernon Cancer Centre, Post Graduate Centre, Rickmansworth Road, Northwood, HA6 2RN

27 July 2016 14:00 - 27 July 2016 16:00

ATTENDEES

Ellen Schroder — Accepted
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East and North Hertfordshire NHS Trust

Alison Bexfield — Accepted
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John Gilham — Accepted
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Julian Nicholls — Accepted
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Bob Niven — Accepted
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Vijay Patel — Accepted
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Nick Carver — Accepted
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Jane McCue — Accepted
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Tom Simons — Accepted
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Stephen Posey — Declined
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Angela Thompson — Accepted
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Brian Owen — Accepted
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Jude Archer — Accepted
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Brian Steven — Accepted
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Joe Maggs — Accepted
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East and North Hertfordshire NHS Trust

AGENDA

#	Description	Owner	Time
1	Chair's Opening Remarks		
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: Medical Director		
5	Minutes of Previous Meeting To approve the minutes of the meeting held on 25 May 2016 05 Draft mins.pdf 7	Company Secretary	
6	Matters Arising and Actions Log For discussion 06 Actions Log.pdf 15	Company Secretary	
7	Annual Cycle To approve the new annual cycle. 07 Board Annual Cycle 2016-17 revised new format.pdf 27	Company Secretary	

#	Description	Owner	Time
8	Chief Executive's Report To approve the Executive Terms of ReferenceAppendix B will follow on Monday 08 FINAL - CE Board Report JULY.pdf 31 08b Trust Floodlights 2016-17 Month 3 FINAL.pdf 35	Chief Executive	
9	Finance and Performance		14:30
9.1	Finance and Performance Committee monthly report For discussion 9.1 FPC Report_to_Board_July 2016.pdf 43	Chair of FPC	
9.2	Finance report For discussion 9.02 Finance Report.pdf 49	Director of Finance	
9.3	Performance Report For discussion 09.3 Performance Report.pdf 71	Deputy Director of Operations	
9.4	Workforce Report For discussion. 09.4 Workforce Report.pdf 81	Director of Workforce and OD	
10	Risk and Quality		15:30
10.1	Risk and Quality Committee report (including Revalidation, Post OCH Quality Benefits Realisation and Infection Control Annual Report) For discussion 10.1 RAQC Report to Board - July.pdf 93	Chair of RAQC	
10.2	Nursing Establishment Review For approval 10.2 Nursing and Midwifery Establishment Review.pdf 183	Director of Nursing	

#	Description	Owner	Time
11	Data pack For information Data Pack.pdf 201 Health and Safety Metrics June 16.pdf 275	All Directors	
12	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.		16:00-18:00
12.1	Commercial-in-confidence		
12.2	Governance Matters		
12.3	Personnel Matters		
13	Date of next meeting: 2pm Wednesday 27 July 2016, Post Graduate Centre, Mount Vernon Cancer Centre, Rickmansworth Road, Northwood, HA6 2RN		

EAST AND NORTH HERTFORDSHIRE NHS TRUST

Minutes of the Trust Board meeting held in public on Wednesday 29 June 2016 at 2pm at the New QEII Hospital, Howlands, Welwyn Garden City,

Present:	Mrs Ellen Schroder	Chair of the Trust Board
	Mr Nick Carver	Chief Executive
	Mr Michael Chilvers	Divisional Chair, Surgery Division
	Mr John Gilham	Non-Executive Director
	Mr Julian Nicholls	Non-Executive Director
	Mr Bob Niven	Non-Executive Director
	Mr Tony Ollis	Director of Finance
	Mr Brian Owens	Acting Director of Operations
	Ms Angela Thompson	Director of Nursing
From the Trust:	Ms Jude Archer	Company Secretary
	Ms Ellen Heaney	Deputy Company Secretary
	Mr Vijay Patel	Non-Executive Director Designate
	Mr Stephen Posey	Deputy Chief Executive
	Mr Tom Simons	Director of Workforce and Organisational Development
	Mr Brian Steven	Interim Director of Finance
In Attendance	Mr Harper Brown	Director of Commissioning East and North Hertfordshire Clinical Commissioning Group
	Ms Jacqui Evans	East and North Hertfordshire NHS Trust
	Sister Dagmar Louw	East and North Hertfordshire NHS Trust

ACTION

16/154 CHAIR'S OPENING REMARKS

16/154.01 The Chair welcomed everyone to the meeting. Mr Steven, Interim Director of Finance was welcomed to his first Trust Board meeting and the Chair and Board thanked the Tony Ollis, Director of Finance for his hard work since joining the Trust in 2014 and wished him well in his retirement.

16/155 DECLARATIONS OF INTEREST

16/155.01 There were no declarations of interest.

16/156 QUESTIONS FROM THE PUBLIC

16/156.01 The Chair confirmed there were no questions from the public.

16/157 APOLOGIES FOR ABSENCE

16/157.01 Apologies for absence were received from Alison Bexfield, Non-Executive Director and Miss Jane McCue, Medical Director. Mr Chilvers deputised for the Medical Director.

16/158 MINUTES OF THE PREVIOUS MEETING

16/158.01 The minutes of the meeting held on 25 May 2016 were considered and approved as an accurate record of the meeting subject to the following amendments

16/129.01 the average daily planned run rate in the first half of the year was £77k deficit reducing to a deficit of £53k….

16/135.01 (2nd sentence) The CTC had set a target expense ratio of 25p….

16/159 ACTIONS LOG

16/159.01 The Board reviewed and noted the actions log. In relation to item 16/97.02 The Acting Director of Operations provided a verbal update on the review of activity carried out following the industrial action. As well as seeing a significant reduction in emergency attendances the Trust had seen a different case mix to normal with a range of conditions not presenting either later at the Trust's ED or elsewhere within the system. Mrs Schroder (Chair of the Trust) asked whether there was a trend or pattern of non-attendance that the CCG and Trust could seek to reproduce. The Acting Director of Operations advised the Board that the System Resilience Group was looking at the attendance patterns but could not find a correlation between actions taken in community and reduced attendance during industrial action that could be replicated.

16/159.02 The Director of Nursing reminded the Board that the reduced attendance had been seen nationwide and that following the industrial action several trusts were now considering introducing an extra stage of triage to determine whether patients should be seen in ED or whether an appointment should be made for them to see a GP. Mrs Schroder asked whether the Trust could introduce a similar measure. Ahead of the industrial action local GPs had supported the Trust by running extra clinics but had not supported the Trust making direct GP appointment bookings on behalf of patients. Mr Niven (Non-Executive Director) suggested that increasing awareness of the pressures on ED and likely wait times may discourage people attending if they could see a GP promptly and easily instead. The Trust and CCG would continue to work together to promote emergency admission avoidance schemes.

16/159.03 The Director of Workforce and Organisational Development suggested that the wording of action 16/102.05 be amended to reflect that the Board Development session should look at the strategic and national picture and how this related to the Trust. Mr Gilham (Non-Executive Director) asked for the board development session to also include a discussion on staff retention. It was noted that the session was scheduled for July 2016. **Director of Workforce and OD**

16/160 ANNUAL CYCLE

16/160.01 The Annual Cycle was noted. Mrs Schroder reminded the Board that from September Board meetings would be held on alternate months with Board development sessions held during the intervening months. A Non-Executive Director pre-meeting would be held 1-2pm before each Board meeting or Board Development session. The Company Secretary would confirm arrangements in writing following the Board meeting. **Company Secretary**

16/161 CHIEF EXECUTIVE'S REPORT

16/161.01 The Chief Executive expressed his gratitude to the Director of Finance for his work since joining the Trust in 2014, these thanks were echoed by the Board. He also welcomed Brian Steven as Interim Director of Finance. The Chief Executive was pleased to report that Summary Hospital level Mortality Indicator (SHMI) for January 2015- December 2015 was 109.7 (within the normal range). The Board also noted that a record low number of falls had been

recorded in May (2.2 per 1000 bed days) and congratulated Enda Gallagher, Acute Falls Prevention Nurse and his team for their work in reducing falls across all sites.

16/161.02 Several Trust staff had recently graduated from the Accelerated Director Development Scheme and 2 more senior staff from the Trust had commenced on the new programme. The Board was also pleased to note that two teams had been shortlisted for the annual Nursing Times award (The Acute Chest Team for improving outcomes for patients with respiratory conditions and the Specialling team for their provision of care to patients with dementia). The Director of Nursing also advised the Board that Sister Tracey Maryan had been nominated for an award following her work to improve culture and performance on Ashwell ward. The Board congratulated all of the teams and individuals involved and asked the Chief Executive to formally pass their thanks and congratulations to those involved and to the staff nominated for the Comet's Community Awards. **CEO**

16/161.03 While discussing the Executive Committee Summary Report to Board Mr Niven asked how the Business Intelligence Design concept differed from the existing IM&T provision. The Deputy Chief Executive explained that using QlikView to drill down into the data shown on the floodlight scorecard allowed teams greater access to the data and tools they needed to take informed decisions and monitor performance accurately. The QlikView system could also be developed iteratively to meet the needs of the Trust and individual teams. The IM&T team was moving away from capturing and providing data (the new tools would allow divisions to do this) and would now be able to dedicate significantly more time to the analysis of data. Mr Niven and Mr Gilham suggested that a Board Development session be held to look at the possibilities and scope of internal data analytics and how this related to finance and workforce. **Company Secretary/ Deputy CEO**

16/161.04 The Board discussed and approved the revised Executive Committee Terms of Reference and noted the floodlight scorecard for May 2016.

STRATEGIC ISSUES

16/162 Mortality Report

16/162.01 The Divisional Chair, Surgery Division, presented the Mortality report. All indicators had shown positive improvements and the Trust was one of eight trusts within the East of England to have a lower than expected Hospital Standardised Mortality Ratio. There had been a slight increase in crude mortality since April 2016 and the Medical Director was investigating the factors causing this and impact it could have on other indicators. Following the closure of the Princess Alexandra Hospital Hyper Acute Stroke Unit (HASU) earlier in the year the Trust had seen a significant increase in stroke patients; the recent announcement that Bedford Hospital HASU would also close would put further pressure on the stroke unit and could potentially affect patient outcomes.

16/162.02 Mr Steven (Interim Director of Finance) noted that performance was strong across the Trust and asked what were the key areas of risk. Other than the risk posed to the stroke service by additional demand, it was noted that vascular surgery (particularly in relation to Abdominal Aortic Aneurism) had slightly higher mortality rates than

expected as did gastroenterology. The Divisional Chair explained that gastroenterology sat across medical and surgical divisions and it was thought that a higher than appropriate number of patients may have been assigned to the surgical division and creating a disproportionate impact on the mortality due to the relatively low patient base in the division. If these patients were correctly assigned to the medical division they had relatively little negative impact on the mortality indicators for the medical division due to the larger patient population but would significantly reduce the mortality rate in the surgical division.

16/162.03 Mr Steven also asked how the Trust was following up the *Getting It Right First Time* work. It was noted that staff involved in the pilot had found individualised performance data extremely useful and the surgery division was discussing the option of allowing consultants and doctors to compare their own and their team's performance against benchmark on a number of indicators through an additional function of Dr Foster. This was currently being costed. Mr Gilham noted that the Risk and Quality Committee had asked for mortality associated with intestinal obstruction (without hernia) to be reviewed and reported on at a future Risk and Quality Committee meeting. **Medical Director**

16/162.04 Mrs Schroder asked for an update on Seven Day Services. Nationally the timetable had been put back and the Trust would now need to have implemented 4 of the 8 measures by 2018 and the remaining 4 by 2021. In key areas the Trust had already prioritised resources to develop seven day services (Critical Care, Respiratory) and had seen significant improvements in patient outcomes as a result.

FINANCE AND PERFORMANCE

16/163 Finance and Performance Committee's Report

16/163.01 Mr Nicholls (Chair of the Finance and Performance Committee) presented the Committee's report to the Board. Under delegated authority the Committee had approved in principle an application to apply for an interest free loan to replace the steam traps at Lister Hospital. The Committee had been satisfied that the new traps would be more efficient but had asked the Trust to look in more detail at the proposal and how the loan repayment would affect cash flow before taking a final decision.

16/163.02 The floodlight scorecard had been discussed by the Committee; the Committee had asked the Trust to ensure that targets were realistic and to consider how progress towards an end of year target could be shown. Service Line Reporting had progressed well. The Committee had asked the Trust to review the regional arrangements for stroke services and to consider what the Trust needed to do to continue to deliver a high quality service in this area.

16/163.03 Mr Gilham asked for an update on the work of the Carter Review Programme Board. The Deputy Chief Executive advised the Board that some of the data initially used in the Carter Review had been re-categorised reducing the potential savings. The Trust however had identified a number of potential schemes and the Finance and Performance Committee was reviewing these and how they were prioritised. The Committee would continue to review progress on a quarterly basis to ensure that the Trust invested in schemes that gave the best return in terms of financial savings or quality. The Trust's Carter Review Programme Board was seen as best practice

regionally and the terms of reference were being shared as best practice with other trusts.

16/164 Finance Report

16/164.01 The Director of Finance presented the Finance Report to the Board. This had been discussed in detail at the Finance and Performance Committee. The Trust had delivered a £2.684m deficit in month against a planned deficit of £2.766m, creating a favourable variance of £82k in month and a year-to-date deficit of £5.095m (£127k favourable variance year-to-date). Clinical income had been higher than budgeted (£568k higher in month) largely due to over performance in elective, day cases and outpatients. This had been partially offset by an under performance in maternity which was being reviewed by the Finance and Women's and Children's teams.

16/164.02 The Board was pleased to note that Cost Improvement Programme (CIP) delivery had been higher than planned in month, achieving 131% of the savings planned in the month. However, it was noted that the CIPs were rear loaded and that the saving requirements would increase significantly in the coming months. Mr Nicholls expressed concerns that not all CIPs had been identified as yet and reminded the Board that starting a CIP later in the year would increase the monthly saving required to meet the target for the year. It was agreed that the newly identified CIPs would be presented to the Finance and Performance Committee at its next meeting. **Director of Finance**

16/165 Performance Report

16/165.01 The Acting Director of Operations presented the Performance Report to the Board. The Trust was performing above the agreed trajectory in ED (84.7% in May against a forecast of 77.0%) but still below the national standard of 95%. The Trust was meeting Referral to Treatment (RTT) targets and diagnostic targets. The Trust had not met the cancer 62 day referral to treatment target in April achieving 80.5% against a target of 85%. The Board noted that if breach sharing rules were applied the Trust would have reported 87% achievement.

16/165.02 The CCG and Trust had been reviewing referrals and both parties agreed that there had been an increase of 15% in referrals which urgently needed to be understood, the Trust and CCG were working together to understand this growth and would discuss this further in the coming week. The growth in referrals would put significant pressure on performance against the targets for RTT, Cancer and diagnostics.

16/165.03 Mrs Schroder asked how the Trust was managing the financial and performance risks associated with the growth in stroke referrals following the closure of Bedford Hospital's HASU. The Trust anticipated treating an additional 100 patients annually. It had been agreed that the Trust would be paid the London tariff for treating these patients; the Trust would need additional staff to manage the increased demand and would look to recover these costs. The Acting Director of Operations reminded the Trust that a general bed could not be easily converted to a stroke bed due to the staff and equipment requirements and that identifying additional stroke beds would be a challenge. Mr Gilham noted that the Trust had not performed well against the 3 hour thrombolysis target but had performed well against the 4.5 hour standard and asked for the data for both targets to be shown so that the Board could monitor **Acting Director of**

progress in this area. **Operations**

16/165.04 Mr Gilham asked how increased demand was affecting the RTT performance. The increased demand placed further pressure on the Trust. Earlier in the year the Trust had cancelled c.200 procedures due to the industrial action leading to significant performance challenges. Nationally Trusts were achieving 91.5% of referrals to treatment so the Trust was still performing well above average but it was noted that the growth in demand coupled with cancellations increased the risk of not meeting this target in coming months.

16/166 Workforce Report

16/166.01 The Director of Workforce and Organisational Development presented his monthly report to the Board. It was noted that the unit pricing had decreased by £10ph for medical staff since November 2015 and by £5.50ph for nursing staff. The Trust would continue to work to bring the unit pricing down further. The Surgical division was piloting real time information giving greater visibility of staffing and allowing managers to see the effects of staffing decisions. A review of resourcing in the ED and how this could be deployed to the best effect had commenced; this would be reported the Board in September.

16/166.02 Recruitment of nurses remained a challenge and the Board noted the methods currently being used including developing a new contracting model with agencies in the Philippines, recruiting directly in India and advertising on trains. A gap analysis had been carried out based on the findings of the bullying and harassment study, this work was an integral part of the Trust's culture and leadership work and would continue to be reported through this section of the reports.

16/166.03 The Trust was aware that it needed to increase the development opportunities for leaders and managers in the Trust, it was also noted that staff wanted more flexibility to manage their work and other commitments. The Trust had reviewed best practice in this area and the Divisional Executive Committee had approved a change in culture around flexible working requests. The 100 most influential leaders in the organisation had completed their coaching and a further 200 staff would be offered coaching.

16/166.04 Mr Niven noted that following the EU Referendum there had been worrying reports of racial abuse across the country and asked whether this had been a problem for staff in the Trust. The Director of Nursing and Director of Workforce and Organisational Development explained the procedures followed where staff were subject to harassment and confirmed that the Trust had liaised with the Trade Unions to discuss these concerns. The Trust's policies and procedures made it clear that harassment of staff would not be tolerated. Mr Niven asked for it to be made known that the Board would not tolerate any form of racial harassment.

16/167 Finance and Performance Committee Annual Report and Terms of Reference.

16/167.01 Mr Nicholls introduced the Finance and Performance Committee's annual report. The Committee had reviewed whether it had discharged the duties set out in the terms of reference by reviewing minutes and asking Committee members to consider how well the Committee had operated and what further improvements could be

made. The Committee had concluded that the duties in the Terms of Reference had been met and had recommended that more focus be given to long and medium term financial strategy and the reviewing of financial risks.

The Committee had also recommended changes to the terms of reference, in particular to the to the attendance of staff at the meetings, with core members being invited to attend all meetings and other staff invited to attend to present their item or as part of their development with the agreement of the Committee Chair. The Company Secretary recommended that the Terms of Reference be further amended to include the Director of Nursing as a core attendee. The Board approved the revised Terms of Reference (incorporating the Company Secretary's proposed change) and noted the work of the Committee over the last year. **Company Secretary**

RISK AND QUALITY

16/168 Risk and Quality Committee Report

16/168.01 Mr Gilham (Chair of the Risk and Quality Committee) presented the Risk and Quality Committee's report to the Board. Many of the matters discussed had been covered in earlier reports or were scheduled for discussion in Part 2 of the meeting. The Committee had discussed the Trust's performance against the highly challenging C.Difficile target. The Director of Nursing reported that the Trust had reported 7 cases of C.Difficile to date this year, 2 of which were being appealed. There was no relation between cases and no evidence of cross-contamination. The Trust remained the 2nd lowest reporter of C.Difficile cases in the East of England.

16/168.02 Mrs Schroder noted that while the number of deprivation of liberty (DoLs) application had increased dramatically the local authority had authorised relatively few. The Local Authority had limited resources to manage the growing number of DoLs applications and had prioritised resources to assess those considered at higher risk; patients in an acute trust were considered to be at low risk of abuse or improper deprivation of liberty. The risks were recognised by both the Trust and the Local Authority.

16/168.03 The Committee recommended the Annual Health and Safety and Annual Adult Safeguarding reports to the Board. The reports were noted and approved.

16/169 Quality Account

16/169.01 The Head of Quality and Patient Safety presented the Quality Account which had been written in line with the regulatory requirements and with input from stakeholders. The report had been discussed at the Risk and Quality Committee meeting. The opinion of the External Auditor was noted. A limited assurance opinion had been given, the Trust noted that this was the mandated response due to the limited nature of the audit.

16/169.02 Mr Patel (Non-Executive Director) asked who the report's intended audience was. The report was intended to be for members of the public but in recent years a number of requirements had been prescribed making the report lengthier and more detailed than originally intended. The report would be published on the Trust's website and NHS Choices. Mrs Schroder suggested that a short summary booklet highlighting key performance measures be **Head of Quality and Patient**

created, preferably ahead of the Trust's Annual General Meeting. **Safety**

16/169.03 The Board thanked the Head of Quality and Patient Safety for her work in preparing the Quality Account. The Quality Account was approved for publication.

16/170 Risk and Quality Committee Annual Report and Terms of Reference

16/170.01 Mr Gilham presented the Committee's Annual Report reviewing how the Committee had met its terms of reference over the year. The assessment had been carried out by reviewing the minutes of meetings and Committee members had been asked to comment on how well the Committee operated. The findings had been similar to those expressed by FPC members with a desire to have a greater focus on strategic risk management. The Committee had agreed to consider what was meant by this and how to deliver it in September. The Board thanked the Committee for its work and noted the contribution of former Committee Chair and Non-Executive Director, Dyan Crowther.

16/170.02 The Terms of Reference were approved.

16/171 DATA PACK

16/171.01 The Board noted the Data Pack.

There being no further business the Chairman closed the meeting at 15:30 pm.

Ellen Schroder
Trust Chair

June 2016

	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 JULY 2016

Meeting Date	Minute ref	Issue	Action	Update	Responsibility	Target Date
27 January 2016	16/16.01	NHS revalidation changes	Discuss the possible impact of the NHS revalidation changes on staff attrition, possible actions and communications.	Feb 16: The impact of this will not be fully known until the Trust has 6 months of revalidation data. Following approval by Board date set to Oct 16. June 2016: Interim report provided to RAQC in June which after first 3 months did not indicate there was a higher level of leavers at present due to revalidation. Further update to be provided in October.	Director of Nursing and Director of Workforce and Organisational Development	**October 2016**
30 March 2016	16.074.3	Charity Strategy	Strategy to reduce the pence per pound spent on overheads to be added to the strategy. CTC to consider whether to continue with the lottery (for ethical and commercial reasons). Revised strategy to be brought back to the Board in 6 months once new Head of Charity in post.	May 16: Strategy is scheduled for review by the CTC and Board in September	Head of Charity	**September 2016**
27 April 2016	16.97.02	Junior Doctors' Industrial Action Debrief	Analyse factors that led to reduced ED attendance during industrial action as part of debrief	July 2016: Verbal update given by the Acting Director of Operations in June 2016, action closed by Board.	Medical Director	**June 2016**

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

Meeting Date	Minute ref	Issue	Action	Update	Responsibility	Target Date
27 April 2016	16.98.02	Sustainability and Transformation Plan	Bring an update on progress of the plan and the governance arrangements to a future Board meeting.	June 2016: STP update will be brought to the July meeting. New date proposed July 2016: Following a meeting between the ALB CEOs and the Hertfordshire and West Essex system it has been agreed that ENHT and Nick Carver will lead the acute work stream feeding in to the STP process. Immediate priorities will be advancing the joint work between ENHT and PAH and understanding the status of the relationship between WHHT and Royal Free. In addition work has commenced to identify opportunities relating to back office functions and shared functions. A paper will be provided to the next meeting of the Trust Board in part 2.	Deputy Chief Executive	**June 2016** ***July 2016**

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

Meeting Date	Minute ref	Issue	Action	Update	Responsibility	Target Date
27 April 2016	16.102.05	Board Development Session	Consider spending a development session reviewing staff retention and the strategic & national workforce issues, how these relate to the Trust.	May 16: Workforce is a scheduled topic for the June 2016 Board Development Session. June 2016: Due to the session on the STP, this has been scheduled for 27 July 2016: Wording revised following June Board meeting; Dir of W&OD agreed the session would look at the national and strategic issues including retention. July 2016 – Session to be held on 27 July	Company Secretary/ Director of Workforce and Organisational Development	**June 2016** ***July 2016**
25 May 2016	16.125.2	Research Risks and Mitigation	(i) Indicate ownership and timescale for actions; (ii) Omit 'international' from the risk 'Awareness of our international research is low'.	July 2016 – see report appended to log	Medical Director	**July 2016**
29 June 2016	16/160.01	Revised Annual Cycle	Confirm arrangements for the new meeting schedule in writing.		Company Secretary	**July 2016**
29 June 2016	16/161.02	Chief Executive's Report	Congratulate staff named in the report for their achievements on behalf of the Board		Chief Executive	**July 2016**
29 June 2016	16/161.03	Board Development Session	Arrange a board development session to look at the capabilities and future developments of data analytics.	July 2016: This has been added to the list of future topics. Timing of the session to be agreed.	Company Secretary / Deputy Chief Executive	**September 2016**

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

Meeting Date	Minute ref	Issue	Action	Update	Responsibility	Target Date
29 June 2016	16.162.03	Mortality	Review mortality associated with intestinal obstruction at Risk and Quality Committee	June 2016: Being monitored through the RAQC action log	Medical Director	**September 2016**
29 June 2016	16.164.02	Cost Improvement Programme	Present newly identified Cost Improvement Programmes to the Finance and Performance Committee for review.	June 2016: On agenda for Finance and Performance Committee July 2016	Director of Finance	**July 2016**
29 June 2016	16.165.03	Thrombolysis target	Show performance against the 3 hour target for thrombolysis and the 4.5 hour standard.	July 2016: verbal update to be provided. To be included from September onwards.	Director of Operations	**July 2016**
29 June 2016	16.167.01	Finance Performance Committee TOR	Amend the Terms of Reference to include the Director of Nursing as a core member.	July 2016: TOR updated attached to July actions log for info.	Company Secretary	**July 2016**
29 June 2016	16.169.02	Quality Account	Prepare a short summary booklet of key quality information.	July 2016: Action completed; see summary appended to log	Head of Quality and Patient Safety	**July 2016**

East and North Hertfordshire NHS
NHS Trust

TRUST BOARD PT 1 – 27 JULY 2016
Action Reference 16.125.2 – Research Risks and Mitigation

Research Strategy 2016 – 2019
Risks and mitigating actions for each of the five objectives

Author: Associate Director Research and Development, 20th July 2016

Version History: This paper has been updated from Version 1 dated 13th May 2016 which was reviewed by the Trust Board on 25th May 2016. The Board requested the following:

- Indicate ownership and timescale for actions;
- Omit 'international' from the risk 'Awareness of our international research is low'.

1 Purpose

1.1 The Research Strategy was approved by the Trust Board on 27th April 2016. During the discussion the Board requested a report covering "showing the risks and mitigating actions for each of the five objectives to the Research Annual Report".

1.2 A total of 13 risks relating to the delivery of the Strategy were identified and summarised below. Details are provided in Table 1.

Risk Category	Number	Meaning of the risk category
High	0	Problematic from a funding or timescale perspective
Medium	6	Mitigating action within timeframe through via diverting existing resources
Low	7	Mitigating action within timeframe through via current resources / approach

2 Overview of the Trust's approach to managing risk associated with delivery of the Research Strategy

2.1 Responsibility for implementation of the Trust's Research Strategy rests with the Associate Director of Research and Development who chairs the R&D Board (which meets quarterly).

2.2 Support is provided via a Lead Research Clinician covering Lister/QEII site, a Lead Research Clinician from MVCC, a Deputy Research Management and Governance manager, a Lead Research Nurse, an R&D Finance Manager. Operational matters are dealt with by the R&D Steering Group which meets monthly.

1.3 The Associate Director of Research and Development has planned monthly meetings with the Medical Director. There is an escalation path whereby all risk events are dealt with or escalated swiftly to ensure that appropriate action can be taken.

3 The 2016/7 our priorities to deliver the Trust's Research Strategy 2016 – 19

1) Continue ground breaking research for patient benefit
2) Patient engagement to increase research activity
3) Incorporate 'Research' into Trust business planning
4) Staff training, appraisal & personal development plans
5) Support key studies which contribute to our Research Strategy

6) Flexible working by staff to support studies
7) Recruit > 1,800 patients to NIHR studies
8) Grow and deliver commercial research, £1.5m income
9) More research grants; increase Sponsor capacity
10) Continued regulatory compliance

Table 1 The Trust's Research Strategy 2016-9 – Strategic Risks and Mitigation

Aims	Performance Indicator	Risk Issue	Risk Category	Mitigation, Risk (Owner and Timescale)
The Trust to be an internationally recognised centre of excellence for research and patient outcome	NIHR league tables for Trust research activity Top 20% of large acute NHS Trusts	On an annual basis, the Research and Development Division supports over 100 staff, recruits >2000 patients to more than 100 studies and requires £2.5m from external sources.	Low	Funding from CRN: Eastern is relatively stable at £1.5m per annum, commercial income can fluctuate (£1 – 1.5m), income from other sources (largely Charities and Research Grants) is less predictable. Actions owned by Associate Director Research & Development. 1) maintain network funding – ongoing 2) increase commercial funding – ongoing 3) agree long-term funding arrangement with charities - to be in place by Dec 2016 to ensure workforce planning for 2017/8 4) tightly control expenditure - ongoing
		Awareness of our research is low.	Med	Identify relevant publications and impact on patient outcome, publicise via web and other Trust communication channels. Actions owned by Associate Director Research & Development. 1) Trust Website – refreshed by July 2016, updating on a regular basis. 2) Trust Communication – publicise via Trust AGM, website, twitter @enhertresearch by July 2016 3) Research Publication list on Trust website by Aug 2016 click here to access website 4) Impact on patient outcome on website – by July 2016, regular updates.
		Data on the NIHR league tables for Trust research activity is updated on an annual basis and reported activity lags actual performance.	Low	Accept that the publically reported activity is made on an annual basis and it takes at least 6 months to be produced. Actions owned by Associate Director Research & Development. 1) Review of situation by Dec 2016.
Patients and public to be engaged with, participate in, and benefit from research and innovation	Number of recruits to NIHR Studies 2015/6 = 1,500 2018/9 = 3,000	High level of engagement with patients to be used to provide effective support to research delivery.	Low	Work with existing Patient Engagement Groups, include Patient Representation on R&D Board and patients on specific workgroups. Actions owned by Associate Director Research & Development. 1) Patient Representation on R&D Board by Sept 2016. 2) Patient engagement event to identify patient involvement in initiatives to deliver the research strategy by Sept 2016.
		Availability of key studies that offer research to large	Med	Implement explicit mechanisms to identify potential key studies, write own grant applications.

Aims	Performance Indicator	Risk Issue	Risk Category	Mitigation, Risk (Owner and Timescale)
		number of patients is limited.		Actions owned by Associate Director Research & Development. 1) Process to identify key studies and monitor deliver on a monthly basis – to be in place by June 2016 Patient Representation on R&D Board by Sept 2016. 2) Practical guidance to be issued and support provided to staff wishing to write grants – by June 2016.
		Ability to support key studies that have a disproportionate contribution could be increased.	Low	Assess potential studies for contribution to Trust's Objectives and prioritise support accordingly. Actions owned by Associate Director Research & Development. 1) Overall approach to move support to optimise contribution to research strategic objectives – to be agreed by R&D Board June 2016 and implementation to start July 2016.
Research is funded via external grant applications, from Industry and with the support of Charities	External research funding Increase by 10% each year	Staff time to complete high quality grant applications is limited.	Med	Employ Provide 'grant writing' capacity through employment of staff and / or via contracting Actions owned by Associate Director Research & Development 1) Issue of Research Capability Funding (£54,398) to support the submission of high quality grant applications – by Oct 2016. 2) Job Description of in-house role to support grant-writing to be written and banded by Nov 2016.
		Some commercial funders are unaware of how we can support their research.	Med	Marketing exercise to increase visibility of Trust to lead to more commercial research. Actions owned by Associate Director Research & Development 1) Content to be published on Trust website By Sept 2016.
		Ability to direct charitable donations into the Trust and to utilise existing funds limited.	Low	Promote the Trust Charities and seek to work closely with other Charities to promote research for the benefit of patients. Actions owned by Associate Director Research & Development 1) Information to be promoted via Research Strategy and website – to be completed by July 2016. 2) Discussion with Trust charities to release funds to support research – by Sept 2016.

Aims	Performance Indicator	Risk Issue	Risk Category	Mitigation, Risk (Owner and Timescale)
Research is embedded into the planning and delivery of routine patient care for all patients	Clinical Directorates with 'research' in Annual Plans 2018/9 = 80%	Importance of research recognised but priority seen as lower than other aspects relating to delivery of route patient care.	Med	Implement the 'Talent Mapping' initiative to identify current situation and work with Directorates to incorporate research into service delivery planning and to ensure research supports the needs of the Trust. Actions owned by Associate Director Research & Development 1) Identify person responsible for research at each Directorate/Department by Sept 2016. 2) Support the explicit planning of embedding research into Annual Plans for 2017/8 – by Mar 2017.
Research is well governed, managed and supported so studies are delivered, as promised	Time to set-up research Top 20% of large acute NHS Trusts	Trust has to maintain a high quality system for research governance and increase capacity to support an expansion in the number of studies that it acts as Research Sponsor.	Low	The Research Office to be strengthened with a post, funded form internal sources, to provide additional capacity and to have a specific function to cover research that the Trust acts as Sponsor. Actions owned by Deputy Research and Development Manager. 1) Advertise for a role to cover the support of studies hosted by the Trust – by Sept 2016.
		Staff to operate flexibly as a 'single team' whilst working across the 4 sites to ensure that key studies are supported across the organisation.	Low	The 'All Staff Day' on 27th April 2016 brought all research delivery support staff together for the first time, 'single team' concept had high level of support, numerous actions identified to take this forward. Actions owned by Lead Research Nurse and Deputy Research and Development Manager. 1) Deploy staff to provide cross-site cover – ongoing. 2) Document a unified way of working for all staff across all sites – by Sept 2016. 3) Identify competency framework and training needs for all staff - ongoing
		Trust to be able to satisfy the requirements of an Inspection by the Regulators (Medicines and Healthcare Products Regulatory Authority).	Med	Action plan prepared and resources identified to deliver a 'MHRA Research Ready' exercise so that the Trust is prepared for an inspection. Actions Deputy Research and Development Manager. 1) Create a project team to ensure that the Trust is 'MHRA-inspection ready' – by June 2016.

Risk Category	Meaning of the risk category
High	Problematic from a funding or timescale perspective
Medium	Mitigating action within timeframe through via diverting existing resources
Low	Mitigating action within timeframe through via current resources / approach

Clinical effectiveness

Our aims for 2015/16: were:

- Reduce mortality to *'as or better than expected'*
- Improve recognition and management of the deteriorating patient
- Improve care and treatment for people after a stroke

How did we do? (Figures for 2014/15 in brackets):

- Mortality rate is as / better than expected
- 89% [83%] of suspected stroke patients were scanned within an hour
- 82% [74%] spent 90% time on the stroke ward
- Audited unexpected admissions to critical care

X We wish to improve the timeliness of treatment for stroke and early transfer to the stroke ward.
In 2016/17 we will focus on stroke care and also use technology to improve observation recording.

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

"Saw nurse in 10 minutes, Xray straight after, then a bit of a wait for a very knowledgeable nurse follow-up and all done in under 2 hours"
(NHS Choices—Urgent Care, QEII)

The Cancer Centre is one of the top 10 centres in the country for research & innovation

Assurances

The Trust works with community partners to better plan care for people with long term conditions.

A team of consultant staff review the notes of people who have died to identify any learning.

Staff participate in inspection visits to assess care & treatment and to share good practices.

Trauma survival rates best in the East of England

91% of relevant patients were screened for sepsis in the Emergency Department (Jan-Mar 2016)

8% of people seen by the **Acute Chest Team** had their admission prevented

East and North Hertfordshire NHS
NHS Trust

Quality Account Summary

2015-16

The Trust manages in-patient services at the Lister Hospital; out-patient services at Hertford County Hospital and the new QEII Hospital; and cancer services at the Mount Vernon Cancer Centre. Renal dialysis is provided from four satellite units and the Trust manages a community children's and young people's service.

The Trust has a turnover of approximately £386m and employs 4,759 whole time equivalent members of staff.

The Care Quality Commission inspected the Trust in October 2015 and rated the Trust as '**requires improvement**' overall but judged Hertford County Hospital and Children's Community Services to be '**good**'.

Overall **Requires improvement**		
	Safe	Requires improvement
	Effective	Requires improvement
	Caring	Good
	Responsive	Requires improvement
	Well-led	Requires improvement

141,000 people attended the Emergency Department

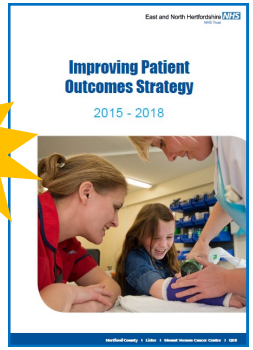
97,000 people were admitted

92% staff surveyed said their role made a difference

For the full report please go to www.enherts-tr.nhs.uk/about-the-trust/our-publications/

Patient safety

Zero MRSA



Our aims for 2015/16: were:

- Reduce the number of falls to below 876 and reduce the number leading to serious harm to 24 or fewer
- Reduce the number of preventable pressure ulcers to 36 or fewer
- Improve medicines management

How did we do? (Figures for 2014/15 in brackets):

- 861 falls [919]
- 11 falls leading to serious harm [14]
- 26 pressure ulcers [54]
- 10% medication incidents leading to harm

X We wish to improve information about the purpose of medication and the side effects.
In 2016/17 we will focus on medication safety and the culture around quality improvement.

"I would return to Lister for further pregnancies as I am very confident they can handle any emergency thrown their way!"
(NHS Choices—maternity services)

Purple Star award for the Day Surgery Unit for the care of people with learning disabilities

Assurances

Staff say they feel confident to report safeguarding concerns.

All serious incidents undergo thorough investigation, leading to learning and improvements.

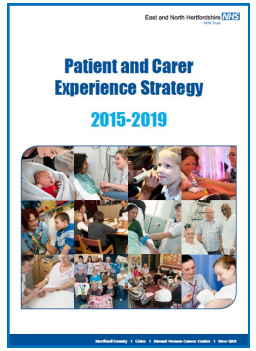
Staffing levels are carefully monitored to ensure they are at safe levels.

6.81 Clostridium *Difficile* infections per 1000 bed days (national average 15.16)

Amongst 10% best Trusts with 3.23 falls per 1000 bed days (national average 6.63)

Audit of 6236 doses found 5.31% doses omitted [10.33% in 14/15]

Patient experiences



Our aims for 2015/16: were:

- Improve survey scores for communication and delays
- Reduce complaints and concerns about communication and delays
- Respond to feedback from GPs

How did we do? (Figures for 2014/15 in brackets):

- Patients reported they understood the answers to important questions 8.1 /10 [7.8] and spent less time on the waiting list 7.9/10 [7.5]
- Complaints reduced in the summer and winter

X Patients told us they wish to be more involved in decisions about their care and GPs have informed us they are not fully aware of all facilities to support referrals such as dedicated phone lines.
In 2016/17 we will focus on improving communication.

Orientation clocks have been provided on all wards to help people with dementia

QEII Endoscopy Unit meets privacy & dignity standards
(National accreditation)

Assurances

Quality on the wards is measured through audits on hand washing, staffing and documentation.

A patient story is considered at each Board meeting.

Display boards show information about safety and care on the wards.

77,000 people answered the Friends & Family Test

9% reduction of formal complaints
(Compared with 2014/15)

96%

of in-patients would recommend their ward for care and treatment

Board Annual Cycle 2016-17 – To meet alternate months from September 2016.

Items	Apr-16	May-16	Jun-16	Jul-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
Standing Items											
CEO Report inc Floodlight Scorecard	x	x	x	x	x		x		x		x
Data Pack[i]	x	x	x	x	x		x		x		x
Patient Testimony (Part 2)	x	x	x	x	x		x		x		x
Suspensions (Part 2)	x	x	x	x	x		x		x		x
Committee Reports											
Audit Committee Report		x			x		x		x		x
CTC Report		x			x				x		x
FPC Report [ii]	x	x	x	x	x		x		x		x
FTC Report (as required)											
RAQC Report	x	x	x	x	x		x		x		x
Strategic											
Annual Operating Plan and objectives	x								x		x
Long Term Financial Model			x								
Sustainability and Transformation Plan (STP)			x								
Other Items											
Audit Committee											
Annual Audit Letter					x						
Annual Report and Accounts(Trust), Annual Governance Statement and External Auditor's Report		x									
Audit Committee TOR and Annual Report					x						
Quality Account and External Auditor's Report			x								
Raising Concerns at Work					x				x		
Review of SO and SFI					x		x				

Board Annual Cycle 2016-17 – To meet alternate months from September 2016.

Items	Apr-16	May-16	Jun-16	Jul-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
Charity Trust Committee											
Charity Annual Accounts and Report		x									
Charity Trust TOR and Annual Committee Review					x						
Finance and Performance Committee											
Detailed Analysis of Staff Survey Results	x										
Draft Floodlight Indicators and KPIs		x									
Financial Plan inc CIPs and Capital Plan											x
FPC TOR and Annual Report			x								
IM&T strategy review			x								
Market Report		x			x				x		
Market Strategy Review		x									
Risk and Quality Committee											
Adult Safeguarding and L.D. Annual Report		x									
Board Assurance Framework and review of delivery of objectives	x			x			x		x		
Equality and Diversity Annual Report and WRES.							x				
GMC National Training Survey					x						
Health and Safety Strategy Review				x							
Improving Patient Outcomes Strategy		x									
Mortality	x		x		x				x		x
Nursing and Midwifery Strategy Review					x						
Nursing Establishment Review				x					x		
Patient Experience Strategy Review				x							
Post OCH Quality Benefits Realisation				x							
PQAF / Education report		x									
RAQC TOR and Annual Review			x								
Research and Development Annual Review		x									
Responsible Officer Annual Review				x							
Safeguarding Children Annual Review				x							

Board Annual Cycle 2016-17 – To meet alternate months from September 2016.

Items	Apr-16	May-16	Jun-16	Jul-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
Serious Incidents Report (Part 2)		x		x	x		x		x		x
Board Development Plan		x									
Shareholder / Formal Contracts											
ENH Pharma (Part 2) [iii]				x					x		
tPP (Part 2)	x	x	x	x	x		x		x		x

[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.

EAST AND NORTH HERTFORDSHIRE NHS TRUST

CHIEF EXECUTIVE'S REPORT

27th July 2016

Stephen Posey, Deputy Chief Executive appointed as Chief Executive at Papworth

Stephen Posey, who joined the Trust in 2008 as its director of strategic development, prior to being appointed deputy chief executive in 2014, will be joining the Papworth Hospital NHS Foundation Trust as its new chief executive in November 2016.

Stephen is the fourth of the Trust's executive directors to be appointed chief executive over recent years and his appointment, therefore, is a further example of how the quality of our clinical and non-clinical staff is being recognised increasingly across the NHS through the attainment of such senior leadership roles.

Whilst we confirm the precise details of Stephen's leaving arrangements, work has commenced on the process that will lead to his successor being appointed and in post before the end of the year. In the meantime, I am sure that you will join with me in congratulating Stephen on his appointment, which brings appropriate recognition for the tremendous work that he has done within our Trust, and wish him well in his new role.

Annual General Meeting

The Trust's AGM was held at the Gordon Craig Theatre in Stevenage on the evening of Tuesday 12th July. Despite torrential rain, over 400 members of the public, staff and partners attended the event, with over 350 in the auditorium for the presentations. Staff and partners showcased services at more than 60 stalls and it was a pleasure to meet so many of the people who support and challenge us.

Presentations on the stage covered a Trust update, highlights of the improvements made to patient care since the Our Changing Hospitals programme presented by Jane McCue, Medical Director, and clinical presentations from Jacinta Dunlea, nursing service manager for children's services who spoke about the community care provided to support children and their families, and Rachel Quail, consultant, who presented on the benefits of ambulatory care. The evening closed with an open question session at which the executive team responded to queries from the audience.

Feedback from the event has been positive and I would like to thank those involved.

Culture change programme

Leaders across the Trust have been invited to the last of the 'ARC' sessions at which I provide an update about the Trust's financial position, patient feedback and response to inspections from the CQC. Steve Andrews, Associate Director for Leadership, then leads a session to introduce the Trust's new leadership model LEND (Listen, Empower, Nurture and Develop). Feedback on the sessions held so far has been very positive and regular meetings will be held in the future under the new LEND programme.

Going forward, LEND will drive the Trust's culture change programme. More on the activities surrounding this will be shared in the near future. To support the changes, the leadership and

management training offered by the Trust are planned to double in capacity from September.

Director of Finance recruitment

At time of writing, we are preparing for the interview process on Tuesday 26th July as we seek to recruit a permanent Director of Finance. With some strong candidates, I look forward to providing a verbal update at the Board meeting.

Academics Foundation Programme

The Trust's Academics Foundation Programme proposal has been accepted by Health Education East of England / Essex Hertfordshire and Bedfordshire Foundation School. The Trust will receive four FY1 academic education posts linked with the University of Hertfordshire and three FY1 research Cambridge linked posts.

Kerry Eldridge named Deputy HR Director of the Year at HPMA awards

Kerry Eldridge, the Trust's Deputy Director of Workforce and Organisational Development has been named Deputy HR Director of the Year at a recent ceremony held by the Healthcare People Management Association. The judges commented that Kerry "demonstrated engagement at all levels of the organisation".

I would like to add my support to their comments that Kerry is an outstanding member of the team and to congratulate her on her success.

Success in renal research

Renal research is one of the Trust's strengths and the Trust has been noted as the top UK recruiter to the Alpha Study. This study will investigate abnormalities in bones in haemodialysis patients and seek to find ways to predict patient outcomes.

Executive Committee Summary Report to Board

Nursing Establishment Review

The Executive Committee have considered and endorse the recommendations of the Nursing Establishment review for approval by the RAQC and Board. It was noted that this report did not cover maternity or the emergency department staffing and that areas were now in the process of review. See full the report under agenda item Risk and Quality Committee.

Performance & Projects

The Committee has continued to provide scrutiny to areas of service development, performance (quality, safety, patient experience, performance targets), operational pressures including ward staffing and emergency department performance, finance, mortality, hospital acquired infections, and key strategic contracts and projects and workforce planning. The Committee is concerned by the significant increase level of referrals received and are working with the teams and Commissioners to understand this and agree actions and mitigate the impact including the risk to delivery of the 62 day cancer pathway and 18 week referral to treatment pathway. Further detail is within the performance report.

The Financial Recovery Board continues to meet weekly to progress key projects.

The key areas for escalation are included in the Director reports to Board and Board Committees.

Floodlight Scorecard

The month three Trust floodlight scorecard is attached as ***(Appendix A)*** and includes the new targets and agreed thresholds for 2016/17. Explanation of red indicators is provided within the appropriate accountable Director's report and the reports in the data pack. The Board committee executive summary reports reflect the key discussions that have taken place at both the Finance and Performance and the Risk and Quality Committees.

Chief Executive
22nd July 2016

East and North Hertfordshire NHS
NHS Trust

TRUST FLOODLIGHT

DASHBOARD AND SCORECARD 2016/17

July 2016 - Month 3

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 2016/17.
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 yet-to-date targets with change when compared to the previous month
Scorecard 2016/17	•Full detail of the Key Performance Indicators showing month-on-month performance
Targets 2016/17	•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.

East and North Hertfordshire NHS
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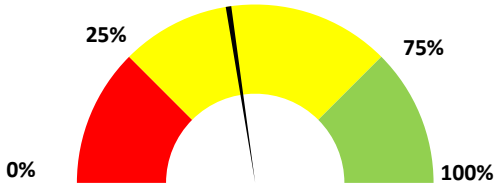
Trust Overall

Percentage of KPIs met



KPI Performance					
Improved		No Change		Declined	
	36		13		36

Highlights;

Lowlights;

Key Findings;

Executive Summary

June's performance against the 6 STF KPIs was green, but with continued pressure accumulating from both routine and 2ww referrals there are three of these measures that are at risk.

Referrals for April and May have been 14% above that which were seen at the same point last year, and early indications are that June's level of demand is going to be higher also, by at least 6%. This issue has been raised to the CCG, and various actions have been discussed, with an agreed action plan to be initiated by the end of July.

The RTT performance has continued to deliver, with July again vulnerable although likely to achieve, but with August proving the higher risk due to a combination of the increased referrals received and the reduced levels of activity due to annual leave being taken.

Trust Floodlights Dashboard
June 2016 (M3)

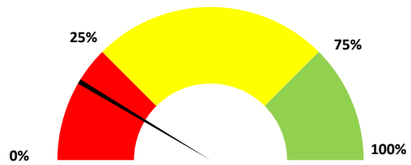
1 - Safe

Percentage of KPIs met

KPI Performance					
Improved		No Change		Declined	
	6		3		10

2- Effective

Percentage of KPIs met



KPI Performance					
Improved		No Change		Declined	
	3		2		1

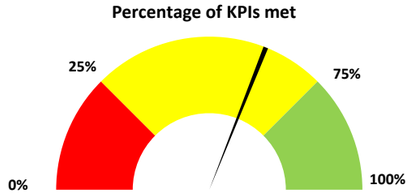
3 - Responsive - Efficiency

Percentage of KPIs met

KPI Performance					
Improved		No Change		Declined	
	3		0		4

4 - Responsive - Key Targets

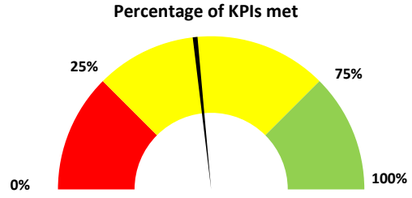
Percentage of KPIs met



KPI Performance					
Improved		No Change		Declined	
	4		0		11

5 - Caring

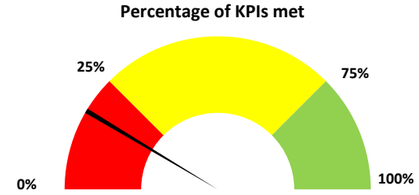
Percentage of KPIs met



KPI Performance					
Improved		No Change		Declined	
	11		1		1

6 - Well-Led

Percentage of KPIs met



KPI Performance					
Improved		No Change		Declined	
	2		4		4

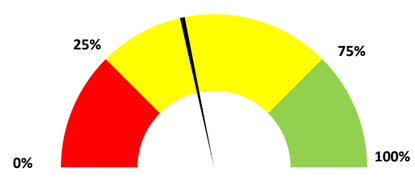
7 - Financial Performance

Percentage of KPIs met

KPI Performance					
Improved		No Change		Declined	
	1		3		4

8 - Sustainability

Percentage of KPIs met



KPI Performance					
Improved		No Change		Declined	
	6		0		1

Trust Floodlights Dashboard
June 2016 (M3)

Year to Date Performance

SAFE

Patient Safety

ID	Indicator (YTD)	Month Change
1.1	Never Events 0	▬
1.2	Safety Thermometer Patients with Harm 20	▲
1.3	Clostridium Difficile Cases 7	▬
1.4	MRSA Post 48 hours Cases 0	▬
1.5	Hospital Aquired Pressure Ulcers Grade 2 or higher 0	▼
1.6	Inpatient Falls 3	▼
1.7	Ambulance Handovers > 30 mins 1960	▲
1.8	Fill Rate RNs (%) 98.8	▼
1.9	Fill Rate RNs Unreg (%) 115.8	▼

Training

ID	Indicator (YTD)	Month Change
1.10	Statutory Mandatory Training 87.1	▼
1.11	Safeguarding Adults Training 88.5	▼
1.12	Safeguarding Children Training 88.5	▼
1.13	Competancy Coverage 63.8	▼

Health & Safety

ID	Indicator (YTD)	Month Change
1.14	RIDDOR Incidents 0.25	▲
1.15	Musculosketal Injuries Reported 0.87	▼
1.16	Physical Assault Incidents 1.06	▲
1.17	Manager Referrals to OH for Stress 0.94	▲
1.18	Staff Slips, Trips & Falls 0.68	▼
1.19	Staff Sharps Injuries 2.12	▲

EFFECTIVE

Mortality

ID	Indicator (YTD)	Month Change
2.1	HSMR 92.7	▲
2.2	SHMI 111.3	▬
2.3	SHMI (Palliative Care Adjustment) 99.6	▬

Admissions

ID	Indicator (YTD)	Month Change
2.4	All Patient Outliers	
2.5	Number of Patients with LOS > 14 days 124	▲
2.6	LOS - Non Elective 4.1	▼
2.7	Readmissions 8.6	▲

FINANCIAL PERFORMANCE

ID	Indicator (YTD)	Month Change
7.1	Pay Spend 100.6	▼
7.2	Net surplus 101.3	▼
7.3	Capital Plan Trajectory 72	▲
7.4	CIP Plan delivered 118	▼
7.5	Capital Cost Absorption 3.5	▬
7.6	Cash Plan 144.1	▲
7.7	Capital Servicing Capacity 1	▬
7.8	Liquidity Ratio (days) 1	▬

RESPONSIVE-EFFICIENCY

ID	Indicator (YTD)	Month Change
3.1	New to Follow-Up Ratio 2.21	▲
3.2	Overnight Bed Occupancy Rate 89.4	▼
3.3	Pre OP bed days (elective) 5	▲
3.4	Delayed Transfer of Care 15	▼
3.5	Post Acute Transfer Delays	
3.6	Ward Discharges before Midday 12	▲
3.7	Cancelled Ops - on Day 109	▲
3.8	Number of Discharges from Discharge Lounge 171	▼

RESPONSIVE-KEY TARGETS

ID	Indicator (YTD)	Month Change
4.1	A&E 4 hour Target 83.6	▼
4.2	RTT Admitted 82.1	▲
4.3	RTT Non Admitted 92.1	▼
4.4	RTT - Open Pathways 92.7	▼
4.5	RTT Patients Waiting > 18 weeks 1926	▼
4.6	Diagnostic Waits < 6 weeks 99.8	▼
4.7	Cancer 2week Ref to Appt 97.5	▲
4.8	Cancer 31day : Diag 95.9	▲
4.9	Cancer 62day : Urgent RTT inc ITP transfers 85.8	▼
4.10	TIA: High Risk treatment within 24 hrs 67.0	▲
4.11	TIA: Low Risk treatment within 7 days from 1st contact 86.3	▼
4.12	4 hrs direct to Stroke Unit 80.2	▼
4.13	90% of time on the Stroke Unit 91.0	▼
4.14	60 minutes to scan 97.6	▲
4.15	Thrombolysed within 3 hrs 4.4	▼

CARING

ID	Indicator (YTD)	Month Change
5.1	Inpatient FFT % of patients would recommend 96.4	▲
5.2	FFT Response Rate % 42.1	▲
5.3	Friends & Family Recommend Place of Care 79.2	▲
5.4	Complaints - % received telephone call 96.3	▲
5.5	% of Complaints concluded within agreed timeframe 35.7	▲
5.6	GP Enquiries Reponse Rate 100	▬
5.7	Team Working 46.4	▲
5.8	Work related stress 58.8	▲
5.9	Support from Manager 64.2	▲
5.10	Harassment Staff (in last 12 months) 27.7	▼
5.11	Communication between senior managers and staff 40.2	▲
5.12	Opportunity to Influence 66.0	▲
5.13	Would feel secure raising concerns 74.2	▲

SUSTAINABILITY

ID	Indicator (YTD)	Month Change
8.1	GP referrals Received - 2WW 2531	▲
8.2	GP referrals Received - non 2WW 24834	▲
8.3	A&E Attendances 24692	▲
8.4	Elective Spells (PBR) 6285	▲
8.5	NonElective Spells 7382	▲
8.6	OP Attendances/Procs (Total) 80716	▲
8.7	Outpatient DNA Rate 8.8	▼
8.8	Theatre Utilisation	

WELL-LED

ID	Indicator (YTD)	Month Change
6.1	Continuity of Services Risk Rating 1	▬
6.2	Risk register	▲
6.3	CQC Outcomes	▬
6.4	NHSI Governance Risk Rating 2	▬
6.5	Friends & Family Recommend Place of Work 60.6	▲
6.6	Vacancy Rate % 13.7	▼
6.7	Vacancy rate (Baseline) 9.9	▼
6.8	Bank Staff Usage 4.67	
6.9	Agency Staff Usage 10.5	
6.10	Sickness % 3.65	▼
6.11	Substantive Staff Turnover 12.9	▼
6.12	Appraisal Rate 79.1	▬

Trust Floodlights Dashboard
June 2016 (M3)

1 - SAFE								
ID	Indicator	Target 16-17	Target YTD	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position
1.1	Never Events	0		0	0			
1.2	Safety Thermometer Patients with Harm	28		20	20			
1.3	Clostridium Difficile Cases	11	3	7	2			
1.4	MRSA Post 48 hours Cases	0		0	0			
1.5	Hospital Aquired Pressure Ulcers Grade 2 or higher	0.16		0.11	0.16			
1.6	Inpatient Falls	3.17		2.80	2.85			
1.7	Ambulance Handovers > 30 mins	2604	651	1960	445			
1.8	Fill Rate RNs (%)	90		98.8	97.5			
1.9	Fill Rate RNs Unreg (%)	90		115.8	112.3			
1.10	Statutory Mandatory Training	90		87.1	87.1			
1.11	Safeguarding Adults Training	90		88.5	88.5			
1.12	Safeguarding Children Training	90		88.5	88.5			
1.13	Competancy Coverage	85		63.8	63.8			
1.14	RIDDOR Incidents	0.56		0.25	0.37			
1.15	Musculosketal Injuries Reported	1.09		0.87	1.28			
1.16	Physical Assault Incidents	1.13		1.06	0.73			
1.17	Manager Referrals to OH for Stress	0.57		0.94	0.55			
1.18	Staff Slips, Trips & Falls	1.18		0.68	0.91			
1.19	Staff Sharps Injuries	2.00		2.12	2.01			

2 - EFFECTIVE								
ID	Indicator	Target 16-17	Target YTD	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position
2.1	HSMR	95.3		92.7				
2.2	SHMI	110		111.3				
2.3	SHMI (Palliative Care Adjustment)	98.5		99.6				
2.4	All Patient Outliers	Method of Data Collection and Definition to be confirmed - Reporting from Month 4						
2.5	Number of Patients with LOS > 14 days	100		124				
2.6	LOS - Non Elective	3.5		4.1	4.0			
2.7	Readmissions	7.75		8.6	8.4			

3 - RESPONSIVE - EFFICIENCY								
ID	Indicator	Target 16-17	Target YTD	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position
3.1	New to Follow-Up Ratio	2		2.21	2.21			
3.2	Overnight Bed Occupancy Rate	85		89.4	89.3			
3.3	Pre OP bed days (elective)	6		5	1.8			
3.4	Delayed Transfer of Care	8		15	15			
3.5	Post Acute Transfer-Total Avg beds blocked	Method of Data Collection and Definition to be confirmed - Reporting from Month 4						
3.6	Ward Discharges before Midday	13		12.0	12.6			
3.7	Cancelled Ops - on Day	504	126	109	47			
3.8	Number of Discharges from Discharge Lounge	780	195	171	53			

4 - RESPONSIVE - KEY TARGETS								
ID	Indicator	Target 16-17	Target YTD	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position
4.1	A&E 4 hour Target	95		83.6	84.7			
4.2	RTT Admitted	90		82.1	69.2			
4.3	RTT Non Admitted	95		92.1	92.2			
4.4	RTT - Open Pathways	92		92.7	92.6			
4.5	RTT Patients Waiting > 18 weeks	1231		1926	1926			
4.6	Diagnostic Waits < 6 weeks	99		99.8	99.7			
4.7	Cancer 2week Ref to Appt	93		97.5	97.5			
4.8	Cancer 31day : Diag	96		95.9	95.9			
4.9	Cancer 62day : Urgent RTT inc ITP transfers	85		85.8	85.0			
4.10	TIA: High Risk treatment within 24 hrs	62.5		67.0	83.9			
4.11	TIA: Low Risk treatment within 7 days from 1st contact	85		86.3	80.4			
4.12	4 hrs direct to Stroke Unit	90		80.2	84.9			
4.13	90% of time on the Stroke Unit	80		91.0	88.6			
4.14	60 minutes to scan	90		97.6	100.0			
4.15	Thrombolysed within 3 hrs	12		4.4	4.6			

5 - CARING								
ID	Indicator	Target 16-17	Target YTD	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position
5.1	Inpatient FFT % of patients would recommend	95		96.4	96.4			
5.2	FFT Response Rate %	40		42.1	42.1			
5.3	Friends & Family Recommend Place of Care	77		79.2	79.2			
5.4	Complaints - % received telephone call	85		96.3	100.0			
5.5	% of Complaints concluded within agreed timeframe	75		35.7	34.0			
5.6	GP Enquiries Reponse Rate	95		100.0	100.0			
5.7	Team Working	74.8		46.4	46.4			
5.8	Work related stress	37		58.8	58.8			
5.9	Support from Manager	73		64.2	64.2			
5.10	Harassment Staff (in last 12 months)	23		27.7	27.7			
5.11	Communication between senior managers and staff	30		40.2	40.2			
5.12	Opportunity to Influence	68		66.0	66.0			
5.13	Would feel secure raising concerns	67		74.2	74.2			

6 - WELL-LED								
ID	Indicator	Target 16-17	Target YTD	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position
6.1	Continuity of Services Risk Rating	3		1	0			
6.2	Risk register	Green		Amber	0			
6.3	CQC Outcomes	Green		Amber	0			
6.4	NHSI Governance Risk Rating	4		2	0			
6.5	Friends & Family Recommend Place of Work	62		60.64	60.64			
6.6	Vacancy Rate %	10		13.71	13.71			
6.7	Vacancy rate (Baseline)	3.75		9.88	9.88			
6.8	Bank Staff Usage	9		4.67	4.67			
6.9	Agency Staff Usage	7		10.5	10.5			
6.10	Sickness %	3.5		3.65	3.65			
6.11	Substantive Staff Turnover	11		12.88	12.88			
6.12	Appraisal Rate	90		79.1	79.1			

7 - FINANCIAL PERFORMANCE								
ID	Indicator	Target 16-17	Target YTD	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position
7.1	Pay Spend	100		100.6	100.6			
7.2	Net surplus	100		101.3	103			
7.3	Capital Plan Trajectory	90		72	72			
7.4	CIP Plan delivered	100		118	131			
7.5	Capital Cost Absorption	3.5		3.5	3.5			
7.6	Cash Plan	90		144.1	144.1			
7.7	Capital Servicing Capacity	3		1	1			
7.8	Liquidity Ratio (days)	3		1	1			

8 - SUSTAINABILITY								
ID	Indicator	Target 16-17	Target YTD	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position
8.1	GP referrals Received - 2WW			2531	955			
8.2	GP referrals Received - non 2WW			24834	8083			
8.3	A&E Attendances	147144	24567	24692	13094			
8.4	Elective Spells (PBR)	37060	6034	6285	3102			
8.5	NonElective Spells	46703	7575	7382	3847			
8.6	OP Attendances/Procs (Total)	471770	76758	80716	40500			
8.7	Outpatient DNA Rate	8		8.82856	8.83861			
8.8	Theatre Utilisation	Method of Data Collection and Definition to be confirmed - Reporting from Month 4						

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 2016/17 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
June 2016 (M3)

Trust Floodlights Dashboard June 2016 (M3)

Monthly Information, Performance and RAG Rating

1 - SAFE																							
ID	Indicator	Target 16-17	Target YTD	Actual YTD	Actual Month	Month Performance	Monthly Change	YTD Position	KPI Met	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12
1.1	Never Events	0		0	0				1	0	0	0									
1.2	Safety Thermometer Patients with Harm	28		20	20				1	35	30	20									
1.3	Clostridium Difficile Cases	11	3	7	2				0	3	2	2									
1.4	MRSA Post 48 hours Cases	0		0	0				1	0	0	0									
1.5	Hospital Aquired Pressure Ulcers Grade 2 or higher	0.16		0.11	0.16				1	0.19	0.00	0.16									
1.6	Inpatient Falls	3.17		2.80	2.85				1	3.38	2.22	2.85									
1.7	Ambulance Handovers > 30 mins	2604	651	1960	445				0	948	567	445									
1.8	Fill Rate RNs (%)	90		99	98				1	99.5	99.3	97.5									
1.9	Fill Rate RNs Unreg (%)	90		116	112				1	117.7	117.5	112.3									
1.10	Statutory Mandatory Training	90		87.1	87.1				0	61.4	87.7	87.1									
1.11	Safeguarding Adults Training	90		88.5	88.5				0	87.0	89.0	88.5									
1.12	Safeguarding Children Training	90		88.5	88.5				0	87.0	89.0	88.5									
1.13	Competancy Coverage	85		63.8	63.8				0	85.8	64.2	63.8									
1.14	RIDDOR Incidents	0.56		0.25	0.37				1	0.00	0.38	0.37									
1.15	Musculosketal Injuries Reported	1.09		0.87	1.28				1	0.94	0.38	1.28									
1.16	Physical Assault Incidents	1.13		1.06	0.73				1	0.57	1.88	0.73									
1.17	Manager Referrals to OH for Stress	0.57		0.94	0.55				0	0.76	1.51	0.55									
1.18	Staff Slips, Trips & Falls	1.18		0.68	0.91				1	0.76	0.38	0.91									
1.19	Staff Sharps Injuries	2.00		2.12	2.01				0	1.51	2.83	2.01									
2 - EFFECTIVE																					
ID	Indicator	Target 16-17	Target YTD	Actual YTD	Actual Month	Month Performance	Monthly Change	YTD Position	KPI Met	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12
2.1	HSMR	95.3		92.7					1	92.4	93.3	92.7									
2.2	SHMI	110		111.3					0	111.3	111.3	111.3									
2.3	SHMI (Palliative Care Adjustment)	98.5		99.6					0	99.6	99.6	99.6									
2.4	All Patient Outliers	Method of Data Collection and Definition to be confirmed - Reporting from Month 4																			
2.5	Number of Patients with LOS > 14 days	100		124					0	134	130	124									
2.6	LOS - Non Elective	3.5		4.1	4.0				0	4.3	3.9	4.0									
2.7	Readmissions	9.0		8.56	8.4				0	8.2	9.1	8.4									
3 - RESPONSIVE - EFFICIENCY																					
ID	Indicator	Target 16-17	Target YTD	Actual YTD	Actual Month	Month Performance	Monthly Change	YTD Position	KPI Met	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12
3.1	New to Follow-Up Ratio	2.0		2.21	2.21				0	2.22	2.22	2.21									
3.2	Overnight Bed Occupancy Rate	85		89.38	89.25				0	91.2	87.7	89.3									
3.3	Pre OP bed days (elective)	6		5.00	1.8				1	3.9	6.1	1.8									
3.4	Delayed Transfer of Care	8		15	15				0	13	9	15									
3.5	Post Acute Transfer-Total Avg beds blocked	Method of Data Collection and Definition to be confirmed - Reporting from Month 4																			
3.6	Ward Discharges before Midday	13.0		12.0	12.6				0	11.8	11.4	12.6									
3.7	Cancelled Ops - on Day	504	126	109	47				1	38	24	47									
3.8	Number of Discharges from Discharge Lounge	780	195	171	53				0	54	64	53									
4 - RESPONSIVE - KEY TARGETS																					
ID	Indicator	Target 16-17	Target YTD	Actual YTD	Actual Month	Month Performance	Monthly Change	YTD Position	KPI Met	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12
4.1	A&E 4 hour Target	95		83.6	84.7				0	81.1	84.7	84.7									
4.2	RTT Admitted	90		82.1	69.2					61.9	69.1	69.2									
4.3	RTT Non Admitted	95		92.1	92.2					91.3	92.8	92.2									
4.4	RTT - Open Pathways	92		92.7	92.6				1	92.7	92.9	92.6									
4.5	RTT Patients Waiting > 18 weeks	1231		1926	1926				0	1891	1886	1926									
4.6	Diagnostic Waits < 6 weeks	99		99.8	99.7				1	99.87	99.74	99.67									
4.7	Cancer 2week Ref to Appt	93		97.5	97.5				1	96.7	97.5	97.4									
4.8	Cancer 31day : Diag	96		95.9	95.9				0	94.8	95.9	94.9									
4.9	Cancer 62day : Urgent RTT inc ITP transfers	85		85.8	85.0				1	86.5	85.0	67.7									
4.10	TIA: High Risk treatment within 24 hrs	62.5		67.0	83.9				1	51.3	70.8	83.9									
4.11	TIA: Low Risk treatment within 7 days from 1st contact	85		86.3	80.4				1	91.9	89.1	80.4									
4.12	4 hrs direct to Stroke Unit	90		80.2	84.9				0	71.2	85.0	84.9									
4.13	90% of time on the Stroke Unit	80		91.0	88.6				1	91.2	93.7	88.6									
4.14	60 minutes to scan	90		97.6	100.0				1	96.0	96.7	100.0									
4.15	Thrombolysed within 3 hrs	12		4.4	4.6				0	3.2	5.5	4.6									
5 - CARING																					
ID	Indicator	Target 16-17	Target YTD	Actual YTD	Actual Month	Month Performance	Monthly Change	YTD Position	KPI Met	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12
5.1	Inpatient FFT % of patients would recommend	95		96.4	96.4				1	96.3	96.4										
5.2	FFT Response Rate %	40		42.1	42.1				1	42.9	39.7	42.1									
5.3	Friends & Family Recommend Place of Care	77		79.2	79.2				1	69.3	69.3	79.2									
5.4	Complaints - % received telephone call	85		96.3	100				1	97	92	100									
5.5	% of Complaints concluded within agreed timeframe	75		35.7	34				0	40	33	34									
5.6	GP Enquiries Reponse Rate	95		100	100				1	100	100	100									
5.7	Team Working	75		46.4	46.4				0	46.4	46.4	46.4									
5.8	Work related stress	37		58.8	58.8				1	58.8	58.8	58.8									
5.9	Support from Manager	73		64.2	64.2				0	64.2	64.2	64.2									
5.10	Harassment Staff (in last 12 months)	23		27.7	27.7				0	27.7	27.7	27.7									
5.11	Communication between senior managers and staff	30		40.2	40.2				0	40.2	40.2	40.2									
5.12	Opportunity to Influence	68		66.0	66.0				0	66.0	66.0	66.0									
5.13	Would feel secure raising concerns	67		74.2	74.2				0	74.2	74.2	74.2									
6 - WELL-LED																					
ID	Indicator	Target 16-17	Target YTD	Actual YTD	Actual Month	Month Performance	Monthly Change	YTD Position	KPI Met	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12
6.1	Continuity of Services Risk Rating	3		1					0	1	1	1									
6.2	Risk register	Green		Amber					0												
6.3	CQC Outcomes	Green		Amber					0												
6.4	NHSI Governance Risk Rating	4		2					0	2	2	2									
6.5	Friends & Family Recommend Place of Work	62		60.6	60.6				0	48.6	48.6	60.6									
6.6	Vacancy Rate %	10		13.7	13.7				0	13.4	13.2	13.7									
6.7	Vacancy rate (Baseline)	3.8		9.9	9.9				0	9.5	9.4	9.9									
6.8	Bank Staff Usage	9		4.7	4.7				1			4.67									
6.9	Agency Staff Usage	7		10.5	10.5				0			10.5									
6.10	Sickness %	3.5		3.7	3.7				1	3.60	3.61	3.65									
6.11	Substantive Staff Turnover	11.0		12.9	12.9				0	12.9	12.7	12.9									
6.12	Appraisal Rate	90.0		79.1	79.1				0	79.4	79.1	79.1									
7 - FINANCIAL PERFORMANCE																					
ID	Indicator	Target 16-17	Target YTD	Actual YTD	Actual Month	Month Performance	Monthly Change	YTD Position	KPI Met	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12
7.1	Pay Spend	100		100.6	100.6				1	100.4	99.9	100.6									
7.2	Net surplus	100		101.3	103				1	102	103	109.3									
7.3	Capital Plan Trajectory	90		72	72				0	88	72	22									
7.4	CIP Plan delivered	100		118.0	131				1	97	131	124									
7.5	Capital Cost Absorption	3.5		3.5	3.5				1	3.5	3.5	3.5									
7.6	Cash Plan	90		144.1	144				1	577.0	144.1	164.0									
7.7	Capital Servicing Capacity	3		1.0	1				0	1	1	1									
7.8	Liquidity Ratio (days)	3		1.0	1				0	1	1	1									
8 - SUSTAINABILITY																					
ID	Indicator	Target 16-17	Target YTD	Actual YTD	Actual Month	Month Performance	Monthly Change	YTD Position	KPI Met	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12
8.1	GP referrals Received - 2WW			2531	955					761	815	955									
8.2	GP referrals Received - non 2WW			24834	8083					8735	8016	8083									
8.3	A&E Attendances	147144	24567	24692	13094				1	11598	13094										
8.4	Elective Spells (PBR)	37060	6034	6285	3102				1	3183	3102										
8.5	NonElective Spells	46703	7575	7382	3847				0	3535	3847										
8.6	OP Attendances/Procs (Total)	471770	76758	80716	40500				1	40216	40500										
8.7	Outpatient DNA Rate	8		8.8	8.8				0	9.0	8.7	8.8									
8.8	Theatre Utilisation	Method of Data Collection and Definition to be confirmed - Reporting from Month 4																			

Agenda Item: 10.01

TRUST BOARD MEETING – 27 JULY 2016

FINANCE AND PERFORMANCE COMMITTEE – 20 JULY 2016
EXECUTIVE SUMMARY REPORT

PURPOSE	To present to the Trust Board the report from the Finance and Performance Committee (FPC) meeting of 20 July 2016
PREVIOUSLY CONSIDERED BY	N/A
Objective(s) to which issue relates *	☑ 1. **Keeping our promises about quality and value** – embedding the changes resulting from delivery of Our Changing Hospitals Programme. ☐ 2. **Developing new services and ways of working** – delivered through working with our partner organisations ☐ **3. Delivering a positive and proactive approach to the redevelopment of the Mount Vernon Cancer Centre.**
Risk Issues (Quality, safety, financial, HR, legal issues, equality issues)	Key assurance committee reporting to the Board Financial risks as outlined in paper
Healthcare/National Policy (includes CQC/Monitor)	Potential risk to CQC outcomes Key statutory requirement under SFIs, SOs. Healthcare regulation, DH Operating Framework and other national performance standards
CRR/Board Assurance Framework *	☐ **Corporate Risk Register** ☑ **BAF**

ACTION REQUIRED *

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

DIRECTOR:	CHAIRMAN OF FPC
PRESENTED BY:	CHAIRMAN OF FPC
AUTHOR:	BOARD COMMITTEE SECRETARY/DEPUTY COMPANY SECRETARY
DATE:	22 JULY 2016

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FINANCE AND PERFORMANCE COMMITTEE – 20 JULY 2016

EXECUTIVE SUMMARY REPORT TO BOARD – 27 JULY 2016

The following members were present: Julian Nicholls (Chair), Vijay Patel, Ellen Schroder (Trust Chair),
Other directors in attendance: Nick Carver, Stephen Posey, Angela Thompson, Tom Simons

DECISIONS MADE UNDER DELEGATED AUTHORITY:

The Finance and Performance Committee (FPC) made the following decision on behalf of the Trust under the authority delegated to it within its terms of reference:

Salix Finance Loan Application

Subject to affordability and following consideration of a full business case requested at FPC in June, the FPC approved the Salix Finance Application for an interest free loan to replace the steam traps on the Lister site.

OUTCOMES:

Floodlight Scorecard Month 3

The FPC reviewed the floodlight scorecard for Month 3 indicating monthly and year-to-date performance, including RAG ratings against trajectories. The FPC noted performance was overall green against the six key performance indicators; a few minor adjustments would be made prior to presentation at Board. The FPC requested future reports contain trend data to indicate direction of travel.

Finance Report Month 3

The FPC received the Month 3 finance report noting the Trust delivered a £0.799m surplus in month creating a £68k favourable variance to plan. The FPC noted the latest information concerning the Trust's Revised Control Total and Sustainability and Transformation Funding. The FPC also noted the significant risks to the delivery of the revised control target and the need to improve the control environment, identify new CIP schemes, reduce agency expenditure and mitigate emerging risks. The FPC discussed staff training to improve the Trust's control environment to deliver the revised control total. Key highlights in month included:

- an additional £800k contingency (£1,220k year to date) had been provided to offset potential risks in the latter half of the financial year
- clinical income was £1,337k higher than plan and £2,189k higher year-to-date with over-performance on non-electives, day cases and outpatients;
- expenditure was £0.4m adverse to plan excluding the impact of increased contingency provision;
- agency expenditure was £253k lower than plan;
- CIP delivery was 124% (118% year to date);
- the cash balance at month end was £1.6m (higher than the £1.0m required minimum cash balance);
- capital expenditure was below plan.

The Committee noted although the Trust reported a positive clinical income position, the activity and income position (specifically non-elective) did not appear to be aligned; a joint audit was being undertaken to understand reasons for this and caution was pragmatic to the Trust's financial risks and opportunities, hence provision of a further contingency. Additionally, a year-end forecast based on quarter one results would be developed for presentation at FPC in September.

The Committee considered the latest run rate analysis which after normalising adjustments was slightly adverse to previous months. It was anticipated this would improve following an income refresh of month 3 income.

The FPC reviewed key headlines relating to activity and contract income noting the main drivers for over-performance were outpatient procedures and unseasonably high attendances in A&E and urgent eye care.

The FPC was concerned that pay expenditure was the highest it had been for six months due to continued vacancies and increased clinical support worker expenditure. The Committee received assurance pay expenditure for clinical support workers within nursing should improve from month 4. The FPC noted the significant increase in waiting list payments to deliver the additional elective and outpatient activity.

The FPC was pleased to note the positive variance in agency expenditure from the agency trajectory submitted to NHSI, specifically due to a decrease in medical locums within the Medical Division.

The FPC noted the latest information relating to non-pay expenditure, CIP's, divisional income and expenditure high level variances, cashflow, capital programme, debtors and creditors.

Recognising the income/CIP variances within Maternity, the Committee requested the Divisional Director Women's and Children's Division be invited to attend FPC to explain reasons/actions in place to ensure improvements.

Service Line Reporting Quarter One Update
The FPC received an update on Service Line Reporting and the quarter one shadow SLR reports which would be produced as a core financial reporting tool from November 2016. The FPC noted progress to date and next steps. The FPC reviewed the top five positive variances from plan and bottom five adverse variances from plan acknowledging a potential for competition between divisions. The FPC was surprised to note the income and expenditure deficit within Urology but satisfied a deep dive would be undertaken to understand reasons for this.

2016/17 Cost Improvement Programme
The FPC was pleased to receive an update on progress made in delivering the 2016/17 Cost Improvement Programme, including proposed process for identification of new CIP schemes, noting a forecast of CIP delivery had been undertaken by each division. The Committee had a positive discussion on lean working processes and approved this was being discussed with Divisional Managers at weekly PMO's. The FPC was concerned at the level of unidentified CIP schemes and made suggestions for improvement. The FPC noted new schemes being explored and requested further discussion of the corporate subsidiary opportunity at FPC in September.

TPP update
The FPC had a lengthy debate on the latest situation concerning TPP noting further discussion would take place at Trust Board Part II.

Performance Report Month 3
The FPC received the Month 3 performance report highlighting the Trust's position against the 6 KPI's agreed with the TDA. Although the Trust did not achieve the ED 4-hour or the stroke 4-hours direct to unit standards, it did achieve the RTT and the 62-day cancer standards. The FPC was very encouraged by the Trust's overall performance.

The FPC noted challenges to delivery of July/August RTT performance; this was due to a significant number of referrals received. The CCG accepted the increased level of referrals to be real (approximately 1000 additional, mostly local to ENHT) and in addition to contract levels. The FPC agreed this situation was unsustainable and supported an urgent

communication to the Trust's commissioners seeking an immediate resolution since this also affected ED and cancer performance.

The FPC was pleased to note within ED there had been no 12-hour trolley waits and the 4-hour standard was ahead of trajectory although remained below the standard. The FPC welcomed the proposal to receive additional support from the Emergency Care Improvement Programme funded through NHSI.

The FPC also noted improvements made within stroke performance; despite 10% more stroke patients in June compared to May, the 4 hours direct to a stroke unit performance had been maintained.

Private Patients Options
The FPC received an update on steps taken to develop a strategy for increasing private patient income including a proposal to commission a market analysis exercise. The FPC supported a decision would be made by the Executive Committee with further consideration of utilisation of the Trust's existing premises.

Workforce Report Month 3
The FPC received the Month 3 Workforce Report concerning management of the workforce. Key areas of focus during the month were:

- Recruitment – The Trust achieved its target for qualified nurses; positive actions were being undertaken within the recruitment pipeline such as an advertising campaign targeting London commuters, intensity of the Filipino campaign and commencement of recruitment in India;
- Temporary staffing – agency price caps continued to fall and retrospective bookings remained under the maximum target;
- Culture – there had been a substantial improvement in the quarter one results of the staff Friends and Family Test reporting 79% of staff who would recommend the Trust for care and 63% who would recommend the Trust as a place to work. It was anticipated the Trust would elevate into the 'average' range nationally.

The Committee noted a briefing on flexible working and staff retention including results of the Trust's exit interview data.

The FPC received assurance the Trust was progressing well with the Junior Doctor contract which was being positively received.

OTHER MATTERS:

Data Quality Metrics
The FPC received a verbal update on data quality actions and plans to improve the quality of data used for clinical outcomes, benchmarking and income. The FPC supported more concise reporting of data requesting the Executive agree key KPI's for future monthly reporting.

Strategic Projects Review
The FPC noted the latest review/progress of the Trust's strategic projects including notification of two additional projects from September; (i) Mount Vernon Clinical Strategy; (ii) the Luton and Dunstable Satellite Renal Dialysis Unit.

FPC Terms of Reference
The Committee noted for information the revised FPC Terms of Reference approved at Trust Board in June 2016.

Julian Nicholls
Chairman

22 July 2016

Agenda Item: 9.2

TRUST BOARD MEETING (PART I) – 27 JULY 2016

FINANCE REPORT MONTH 3

PURPOSE	To set out the Trust's financial position for the period ending 30 June 2016
PREVIOUSLY CONSIDERED BY	Finance and Performance Committee
Objective(s) to which issue relates *	☑ 1. **Keeping our promises about quality and value** – embedding the changes resulting from delivery of Our Changing Hospitals Programme. ☐ 2. **Developing new services and ways of working** – delivered through working with our partner organisations ☐ **3. Delivering a positive and proactive approach to the redevelopment of the Mount Vernon Cancer Centre.**
Risk Issues (Quality, safety, financial, HR, legal issues, equality issues)	Financial risks are described in the main report
Healthcare/ National Policy (includes CQC/Monitor)	Financial and contractual compliance with Department of Health policies including the Operating Framework for 2013/14. Monitor's Financial Risk Rating metrics are used within the report and appendices.
CRR/Board Assurance Framework *	☐ **Corporate Risk Register** ☑ **BAF**

ACTION REQUIRED *

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

DIRECTOR:	Interim Director of Finance
PRESENTED BY:	Interim Director of Finance
AUTHOR:	Assistant Director of Finance
DATE:	July 2016

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***** tick applicable box

East and North Hertfordshire NHS Trust

Financial Summary - June 2016

Key issue	Summary	Pages	In Month	YTD
I&E Summary	The Trust delivered a £0.799m surplus in month, against a planned surplus of £0.731m, creating a £68k favourable variance. Year to date there is a £4.294m deficit, which is £198k favourable to plan.	*4*		
Run rate analysis	There is a deterioration to the normalised run rate in month, compared with the previous months, mainly due to increased expenditure which is not offset by an increase in income.	*5*		
Activity & Income	Clinical income was £1,337k higher than plan in the month, and is £2,189k higher than plan year to date. There was over performance in month on non-electives, daycases and outpatients, which had been partially offset by under performances in maternity.	*6*		
Expenditure	Expenditure is £0.4m adverse to plan in month, excluding the impact of an increased contingency provision.	*7, 8, 10*		
Agency Expenditure	Agency expenditure was £253k lower than plan in month (£1,078k year to date).	*9*		
CIP plans	CIP delivery in month was 124% (118% ytd), although the CIP plan increases in the next month	*11*		
Divisional Analysis		*12*		
Cash	There was a £1.6m cash balance at the end of the month, which is higher than the £1.0m required minimum cash balance	*13*		
Capital	Capital expenditure is below plan in the month, as orders have been placed but goods and services have not yet been received	*14*		

Green	Better than plan
Amber	0-5% adverse to plan
Red	>10% adverse to plan

Financial Narrative - Key Issues - June 2016

The key issues identified for month 3 are as follow:

Although the quarter one position is positive with a £1,418k favourable variance from plan, prior to an additional £1,220k contingency, the Trust has significant risks to delivery of it's revised control target.

Revised Control Total

- The Trust has signed up on the 28th June 2016 to the revised control total of £8.65m, which would allow access to the £10.7m sustainability and transformation funding, subject to the conditions. To achieve the revised control the Trust has assumed the removal of £2.0m readmissions penalties, in line with national guidance, and £1.6m additional CCG funding.

- There was unfortunately an error in the plan phasing which was submitted to the NHSI and so the Trust internal plan and NHSI plan are not aligned. NHSI have confirmed that they are not able to change the phasing . They have requested that the Trust clearly highlights on NHSI returns and internal Board reports the variance arising as a result of the differing plan phasing .

Sustainability and Transformation Funding

- The revised plan assumes that the STF funding of £10.7m funding will be received in full. Further guidance has been issued regarding the criteria to access the fund, which is attached as appendix 1. This confirms that 70% of the fund will be broadly based on quarterly performance against the NHSI agreed financial plan and 30% across the three main access targets. The plans are also to include milestones for Carter implementation and agency spend reduction, as well as having a recovery plan in place that demonstrates how at least a breakeven position will be delivered within a reasonable timeframe.

To deliver the revised control total, the Trust needs to improve its control environment, identify new CIP schemes, reduce agency expenditure and mitigate emerging risks. This needs to be collated into an overall financial recovery plan for 2016/17 and then future years.

1) Improving Control environment

- To strengthen the control environment the Chief Executive has written to all budget holders outlining their responsibilities as a budget holder. A copy of the SFIs has been circulated and each budget holder has been asked to sign to confirm that they have read the relevant sections of the SFIs and understand their responsibilities as a budget holder
- The Division senior management teams need to actively approve the daily purchase orders, before the order is processed by the procurement team
- Establish a weekly Executive level vacancy control process to review requests to advertise new posts (both fixed term (including agency workers/ interim/ contractors) and substantive which includes business cases for any new posts and Agenda for Change re-banding applications.

2) CIP Forecast and Phasing
- The CIP programme is phased to deliver 31% CIPs in the first half of the year and 69% in the second half. The current CIP forecast indicates a £3.2m shortfall against the £15.5m target. Further details of the CIP forecast and the proposal to strengthen the CIP process and to identify new CIP schemes was presented to the July FPC meeting.

3) Reducing Agency Expenditure
It is a requirement of the STF funding that the Trust has a plan to reduce agency. The Trust has been issued an agency ceiling target of £16.7m from NHSI, compared with the Trust's forecast of £28.6m. Although the Trust can demonstrate good progress with pay rates, there needs to be a reduction in agency demand. A detailed plan has been developed for nursing, but a plan needs to be developed for other staff groups. A financial recovery sub group has been set up, which is chaired by one of the Divisional Chairs, to review medical agency expenditure .

4) Income
The Trust is reporting a positive position on clinical income . However, the activity and income position do not appear to be aligned, particularly for non elective income. Until the reasons for this are fully understood then there may be a later negative or positive adjustment.

5) tPP
The quarter one position does not relect any adverse impact relating to tPP.

6) Mitigate Risks and Develop Opportunities
The Trust continues to experience a number of emerging risks and opportunities, and an updated risks and opps schedule will be presented to part II of the Board. A detailed action plan for mitigating the risks and developing the opportunities will be presented with the year end forecast paper in September.

7) Cash
Cash support from DH is expected of £8.6m to cover the 2016/17 forecast deficit plus an additional £4.2m to cover the additional 2015/16 deficit, although NHSI have indicated that a separate application will be required for the latter. Should the deficit increase then cash will again become very restricted and the Trust will need to seek further DH support.

Year end forecast
A year end forecast, based on quarter one results, will be developed and presented to the Executive team for the first week of August. The year end forecast will be presented at the September FPC and Board meetings.

Income and Expenditure Summary - June 2016

Performance against internal plan

	Current Month Plan £000s	Current Month Actual £000s	Current Month Variance £000s	Year to Date Plan £000s	Year to Date Actual £000s	Year to Date Variance £000s	Annual Plan £000s
Income							
Income from NHS activities	30,566	31,903	1,337	90,590	92,779	2,189	362,505
Income from non NHS activities	530	407	(123)	1,497	1,285	(211)	6,328
Other operating income	6,048	6,080	32	12,263	12,453	189	52,474
Total Income	**37,145**	**38,391**	**1,246**	**104,350**	**106,517**	**2,167**	**421,307**
Expenditure							
Pay	(21,283)	(21,419)	(136)	(63,591)	(63,778)	(188)	(252,160)
Non-Pay	(13,355)	(13,619)	(264)	(39,992)	(40,627)	(635)	(153,619)
Unallocated Budgets	(489)	(489)	0	(950)	(903)	47	(6,941)
Total Expenditure	**(35,127)**	**(35,527)**	**(400)**	**(104,532)**	**(105,308)**	**(776)**	**(412,720)**
EBITDA	**2,018**	**2,863**	**846**	**(183)**	**1,209**	**1,392**	**8,588**
PDC Dividends payable	(68)	(67)	1	(583)	(582)	1	(2,333)
Depreciation	(691)	(691)	(0)	(2,072)	(2,073)	(1)	(8,290)
Investment Revenue	2	4	2	6	12	6	25
Finance Costs	(280)	(260)	20	(910)	(890)	20	(3,640)
NET SURPLUS / (DEFICIT) before contingency	**981**	**1,849**	**868**	**(3,742)**	**(2,324)**	**1,418**	**(5,650)**
Contingency	**(250)**	**(1,050)**	**(800)**	**(750)**	**(1,970)**	**(1,220)**	**(3,000)**
NET SURPLUS / (DEFICIT) after contingency	**731**	**799**	**68**	**(4,492)**	**(4,294)**	**198**	**(8,650)**

Headlines against internal Trust plan:

- There was a positive position in month, excluding the impact of contingency, of £868k . Year to date there is a £1.4m favouarble variance, excluding the impact of contingency.

- A contingency of £800k, in additional to the £250k planned contingency, was provided in the month. The year to date contingency is now £2.0m, £1.2m higher than plan. This is expected to offset significant risks which are developing in the latter half of the financial year.

- Clinical income was significantly (£1.3m) above plan in the month, £900k of which relates to a refresh of prior months activity and income.

- Non elective income was £959k favourable to plan in month and £1,270k year to date . Non elective income is now 7% above plan year to date, whilst activity is 3% below plan. A joint audit is being undertaken with the CCG to understand the reasons for the apparant discrepancy between activity and income.

Performance against NHSI plan

	Current Month Plan £000s	Current Month Actual £000s	Current Month Variance £000s	Year to Date Plan £000s	Year to Date Actual £000s	Year to Date Variance £000s	Annual Plan £000s
NET SURPLUS / (DEFICIT) after contingency	**1,270**	**799**	**(471)**	**(5,789)**	**(4,294)**	**1,495**	**(8,650)**

Headline against NHSI plan

The revised plan submitted to NHSI in June had a different phasing to the Trust's internal plan. The Trust year to date position against NHSI plan is a £1.495m favourable variance

Run Rate Analysis - June 2016

	Jan-16 Actual £000s	Feb-16 Actual £000s	Mar-16 Actual £000s	Apr-16 Actual £000s	May-16 Actual £000s	Jun-16 Actual £000s	Jul-16 Plan £000s	Aug-16 Plan £000s	Sep-16 Plan £000s	Oct-16 Plan £000s	Nov-16 Plan £000s	Dec-16 Plan £000s	Jan-17 Plan £000s	Feb-17 Plan £000s	Mar-17 Plan £000s
Income															
Income from NHS activities	29,031	28,648	30,229	30,548	30,329	31,903	30,110	29,691	30,698	30,392	30,715	29,061	30,435	29,046	31,766
Other income	3,510	3,848	(1,894)	3,736	3,514	6,488	4,785	4,775	4,580	5,162	5,151	5,145	5,138	5,156	5,150
Total Income	**32,541**	**32,496**	**28,335**	**34,284**	**33,842**	**38,391**	**34,895**	**34,465**	**35,278**	**35,554**	**35,866**	**34,206**	**35,573**	**34,203**	**36,916**
Expenditure															
Pay	(20,591)	(20,817)	(21,029)	(21,174)	(21,185)	(21,419)	(21,138)	(21,118)	(20,909)	(20,881)	(20,878)	(20,877)	(20,904)	(20,906)	(20,957)
Non Pay	(12,613)	(12,878)	(14,656)	(13,846)	(13,164)	(13,619)	(13,002)	(12,976)	(12,941)	(12,479)	(12,470)	(12,465)	(12,497)	(12,501)	(12,294)
Unallocated budgets	700	1,114	539	(417)	(917)	(1,539)	(1,103)	(1,005)	(996)	(867)	(867)	(867)	(700)	(900)	(931)
Total Expenditure	**(32,504)**	**(32,581)**	**(35,146)**	**(35,437)**	**(35,267)**	**(36,577)**	**(35,242)**	**(35,100)**	**(34,845)**	**(34,227)**	**(34,215)**	**(34,209)**	**(34,101)**	**(34,307)**	**(34,182)**
EBIDTA	**37**	**(85)**	**(6,811)**	**(1,153)**	**(1,425)**	**1,813**	**(348)**	**(635)**	**433**	**1,327**	**1,652**	**(3)**	**1,472**	**(105)**	**2,735**
Financing costs	(1,182)	(1,247)	(566)	(1,259)	(1,259)	(1,014)	(1,188)	(1,188)	(1,188)	(1,188)	(1,188)	(1,188)	(1,188)	(1,188)	(1,188)
Profit on sale of land			4,159												
Reported Net (Deficit)	**(1,145)**	**(1,332)**	**(3,218)**	**(2,412)**	**(2,684)**	**799**	**(1,535)**	**(1,822)**	**(754)**	**139**	**464**	**(1,190)**	**285**	**(1,292)**	**1,547**
Normalised Adjustments:															
CCG funding			5,500												
Profit on sale of land			(4,159)												
Contingency				250	670	1,050	250	250	250	250	250	250	250	250	250
High cost drugs				55	(55)										
NHS Income refresh				291	604	(896)									
Sustainability & Transformation Funding						(2,675)	(892)	(892)	(892)	(892)	(892)	(892)	(892)	(892)	(892)
Finance costs				74	74	(149)									
Normalised Net (Deficit)	**(1,145)**	**(1,332)**	**(1,877)**	**(1,742)**	**(1,391)**	**(1,871)**	**(2,177)**	**(2,464)**	**(1,396)**	**(502)**	**(178)**	**(1,832)**	**(357)**	**(1,934)**	**905**
Actual/Forecast (Deficit) per working day	**(37)**	**(46)**	**(61)**	**(58)**	**(45)**	**(62)**	**(70)**	**(79)**	**(47)**	**(16)**	**(6)**	**(61)**	**(12)**	**(64)**	**29**

Headlines:

The planned deficit decreases in the second half of the year. The step up in the CIP programme accounts for a £32k per day reduction, which has been partially offset by the expected costs of winter ward and utilities.

Although the actual reported run rate (£799k surplus) is significantly better in June than in previous months (£2.4-£2.6m deficit), there have been a few significant normalising adjustments in the month.

The main normalised adjustments for June are:

- Inclusion of £1,050k contingency

- Impact of income refresh where month 3 reported income includes a positive benefit of £291k for month 1 freeze and £604k for month 2 refresh. The income has been rephased in this section to more accurately reflect the monthly operational run rate

- The inclusion of quarter one STF funding (£2,675k)

- It is expected that the operational run rate for June will improve with the refresh of month 3 income

Activity and Contract Income - June 2016

Prior year actual YTD Month 3	Activity	Current Month Plan	Actual	Variance	%	Year to Date Plan	Actual	Variance	% Var	Annual Plan
5,572	Day Cases	2,130	2,350	220	10	5,997	6,765	768	13	24,347
2,957	Elective	999	816	(183)	(18)	2,832	2,387	(445)	(16)	11,429
11,352	Non Elective	3,657	3,584	(73)	(2)	11,065	10,777	(288)	(3)	45,682
19,881	***Total Inpatients***	***6,785***	***6,750***	**(35)**	**(1)**	***19,893***	***19,929***	***36***	***0***	***81,458***
4,919	*Excess bed days*	1,679	1,664	(15)	(1)	5,054	3,830	(1,224)	(24)	*20,264*
4,919	***Total Excess bed days***	**1,679**	**1,664**	**(15)**	**(1)**	**5,054**	**3,830**	**(1,224)**	**(24)**	***20,264***
24,447	Consultant first attendance	8,994	9,166	172	2	25,702	25,872	170	1	103,004
42,448	Consultant follow up	15,603	16,450	847	5	44,683	46,762	2,079	5	178,733
13,893	Outpatient Procedures	6,000	6,663	663	11	17,144	18,927	1,783	10	69,992
41,098	Other outpatients	16,492	15,959	(533)	(3)	46,289	45,253	(1,036)	(2)	188,601
121,886	***Total Outpatients***	***47,089***	***48,238***	***1,149***	***2***	***133,818***	***136,814***	***2,996***	***2***	***540,330***
34,457	A&E attendances	12,842	13,079	237	2	38,926	39,330	404	1	156,216
19,815	Renal Dialysis	7,163	7,163	0	0	20,531	21,177	646	3	82,129
1,501	Adult Critical Care	599	588	(11)	(2)	1,817	2,028	211	12	7,287
1,364	Maternity Births	484	499	15	3	1,468	1,422	(46)	(3)	5,907
37,944	Mount Vernon	13,926	13,266	(660)	(5)	40,042	40,022	(20)	(0)	160,196

Headlines:

The main driver for Over performance in Admitted patient care is Day Case activity which is due to additional waiting list sessions being put on, principally by Surgery for T&O, Oral Surgery and Opthalmology.

A&E continue to be unseasonably high seeing 13,077 attendances (12,256 A&E and 821 Urgent Eye)

Dialysis activity was not available for reporting so it is showing as planned levels for the month.

Maternity saw an increase in births against plan and continues to see more births than the same period last year.

Prior year actual YTD Month 3	Income	Current Month Plan £000s	Actual £000s	Variance £000s	Var %	Year to Date Plan £000s	Actual £000s	Variance £000s	Var %	Annual Plan £000s
2,909	Day Cases	1,767	1,967	200	11	4,968	5,799	831	17	20,190
3,725	Elective	1,958	1,880	(78)	(4)	5,583	5,502	(81)	(1)	22,433
11,354	Non Elective	5,805	6,764	959	17	18,572	19,842	1,270	7	75,185
17,988	***Total Inpatients***	**9,530**	**10,611**	**1,081**	**11**	**29,123**	**31,143**	**2,020**	**7**	**117,808**
806	Excess Bed days	424	412	(12)	(3)	1,276	962	(314)	(25)	5,114
806	***Total Excess bed days***	**424**	**412**	**(12)**	**(3)**	**1,276**	**962**	**(314)**	**(25)**	**5,114**
2,673	Consultant first attendance	1,572	1,611	39	2	4,493	4,598	105	2	18,001
2,732	Consultant follow up	1,595	1,665	70	4	4,569	4,787	218	5	18,277
1,515	Outpatient Procedures	1,030	1,180	150	15	2,933	3,268	335	11	11,850
2,585	Other outpatients	1,285	1,292	7	1	4,464	4,547	83	2	18,122
9,506	***Total Outpatients***	**5,482**	**5,748**	**266**	**5**	**16,459**	**17,199**	**741**	**5**	**66,250**
2,721	A&E attendances	1,486	1,829	343	23	4,479	4,763	284	6	18,050
2,015	Renal Dialysis	1,117	1,117	0	0	3,207	3,269	62	2	12,832
1,386	Adult Critical Care	813	762	(51)	(6)	2,465	2,739	274	11	9,884
4,168	Maternity	2,436	2,276	(160)	(89)	7,142	6,655	(487)	(48)	28,656
8,312	Mount Vernon	4,903	4,947	44	1	13,358	13,376	18	0	53,734
2,957	Drugs	1,849	1,756	(93)	(5)	5,533	5,243	(290)	(5)	20,322
3,599	Other Non-PbR cost & volume	2,022	1,908	(114)	(6)	6,038	5,815	(223)	(4)	23,806
945	Acute CQUIN	504	537	33	7	1,511	1,615	104	7	6,049
54,491	**Total NHS Income**	**30,566**	**31,903**	**1,337**	**(62)**	**90,590**	**92,779**	**2,189**	**(43)**	**362,505**

Headlines:

Clinical income was £1.3m above plan in the month of which £0.9m relates to prior months refresh.

There is a significant overperformance in Non Elective income, despite activity being behind plan both in the month and year to date. The Trust is working closely with ENHCCG and the information team to understand the drivers behind this price mix increase . The impact of refreshing prior months income is £232k, with month 3 income being £727k above plan.

Maternity continues to show under performance on antenatal pathways due to an increase in bookings at other Trusts. The Division is working up plans to mitigate this.

There was an exceptional impact of the refresh of prior months income in month 3. The income team are working alongside information and operational colleagues to understand and address timeliness of information and coding backlog.

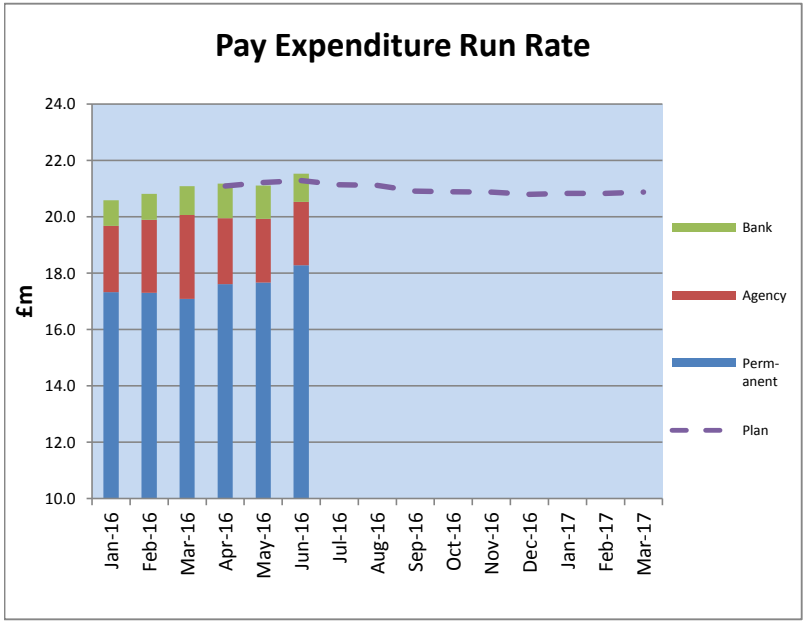
Expenditure - June 2016

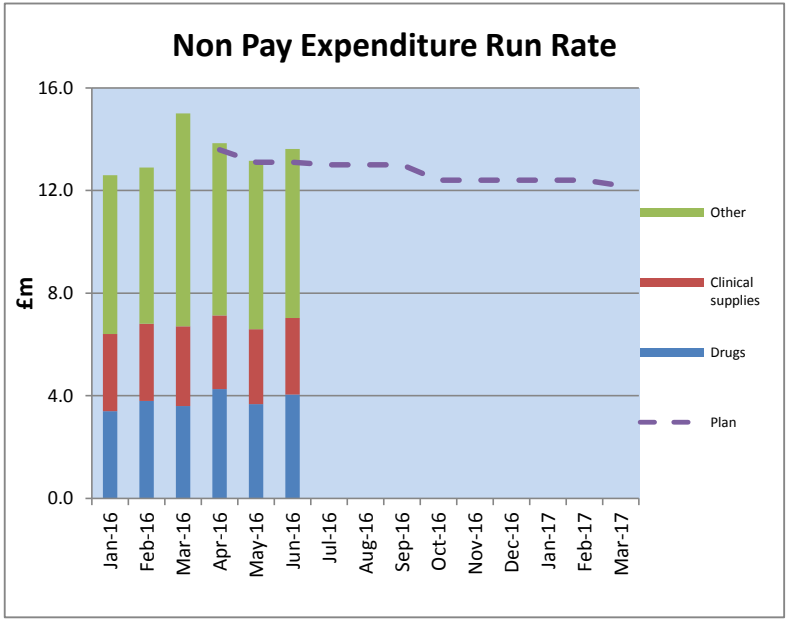
Prior year actual YTD	Staff group	Current Month Plan	Actual	Variance	% Var	Year to Date Plan	Actual	Variance	% Var	Annual Plan
	Pay									
19,080	Nursing	6,933	6,837	96	1%	20,730	20,470	260	1%	82,657
18,754	Medical	6,739	6,755	(16)	(0%)	20,284	20,372	(88)	(0%)	79,602
8,635	Non Clinical	3,335	3,362	(27)	(1%)	9,875	9,792	83	1%	38,993
12,290	Other Clinical	4,276	4,466	(190)	(4%)	12,702	13,146	(443)	(3%)	50,910
58,758	**Total Pay**	**21,283**	**21,419**	**(136)**	**(1%)**	**63,591**	**63,778**	**(188)**	**(0%)**	**252,163**
	Non Pay									
10,802	Drugs	3,928	4,045	(117)	(3%)	11,686	11,976	(289)	(2%)	45,147
7,902	Clinical Supplies	2,827	2,980	(153)	(5%)	8,458	8,766	(308)	(4%)	33,482
17,164	Other	6,599	6,592	7	0%	19,847	19,886	(38)	(0%)	74,987
35,867	**Total Non Pay**	**13,355**	**13,618**	**(263)**	**(2%)**	**39,992**	**40,627**	**(635)**	**(2%)**	**153,617**
94,626	**Total Expenditure**	**34,638**	**35,037**	**(399)**	**0**	**103,582**	**104,405**	**(823)**	**0**	**405,780**

Headlines - Variances from plan:

Pay: There continues to be an underspend in nursing offset by overspends on CSWs. Across the Medicine division these variances offset each other. Aside from this issue, the remaining Other Clinical staff overspends are predominantly activity driven in Surgery (£64k)

Non-Pay:
The adverse variances against Clinical Supplies is driven by additional activity in Trauma & Orthopaedics (variance of £173k), this was matched by higher income and partially offset by underspending areas elsewhere in Surgery.





Headlines - Run Rate

Pay:
Total spend on pay rose by £234k, with increases in bank and locums (£208k) and substantive (£90k) partially offsett by a drop in agency (£64k).

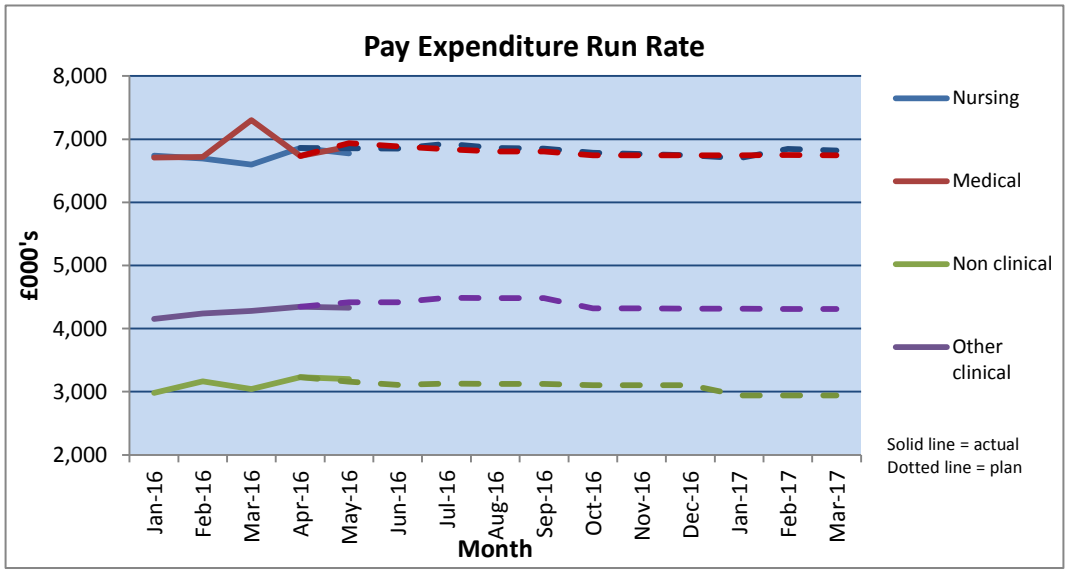
Non-pay:
There was a large increase of £454k compared with month 2, of this £377k relates to drugs. £295k of this is high cost drugs which are recharged to commissioners.

The reduction in both the pay and non pay plan from October is due to the phasing of cross cutting CIP schemes.

Pay Expenditure - June 2016

		Jan-16 £000s	Feb-16 £000s	Mar-16 £000s	Apr-16 £000s	May-16 £000s	Jun-16 £000s	Jul-16 £000s	Aug-16 £000s	Sep-16 £000s	Oct-16 £000s	Nov-16 £000s	Dec-16 £000s	Jan-17 £000s	Feb-17 £000s	Mar-17 £000s	YTD £000s
Nursing	*Plan*	6,552	6,481	6,357	6,910	6,887	6,933	6,942	6,943	6,875	6,853	6,854	6,853	6,863	6,864	6,881	20,730
	Actual	6,742	6,694	6,600	6,859	6,774	6,837										20,470
	Variance	(190)	(213)	(243)	51	113	96										260
Medical	*Plan*	6,168	6,342	6,602	6,699	6,846	6,739	6,694	6,694	6,576	6,548	6,550	6,549	6,566	6,568	6,573	20,284
	Actual	6,711	6,719	7,304	6,735	6,881	6,755										20,372
	Variance	(543)	(377)	(702)	(36)	(35)	(16)										-88
Non Clinical	*Plan*	2,862	3,106	2,881	3,269	3,271	3,335	3,236	3,236	3,233	3,233	3,233	3,233	3,233	3,233	3,246	9,875
	Actual	2,984	3,166	3,043	3,232	3,198	3,362										9,792
	Variance	(122)	(60)	(162)	37	73	(27)										83
Other Clinical	*Plan*	3,887	3,879	3,897	4,218	4,209	4,276	4,266	4,245	4,224	4,247	4,242	4,242	4,242	4,242	4,257	12,702
	Actual	4,154	4,238	4,281	4,348	4,332	4,466										13,146
	Variance	(267)	(359)	(384)	(130)	(123)	(190)										-443
Total	***Plan***	**19,469**	**19,808**	**19,737**	**21,095**	**21,213**	**21,283**	**21,138**	**21,118**	**20,909**	**20,881**	**20,878**	**20,877**	**20,904**	**20,906**	**20,957**	**63,591**
	Actual	**20,591**	**20,817**	**21,228**	**21,174**	**21,185**	**21,419**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**63,778**
	Variance	**(1,122)**	**(1,009)**	**(1,491)**	**(79)**	**27**	**(136)**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**(188)**

Waiting Lists	*Actual*	266	304	337	366	447	412										1,225



Headlines:

Nursing & CSWs - The monthly spend on nursing has increased, predominantly in the Medical Division. Continued vacancies mean that Trustwide, nursing is under plan however the CSW spend, shown above within the Other Clinical category, has been increasing. Within the Medicine Division £142k of the overspend relates to higher CSW spend offset by £139k of underspends on nursing vacancies. An overspend of £51k in Surgery in month 3 has been driven by Waiting List activity and higher admissions .

Other Clinical - Excluding CSWs, there is an in-month variance of £15k which mainly relates to Cardiology technicians.

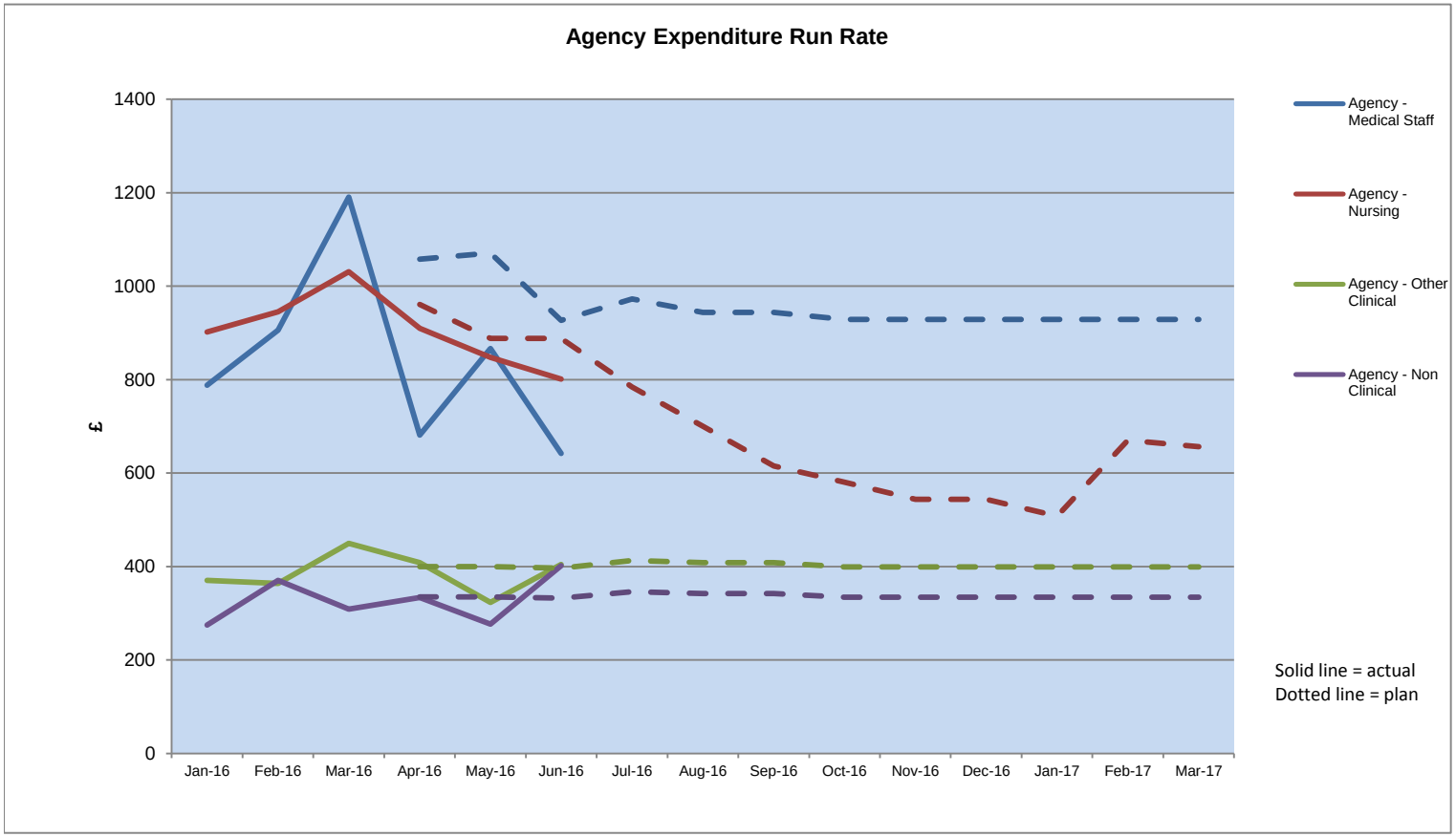
Waiting Lists - There has been a significant increase in waiting list payments in quarter one to deliver the additional elective and outpatient activity. Whilst income typically exceeds the costs of delivering additional waiting lists, the Trust can improve it's margin on this activity by ensuring that it fully utilises its current capacity, as well as to try to substantively staff regular waiting list sessions.

Agency Expenditure - June 2016

Prior year actual YTD	Staff group	Current Month Plan	Current Month Actual	Current Month Variance	Year to Date Plan	Year to Date Actual	Year to Date Variance	Annual plan
2,484	Nursing	847	801	46	2,676	2,559	117	8,421
1,589	Medical	927	642	285	3,056	2,190	866	11,284
395	Other Clinical	424	404	20	1,281	1,136	145	5,093
667	Non clinical	305	402	(97)	964	1,013	(49)	3,771
5,134	**Total**	**2,503**	**2,250**	**253**	**7,977**	**6,899**	**1,078**	**28,569**

Headlines - against NHSI plan:

There is a positive variance in month from the agency trajectory which the Trust submitted to NHSI. This trajectory did not, however, comply with the proposed £16.7m agency ceiling. The full year cost at current run rate is £27.6m.



Headlines - agency run rate

During Qtr 1 the two main reasons for NHSP agency use were vacancy (72%) and sickness (9%).
The monthly premium for the agency staff was £660k and £2.0m year to date.

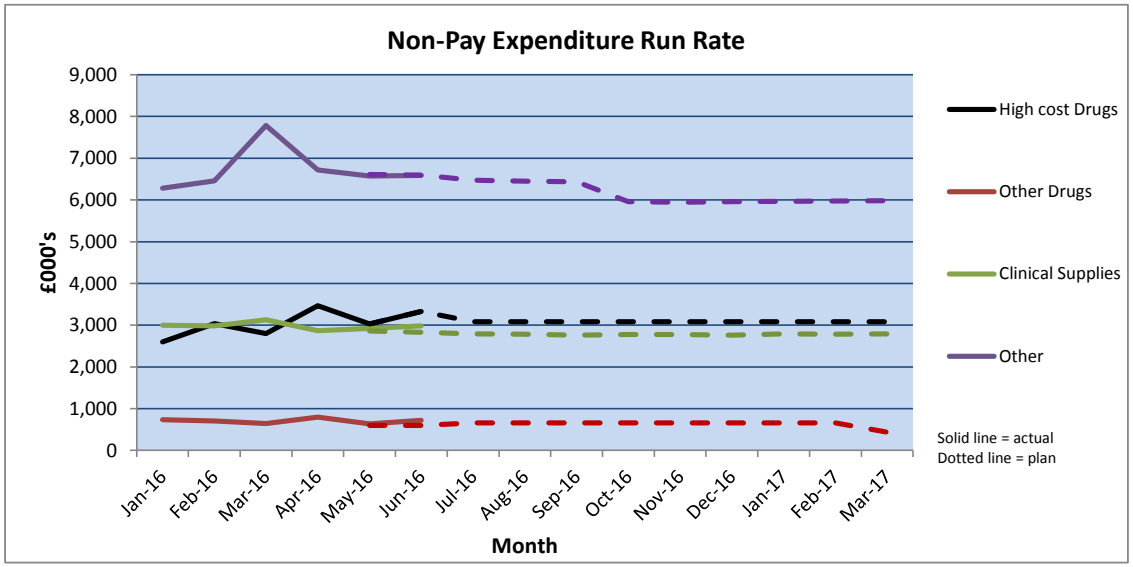
Nursing - Across the Trust there was a small increase in hours this month (£4k) but a further drop in the average hourly rate of £1.19 to £28.18 (£34k) has meant a reduction in spend compared to month 2.

Medical - There is continued uncertainty regarding the actual levels of agency medical staff usage . The implementation of the new NHSP Connect system for booking medical staff mean the expenditure for months 2 & 3 have included some estimates, based on cross checking departments own records with those of NHSP. Colleagues are working closely with NHSP and departments to ensure the month 4 data is complete.

Non Clinical - Spend was £125k higher than in month 2. The main increases were £26k in Clinical Coding, £25k in information management and £51k in Finance (including covering vacancies in the Income team).

Non-Pay Expenditure - June 2016

		Jan-16 £000s	Feb-16 £000s	Mar-16 £000s	Apr-16 £000s	May-16 £000s	Jun-16 £000s	Jul-16 £000s	Aug-16 £000s	Sep-16 £000s	Oct-16 £000s	Nov-16 £000s	Dec-16 £000s	Jan-17 £000s	Feb-17 £000s	Mar-17 £000s	YTD £000s
High Cost Drugs	*Plan*	2,596	3,037	2,802	3,463	3,033	3,328	3,082	3,082	3,082	3,082	3,082	3,082	3,082	3,082	3,082	9,824
	Actual	2,596	3,037	2,802	3,463	3,033	3,328										9,824
	Variance	0	0	0	0	0	0										0
Drugs	*Plan*	646	660	669	666	597	600	661	661	661	661	661	661	661	661	438	1,863
	Actual	733	702	640	800	635	717										2,152
	Variance	(87)	(42)	29	(134)	(38)	(117)										(289)
Clinical Supplies	*Plan*	2,587	2,649	2,911	2,772	2,858	2,827	2,789	2,784	2,762	2,779	2,780	2,760	2,789	2,787	2,795	8,458
	Actual	2,998	2,980	3,131	2,866	2,920	2,980										8,766
	Variance	(410)	(330)	(220)	(94)	(61)	(153)										(308)
Other	*Plan*	5,609	5,917	7,060	6,633	6,615	6,599	6,471	6,450	6,436	5,958	5,948	5,963	5,966	5,971	5,980	19,847
	Actual	6,284	6,456	7,783	6,717	6,577	6,592										19,886
	Variance	(674)	(540)	(722)	(84)	38	7										(38)
Total	***Plan***	**11,439**	**12,264**	**13,442**	**13,534**	**13,103**	**13,355**	**13,003**	**12,976**	**12,941**	**12,479**	**12,470**	**12,465**	**12,497**	**12,501**	**12,294**	**39,992**
	Actual	**12,610**	**13,176**	**14,356**	**13,845**	**13,164**	**13,618**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**40,627**
	Variance	**(1,171)**	**(912)**	**(913)**	**(311)**	**(62)**	**(263)**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**(635)**



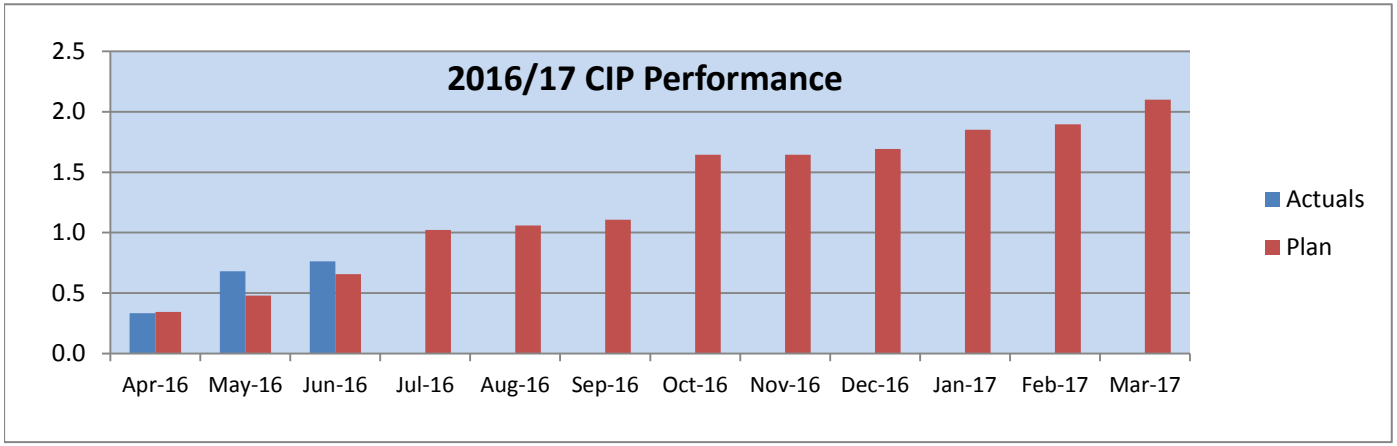
Headlines:

High Cost Drugs- There is a £295k increase in high value drugs which are directly recharged to commissioners. Investigations continue to ensure all eligible drugs are correctly identified and claimed for.

Other Drugs- The drugs overspend is entirely within the Medical Division, the majority of this relates to additional activity. There is an adverse impact in Renal, however, of £27k which does not appear to be offser by income and this is being investigated.

Clinical Supplies- £94k of this overspend is in Surgery where Trauma & Orthopaedics in particular saw high admissions, and higher income. A further £29k is in Cardiology, partially covering mth 2 costs that were delayed.

Cost Improvement Programme - June 2016



Division	In Month Plan £000s	In Month Actual £000s	In Month Variance £000s	Year to Date Plan £000s	Year to Date Actual £000s	Year to Date Variance £000s	Annual Plan £000s	YTD Var to annual plan £000s
Medical	94	348	254	176	556	380	1,091	535
Surgical	106	107	1	236	263	27	2,399	2,136
Womens & Childrens	98	65	(33)	250	182	(68)	133	- 49
Cancer	79	46	(33)	147	158	11	1,839	1,681
Clinical Support	116	114	(2)	321	311	(10)	1,160	849
Corporate/Trustwide	161	128	(33)	348	270	(78)	3,162	2,892
Total	**654**	**808**	**154**	**1,478**	**1,740**	**262**	**9,784**	**8,044**

Headlines:

The CIP profile assumes greater levels of delivery as the year progresses (69% of the £15.5m total is profiled for the 2nd half of the year). A separate paper was presented to the June FPC regarding the identification of new CIP schemes.

Year to date CIP delivery is 110%, although this is against a modest CIP target for the first three months of the year. The CIP target for July increases significantly by £365k.

Overall performance in month 3 is 124% delivery, this is driven by the large favourable variance in the Medical Division. This favourable variance offsets underperformance elsewhere.

The Cancer Division has a shortfall against it's cyberknife private patient income scheme. The W&C division have a shortfall on three schemes, of which two have been delayed until the summer and the other will not deliver. The corporate variance is due to delays in BIMS/PAS reconciliation and unidentified schemes.

Schemes are being developed to address the shortfall.

Divisional Analysis (High Level Variances) - June 2016

	Income			Expenditure					Breakdown of month 3 expenditure variances			
In Month Variance	Clinical Income £000s	Other Income £000s	Total Income Variance £000s	Pay £000s	Non Pay £000s	Total Expenditure Variance £000s	Net I&E Variance £000s	Year to date I&E variance £000s	Operational/ Activity £000s	CIP £000s	Other (incl vacancies) £000s	Total Expenditure £000s
Medical	1,206	59	1,265	88	(135)	(47)	**1,218**	1,477	(247)	2	198	(47)
Surgical	399	(10)	389	(190)	(107)	(297)	**92**	703	(279)	28	(46)	(297)
Womens & Childrens	(226)	(15)	(241)	(59)	(22)	(81)	**(322)**	(796)	(67)	0	(14)	(81)
Cancer	209	(46)	163	44	(44)	0	**163**	65	(16)	(22)	38	0
Clinical Support	(113)	14	(99)	(4)	(8)	(12)	**(111)**	(91)	(36)	17	7	(12)
Corporate/Other	(138)	(92)	(230)	(16)	54	38	**(192)**	34			38	38
EBIDTA	**1,337**	**(90)**	**1,247**	**(136)**	**(263)**	**(399)**	**848**	**1,392**	**(645)**	**25**	**221**	**(399)**

Divisional Variances - Headlines

Of the £1,337k favourable clinical income variance, £896k relates to the impact of prior months.

Medical - The Division saw a significant £1.2m favourable clinical income variance this month particularly relating to non elective activity and ED. The month 3 figure includes £406k from refresh of months 1 & 2. The favourable pay variance mainly relates to medical staff: although there is an underspend of £139k on nursing budgets due to vacancies, this is offset by a £142k overspend on CSWs. The adverse non-pay variance is against drugs and linked to the additional activity and income.

Surgical - The Division had a £399k favourable income variance of which £152k relates to the refresh of months 1 & 2. The in-month position at this time is therefore a favourable income variance of £249k and an adverse expenditure variance of £297k, driven by waiting list activity and outsourcing. It is expected that income will further improve on the month 3 refresh.

Womens & Childrens - Month 3 has seen adverse variances against income and expenditure (as month 2). Maternity income shortfalls are £160k in month and £487k to date mainly relating to antenatal attendences . Gynaecology and Paediatric Outpatient income was also £99k below plan in the month with gynaecology elective activity and NICU above plan. The expenditure variances relate to activity overperformance in Gynae elective and NICU.

Cancer - The Clinical Income has a positive variance of £209k which includes £443k of additional income from prior months refresh. This was an unusually large refresh due to several difficulties with the month 2 information. Excluding the impact of prior months there was an adverse in-month 3 position of £234k. The Division and finance teams are reviewing activity and processes to ensure future adjustments are minimised. The Other Income also has an adverse position, this mainly relates to an underperformance on Radiotherapy and Cyberknife Private Patients.

Clinical Support - The adverse income variance this month relates to drugs, which is being investigated.

Corporate - The Clinical income adverse variance includes adjustments which can not be allocated out to departments, including a reduction in income to reflect where emergency activity has exceeded the threshold (30% reduction above threshold). Month 3 saw a further adverse variance against RTA income (£64k). The non pay variance includes one off benefit in IT to reclaim costs from 2015/16 regarding datalink contracts.

East and North Hertfordshire NHS Trust

12 Month Rolling Cashflow - June 2016

	Jun-16 £000 *Actual*	Jul-16 £000 *Forecast*	Aug-16 £000 *Forecast*	Sep-16 £000 *Forecast*	Oct-16 £000 *Forecast*	Nov-16 £000 *Forecast*	Dec-16 £000 *Forecast*	Jan-17 £000 *Forecast*	Feb-17 £000 *Forecast*	Mar-17 £000 *Forecast*	Apr-17 £000 *Forecast*	May-17 £000 *Forecast*
Opening Balance	**1,441**	**1,641**	**1,000**	**1,000**	**1,000**	**1,000**	**1,000**	**1,000**	**1,000**	**1,000**	**1,000**	**1,000**
Receipts												
NHS Acute Activity Income	31,956	31,487	31,526	34,907	31,889	34,297	31,562	34,599	29,460	37,929	32,587	32,587
Education/Merit awards/R&D	18	869	869	869	869	869	869	869	869	869	869	869
Other income	3,202	2,683	2,640	2,646	2,646	2,756	2,677	2,677	2,706	2,892	2,892	2,892
Interest	4	2	3	3	3	2	3	3	3	2	2	2
Sale of Non-current assets	150	0	0	0	0	0	0	0	0	1,800	0	0
Interim Revolving Working Capital Support (IRWCS)	2,224	2,393	0	0	0	0	0	0	0	0	0	0
Interim Revenue Support Loan	0	0	0	10,023	0	0	0	0	0	1,825	0	0
Strategic Capital Loans	0	1,115	0	2,446	0	0	39	0	0	5,744	0	0
PDC Received	0	0	0	0	0	0	0	0	0	0	0	0
Sub-total Receipts	**37,554**	**38,549**	**35,038**	**50,894**	**35,407**	**37,924**	**35,150**	**38,148**	**33,038**	**51,061**	**36,350**	**36,350**
Salaries & Wages	10,370	10,256	10,256	10,256	10,256	10,256	10,256	10,256	10,256	10,256	10,256	10,256
PAYE / Superannuation/ NI	7,749	7,790	7,790	7,790	7,790	7,790	7,790	7,790	7,790	7,790	7,790	7,790
Creditors	19,235	21,144	16,955	19,149	17,361	19,878	17,104	20,102	14,889	29,305	18,304	18,304
Dividend Paid	0	0	0	1,066	0	0	0	0	0	1,167	0	0
Interest on DH CILs	0	0	0	800	0	0	0	0	0	769	0	0
Repay IRWCS	0	0	0	10,023	0	0	0	0	0	0	0	0
Interest on IRWCS	0	0	0	516	0	0	0	0	0	480	0	0
Repay Interim Rev Support Loan	0	0	0	0	0	0	0	0	0	0	0	0
Interest on Int. Rev. Support Loan	0	0	37	0	0		0	0	103	0	0	0
PDC 1% fee	0	0	0	0	0	0	0	0	0	0	0	0
DH Loan Repayments - CIL	0	0	0	1,294	0	0		0	0	1,294	0	0
DH Loan Repayments - HCA	0	0	0	0	0	0		0	0	0	0	0
Sub-total Payments	**37,354**	**39,190**	**35,038**	**50,894**	**35,407**	**37,924**	**35,150**	**38,148**	**33,038**	**51,061**	**36,350**	**36,350**
Net in Month Cash Movement	**200**	**(641)**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Closing Balance	**1,641**	**1,000**	**1,000**	**1,000**	**1,000**	**1,000**	**1,000**	**1,000**	**1,000**	**1,000**	**1,000**	**1,000**
Trust Cash plan	**1,000**	**1,000**	**1,000**	**1,000**	**1,000**	**1,000**	**1,000**	**1,000**	**1,000**	**1,000**	**1,000**	**1,000**

Headlines:

The cash balance at the end of June 2016 was £1.6m, which was £600k higher than the minimum balance required as a condition of our working capital support.

The resubmitted planned deficit for 2016/17 shows that the Trust requires working capital support of £12.876m (£8.650m in relation to the revised 2016/17 deficit and a further £4.226m because the 2015/16 deficit was higher than forecast).

Working capital support of £2.224m was drawn in June (total YTD £8.658m), with further draws being required in July 2016 and March 2017. The Trust has extended the IRWCS facility to allow for the July drawdown. It is anticipated that the IRWCS received in 2016/17 will be converted to Interim Revenue Support Loan in September 2016. The initial plan for 2016/17 assumed that working capital borrowings would be converted to PDC during the financial year, however that is no longer the case with the resubmitted plan. NHSI have informed the Trust only loans will be available in 2016/17.

£150k was received in June for the sale of a parcel of QE2 land to the hospice. The sale of the care home is expected to complete by March 2017.
The plan for the remainder of the financial year is to end each month with a balance of £1.0m which is the minimum permitted by the Department of Health.

Capital Programme - June 2016

Capital Programme	Annual plan capital spend to achieve CRL	Forecast Expenditure to 31 March 2016	Forecast year end Variance	YTD Plan	YTD Expenditure	YTD Variance
	£000s	£000s	£000s	£000s	£000s	£000s
IM&T						
Network Support Infrastructure	150	150	-	19	19	0
Pharmacy System	450	450	-	0	0	0
Other 2016/17 projects	400	400	-	131	73	58
TOTAL IM&T	1,000	1,000	0	150	92	58
MEDICAL EQUIPMENT						
Trust wide equipment	1,000	1,000	0	150	66	84
TOTAL MEDICAL EQUIPMENT	1,000	1,000	0	150	66	84
ESTATES						
Main Hospital Chimney Flue Relining	250	250	-	-	-	-
Substation 5 - Blue Panel	250	250	-	-	-	-
D1 Pump Replacement	170	170	-	-	-	-
Other Estates 2016/17 Allocation	330	330	-	150	23	127
	1,000	1,000	0	150	23	127
TOTAL ESTATES						
OTHER CAPITAL						
Capitalisation of project costs - 2016/17	2,000	2,000	0	150	156	(6)
Other 2016/17 schemes	500	500	0	0	2	(2)
TOTAL OTHER	2,500	2,500	0	150	158	(8)
TOTAL - TRUST OPERATIONAL SCHEMES	**5,500**	**5,500**	**-**	**600**	**339**	**261**
STRATEGIC SCHEMES						
Lorenzo EPR	5,427	5,427	-	678	256	422
Linacs	2,212	2,212	-	57	-	57
Renal Reconfiguration	2,758	2,758	-	437	-	437
New Beds	2,200	2,200	-	-	-	-
TOTAL - TRUST STRATEGIC SCHEMES	**12,597**	**12,597**	**0**	**1,172**	**256**	**916**

Headlines:

IM&T management report that orders have been placed in excess of £92k. These goods/ services have not been received as at 30th June.

Orders totalling £100k have been placed for medical equipment . The report will be updated once the Trust has received the equipment.

Estates Management report that orders have been placed against this allocation totalling £290k. The goods /services have not been received at 30 June.

NHSI have approved the funding for Lorenzo EPR.

The Trust is currently discussing the funding arrangements for the other 3 strategic

Balance Sheet - June 2016

	Opening Balance as at 01/04/16 £000	Balance Sheet as at 30/06/16 £000	Forecast as at 31/03/17
FIXED ASSETS			
Property, Plant Equipment	187,801	186,217	196,993
Trade & Other Receivables Non-Current	2,562	2,562	2,562
Other Financial Assets	2,505	2,505	2,505
TOTAL FIXED ASSETS	**192,868**	**191,284**	**202,060**
CURRENT ASSETS			
Inventories	5,264	5,264	4,264
Cash & Cash Equivalents	15,863	1,641	1,000
Trade & Other Receivables - Current	41,513	45,549	40,140
Assets Held for Sale - QE2	1,700	1,700	0
TOTAL CURRENT ASSETS	**64,340**	**54,154**	**45,404**
Creditors: Amounts Falling Due Within One Year	(74,796)	(58,662)	(52,457)
NET CURRENT ASSETS (LIABILITIES)	**(10,456)**	**(4,508)**	**(7,053)**
FIXED & NET CURRENT ASSETS LESS CURRENT LIABILITIES	**182,412**	**186,776**	**195,007**
Creditors: Amounts Falling Due More Than One Year	(94,080)	(102,738)	(115,322)
Provisions For Liabilities & Charges	(771)	(771)	(774)
NET ASSETS	**87,561**	**83,267**	**78,911**
FINANCED BY			
TAXPAYERS EQUITY:			
Public Dividend Capital	169,950	169,950	169,950
Revaluation Reserve	45,069	45,069	45,069
Retained Earnings	(127,458)	(131,752)	(136,108)
TOTAL TAXPAYERS EQUITY	**87,561**	**83,267**	**78,911**

Headlines:

Other Financial Assets consists of £1m ENH Pharma and £1.505m tPP

Cash at 1st April was high due to QEII land receipts received 31st March 2016. Balance at 30th June above minimum £1m requirement.

The proceeds from sale of QE11 land was received on 31 March hence the high opening creditor balance. Current creditors at 31st March 2016 included an HCA Loan of £5.9m which was repaid on 27th May 2016.

The Trust has increased long-term liabilities during 2016/17 to support its working capital requirements.
The forecast Balance Sheet provided last month was based on the initial annual plan which assumed that working capital borrowings would be converted to PDC, but this version has been amended to reflected the resubmitted plan in which they remain as long-term liabilities.

PDC is no longer forecast to increase. Retained earnings forecast based on £8.650m deficit for 2016/17.

Sustainability and Transformation Fund 2016/17

Criteria to access the fund

1. The planning guidance introduced a £1.8 billion Sustainability and Transformation Fund (STF) for 2016/17 to support providers' move to a sustainable financial footing.

2. This note sets out the principles underpinning the deployment of the STF. The overarching objectives for the STF include:

   - to reduce the number of providers that are in deficit in 2016/17 and enable the provider sector to deliver its overall control total in 2016/17;
   - to accelerate the recovery trajectory of those providers in deficit;
   - to demonstrate progress towards the achievement of the constitutional service standards;
   - eligible providers must have a recovery plan in place that demonstrates how they deliver a breakeven position or better within a reasonable timeframe.

3. In addition to these, as a condition of the overall funding being approved, the NHS has to demonstrate tangible progress towards a credible plan for achieving seven day services for patients across the country by 2020. Recipients of funding will be expected to continue to make progress towards achieving seven day services in 2016/17 in line with agreed plans.

4. Ambulance trusts will need to be able to demonstrate full engagement in the ARP pilots and the UEC review.

5. Providers eligible for funding must meet the following criteria:

Table 1: STF Criteria /Measurement

Objective	Criteria / Measurement
Provider deficit reduction / surplus increase	Q1-Q4: Delivery of the YTD provider plan profile of the control total. Plans to include milestones for Carter implementation and Agency spend reduction.
Access standards	Q1: Agreement of stretching, but credible improvement plan including milestones with NHSI and NHSE to deliver on core standards including accident and emergency four hours, RTT 92%, and 62 day Cancer. Q2-Q4: Delivery of agreed milestones in plan

6. The STF funding will be ring fenced as ‘pass through’ payments to providers in addition to normal contractual payments from its lead commissioner.

7. Release of the funding will be subject to a quarterly review process in arrears. This review process will cover delivery against the STF conditions only. Access to funding will be through the monitoring system set out below in advance of any funds being paid.

8. Providers that meet the conditions of the fund will not face a ‘double jeopardy’ scenario whereby they incur contract penalties as well as losing access to funding; a single penalty will be imposed.

   Access to STF funding will operate on the following basis:

   - the financial control totals are a binary on/off switch to secure STF funding – i.e. having achieved the year-to-date control total in a quarter, the organisation becomes eligible for funding, the size of which is determined by the level of success with the other criteria;

   - achievement of the yer-to-date financial control total for the quarter is weighted at a minimum of 70% dependant on the range of agreed performance trajectories;

   - the yer-to-date financial control total being measured is excluding any STF funding, hence avoiding any a situation where a provider is penalised twice for a single issue i.e. withholding a proportion of the fund because of a performance failure that results in the provider missing its financial control total;

   - performance against agreed trajectories is weighted at 30%, with RTT and accident and emergency accounting for 12.5% each, Cancer 62 days at 5%. Diagnostics has also been included as improvement trajectories were collected but will carry a 0% weighting.

9. We are assuming that the current collaborative approach adopted by providers to engaging with STPs will continue and therefore does not require further incentivisation through the STF. We will therefore not be linking payment to STP engagement as originally proposed but will keep provider engagement in the STP progress under review. Access to allocation growth in 2017/18 by Clinical Commissioning Groups (CCGs) will remain conditional upon sign off a STP by Quarter 4 locally by NHS Improvement (NHSI) and NHS England (NHSE).

10. Providers will receive the STF if they have performance that achieves the agreed trajectory or if it delivers the national standard. This is to ensure that we do not disincentivise providers from agreeing plans that go further than just the national target but without putting at risk the funding.

Tolerances

Access standards

11. It was agreed that the approach should introduce a tolerance on delivery of the Improvement Trajectory and that the tolerance should be weighted towards the earlier part of the year when current performance is expected to be turned around and therefore delivery of an absolute trajectory percentage may be less certain. This should ensure that for later in the year the provider should have a much better grip on performance and therefore the tolerance should be less.

12. Table 2 below sets out the proposed tolerance levels that will be applied to the Improvement Trajectories relating to access standards.

Table 2: Improvement trajectory tolerances

Period	Tolerance
Quarter 1	None as fund allocated on agreement of trajectories only
Quarter 2	1.0%
Quarter 3	0.5%
Quarter 4	No tolerance

13. So if a provider misses their Improvement Trajectory in Quarter 2 but by less than 1% they will still earn their STF payment for the period but in Quarter 4 they will be expected to achieve the trajectory in full with no tolerance applied.

14. We will develop an approach to exceptional circumstances which provides an objective basis for reopening trajectories for example, for RTT in the event of major movements in the level of GP referrals.

Financial performance

15. The intention is that there will be no tolerances around the quarterly finance control totals.

Incentive to earn missed payments

Access standards

16. It was agreed that the STF should also incentivise providers to over-perform against their agreed trajectories and earn back any parts of the fund that they have failed to achieve in previous periods.

17. The table below sets out how the assessment of performance against trajectory will work each quarter and the criteria that will be applied to earn back payments from previous quarters.

Table 3: Criteria for Assessing Delivery of Improvement Trajectories

Metric	% allocation	Monthly assessment	Quarterly assessment	Cumulative (earn back)
Referral to treatment	12.50%	In month assessment of performance against trajectory	Earn back any missed monthly payments in the quarter by the performance exceeding the trajectory by the number of patients missed on a cumulative basis.	Earn back any missed monthly payments in the quarters by the performance exceeding the trajectory by the number of patients missed on a cumulative basis.
Accident and Emergency	12.50%	In month assessment of performance against trajectory	Receive the whole quarter if year to date performance exceeds trajectory	Earn back any missed monthly payments from the previous quarter if at the end of the next quarter the trajectory on a cumulative basis is achieved.
Cancer	5%	In month assessment of performance against trajectory	Receive the whole quarter if quarterly performance exceeds trajectory.	Quarterly data overwrites monthly data therefore there is no earn back on cancer.
Diagnostics	0%	In month assessment of performance against trajectory	Achieve the whole quarter by the performance exceeding the trajectory by the number of patients missed on a cumulative basis.	

Financial performance

18. The finance aspect of the STF will operate on a cumulative basis so that if a provider misses the YTD control total in a quarter but achieves the control total in a subsequent quarter it could receive the full amount of funding.

Phasing

Access standards

19. Performance will be assessed each quarter against each standard on a monthly basis against the monthly Improvement Trajectory for that month.

20. For Quarter 1 the allocation of the fund will be dependent on agreeing Improvement Trajectories and the process for assessment of delivery of the trajectories for the year. So the first assessment of performance against the Improvement Trajectories will be in Quarter 2 and for the months of July, August and September with achievement each month earning a third of the fund for that performance area for the quarter. This should ensure that providers are incentivised to make sure that they do everything they can to deliver the trajectory each month but that if they should fail for one month they can still earn two thirds of the quarterly payment in that performance area as well as earning payment missed from previous quarters as set out above in Table 3.

Financial performance

21. Finance will be assessed each quarter against the agreed year-to-date control total. Quarter 3 and 4 will be assessed together and will be based on Quarter 3 actual year-to-date and Quarter 4 forecast outturn. The same process will also be applied to performance against the improvement trajectories but with Quarter 4 performance based on the provider self-assessment of forecast performance which they will provide along with their Quarter 3 finance submission.

22. Quarter 4 cash will be paid on account based on the Quarter 4 forecast outturn and will be subject to adjustment based on outturn and performance at the year end. As a material item the adjustment will be subject to external audit.

23. Delivery against the STF during 2016/17 will be subjected to an annual review process and signed off by the Department of Health (DH)/NHSE/NHSI/HM Treasury along with any recommended changes required for the STF in 2017/18. This review is expected to be complete by the end of June 2017.

Underlying assumptions

24. In preparing the Improvement Trajectories it will be vital that there is an agreed set of underlying assumptions regarding the levels of activity and capacity that will be needed to deliver against the trajectory. This will include assumptions around what levels of growth have been assumed in agreeing the trajectory and the implications for access to the STF if growth is higher or lower than assumed and delivery against the agreed trajectory is no longer possible.

25. If a provider or commissioner can demonstrate that there has been a material change in the underlying assumptions, be it an increase in GP Referrals, change in activity delivered or some other factor that means the agreed trajectory could not be achieved during the quarter there is an appeals process to the Regional Directors of both NHSE and NHSI. If the appeal is upheld the provider and commissioner will need to agree a revised trajectory for the remainder of the year. The appeals will be by exception and treated on a case by case basis only.

East and North Hertfordshire NHS Trust

Agenda Item: 9.3

TRUST BOARD PART I – 27 JULY 2016

PERFORMANCE REPORT MONTH 3

PURPOSE	To update Trust Board on: • Progress against Monitor Compliance Framework, DH Operating Standards, Contractual standards and local performance measures. • Exception reports outlining action take and next steps are provided for indicators that are either 'red' in month, or at risk year to date.
PREVIOUSLY CONSIDERED BY	**FPC on 20 July 2016**
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 Monitor, CQC, DH Operating Framework and other national and local performance standards.
CRR/Board Assurance Framework *	☑ **Corporate Risk Register** ☑ **BAF**

ACTION REQUIRED *

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

DIRECTOR:	ACTING DIRECTOR OF OPERATIONS
PRESENTED BY:	ACTING DIRECTOR OF OPERATIONS
AUTHOR:	SPECIAL PROJECTS MANAGER
DATE:	JULY 2016

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

***** tick applicable box

PERFORMANCE REPORT

1. Key Headlines

The following table shows the trust's position against the 6 KPIs that have been agreed with the TDA, and are linked to the STF recovery trajectories.

RTT - 52 week waits

	Apr	May	Jun	Commentary
Forecast	4	4	4	June's position is not fully validated, but it is not anticpated that it will change from this figure.
Actual	4	3	3	

RTT - Incompletes

	Apr	May	Jun	Commentary
Forecast	92.0%	92.1%	92.4%	On track.
Actual	92.7%	92.9%	92.6%	

A&E - 12 hour trolley waits

	Apr	May	Jun	Commentary
Forecast	0	0	0	On track.
Actual	1	0	0	

A&E - 4 hour waits

	Apr	May	Jun	Commentary
Forecast	76.00%	77.00%	79.00%	Ahead of tractory.
Actual	81.10%	84.70%	84.66%	

Cancer - 62 Day referral to treatment

	Apr	May	Jun	Commentary
Forecast	78.0%	81.0%	85.0%	On track. June performance at risk.
Actual	80.5%	85.0%		

Diagnostics - Over 6 weeks waits

	Apr	May	Jun	Commentary
Forecast	99.5%	99.5%	99.5%	On track and compliant performance forecasted to continue.
Actual	99.9%	99.7%	99.7%	

June '16 (STF) KPI Performance

Although the Trust did not achieve the ED 4 hour standard, (section 3), or the Stroke 4 hours Direct to Unit standard, (section 5), it did achieve the RTT standard, the 62 day cancer standard, (section 4), and the performance levels of the 6 KPIs that have been agreed with the TDA were all either met or exceeded in June.

2. RTT – 18 weeks

ENHT achieved the aggregated performance across the Open pathway standard in June at 92.6%, with the national position showing no discernible improvement in performance.

RTT Trust Aggregated Performance			
Month	Non Admitted (95%)	Admitted (90%)	Open Pathways (92%)
July 2015	94.4%	87.5%	94.2%
August 2015	94.2%	82.2%	93.4%
September 2015	91.9%	83.2%	93.0%
October 2015	91.6%	81.9%	92.7%
November 2015	90.4%	81.5%	92.6%
December 2015	90.6%	79.7%	92.0%
January 2016	89.3%	69.1%	92.6%
February 2016	91.3%	67.0%	92.6%
March 2016	91.9%	67.4%	92.0%
April 2016	91.3%	61.9%	92.7%
May 2016	92.8%	68.9%	92.9%
June 2016	92.2%	69.2%	92.6%

June ’16 RTT Performance

2.1 RTT performance

ENHT has continued to achieve the national standard for open pathways, and is forecasting continued achievement in July, although the position looks vulnerable, and performance will be close to 92%.

The open pathway numbers seem to have stabilised for the moment but work continues to understand the growth. It appears to be primarily occurring in the first outpatient part of the pathway. Analysis of the wait for first outpatient appointments shows that there is some opportunity to improve our performance here and we are developing an outpatient KPI tool.

The forecast performance figure for August has improved and the booking profile is in line with July. There is still a real risk to August due to the lower levels of activity we deliver and the effect of the increased referral rates.

2.2 Referral volumes

Following further meetings with the commissioners, there is acceptance that this increased level of referrals is real, and is both significantly higher than the same period last year, and more pertinently, significantly higher than contracted levels for 16/17.

Over the past few weeks there has been detailed analysis to assess where the increases are. Across the specialties, broadly there is an increase across all, but some in particular such as ENT, Gastroenterology, and Community Paeds. There has been an increase in cancer referrals as well, which will put further pressure on both diagnostics and 62 day performance. There are no GP practices that are showing a sharp increase in referral volumes, and the same is being seen at commissioner level, with clearly the largest increase from our own ENH CCG, although Herts Valley seems to have sent in more cancer referrals in the first 2 months of the year, up 31% from the same point last year.

Initial analysis of June referrals indicates that this increase in referral volume is showing no signs of abating. At time of writing, (14th July), there is a 6% increase on referral volumes in June 2016 compared with June 2015, but it is very early in the month to conclude that this will be the final figure, due to data lag. It is likely that the final figure will be 10%+.

This referral level is not sustainable, and this has been formally raised to the CCG formally in the contract meeting. The outcome of this is a further meeting on Monday 18th July at which it is anticipated there will be one of four outcomes:

1. Acceptance that this referral volume is real, and ENHT and ENH CCG will agree referral caps for the rest of the year to allow the trust to stabilise the RTT, Diagnostics and Cancer position. This will mean that the CCG will need to commission activity elsewhere.
2. Acceptance that this referral volume is real, and raise the treatment threshold level for people already on a waiting list, and for referrals coming in.
3. Acceptance that this referral volume is real and a combination of the two options above.
4. Agreement that this referral volume is not real and ENHT will continue business as usual. This is highly unlikely, as even if the comparison with last year's figures is incorrect, this year's referrals compared to contracted levels for 2016/17 are much higher.

In order to try to alleviate some pressure on services, the trust has started speaking to other providers about outsourcing some activity, such as Hinchingbrooke. Although they have some surgical capacity, experience would suggest that patients who are offered earlier treatment at other sites typically choose to stay under the care of ENHT. Although this data needs updating, we have seen rates as low as 30% of patients offered procedures elsewhere accepting this offer, with the remainder declining and accepting a longer wait to stay at ENHT.

3. ED Performance

ENHT did not achieve the 4 hour standard in June, but did achieve 84.66%, which is higher than the STF improvement trajectory.

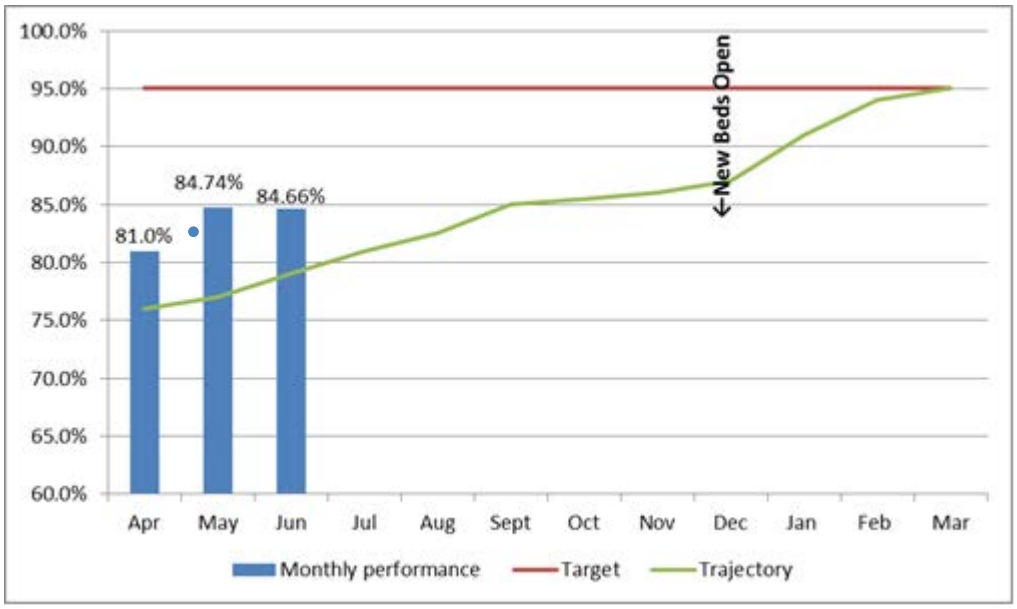
Month	% Performance	Quarterly Performance
Apr-15	95.18%	
May-15	93.17%	
Jun-15	95.13%	Q1 94.46%
Jul-15	91.02%	
Aug-15	87.84%	
Sep-15	85.93%	Q2 88.31%
Oct-15	84.38%	
Nov-15	77.82%	
Dec-15	80.50%	Q3 80.59%
Jan-16	80.45%	
Feb-16	76.28%	
Mar-16	75.53%	Q4 77.33%
Apr-16	81.12%	
May-16	84.70%	
Jun-16	84.66%	Q1 83.58%

June '16 ED performance against 4 hour standard.

Department	Apr-16		May-16		Jun-16	
	Attendances	Admitted	Attendances	Admitted	Attendances	Admitted
Majors	4166	1908	4550	2158	4457	2108
Minors	4225	226	5154	243	4559	220
Resus	545	433	628	498	593	454
Triage	323	85	342	126	347	144
Primary Care	2347	110	2461	115	2327	111
Others	0	0	0	0	1	0
Total	**11606**	**2762**	**13135**	**3140**	**12284**	**3037**

June ’16 ED attendance and admission figures

The system-wide 4 hour recovery trajectory, as below:



June ’16 - 4 hour performance trajectory

ED performance is continuing to achieve against the STP trajectory but is still well below the national target.

The Emergency pathway project has delivered improvements in regard to discharge processes and freeing up assessment capacity but a number of issues in ED have led to a levelling of performance rather than the increase improvement we planned for. Specifically, work is ongoing around referrals to specialities to try and improve the time it takes to get patients seen by speciality doctors and then moved to appropriate beds. Also pathology are reviewing a number of audits to see if any improvements in processes can take place.

We are now using the Lean Six Sigma approach to review the whole Emergency pathway starting with Ambulance handovers. It should be noted that June’s performance dipped even though the activity reduced; as a result we are carrying out a detailed analysis of the month to see if there is anything further we need to pick up in the pathway work.

In addition we have had preliminary discussions with NHSI about receiving additional support from ECIP (Emergency Care Improvement Programme). The intention is that ECIP would provide a team that worked along us until recovering of the national performance standard was maintained. This support would be welcomed and might help facilitate changes in some of the more challenging areas of the pathway.

4. Cancer

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

Cancer Flash Report

Performance May 2016

Target	Goal	Threshold	Month To Date	Quarter To Date	Year To Date	Nat Average	Nat Average
Target Referrals							
Cancer Referral to 1st Outpatient Appointment	< 14 Days	93.0%	97.4% ▼	97.4% ▲	97.4% ▲	94.0%	94.7%
Referrals with Breast Symptoms (wef January 2010)	< 14 Days	93.0%	97.2% ▲	94.6% ▲	94.6% ▼	92.1%	93.6%
Cancer Treatments							
Decision to Treat to 1st Definitive Treatment for all Cancers	< 31 Days	96.0%	94.9% ▼	95.4% ▲	95.4% ▼	97.7%	97.5%
Referral to Treatment from Screening (62 Day)	< 62 Days	90.0%	84.2% ▼	91.4% ▲	91.4% ▲	90.8%	91.9%
Second or Subsequent Treatment (Anti Cancer Drug Treatments)	< 31 Days	98.0%	98.3% ▲	98.2% ▲	98.2% ▼	99.5%	99.2%
Second or subsequent treatment (Radiotherapy Treatments)	< 31 Days	94.0%	94.9% ▲	94.5% ▲	94.5% ▼	97.5%	97.4%
Second or subsequent treatment (Surgery)	< 31 Days	94.0%	100.0% ▲	96.2% ▲	96.2% ▼	94.8%	95.3%
Urgent Referral to Treatment of All Cancers	< 62 Days	85.0%	81.6% ▲	81.0% ▲	81.0% ▲	81.3%	81.9%

May '16 (Unadjusted) Cancer performance

4.1 Performance

ENHT has reached agreement with the CCG and the TDA that the reportable 62 day cancer figure will be the IPT (Inter-provider Transfer), figure that reallocates breaches due to late referrals (later than 38days). From June, the flash report will be based on the new calculation. (This is why there is a difference between the table in section 4 and the STF trajectory table in section 1).

ENHT has achieved the 62 day standard, with the final figure at 85.0% which is also above the trajectory agreed with the TDA. The unadjusted figure was 81.6%, which is still above the national average for this standard at 81.3%.

The increase in referrals has yet to have an impact on the performance, whilst it is likely that 2ww performance will be maintained, with the loss of routine appointments to accommodate more 2ww patients, it is the diagnostic and treatment pathways that are most vulnerable. There would also be a risk to routine 18 week pathways with this loss of these routine clinic appointments.

The June position looks to be under pressure, with further work to fully understand the impact of referral pressure on the later elements of the cancer pathways ongoing.

5. Stroke

Stroke Performance for June 2016. Is shown below:

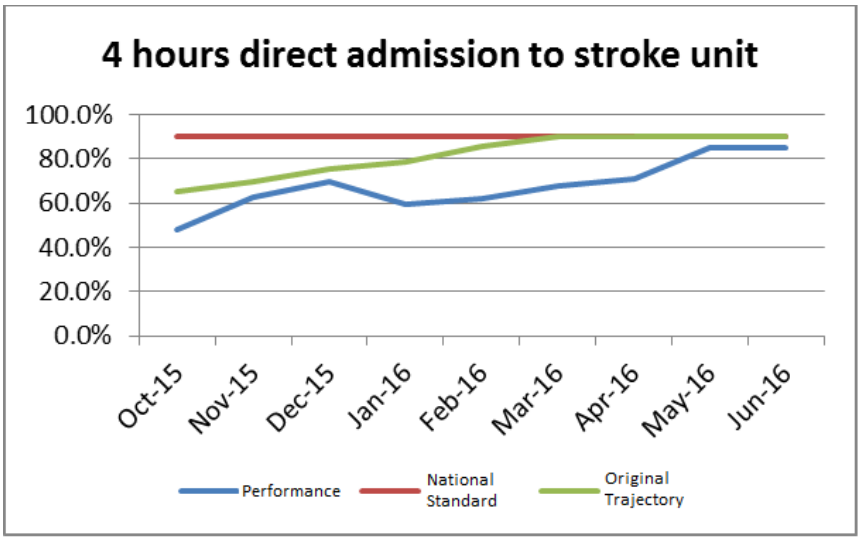
Metrics	Oct '15	Nov '15	Dec '15	Jan '16	Feb '16	Mar '16	Apr '16	May '16	Jun '16
Stroke Discharged with AF on anticoagulants (ASI 1)	83.3%	80%	87.5%	66.7%	50%	100%	66.7%	100%	84.6%
Stroke – 4 hours direct to stroke unit (ASI 2)	48.9%	62.5%	69.4%	59.6%	61.8%	68.1%	71.2%	85%	84.8%
Stroke – 90% of time on the stroke unit (ASI 3)	89.6%	86%	75%	87%	71.4%	88.6%	91.2%	93.7%	88.6%
Stroke – 60 min to scan 9ASI 4a)	40%	50%	50.9%	40%	48.3%	50.7%	42.6%	65%	55.1%
Stroke 60 mins to scan urgent only	87.5%	96%	91.7%	82.6%	84.4%	93.9%	96%	96.7%	100%
Stroke – scanned within 24 hrs (ASI 4b)	97.9%	98%	96.2%	96.4%	98.4%	100%	100%	96.7%	100%

Stroke thrombolysed within 3hrs	0%	7%	12.5%	7.7%	5.2%	6.2%	3.2%	5.5%	4.6%
Stroke – discharged with JCP (ASI 7)	93.5%	96.9%	100%	100%	89.5%	96%	98%	97.4%	87.8%
Stroke –discharged with ESD (ASI 9B)	36.1%	36.8%	38.1%	35.7%	40%	40.7%	39.6%	23.3%	43.5%
TIA – high risk, not admitted, tx within 24hrs	85%	69.6%	48.4%	75.9%	69.2%	66.7%	51.3%	70.8%	83.9%
TIA – high risk tx within 24hrs	85%	69.6%	51.5%	75.9%	69.2%	66.7%	50%	68%	83.9%
TIA – low risk, treated within 7 days from first contact	88.2%	82.9%	73%	88.1%	94.7%	83.8%	91.9%	89.1%	80.4%
TIA – low risk, treated within 7 days from onset	47.1%	53.7%	45.9%	59.5%	63.2%	54.1%	59.5%	58.7%	42.9%

May '16 Stroke performance

5.1 4 hours direct admission to a stroke unit

Despite 10% more stroke patients in June compared with May (still in line with b/c), 4hrs to stroke unit has been maintained at just under 85%.



June '16 4 hour direct admission performance

Additional actions to achieve trajectory

- Ensure stroke nurses have rights for requesting CT's.
- A fast –ve audit completed. Revealed 30% of fast negative patients turn out to be strokes. A further month's prospective audit underway.
- Continued communication and feedback to GP's via CCG regarding stroke patients who are 'missed' as potential strokes.

Risks to performance

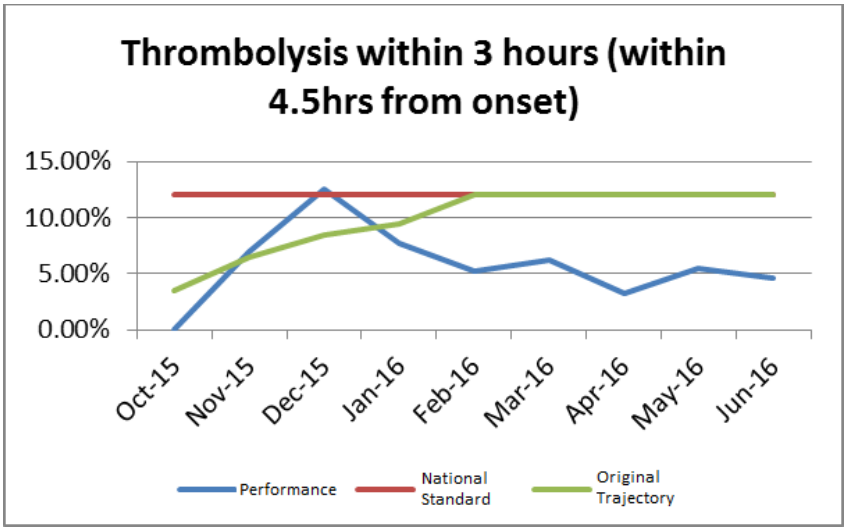
Overall Trust bed pressures have impacted on the stroke service during the end of June into the first two weeks of July. 14 medical patients were admitted to the stroke unit during the final week of June. The unit continues to receive medical patients, which has already caused breaches in terms of 4hr target and length of stay.

The pressures and demand on ED directly affects the stroke service out of hours, where time to be seen by a Doctor often exceeds 4hrs.

We have yet to receive additional Bedfordshire patients but expect to admit 60 additional confirmed stroke patients from this region over the next 12 months. L&D are currently underperforming within stroke. If this

poor performance continues, there is a risk that further demand may be diverted to ENHT, although this is hypothetical at this stage.

5.2 Thrombolysis within 3 hours



June '16 Thrombolysis within 3 hours performance

The thrombolysis target is 12%, however we are measured on this target for those patients thrombolysed in 3 hours, despite the guidelines for thrombolysis within 4.5 hours.

Risk to Thrombolysis:

Patients coming from further afield i.e. West Essex arriving outside the thrombloysable window. Additional Bedfordshire demand will increase ED activity.

** End of document **

East & North Hertfordshire NHS Trust :Board Performance Report (2016-17) - Month 3 DRAFT

Monitor Compliance Framework and SHA Provider Management Regime

Monitor Compliance Framework - Performance Thresholds for 2016-17

Indicator		Achieve		Under-achieve		Fail	Weighting	Area	Lead Director	Apr-16	May-16	Jun-16	Year to date
Clostridium Difficile -(profiled as 1 per month)	≤	14	≤		>	14	1	Safety	AT	3.00	2.00	2.00	7.00
MRSA	≤	0	≤		>	0	1	Safety	AT	0.00	0.00	0.00	0.00
*All Cancers: 31-day wait from diagnosis to treatment 96% (1month in arrears)	>	96%	>	-	<	96%	0.5	Quality	JW	95.9%	94.9%	Not Yet Due	95.4%
*All Cancers: 31-day wait for second or subsequent treatment - Surgery ³94% (1month in arrears)		All 3 targets met		-		1 or more target	1	Quality	JW	93.3%	100.0%	Not Yet Due	96.2%
*All Cancers: 31-day wait for second or subsequent treatment - Drug ³98% (1month in arrears)								Quality	JW	98.1%	98.3%	Not Yet Due	98.2%
*All Cancers: 31-day wait for second or subsequent treatment - Radiotherapy ³94% (1month in arrears)								Quality	JW	94.0%	94.9%	Not Yet Due	94.5%
*All Cancers: 62-day wait for first treatment - Urgent GP referral ³85% (1month in arrears)		Both targets met		-		1 or more target	1	Quality	JW	80.5%	81.6%	Not Yet Due	81.0%
*All Cancers: 62-day wait for first treatment - Consultant Screening Service ³90% (1month in arrears)								Quality	JW	100.0%	84.2%	Not Yet Due	91.4%
*Cancer 2-week wait from referral to date first seen - All cancers ³93% (1month in arrears)		Both targets met		-		1 or more target	0.5	Quality	JW	97.5%	97.4%	Not Yet Due	97.4%
*Cancer 2-week wait from referral to date first seen - Symptomatic breast patients ³93% (1month in arrears)								Quality	JW	91.6%	97.2%	Not Yet Due	94.6%
Maximum Waiting Time of 18-weeks from Referral to Treatment - Admitted	≥	90%		-	<	90%	1	Patient Experie	JW	61.88%	68.78%	69.21%	66.76%
Maximum Waiting Time of 18-weeks from Referral to Treatment - Non-Admitted	≥	95%		-	<	95%	1	Patient Experie	JW	91.31%	92.80%	92.23%	92.13%
Maximum Waiting Time of 18-weeks from Referral to Treatment - Incomplete	≥	92%		-	<	92%	1	Patient Experie	JW	92.71%	92.94%	92.63%	92.74%
A&E: Maximum Waiting Time of four hours from Arrival to Discharge or Admission	≥	95%		-	<	95%	1	Quality	JW	81.12%	84.74%	84.66%	83.58%

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

RED

AMBER

GREEN

Department of Health Operating Framework measures

Service Performance Indicators for 2016-17

Indicator		Achieve		Under-achieve		Fail	Weighting	Area	Lead Director	Apr-16	May-16	Jun-16	Year to date
RTT Delivery in all Specialties (Treatment Functions not delivered (Admitted, Non-Admitted & Incomplete Pathways)	≤	0	≤	20	>	20		Patient Exper	JW	42.00	31.00	22.00	97.00
Diagnostic Test Waiting Times (patients waiting >6-weeks for 15 key diagnostic tests)	≤	1.0%	≤	5%	>	5%		Patient Exper	JW	0.13%	0.26%	0.33%	0.24%
Post Acute Transfers at Midday	≤	12	≤	18	>	18		Quality	JW	36.00	26.00	32.00	2.00
Post Acute Transfers-Total Average Beds Blocked per Day	≤	8	≤	14	>	14		Quality	JW	15.00	13.00	16.00	15.00
MSA breaches - Numbers of unjustified breaches	≤	0.0%	≤	0.5%	>	0.5%		Patient Exper	AT	0.00	0.00	0.00	0.00
VTE Risk Assessment	≥	98.0%	≥	93%	<	93%		Safety	JM	95.50%	TBC	TBC	

East & North Hertfordshire NHS Trust :Board Performance Report (2016-17) - Month 3 DRAFT

Trust Clinical Efficiency KPIs

Performance Thresholds for 2016-17

Indicator		Achieve		Under-achieve		Fail	Weighting	Area	Lead Director	Apr-16	May-16	Jun-16	Year to date
DNA rate	≤	Plan	≤	Plan +1%	>	lan +1%		Productivi	JW	9.23%	8.90%	8.82%	8.81%
New to Follow-up outpatient appointment ratio	≤	1.75	≤	2.27	>	2.27		Productivi	JW	1.94	1.79	1.78	1.89
*Pre-op bed-days	≤	6.0%	≤	12.0%	>	####		Productivi	JW	3.60%	6.10%	1.80%	4.00%
OCH Bed Occupancy - Elective (latest available position)	≤	92.5%	>	92.5%	>	####		Resource	JW	73.90%	92.90%	95.40%	87.50%
OCH Bed Occupancy - Emergency (latest available position)	≤	92.5%	>	92.5%	>	####		Resource	JW	100.00%	100.00%	100.00%	100.00%
Length of Stay (Overall)	≤	4.5	≤	6	>	6		Resource	JW	3.92	3.62	3.78	3.76

Key Contract Requirements

Performance Thresholds for 2016-17

Indicator		Achieve		Under-achieve		Fail	Weighting	Area	Lead Director	Apr-16	May-16	Jun-16	Year to date
A&E Quality Indicator - Total Time in A&E (95th percentile)								Quality	JW	1.0 'Timeliness' indicator not achieved	1.0 'Timeliness' indicator not achieved	1.0 'Timeliness' indicator not achieved	1.0 'Timeliness' indicator not achieved
A&E Quality Indicator - Time to initial assessment (95th percentile)	≤	0.5			=	1	1.0 (failing 3 or more) OR 0.5 (failing 2 or less)	Quality	JW				
A&E Quality Indicator - Time to treatment decision (median)								Quality	JW				
A&E Quality Indicator - Unplanned reattendance rate	≤	1				1		Quality	JW	5.30%	5.90%	6.10%	5.80%
A&E Quality Indicator - Left without being seen	≤							Quality	JW	1.60%	1.50%	1.50%	1.50%
Ambulance Turnaround (To Apply from Q2)	≤	15 minute			>	minutes		Quality	JW	62.10%	71.90%	Not Yet Available	67.00%
Choose & Book Slot issues under 5%	<	5%	>	5 % <EoE	>	EoE Avg		Quality	JW	20.90%	Not Yet Available	Not Yet Available	20.90%
Cancelled Operations - on the day and not rebooked within 28 days	<	0.80%	≥	0.8%	>	####		Quality	JW	9.37%	0.00%	2.17%	3.70%
Readmissions following non-elective admission	≤	9%	≤	13%	>	13%		Activity	JW	7.34%	6.60%	TBC	7.10%
Admissions to a Critical Care Bed >4-hours from Decision to Admit	≥	0				>1 per mont		Quality	JW	0	0	0	0
Admissions to a Stroke Bed <4-hours from Arrival at A&E* (*Q1 – 50% pts, Q2 – 70% pts, Q3 – 90% pts, Q4 - 90% pts)	≥	90%	≥	81%	<	81%		Quality	JW	71.21%	85.00%	84.85%	80.21%

Performance Thresholds for 2016-17

Indicator		Achieve		Under-achieve		Fail	Weighting	Area	Lead Director	Apr-16	May-16	Jun-16	Year to date
Stroke Care - % of patients spending 90% of hospital stay on a specialist stroke unit	≥	80%		70%	<	70%		Local Prior	JW	91.18%	93.65%	88.57%	91.04%
Stroke Care - % patients with high risk TIA seen and scanned/treated within 24 hours	≥	63%	≥	45%	<	45%		Local Prior	JW	51.28%	70.83%	83.87%	67.02%
PPCI – 150 minute call to balloon time	≥	80%		75%	<	75%		Local Prior	JW	100.00%	100.00%	100.00%	100.00%
Two-week wait access for Rapid Access Chest Pain Clinics.	≥	98%			<	98%		Local Prior	JW	100.00%	100.00%	100.00%	100.00%
MRSA Elective screening	≥	100%	≥	99%	<	99%		Local Prior	AT	Not Yet Available	Not Yet Available	Not Yet Available	Not Yet Available
MRSA Emergency screening	≥	100%	≥	95%	<	95%		Local Prior	AT	Not Yet Available	Not Yet Available	Not Yet Available	Not Yet Available

Agenda Item: 9.04

TRUST BOARD MEETING (PART I) – 27 JULY 2016

WORKFORCE REPORT MONTH 3

PURPOSE	To provide information on standard monthly metrics and Trust wide issues relating to management of the workforce
PREVIOUSLY CONSIDERED BY	**Finance and Performance Committee.**
Objective(s) to which issue relates *	☑ 1. **Keeping our promises about quality and value** – embedding the changes resulting from delivery of Our Changing Hospitals Programme. ☑ 2. **Developing new services and ways of working** – delivered through working with our partner organisations ☐ **3. Delivering a positive and proactive approach to the redevelopment of the Mount Vernon Cancer Centre.**
Risk Issues (Quality, safety, financial, HR, legal issues, equality issues)	Financial: increased workforce costs HR: failure to meet agreed standards Legal: failure to meet CQC and other national standards Patient Safety: failure to maintain appropriately trained workforce
Healthcare/ National Policy (includes CQC/Monitor)	CQC 13 and 14 NHSLA
CRR/Board Assurance Framework *	☑ **Corporate Risk Register** ☐ **BAF**

ACTION REQUIRED *

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

DIRECTOR:	Director of Workforce and Organisational Development
PRESENTED BY:	Director of Workforce and Organisational Development
AUTHOR:	Head of Workforce Performance, Information & Planning
DATE:	July 2016

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 2016

1.0 Purpose

This paper provides an update to the Finance and Performance/RAQC Committee for July 2016 on workforce performance.

2.0 Our Culture – Ambition

We want to be known as an organisation where our people feel engaged, valued and supported and empowered to deliver excellent patient care and services they are proud of.

2.1 Culture Programme - ARC

Strategy: The Culture Programme aims to improve staff engagement so that we are 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. Our approach is defined within the ARC, next steps culture programme.

Actions: Coaching as an Approach to Leadership (Phase 3) Training dates will commence in September and a wide multidisciplinary group will be encouraged, invited and recommended to attend. Leadership & Management training offer will double in capacity from September. New pathways have been designed and course content under review.

Performance: Final ARC sessions will run in July. ARC steering group will cease and a piece of work will be undertaken to ensure all activity under ARC is now regarded as normal operating practice or has an appropriate supportive home. ARC funding will be reviewed.

LEND Leadership Forum and LEND Leadership Steering Group will be developed over July and August, with LEND Leadership Model launched in July

From Q1 2016/2017 the Staff Friends & Family Test will be the main indicator used to measure staff experience. This quarter the survey was completed by 344 staff, on a par with previous quarters. In Q1 the percentage of staff who would recommend the Trust for care is 79% and the percentage of staff who would recommend the Trust for work is 63%. This is a substantial improvement on our results in previous quarters and it is anticipated that we will also show an improvement when compared to the national average, which will be published in late August 2016.

2.2 Health at Work

Strategy: To achieve the staff health and wellbeing CQUIN goal for 2016/2017, to improve the support available for staff to help promote their health and wellbeing in order for them to remain healthy and well. The Health at Work service are working in partnership with other key services to develop initiatives and process pathways to enhance workplace health and wellbeing.

Actions: The staff health and wellbeing CQUIN plan was submitted to the CCG on the 1st July. This was developed following a review of current physical activity schemes, physiotherapy and mental health indicatives, a review of food and drinks available to staff, patients and visitors and an evaluation of the last staff influenza vaccine campaign. Ideas from staff have been sought in the development of the plan and staff have been asked to

respond to a wellbeing survey. Survey Monkey will close at the end of July and so far has 95 responses.

The Health at Work Service has begun undertaking some staff health and wellbeing initiatives. Eat Well at Work Day was held on 14 June, and One You Day on the 7 July. A meeting has been held with Workplace Options the Trust's Employee Assistance Programme on 27 June to expand current services provided within the Trust contract for EAP services.

Performance: The Health at Work Service received and processed 194/194 (100%) pre-placement health clearances within 2 working days. 61 of these were new doctors due to commence in August 2016. 99 manager referrals were received of which 5 were incomplete. 89/94 (94.8%) were booked within agreed delivery times. Following attendance in clinic 71/71 (100%) reports were issued within the 2 day target delivery time.

3.0 Developing our people

Ambition: We want to develop our people so that everyone has the skills and knowledge they need to deliver high quality patient care and so that we can build our workforce for the future.

3.1 Appraisal rate

Strategy: That all Trust staff have an annual appraisal that sets clear objectives, recognises achievement and agrees development goals, the Trust target is 90% compliance.

Action: Divisional Director leadership teams are personally overseeing the approval process of switching off automatic pay progression for staff who have not received an appraisal and are fully statutory / mandatory training compliant; this has also been effective for managers who supervise staff and for all staff from 1st December 2016.

Performance: The overall appraisal rate for the Trust was 79.11% in June compared to 79.08% in May (12 month rolling); see Appendix 1, Section 3, Table 1. The appraisal rates over a rolling 12 month period were highest in CSS (89.23%). Compliance from surgery this month saw an increase to 80.10 from 77.52% in May. Medicine division compliance is 63.69%. As approximately a third of all staff appraisals are due in September and October, the current appraisal rate is likely to remain reasonably static until November, after which the rate is expected to increase significantly to approximately 90%.

3.2 Statutory and Mandatory Training

Details of statutory and mandatory training data can be found in Appendix 1, Section 3, Table 3.

4.0 People Performance

Ambition: We want to ensure that we have the people we need and are clear about the standards we expect. This will enable and support the delivery of safe, consistent and high quality patient care.

4.1 Vacancy Rates

Strategy: Following on from 244 wte establishment increase in April 2016 the Trust aims to reduce the overall vacancy rate to below 6% by February 2017. The approach to achieving this is to use a variety of interlinked attracting, recruitment and retention strategies supported by sophisticated vacancy predictor tool.

Action: The Trust has been continuously reviewing and improving its attracting, recruitment and retention plans to meet the increasing demand of permanent staff across all divisions with the main focus given to qualified nursing and midwifery staff group. A monthly nursing strategy steering group has been set up to understand the challenges and develop robust plans to address the issues around permanent and temporary appointments. As a result of the strategy steering group, permanent recruitment work stream has been meeting on regular basis, where vacancies and plans to fill those are being discussed.

As a consequence of the work undertaken by the workforce department and the nursing directorate, it has been decided that the trust will:

- Carry on with the UK recruitment – in order to support this, new advertising campaign is currently being agreed and is planned to be launched in August/September 2016. The main audience of the campaign will be people who commute to work by public transport. Adverts are planned to be put up at the train stations on the lines to London as well as at King's Cross train station. Smaller posters will be placed inside of the trains.
- Target UK student nurses and newly qualified nurses – the trust has been advertising on the universities' websites. As a result, there are currently 53 student nurses in the recruitment pipeline (they are due to start in August/September/October 2016)
- Increase Filipino campaigns – the trust has recently visited the Philippines and met with number of recruitment agents. Following on from initial meeting, 5 agents who could provide candidates directly to the trust have been shortlisted and terms and conditions are currently being reviewed and agreed. It is important to note, that this is still reliant on the official sign off from the Philippine Overseas Labour Office (POLO) and the Philippine Overseas Employment Administration (POEA).
- Commence India recruitment – a campaign in Kerala is planned for the beginning of September. Deputy Director of Nursing along with support from Nurse Education and Workforce departments will be interviewing candidates with IELTS. In addition, visits to local universities and hospitals are being planned as part of the research into quality of teaching and patient care.
- Continue sourcing nurses from within the EU
- Consider alternative overseas labour markets
- Consider alternative pension options to band 5 and 6 nursing staff – this has been discussed by the NHSI and Board (part 2) committees.
- Increase the CSW recruitment episodes due to the increased establishment

A detailed vacancy trajectory taking into account a set of assumptions and estimates is presented in the appendix 2 of this report.

Performance: The vacancy rate is at 9.27% in June compared to 9.37% in May.

There were 244 wte added to the establishment in May (211 wte substantive posts and 33 wte bank and agency posts), this included 52 wte qualified nursing posts and 21 wte bank and agency qualified nursing posts. An additional 33 wte Unqualified Nursing posts have been added to the establishment. The increase in establishment will add 3.86% to the vacancy level. Appendix 1, Section 4, Tables 3 & 4 provides a breakdown of the establishment changes by staff group and division.

In June, there was a revision to the new 16/17 establishment with 14.67 wte posts added to the substantive establishment, however there was a 34 wte reduction in the bank establishment.

There are currently 384 wte external candidates undergoing cohort recruitment, pre-employment checks and awaiting start date of which 257 wte are qualified nurses. The initial Filipino pipeline (interviewed in April and November 2015) is still to result in arrival of 81 candidates within the next 6-9 months (this number has reduced by about 30% compared to May 2016 due to the candidates' inactivity for more than 4 weeks). As a result of having recently engaged with additional recruitment agencies, the trust interviewed within the last 6-8 weeks 45 overseas candidates. Those candidates already hold the IELTS, which will positively impact their time to hire – it is estimated that majority of the candidates will be starting within 3-4 months from the interview date (12 of those have already stared).

The EU labour market still appears to be very limited in terms of the numbers of candidates with the IELTS therefore, very small increase of the EU pipeline will be seen in the coming months (the trust appointed 3 EU nurses within the last 4 weeks). Due to the additional 244wte added to the establishment (captured in the Appendix 2 in June 2016) the initially estimated vacancy rate of below 6% has now moved from September 2016 to February 2017. The trust would still have achieved its target by September 2016 in line with the 2015/16 establishment. Additional agencies from the Philippines are currently sourcing candidates directly to the trust. It is expected, that once the project has been approved by the POLO and POEA 15-20 additional candidate may be appointed per month. The agencies have also been asked to reengage with all those nurses who have initially been offered positions in the trust, but for a variety of reasons have not been engaged in the process for more than 4 weeks now.

Appendix 1, Section 4, Table 5 provides benchmarking data across Bedfordshire and Hertfordshire NHS Organisations and details Vacancy, Turnover and Agency costs comparisons in Quarter 4.

4.2 Resourcing Performance

Strategy: To be quicker than our competitors in converting offers of employment into commencement of work in the Trust. To ensure we fulfil all governance requirements to safely recruit staff and provide excellence in customer service

Action: Deep dive recruitment process review is currently under way to streamline the recruitment process further whilst maintaining 100% compliance with the regulatory bodies' guidance, the trusts' processes and policies. Additional support has been recently transferred in to support the team in redesigning current process and providing refresher training on all aspects on the NHS Pre-employment checks as well as the new recruitment process. It has now been linked with the East of England streamlining agenda.

Monthly GAP analysis report identifying potential issues and training needs is produced monthly and the most recent results are very positive with a score of around 99% compliance in the first run.

The internal and external training is continuously provided to the team as part of their development and refresher requirements to reduce time to hire.

Performance: The monthly GAP analysis results increase month on month, with the most recent one reaching 99% compliance in first run of the report.

Time to hire has remained within the target of 9 weeks for the 3rd month running with the pre-employment checks (from conditional offer to unconditional offer) oscillating around 3 weeks.

It is anticipated that following on full implementation of streamlining of the recruitment processes, the time to hire will reduce significantly.

4.3 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 the optimal delivery of the temporary staffing service and financial control. To build a clear demand model aligned to the permanent recruitment plan to give greater certainty and visibility around agency and bank costs.

Action: The Trust continues to lead on the strategy to implement the agency price caps working as part of the Hertfordshire and Bedfordshire Regional Cluster. As part of this activity agencies supplying nurses in Critical Care and Midwives were asked to submit their rate cards for a Tiering process based on price. The output was all midwives being supplied at April cap and a regional cascade implemented for the Critical Nursing areas with two thirds of the agencies supplying at April cap. A mini competition for Doctors was also run and a regional cascade has been agreed to be implemented on 4th July. This cascade will be built into the new Medical locum booking system. The Cluster will now focus on the Allied Health Professional (AHP) staff group.

The 'Love the NHS' initiative continues across the Trust and has seen increasing numbers of agency workers joining the bank. Further initiatives are being co-ordinated by the Agency Reduction Committee. These include the switch off of agency care support workers with stringent control measure in place when requesting these agency workers. There is also focus on agency nurses currently booked into long line shift patterns.

As part of the doctors' service transformation project which includes a review of systems and processes to improve the overall service offering, a new medical booking platform has been introduced. This system provides the core online function to source medical locums for jobs, ensure compliance documentation is available and provide cost control measures to view rates in advance of engaging locums. The new regional doctors cascade will also be uploaded into the system for an additional cost control measure. During this time of embedding, training gaps have been addressed and system developments identified.

A new Temporary Staffing Analytical Tool, Qlikview, has been rolled to Finance Managers and HRBPs with a view to enabling the operational teams to access this as an aid to measure and analyse their temporary staffing spend.

Performance: Through implementation of agency price caps agency unit cost continues to fall. Qualified nursing reduced by £1.47 per hour, Doctors by £1.70 and other clinical by £6.18. Agency hours reduced compared to the previous month with qualified nursing reducing by 1,300 hours. Medical agency hours in June showed a positive trend in reducing agency hours from 7334 to 6654, a reduction of 680 agency hours.

Retrospective bookings over two weeks increased compared to the previous month, however they have remained under the maximum target.

4.4 Turnover

Strategy: Employee turnover affects the performance and structure of the Trust. When an employee leaves, we lose training, information and knowledge. However, turnover can also

bring new skills and experience. The goal is to have an optimal rate of turnover at a sustainable level, for this Trust this been assessed at between 10 - 11%.

Action: Turnover data has been provided at a division, directorate and staff group level so that action can be taken to assess and address areas of high turnover. Exit questionnaires and interviews have been conducted with those leaving the Trust to help divisions identify themes. The Trust has identified a number of retention initiatives that require funding and these are currently being assessed by the Investment and Scrutiny Committee.

Performance: The Trust's turnover increased to 12.88% in June compared to 12.65% in May. 70.95 wte staff started in June compared to 62 wte leavers (including M&D staff). 18.87 wte qualified nursing staff started in June compared to 11.34 wte qualified nurse leavers. Appendix 1, Section 3, Graph 1 details the starters and leavers trend over the last year.

4.5 Medical Staffing

4.5.1 New national contracts proposed for Junior Doctors and Consultants

Strategy: To manage the successful and timely implementation of the new national contract for junior doctors. To maintain positive relationships with the medical workforce during this period of pause negotiations.

Action: The Government will impose a contract on junior doctors across England following the junior doctors and medical students vote to reject a deal between the British Medical Association (BMA) and the Government. NHS Improvement have advised trusts to proceed with the appointment of the Guardian role. As per agreed communications plan a memo from Jane McCue was issued to all junior doctors on 2nd June. The trust has been successful appointed Stephen Bates, Consultant Anaesthetic during the panel interview held on 27 June 2016. .

A Junior Doctor Contract Project Group has been set up with agreed stakeholders including BMA junior doctor rep, finance rep to meet fortnightly.

Performance: A model offer letter from NHS Employers was issued on 10 June to allow trusts to make offers for the first placement only. All offers for the first placement have been issued for trainees confirmed to commence at the East & North Herts.

4.6 Employee Relations

Strategy: The aim of the Employee Relations Advisory Service (ERAS) is to deliver a customer service focused ER function, providing both managers and staff with advice and support on all Employee Relations issues, eradicating bullying and harassment.

Action: The ERAS team has introduced a number of measures to support both managers and staff. These include immediate responses to queries, the implementation of the anonymous raising concerns platform (Speak in Confidence) and the bullying and harassment survey that has been undertaken by Duncan Lewis.

ERAS has implemented a number of training programmes for managers, these include; Absence management, Disciplinary, Emotional Intelligence, Difficult conversations, Bullying and Harassment, Raising concerns and Performance management

Performance: In June, the percentage of employee relations cases within the Trust was 4.0% and within the target range. The overall number of live employee relations cases increased from 205 to 214. The high number of cases is mainly due to the work the ERAS team is undertaking to record sickness cases which have been identified in departments.

The customer feedback score in June for the ERAS service was 2.8 (measured on a scale of 1 to 3 with 3 being excellent). A detailed table showing the ERAS performance in all employee relations areas can be found in Appendix 1, Section 4, Table 7.

Exit Interview Data

From the 40 exit interviews that were undertaken in June, further education was cited by 25% of leavers. 12 % stated that they were relocating. 10 % cited enhanced job opportunity, 10% lack of challenge, 10% career change and 10% retirement.

A detailed table showing the Exit Interview Data can be found in Appendix 1, Section 4, Table 8 including qualitative data from leaver's responses.

4.7 Disciplinary Cases

Strategy: The aim of the ERAS team is that all disciplinary cases are effectively managed and resolved within 90 days of the case being opened.

Action: ERAS has trained over 400 managers on disciplinary processes since June 2015. ERAS has developed new training programmes for 2016 to help managers deal with disciplinary procedures. A review of the current disciplinary policy is underway. The proposed new policy will enable a quicker approach to concluding disciplinary cases.

Performance: The benchmark across five NHS organizations for the percentage of disciplinary cases of headcount is between 0.5% and 1.0%. In June, the Trust percentage was 0.2% and within the target range.

The Trust's Key Performance Indicator is to complete all disciplinary cases within 90 days. Priority has been given to support the management of disciplinary cases that have been open for a considerable amount of time. Out of the 13 live cases in June, 6 were over the Trust's KPI of 90 days. These cases have been identified and are under management with ERAS support to ensure completion without further delay.

4.8 Sickness Absence

Strategy: To reduce sickness absence below 3.5% by June 2017. 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.

Action: Workforce and OD have implemented both Absence Assist and the ERAS team to support with the management of sickness absence as well as the Health at Work service.

Performance: The Trust annual sickness absence rate increased in to 3.65 % in June compared to 3.61% in May. In month, sickness saw a decrease to 3.96% in June from 4.01 % in May. Long term in month sickness decreased to 2.01% in June from 2.08% in May. The number of staff on long term sick has increased to 96 in June compared to 93 in May. Currently long term sickness cases (including under monitoring cases) are being managed through the HR Advisory Service. A review of all long term sickness cases continues to be undertaken.

Short-term sickness in month increased to 1.96% in June compared to 1.93 % in May. The number of days lost to sickness in June was 5663.48 compared to 5911.47 in May.

The sickness rate for nursing and midwifery is higher than the Trust average with an overall rate of 5.09%, which was 3135.27 days lost and has driven agency expenditure in ward areas. Further work has been carried out in ward areas to ensure effective sickness

management and the value of having a centralised model of sickness absence reporting is currently being explored. See Appendix 1, Section 1, Graph 1, Sickness Absence.

4.9 HR Policies and Procedures

Strategy: To review policies in line with the planned policy review date, so that policies are updated in a timely fashion.

Action: Following the handover of all Workforce and OD policies to the ERAS team, the first policy Lock in Meeting took place between ERAS and the Unions at the end of June. During the meeting the Unions were in support of a new approach to policies and agreed with the view of making policies more streamlined and user friendly. The planned new approach will be to shorten our HR policies with a view to making them user friendly to encourage their use. During the meeting the Unions also responded to the Equality, Diversity and Inclusion Policy, overall the response was extremely negative however they did not attend the meeting prepared with their formal feedback. We have requested for their formal feedback, in writing, by Friday 15 July 2016; to allow for a second draft of the policy to be considered.

Performance: A timetable for future policies has been defined and the following policies have been extended to allow for additional time due to extenuating circumstances. The team are currently working in updating the Capability, Change Management, Disciplinary and Work Life Balance Policies.

4.10 Governance

Strategy: To ensure the Workforce and OD team achieves compliance with governance requirements and reviews processes where appropriate.

Action: Annual compliance checks required for Trust executive directors under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, known as the 'fit and proper persons' checks, will be made during July.

Performance: The ESR gap analysis reports for May starters recorded 98% compliance for the first run and 99% compliance on the second run of the report.

5.0 Areas of Note

5.1 ESR

Strategy: The ESR eForms project team has successfully processed changing the Trust's current paper-based staff change of circumstance (CoC), resignation and exit questionnaire forms to an electronic version. Whilst replacing the current eLeavers system on the Knowledge Centre to the new Greenlight eLeaver system.

Action: Since the last update the project team has continued to conduct a large number of implementation workshops for the Trust authorised signatories. Whilst continuing to target the remaining staff who requires training the PT is concentrating on finalising the Transition to BAU requirements, with the team having:

- Developed the operational support structure for the central and operational teams.
- BAU Roles & Responsibilities having been defined and agreed by all parties.
- Support material has been generated and made available to all AS and central support teams to assist with the system embedding even further into the organisation.

- Communications going out on a weekly basis to relevant staff notifying them of pertinent matters and support material available to them.
- Conduct final –Transition to BAU workshops with the central teams i.e. Payroll, HR, Finance and IT.
- Finalise the eForms eLearning package and HR resource that can deliver 1:1 training as required to accommodate with staff turnover and promotions.

Performance: The project has gone very well considering the large change management process which impacts the majority, if not all Trust staff. However, the project has had the usual hurdles to overcome with some staff reluctant to engage with the change requirements, managing varying levels of computer literacy. But the main hurdle has being the volume of DNA's experienced at our planned implementation workshops, which we have seen the volume of DNA's range between 30% to 50% through the staggered implementation life cycle. This has resulted in the project being extended by six weeks. Stating this we have managed too:

- Train 339 of the 402 AS at the Trust to date with further implementation workshops being scheduled.
- This equates to 100% of CCS AS trained – 100% of W&C AS trained – 83% of Corp AS trained – 86% of Cancer Services AS – 85% of Surgery trained and 76% of Medicine trained to date.
- This has resulted in the number of paper coc being processed versus the number of eCoC being processed as to be expected. In May 50 eCoC were operationally processed, in June 63 were processed and so far 30 has been submitted / processed in June.
- As of Monday no paper CoC will be accepted and or processed by the central teams, with communications having gone out over the last month notifying staff of this change, which in turn we hope will engage the final remaining AS that require training.
- A full review of requested changes that previously came via the paper CoC has been completed with clear guidance available what staff should do moving forward.

The project officially closes on 17th July2016, the eForms products and associated procedures have embedded well into the organisation, with the operational end to end processes working well. And this will continue over the coming weeks and months now the paper CoC has been removed from the operational environment.

5.2 Quarterly Update on Independent Contractors

Strategy: Engagement of independent contractors should be in line with Department of Health guidance and Trust policy.

Action: A quarterly update on usage of independent contractors is requested from Divisions and Directorates, so that this can be monitored by the Trust Board via this report.

Performance: There were 16 people reported as working in the Trust and falling within the definition of independent contractors (excluding high value agency workers) during the period April 2016 to end June 2016, of whom three had left the Trust by the end of the quarter. See Appendix 1, Section 4, Table 8 for further details.

Updates on the following areas will be given, when appropriate: Equality and Diversity, Job Planning, Medical Rostering, Community Hub and Staff Survey.

5.3 Staff retention

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

Action: To recruit, retain and develop high calibre staff who exhibit the key skills and experience to undertake their roles effectively whilst demonstrating the right attitudes, values and behaviours to deliver safe, high quality compassionate care.

Performance: The Workforce and OD team have agreed three key objectives in relation to staff retention for 2016/17. They are; Improved internal communication and staff engagement, Increased retention of staff and Increased attendance at work. The main focus over the last three months has been;

- To build on a culture which embraces flexibility in working patterns and contracts arrangements for staff throughout the organisation to attract and retain the best staff.
- To enable a culture of growing, developing and nuturing our own staff to meet the workforce requirements of the future.
- To reduce the perceived long-hours culture within the organisation.
- To improve staff engagement and create a two-way dialogue with the organisation.
- To improve internal communications by setting up 'Your Voice' staff engagement feedback sessions on our four main hospital sites and Wiltron House where the majority of our Corporate staff are based. As part of the first sessions feedback sessions staff asked for an easy to read short newsletter to keep them informed of developments which affect them within the organisation. We established 'Your Voice' monthly staff newsletter.

Please see Appendix 3 - DEC briefing update paper dated 23rd June 2016 for an overview of the detailed discussion regarding current actions and agreed future actions.

(This report is based on data as at the end of June 2016)

East and North Hertfordshire NHS Trust

Agenda Item: 10.1

TRUST BOARD MEETING – 27 JULY 2016
RISK AND QUALITY COMMITTEE – 19 JULY 2016
EXECUTIVE SUMMARY REPORT

PURPOSE	To present to the Trust Board the report from the Risk & Quality Committee (RAQC) meeting of 19 July 2016.
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. Any major financial implications of matters considered by the RAQC are always referred to the FPC.
Healthcare/ National Policy (includes CQC/Monitor)	In line with Standing Orders and best practice in corporate governance.
CRR/Board Assurance Framework *	[ ] **Corporate Risk Register** [X] **BAF**

ACTION REQUIRED *

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

DIRECTOR:	Chair of RAQC
PRESENTED BY:	Chair of RAQC
AUTHOR:	Corporate Governance Officer / Company Secretary
DATE:	July 2016

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

RISK AND QUALITY COMMITTEE – MEETING HELD ON 19 JULY 2016

SUMMARY REPORT TO BOARD – 27 JULY 2016

The following Non-Executive Directors were present:
John Gilham (Chair), Ellen Schroder (Trust Chair), Bob Niven, Vijay Patel (Designate)

The following Executive Directors were present:
Jane McCue, Brian Owens (Acting), Tom Simons and Angela Thompson

Outcomes:

Divisional Presentation – Women's

The Head of Midwifery, Divisional Director for Women's and Children's and Divisional Chair for Women's delivered a presentation regarding Women's services at the Trust. The presentation highlighted key trends and challenges, learning from incidents and complaints, detail of the division's top risks and mitigations and detail of actions arising from the Trust's CQC inspection. A key trend affecting the service that was highlighted was an increase in births, predominantly from within the Trust's own catchment area. Cultural change and staffing were amongst the areas reported as presenting a challenge for the service, and plans were in place to address these areas. The Committee considered the risks detailed within the presentation, and there was some discussion around whether some specific risks could be downgraded. The Committee also discussed whether an increase in births translated to an increase in income and it was suggested that this was a risk for the service. In relation to the trend for increasing births, it was suggested that a review of the local demography might be beneficial. It was also reported that the areas of concern raised by the CQC were being addressed, with some specific updates provided.

Emergency Preparedness Report and Core Standards Submission

The Committee received the latest quarterly update regarding emergency preparedness progress which included the core standards submission for approval, ahead of the deadline for submission in August. The update highlighted concerns around Netcall (confirmer). It was agreed that further work was needed in this area and that the Chief Information Officer would take this forward. The report also highlighted training and exercises that had taken place and were planned. It was noted that the emergency preparedness policies would be updated on a rolling basis, the first being the Lockdown policy. The Committee discussed the risks associated with business continuity, and it was noted that knowledge of business continuity plans had arisen as an area for improvement from the recent tabletop exercise. The Committee also discussed the resources and budget required for Emergency Preparedness, though it was considered that further work was needed to gauge this accurately. The possibility of undergoing a peer review was discussed and it was agreed that this would be looked into further.

In relation to the core standards submission, it was agreed that some further work was needed prior to final submission. It was agreed that a revised version would be reviewed and approved by the RAQC Chair, the Acting Director of Operations, the Company Secretary and the Chief Executive before the deadline for submission on 31 August.

Pathology Performance Update and Recovery Plan

The Committee noted the Pathology Performance Update and Recovery Plan which indicated that there had been a continued improvement in performance that was consistent with the report received at the last RAQC meeting.

Floodlight Scorecard / Exception Reports

The Floodlight Scorecard had not yet been finalised so was not considered by the Committee. The Committee discussed the sign off process and possible ways of improving this going forward. The Committee requested that the scorecard be provided for future meetings in as full a state of completion as was possible, acknowledging that some data may not be ready in time.

Incident Report

The Committee received the latest version of the Incident Report which provided incident data at a Trust-wide level, highlighting any trends and common themes. The report set out that the Trust was reporting 26.61 patient safety incidents per 1000 bed days for April – September 2015. This was an increase compared with the previous half year but still within the lower quartile of acute Trusts. Better processes around more timely sign-off and monitoring aimed to increase the figure in future, with anticipated data showing an improved position. The most common types of incident reported remained consistent with the previous report and medication incidents continued to fall.

The Committee discussed that there had been a peak in the number of incidents reported around October 2015. It was considered that this could have been in part due to a greater awareness ahead of the CQC inspection. The Committee noted the report and considered it likely that actions the Trust was taking were at least in part responsible for the fall in the number of certain types of incidents. The Committee took assurance from the report that appropriate actions were being taken by the Trust regarding incidents.

Serious Incident Report

The Medical Director reported that there had been 7 Serious Incidents (SIs) reported during May and June 2016. Details of the incidents were set out within the report, along with root cause analyses and action plans for previously reported SIs. The Committee considered that the report provided assurance and evidence of learning from SIs.

IG Strategy

The Company Secretary presented the Information Governance report. The report included the draft IG Strategy 2016-19 for approval. The strategy was previously considered by RAQC in March 2016. At that time, the Committee had requested a further review of the objectives, inclusion of key milestones and measures and assurance that the strategy would address the risks identified during the 2015/16 IG toolkit assessment. The strategy had subsequently been revised accordingly and endorsed by the IG Steering Group at its meeting in July. The Committee approved the revised version of the strategy.

There was also an update on the latest position regarding the IG toolkit, with the current position consistent with the 2015/16 year end position. The Committee discussed the Trust's compliance with the toolkit over recent years, noting a slight downward trend. It was explained that the measures against which the Trust was scored changed year on year, so a direct comparison was not possible. It was reported that the Trust's assessment results were broadly in line with its peer group. It was also considered that the robustness of the Trust's submission had improved over the years. Finally, the report highlighted one item of escalation from the IG steering group. This was regarding temporary cards for locums. The Head of IT had confirmed he would link with the Divisional Director and urgent action was being taken to address this issue. The Committee noted the report.

Nursing and Midwifery Establishment Review

The Director of Nursing presented the report regarding the biannual review for ward establishments. The data reviewed was from a 20 day period in April 2016 and followed the required methodology. The report included a benchmark of the Trust against 3 others. The review recommended some changes to the establishment and supported the Trust's existing approach of flexibly managing staffing levels and the national initiative to implement the Band 4 nursing associate role. The recommendations of the report were to:

- Increase 10B unregistered day coverage from 5+3 to 5+4 on the early and from 4+3 to 4+4 on the late; this is a cost increase of £49,770.

- Increase 11A band 2 CSW night coverage from 5+1 to 5+2 on the night; this is a cost increase of £74,952.

- Convert 1 band 5 RN Post to a band 4 Nursing Associate role on 24 wards (Excluding NICU, Maternity, ICU, and Bluebell) at a potential annual cost saving of £130,359. This is part of a scoping exercise over the next two years to enable wards to introduce the new Nursing Associate Role and develop clear career pathways.

It was noted that bank staff were currently being employed to provide the coverage referred to in the first two recommendations detailed above. The Committee supported and approved the recommendations set out within the report.

Safer Nurse Staffing Levels

The Committee received the quarterly Safer Nurse Staffing Levels report. The report highlighted that there had been a slight increase in the number of shifts initially triggering red from May to June 2016. There was no evidence to suggest that agency and vacancy rates had a meaningful impact on patient safety, with the complexity and acuity of patients considered the key factor. The Committee were assured by the report regarding the management of safe nursing and midwifery staffing for the month of June 2016.

OCH: Post Centralisation of Acute Services: Clinical Quality Review

The Medical Director presented a report which provided a review of the impact on clinical quality (focusing on Mortality and Patient Outcomes) of the completion of the centralisation of acute services at the Lister site embodied in the Our Changing Hospitals programme (OCH). The Committee had previously received a paper on the topic in December 2015. At that time it was considered that, whilst some improvements had been seen, it was still too early to gain a clear picture of the impact of the centralisation process. The latest report provided a comparison of a number of key metrics from prior to and after OCH; these were the same metrics as had previously been considered in the report from December 2015. The metrics demonstrated a clear improvement in patient safety and some evidence suggestive of improvement in clinical effectiveness and patient experience. It was also considered that the quality benefits would continue to develop as it was still relatively soon after OCH. It was acknowledged that other factors outside of the Trust's control may also have played a role in performance, and in particular the increase in demand that had been experienced had negatively impacted on ED performance. The Committee noted the report and supported the findings. Please see Appendix 1 for a copy of the report.

Complaints, PALS and Patient Experience Report (including Patient Experience Strategy Review)

The Director of Nursing presented the Complaints, PALS and Patient Experience Report. The report provided details of the Trust's position with regard to the Quarter 1 complaints

and PALS activity and patient experience feedback. The results of the National CQC Inpatient Survey 2015 and National Cancer Survey 2015 were detailed within the report. It was considered that there was room for improvement on the back of the results of both surveys and the Trust's patient experience action plans would be reviewed in light of the results. It was noted that the results of Inpatient Survey highlighted communication as an area for improvement.

The Committee reviewed the latest data showing the number of complaints that were responded to within the agreed timeframe. The Medicine Division remained the area with the lowest compliance against this target but work was underway to address this. The report included the latest data from the Parliamentary and Health Service Ombudsman (PHSO) on complaints about acute Trusts for the period from January 2016 to March 2016. This allowed for benchmarking against other Trusts in the locality. It was agreed that there would be a deep dive of some of the common themes from issues raised with PALS in the next report. The Committee noted the report.

Annual Responsible Officer's Revalidation Report

The Medical Director presented the Annual Responsible Officer's Revalidation Report, which sought to inform the Committee of the appraisal and revalidation arrangements with the Trust and to provide assurance that the Responsible Officer and the Designated Body are discharging their statutory responsibility. Between 1 April 2015 and 31 March 2016 a total of 114 doctors for whom East and North Herts Trust was the Designated Body had been revalidated. The Maintaining High Professional Standards and GMC case loads within ENHT lay within the expected range. It was noted that the Trust's CQC inspection report had included reference to the fact that there were robust processes in place for medical revalidation. The Committee were assured that the process was completed effectively. The Committee endorsed the report, subject to the Medical Director reviewing the data in Appendix B to ensure it was correct. Please see Appendix 2 for a copy of the report.

Infection Prevention Control Annual Report and Monthly Update

The Committee received the IPC Annual Report which provided information on infection prevention control performance for the period April 2015 to March 2016. During the period covered by the report the Trust had reported zero cases of MRSA bacteraemia, which was in line with the Trust's target. The target for hospital acquired C.difficile associated disease (CDAD) was 11. The Trust had reported 15 cases during the period and 2 had been successfully appealed. Whilst the target had not been achieved, the Trust reported one of the lowest levels of CDAD in the region and was in the upper decile nationally of comparator organisations. The Committee approved the report. Please see Appendix 3 for a copy of the report.

The Committee also noted the monthly Infection Prevention Control report, which provided details of performance to 30 June 2016. There had been 0 cases of MRSA and 7 cases of C.diff in that period. A copy of the C.diff reduction action plan was appended to the report. The Committee noted that all cases of C.diff in the year to date were within the Medicine Division and it was confirmed that actions were being taken to address this. The Committee noted the report and actions in place.

The following reports were noted by the Committee:

1. **Regulation and Compliance Update**
   The Committee noted the Regulation and Compliance Update, which provided assurance around actions taken to ensure compliance with the Care Quality Commission regulations and other regulations.

2. **RAQC Terms of Reference**
   The Committee noted the RAQC Terms of Reference, as approved by the Trust Board in June 2016.

The following points are specifically highlighted to the Trust Board:

1. Estates Capital Allocation and Associated Risks Update

The Director of Estates and Facilities provided a report detailing the prioritised risk-assessed estates capital allocation. The Committee requested further information regarding the level of deferred investment and what this would mean for estates capital requirements for the coming years. The Director of Estates and Facilities explained that a six facet survey was due to be undertaken which would help to inform decision making for the next financial year. It was agreed that a further update would be provided later in the year once the results of the six facet survey had been received. The Committee noted that this was an area where risk was possibly increasing.

2. Corporate Risk Register

The Committee received the latest version of the Corporate Risk Register. The Committee considered that a more proactive and consistent approach was needed with regard to risk management across the Trust. It was considered that there was a variable understanding and use of risk registers across the divisions and further work was needed in this area. In relation to the number of risks that were reviewed within 4 weeks, the KPIs indicated a slight improvement over the last year. There was discussion regarding whether a 4 week period ought to be enforced as the limit for overdue risks requiring review, with a view to having no risks requiring review outstanding for longer than that timeframe. It was agreed that this would be discussed further initially by the executive team. The report included an update on progress made against the action plan that was in place following the CQC inspection in relation to risk registers.

John Gilham
Chairman

July 2016

RAQC Report – Appendix 1

OCH: POST CENTRALISATION OF ACUTE SERVICES: CLINICAL QUALITY REVIEW

1. INTRODUCTION

In December 2015 an initial paper was provided to the Risk and Quality Committee in response to its request for a clinically led review of clinical quality evidenced by the Trust following completion of the centralisation of Acute Services at the Lister site in October 2014. While improvements were seen to have been achieved in numerous areas it was felt that it was still too early to gain a clear picture of the impact of the centralisation process.

The original business case for centralisation, which formed a key element of the Our Changing Hospitals (OCH) programme, was clear; that acute service consolidation would bring benefits to clinical outcomes, patient safety and patient experience. The proposal was fully supported by all clinical professional groups and seen as the solution to meet the needs and demands of the local population.

This current paper is the outcome of a request for a 6 month update to the December 2015 report. Further information on the key metrics and developments contained in this summary page are provided in the in-depth report contained in Appendix 1. Now that some twenty months have elapsed since the achievement of the final milestone in the OCH programme in October 2014 when the centralisation of acute services at the Lister site was completed, it is hoped that this report will provide an indication of the extent to which anticipated improvements in clinical quality have so far been realised.

2. KEY METRICS

Metric	Pre OCH	Post OCH
Clinical Effectiveness		
Headline Mortality Rates		
Average LOS & Readmissions		
ED Four Hour Standard		
7 Day Services		
Patient Safety		
Nursing Quality Indicators		
Medication Management		
Intentional Rounding		
Serious Incidents		
Never Events		
Number of “high risk of settlement” Claims		
Patient Experience		
Complaints (% of Finished Consultant Episodes)		
Friends and Family Test:ED Patients who would recommend		

3. CONCLUSION

Whilst it has not been possible to provide definitive evidence of an overall improvement in quality clear improvement has again been seen in patient safety and some evidence suggestive of improvement in clinical effectiveness and patient experience.

Appendix 1

OCH: POST CENTRALISATION OF ACUTE SERVICES: CLINICAL QUALITY REVIEW: DETAILED UPDATE

1.0 EXECUTIVE SUMMARY

In December 2015 an initial paper was provided to the Risk and Quality Committee in response to its request for a clinically led review of clinical quality evidenced by the Trust following completion of the centralisation of Acute Services at the Lister site in October 2014. While improvements were seen to have been achieved in numerous areas it was felt that it was still too early to gain a clear picture of the impact of the centralisation process.

This current paper is the outcome of a request for a 6 month update to that initial piece of work. Whilst it has not been possible to provide definitive evidence of an overall improvement in quality clear improvement has again been seen in patient safety and some evidence suggestive of improvement in clinical effectiveness and patient experience.

2.0 INTRODUCTION AND BACKGROUND

The original business case for centralisation, which formed a key element of the Our Changing Hospitals programme, was clear; that acute service consolidation would bring benefits to clinical outcomes, patient safety and patient experience. The proposal was fully supported by all clinical professional groups and seen as the solution to meet the needs and demands of the local population.

Now that some twenty months have elapsed since the achievement of the final milestone in the Our Changing Hospitals programme in October 2014 when the centralisation of acute services at the Lister site was completed, it is hoped that this report will provide an indication of the extent to which anticipated improvements in clinical quality have so far been realised.

Fig 1: Clinical Quality Outline

The report will assess quality under the key headings of Clinical Effectiveness, Patient Safety and Patient Experience. While Safe staffing, which impacts on each of these areas, is recognised to be of pivotal importance, it will not be covered in this review as it has already been reported on in depth in other Executive fora.

In order to assess the impact of centralisation, data and information relating to a number of key measures have been compared for two 12 month periods, one prior to, and one following, centralisation. The chosen periods are as follows:

- September 2013 to August 2014
- April 2015 to March 2016.

Where this has not been possible, indicative pre and post centralisation information has been compared and the relevant details provided.

3.0 CLINICAL EFFECTIVENESS

3.1 Mortality

While the correlation between mortality rates and quality of clinical care is a complex one, there can be no doubt that a reduction in mortality rates is a strong indication of improvements in patient care and clinical outcomes. For this reason reducing mortality is one of the Trust's key objectives. Schemes to reduce mortality form an important part of the current *Improving Patient Outcomes Strategy 2015-2018* and link closely with other clinical quality initiatives such as Clinical Effectiveness, Patient Safety and Patient Experience.

3.1.1 Headline mortality information

Table 1 below provides headline information regarding the Trust's mortality data for the two periods in question:

Table 1: Trust Headline Mortality Rates

Trust Mortality Rates	Sep13 to Aug14	Apr15 to Mar16
Crude Mortality	1.72%	1.60%
HSMR	95.06	**92.73**
SMR (All diagnosis)	**93.34**	**90.81**
SHMI	112.0 Oct13 to Sep14	109.7 Jan15 to Dec15

These figures show a reduction in both Crude Mortality and HSMR (using December 2015 benchmark) for the post centralisation periods reviewed compared to the pre-centralisation year. At the time of this report it is not possible to provide a comparison of SHMI statistics since the entire year of data is not yet available for the second time period although an All Diagnosis SMR is shown which is indicative data.

It is possible to provide SHMI data for two indicative 12 month periods pre/post centralisation as Jan15-Dec16 is the most up to date SHMI available. This latest SHMI shows a significant reduction and represents our lowest recorded SHMI since the indicator was first published in 2011.

In summary all these key headline mortality rates have shown improvement.

3.1.2 Key Pathway Mortality Information

Mortality rates can also be used at a more granular level to provide an indication of clinical quality within specific pathways.

The Trust has focussed on the following key pathways over recent years both generally and via individual CQUINs. The provision of quality services has been augmented by the development of specialty teams on a centralised in-patient site.

Table 2 below provides headline mortality data for key pathways within the Trust. There had been a centralised service for Fractured Neck of Femur in place for over two years by this time of OCH and good HSMR has been maintained since then. Improvements have been seen for the Respiratory basket and Stroke. At the same time there have been significant increases in AKI and Sepsis where there is current work in train via CQUINs and broader Trust initiatives to understand and address the potential concerns raised by the data.

Table 2: Pathway Mortality Rates Pre/Post Centralisation

HSMR Rates	Sep13 to Aug14	Apr15 to Mar16
Acute Kidney Injury (Renal Failure)	83.72	98.40
Fractured Neck of Femur (Hip)	76.15	78.54
Respiratory Basket	102.91	100.50
Sepsis	88.63	96.05
Stroke (ACD)	88.54	80.84

3.1.3 Other Effectiveness Indicators

In addition to mortality, length of stay and readmissions are also seen as key indicators of clinical effectiveness. As can be seen from Table 8 below improvements have been seen in both indicators between the two periods under review.

Table 3: Key Quality Indicators

Key Quality Indicators	Sep13 to Aug14	Apr15 to Mar16
Average Length of stay	3.61	3.50
Readmissions within 28 days	10.23%	9.63%

3.2 Emergency performance

Table 4: Emergency Performance

Emergency performance	Sep13 to Aug14	Apr15 to Mar16
Four hour standard	94.72%	85.05%
Pre-operative length of stay for emergency patients (Those waiting for more than 24 hours)	4.84%	4.81%

Our Emergency Department continues to face significant challenges, with a continued increase in patients presenting, volume of admissions (including an increase in activity from outside our catchment area) together with an increase in the percentage of

patients admitted suffering from severe conditions. There has been a marked deterioration in performance against the 4 hour standard during the second period.

Despite these factors table 4 above shows a slight improvement in the percentage of emergency patients having to wait more than 24 hours for surgery following an emergency admission.

3.3 7 day services

The Trust is working towards 7 day working and fully achieving the Keogh standards set out in the report NHS Services, seven days a week. The revised schedule sees ENHT in the tranche of trusts that are aiming to achieve compliance against the four prioritised standards by the end of March 2018, and the remaining standards by the end of March 2021. Detail of the four prioritised standards and an indication of our current progress towards compliance is shown in table 5 below:

Table5: 7 Day Service Prioritised Standards

Keogh Standard	Progress towards compliance
Standard 2: Time to Consultant Review	Average
Standard 5: Access to Diagnostics	Good
Standard 6: Access to Consultant-directed Interventions	Good
Standard 8: On-going Review	Poor

We continue to lobby our Commissioners regarding the levels of funding required to enable the Trust to achieve compliance with these important standards.

In the meantime the Respiratory 7 day service, which sees Consultants and Specialist nurses work full days on Saturday and Sunday has been in place for one year. There are now 7 wte and 1 locum in place and although the service is still one Consultant short the existing team continues to ensure the provision of the service by means of cross cover for empty slots on the rota.

Table 6 below shows a slight increase in both the Respiratory HSMR, where respiratory is the specialty of discharge and for Readmissions. This is likely to reflect the impact of admission prevention by the Acute Chest team for 200 less severe cases. There has been a marginal reduction in the average length of stay.

Table 6: Respiratory 7 Days Service Data

Respiratory (Speciality of discharge)	Sep13 to Aug14	Apr15 to Mar16
HSMR	99.10	101.48
Average LOS (HSMR basket)	17.65	17.03
Readmissions within 28 days (HSMR basket)	16.31%	16.76%

While external reviews and the CQC inspection have spoken extremely highly of the quality of care provided by our Respiratory service, and table 2 indicated a reduction in the standard respiratory HSMR basket, this has not yet been reflected in the respiratory (specialty of discharge) HSMR or respiratory readmissions despite regular 7 day provided Consultant care.

In addition to the Respiratory 7 Day service there is now increased weekend services in the following areas:

- 7 day TIA service for high risk TIAs and review of new patients on HASU by consultants commenced June 2016
- 7 day Integrated Discharge service in place
- Cardiology: increased weekend ward rounds.

Table 7 below shows Dr Foster HSMR rates pre and post centralisation for weekend (Sat/Sun) non-elective admissions and demonstrates little change over this period.

Table 7: Non-Elective Weekend Mortality Data Pre/Post Centralisation

HSMR Rates	Sep13 to Aug14	Apr15 to Mar16
All Diagnoses	93.3	95.5

3.4 Outcome Data from Clinical Audits

While in theory a comparison of outcome data from Clinical Audits pre and post centralisation would seem likely to provide evidence of the impact of the centralisation of acute services on clinical quality, in reality, due to a number of factors, it is difficult to make useful comparisons or draw meaning conclusions from this source. In particular the phasing of centralisation would render some available audits too historic to be useful, and the highly variable incidence and content of audits hinders comparison. Of the National Audits undertaken, only the National Heart Failure audit was deemed potentially appropriate to look at. However the latest available report covers the period April 2013 to March 2014, demonstrating that with regard to audit lifecycles in many cases it is still too soon for appropriate report outputs to be available.

3.5 External Reviews

Since the consolidation of acute services to the Lister site was completed a number of clinical areas have undergone national peer/external reviews. The general theme of the outcomes of these has been highly complimentary regarding the quality of clinical care experienced by our patients as detailed below in table 8.

While the picture prior to the centralisation of acute services was not all doom and gloom, the contrast seen between the pre and post consolidation Respiratory service reviews detailed below was marked and highlights the improvement in patient outcomes which has been achieved within the *Our Changing Hospital* programme.

Table 8: External Reviews

Clinical Area	Review Detail
Respiratory	**RCP Review of Hospital/Community Respiratory Service: August 2015** The report considered the Respiratory Service to be in the vanguard of services nationally and an exemplar of how to work collaboratively with CCGs. It praised both the leadership and the strong evidence of team-working.

Clinical Area	Review Detail
Cardiology	**PPCI Review, Oct 2014** Deemed fully compliant, with good progress having been made.
Critical Care	**Peer Review, Nov 2014** Excellent areas of practice, including consultant-led care with good consistency and continuity and the MDT approach taken to patient-led care.
Trauma	**Peer Review, Jan 2015** Highly complimentary: well-functioning team, with strong clinical leadership. Evidence of team work and a team approach to trauma.
Pathology	**Royal College of Pathologists Review 2015** Well evidenced and comprehensive. Generally positive regarding current standards of Clinical Governance within the Pathology directorate.
Emergency Services	**RCEM Review of Emergency Care Services March 2015** This review was generally positive for example it stated that the breadth and depth of senior clinical care would be in the top centile nationally for their ability to provide senior sign-off of cases in the Majors area and Resuscitation Room. It also identified areas of good practice with close liaison evident between the Emergency Department and the Acute Care Physicians. At the same time it also highlighted areas for development such as certain aspects of the overall pathway which it was felt required closer scrutiny and refinement.

3.5.1 CQC Inspection

The Care Quality Commission published the Trust's inspection report on 5th April 2016, following the visit by its inspectors last October 2015. Overall the Trust was rated as requires improvement including 'good' for caring – which was the outcome the Trust anticipated prior to the inspection taking place. It is also the rating given to nearly 70% of NHS trusts inspected to date.

In total, the report highlighted 19 different areas of outstanding practice, with just five where further changes needed to be made. It was also clear that following the changes made at the Lister and QEII hospitals since 2010, those services that were brought together earlier – for example surgery and critical care – fared much better than those that underwent similar changes more recently, such as the Lister's emergency department. Of particular note was that Surgery services at the Lister were rated as good across the board – one of the few times in any CQC inspection nationally when this has been achieved. In particular, the inspectors remarked upon the high quality of day surgery, ophthalmology and urology robotic surgical services.

Our contention that the benefits of centralisation are in many areas only just starting to become apparent was supported by comment made by lead CQC inspector, Professor Sir Norman Williams, before he left the Trust when he stated that it was clear that the Trust was an organisation on an upward trajectory.

4.0 PATIENT SAFETY

4.1 Clinical Risks

4.1.1 Transitional consolidation phase

At the beginning of 2014 the most significant clinical risks were identified as relating to the postponement of speciality consolidation. This belief was based on robust evidence that larger speciality units, with a critical mass of appropriately trained and skilled staff saves lives.

At that time the key clinical risks were perceived as:

- The increased demand for acute services on the Lister site and the increased activity coming through the emergency department before the appropriate infrastructure was in place
- Sustaining the QEII hospital as an acute site until late 2014
- The ability of EEAST and individuals to attend the right ED site and thus avoid the need for subsequent transfers that may impact on patient care.

At the same time the levels of emergency activity at the Lister site were continually increasing as services consolidated on the site and changes were made to the emergency pathways at the QEII hospital. These changes impacted on the following areas:

- Emergency theatre capacity
- Critical care capacity
- Inpatient bed capacity
- Capacity within the emergency department to manage the patient numbers.

As services transferred from QEII to Lister the flow of activity exceeded that which had been planned or modelled for. As a result of the impact on the above areas the following mitigating measures were taken:

- Closure of a further 15 bedded ward at QEII and transfer of those beds to Lister hospital to create additional capacity on 10B South
- Review of Winter planning and business continuity contingencies, particularly triggers for opening of ‘contingency ward’ for the Winter with planned staffing
- The re-allocation of hand surgery services to QEII as it was impossible to protect this capacity at the Lister given the emergency demand pressures
- Additional theatres and the provision of a 29 bedded contingency ward on 11A North/South.

4.1.2 Post consolidation situation

Following centralisation of acute services at the Lister site the following short term risks have been encountered:

- Activity levels were greater than planned for in both the Outline and Full Business Case which resulted in the need to create additional inpatients beds on ward 7a and the move of the Early Pregnancy Unit and Gynaecology Emergency Unit. Additionally it led to the opening of the escalation ward for the majority of the year

- The delay in Hertfordshire Partnership Foundation Trust delivering their reconfiguration strategy resulted in the Mental Health Unit not being available as the main administration space for the co-location of Clinical staff.

Additionally a number of longer term risks have also been identified:

- Potential capacity shortfall to support the diagnostic, outpatient and emergency demand associated with the planned new housing developments
- The requirement for the operating theatres to be replaced by 2020, if not before, with attendant construction and decant requirements
- Changes to the national policy regarding overseas recruitment has limited access to the wider resource pool.

The increased activity levels mentioned above have been particularly evident in ED, which has continued to under-perform following consolidation of the service at Lister. The Non-Elective Pressures and Performance Review Report (Seamus McGirr Report) was commissioned by the CCG and conducted in November 2015 to try to better understand the root cause of this.

The report identified the most significant factor being the degree of case mix enrichment seen in patients presenting at Lister ED that occurred as a result of the reconfiguration of the service and opening of the QEII walk in service. It identified that the current arrangement of services requires further development. Among its key recommendations was the development of improved assessment services beyond ED together with work on the wards to facilitate a more effective discharge process.

4.2 Quality Indicators

4.2.1 Nursing Quality Indicators

The levels of avoidable harms are seen as key indicators of the quality of nursing care. Table 9 details outputs for the main measures used to monitor performance in this regard.

Table 9: Nursing Quality Indicators

Nursing Quality Indicators		Sep13 to Aug14	Apr15 to Mar16
Falls		907	861
Pressure ulcers		41	26
MRSA	**number**	2	0
	Rate (per 100,000 bed days)	0.94	0
C.diff	**number**	11	*16
	Rate (per 100,000 bed days)	5.18	*7.14
VTE (compliance: assessment within 24 hours)		97.76%	96.39%
Safety thermometer harms		356	308
% of NEWS score completion		92.65%	96.29%
NEWS escalation		95.72	96.00

* Note: PHE has only recorded 15 C.diff cases against us for Apr15-Mar16, but we have agreed with the CCG to include an additional case. The PHE supplied bed day rate of 6.68 cases has been adjusted accordingly to 7.14 for this period. Furthermore, the CCG has advised the Trust that two of the cases in 2015-16 have been deemed to be unavoidable as there were no lapses in the patients' care.

The April 2015 to March 2016 data shows that significant improvements have been achieved regarding each of these indicators in comparison to the earlier period, with

the exception of VTE assessment compliance, which fell slightly and the number of C.diff infections that increased. It is worth noting that in the period April 2015 to March 2016 the Trust had the second lowest incidence rate of C.diff in the East of England region with a rate of less than half that of the region's overall rate of 14.93 cases per 100,000 bed days.

Hand in hand with the increase in activity has also been the challenge of dealing with a nurse vacancy rate regularly in the region of 15%. While this is good when compared to national rates it is relatively high for our region. This does impact on clinical care and outcomes.

Bearing in mind the challenges faced as a consequence of the increase in activity and significant nurse vacancy rates experienced by the Trust the sizeable improvements shown in table 8 above are even more noteworthy.

4.2.2 Safety Thermometer Audit

The NHS Safety Thermometer audit provides a 'temperature check' on levels of harm and enables the measurement of 'harm free care'. Harm free care is defined by the absence of pressure ulcers, harm from a fall, a urine infection (UTI) in patients with a catheter and new venous thromboembolism (VTE). The safety thermometer audit is a national audit carried out on one day of each month, with results collated by the Health and Social Care Information Centre.

The safety thermometer audit has been undertaken since January 2012. The proportion of harms reported each year continues to fall.

Fig 2: Safety Thermometer Audit % Patients with Harm: 2012-2016

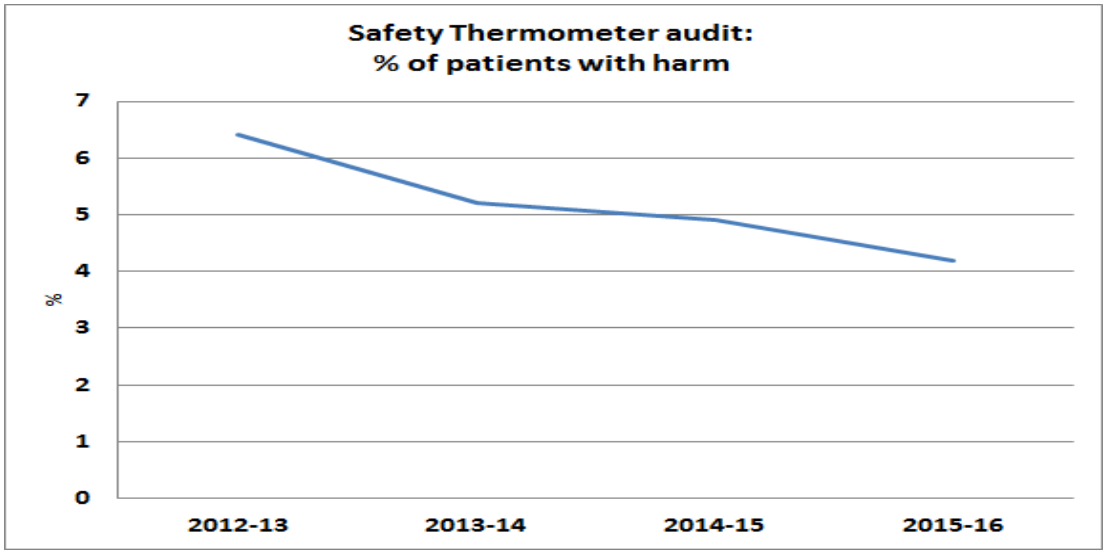
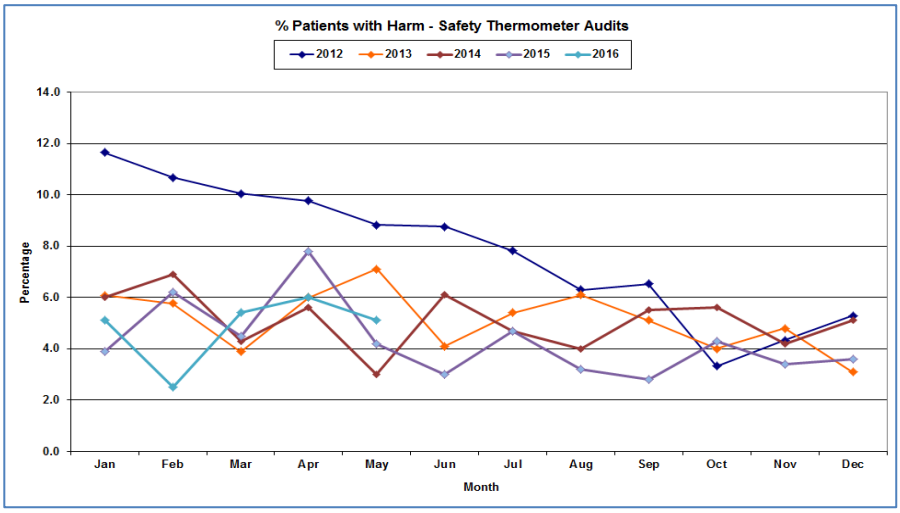


Fig 3 below compares the proportion of patients with harm recorded in the safety thermometer audits in the period March 2012 – May 2016. The Trust has consistently reported below the national average number of patients with a pressure ulcer and harm from a fall and the proportion of patients with a CAUTI and new VTE continue to fall.

Fig 3: Safety Thermometer Audits Annual Data Comparison: 2012-

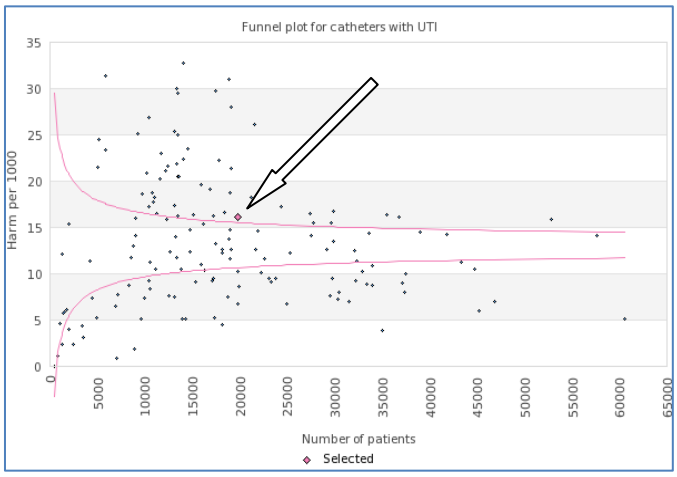


There have been significant improvements in the proportion of patients with a catheter and UTI reported in the safety thermometer audits. Fig 4 below shows ENHT's position compared to all other Trusts in May 2014 (when this information first became available) and at March 2016. In May 2014 the Trust was reporting more than the average number of patients with a CAUTI; in March 2016 the Trust is average compared to other Trusts.

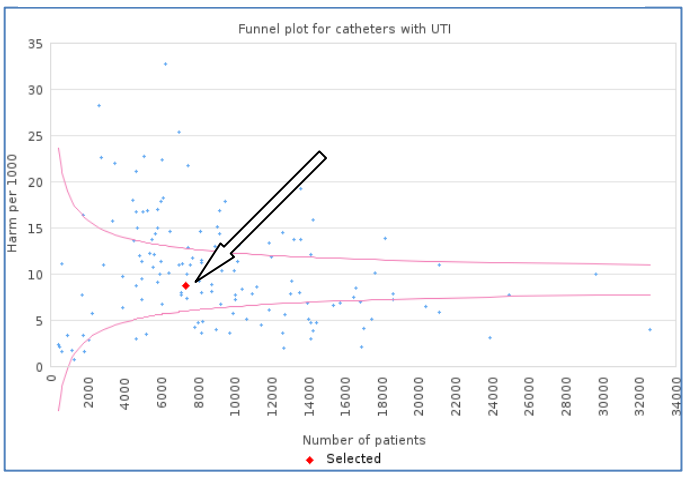
4.2.3 Medication Management

Fig 4: Safety Thermometer Audits CAUTI Data Comparison: 2014 &2016

May 2014: Rolling 12 months data



March 2016: Rolling 12 months data



While Table 10 below shows a marked downward trend in critical medication omissions between mid-2014 and the end of 2015 we are aware that further improvement is required. The introduction of the medication safety thermometer in June 2015 (reported to the Patient Safety Committee via the Medication Forum) is aimed at supporting the continued reduction in omissions.

Medication Management	May 2014 Audit	June 2015 to Feb 2016 Medication Safety Thermometer
Critical medication omissions	23.3%	8.7%*
Percentage of patients to have had their medicines reconciled within 24 hours of admission (during working week days)	Not available	76.4%

***Note:** The basket of drugs in the audit includes medicines on the critical drug list within the Trust omitted medicines policy. The medication safety thermometer basket includes opiates, anticoagulants, sedatives, insulin and antibiotics as critical medicines so these figures are not comparative.

As indicated in the note above the Safety Thermometer data cannot be directly compared to the previous audit figures as the basket of medicines differs. While our target remains to be better than other Trusts (average 5.5%), significant improvements have been made since our pre centralisation position.

However, the CQC inspection did raise concerns regarding the omission of critical medicines within the Trust and while the average for June 2015 to February 2016 was 8.7% as shown above, the medication safety thermometer in February 2016 demonstrated a Trust Median value of 9.5% of patients with an omission of a critical medicine compared with a national acute trust median value of 6.8%. An action plan has been developed as part of the CQC medicines management quality development plan to address this issue.

4.2.4 Intentional Rounding

Table 11: Intentional Rounding

	Sep13 to Aug14	Apr15 to Mar16
Percentage intentional rounding completed correctly	91.94%.	97.60%

Table 11 above shows a significant improvement in the percentage of intentional roundings completed correctly by the Trust.

4.3 Serious Incidents/Never Events

Table 12 below shows the number of serious incidents for September 2013 to August 2014 and April 2015 to March 2016. Incidents that were subsequently downgraded as no deficiency in care could be identified have not been included. Despite an increase in activity the number of serious incidents has declined.

Table 12: Serious Incidents

Serious incidents	Sep13 to Aug14	Apr15 to Mar16
Lister	52	51
QEII	12	1
All Trust	**64**	**52**

Table 13: Never Events

Serious incidents	Sep13 to Aug14	Apr15 to Mar16
Lister	1	4
QEII	0	0
All Trust	**1**	**4**

The increase in the number of never events shown in table 13 above has been disappointing although it is now over 9 months since the most recent case was recorded. The root causes were unrelated to the OCH programme and are being addressed actively.

4.4 Clinical Incidents

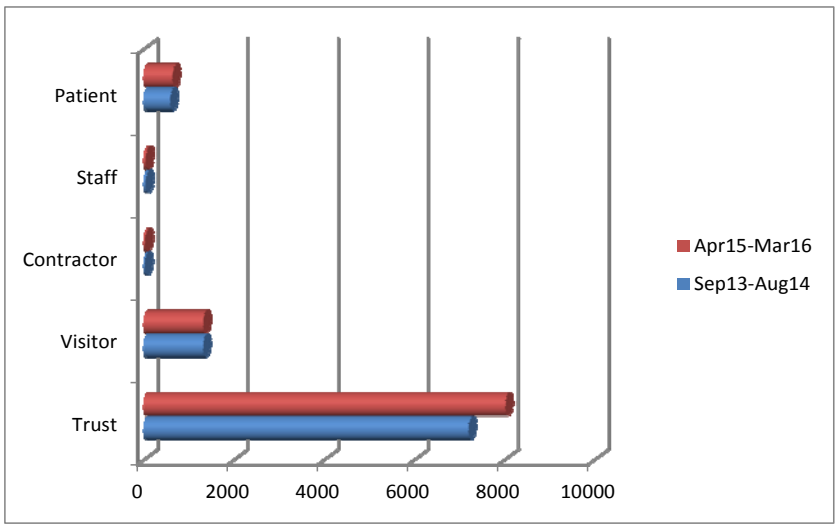
Table 14: Trust Clinical Incidents

All incidents on Datix including patient, staff , visitors , infrastructure (rejected incidents deducted)	Sep13 to Aug14	Apr15 to Mar16
Lister	7545	9310
QEII	1617	746
All Trust	**9162**	**10,056**

The picture regarding the totality of incidents reported on Datix shows an increase in incidents of just over 10% (see table 14 above). Within this figure there has been a significant reduction in incidents on the QEII site of 54% and an increase of 10% at the Lister site. Since Datix/Clinical Incident reporting is indicative of robust safety culture the Trust would not be looking to see an overall downward trend. At the same time if a spike was detected in a specific area this might suggest an underlying cause for concern.

Fig 5 below shows there has been no significant increase in individual categories.

Fig 5: Clinical Incidents by Category



4.5 Claims

In terms of assessing the effects of the centralisation of services on clinical negligence claims it is still too early to draw firm conclusions given the time lag involved in a claim's life cycle. Patients have three years from the 'date of incident' or their 'date of knowledge' of their injury to make a clinical negligence claim. The caveats to this are patients without capacity, who have no limitation limit and injured children, who have until they are aged 21. Therefore there is often a significant time lag from an incident occurring and a patient making a claim.

As discussed in the previous report, maternity services were centralised onto the Lister site in October 2011. Their claims data was analysed last year for the purposes of this report and showed that although the total number of claims received remained broadly similar since centralisation, the proportion of those claims that were high risk had reduced.

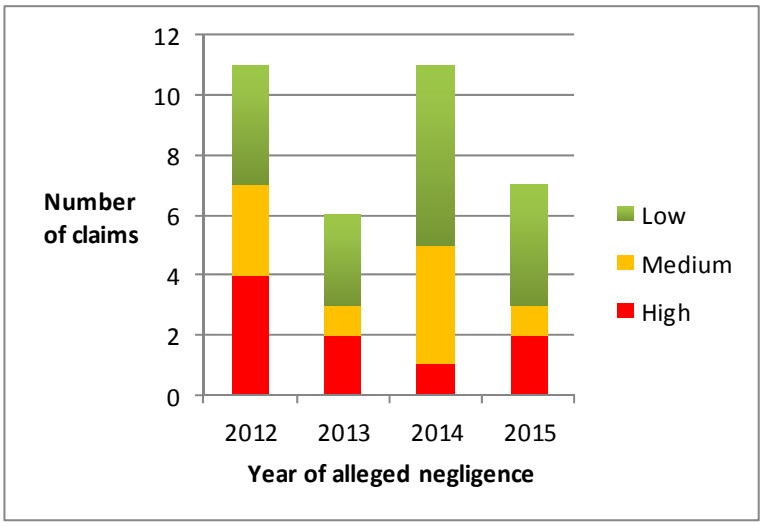
The updated current figures for Obstetrics are shown below in table 15:

Table 15: Obstetrics Clinical Care Claims 2012-2015

Year of incident	No of Obstetrics claims
2012	11
2013	6
2014	11
2015	7

Since the last report we have received new claims concerning incidents in 2012 and 2014, both of which are high risk. Fig 6 below shows that the number of high risk Obstetric cases was decreasing however 2015 has seen a slight increase.

Fig 6: Obstetrics: High risk of settlement 2012-2015



As table 16 demonstrates, to date, we have received significantly fewer claims relating to care provided in the timeframe April 2015 – March 2016. This would be expected given the time lag between care episodes and notification of the claim as explained above. However the percentage of claims that are assessed at being of high risk of settlement has significantly reduced.

Table 16: Clinical Care Claims

	Care provided in Sept 2013 – Aug 2014	Care provided in Apr 2015 – Mar 2016
No of claims	81	35
High risk	27%	6%
Medium risk	26%	26%
Low risk	47%	68%

Table 17 compares the number of claims relating to the care provided in the two timeframes in the top 6 specialties. It demonstrates a fall in numbers in all specialties however, given the time lag between care delivered and claim received; it is too early to say whether the fall in numbers is due to centralisation or simply that the claims have not yet come in because the care provided was so recent.

Table 17: Key Specialty Clinical Care Claims

	Care provided in Sept 2013 – Aug 2014	Care provided in Apr 2015 – Mar 2016
ED	7	4
General Surgery	6	3
Orthopaedics	12	6
Gynaecology	6	2
Plastics	5	0

4.6 Safety Inspections

Table 18: Safety Walkabouts

	Sep13 to Aug14	Apr15 to Mar16
Number of inspection tours	13	18
Number of clinical staff participating	0-1 clinical staff in each.	1- 12 clinical staff

The visits undertaken from April 15 to March 16 fell into three categories

- 6 Patient Safety and Quality Inspections (short, focussed inspections based on CQC key lines of enquiry and led by the Head of Quality and Patient Safety and Deputy Company Secretary)
- 3 Fifteen step challenges led by the Deputy Company Secretary with clinical staff and patient representatives
- 9 Mock CQC inspections led by the Corporate Governance team with internal clinical staff participating in all mock inspections and external clinical staff participating in three mock inspections.

By diversifying the form of inspections (from purely Patient Safety and Quality Inspections in 2014) it was possible to draw upon a wider pool of participants (including patient representatives and external clinical representatives). This enabled us to develop a more robust process, identifying more opportunities for improvement and minimising bias. The inclusion of external clinical representatives also provided the opportunity to share best practice with colleagues from other trusts.

5.0 PATIENT EXPERIENCE

5.1 Complaints

Table 19 below shows the number of complaints received between the periods September 2013 to August 2014 and April 2015 to March 2016 together with the number of complaints per bed days for these two periods.

Table 19: Complaints

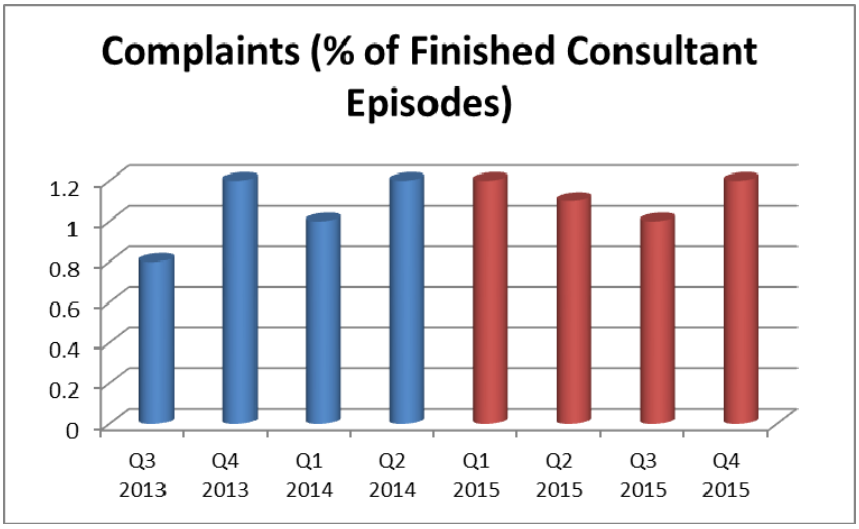
	Sep13 to Aug14				Apr15 to Mar16			
	Lister	QEII	Trust	Per bed days	Lister	QEII	Trust	Per bed days
Not upheld	225	50	295	0.14%	233	23	269	0.12%
Partly upheld	278	65	363	0.18%	319	35	373	0.18%
Upheld	181	37	243	0.12%	247	32	300	0.14%
Total	718	162	947	0.46%	923	93	1073	0.51%

This information shows that the migration of services from the QEII with corresponding increase in volume at Lister is to an extent mirrored in the numbers of complaints received regarding the two sites.

However this picture does not take account of the overall increase in volume of patients being seen by the Trust. When complaints are viewed as a percentage of bed days, there is a small increase.

Given the increase in volume of activity another useful way of viewing this data to assess performance is to look at complaints as a percentage of finished consultant episodes. Figure 7 below details this information for the periods October 2013 to September 2014 and April 2015 to March 2016. It can be seen that from Q1 2015 there was a marked downward trajectory until January 2016 since when there was a sharp increase. The fact that this quarter correlates to the Junior Doctor industrial action, which saw more than 2000 appointments cancelled, may account for such an increase in complaints.

Fig 7: Complaints (% of Finished Consultant Episodes)



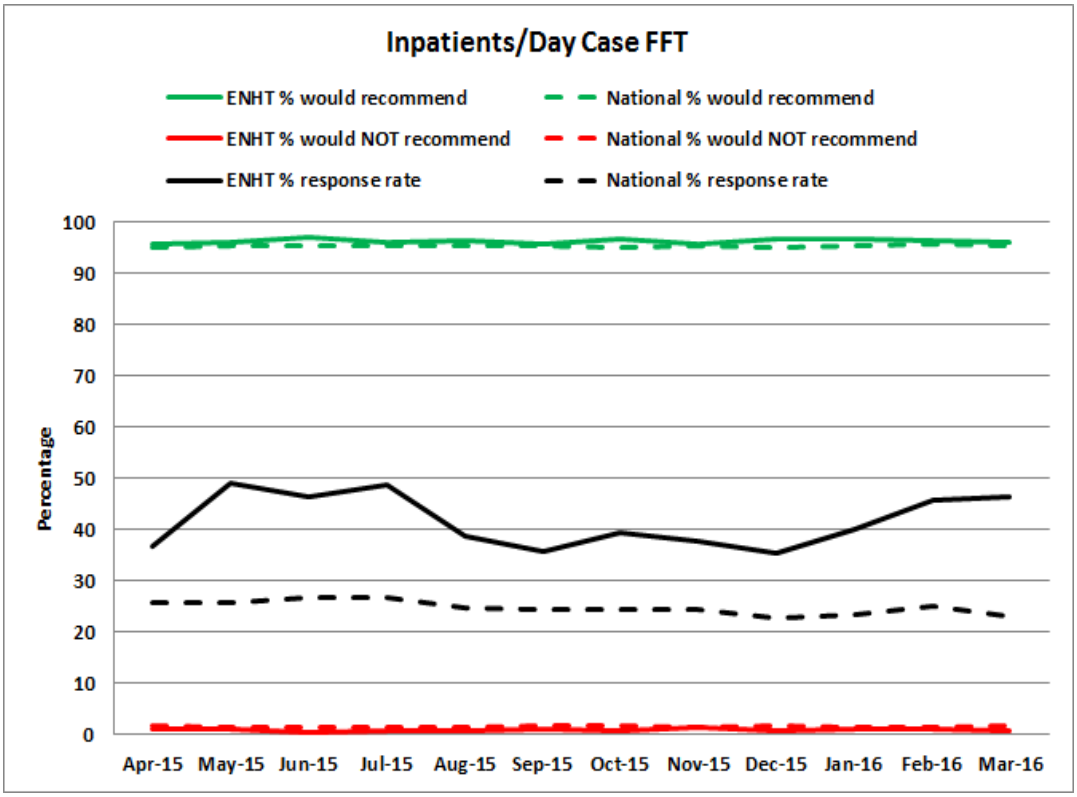
5.3 Friends and Family Test

As the result of the number of changes made by NHS England to the collection of the Friends and Family Test (FFT) feedback over the last four years, it has not been possible to undertake a detailed comparison of data. In October 2014 the FFT scoring methodology changed from a 'net promoter' score to 'the percentage of patients who would/would not recommend' a service. In April 2015 the inpatient FFT was extended to include day case patients and children. In January 2014 the Trust commenced collection of the A&E FFT feedback via text message. It has been noticed that feedback received by text message is generally less positive than that received by patients completing paper surveys whilst still in hospital.

For each element of the Friends and Family Test question, the Trust monitors the percentage of patients who would recommend the Trust, the percentage of patients who would not recommend us and the response rate. Fig 8 below shows an analysis of the inpatient/day case FFT responses for 2015-16. The proportion of patients who would recommend the Trust is above the national average and the response rate is significantly higher than the national average. This demonstrates the Trust's commitment to collecting, sharing and acting on patient feedback.

In 2014-15 and 2015-16 the proportion of inpatients who would recommend the Trust was 96%.

Fig 8: FFT Inpatient/Day Responses 2015/16



Analysis of the A&E FFT data shows that the proportion of patients who would recommend the service increased from 78.18% in 2014-15 to 81.15% in 2015-16.

6.0 SUMMARY/CONCLUSION

While in many ways it remains early days for an in-depth assessment to be made of the effect on clinical quality of the centralisation of acute services, the evidence to date is generally positive. In particular this report has highlighted:

- Improvements in crude mortality, HSMR, all diagnosis SMR and SHMI
- Improvements in length of stay and readmission rates
- Introduction of 7 Day Services
- Positive External Reviews
- Reduction in the number of Serious Incidents
- Improvement in Nursing Quality Indicators (with the exception of C.diff)
- Improvement in Medication Management
- Improvement in Intentional Rounding
- Claims – early indications suggest reduction in the number of “High risk of settlement” claims
- Friends and Family Test: increase in ED of those who would recommend the Trust.

RAQC Report – Appendix 2

Annual Responsible Office Board Revalidation Report

July 2016

Executive Summary

The process of Appraisal and Revalidation for doctors within East & North Herts (ENHT) has become well established since its commencement on 1st April 2013 and this was acknowledged in the CQC Inspection report which stated". There were robust processes in place for medical revalidation".

On 31st March 2016 there were 384 doctors who had a prescribed connection to ENHT. The completed appraisal rate is 89% with only 4% who had an unapproved, incomplete or missed appraisal.

Between 1st April 2015 and 31st March 2016 a total of 124 doctors for whom East & North Herts is the Designated body have been Revalidated, 23 were deferred of whom 7 were recommended later in 2015/16 and 16 were deferred to 2016/17.

The Maintaining High Professional Standards and GMC case loads within ENHT lie within the expected range.

Responsible Office area	RAG Rating
Medical Appraisal	
Medical Revalidation	
Maintaining High Professional Standards cases	
GMC cases	

The current risks and proposed developments are summarised below and fuller details of all elements are provided in Appendix 1.

Current Risk	Mitigated risk	Impact	Mitigation and Proposed Actions
Variable quality of appraisal	Low	Appraisal ineffectual. Trust vulnerable to litigation from Consultants. Poor morale	PremierIT integral Appraiser assessment Quality Assurance processes Top-up appraiser training
Inconsistent data quality	Moderate	Assurance regarding outcomes from Trust information sources may be limited.	Completion of ongoing Coding Improvement Plan and Implementation of Responsible Consultant guidance for Medicine
Minimal back up for RSO	Low	Inadequate support for doctors could result in inability to maintain high appraisal and Revalidation rates.	Train Medical Director's PA to have basic knowledge of Medical Appraisal and Revalidation including use of the Premier IT system.

- Electronic job planning for non-training grade doctors will be introduced during 2016/17 and we will explore automatic extraction from Allocate to PremierIT.

APPENDIX 1

1. Purpose of the Paper

The purpose of this paper is to inform Board members of Appraisal and Revalidation arrangements within ENHT and to provide assurance that the Responsible Officer and the Designated Body are discharging their statutory responsibility.

2. Background

Medical revalidation was launched in 2012 to strengthen the way that doctors are regulated, with the aim of improving the quality of care provided to patients, improving patient safety and increasing public trust and confidence in the medical system.

Provider organisations have a statutory duty to support their Responsible Officers in discharging their duties under the Responsible Officer Regulations[1] and it is expected that provider boards / executive teams will oversee compliance by:

- monitoring the frequency and quality of medical appraisals in their organisations;
- checking there are effective systems in place for monitoring the conduct and performance of their doctors;
- confirming that feedback from patients and colleagues is sought periodically so that their views can inform the appraisal and revalidation process for their doctors; and
- Ensuring that appropriate pre-employment background checks (including pre-engagement for locums) are carried out to ensure that medical practitioners have qualifications and experience appropriate to the work performed.

4. Governance Arrangements

4.1 Organisational Structure and Responsibilities

4.1.1 Responsible Officer (RO)

The Medical Director as RO leads the Appraisal and Revalidation process within ENHT and communicates her expectations in this area to all doctors within our Designated Body. She determines any action to be taken against doctors whose appraisals are late, decides when appraisals can be deferred for valid exceptional reasons and holds Divisional Chairs to account during monthly performance reviews for Divisional appraisal rates. She personally reviewed the majority of Revalidation portfolios (except where specifically delegated to the Associate Medical Director) to determine whether they have reached a satisfactory standard, seeking further information or evidence where necessary. She ensures the AOA questionnaire is completed in a timely fashion and provides the RO/MD reports to the Board through RAQC in line with national guidance.

The RO has established good relations with the GMC Liaison Officer holding regular meetings and seeking advice when required. The GMC have issued detailed instructions via their website and have established an on-line system called GMC Connect to foster communication between Trusts and the GMC and to enable ROs to make recommendations.

[1] The Medical Profession (Responsible Officers) Regulations, 2010 as amended in 2013' and 'The General Medical Council (Licence to Practise and Revalidation) Regulations Order of Council 2012'

The RO is fully trained, including as an appraiser, and attends RO network meetings and top-up training. These network meeting are organised by the Deputy Medical Director for NHS Midlands & East and provide ongoing training and peer support.

4.1.2 Associated Medical Director for Professional Standards (AMD)

The AMD is the Lead Appraiser for the Trust and led on the development of crucial policies such as the *Failure to Engage Policy*, the revised *Appraisal Policy* and the more recent *Appraiser Selection and Allocation Policy.*

The AMD has completed all Modules of RO training, and is thus able to deputise in the RO's absence as occurred during a period of sick leave and during the height of the CQC inspection preparations. He is an enhanced appraiser and attends the regional Appraiser top-up training.

The AMD also carries out Quality Control on a sample of non-revalidation year appraisals and addresses deficiencies where identified with both appraisee and appraiser.

4.1.3 Revalidation Support Officer (RSO)

The RSO creates access to the Premier IT appraisal system for new doctors, provides training on using the system, maintains the database of Non-Premier IT appraisees (primarily those on short-term contracts) provides information to doctors regarding appraisal dates and reinforces the Trust and GMC requirements. The RSO also reminds appraisees to conduct their appraisals on time, chasing as necessary. She carries out the first scrutiny of Revalidation portfolios against a checklist devised by the RO and supports the RO with any action required. The RSO also prepares reports, returns and analyses through interrogation of the Premier IT system and the database for Non-Premier IT appraisees. She keeps the Knowledge Centre up to date with contact details, policies, appraiser details etc.

The RSO allocates appraisers to each appraisee in line with the new policy and arranges appraiser Top-Up training where required and Appraiser User Group meetings.

4.2 Progress Monitoring

The progress of appraisals is monitored constantly through a real time display of the dashboard on Premier IT. Access to this dashboard has been given to Divisional Chairs (DC), Clinical Directors (CD), Responsible Officer, Associate Medical Director and the Revalidation Support Officer. This allows DCs and CDs to progress chase individuals within their department, as well as the RSO to progress chase doctors from all departments.

4.3 Process for maintaining accurate list of prescribed connections

There is a threefold process for maintaining an accurate list of prescribed connections to the Designated Body:

1) When a doctor is added or removed from the GMC list we receive an automatic email notification to the Revalidation email address. This information is checked with both the Electronic Staff record and the Medical Staffing list;
2) The Medical Staffing list (detailing starters and leavers) received monthly is checked against the GMC email notifications;

3) Should a permanent consultant not add themselves to our Designated Body on GMC, and are not yet listed on the monthly Medical Staffing list, then they are picked up at their Induction Meeting with the Medical Director/RO.

The RO, AMD and RSO have access to GMC Connect which allows amendments to be made to the list as necessary/appropriate. A complete log is retained within the Revalidation email folders. Where there is any uncertainty, information is sought from Medical Staffing and NHS Professionals to confirm the status of the doctor and whether s/he should be on our list.

4.4 Process of internal assurance

Internal assurance is provided by the following sources

- RO reports to RAQC and Board, to which the Annual Organisational Audit (AOA) is appended.
- Information from GMC on comparative Recommendation rates.
- RO, AMD and Appraisers continue to update their skills in Revalidation and Appraisal matters

4.5 New Policy and Guidance

Following discussion at the NHS England RO and Lead Appraisers Meetings, it was agreed that best practice is to allocate appraisers to appraisees. The *Appraiser Selection and Allocation Policy* was ratified in March 2016 and put into practice immediately for appraisals due from 1st April 2016.

4.6 External Assurance

The Trust underwent a CQC Inspection in October 2015. In their summary of findings document it states that "*There were robust processes in place for Medical Revalidation".*

Recommendations from the previous year's external review led by the Medical Director for Midlands and East are now completed – current appraisers are receiving Top Up training, attending 6 monthly User Group Forms, and the number of appraisers has been rationalised.

5. Medical Appraisal

5.1 Appraisal and Revalidation Performance Data

ENHT is the Designated Body for its non-Training grade permanent Medical staff but not for around 350 Trainee doctors who are the responsibility of Health Education England. All Training doctors undergo the equivalent of an annual appraisal to determine their suitability to advance to the next stage of training.

Locum doctors generally connect to their main Locum agency for the purposes of Revalidation. Irrespective of whether ENHT is their Designated Body, long-term locums are generally appraised within the Trust.

The Annual Organisational Audit (AOA) End of year Questionnaire was returned to NHS England on 27th May 2016 (see Appendix G). This reported that 89% of non-training grade doctors that had a connection to ENHT had a Completed Appraisal (AOA Category 1A and 1B). The definitions used for category 1a and 1b appraisals have changed substantially this year and are not directly comparable to last year.

Category	2015/16 Appraisal Status	%
1a	Completed Appraisal 1	29
1b	Completed Appraisal 1	61
2	Approved Incomplete or Missed Appraisal	6
3	Unapproved Incomplete or Missed Appraisal	4

There were 24 doctors (6%) classed as having an Incomplete or Missed Appraisal (AOA Category 2) and the reasons are shown below:

- 9 joined the Trust from abroad and had been employed for less than 12 months on 31/03/15 and were therefore not yet due an appraisal;
- 5 had an agreed postponement due to maternity leave;

Each of the following reasons were applicable to fewer than 5 doctors:

- an agreed postponement due to exclusion/phased return to work;
- an agreed postponement due to a foreign sabbatical;
- an agreed postponement due to long term sick leave;
- an agreed postponement on compassionate grounds which took place after 31/03/15 but within the required 9-15 months window from their last appraisal;
- late due to late appraisal meetings last year;
- retired/resumed, appraisal meeting date reset but did not hold appraisal in 2015/6.

There were 16 doctors (4%) who were classed as having an Unapproved, Incomplete or Missed Appraisal (AOA Category 3) which is the same percentage as last year. Of those, the majority had an appraisal within 9-15 months of their previous appraisal, however it took place after 31/03/2016 (the vast majority of these doctors were due for appraisal in March). The remaining doctors who were classed as having an Unapproved, Incomplete or Missed Appraisal had not undergone appraisal by the time they left the Trust to practise abroad.

Last year completed appraisal rates at 94% were 14% higher than comparator Trusts. Comparative data for 2016/17 has yet to be released.

See **Appendix A:** Audit of all missed or incomplete appraisals audit.

5.2 Appraisers

At the start of the year the Trust had 110 Appraisers. Following the introduction of the Appraiser Selection and Allocation Policy this list was rationalised, and we now have 80 trained appraisers with further Top Up training planned for later in the year to maintain and enhance their expertise.

Appraiser User Group Forums are held 6 monthly, led by the AMD. These have been well attended.

5.3 Quality Assurance

In Revalidation years all appraisals are initially assessed by the Revalidation Support officer (RSO) against the checklist criteria and then scrutinised by the Responsible Officer (or AMD) to ensure compliance. Those that are not fully compliant cannot be recommended for Revalidation at that stage.

The checklist (Appendix F) includes:

- Full scope of work
- Supporting Information
- Multi-Organisational Working Form requirement
- Pre-appraisal declarations
- Input accepted by appraiser
- Personal Development Plan (PDP)
- Output summary sign-off by appraisee and appraiser

Both the RO and the RSO provide constructive feedback to appraisees and appraisers where the requisite standard has not been reached. Whilst a completed appraisal cannot be amended by either the appraisee or appraiser the appraisal documentation can be unlocked by the RSO to enable additional upload.

In non-Revalidation appraisal years the Associate Medical Director for Professional Standards monitors a random sample of appraisals against the same criteria. (as described in 3.1) Appraisals that do not reach the standard of documentation required are returned for improvement.

Appraisers are scored by their appraisees, this is done anonymously at the end of their appraisal following acceptance of their Appraisal Output Form. To maintain anonymity a report is produced for the appraiser once they have completed a minimum of 3 appraisals. The report is attached to their portfolio for reflection in their own appraisal. The report covers nine different aspects of appraisal and also includes areas for free typed comments:

See **Appendix B;** Quality assurance audit of appraisal inputs and outputs.

5.3.1 Pre-Appraisal Declarations

The structure of the online appraisals requires these inputs and declarations to be completed prior to submission to the appraiser, ideally at least two weeks prior to the appraisal meeting. The appraiser has to read, review and accept the inputs. The appraiser must be satisfied that all supporting information is appropriate. Further assurance is provided by the ENHT Revalidation team as described above.

5.3.2 Appraisal Outputs

Again the structure of the online appraisal system requires declaration sign offs by the appraiser prior to sending to the appraisee for acceptance. The Premier IT system prompts development of the forthcoming PDP in both Input and Output forms. The system does not at present mandate a PDP however the RSO has written to Premier IT to request this with a future. All appraisees and appraisers are aware of the requirement for a PDP to be agreed for the forthcoming year and reviewed for the past year. The assurance provided by the ENHT Revalidation team and described in 5.3 applies here too.

5.3.3 Divisional Performance

The timeliness by Division shown in Table is based on the full cohort of doctors who were in post on 31st March 2016

Table 1 Divisional Breakdown of Appraisals due 1st April 2015 – 31st March 2016

	Cancer Services	Clinical Support Services	Medicine	Surgery	Women & Childrens	Total
Category 1A	**20**	**7**	**29**	**32**	**22**	**110**
Category 1B	**16**	**26**	**57**	**110**	**25**	**234**
Category 2	**3**	**2**	**8**	**7**	**4**	**24**
Category 3	**1**	**2**	**3**	**9**	**1**	**16**
Total	**40**	**37**	**97**	**158**	**52**	**384**

5.3.4 Lessons Learned from any Complaints or Significant Events

At an individual level doctors are required to reflect on these events in the appraisal input form, if appropriate during the appraisal discussion and where relevant ensure that actions are incorporated into the PDP for the forthcoming year.

In terms of wider learning within ENHT lessons from complaints are provided to the Directorates for educational discussion within the directorate clinical governance RHD. Lessons from significant events are provided to the Directorates in tailored exception reports for educational discussion within the same meetings.

5.4 Access, Security and Confidentiality

Premier IT does remind appraisees that no patient identifiable data should be included in the uploaded Supporting Information documentation. Additional assurance can be provided by the appraiser when checking appraisal inputs and by the RSO/RP when checking portfolios for Revalidation and the AMD when conducting Quality Assurance Checks.

The Premier IT system complies with Information Governance standards for the Trust.

5.4 Clinical governance

Complaints and Serious Incident Reports are sent to the RSO on a monthly basis, the information from this is uploaded to Premier IT which is then listed on the Doctors profile for their reflection. It is still the Consultant's responsibility to request this information and there are prompts within the appraisal input form to collect this information. This information includes:

- Complaints (including those directly about the Consultants as well as any aspect of care whilst under the care of the Consultant's team.)
- Serious Incident investigation reports from the Clinical Risk department
- Medico-legal information from the Legal department
- Clinical audit department records

Clinical activity data can be provided through Dr Foster, Theatre and Endoscopy CIPTS, the hospital PAS system and other clinical information systems within the Trust.

The updated Appraisal policy deems it mandatory for consultant-level activity and outcomes from the national clinical audits that are part of the Consultant Outcomes Publication initiative (www.nhs.uk/consultantdata) to be presented in the appraisal portfolio.

All Consultants responsible for the care of inpatients have access to the Acumen system which records inpatient deaths and crude mortality by Consultant. Consultants are notified by email when a death has been attributed to their care to allow the opportunity to verify the data held.

The Trust has a requirement that each of its doctors conducts at least one clinical audit project annually and the findings should be presented as supporting information. This should demonstrate evidence of personal participation in reviewing, implementing or taking forward the results of such activity.

See **Appendix C;** Audit of concerns about a doctor's practice.

6 Revalidation Recommendations

A total of 147 doctors for whom East & North Herts is the Designated body were due for a recommendation regarding Revalidation between 1st April 2015 and 31st March 2016. 124 (84%) were recommended and Revalidated and 23 were deferred by the RO (16%). Seven of these deferred doctors were Revalidated later in 2015/16 and 16 were deferred to 2016/17.

1 doctor was deferred by the GMC as he was undergoing investigation at that time. No action was taken against the doctor and the case was closed. This doctor has been excluded from Appendix C as the Trust were not involved in the recommendation

See **Appendix D;** Audit of revalidation recommendations.

7 Recruitment and engagement background checks

The Trust undertakes its employment checks in line with the NHS Employment Check Standards (Identity, Right to Work, Professional Registration and Qualifications, Employment History and References, Criminal Record and Barring and Work Health Assessments). There is an electronic employment check system (TRAC) in place to collect Revalidation related information including for Trust employed locums.

External locums have the same standards applied by NHS Professionals.

See **Appendix E.** Audit of recruitment and engagement background.

8 Monitoring Performance

The performance of all doctors is monitored through a variety of mechanisms. There is an open culture within the organisation so that discussion of outcomes amongst peers is encouraged. Monthly clinical governance half days review mortality and morbidity within each department and where areas of performance concern are raised these are discussed.

If significant performance issues are raised the Medical Director is informed and in conjunction with the AMD further investigations are carried out.

The updated Appraisal policy states that unjustified refusal to comply with local standards should trigger performance review and nationally benchmarked Consultants Outcomes data is published and relevant to the Trust in 9 specialties.

ENHT purchases the Dr Foster information system that permits assessment of case-mix adjusted mortality, length of stay and readmission dates by Trust, Directorate and Individual Consultant level.

Serious incident investigation can identify deficient performance that needs addressing through performance and/or remediation routes. The Trust also has a structured Mortality Review process that is designed to promote learning within the Trust but may, on occasion, identify development needs.

The RO sees all complaints involving Consultants as well as the subsequent complaints response. Dependent of the severity of the complaint she may require specific action and may escalate (*eg* to Serious Incident status) if appropriate. The CDs see the complaints regarding non-training grade doctors.

Patient and Colleague multi-source feedback is facilitated through the Premier system once every five years. Performance is benchmarked against doctors from the same specialty and when found to be outlying specific measures to address must be built into the PDP. In response to specific concern multi-source feedback can be requested more frequently. Certain departments *e.g.* Obstetrics and Gynaecology arrange Patient MSF on an annual basis.

9 Responding to Concerns and Remediation

The Trust responds to all concerns in a timely manner. The policies that are used when a concern is raised are the *Raising Concerns at Work* policy and the *Complaints and Concerns* policy. Concerns/complaints that involve non-training grades are escalated through the Medical Director's office whilst those relating to trainees also involve the Director of Education and the Postgraduate Dean.

All significant concerns relating to medical staff are assessed through the *MHPS Framework*, are discussed with NCAS and, following advice, are either dealt with informally or through a formal MHPS investigation. Many minor concerns can be dealt with informally within the Directorate providing the doctor is open, reflective and committed to improvement.

The Trust has a *Conduct, Performance and Ill-Health Policy for Medical Staff* based on the *MHPS* framework and a separate *Remediation* policy designed to reskill and rehabilitate where deficient practice has been identified. Although trainee doctors are not part of ENHT designated body in the event of concerns raised they are subject to investigation through Trust *MHPS* processes.

In the past year there have been 6 completed *MHPS* investigation reports. As a result of these reports three doctors underwent disciplinary hearings which led to sanctions on the individuals in the form of written warnings.

The 3 other MHPS reports have led to informal letters of advice and meetings to discuss with the individual doctors the issues and ways forward for improving their professional standards.

At present there are 2 ongoing *MHPS* investigations.

In terms of GMC cases an average of 7 cases are active at any one time (less than 1% of Trust doctors). Some of these cases can be over two years old at the time of closure. During the past year one doctor was suspended from the medical register for a period of 7 months. Other lesser sanctions include warnings and undertakings but several cases have been closed without further action.

10 Risks and Issues

Risk	Likelihood Post-mitigation	Adverse Impact	Consequence
Variable quality of appraisal	Low	Appraisal may be ineffectual	Trust vulnerable to litigation from Consultants Poor morale
Inconsistent data quality	Moderate	Difficult to provide and automate Consultant specific information regarding practice	Assurance regarding outcomes from Trust information sources may be limited Loss of Consultant confidence
Minimal back up for RSO	Low	Failure to support doctors through appraisal and Revalidation	Inability to maintain high appraisal and Revalidation rates.

11 Board Reflections

The Revalidation Annual Report and audit for 2015/16 was presented to the Trust's Risk and Quality Committee (RAQC), formal Committee of the Board, in July 2016. In addition to the internal assurances the Committee acknowledge the CQC Inspection report, October 2015 stated "*There were robust process in place for medical revalidation"*.

In summary, the RAQC welcomed the comprehensive report and received assurance on the quality processes in place to support revalidation across the Trust in line with the statutory responsibilities.

The RAQC approved the report and endorsed the development plan to continue to strengthen the revalidation service in 2016/17. This was reported to the Trust Board in July 2016.

12 Corrective Actions, Improvement Plan and Next Steps

12.1 Updated action plan from 2015/6

Area for Development	**Action required**	**Responsible Person**	**Status**
Consider system to ensure that key specific complaints and significant events are populated into appraisal input forms	Finalise process to generate monthly report for complaints and SIs by doctor.	RSO/Head of Complaints/ Clinical Risk Manager	Complete

Rationalise number of appraisers to ensure sufficient expertise is maintained.	Develop process to reduce number of appraisers based on performance to date, caseload and ongoing training	RSO/AMD (Professional Standards)	Complete

12.2 Action plan for 2016/7

Area for Development	Action required	Responsible Person	Completion by
Variable quality of appraisal	Appraisal top-up training	AMD	November 2016
Import of e-job plans into appraisal portfolio	Explore whether this can be automated	RSO/ e-Job Planning Lead	March 2017
Inconsistent data quality	Completion of ongoing Coding Improvement Plan and Implementation of Responsible Consultant guidance for Medicine	Head of Coding DC Medicine	March 2017
Train Medical Director's PA to have basic knowledge of Medical Appraisal and Revalidation including use of the Premier IT system.	Practical demonstration Shadowing role Reading	RSO	October 2016

13 Recommendations

The Board is asked to approve the report which will be shared, along with the annual audit, with the Level 2 Responsible Office for NHS Midlands and East and to consider any needs/resources. Following this the Chairman or Chief Executive will be asked to sign, by 31st August 2015, the 'statement of compliance' confirming that ENHT, as a designated body, is in compliance with the regulations

14 Reporting with small numbers

Any further publication or dissemination of this report, in particular the appendices, should take into account the possibility whether this will identify individuals or make them potentially more identifiable. In such cases, it would be appropriate to provide a summary of the findings that removes or reduces these issues.

RAQC Report – Appendix 3

East and North Hertfordshire NHS Trust

Infection Prevention & Control

Annual Report

2015-2016

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1. Executive summary

This report from the Director of Infection Prevention and Control (DIPC) is the annual report to the Trust Board summarising key data in relation to relevant healthcare associated infections.

The Trust has met the MRSA blood stream infections (BSI) target set nationally and agreed with the Clinical Commissioning Group. The Trust reported zero MRSA BSI for the first time in the Trust's history.

The Trust reported a low number of cases of *Clostridium difficile* of 15 cases. However, as the Trust is set a target of 11 (based on the previous year's very low numbers) the Trust has reviewed all cases. Following an appeal to the Clinical Commissioning Group (CCG) two cases were removed. The Trust currently has one of the lowest levels of *Clostridium difficile* associated disease (CDAD) in the region and is in the upper decile nationally of comparator organisations.

Devolution of accountability for IP&C to local clinical teams continued during 2015/16 through strengthening of the role of IP&C link practitioners and IPC leads for all Trust divisions. The Divisional IP&C leads regularly report to the Trust Infection Prevention and Control Committee. Additionally Consultant IPC Leads present to their respective divisional rolling half days.

The Trust has declared compliance with the Hygiene Code and is unconditionally registered with the CQC.

Objective	Narrative	Outcome	
Compliance with Criterion 1: b- Monitoring the prevention and control of infection	In 2015-16 the Trust has a target of 0 MRSA bacteraemias	The Trust reported 0 MRSA bacteraemia for 2015-16	Green
	In 2015-16 the Trust has a target of 11 cases of hospital acquired *C difficile*-associated disease	The Trust reported 15 cases of CDAD, two were successfully appealed with the CCG.	Red
	In 2015-16, the Trust has opted to undertake surveillance for three of the surgical site infection categories: Total Hip Replacement (THR); Total Knee Replacement (TKR) & Repair Neck of Femur Fracture (RNoF) .	The Trust reported a reduction in infection rates from previous years. However, we continue to work with all stakeholders to maintain these improvements and to achieve further reductions.	Amber
	In 2015-16, the Trust has undertaken to take all reasonable precautions to prevent or control the harmful effects of contaminated water to residents, patients, visitors, staff and other persons working at or using its premises.	The Trust has in place robust policies and protocols to detect and manage water contamination. No cases of infection resulting from water contamination were reported in 2015-16.	Green

2. Introduction

The Trust Board recognises and agrees their collective responsibility for minimising the risks of infection and has agreed the general means by which it prevents and controls these risks. The responsibility for infection prevention and control is designated to the Director of Infection Prevention & Control (DIPC) supported by the Lead Infection Control Doctor, Assistant DIPC and Lead Infection Control Nurse.

The Infection Prevention & Control (IPC) Annual Report, together with the monthly Risk and Quality Committee IPC Report, Annual IPC Plan and IPC Assurance Framework are the means by which the Trust Board assures itself that prevention and control of infection risks are being managed effectively and that the Trust remains registered with the Care Quality Commission (CQC) without conditions.

In addition, the Annual Report seeks to assure the Trust Board that progress has been made against the 2015/16 Annual Plan, to reduce healthcare associated infections (HCAIs) and sustain improvements in infection prevention and control practices for 2016/17. It demonstrates that priorities identified in the Annual Plan last year have been addressed by employing a robust programme of work that enabled some notable successes on which to build. These improvements have been achieved despite major reconfiguration as part of the 'Our Changing Hospital' programme that included the Pathology Modernisation Process and the repatriation of the Microbiology Laboratory to a central hub based at Cambridge Addenbrookes Hospital and run by Public Health England, and major challenges relating to staff shortages, due to vacancy and maternity leave, in the Consultant Microbiologists' and IPC nurses' teams.

Key achievements:

- Achieving the target for MRSA BSI by reporting zero cases for the first time in the history of the Trust.
- Reporting 15 *Clostridium difficile* cases against a target of 11 cases. It is important to note that the total number of cases is similar to the number of cases last year, and constitutes a target most Trusts of similar size would not achieve. On appeal, 2 cases were considered unavoidable with no breach of the Trust's policies and procedures. For the purpose of target attainment the number of cases is 13 cases.
- Improving prescribers' compliance with the Trust-wide reduction in the use of antibiotics that are known to precipitate *Clostridium difficile,* MRSA BSI, Carbapenemase Resistant Enterobacteriaecae and other HCAIs.
- Addressing the threat of *Pseudomonas aeruginosa* in the water supply of critical care and high dependency units and the threat of *Legionella sp*

and other water-borne pathogens by creating a Water Safety Group and having a robust Water Safety Plan in place.

- Working in a collaborative manner with PHE and other Trusts to manage a number of infection control incidents.

Challenges that remain include:

- Improving the turnaround of action plans relating to audits of the clinical area, thereby closing the loop on issues identified.
- Ability to demonstrate cleanliness of equipment and identifing designated dirty and clean equipment storage areas at ward and departmental level.
- Whilst progress has been made in the past year, the reduction of surgical site infection rates in Trauma and Orthopaedic surgery remains a priority for further improvement.

The provision of this report fulfils the legal requirements of sections 1.1 and 1.3 of the Health and Social Care Act 2008: Code of Practice for health and adult social care on the prevention and control of infections and related guidance. The information provided in this report should be released to the public following the Trust Board's approval.

3. Compliance with the Health and Social Care Act 2010

The CQC has used the Code of Practice as a key feature of registration. Failure to observe the Code may either result in an improvement notice being issued to the Trust by the CQC following an inspection, or in it being reported for significant failings and placed on "special measures". All NHS organisations must be able to demonstrate that they are complying with the Code. The Trust Risk and Quality Committee and Board have continued to receive monthly reports on Infection Control performance and compliance during the reporting year.

The Trust continues to be registered with the CQC, without conditions across all sites.

4. Compliance with Criterion 1: a- Systems to manage and monitor the prevention and control of infection

IPC is the responsibility of everyone in the organisation. Key roles and arrangements are detailed below:

4.1 IPC Structure

The Chief Executive Officer has overall responsibility for the control of infection within East and North Hertfordshire NHS Trust.

4.2 Senior IPC Management Team

The senior IPC management team includes the DIPC, the Infection Control Doctor (ICD), the Assistant DIPC (ADIPC) and the lead IPC Nurse and meets every two weeks to discuss activity and issues. The Consultant Microbiologists, Estates Lead and other Trust officers attend some of these meetings by invitation.

4.2.1 The DIPC

The DIPC is the Executive Lead for the IPC service, and oversees the implementation of the IPC plan through her role as Chair of the Trust Infection Prevention and Control Committee (TIPCC). The DIPC approves the Annual IPC report and releases it publicly. She reports directly to the Chief Executive and the board on IPC matters. The DIPC has the authority to challenge inappropriate practice.

4.2.2 The Infection Control Doctor (ICD)

The ICD is the Clinical Lead for the IPC service. The role includes:

- Advising and supporting the DIPC
- Oversees local IPC policies and their implementation by ensuring that adequate laboratory support is in place
- Chairs the Water Safety Group (which replaces the Pseudomonas Risk Assessment Group and the Legionella Steering Group).
- Chairs the Trust Antimicrobial Forum (TAF).
- Supervises IPC education for doctors and delivers the mandatory training lecture for consultants.
- Provides expert clinical advice on infection management.
- Manages an infection control doctor service level agreement with the Hertfordshire Community NHS Trust.
- Produces, together with the assistant DIPC and the Lead IPC Nurse, the annual IPC report.
- Has the authority to challenge inappropriate practice including inappropriate antibiotic prescribing decisions.

The ICD reports to the DIPC on IPC matters.

4.2.3 The Assistant DIPC

The ADIPC reports directly to the DIPC and works with the ICD. The role includes:

- Advising and supporting the DIPC and the ICD.

- Chairing the TIPCC Meetings in the absence of the DIPC.
- Chairs the Joint IPC monthly meeting of Consultant Microbiologists, Nursing Team and Antimicrobial Pharmacists.
- Deputising for the DIPC in her absence.
- Line manages the Lead Nurse.

4.2.4 The Lead IPC Nurse

- Manages and chairs the Divisional IPC Committees which meet bi-monthly and report to the TIPCC and Divisional Boards
- Leads the Trust Decontamination service, including managing and chairing the Trust Decontamination Committee which meets quarterly and reports to the TIPCC
- Responsible for the delivery of IPC training for all Trust staff with the exception of the doctors
- Ensures that all policies and guidelines related to infection prevention are valid and implemented across the service
- Manages infection control nurse's service level agreements with 1 external hospice
- Produces, together with the DIPC and the ICD, the IPC Annual Plan, which includes the IPC Strategy and Assurance Framework, and the Annual IPC Report.

4.3 The Infection Prevention & Control Nursing Team:

In 2015-2016 the team consisted of:

1.0	WTE	Assistant DIPC	(Band 8D)
1.0	WTE	Lead Nurse	(Band 8B)
2.4	WTE	Clinical Nurse Specialists Infection Control	(Band 7)
1.0	WTE	Infection Control Nurse	(Band 6)
1.0	WTE	Infection Control Clinical Support Worker	(Band 4)
0.8	WTE	PA/Admin support (Bank)	(Band 4)

The Surgical Site Surveillance Nurse is also part of the wider team:

1.0	WTE	Surgical Site Surveillance Nurse	(Band 6)

4.4 The Consultant Microbiologists

In addition to the Infection Control Doctor, the Trust employs two other consultant medical microbiologists (CMMs) who play an active role in IPC. There is cover 24 hours a day, 7 days a week provided by a CMM for clinical microbiology/infection control.

4.5 The Antimicrobial Pharmacists

The Trust employs 1.2 WTE Antimicrobial Pharmacists who work closely with the ICD and other members of the IPC team. There is robust management of antimicrobial stewardship throughout the Trust. One antimicrobial pharmacist is the secretary of the Trust Antimicrobial Forum (TAF), a subcommittee of the New Drugs and Formulary Committee. The TAF is chaired by the ICD and is responsible for writing and disseminating Trust specific antimicrobial guidelines. These guidelines are ratified by the Therapeutics Policy Committee.

The role of the antimicrobial pharmacists also includes:

- Attending and contributing to the Trust Infection Prevention & Control Committee meetings and the Joint Infection Prevention & Control Committee meetings (with the infection control team)
- Supporting antimicrobial stewardship initiatives by working closely with the ICD and the CMMs
- Participating in and contributing to the Antimicrobial Ward Rounds with the CMMs
- Carrying out audits in line with national guidance
- Providing training regarding antimicrobial stewardship to clinical staff within the Trust.

4.6 The Trust Infection Prevention & Control Committee (TIPCC)

The Committee is chaired by the DIPC. Its membership includes, in addition to the Medical Consultant IPC leads from all specialities, the local Consultant for Communicable Disease Control, the Infection Prevention & Control Nurse from the CCG, an Occupational Health representative, the Clinical Governance officer, Head of Estates and Facilities, education leads, matrons and the antimicrobial pharmacists. The terms of reference and membership were reviewed in 2015. The TIPCC meets 11 times a year (not August) and reports to the Trust Board via the Risk and Quality Committee.

4.6.1 Medical Consultant IPC Leads

Each speciality has a designated lead that forms the link between their division and the Trust Infection Prevention & Control Committee. Their role includes presenting a bi-monthly report on local infection prevention issues, taking back information to their divisions and working with the divisional matrons on new clinical initiatives and the resolution of local issues supported by the Lead nurse for IPC at monthly divisional meetings.

4.7 The Annual Plan

An Annual Plan is prepared by the Lead nurse for IPC in conjunction with the IPC team and agreed at TIPCC prior to approval by the Board. The plan of work is mapped to the duties of the Code of Practice. Progress against the Annual Plan is monitored by the TIPCC and reported to the RAQC quarterly. The plan for 2015/16, updated with progress to end of Quarter 4, can be found at Appendix I, and the plan for 2016-2017 can be found at Appendix II.

5. Compliance with Criterion 1: b- Monitoring the prevention and control of infection

5.1 Mandatory Surveillance

Mandatory surveillance comprises of MRSA, MSSA and *Escherichia coli* (*E.coli*) bacteraemia cases, cases of *Clostridium difficile* infection and surgical site infection in elective fracture neck of femur, total hip and knee replacement surgery.

5.1.1 MRSA blood stream infections (BSI)

Isolates of MRSA (Meticillin Resistant *Staphylococcus Aureus*) from blood cultures have been reported since 2002; enhanced reporting using the Health Protection Agency (HPA) MRSA Data Capture System began in 2006. The HPA is now known as Public Health England (PHE).

National and local MRSA bacteraemia figures may be seen at:
https://www.gov.uk/government/collections/staphylococcus-aureus-guidance-data-and-analysis

The table below shows the performance of the Trust since the introduction of Mandatory Surveillance targets in 2005. Red font indicates MRSA blood stream infections (BSI) numbers exceeding yearly targets.

Year	05/06	06/07	07/08	08/09	09/10	10/11	11/12	12/13	13/14	14/15	15/16
Trust total	58	53	33	18	10	5	3	2	2	5*	0
Target	39	31	22	21	15	3	3	3	0	0	0

* 5 cases reported (4 avoidable, 1 unavoidable).

The Trust target for 2015/16 was set at 0 preventable MRSA Blood Stream Infections (BSI). For the first time in the history of the Trust we had no cases of MRSA BSI. It is difficult to single out one intervention that has led to this achievement and it is probably due to a combination of actions including avoiding pseudo-bacteraemia by the introduction of mandatory training in taking blood cultures and the introduction of closed venepuncture system coupled with the introduction of a novel blood culture collection policy.

Maintaining this achievement in the coming year will require continued vigilance in applying measures that have been shown to have a significant impact, combined with the introduction of a number of new initiatives including:

- Development of a specialist nursing team to review the management of all types of IV devices in the Trust.
- The introduction of an enhanced surveillance programme for all bacteraemia in the Critical Care Unit, with a view to expanding this programme to other areas with high use of intravascular devices.
- Enhanced audits by the IPC team of practice across all wards, reporting back to TIPCC, Divisional meetings and Ward Managers.
- Review of medical staff training in blood culture taking and the avoidance of contamination of blood culture bottles.

5.1.2 *Clostridium difficile*-associated disease (CDAD)

Clostridium difficile is a type of bacterium found in the gut that can cause diarrhoea in certain circumstances. It can cause a spectrum of symptoms from mild antibiotic-associated disease to severe colitis. The bacterium is found without ill effects in a percentage of the population such as infants (hence we do not test patients <2 years of age) and the elderly, where up to 50% in some studies are colonized without ill effects. As the current testing technologies only detect the presence of the bacterium, the DH has produced a number of guidelines advising laboratories on how and when to test.

The incidence of *C.difficile* infection has reduced nationally year on year for the past three years. National and local results can be seen at: https://www.gov.uk/government/collections/clostridium-difficile-guidance-data-and-analysis

The table below shows the performance of the Trust since the introduction of Mandatory Surveillance in 2004. Red font indicates CDAD numbers exceeding yearly targets.

Year	04/05	05/06	06/07	07/08	08/09	09/10	10/11	11/12	12/13	13/14	14/15	15/16
Total	474	487	594	457	108	81	56	12	13	14	12	15
Target	n/a	n/a	n/a	414	183	90	63	65	14	14	15	11

In addition to the improvements in the patients' outcomes and experience and in the image of the Trust (as the CDAD rate is considered by many authorities to be a reliable proxy for hospital cleanliness), there are significant financial savings. The cost of a single case of CDAD has been estimated to be between £5,846-£7,297. Taking the lower figure, the potential cost to the health economy in 2006/7 was £3.47M compared to £87,690 last year.

5.1.3 Other Mandatory Surveillance organisms

We also report on BSI caused by Meticillin Sensitive *Staph Aureus* (MSSA) and *E. Coli*, although no targets are set. The table below shows the numbers of hospital associated BSI from 2011/12.

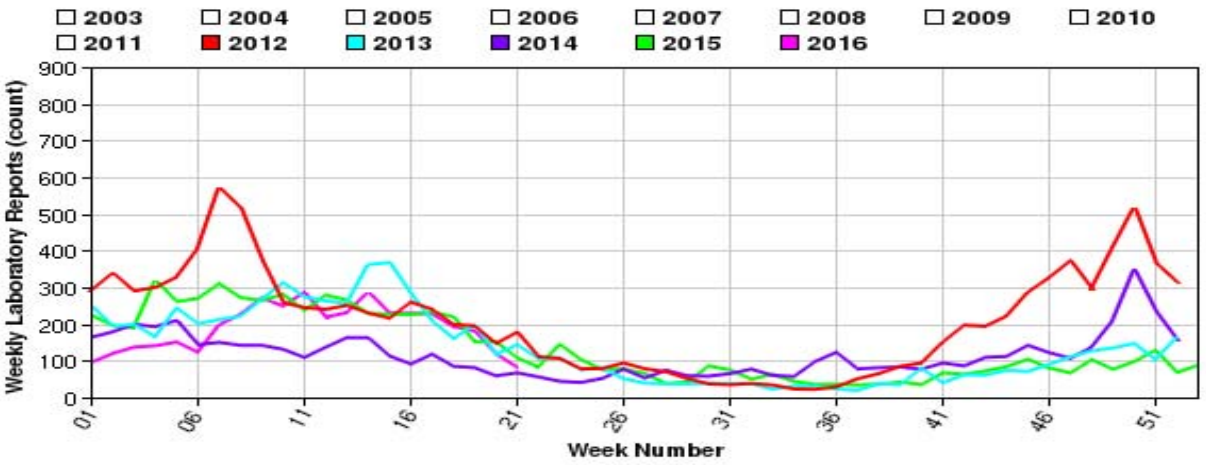
Bacteraemia	MSSA	E coli
2011/12	18	30
2012/13	15	43
2013/14	9	53
2014/15	15	38
2015/16	14	24

5.2 Incidents related to infections (including outbreaks)

5.2.1 Norovirus outbreaks

Norovirus is a highly contagious pathogen responsible for outbreaks in the community (e.g., schools, cruise ships, residential homes, etc.). Norovirus outbreaks occurring in hospitals normally occur as a result of increased activity in the community and the admission of a symptomatic patient from the community.

Nationally, Norovirus activity has been low in 2015/16. PHE observed that Laboratory reports of Norovirus in the current season are thirteen percent lower overall compared to the five year seasonal average (from season 2009/10 to season 2014/15). Outbreaks of diarrhoea and vomiting in hospitals continue to be reported but at lower levels than in previous years.



(PHE Graph)

Locally, the national picture has not been reproduced. During 2015/16, the Trust has seen an increase in the number of Norovirus outbreaks. At ENHT, this resulted in a total of 13 ward closures (with a loss of 249 bed days resulting from 10 confirmed outbreaks and 3 unconfirmed ones) compared to 10 ward closures in the 2014/15 season (with a loss of 350 bed days resulting from 5 confirmed outbreaks and 5 additional outbreaks with no laboratory confirmation). Although the number of outbreaks was higher in 2015/16 compared to the previous year, the timely response of staff and strict compliance with well-drilled policies and protocols resulted in significant improvement in management of these outbreaks with significant reduction in the number of bed days lost.

The PHE regional unit provides the Trust (and other local healthcare providers) with daily updates on outbreaks in residential and nursing homes which are routinely circulated to all wards and the Emergency Department. Thus staff can identify in advance patients attending ED who may be symptomatic with Norovirus. In addition, regular reports of the number of positive samples from our region are monitored and email alerts issued when a significant increase in the number of positive samples is observed. These alerts help to inform staff of local Norovirus activity and, in turn, to maintain awareness and vigilance in looking out for patients presenting with diarrhoea and vomiting on admission, leading to prompt isolation as required.

5.3 Surgical site infection

It is a mandatory requirement to conduct surveillance of orthopaedic surgical site infections using the Surgical Site Infection Surveillance Service of Public Health England. The minimum requirement is for a 3 month module of surveillance of *one* of the following orthopaedic options:

- Open reduction of long bone fracture
- Total Hip Replacement (THR)
- Total Knee Replacement (TKR)
- Repair Neck of Femur Fracture (RNoF)

The Trust has opted to undertake surveillance for three of these categories namely THR, TKR and RNoF for the full twelve months for 2015/16. See table below.

Surgical site infection rates:

Category of surgery	National benchmark	ENHT 2015/16
Total Knee Replacement	0.6%	2.5%
Total Hip Replacement	0.7%	2.1%
Repair Neck of Femur Fracture (RNoF)	1.4%	1.1%

These results demonstrate a reduction in infection rates from previous years. However, we continue to work with all stakeholders to maintain these improvements and to achieve our aim of reducing the infection rates associated with these procedures in line with the national benchmarks (see table above). To oversee this improvement programme, a surgical site infection group meets regularly and reports progress to the Trust Infection Prevention and Control Committee.

6. Criterion 2: Clean and appropriate environment

6.1 Environmental Cleaning

6.1.1 Cleaning Services

The majority of services are managed by external companies: G4S for Lister and Accuro for QEII. Outcomes are aligned to the national cleaning specifications. Services at Mount Vernon Cancer Centre are provided in–house by the Hillingdon Hospital Foundation Trust. The cleaning services in the satellite renal dialysis units are managed through service level agreements with the respective Trusts that they are located in. Cleaning at the Bedford Unit is managed by an external company named Cleaning Matters.

6.1.2 Monitoring arrangements

Dedicated monitoring officers undertake and record technical monitoring on a regular basis as required by the National Specification. The monitoring of waste streams is also included in their audits.

Ward Sisters/Charge Nurses, Matrons and Divisional Nurses undertake the bi-weekly cleaning/environmental audit in their clinical areas. Failure to achieve 95% compliance with the cleaning audit triggers actions to bring cleaning up to the required standard. Cleaning is discussed at the Divisional IPC meetings and monitored at the monthly contract meetings.

6.1.3 Deep Clean Programme

A deep clean of specified clinical areas including the use of hydrogen peroxide vapour (fogging) has been completed following outbreaks of viral gastroenteritis and refurbishments where rooms and bays were accessible. A deep clean without fogging was completed in those areas which could not be vacated. Deep cleans have occurred on all inpatient areas with confirmed or suspected Norovirus outbreaks
The Neonatal Unit underwent a deep clean which included the use of hydrogen peroxide vapour as a new control measure following an increased incidence of MRSA colonisations in the unit.

6.2 Environmental Monitoring

6.2.1 Water Safety Group

East and North Hertfordshire NHS Trust accepts its responsibility under the Health and Safety at Work etc. Act 1974 and the Control of Substances Hazardous to Health Regulation 2002 (as amended), to take all reasonable precautions to prevent or control the harmful effects of contaminated water to residents, patients, visitors, staff and other persons working at or using its premises.

The Water Safety Group Committee was established in 2013/14 following advice from the DOH to create a multi-disciplinary group of committee members, to include clinical and non-clinical personnel and chaired by the Infection Control Doctor. This group met quarterly during 2015/16 and was well attended by the nominated committee members and the Trust's external water safety consultants (Hydrop).

During the past year, the Water Safety Group has instructed Hydrop to undertake Pseudomonas Water Risk Assessments with particular focus on the Trust's renal units which were not done the previous year. These include: - Lister Hospital renal units on L3 & L6, renal satellite units at Harlow, Bedford & St. Albans. During the last year, Hydrop has completed site-wide Water Risk Assessments for Lister Hospital and the identified action plans have been circulated to ICT & relevant Estates teams.

A Water Safety Policy and Plan has been developed to manage all Water Services that fall under the responsibility of the Trust. These documents were ratified by the Trust Infection Prevention & Control Committee (TIPCC) in 2015. However, water services for the Trust's Cancer Services at Mount Vernon Hospital, the New QEII Hospital, Hertford County Hospital and the Trust's renal satellite units are managed by other NHS Trusts & private third party organisations such as Semperian, Accuro & Diaverum. The Trust ensures compliance via the appointment of a Trust Estates representative who liaises with other NHS Trusts and private organisations to ensure compliance.

During the past year, there were several *Legionella sp* positive water samples for Mount Vernon Cancer Centre (MVCC), in the Chemo suite, Ward 10 & 11, Nuclear Medicine & the main block. During December 2015, there was an investigation headed by PHE regarding a patient who died from *Legionella* infection who was an outpatient at the Chemo suite and was an in-patient on ward 10 in MVCC and was also admitted during the same period to Ealing Hospital. The PHE subsequently traced the strain of *Legionella* from the patient to a sink in a ward within Ealing Hospital where the patient had stayed. The likelihood of the infection being acquired at the Ealing Hospital was also consistent with the water sampling results, the presence of other cases within the Ealing Hospital and with the incubation period of the disease. Following this investigation, there were no actions for ENHT but PHE asked Hillingdon

Hospital, who owns the MVCC estates, to update the current Water Risk Assessment for the site.

On finding *Legionella sp* positive samples on the Mount Vernon hospital site, Hillingdon Hospital works in a similar way to ENHT and implements immediate remedial actions, consisting of immediately fitting a POU (Point of Use) filter and local disinfection procedures. The two NHS Trusts work closely together to resolve any operational issues, and there is Estates RP (Responsible Persons) representation from both Trusts at each Trust's Water Safety Group Committee meetings to ensure inter NHS Trust understanding and communications.

In addition to the regular testing regime for *Legionella* and *Pseudomonas*, the Trust's Water Safety Plan specifies that the main control strategy for monitoring water quality on the Lister Hospital site will be by weekly TVC water sampling & covering the entire hospital site annually. Any abnormal results are addressed through the Water Safety Group and are reported to Divisional Infection Prevention & Control meetings in addition to the Trust Infection Prevention & Control Committee (TIPCC). During the past year, Estates staff responsible for water management have attended divisional meetings to update senior nursing and medical staff on good practice requirements and the requirement for flushing infrequently used water outlets.

7. Criterion 3 & 4: Information on infections to service users and their visitors & information on infections to other providers

In addition to the use of pop up banners to inform the public of increased incidence of Norovirus and a separate banner for notification of an actual outbreak, the Trust continues to use the switchboard as a mechanism for informing the public of infection outbreaks, should they occur. A pre-recorded message is used at the time of outbreaks and removed once they are over. Notification is also displayed on the Trust website. Infection Prevention & Control information leaflets are available on the Trust website for the patients and public to access. Printed copies are available for patients identified with infections at ward level.

Washable information labels have been placed on all in-patient lockers and dialysis trolleys informing the public of the importance of hand hygiene whilst in the hospitals, and drop down signage has been mounted from the ceilings in long corridors informing the public of gel dispensers and sinks at the entrances to departments and requesting that they be used.

The Trust has an IPC section on the external website which provides information to patients on a number of IPC issues including numbers of cases of Clostridium *difficile* and MRSA BSI.

8. Criterion 5: Identification and prompt management of infection

The ICD and the consultant microbiologists provide advice on the prompt diagnosis and treatment of infections, including the appropriate use of antibiotics. Close working relationships are also in place to facilitate the reporting of infections of public health significance to the local Public Health England (PHE) Unit. In addition, the ICD works closely with PHE in the management of infection-related serious incidents in the hospital. The IPCNs also liaise with their Public Health nursing colleagues in respect of infection control incidents.

During the last year the Trust has continued to advance the Antimicrobial Stewardship agenda, including the following activities which facilitated an evidence-based approach to the use of antimicrobials throughout the organisation:

- Policies and guidelines on the use of antibiotics in adults, children and neonates and on the use of antifungal agents are available to all Trust prescribers via the Knowledge Centre. These policies and guidelines have been reviewed and/or updated during this last year.
- Clinical audit has enabled compliance with various aspects of Trust policies and guidelines to be assessed. These audits include an annual point prevalence audit, which is concerned with the extent of prescribing in the Trust and a 'stop policy audit' which is concerned with adherence to the antimicrobial 'stop' policy.
- There is a rolling programme of education and training for clinical staff to ensure that the antimicrobial stewardship agenda is embedded in everyday clinical practice across the Trust.
- There was a complete evaluation of antimicrobial consumption throughout the Trust in line with the validation protocol published by Public Health England.
- A comprehensive review of antimicrobial stewardship activity in the Trust was carried out by way of a gap analysis of NICE guidelines NG15 (Antimicrobial stewardship: systems and processes for effective antimicrobial medicine use). Appropriate action plans were developed to address the gaps identified.
- Formal evaluation of the antimicrobial stewardship action plans was performed through the Trust Antimicrobial Forum which met every three months in 2015/16.

9. Criterion 6: Involvement of all staff

The IPCT works closely with all Trust staff to implement good practice and reduce HCAIs. The IPCT is an integral part of the Trust induction programme for all new staff (with presentations on both Infection Prevention and Antimicrobial Stewardship) and delivers mandatory updates on key and emerging issues.

In addition, a number of educational activities have been developed:

- A report by the ICD is now an integral part of the "Learning Points" issued monthly to all Clinical Directors for discussion at the specialities' monthly Clinical Governance meetings.
- The IPC team has presented information on screensavers displayed on Trust-wide computers at monthly intervals throughout 2015/16, highlighting key IPC issues. Topics covered have included *Clostridium difficile*, MRSA, influenza, hand hygiene and antibiotics.
- The IPCNs produce a monthly mail shot called 'Quick Pics' which is sent to all nursing staff and highlights news and hot topics relating to infection prevention & control.

10. Criterion 7: Isolation facilities

The Trust has a dedicated isolation ward with 15 beds (3 x 4 bedded bays with doors and 3 side rooms). The number of side rooms available across the Trust has increased since the opening of the new ward block, resulting in a total of 127 side rooms (some with en-suite facilities). This number has varied with the reconfiguration of the wards. It is important to note that in the maternity unit the delivery rooms are all single rooms (with en-suite facilities).

During 2015/16, the isolation ward has not needed to be reserved for patients requiring isolation for *Clostridium difficile* due to the reduced number of such patients. Therefore, the bays are currently used flexibly to admit other patients requiring isolation for other infections and also general medical patients. Some HCAI patients including CDAD patients required specialist care and were nursed in isolation in the Renal and the Critical Care Units. However, the isolation ward is deemed essential to maintaining the low numbers of infections across the Trust and the Trust is committed to maintaining this facility.

11. Criterion 8: Laboratory support

During 2015/16, the Microbiology laboratory was relocated to the PHE Microbiology Laboratory at Addenbrookes Hospital in Cambridge. This is part of the TPP process that saw the consolidation of the Pathology Departments of six Trusts in the East of England into two hub laboratories. As with any move of similar magnitude there were some initial difficulties, mostly related to IT instability and a specimen backlog in the first three weeks following the move. One of the IT challenges was the incompatibility of the new laboratory system with ICNet (the software used by the ENHT Infection Control team to pick up results of IPC significance from the laboratory system). The Trust has worked together with TPP and PHE to resolve these initial difficulties. By

the end of the financial year, the microbiology service was satisfactory. Efforts will continue in the coming financial year to realize the full benefits of laboratory consolidation and to ensure that ICNet continues to be a functional and effective tool in the transfer of significant laboratory data relating to HCAIs to the IPC team in a timely manner.

12. Criterion 9: Policies

All policies required for compliance with the Health Code are in place and audited through the Annual Plan (see Appendices I & II). The results of audits are shared and discussed at Divisional level and any remedial actions required are addressed through a written plan of action which is followed up through the divisional meetings and signed off when completed by the ADIPC. Support is given by the IPCT to the clinical areas to ensure adherence to policies.

Most IPC policies are written by the IPC team members with support from other Trust staff with expertise in the relevant areas. Some policies are written by other teams in the Trust with relevant experience and are approved by the IPC team. These policies are uploaded centrally to the Knowledge Centre (KC) where they are accessible to all staff.

13. Criterion 10: Health care workers: Infection Status, protection from infection & education in infection prevention & control

In 2015/16, The Health at Work Service (HWS) has worked closely with the IPC team. The service has been fully involved in IPC related incidents that affect staff health, such as Norovirus outbreaks, needle-stick injuries and staff exposure to illnesses in patients, such as chicken pox.

13.1 Sharps/splash incidents

The HWS assists the Trust in managing potential exposure to blood borne viruses. During standard working hours, HWS risk assess, advise and follow up potential blood borne virus exposure incidents reported to the service. There is monthly reporting of devices involved in sharps injury and the likely cause of injuries. Post injury advice reports are sent to managers and injured employees.

A sharps injury prevention and awareness event was held in the Community Hub at Lister Hospital during January 2016. This event was supported by posters throughout the Trust and information was disseminated via the Trust screensavers and the Knowledge Centre. The event provided information to staff on the Trust Policy for the management of blood borne virus incidents, promoting the individual's role and the manager's role in the management of such incidents.

Description	Quarterly Performance				
Sharps/body fluid splash injury	Q1	Q2	Q3	Q4	**Total**
Number of staff seen in HWS following sharps injury/body fluid contact	38	43	44	41	166
Number of staff referred to GUM	1	5	4	5	15
Number of staff commencing on PEP	0	3	1	2	6
Number of staff needing to complete PEP course	0	3	1	1	5
Number of sharps injuries with known positive HIV patients	0	2	2	0	4
Number of sharps injuries with known positive Hep B patients	0	0	0	0	0
Number of sharps injuries with known positive Hep C patients	1	2	1	0	4

13.2 Immunisations and blood tests

The HWS continues to screen all new NHS Employees to identify specific workplace immunisations required in order to assure compliance with Criterion 10 of the Health and Social Care Act 2010. The HWS continues to work to ensure that existing staff are compliant with immunisations appropriate to their role in line with Department of Health Guidelines.

In addition to routine immunisation programmes, the HWS facilitated the Seasonal Flu Immunisation Programme 2015 / 2016.

Staff Group	Number of frontline staff in Trust	Total vaccinated	% vaccinated	% vaccinated end of 2014/15 campaign
Doctors	769	407	52%	66%
Nurse, Midwives, Health visitors	1767	720	40%	54%
Allied Healthcare professionals	417	192	46%	41%
Support staff	1632	981	60%	68%
Total	4585	2300	50.1%	59.5%

Immunisations / bloodtests

Description	Quarterly Performance				
Immunisations/ Blood tests	Q1	Q2	Q3	Q4	**Total**
Number of attended appointments	510	402	368	396	1676
Number of Immunisations / blood tests given	1570	1258	3492	1237	7557
Number of DNA's	75	70	77	81	303
Number of new starter Immunisation advice sheets sent	258	248	152	163	821

14. CQC visits

The Trust was inspected by the Chief Inspector of Hospitals inspection team during 2015/16.

Some IPC-related concerns were raised, including hand hygiene compliance in the ED which the Trust has linked to the East of England Ambulance Service (EEAST); measures are being implemented to ensure compliance across all staff groups in the ED. As outlined in the CQC report, the Trust has in place established governance structures, systems and processes and has demonstrated continuous improvement and learning. The improved performance in all IPC issues over the past year and the future maintenance of this high standard will ensure that the Trust continues to be compliant with the Health and Social Care Act 2008: Code of Practice, and is fully accredited by the CQC.

15. Trust Development Authority (TDA) visits

The Trust reports monthly to the TDA on infection control performance and compliance.

There were two TDA visits to the Trust in 2015/16; one on 28th May 2015 and a two-day visit on 30th June and 1st July 2015.
The TDA inspector observed that most staff demonstrated good understanding of IPC practices and responsibilities with evidence of excellent leadership. Some areas for improvement were also noted including:

- Escalation of the business case for improvements to the theatre suite.
- Focus on the poor condition of the estate at Mount Vernon.
- Refreshing the correct use of Personal Protective Equipment (PPE) across the Trust.

- Improving the cleaning audit process, including involvement of ward staff as part of the process.

The CCG IPC lead also attended part of the TDA review and contributed to the recommendations made (see above).

It should be noted that the TDA has now amalgamated with Monitor to form NHS Improvement.

The above issues, excluding MVCC, were addressed and no concerns were raised at the time of the CIH CQC inspection. MVCC will be addressed through the development of the MVCC strategy.

16. CCG visits

In addition to the above joint visit, the CCG IPC nursing lead has made a number of regular visits to the Trust throughout the year, working collaboratively with the Trust IPCT. The Trust also participates in a Hertfordshire Whole Health Economy meeting and joint working group meetings to reduce *Clostridium difficile* numbers, particularly in the community.

The CCG IPC Lead is a member of the Trust Infection Prevention and Control Committee and attends meetings regularly.

17. Conclusion

The Trust has continued to implement a robust plan of IPC in collaboration with the dedicated IPC team and clinical colleagues. This is evidenced by the low numbers of hospital associated infections reported and by the appropriate management of outbreaks and isolated infection control incidents such as the *Legionella* incident.

APPENDIX I: The Infection Prevention & Control 2015/16 Annual Plan – Updated to end Quarter 4

The Infection Prevention & Control Strategy is driven by the aim to prevent all avoidable health care associated infections and to ensure we meet the requirements of the Health and Social Care Act (2008) – Code of Practice on the prevention and control of infections and related guidance, the Department of Health and the Care Quality Commission.

To meet these aims the annual plan for Infection Prevention & Control for April 2015 - March 2016 sets out the proposed activities for the Infection Prevention & Control service (IP&C) at E&N H Trust This plan will ensure that the Trust continues to meet the requirements of the Department of Health and the Care Quality Commission. The plan also takes into account locally agreed actions as well as internal programmes of work that the Trust will deliver on during this financial year. This programme of work is mapped to the compliance criteria, which will ensure that the Trust continues to maintain compliance and strengthen and broaden IP&C activity.

This plan has been reviewed on a quarterly basis, with progress and evidence of completing actions documented. Actions have been regularly reviewed at the Trust Infection Prevention and Control Committee. Progress on actions has also been followed up through Divisional meetings.

Work Plan Referenced to 10 criteria of the Hygiene Code (2008)	Actions	Target Date	Lead	Measure of success	Progress May 2016 2016	Date Completed	Evidence Outcome
Criterion 1 – Systems to manage and monitor the prevention and control of infection To ensure that the governance arrangements for IP&C remain robust & provide assurance that the board to ward philosophy is embedded across the Trust	The Trust Infection Prevention and Control Committee (TIPCC) will continue to meet monthly. The TIPCC will receive updates from the following groups and committees: • Divisional IPC Committees • Decontamination Committee • Water safety Group • Trust antimicrobial Forum • Surveillance Surgical site infection sub group The Trust will publish the IPC annual report & Quality Accounts The IP&C service will provide data for all alert organisms and HCAI rates. The trust will receive monthly reports monitoring progress against national targets for MRSA bacteraemia and C. difficile infection and the mandatory reporting of MSSA & E coli BSI and any significant IP&C issues The trusts corporate risk register will continue to identify and monitor any Trust wide risks in relation to IP&C.	Monitor annual	DIPCC	Evidence of structures and processes in place. TIPCC agenda and Minutes	TIPCC meets monthly. Agenda includes reports from decontamination committee, reports to be requested from the SSI group. TIPCC monitors national. Risk register up to date.	In place	TIPCC agenda and Minutes

	Review High Impact intervention (HII) audit tools and processes and ensure process provides assurance of practice associated with IPC.	30/3/16	IPC Lead Nurse	High Impact Intervention audits reported to Divisional Boards provide assurance.	HII reports modified 12/15 to ensure transparency and alignment of audits	December 2015..	HII audit reports
Management of healthcare associated infection (HCAI) 1) MRSA Bacteraemia Five cases of bacteraemia identified in 2014/15. Three of these were contaminants. Zero tolerance of MRSA bacteraemia for 2015-16..	Ensure screening is embedded in practice	30/11/15	Divisions	Audited level of compliance with MRSA Policy >90%.	HII audit report 69%. Training in clinical areas introduced. Focussed audit tool to identify process and system errors	Priority for 2016/17 Plan to improve compliance Incorporating focussed education and audit with feedback	HII Meridian audit reports
	• Develop screening compliance measure	30/10/15	IPC Lead nurse				
	• Develop Audit against MRSA policy	30/10/15	IPC Lead Nurse				
	• Ensure all patients who have a positive MRSA screen commence decolonisation therapy within 24hrs of positive result.	30/11/15	Divisional Nurses/ Consultant Leads				
	All MRSA and MSSA BSIs will continue to be subject to an RCA/PIR. All actions and recommendations agreed will be implemented by the divisions	1/4/16	Divisional Nurses/ Consultant Leads IPC Lead Nurse	Completed RCA/PIR process with evidence of implemented actions..	PIRs undertaken for identified MSSA BSI. Process modified investigation clinical practice around devices associated with MSSA. No MRSA bacteraemias reported	In place March 2016	Joint clinical audits and local action plans

	• To produce and implement an Aseptic non touch technique (ANTT) policy	1/04/16	IPC Lead Nurse/ Divisional Nurses/ Education team	ANTT policy. Audited compliance against ANTT policy>95%	Trust ANTT policy is current. Competency process to be introduced 2016/17 as a priority.	Priority for 2016/17 for competence process	Trust ANTT policy. Meridian reports
	• To ensure all intravenous lines are managed appropriately in line with policy.	30/11/15	Divisional Nurses/ Consultant Leads	Audited compliance >95%	.Merdiian reports demonstrate adherence	April 2016	Meridian Reports
	• Vascular access team (VAT) to be established	30/03/16	Vascular Nurse	Established VAT.	Business case approved for establishment of a VAT.		
Management of Healthcare Associated Infection (HCAI) 2) MSSA blood stream infection. Currently there is no national guidance for rate reduction.	• On going surveillance of MSSA bacteraemia. • .	30/3/16	IPC Lead Nurse	Process to identify all MSSA BSI	MSSA BSI reported daily to IPC team from Oct 2015.	In place	Microbiology reports
	• On going RCAs of MSSA with actions and arising recommendations implemented	30/3/16	Divisional Nurses/ Consultant Leads	Documentary evidence of MSSA BSI PIR with documented evidence of implemented actions.	Process modified investigation clinical practice around devices associated with MSSA.	In place	Joint clinical audits and local action plans

Management of Healthcare Associated Infection (HCAI) 3) E.coli blood stream infection Currently there is no national guidance for rate reduction.	• On-going surveillance of all post 48 hour cases will include a review to ascertain the source of infection.	, 30/03/16	IPC Lead Nurse Infection Control Doctor	Monthly reports of E coli bacteraemia cases	From October E. coli bacteraemia data available from laboratory direct to IPC team. Process to review case to ascertain source in development for launch 04/16.	Priority for 2016/17	Priority for 2016/17
	• If device related, an PIR to be carried out and arising recommendations implemented.	30/3/15	Consultant Leads Divisional Nurses/	PIR process for all identified E coli bacteraemia cases associated with catheters/ invasive devices.	Process to review cases in development for launch April 2016	Priority for 2016/17	Priority for 2016/17
Management of Healthcare Associated Infection (HCAI) 4) Clostridium difficile Externally set ceiling for cases of Clostridium difficile for 2015/16 is 11.	The Trust will continue surveillance and reporting of all cases of C. difficile infections. An RCA/PIR will continue to be held for any infections identified and any actions and recommendations implemented.	30/3/15	IPC Lead Nurse	Completed RCA/PIR process with evidence of implemented actions. *C. difficile* infection ceiling of 11 not exceeded.	Annual target breached. 7 cases sent for appeal. C. difficile action plan drafted.	RCA Systems in place	RCA documents

Management of Healthcare Associated Infection (HCAI) 5) Antimicrobial stewardship.	Implementation of the National strategy “Start smart, then focus”. Annual audit of compliance with antibiotic policy and monitor. Trust antimicrobial forum (TAF) meets quarterly. Quarterly reports to TIPC.	30/3/15	Lead infection pharmacist Infection Control Doctor Divisional Leads IPC Lead Nurse	Audited compliance> 95%	New CQUIN for 2016/17	2015/16 requirements met.	Antibiotic audit. Antiotic audit. Trust antibiotic forum minutes.
Management of Healthcare Associated Infection. (HCAI) 6) Carbapenemase producing organisms (CPO)	Surveillance for potential CRE to be continued. Ensure screening for CRE is carried out in compliance with the trust policy and PHE guidance. Ensure any patients identified with a CRE are managed in compliance with the trust policy and PHE guidance. Audit screening compliance against the policy.	20/12/15	Divisional Clinical lead. IPC Lead	Audited screening results >95%.	IPCT audit of screening assessment and associated screening completed and presented TIPCC December 15. Compliance >90%. Quarterly audit cycle.	2015/16 requirements met	CRE screening policy. Audit results.

Management of Healthcare Associated Infection 8) Surgical site infection surveillance (SSI).	The trust will continue surveying orthopaedic surgical site infection (SSI) utilising the national surgical site surveillance scheme.. Work with the SSI group led by the Clinical director –orthopaedics to implement compliance with NICE QS49. SSI group to produce action plan and monitor.	30/3/16	IPC Lead Nurse	Quarterly reports of SSI data. Documentary evidence of quality improvement. Minutes of the SSI group. Audit against NICE guidance.	Surveillance continues. Action plan updated. On the TIPCC agenda quarterly.	2015/16 requirements met	SSI surveillance results. SSI action plan
Prevention of infection. 1) Line safety and management	Surveillance of central line associated blood stream infections will be undertaken and reported monthly	30/3/16	IPC Lead Nurse	Central Line associated blood stream infection surveillance reports.	Developing process with draft algorithm. Working with ITU.	Priority for 2016/17	Priority for 2016/17
	All policies and supporting guidance and tools relating to vascular access will be updated and reviewed as required.	30/3/16	IPC Lead Nurse	Reports of Staff competency	Trust policy for the prevention of intravascular related infections due for review by December 2017.Reviewing supporting tools to ensure alignment.	Policy in date 2015/16	Current trust policy
	Vascular access team to be established.	30/3/16	Senior Nurse Ambulatory care	Established vascular access team	Business case approved.		

	The Trust will define the competency process for vascular devices and the structure and processes will be in place.	30/3/16	IPC Lead Nurse	Defines system and process for ensuring competency for vascular devices.	Current policy identifies a competency process.	Competency process priority for 2016/17	
	Vascular access practice subject to 1) High Impact Intervention audits conducted twice a month; and 2) IPC annual audits.	30/3/2016	Divisional Nursing services managers IPC Lead Nurse	Audited scores >95%	IPC Team audit being undertaken October 2015. High Impact intervention audits undertaken by clinical teams. Reported to Divisonal IPC boards.	2015/16 requirements met	Audit Reports
Prevention of infection. 2) Aseptic Non Touch Technique (ANTT)	IPC Team will audit aseptic technique practice as part of the annual IPC audits. Competency process to be reviewed to provide assurance that all clinical employees are assessed as competent in the process..	30/3/16	IPC Lead Nurse	Audit >95% Evidence of competency.	ANTT policy due for review 2016. Assessment tool incorporated in policy. Agreed competency approach.	Competency process priority for 2015/16	Competenc y process priority for 2015/16

Prevention of infection 3) Hand Hygiene	To continue audits of hand hygiene compliance twice a month and report via meridian. These are reported to the Divisional Boards. IPC audit as part of the annual IPC audit programme of facilities and practice. To produce a hand hygiene strategy encompassing facilities, education and training and audit process. To incorporate a plan to ensure appropriate use of gloves in clinical practice. IPC to liaise with Estates to prioritise provision of hand hygiene sinks.	30/3/16	IPC Lead Nurse	Audit of hand hygiene facilities >95% Audit of hand hygiene practice >90%	Twice monthly audits of hand hygiene reported on Meridian system/ IPC audit of hand hygiene facilities and practice completed. Feedback reported to individual units and matrons. Hand hygiene strategy drafted.	Requirements met for audit. Hand hygiene strategy to be introduced as a priority 2016/17	Audit reports
Prevention of Infection 4) Catheter associated urinary tract infections (CAUTI)	IP&C will continue reporting prevalence of cauti as part of the safety thermometer data. See actions above related to Management of Healthcare Associated Infection (HCAI) 3) E.coli blood stream infection To work with urology nurse specialists to reduce urethral catheter usage by appropriate assessment of patients. IPC audit of urethral catheter management	30/3/16	IPC Lead Nurse	CAUTI reduction target of 25% achieved.	IPC team monitor reports of CAUTI as part of the safety thermometer programme.	Requirements for 25/16 met	Safety Thermometer reports

Criteria 2 - Provide and maintain a clean and appropriate environment in managed premises which facilitates the prevention and control of infections.	IP&C will continue to ensure that there is expert infection control input into environmental monitoring systems and implementation of national standards for cleanliness IP&C will continue to collaborate with the estates and facilities Directorate to provide expertise in the development of written policies and standard operating procedures. Estates and facilities will continue to have the responsibility, to have in place the relevant planned preventative maintenance programmes and will work with IP&C to ensure appropriate expert input. IP&C will provide expert clinical advice to the Water Safety Group. The operational management will be the responsibility of the end users and overseen by estates and facilities. The Trust Decontamination lead, will ensure that the decontamination committee meet at least 4 times per year.	30/3/2016	IPC Nurse Lead	Documented evidence of IPC input into Estates Project.	Estates Policy updated and approved. IPC Team have input into developments. IPC are members of the water Safety Group which meets quarterly.	2015/16 requirements met	Minutes of the water safety and decontamination committees

Criteria 3 - Provide suitable accurate information on infections to service users and visitors	Ensure that the IP&C Annual Report is published on the source and made available as a public document. The Trust will publish and make publically available the annual quality accounts The Trust will continue to undertake a rolling programme of policy review, this will also take into consideration changes to national policy and guidance. The policy review matrix will be a standing agenda item at the TIPCC. IP&C will continue to work with Complaints, Legal Dept, Comms team and FOI officer to provide timely, accurate and comprehensive information regarding press enquiries, FOI requests and patient concerns/complaints. The Trust will use input from local patient and public experience for continuous quality improvement to minimise harm from HCAI's The IP&C team will review the patient experience survey to identify areas for improvement. IP&C data to be publically available on all ward IP&C notice boards. Patients and visitors will have access IP&C information leaflets in all wards and departments	30/3/16	IPC Lead Nurse IPC Doctor	Annual Report completed. All IPC policies updated. IPC data available for users and clinical teams. All IPC information leaflets available for patients and visitors	Annual IPC Report for 2015/16 to be completed. Reports circulated to RACQ, the Board and TIPCC report key infection data including MRSA BSI and C. difficile data. Key data available on Trust website.	2015/16 requirements met	Trust website. Board Reports Patient information leaflets.

Criteria 4 - Provide suitable accurate information on infections to any person concerned with providing further support or nursing/medical care in a timely fashion **Criteria 5 - Ensure that people who have or develop an infection are identified promptly and receive the appropriate treatment and care to reduce risk of passing on infection to other people**	The IP&C team will utilise their IT surveillance system to identify areas across the Trust that may require targeted support. The IP&C team will continue to work with clinical teams in the investigation all MRSA and MSSA BSIs, and C. difficile infections and will continue to identify any themes or learning for the clinical teams. All appropriate policies and programme of education will be made available to support the management of patients with infections. IP&C will continue to review all identified patients and environment during clinical rounds and ward visits providing support, guidance and information.	30/03/16	IPC Lead Nurse	.Audit of ICNet system shows completed patient records with appropriate IPC advice documented. PIR/RCA documentation evidences embedded learning. IPC audit programme to include isolation demonstrates prompt isolation of patients with identified transmissible conditions.	Interface issues to be resolved. Ongoing communication between pathology partnership, trust and ICNet. Interim arrangements remain in place. Target date not met. Alternative temporary systems in place. IPC review patients with alert organisms and advise accordingly.	2015/16 systems in place. To identify alert organisms permanent IT system solution for 2016/17	Documented advice. Information for alert organisms.

Criteria 6 - Ensure that all staff employed to provide care in all settings are fully involved in the process of preventing and controlling infections	Refer to criteria 1 - HCAI governance structure is designed to involve representatives of all relevant disciplines.	30/3/16	IPC Lead Nurse	TIPCC minutes demonstrate attendance of divisional representatives.	TIPCC held monthly (excepting August).	2015/16 requirements met	
	Bi monthly hand hygiene audits will be undertaken by all clinical areas, the results will be reported monthly to the Trust and Divisions and made publically available. Ward teams will continue to audit clinical practices as identified in the 'Saving Lives' campaign on a bi-monthly basis. Results of audits and any actions taken will be reported by the Divisions	30/3/16	IPC Lead Nurse/ Divisional Nurse Managers	Completed bi monthly audits for all identified clinical areas completed. Action plans to be available for gaps demonstrated.	Gaps identified in certain wards fed back at divisional IPC meetings. Review of questions and audit processes commenced to ensure consistency and rigor.	2015/16 requirements met	
	An annual programme of audit will be developed and undertaken by the IP&C team which will encompass both environmental and clinical practices. Feedback of recommendations required as a result of the audits will follow an appropriate process to ensure relevant necessary action is taken.	30/3/16	IPC Lead Nurse	Completed programme of annual IPC audits.	IPC annual programme of audits commenced October 2015. Audits	2015/16 requirements met	Audit reports
	An annual programme of education will be made available to all relevant staff.	30/3/16	Education Team / IPC Lead Nurse	IPC involvement in 'Vital' Training and Induction programmes	IPC team members delivering sessions.	2015/16 requirements met	Vital training records

Criteria 7 - Provide or secure adequate isolation facilities	Links to Criteria 2, regarding new building/refurbishment programmes. The Trusts corporate risk register will highlight the low ratio of isolation capacity as risk to appropriately managing patients with infections.	30/3/16	IPC Lead Nurse	IPC isolation audit demonstrates all patients with a transmissible condition or organism are nursed in accordance with the isolation policy. Isolation report demonstrates all patients in a side room within 2 hrs of identification of organism / condition.	IPC Team risk assesses patients for isolation if sideroom is not available. System in place for ward teams to escalate patients who need side rooms to bed managers. Isolation report produced monthly.	2015/16 requirements met	Documented isolation reports
Criteria 8 - Secure adequate access to laboratory support	Ensure that standard operating procedures are up to date. To ensure appropriate and timely microbiology information to be available to clinicians and the IPC team.	30/3/16	IPC doctor Support Services director	SOPs are available	Up to December inadequate alert organism data supplied impinging on IPC functions. Additionally inadequate microbiology data not supplied ina timely manner Recorded on the Trusts Risk Register.	2015/16 systems in place. To identify patients with alert organisms Permanent IT system solution for 2016/17	

Criteria 9 - Have and adhere to appropriate policies and protocols for the prevention and control of infection	Review and update where necessary the policies/guidance, listed in policy review matrix. All policies will be developed and updated in accordance with national guidelines and local need. They will be written in accordance with evidence based practice guidelines. IPC annual programme of audits.	30/3/16	IPC Lead Nurse	All IPC policies in date and in line with National guidance.	IPC Team have updated all IPC policies due for review.	2015/16 requirements met	IPC policies
Criteria 10 - Ensure, so far as is reasonably practicable, that care workers are free of and are protected from exposure to infections that can be caught at work and that all staff are suitably educated in the prevention and control of infection associated with health and social care Policy.	The Trust will provide an occupational health service ensuring advice, guidance and policies are available to minimise exposure to infections. Appropriate vaccinations are given to identified staff in line with DH guidance and risk assessments for staff are undertaken. The Trust will continue to provide a workforce that is informed and aware of their responsibilities regarding the prevention and control of infection by: • Ensuring all staff are provided with appropriate information at induction . The divisions will ensure all staff attend their VITAL update on the prevention and control of infection. All staff will have infection prevention and control activities reflected in their job description and updated through their performance development review. IP&C will initiate training needs analysis in those areas identified as	30/11/15	IPC Lead Nurse	Metrics demonstrate >90% of staff up to date with IPC vital training. Occupational health policies, employment risk assessments and vaccination programmes for staff.	88% of employees have received IPC training as part of vital training. Occupational Health policies are up to date. Staff are assessed and vaccinations are given in line with DH guidance.	89% of employees have received IPC training. Online training for IPC as a priority for 2016/17	Vital training records

	hot spots and provide input and support as necessary. IP&C will review the Link Practitioner system ensuring effectiveness clarifying roles and responsibilities with clinical teams. Participate in joint initiatives involving IP&C teams across the healthcare community as well as contribute to national and international events.						

APPENDIX II: The Infection Prevention & Control 2016/17 Annual Plan

The Infection Prevention & Control Strategy is driven by the aim to prevent all avoidable health care associated infections and to ensure we meet the requirements of the Health and Social Care Act (2008) – Code of Practice on the prevention and control of infections and related guidance, the Department of Health and the Care Quality Commission.

To meet these aims the annual plan for Infection Prevention & Control for April 2015 - March 2016 sets out the proposed activities for the Infection Prevention & Control service (IP&C) at E&N H Trust This plan will ensure that the Trust continues to meet the requirements of the Department of Health and the Care Quality Commission. The plan also takes into account locally agreed actions as well as internal programmes of work that the Trust will deliver on during this financial year. This year's programme of work is mapped to the compliance criteria, which will ensure that the Trust continues to maintain compliance and strengthen and broaden IP&C activity.

This plan will be reviewed on a quarterly basis, with progress and evidence of completing actions documented. Actions will be regularly reviewed at the Trust Infection Prevention and Control Committee. Progress on actions will also be followed up through Divisional meetings.

Work Plan Referenced to 10 criteria of the Hygiene Code (2008)	Actions	Measure of success
Criterion 1 – Systems to manage and monitor the prevention and control of infection To ensure that the governance arrangements for IP&C remain robust & provide assurance that the board to ward philosophy is embedded across the Trust	The Trust Infection Prevention and Control Committee (TIPCC) will continue to meet monthly. The TIPCC will receive updates from the following groups and committees: • Divisional IPC Committees • Decontamination Committee • Water safety Group • Trust antimicrobial Forum • Surveillance Surgical site infection sub group The Trust will publish the IPC annual report & Quality Accounts The IP&C service will provide data for all alert organisms and HCAI rates. The Trust will receive monthly reports monitoring progress against national targets for MRSA bacteraemia and C. difficile infection and the mandatory reporting of MSSA & E coli BSI and any significant IP&C issues The Trust's corporate risk register will continue to identify and monitor any Trust wide risks in relation to IP&C. Review High Impact intervention (HII) audit tools and processes and ensure process provides assurance of practice associated with IPC.	Evidence of structures and processes in place. TIPCC agenda and Minutes High Impact Intervention audits reported to Divisional Boards provide assurance.

Management of healthcare associated infection (HCAI) 1) MRSA Bacteraemia Five cases of bacteraemia identified in 2014/15. Three of these were contaminants. Zero tolerance of MRSA bacteraemia for 2015-16..	• Ensure screening is embedded in practice	Audited level of compliance with MRSA Policy >90%.
	• Develop screening compliance measure	
	• Develop Audit against MRSA policy	
	• Ensure all patients who have a positive MRSA screen commence decolonisation therapy within 24hrs of positive result.	
	All MRSA and MSSA BSIs will continue to be subject to an RCA/PIR. All actions and recommendations agreed will be implemented by the divisions	Completed RCA/PIR process with evidence of implemented actions..
	• To produce and implement an Aseptic non touch technique (ANTT) policy	ANTT policy. Audited compliance against ANTT policy>95%
	• To ensure all intravenous lines are managed appropriately in line with policy.	Audited compliance >95%
	• Vascular access team (VAT) to be established	Established VAT.
Management of Healthcare Associated Infection (HCAI) 2) MSSA blood stream infection. Currently there is no national guidance for rate reduction.	• On going surveillance of MSSA bacteraemia. • .	Process to identify all MSSA BSI
	• On going RCAs of MSSA with actions and arising recommendations implemented	Documentary evidence of MSSA BSI PIR with documented evidence of implemented actions.
Management of Healthcare Associated Infection (HCAI) 3) E.coli blood stream infection Currently there is no national guidance for rate reduction.	• On-going surveillance of all post 48 hour cases will include a review to ascertain the source of infection.	Monthly reports of E coli bacteraemia cases
	• If device related, an PIR to be carried out and arising recommendations implemented.	PIR process for all identified E coli bacteraemia cases associated with catheters/ invasive devices.

Management of Healthcare Associated Infection (HCAI) 4) Clostridium difficile Externally set ceiling for cases of Clostridium difficile for 2015/16 is 11.	The Trust will continue surveillance and reporting of all cases of C. difficile infections. An RCA/PIR will continue to be held for any infections identified and any actions and recommendations implemented.	Completed RCA/PIR process with evidence of implemented actions. *C. difficile* infection ceiling of 11 not exceeded.
Management of Healthcare Associated Infection (HCAI) 5) Antimicrobial stewardship.	Implementation of the National strategy "Start smart, then focus". Annual audit of compliance with antibiotic policy and monitor. Trust antimicrobial forum (TAF) meets quarterly. Quarterly reports to TIPC.	Audited compliance> 95%
Management of Healthcare Associated Infection. (HCAI) 6) Carbapenemase producing organisms (CPO)	Surveillance for potential CRE to be continued. Ensure screening for CRE is carried out in compliance with the trust policy and PHE guidance. Ensure any patients identified with a CRE are managed in compliance with the trust policy and PHE guidance. Audit screening compliance against the policy.	Audited screening results >95%.
Management of Healthcare Associated Infection 8) Surgical site infection surveillance (SSI).	The trust will continue surveying orthopaedic surgical site infection (SSI) utilising the national surgical site surveillance scheme.. Work with the SSI group led by the Clinical director –orthopaedics to implement compliance with NICE QS49. SSI group to produce action plan and monitor.	Quarterly reports of SSI data. Documentary evidence of quality improvement. Minutes of the SSI group. Audit against NICE guidance.
Prevention of infection. 1) Line safety and management	Surveillance of central line associated blood stream infections will be undertaken and reported monthly	Central Line associated blood stream infection surveillance reports.
	All policies and supporting guidance and tools relating to vascular access will be updated and reviewed as required.	Reports of Staff competency
	Vascular access team to be established.	Established vascular access team

	The Trust will define the competency process for vascular devices and the structure and processes will be in place.	Defines system and process for ensuring competency for vascular devices.
	Vascular access practice subject to 1) High Impact Intervention audits conducted twice a month; and 2) IPC annual audits.	Audited scores >95%
Prevention of infection. 2) Aseptic Non Touch Technique (ANTT)	IPC Team will audit aseptic technique practice as part of the annual IPC audits. Competency process to be reviewed to provide assurance that all clinical employees are assessed as competent in the process..	Audit >95% Evidence of competency.
Prevention of infection 3) Hand Hygiene	To continue audits of hand hygiene compliance twice a month and report via meridian. These are reported to the Divisional Boards. IPC audit as part of the annual IPC audit programme of facilities and practice. To produce a hand hygiene strategy encompassing facilities, education and training and audit process. To incorporate a plan to ensure appropriate use of gloves in clinical practice. IPC to liaise with Estates to prioritise provision of hand hygiene sinks.	Audit of hand hygiene facilities >95% Audit of hand hygiene practice >90%
Prevention of Infection 4) Catheter associated urinary tract infections (CAUTI)	IP&C will continue reporting prevalence of cauti as part of the safety thermometer data. See actions above related to Management of Healthcare Associated Infection (HCAI) 3) E.coli blood stream infection To work with urology nurse specialists to reduce urethral catheter usage by appropriate assessment of patients. IPC audit of urethral catheter management	CAUTI reduction target of 25% achieved.

Criteria 2 - Provide and maintain a clean and appropriate environment in managed premises which facilitates the prevention and control of infections.	IP&C will continue to ensure that there is expert infection control input into environmental monitoring systems and implementation of national standards for cleanliness IP&C will continue to collaborate with the estates and facilities Directorate to provide expertise in the development of written policies and standard operating procedures. Estates and facilities will continue to have the responsibility, to have in place the relevant planned Preventative maintenance programmes and will work with IP&C to ensure appropriate expert input. IP&C will provide expert clinical advice to the Water Safety Group. The operational management will be the responsibility of the end users and overseen by estates and facilities. The Trust Decontamination lead, will ensure that the decontamination committee meets at least 4 times per year.	Documented evidence of IPC input into Estates Project.
Criteria 3 - Provide suitable accurate information on infections to service users and visitors	Ensure that the IP&C Annual Report is made available as a public document. The Trust will publish and make publically available the annual quality accounts The Trust will continue to undertake a rolling programme of policy review. This will also take into consideration changes to national policy and guidance. The policy review matrix will be a standing agenda item at the TIPCC. IP&C will continue to work with Complaints, Legal Dept, Comms team and FOI officer to provide timely, accurate and comprehensive information regarding press enquiries, FOI requests and patient concerns/complaints. The Trust will use input from local patient and public experience for continuous quality improvement to minimise harm from HCAI's The IP&C team will review the patient experience survey to identify areas for improvement. IP&C data will be made publically available on all ward IP&C notice boards. Patients and visitors will have access IP&C information leaflets in all wards and departments	Trust website. Board Reports Patient information leaflets.

Criteria 4 - Provide suitable accurate information on infections to any person concerned with providing further support or nursing/medical care in a timely fashion **Criteria 5 - Ensure that people who have or develop an infection are identified promptly and receive the appropriate treatment and care to reduce risk of passing on infection to other people**	The IP&C team will utilise their IT surveillance system to identify areas across the Trust that may require targeted support. The IP&C team will continue to work with clinical teams in the investigation all MRSA and MSSA BSIs, and C. difficile infections and will continue to identify any themes or learning for the clinical teams. All appropriate policies and programme of education will be made available to support the management of patients with infections. IP&C will continue to review all identified patients and environment during clinical rounds and ward visits providing support, guidance and information.	Documented advice. Information for alert organisms.
Criteria 6 - Ensure that all staff employed to provide care in all settings are fully involved in the process of preventing and controlling infections	Refer to criteria 1 - HCAI governance structure is designed to involve representatives of all relevant disciplines.	
	Bi monthly hand hygiene audits will be undertaken by all clinical areas, the results will be reported monthly to the Trust and Divisions and made publically available. Ward teams will continue to audit clinical practices as identified in the 'Saving Lives' campaign on a bi-monthly basis. Results of audits and any actions taken will be reported by the Divisions	
	An annual programme of audit will be developed and undertaken by the IP&C team which will encompass both environmental and clinical practices. Feedback of recommendations required as a result of the audits will follow an appropriate process to ensure relevant necessary action is taken.	Audit reports
	An annual programme of education will be made available to all relevant staff.	Vital training records

Criteria 7 - Provide or secure adequate isolation facilities	Links to Criteria 2, regarding new building/refurbishment programmes. The Trust's corporate risk register will highlight the low ratio of isolation capacity as risk to appropriately managing patients with infections.	Documented isolation reports
Criteria 8 - Secure adequate access to laboratory support	Ensure that standard operating procedures are up to date. To ensure appropriate and timely microbiology information to be available to clinicians and the IPC team.	
Criteria 9 - Have and adhere to appropriate policies and protocols for the prevention and control of infection	Review and update where necessary the policies/guidance, listed in policy review matrix. All policies will be developed and updated in accordance with national guidelines and local need. They will be written in accordance with evidence based practice guidelines. IPC annual programme of audits.	IPC policies
Criteria 10 - Ensure, so far as is reasonably practicable, that care workers are free of and are protected from exposure to infections that can be caught at work and that all staff are suitably educated in the prevention and control of infection associated with health and social care Policy.	The Trust provides an occupational health service ensuring advice, guidance and policies are available to minimise exposure to infections. Appropriate vaccinations are given to identified staff in line with DH guidance and risk assessments for staff are undertaken. The Trust will continue to provide a workforce that is informed and aware of their responsibilities regarding the prevention and control of infection by: • Ensuring all staff are provided with appropriate information at induction The divisions will ensure all staff attend their VITAL update on the prevention and control of infection. All staff will have infection prevention and control activities reflected in their job description and updated through their performance development review. IP&C will initiate training needs analysis in those areas identified as hot spots and provide input and support as necessary. IP&C will review the Link Practitioner system ensuring effectiveness clarifying roles and responsibilities with clinical teams. Participate in joint initiatives involving IP&C teams across the healthcare community as well as contribute to national and international events.	Vital training records

East and North Hertfordshire NHS
NHS Trust

Agenda Item: 10.02

TRUST BOARD PART I – 27 JULY 2016

NURSING AND MIDWIFERY ESTABLISHMENT REVIEW

PURPOSE	To provide the Board the bi annual review report for ward establishments for April 2016
PREVIOUSLY CONSIDERED BY	Previously considered by the Nursing and Midwifery Executive Committee (NMEC) Executive Committee and Ward Sisters and Matrons Committee and RAQC
Objective(s) to which issue relates *	☑ 1. **Keeping our promises about quality and value** – embedding the changes resulting from delivery of Our Changing Hospitals Programme. ☐ 2. **Developing new services and ways of working** – delivered through working with our partner organisations ☐ **3. Delivering a positive and proactive approach to the redevelopment of the Mount Vernon Cancer Centre.**
Risk Issues(Quality, safety, financial, HR, legal issues, equality issues)	Poor quality patient experience Impact on safety Impact upon annual assessment ratings Non-compliance with regulatory and legislative requirements Trust reputation
Healthcare/ National Policy (includes CQC/Monitor)	CQC standards, NHSLA standards, NICE Guidance Safe Staffing for nursing in adult in patient wards in acute hospitals (2014). NICE Guidance Safe midwifery staffing for maternity settings (2015). National Quality Board – How to ensure the right people, with the right skills, are in the right place at the right time. (2013)
CRR/Board Assurance Framework * * tick applicable box	☑ **Corporate Risk Register** ☐ **BAF**

ACTION REQUIRED *

For approval	x	For decision	☐
For discussion	☐	For information	☐

DIRECTOR:	Director of Nursing and Patient Experience / DIPC
PRESENTED BY:	Director of Nursing and Patient Experience / DIPC
AUTHOR:	Director of Nursing and Patient Experience
DATE:	July 2016

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

East and North Hertfordshire NHS
NHS Trust

Nursing and Midwifery Establishment Review

April 2016

1. Executive Summary

The data collection for the nursing and midwifery establishment review was undertaken in April 2016. Actual staffing data was reviewed over a 20 day period along with patient acuity data and benchmarking data from other Trusts. Recommendations from the NICE guidelines for safe staffing in adult inpatient wards in acute hospitals (2014), in relation to staffing ratios and skill mix have also been taken into consideration.

The review recommends some changes to nursing and midwifery establishments and supports the Trust's existing approach of flexibly managing staffing levels and the national initiative to implement the Band 4 Nursing Associate role. The Trust is currently mapping the bands 2-4 workforce, to understand who we have, where our talent is and how we develop our staff. The Trust is bidding to be a pilot site for the Nursing Associate role with stakeholders across Hertfordshire and West Essex.

Summary of recommendations:

- Increase 10B unregistered day coverage from 5+3 to 5+4 on the early and from 4+3 to 4+4 on the late; this is a cost increase of £49,770.

- Increase 11A band 2 CSW night coverage from 5+1 to 5+2 on the night; this is a cost increase of £74,952.

- Convert 1 band 5 RN Post to a band 4 Nursing Associate role on 24 wards (Excluding NICU, Maternity, ICU, and Bluebell) @ a potential annual cost saving of £130,359. This is part of a scoping exercise over the next two years to enable wards to introduce the new Nursing Associate Role and develop clear career pathways.

Based on the current assumptions the cost of 11A and 10B additional staffing (£123,722) will be offset by the year 1 and 2 savings of the band 4 conversion (£132,580.24), generating a cost saving of £7,858.24 per year over the next 2 years.

2. Introduction

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

The Nursing and Midwifery Council (NMC) sets out nurses responsibilities in relation to safe staffing levels. Demonstrating safe staffing is one of the six essential standards that all health care providers must meet to comply with Care Quality Commission (CQC) regulation. This is also incorporated within the NICE guidelines 'Safe Staffing for nursing in adult inpatient wards in acute hospitals' (2014). The NHS England guidance 'A Guide to Care Contact Hours' (2014) recommends inclusion of contact time by nursing staff in the establishment reviews. This is referred to as 'care hours per patient day' (CHPPD).

The evidence suggests that appropriate staffing levels and skill mix influences patient outcomes, all of which align to the Trusts priorities for 2016:

- Improved mortality.
- Reducing 30 day readmissions.
- Reducing failure to rescue.
- Reducing pressure ulcer incidence.
- Reducing adverse incidents, particularly related to medication errors and patient falls.

- Reducing the length of stay for specific identified conditions, such as myocardial infarction and stroke.
- Improving patient experience.

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

3. Purpose

This is the seventh nursing and midwifery establishment review undertaken by the current Director of Nursing.

This establishment review was under taken for a number of reasons including:-

- The need to provide assurance both internally and externally that ward establishments are safe, that staff are able to provide appropriate levels of care to patients and levels of care that reflect the Trust values and the 6 C's contained within the national Nursing Strategy (2016).

- To provide establishment data that will inform the Trust Workforce Strategy and People Strategy 2014-19.

- To conform to Care Quality Commission requirements under the Essential Standards of Quality and Safety, including outcomes 13 (staffing) and 14 (supporting staff).

- To support the implementation of the Trust's annual and strategic objectives, the Nursing and Midwifery Ambitions and Patient and Carer Experience Strategy.

4. Summary of key actions implemented following previous establishment review

Since the establishment reviews commenced in 2012 over £5million has been invested in the nursing and midwifery establishments. Some investments have been as a result of direct recommendations from previous establishment reviews and others the result of approved business cases. A summary of key establishment uplift can be seen in **Appendix 1.**

5. Establishment Review methodology

See Appendix 2

6. Current Assumptions - Skill Mix and Nurse to Bed Ratio

The Royal College of nursing (RCN) recommends that there is a minimum 60:40 ratio of registered to unregistered nursing staff. The trust agreed ratios are:- 60:40 for Medicine and 65:35 in Surgery, the current average registered to unregistered staff ratio for Medicine is 62:38 and in Surgery is 63:37. Children's ratios are age and acuity dependent i.e. for under 2's the ratio is 1:3 and over 2 years 1:4.

All wards have a planned registered nurse to patient ratio of no more than 8 patients to one registered nurse during the day and night in line with national recommendations and dependant on speciality. The target and actual skills mix available can be seen in **Appendix 3 – Table 1.** The number of registered and unregistered nurses along with registered nurse to bed ratio for each inpatient ward can be seen in **Appendix 3 -Table 2.**

The staff to bed ratio indicates the total number of registered nurses required to care for a specific number of patients, this will vary according to the type of ward, acuity and patient, location/ward layout, activity and patient flow.

7. Data Triangulation

7.1 Care Hours Per Patient Day (CHPPD) Benchmark

The review of NHS productivity, chaired by Lord Carter, is part of an overall NHS plan to regain £5 billion in efficiencies. To provide a single consistent way of recording and reporting deployment of staff working on inpatient wards, Lord Carter's team developed and adopted Care Hours per Patient Day (CHPPD). CHPPD can be used to describe both the staff required and staff available in relation to the number of patients. It is calculated by adding the hours of registered nurses to the hours of healthcare support workers and dividing the total by the number of inpatients at 23:59 hours.

CHPPD should not be used in isolation and should be used alongside triangulated data which includes skill mix, nurse to bed ratio, Safer Nursing Care tool and the professional judgement model.

At ENHT CHPPD has been used in triangulation with other methods to set the establishment since 2012. The CHPPD methodology used by the Trust is based on the Western Australia model which differs from the Carter methodology as it defines all patient activity over a 24 hour period thus providing a more meaningful measure, than the midnight inpatient count.

Care Hours per Patient Day includes:

Direct patient care
- all hands-on care (for example assistance with eating and drinking, patient hygiene, administering medication, taking clinical observations)
- providing one-to-one observation or support to patients (for example, taking them too or from theatre)
- all direct communication with patients

Indirect patient care time :
- patient documentation
- professional discussions to plan patient care
- discharge planning
- communication with patients relatives and friends
- ordering investigations
- shift handovers

Cost of Care Hours per Patient Day

The CHPPD Trust target by ward is set at a bed occupancy of 95%. If the occupancy is higher than the CHPPD will increase. Table 1 below demonstrates that during April in the division of surgery the costs per patient day were more than the allocated budget but less than the actual budget required to meet the demand, whilst in the other 3 divisions the cost of care hours per patient day was less than the budgeted allocation.

The table below shows the, budgeted, required and actual cost of a care hour per patient day by division.

Table 1.

Division	Average Service Required CHPPD April 2016	Average Service Actual Required CHPPD April 2016 SafeCare	Average Service Actual CHPPD April 2016 SafeCare	Average Budget cost per care hour	Required cost per care hour based Average on actual patients	Actual Cost per Average Care hour	Variance of reOuired vs Actual cost of care hours
Medicine	5.76	7.13	6.73	£ 675.54	£ 586.19	£ 556.41	£ 89.35
Surgery (Excluding Critical Care)	5.76	5.88	5.86	£ 498.43	£ 539.92	£ 527.90	-£ 41.50
Women's and Children's	6.80	7.36	8.40	£ 488.51	£ 336.17	£ 390.01	£ 152.34
Cancer	7.00	6.41	8.04	£ 382.51	£ 293.67	£ 363.28	£ 88.84

A Full breakdown of Cost of Care Hours Per Patient Day by ward can be seen in **Appendix 3 table 5.**

7.2 Safer Nursing Care Tool (SNCT)

Safecare has been used for the second time to provide the safer nursing care data for the establishment review. Table 2 shows the total funded operational WTE compared to the total actual worked WTE for each Division, this is then compared to the SNCT recommended WTE. The CHPPD benchmarking data for each ward is compared to the SCNT data in **Appendix 4**.

A comparison of the funded establishment and SNCT recommended establishment shows that funded staffing for ward areas are relatively in line within Medicine and Surgery and is over the recommended WTE in Women's and Children's and Cancer. This is due to other factors such as extra clinics, ward attenders and other outpatient services these areas provide. Ward 10B and 11A were both highlighted as being short on CHPPD - see **Appendix 4.** This is consistent with the other data collected as part of this establishment review. A summary of the overall findings of the establishment review can be seen in the recommendation section at the end of the report.

7.2.1 Safer Nursing Care Tool and Safecare

The Shelford Safer Nursing Care tool is an evidence based tool developed to help NHS hospitals measure patient acuity and dependency to inform evidence-based decision making on staffing and workforce. Acuity/dependency is measured on all inpatient wards three times a day and recorded on Safecare. SafeCare has now been implemented on all inpatient wards.

This live information informs the senior nurses that wards are staffed safely throughout the day and night shifts, and highlights any red flag events that require escalation. When using this tool other variables should also be taken into consideration:

- Clinical model
- Labour market
- Staff capacity, capability, seniority and confidence
- Organisational support and support roles
- Ward manager supervisory time

In order to test some of outcomes from the SNCT data results the following actions were implemented:

- Inter-rater reliability- To ensure that the SNCT data is valid, inter-rater reliability exercises have been undertaken with the nursing teams to ensure consistent data collection
- Matron Acuity Audits- Throughout the Data collection period Matrons audited their wards on a weekly basis to ensure valid data collection. Any discrepancies in the acuity data were picked up with the ward manager.
- Implementation of revised acuity tool for elderly care- Elderly care are now using the Shelford SNCT for Acute Elderly Care which is more appropriate for their patient type. We have found that this tool works well for 9A and 9B and is showing consistent information.
- External benchmarking with other organisations- We have benchmarked our establishments with three similar size acute NHS trusts - see **Appendix 5.** The data shows that we are generally in line with their establishments.

7.1 Nursing and Midwifery Quality Indicators

The Trust uses readily available information and statistical tools to examine indicators of care. The indicators are; pressure ulcers, complaints, patient falls, drug administration errors, C-difficile rates, MRSA rates.
To allow comparisons to be made, the base information is adjusted for bed nights and a statistical tool highlights wards whose indicators are higher than anticipated. Whilst not necessarily indicating a problem or issue, any indicator triggering above the upper confidence interval is subject to detailed analysis and an action plan developed. This raises awareness of the quality of care to the reduction of risks - see **Appendix 6**

7.2 Red Triggered Shifts

The Trust reports red triggered shifts on a daily and monthly basis. **Appendix 7** shows the percentage of shifts that fell below minimum levels during the establishment review. Mitigating action is taken by the senior nurses on call for the division each day.

Factors affecting red triggering shifts:
- Temporary Staffing Fill
- Vacancy Rate
- Sickness
- Specialling requirements
- Opening of surge capacity areas
- National strategy for agency reduction restricted the use of cap non-compliant agencies

The pattern of red triggered shifts has been used to triangulate the recommendation to cover days on 10B and nights on 11A with additional CSW support.

8 Maternity Services

A review of midwifery staffing is being out and a separate business case will submitted when available.

9 Emergency Department

An external independent review is currently being undertaken and a separate report will be submitted when available.

10 NICU

Neonatal staffing is based on nationally recognised tools (BAPM standards) and are currently within accepted standards. BAPM standards are based on 80% occupancy and three dependency levels. Level one relates to the neonates requiring intensive care and requires one nurse per patient, level two requires one nurse per two patients and level 3 requires one nurse per four patients.

11 Summary of Recommendations for Executive Approval

The SNCT requirements were in line with current establishments; this review has demonstrated there is a reasonable coverage of nurse to patient ratio of 1:6 to 1:8 for adult in patient wards. In addition all other triangulated data would suggest most inpatient wards are suitably established for the activity, dependency and occupancy of patients. The data does suggest that there are two wards that would benefit from an increase in staffing, these are summarised below:

- **Clinical Support Worker uplift for a long day on 10B**

A recommendation is that 10B has an uplift of 1 CSW on a long day due to high acuity and dependency needs on the ward. CHPPD benchmarking, SNCT and Safecare have all shown 10B to

have lower budgeted WTE than is required. Safecare has highlighted the early and late shifts are consistently short of care hours based on actual patient acuity and dependency on the ward. The ward has a number of patients requiring enhanced nursing care that is currently covered by temporary staff the majority of which will be agency CSWs with the additional associated costs. The data suggests that the acuity and dependency of patients on 10B has increased over the last 12 months, these patients can no longer be managed within the current establishment. The nursing and midwifery quality indicators and red triggered shifts data support the identified uplift. To support the safe management of patients with the increased acuity the ward is currently using temporary staff to support this increased need, for the month of April this cost £5,625.78 compared to a £4,147.50 is these hours had been worked substantively.

2.54 WTE - Increase 10B unregistered day coverage to 5+4 on the early and 4+4 on the late; this is a cost increase of £49,770.

- **Unregistered uplift for a night shift on 11A**

A recommendation is that 11A has an uplift of 1 unregistered member of staff on a night shift. CHPPD benchmarking, SNCT and Safecare have all shown 11A to have lower budgeted WTE than is required. Safecare has highlighted the night shifts are consistently short of care hours based on actual patient acuity and dependency on the ward. The service nature of the respiratory support unit means that 11A has a number of level 2 high dependency patients, increasing the required CHPPD. In addition respiratory patients require an escort to and from radiology; this is often out of hours depleting the nursing workforce on the ward. The data suggests that the acuity and dependency of patients on 11A has increased over the last 12 months, particularly at night, these patients can no longer be managed within the current establishment. The nursing and midwifery quality indicator and red triggered shifts data support the identified uplift. To support the safe management of patients with the increased acuity the ward is currently using temporary staff, for the month of April this cost £6,909.44 compared to a £6,246.00 if these hours had been worked substantively.

2.95 WTE - Increase 11A unregistered night coverage to 5+2 on the night; this is a cost increase of £74,952.

- **A Scoping Exercise developing band , 3 and 4 support/ associate Nursing roles**

Since the publication of the Francis Inquiry many Trusts have increased their nursing establishment, and this coupled with national reductions in pre-registration nursing intakes, has led nationally to a general shortage in the number of nurses available to recruit. As a Trust we need to look at new ways of working and 'growing our own' to ensure we can continue to give quality value care to our patients.

Commitment 8 of 'Leading Change Adding Value' states "We will seek to widen access and develop new roles and more flexible routes to graduate education". Developing a successful workforce depends on providing the necessary motivation, skills, behaviours and opportunities, as set out in the 2015 review by Lord Willis, 'Raising the bar - Shape of caring; a review of the future education and training of registered nurses and care support workers'. The Trust recognises the importance of building up the future workforce, through talent spotting, making the education, learning and training of staff a priority to drive new ways of working across organisational and professional boundaries. The Trust supports the differing needs of older and younger staff and ensure all caring roles are fulfilling and ones in which staff are supported, have a positive experience and want to stay in our organisation.

The Scoping Exercise is:

- Convert a band 5 post to a band 4 post on 24 inpatient wards from October 1st 2016
- Implement Talent for Care (A Framework from NHS England)
- Ensure robust training and competencies are embedded for the band 4 role in line with the national framework.
- This model once fully implemented would generate a potential saving of £130,359 per year.

Table 2 below highlights indicative saving for the band 4 conversion program and is based on the following assumptions:

- The off-site training for the band 3 will be covered by a substantive or bank band 2 CSW
- This will be for 1 day per week for 30 weeks of the year
- The backfilled shift will be a 11.25 hour long day.

Table 2

First 2 Year	WTE	Band 5 Cost	Band 3 Cost	Band 2 Back fill cost	Cost Saving Per Annum
24 WTE Reduction of band 5 Paid as Band 3 CSWs	24	£ 777,762.00	£ 558,065.09	£ 87,116.67	-£ 132,580.24
Total Saving over 2 years					-£ 265,160.48
Ongoing	**WTE**	**Band 5 Cost**	**Band 4**	**Cost Saving**	
24 WTE Reduction of band 5 Paid as Band 4 CSWs	24	£ 777,762.00	£ 647,222.69	-£ 130,539.31	

The table suggests indicative cost saving that will be fully established during the scoping exercise. Further work will be carried out during scoping to establish the potential unitisation of the band 4 roles. Costs will be confirmed when the national guidance is available, the above indicative savings are based on a 2 year training programme and with 1 day per week band 2 bank back fill for training for 30 weeks per year.

12 Next Steps

- Continue to undertake acuity and dependency reviews to measure against seasonal changes.
- Continue to benchmark with other Trusts
- Monthly Matron auditing of acuity/dependency on all wards using Safecare
- Implement 'The Talent For Care' Toolkit
- Develop the band 3 and 4 roles on all wards in line with national guidance
- Evaluate the implementation of the Enhanced Care Team (Specialling)
- External review of the Emergency Department non-medical staffing.

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

Appendices

Appendix 1

Establishment Review Summary

Year	WTE	Speciality	Costs
Establishment Review - 2012	13.52	Medicine	£473,200.00
Establishment Review - 2013	18.61	Medicine and surgery	£485,324.00
Establishment Review - Feb 2014	19.78	Medicine and surgery	£991,984.00
Establishment Review - Oct 2014	Increase in Band 7 supervisory to 3 days a week	All in patient ward managers	£550,000.00
Establishment Review October 2015	Increase night coverage to 4+2 for all tower block wards 10.16 WTE over 4 wards Additional CSW on Bluebell for the day Reduction in Mount Vernon Establishment based on Activity	Paediatrics Medicine Surgery	£201,093.00
Total	51.91		£2,701,601.00

Establishment Changes as a result of business cases

Year	WTE	Speciality	Costs
Emergency Department Business Case	Full external review of both Children's and Adult Accident & Emergency departments resulted in an additional £1.5million increase the nursing establishment and skill mix, this was requirement was phased in with full implementation in October 2015.	Emergency Department	£1,500,000.00
24/7 Matron Business Case	3	Matron	£155,962.00
Interim Establishment Changes 2015/16	Swift ward funded for 7 day opening Introduction of Enhanced dementia support team introduced Escalation ward (7AN opened for winter pressures 8B Bed Capacity increase	Corporate Nursing Medicine Surgery	£961,223.00
Total			£2,617,185.00
Total Additional Budget			£5,318,786.00

Appendix 2

Methodology

The Safer Nursing Care Tool methodology recommends that key patient, staffing and flow information is collected over a 20 day period.
The following information was also collected and reviewed; a review of all relevant literature and guidelines was undertaken prior to commencement of this review, these included:

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

As part of this review the information was collected and reviewed. This data was then used to inform the recommendations.

- Comparison of current establishment review data with previous reviews to identify changes or trends
- Service or speciality provided, this includes identify any geographical or layout changes undertaken during the last six months.
- Patient number and acuity for each ward for a continuous 20 day period.
- An in-depth review of actual staffing levels (both temporary and substantively employed) over the same 20 days period.
- An exercise benchmarking key metrics with three other Trusts namely:
    - Burton NHS Foundation Trust
    - Bedford NHS Trust
    - The Ipswich Hospital NHS Trust
- Number of inpatient beds
- Ward Speciality
- Funded WTE
- The registered to unregistered nursing skill mix was assessed against national guidelines.
- The registered nurse to bed ratio for each shift was assessed against national guidelines.
- Target care hours per patient day (CHPPD) was used to calculate appropriate staffing required.
- The Safer Nursing Care tool (SNCT) was used to calculate the appropriate staffing required.
- Incidents of red triggering shifts, indicating when wards fall below acceptable staffing levels for the patients on the ward
- Current staffing shortfalls for each ward
- Current levels of specialling required for each ward
- Analysis of the current applied headroom compared to actual staff unavailability
- A review of nursing and midwifery quality indicators, this includes reviewing falls, hospital acquired pressure ulcers and 'harm events' as per national guidelines.
- Other clinical factors including a review of serious incidents, Datix incidents and complaints for which staffing could have an impact.

Appendix 3

Table 1

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

Div	Speciality	Ward	Trust Recomended Registered Nurse %	Trust Recomended Unregistered Nurse %	Actual Registered Nurse %	Actual Unregistered Nurse %
Medicine	Care of the Elderly	9B	60.00	40.00	44.86	55.14
		Ashwell	60.00	40.00	52.31	47.69
		9A	60.00	40.00	51.90	48.10
	Stroke	Pirton	65.00	35.00	63.33	36.67
	Stroke	Barley	60.00	40.00	51.77	48.23
	General	6A	60.00	40.00	61.01	38.99
	General	10B	60.00	40.00	55.66	44.34
	Respiratory	11A	75.00	25.00	70.37	29.63
		7AN	70.00	30.00	64.84	35.16
	Cardiology	ACU	60.00	40.00	67.42	32.58
	Acute	AMU Ward	60.00	40.00	56.97	43.03
		SSU	60.00	40.00	60.99	39.01
	Renal	6B	60.00	40.00	64.40	35.60
Surgery	General	8A	65.00	35.00	61.74	38.26
		8B	65.00	35.00	66.15	33.85
	Surgical Spec	11B *	65.00	35.00	64.94	35.06
		7B	65.00	35.00	62.03	37.97
	T&O	5A	65.00	35.00	61.10	38.90
		Swift	65.00	35.00	45.80	54.20
		5B	65.00	35.00	53.55	46.45
	ATCC	Critical Care	90.00	10.00	94.20	5.80
W&C	Gynae	7A *	60.00	40.00	64.84	35.16
	Paeds	Bluebell	70.00	30.00	84.74	15.26
Cancer	Inpatient	Ward 10	70.00	30.00	77.12	22.88
		Ward 11	70.00	30.00	81.27	18.73
		Michael Sobell House	70.00	30.00	63.72	36.28

Table 2

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

Div	Speciality	Ward	Available Shifts (RN + Unreg)						RN to Bed Ratio		
			Early Reg	Early Unreg	Late Reg	Late Unreg	Night Reg	Night Unreg	Early	Late	Night
Medicine	Care of the Elderly	9B	5 (4)	3	4	4	4	2	1/7	1/7	1/7
		Ashwell	5	4	4	3	3	2	1/5	1/6	1/8
		9A	5 (4)	3	4	4	4	2	1/6	1/7	1/7
	Stroke	Pirton	5	2	5	2	3	2	1/4	1/4	1/7
	Stroke	Barley	5	3	4	2	3	2	2/9	1/5	1/7
	General	6A	5	4	4	4	4	2	1/6	1/7	1/7
	General	10B	5	3	4	3	4	2	1/6	1/7	1/7
	Respiratory	11A	6	2	6	2	5	1	1/5	1/5	1/6
		7AN	3	1	3	1	2	1	1/5	1/5	1/7
	Cardiology	ACU	8	4	8	4	7	3	1/4	1/4	1/5
	Acute	AMU Ward	5	3	5	3	4	3	1/5	1/5	1/6
		SSU	5	3	4	3	4	2	1/6	1/7	1/7
	Renal	6B	6	4	5	4	3	2	1/4	1/5	1/8
Surgery	General	8A	5 (4)	3	4	3	4	2	1/6	1/7	1/7
		8B	5	3	4	3	4	1	1/6	1/7	1/7
	Surgical Spec	11B *	3	2	3	2	2	1	1/5	1/5	1/7
		7B	5	3	4	3	4	1	1/6	1/7	1/7
	T&O	5A	5	4	5	2	4	1	1/6	1/6	1/8
		Swift	5	3	4	3	3	2	1/5	1/6	1/8
		5B	5	4	4	3	4	2	1/6	1/7	1/7
	ATCC	Critical Care**	19	2	19	2	17	1	1	1	6/7
W&C	Gynae	7A *	3	2	3	2	2	1	1/5	1/5	1/8
	Paeds	Bluebell	5	2	5	1	5	0	1/4	1/4	1/4
Cancer	Inpatient	Ward 10	4	2	4	2	3	0	1/6	1/6	1/8
		Ward 11	4	2	4	2	3	0	1/5	1/5	1/7
		Michael Sobell House	4	2	2	2	2	1	1/4	1/8	1/8

Table 3

The table below shows the current funded and actual staffing for the last 3 years, this includes vacancies and variance from the reported position in April 2015

Div	Speciality	Ward	Funded establishment (WTE)			Actual Staff in Post (WTE as of 01/11/2015)			Current vacancies			
			April 2015	Oct 2015	April 2016	April 2015	Oct 2015	April 2016	April 2015	Oct 2015	April 2016	Variance
Medicine	Care of the Elderly	9B	35.12	35.12	35.2	22.64	26.12	25.40	-12.48	-9.00	-9.80	-0.80
		Ashwell	31.65	31.31	31.2	25.62	29.28	28.60	-6.03	-2.03	-2.60	-0.57
		9A	35.12	35.12	35.2	31.9	26.12	27.5	-3.22	-9.00	-7.70	1.30
	Stroke	Pirton	30.11	30.2	30.2	25.87	25.5	19.8	-4.24	-4.70	-10.40	-5.70
	Stroke	Barley	30.84	30.84	30.9	20.66	19.96	15	-10.18	-10.88	-15.90	-5.02
	General	6A	34.49	34.11	36.6	27.45	27.96	24.01	-7.04	-6.15	-12.59	-6.44
	General	10B	31.19	31.65	34.1	28.01	29.21	25.5	-3.18	-2.44	-8.60	-6.16
	Respiratory	11A	35.12	35.02	35.1	29.6	28.7	27.7	-5.52	-6.32	-7.40	-1.08
		7AN			17.8			9.6			-8.20	-8.20
	Cardiology	ACU	54.68	54.68	54.7	43.49	48.03	47.8	-11.19	-6.65	-6.90	-0.25
	Acute	AMU Ward	36.87	36.87	36.7	30.78	31.13	26.4	-6.09	-5.74	-10.30	-4.56
		SSU	34.11	34.11	34.1	28	28.7	28.8	-6.11	-5.41	-5.30	0.11
	Renal	6B	36.24	35.52	35.5	34.47	35.02	34.7	-1.77	-0.50	-0.80	-0.30
Surgery	General	8A	31.56	31.56	34.1	26.04	23.71	25	-2.22	-5.52	-7.85	-2.33
		8B	25.29	32.31	32.1	26.13	21.16	20.8	1.19	0.84	-11.15	-11.99
	Surgical Spec	11B *	27.99	27.43	28.8	24.31	20.79	23	0.68	-3.68	-6.64	-2.96
		7B	31.19	31.19	31.2	29.54	28.63	27	-4.45	-1.65	-2.56	-0.91
	T&O	5A	33.53	33.76	33.9	28.7	30.16	27.3	-3.41	-4.83	-3.60	1.23
		Swift	24.17	27.44	27.7	23.78	24.43	22.3	-6.22	-0.39	-3.01	-2.62
		5B	33.25	33.25	35.7	30.42	31.08	24.7	-4.09	-2.83	-2.17	0.66
	ATCC	Critical Care	105.4	110.39	102.2	95.8	79.98	86	-9.79	-9.60	-30.41	-20.81
W&C	Gynae	7A *	34.98	36.6	37.8	30.24	31.94	33.6	-4.74	-4.66	-4.20	0.46
	Paeds	Bluebell	26.5	26.47	31.8	25.18	28.79	23.70	-1.32	2.32	-8.10	-10.42
Cancer	Inpatient	Ward 10	27.14	27.14	26.1	25.79	25.99	20.5	-1.35	-1.15	-5.60	-4.45
		Ward 11	24.85	22.54	25.70	22.4	21.4	19.8	-2.45	-1.14	-5.90	-4.76
		Michael Sobell House	26.54	22.81	22.8	24.8	23.8	25.3	-1.74	0.99	2.50	1.51

Table 4

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

Div	Speciality	Ward	Bed Occupancy % April 2016	Recommended SNCT recruitable WTE based on occupancy	Recruitable Establishment Oct 2015	Variance from actual funded WTE
Medicine	Care of the Elderly	9B	97.7%	32.23	35.2	2.97
		Ashwell	111.9%	37.67	31.2	-6.47
		9A	98.3%	37.84	35.2	-2.64
	Stroke	Pirton	77.5%	23.02	30.2	7.18
	Stroke	Barley	96.6%	30.44	30.9	0.46
	General	6A	95.5%	35.05	36.6	1.55
	General	10B	96.8%	38.33	34.1	-4.23
	Respiratory	11A	98.4%	40.45	35.1	-5.35
		7AN	94.3%	16.34	17.8	1.46
	Cardiology	ACU	103.5%	42.08	54.7	12.62
	Acute	AMU Ward	93.5%	31.67	36.7	5.03
		SSU	92.1%	34.88	34.1	-0.78
	Renal	6B	102.7%	31.88	35.5	3.62
Surgery	General	8A	94.2%	33.80	34.1	0.30
		8B	91.7%	29.75	32.1	2.35
	Surgical Spec	11B *	86.7%	15.13	28.8	13.67
		7B	90.2%	29.22	31.2	1.98
	T&O	5A	94.5%	37.89	33.9	-3.99
		Swift	89.0%	23.93	27.7	3.77
		5B	86.2%	35.93	35.7	-0.23
	ATCC	Critical Care	84.8%	56.50	102.2	45.70
W&C	Gynae	7A *	90.6%	16.34	37.8	21.46
	Paeds	Bluebell	72.8%	19.45	31.8	12.35
Cancer	Inpatient	Ward 10	64.4%	16.58	26.1	9.52
		Ward 11	63.8%	14.75	25.70	10.95
		Michael Sobell House	67.2%	17.09	22.8	5.71

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

Table 5

The table below shows the cost of care hours per patient day (CCHPPD)

Div	Speciality	Ward	Service Required CHPPD April 2016	Service Actual Required CHPPD April 2016 SafeCare	Service Actual CHPPD April 2016 SafeCare	Budget cost per care hour	Required cost per care hour based on actual patients	Actual Cost per Care hour	Variance of required vs Actual cost of care hours
Medicine	Care of the Elderly	**Ward 9A Elderly Care**	5.5	6.86	6.18	£ 609.49	£ 689.56	£ 621.21	-£ 80.07
		Ashwell ward	5.5	7.59	6.23	£ 512.52	£ 637.02	£ 522.88	-£ 124.51
		Ward 9B Elderly Care	5.5	7.64	6.44	£ 579.94	£ 606.49	£ 511.23	-£ 26.54
	Stroke	**Pirton HASU**	6	8.46	7.82	£ 670.05	£ 428.58	£ 396.16	£ 241.46
	Stroke	**New Barley**	6	9.03	7.76	£ 626.92	£ 429.52	£ 369.11	£ 197.40
	General	**Ward 6A**	5.5	6.05	5.93	£ 769.52	£ 555.92	£ 544.89	£ 213.60
	General	**Ward 10B**	5.75	6.93	5.5	£ 588.97	£ 756.49	£ 600.39	-£ 167.52
	Respiratory	**Ward 11A Respiratory**	6	6.92	6.29	£ 583.41	£ 655.07	£ 595.44	-£ 71.67
		7A North Respiratory	5.5	6.32	6.11	£ 437.50	£ 321.75	£ 311.06	£ 115.76
	Cardiology	**Acute Cardiac Unit**	6.42	5.92	8.29	£ 932.18	£ 532.27	£ 745.35	£ 399.91
	Acute	**Acute Medical Unit**	5.75	7.77	8.42	£ 1,233.80	£ 819.40	£ 887.95	£ 414.40
		Short Stay Unit - SSU	5.75	6.78	6.15	£ 589.91	£ 582.82	£ 528.66	£ 7.09
	Renal	**Ward 6B**	5.75	6.46	6.39	£ 647.80	£ 605.52	£ 598.96	£ 42.28
Surgery	General	**Gen Surgery Ward 8A**	5.75	5.76	5.18	£ 522.19	£ 637.10	£ 572.95	-£ 114.91
		Gen Surgery Ward 8B	5.75	5.19	5.49	£ 521.76	£ 497.03	£ 525.76	£ 24.73
	Surgical Spec	**Ward 11B Plastics & ENT**	6.6	5.83	6.95	£ 339.92	£ 290.36	£ 346.14	£ 49.56
		Urology Ward 7BN	5.75	5.19	5.68	£ 529.78	£ 546.82	£ 598.44	-£ 17.04
	T&O	**T&O Ward 5A**	5.5	6.57	5.54	£ 523.32	£ 620.08	£ 522.87	-£ 96.76
		Swift Ward	5.5	4.97	6.08	£ 479.50	£ 436.83	£ 534.39	£ 42.67
		T&O Ward 5B	5.5	7.68	6.08	£ 572.52	£ 751.24	£ 594.73	-£ 178.72
	ATCC	**Critical Care Unit**	26	26	26	£ 419.90	£ 440.63	£ 440.63	-£ 20.73
W& C	Gynae	**Gynaecology Ward 7a**	6.6	4.74	7.77	£ 468.11	£ 233.75	£ 383.17	£ 234.36
	Paeds	**Children Bluebell Ward**	7	9.98	9.03	£ 508.91	£ 438.60	£ 396.85	£ 70.31
Cancer	Inpatient	**MV Ward 10**	6.75	5.52	6.35	£ 423.76	£ 414.37	£ 476.67	£ 9.40
		MV Ward 11	6.75	5.59	8.31	£ 405.45	£ 218.22	£ 324.40	£ 187.23
		MV M.S.H Inpatient Unit	7.5	8.13	9.45	£ 318.30	£ 248.42	£ 288.75	£ 69.88

Appendix 4

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

Div	Speciality	Ward	CHPPD Bench Marking Data			SNCT Recommended Data		
			Recommended CHPPD recruitable WTE based on occupancy	Recruitable Establishment April 2016	Variance form actual funded WTE	SNCT recommended WTE	Recruitable Establishment April 2016	Variance of operation establishment to SNCT recommended
Medicine	Care of the Elderly	**9B**	34.61	35.2	0.59	32.23	35.2	2.97
		Ashwell	31.71	31.2	-0.51	37.67	31.2	-6.47
		9A	34.82	35.2	0.38	37.84	35.2	-2.64
	Stroke	**Pirton**	19.96	30.2	10.24	23.02	30.2	7.18
	Stroke	**Barley**	27.37	30.9	3.53	30.44	30.9	0.46
	General	**6A**	33.83	36.6	2.77	35.05	36.6	1.55
	General	**10B**	35.85	34.1	-1.75	38.33	34.1	-4.23
	Respiratory	**11A**	36.75	35.1	-1.65	40.45	35.1	-5.35
		7AN	0.00	17.8	17.80	16.34	17.8	1.46
	Cardiology	**ACU**	48.50	54.7	6.20	42.08	54.7	12.62
	Acute	**AMU Ward**	27.70	36.7	9.00	31.67	36.7	5.03
		SSU	31.83	34.1	2.27	34.88	34.1	-0.78
	Renal	**6B**	30.42	35.5	5.08	31.88	35.5	3.62
Surgery	**General**	**8A**	34.88	34.1	-0.78	33.80	34.1	0.30
		8B	33.96	32.1	-1.86	29.75	32.1	2.35
	Surgical Spec	**11B ***	18.43	28.8	10.37	15.13	28.8	13.67
		7B	33.01	31.2	-1.81	29.22	31.2	1.98
	T&O	**5A**	33.47	33.9	0.43	37.89	33.9	-3.99
		Swift	26.27	27.7	1.43	23.93	27.7	3.77
		5B	30.53	35.7	5.17	35.93	35.7	-0.23
	ATCC	**Critical Care**	94.66	102.2	7.54	56.50	102.2	45.70
W&C	**Gynae**	**7A ***	20.54	37.8	17.26	16.34	37.8	21.46
	Paeds	**Bluebell**	21.88	31.8	9.92	19.45	31.8	12.35
Cancer	**Inpatient**	**Ward 10**	22.40	26.1	3.70	16.58	26.1	9.52
		Ward 11	18.49	25.70	7.21	14.75	25.70	10.95
		Michael Sobell House	17.31	22.8	5.49	17.09	22.8	5.71

Appendix 5

Div	Speciality	Ward	ENHT			Trust 1				Trust 2				Trust 3				Variances		
			Total Beds	Funded WTE	Staff to bed ratio	Service Description	Total Beds	Funded WTE	Staff to bed ratio	Service Description	Total Beds	Funded WTE	Staff to bed ratio	Service Description	Total Beds	Funded WTE	Staff to bed ratio	Trust 1	Trust 2	Trust 3
Medicine	Care of the Elderly	9B	30	35.2	1.17	Elderly care	27	30.69	1.14	Elderly Care	15	23.54	1.57	Elderly Care	28	38.27	1.37	0.04	-0.40	-0.19
		Ashwell	24	31.2	1.30	Rehabilitation	21	28.42	1.35	Elderly Care	25	33.55	1.34	SSU for older	28	35.45	1.27	-0.05	-0.04	0.03
		9A	30	35.2	1.17	Elderly care	27	30.69	1.14	Elderly care	23	33.55	1.46	Elderly care	28	38.17	1.36	0.04	-0.29	-0.19
	Stroke	Pirton	20	30.2	1.51	Stroke	27	43.40	1.61	Stroke	20	29.09	1.45	Stroke	28	36.06	1.29	-0.10	0.06	0.22
	Stroke	Barley	22	30.9	1.40									EC/Neuro rehab	28	37.05	1.32			0.08
	General	6A	30	36.6	1.22	Medicine/Haem	22	27.44	1.25	Medical	18	23.94	1.33					-0.03	-0.11	
	General	10B	30	34.1	1.14					Med/Gastro	26	34.02	1.31	Diabetes	24	29.16	1.22		-0.17	-0.08
	Respiratory	11A	29	35.1	1.21	Respiratory	31	44.67	1.44	Respiratory	30	39.06	1.30	Respiratory	28	38.75	1.38	-0.23	-0.09	-0.17
		7AN	14	17.8	1.27	Respiratory	31	44.67	1.44									-0.17		
	Cardiology	ACU	34	54.7	1.61	coronary care	10	17.66	1.77	CCU	16	21.52	1.35	Cardiac Ward	24	34.96	1.46	-0.16	0.26	0.15
	Acute	AMU Ward	24	36.7	1.53					AAUnit 25+3 trolleys	28	42.9	1.53	EAU	21	57.68	2.75		-0.00	-1.22
		SSU	28	34.1	1.22	SSU	32	40.33	1.26					SSU	28	34.96	1.25	-0.04		-0.03
	Renal	6B	24	35.5	1.48															
Surgery	General	8A	30	34.1	1.14	Surgery	26	30.43	1.17	Surg/Trauma	32	35.04	1.10	surg/gastro	28	31.04	1.11	-0.03	0.04	0.03
		8B	30	32.1	1.07					Surg/Vascular	29	35.63	1.23	surg/SAU	40	54.34	1.36		-0.16	-0.29
	Surgical Spec	11B *	15	28.8	1.92	surgery	12	22.66	1.88									0.04		
		7B	30	31.2	1.04									surgical	28	27.74	0.99			0.05
	T&O	5A	30	33.9	1.13	Orthopaedics	25	24.97	1.00	T+O Surg/Breast	27	30.14	1.12	T+O	28	28.29	1.01	0.13	0.01	0.12
		Swift	25	27.7	1.11									T+O	28	25.46	0.91			0.20
		5B	30	35.7	1.19	Trauma and orth	28	32.53	1.16	CofE+#NOF	24	32.99	1.37	#NOF	28	35.59	1.27	0.03	-0.18	-0.08
	ATCC	Critical Care**	20	102.2	5.11		9	62.85	6.98					critical care	12	60.48	5.04	-1.87		0.07
O&G	Gynae	7A *	16	37.8	2.36	Gynae	16	22.32	1.40	Gynae	11	11.51	1.05					0.97	1.32	
	Paeds	Bluebell	20	31.8	1.59		24	49.94	2.08					Child services	21	40.09	1.91	-0.49		-0.32
Cancer	Inpatient	Ward 10	24	26.1	1.09									Cancer ward	25	28.46	1.14			-0.05
		Ward 11	20	25.7	1.29															
		Michael Sobell House	16	22.8	1.43															

Appendix 6

NURSING & MIDWIFERY QUALITY INDICATORS: APRIL 2016

East and North Hertfordshire NHS Trust

All data is collated using nursing & midwifery establishment figures and inpatient wards only -RAG Rating for Patient Experience is Provisional

SUMMARY		Trust	Medicine	Surgery	Women & Children	Cancer	Dialysis Units
Beds	Total Beds	733	344	203	131	55	Not Applicable
	Bed occupancy % (at Midnight)	87.78%	95.29%	90.72%	74.27%	62.12%	Not Applicable
e-Rostering	% E-roster Deadline Met	82.55%	74.08%	95.75%	76.00%	100.00%	
	Net Hours %	-0.20%	-0.88%	-0.01%	-0.11%	-0.30%	
	Net Hours Position *	-608.55	-463.21	-33.96	39.17	-32.63	
	% of Actual Annual Leave	16.18%	15.65%	16.54%	15.37%	16.93%	
Staffing	Funded WTE *	2475.18	973.91	681.19	475.88	190.41	
	Actual WTE *	2064.82	746.21	575.44	435.09	171.04	
	Vacancy rate %	16.58%	23.38%	15.52%	8.57%	10.17%	
	RN Fill Rate (day shifts)*	98.33%	100.88%	98.00%	100.37%	96.80%	Not Applicable
	Sickness %	4.71%	4.87%	4.41%	5.59%	4.40%	
	Agency usage %	19.20%	23.00%	21.60%	9.60%	4.60%	7.54%
	Bank usage %	12.40%	12.70%	9.40%	11.70%	11.20%	13.36%
	Staff Appraised % (rolling 12 months)	75.51%	63.12%	82.06%	81.39%	78.26%	
	Missed Breaks *	213	44	18	95	3	Not Applicable
	Nursing Overtime						Not Applicable
	Statutory Mandatory Training all 9 Competency %	62.99%	57.11%	64.31%	63.28%	67.79%	
	Statutory Mandatory Training Overall Coverage %	87.79%	85.02%	88.38%	90.10%	86.85%	
	No of shifts where staffing initially triggered Red *	245	112	50	40	0	Not Applicable
	% Shifts Triggered Red in Month	7.79%	9.57%	6.94%	6.35%	0.00%	Not Applicable
LOS	No. Delayed Discharges *	34	25	9	0	0	Not Applicable
Patient Safety	No. Inpatient falls *	75	45	20	1	7	2
	No. Inpatient falls resulting in serious harm *	2	2	0	0	0	0
	No. of Hospital Acquired Pressure Ulcers *	4	3	0	0	1	Not Applicable
	% News Score Completion	94.00%	94.75%	89.43%	98.33%	93.50%	Not Applicable
	News Escalation *	95	90	95	100	94	Not Applicable
	No. Medication Reported errors *	89	25	24	13	19	0
	% Medication administered as prescribed	98%	100%	97%	98%	96%	Not Applicable
	% Analgesia administered as prescribed	93%	83%	98%	96%	97%	Not Applicable
	Intentional rounding completed*	97%	95%	95%	100%	99%	Not Applicable
	Safety Thermometer Patients with harm *	35	24	10	0	1	Not Applicable
	% of Compliance with Hand Hygiene	95.97%	96.07%	98.50%	99.60%	99.19%	97.65%
Patient Experience	% Response to Inpatient Survey	34.50%	40.50%	45.60%	25.70%	24.90%	Not Applicable
	Help to eat meals/Infant Feeding	89	93	90	90	83	Not Applicable
	Enough nurses on duty	80	75	71	81	91	Not Applicable
	Respond to call bell	72	74	64	73	78	Not Applicable
	Pain Control	92	94	90	87	96	Not Applicable
	Understand answers from nurses	91	92	87	94	94	Not Applicable
	Someone to talk to about worries and fears	83	83	75	73	89	93
	Enough emotional support from staff	86	87	82	82	94	Not Applicable
	Know named nurse	78	76	70	82	83	Not Applicable
	Inpatient FFT - % of patients would recommend	96.30%	95.90%	96.22%	95.88%	99.09%	Not Applicable
	Inpatient FFT - % of patients would not recommend	0.94%	1.69%	0.85%	0.00%	0.00%	Not Applicable
	FFT Response Rate %	42.90%	38.64%	48.02%	25.73%	34.27%	Not Applicable
	No.of Complaints *	32	8	9	2	0	0

Appendix 7

Month	10th - 29th April	Days in Month	20

The table below shows the % of shifts that fell below minimum staffing levels during the establishment review period.

Division	Speciality	Ward	INITIAL REDS						FINAL REDS				
			Total no. of shifts available	Early	Late	Night	Number of shifts where staffing initially fell below agreed levels	% of shifts where staffing fell below agreed levels and triggered a Red rating	Early	Late	Night	Number of shifts where staffing initially fell below agreed levels	% of shifts where staffing fell below agreed levels and triggered a Red rating
Medicine	Care of the Elderly	9A	60	4	5	0	9	15.00	0	2	0	2	3.33
		9B	60	0	0	0	0	0.00	0	0	0	0	0.00
	Stroke	Barley	60	1	0	0	1	1.67	0	0	0	0	0.00
		Pirton	60	3	7	1	11	18.33	0	1	1	2	3.33
	General	6A	60	6	2	0	8	13.33	0	0	0	0	0.00
		10B	60	6	5	2	13	21.67	0	0	1	1	1.67
	Respiratory	11A	60	0	3	1	4	6.67	0	0	0	0	0.00
		Escalation Ward	60	1	4	0	5	8.33	0	0	0	0	0.00
	Cardiology	ACU	60	0	1	0	1	1.67	0	0	0	0	0.00
	Acute	AMU-A	60	0	0	0	0	0.00	0	0	0	0	0.00
		SSU	60	1	3	1	5	8.33	0	0	0	0	0.00
		AMU-W	60	0	0	1	1	1.67	0	0	0	0	0.00
	Renal	6B	60	3	4	2	9	15.00	0	0	0	0	0.00
	DTOC / gastro	Ashwell	60	3	2	0	5	8.33	0	0	0	0	0.00
	ED	A&E	60	7	7	0	14	23.33	0	2	0	2	3.33
		UCC QEII	60	0	0	0	0	0.00	0	0	0	0	0.00
Total			**960**	**35**	**43**	**8**	**86**	**8.96**	**0**	**5**	**2**	**7**	**0.73**
Surgery	General	8A	60	2	0	2	4	6.67	0	0	1	1	1.67
		8B	60	3	0	1	4	6.67	0	0	0	0	0.00
		SAU	60	0	1	0	1	1.67	0	0	0	0	0.00
	Surgical Spec	11B	60	0	1	0	1	1.67	0	0	0	0	0.00
		7B	60	3	0	1	4	6.67	0	0	0	0	0.00
	T&O	5A	60	4	3	0	7	11.67	1	0	0	1	1.67
		5B	60	1	2	1	4	6.67	0	0	0	0	0.00
		Surgicentre Swift	60	3	4	1	8	13.33	0	0	0	0	0.00
	ATCC	Critical Care 1	60	0	0	0	0	0.00	0	0	0	0	0.00
		ASCU	60	0	0	0	0	0.00	0	0	0	0	0.00
Total			**600**	**16**	**11**	**6**	**33**	**5.50**	**1**	**0**	**1**	**2**	**0.33**
Women's & Children	Gynae	7A Gynae	60	0	1	1	2	3.33	0	0	0	0	0.00
	Paeds	Bluebell	60	4	4	2	10	16.67	0	1	1	2	3.33
		Child A&E	60	2	8	3	13	21.67	0	5	1	6	10.00
		NICU	60	5	6	1	12	20.00	0	0	0	0	0.00
	Maternity	Dacre	60	0	0	0	0	0.00	0	0	0	0	0.00
		Gloucester	60	1	0	0	1	1.67	0	0	0	0	0.00
		Mat MLU	60	1	0	0	1	1.67	0	0	0	0	0.00
		Mat CLU 1	60	0	0	0	0	0.00	0	0	0	0	0.00
Total			**480**	**13**	**19**	**7**	**39**	**8.13**	**0**	**6**	**2**	**8**	**1.67**
Cancer	Inpatient	Ward 10	60	0	0	0	0	0.00	0	0	0	0	0.00
		Ward 11	60	0	0	0	0	0.00	0	0	0	0	0.00
		Michael Sobell House	60	0	0	0	0	0.00	0	0	0	0	0.00
Total			**180**	**0**	**0**	**0**	**0**	**0.00**	**0**	**0**	**0**	**0**	**0.00**
		TRUST TOTAL	**2220**	**64**	**73**	**21**	**158**	**7.12**	**1**	**11**	**5**	**17**	**0.77**

DATA PACK

Contents

1. **Data & Exception Reports:**
   - FFT report
   - Health & Safety Indicators
   - Nursing Quality Indicators
2. **Performance Data:**
   - Performance Report
   - CQC Outcomes Summary
3. **Workforce Appendices**
4. **Risk and Quality Committee Reports:**
   - Safer Staffing
   - Infection Control Data

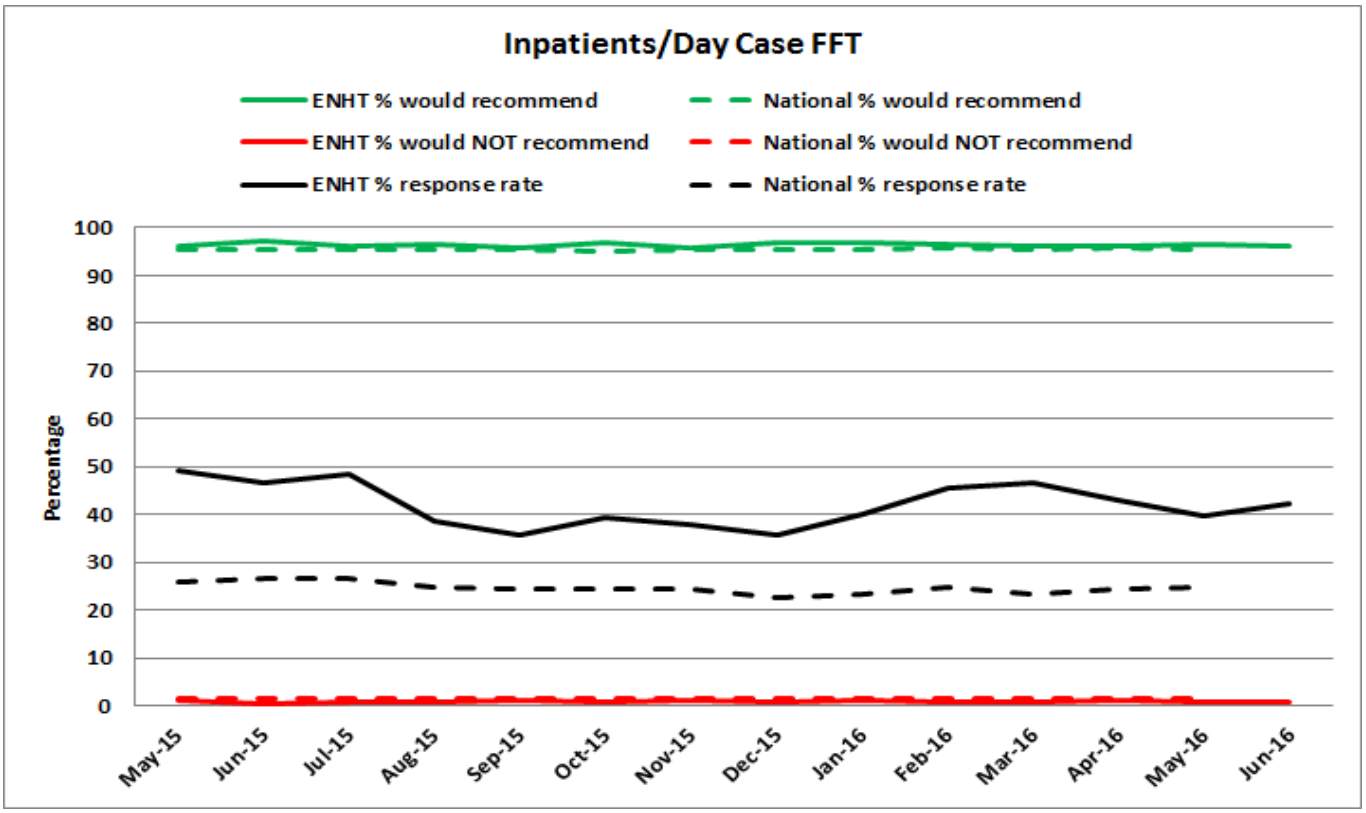
DATA & EXCEPTION REPORTS

Friends and Family Test
Health and Safety Indicators
Nursing Quality Indicators

Friends and Family Test

Inpatients & Day Case

	Would recommend		Would not recommend		Response rate	
	%	Compared to last quarter	%	Compared to last quarter	%	Compared to last quarter
Trust target	94% 2015-16 95% 2015-16				40% 2015-16 40% 2016-17	
Q1 Apr-Jun-15	96.40	↑	0.79	↓	43.96	↑
Q2 Jul-Sept-15	96.11	↓	0.78	↓	40.95	↓
Q3 Oct-Dec-15	96.50	↑	0.88	↑	37.64	↓
Q4 Jan-Mar-16	96.49	↓	0.84	↓	44.14	↑
Q1 Apr-Jun-16	96.32	↓	0.77	↓	41.61	↓



All staff I came into contact with within the department were very friendly. They explained everything clearly and made me feel at ease. If I had to attend another appointment I would feel in very safe hands.

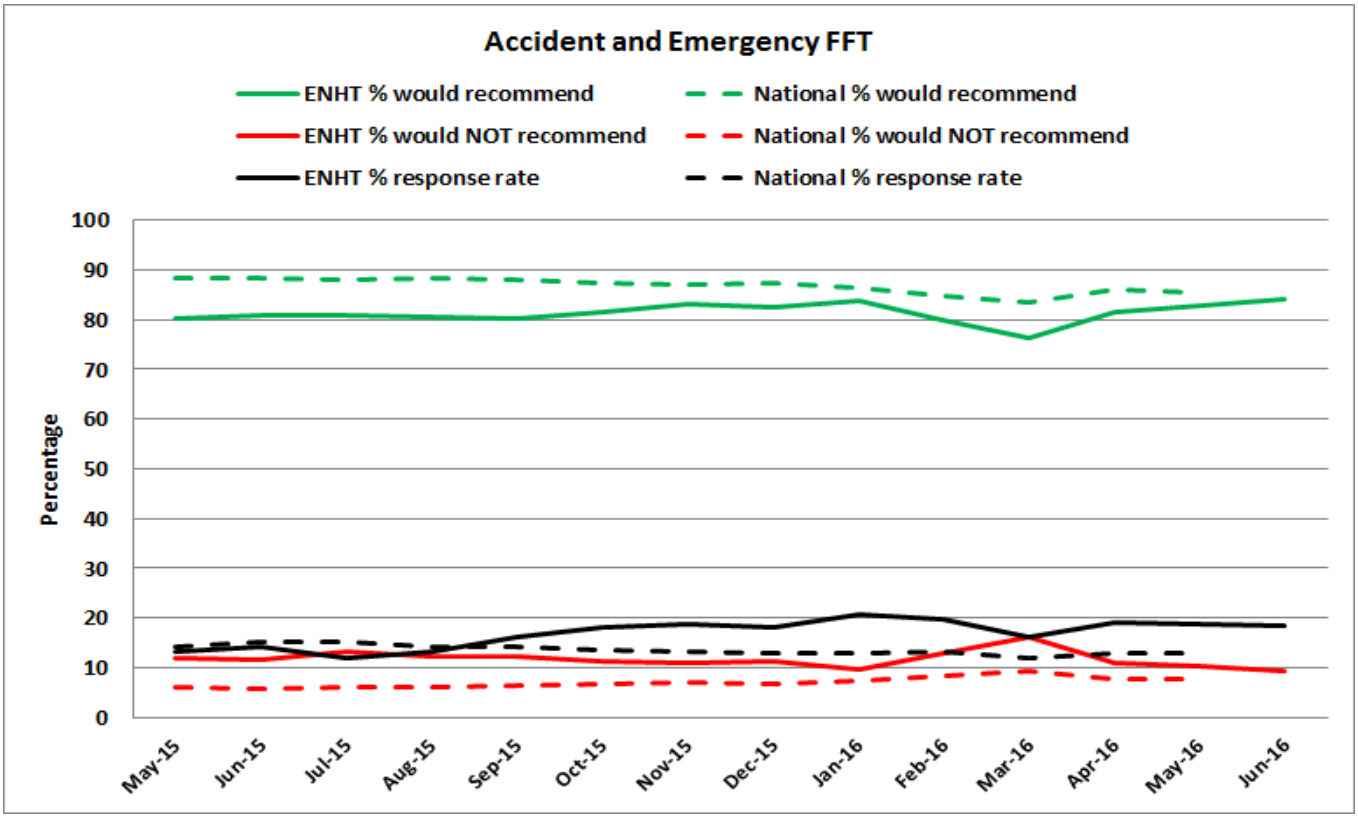
Endoscopy, Lister Jun-16

Some of the night staff did not talk to you as they were doing observations. Would like to have been updated more often about when I was likely to go home or at least what was causing delay. Staff talking loudly in the early hours of morning.

Ward 7AS Jun-16

Accident and Emergency

	Would recommend		Would not recommend		Response rate	
	%	Compared to last quarter	%	Compared to last quarter	%	Compared to last quarter
Trust target	78% 2015-16 80% 2016-17				19% 2015-16 15% 2016-17	
Q1 Apr-Jun-15	81.53	↓	10.89	↑	15.00	↓
Q2 Jul-Sept-15	80.40	↓	12.46	↑	13.69	↓
Q3 Oct-Dec-15	82.42	↑	11.09	↓	18.32	↑
Q4 Jan-Mar-16	80.17	↓	12.70	↑	18.74	↑
Q1 Apr-Jun-16	82.84	↑	10.15	↓	18.70	↓



Absolutely excellent. Have been treated there twice in the last 12 months, each time fantastic service and staff. I am a huge advocate. Both times in and out in less than an hour despite a full waiting room and the first time was after x-rays on a broken shoulder.

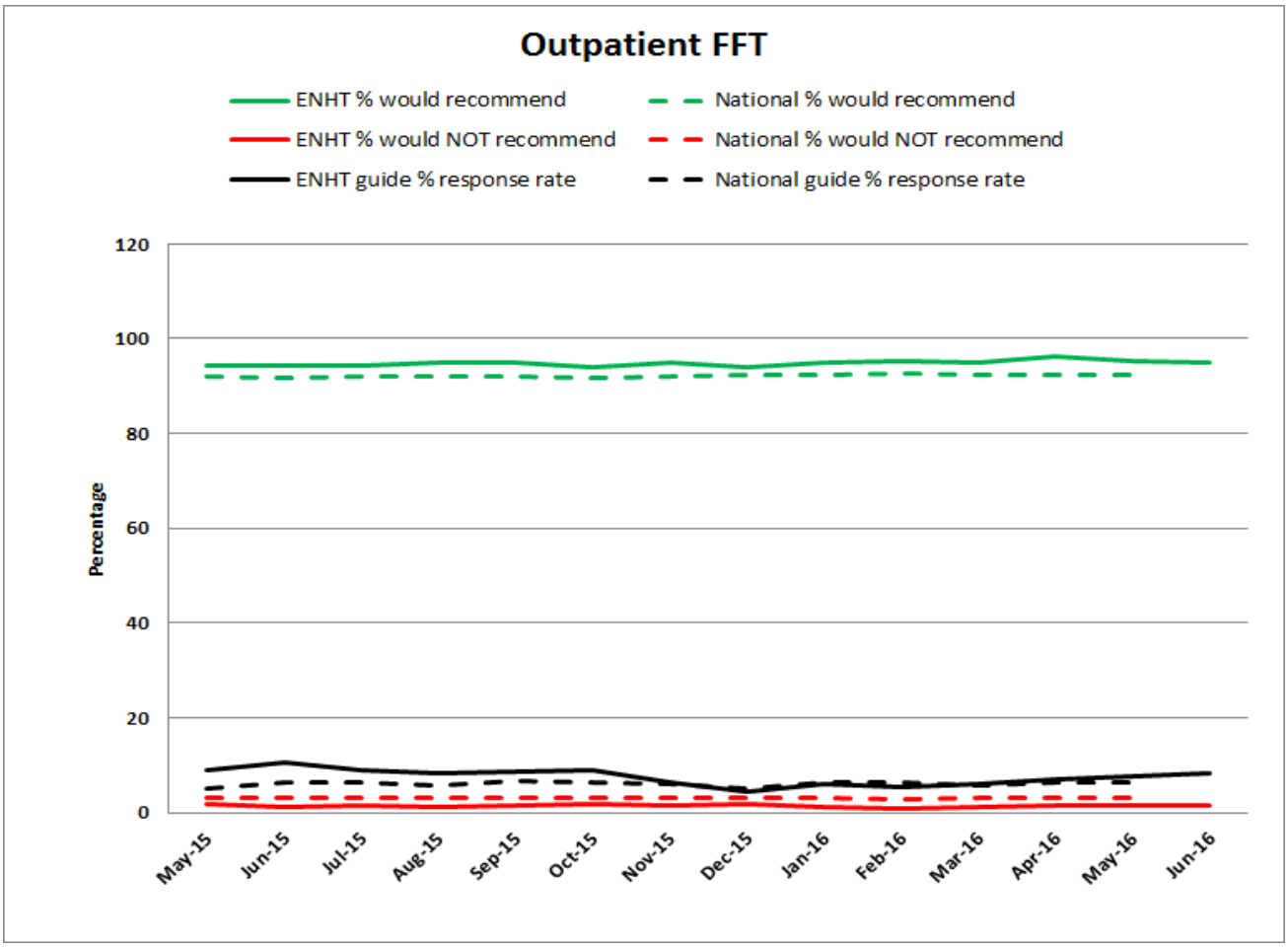
UCC, New QEII Jun-16

Department was not very clean, lots of cups on the floor, overflowing bins, filthy toilet brush, blood on floor. Were not kept very well informed about what was happening when. Would have been nice to have had one member of staff looking out for us and keeping us informed as to what would happen next instead of people passing by asking what we were waiting for and why we were still there?

ED, Lister Jun-16

Outpatient FFT:

	Would recommend		Would not recommend		Response rate	
	%	Compared to last quarter	%	Compared to last quarter	%	Compared to last quarter
Trust target	93% 2015-16 94% 2016-17					
Q1 Apr-Jun-15	94.27	↓	1.73	↑	8.54	↑
Q2 Jul-Sept-15	94.74	↑	1.35	↓	8.07	↓
Q3 Oct-Dec-15	94.30	↓	1.72	↑	6.50	↓
Q4 Jan-Mar-16	95.03	↑	1.04	↓	5.89	↓
Q1 Apr-Jun-16	95.44	↑	1.44	↑	7.64	↑



Note: Outpatient attendance data taken from the NHS England Quarterly Activity Return and presented as monthly average. This data is intended as a guide to the response rate.

Examples of comments from Outpatient FFT responses:

Everyone was very nice and I played with a robot called Robin. He likes it when you stroke his head. He always looks at the sugar so that means he is having a hypo.

Paediatrics, QEII Jun-16

Appointments are always running late, last week appointment was moved on the system 1 hour and 40 minutes and I was not informed, still late and beyond new time. Today 40 minutes late. Waited 3 hours to be called by dietician before giving up last week.

MVCC Radiotherapy Jun-16

Lovely people. I was impressed to get a phone call today co-ordinating my acupuncture with my new appointment. The acupuncture really helps the pain.

Pain, New QEII Jun-16

Was made to feel at ease. Nice surroundings and very pleasant staff – also answered any questions with ease. Was offered lunch which was nice and drinks. Also double checked with consultant that my dose was correct as they picked up that it was higher than normal which they put right.

Ambulatory Care, Lister Jun-16

I need to get treatment sooner as I am reliant on transport. This is very, very stressful. I have so far waited or 3 hours for my drug to appear on the ward – NOT acceptable.

Marie Curie, New QEII Jun-16

Doctor was extremely informative and thorough with the explanation and treatment of the patients respiratory problems.

Respiratory, HCH Jun-16

Need better signage on entrance and for disabled parking directing vehicles to it. More wheelchairs at entrance. Realistic appointment times, over 40 minutes late.

Gastroenterology, New QEII Jun-16

I felt a bit cold while I was sleeping, a cover would have been helpful.

Respiratory/Sleep Disorder, Lister Jun-16

Excellent care. All staff friendly and professional from receptionist to nurse specialist. Brilliant specialist – he listened and made me feel that he cared about my condition and acted correctly upon isues.

Rheumatology, Lister Jun-16

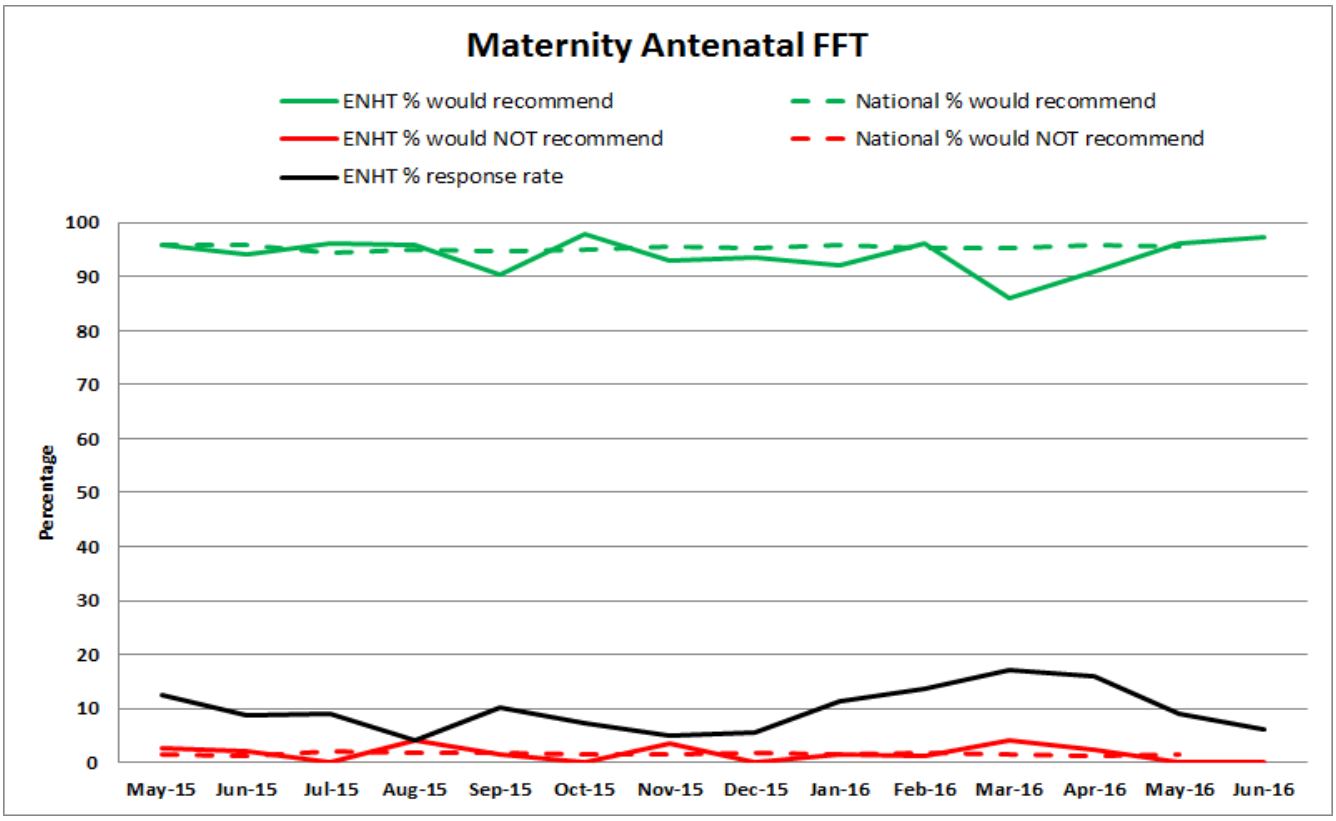
A missing letter from records so confusion as to what was happening really is worrying! 8.55am reception staff still not ready to book patients in.

Fracture Clinic, Lister Jun-16

Maternity : Antenatal, Birth, Postnatal and Community Midwifery

Antenatal

	Would recommend		Would not recommend	
	%	Compared to last quarter	%	Compared to last quarter
Trust target	93%			
Q1 Apr-Jun-15	94.09	↓	2.69	↑
Q2 Jul-Sept-15	93.57	↓	1.43	↓
Q3 Oct-Dec-15	95.24	↑	0.95	↓
Q4 Jan-Mar-16	90.83	↓	2.50	↑
Q1 Apr--Jun-16	93.79	↑	1.13	↓



Appointments were regular and easy to book, scans were easy to book, work-life was not interrupted as appointments could be booked at convenient times.

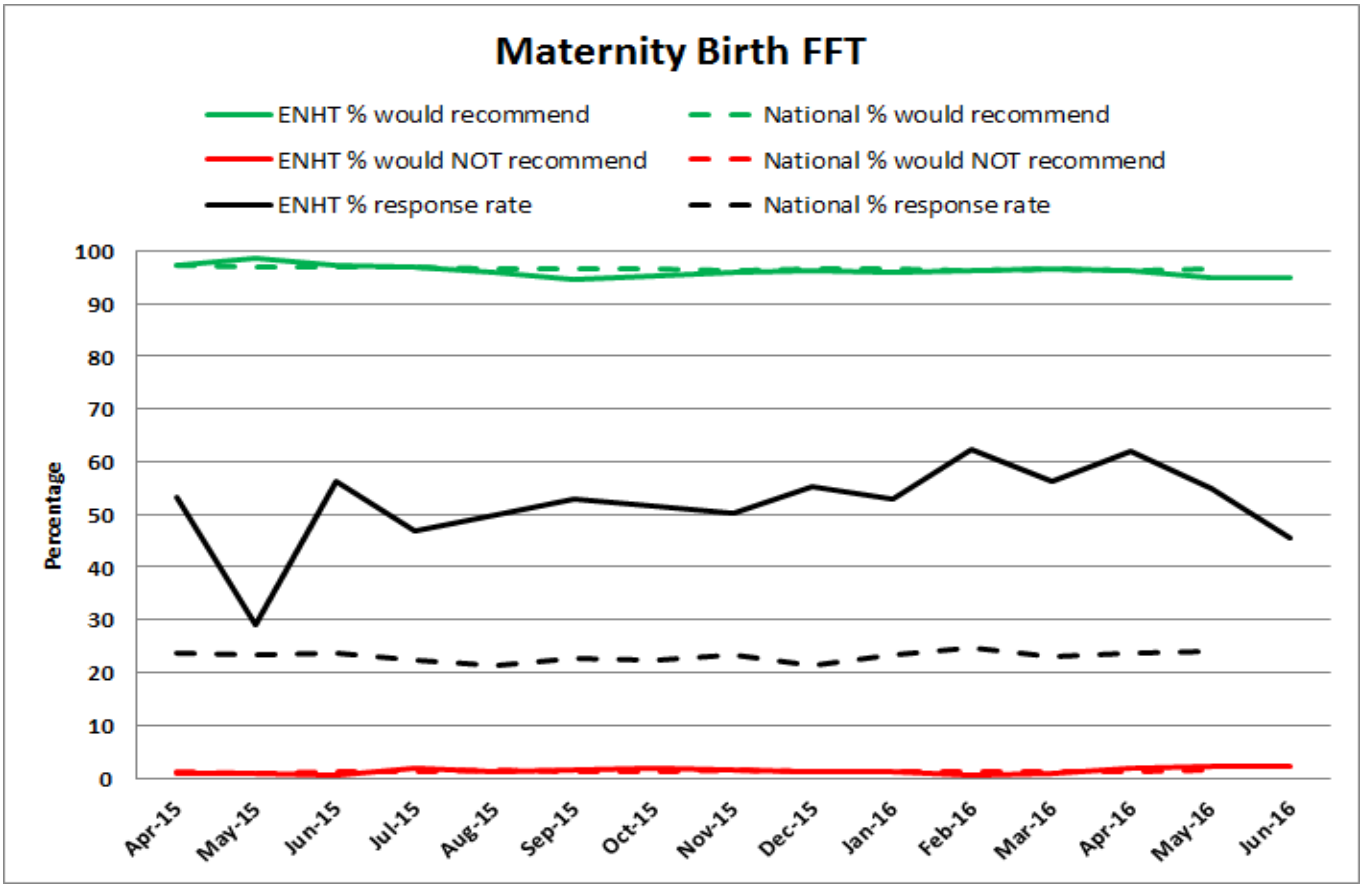
Antenatal Jun-16

I saw quite a few different midwives and they were all lovely but it would have been nice to see the same ones. Not much information given during scans, had to ask for it and being a first-time mum didn't know what to ask!

Antenatal Mar-16

Birth

	Would recommend		Would not recommend		Response rate	
	%	Compared to last quarter	%	Compared to last quarter	%	Compared to last quarter
Trust target	93%				30% combined 4 elements	
Q1 Apr-Jun-15	97.54	↑	0.61	↑	46.67	↓
Q2 Jul-Sept-15	95.77	↓	1.50	↑	49.90	↑
Q3 Oct-Dec-15	95.68	↓	1.57	↑	52.26	↑
Q4 Jan-Mar-16	96.27	↑	0.75	↓	57.06	↑
Q1 Apr-Jun-16	95.41	↓	2.10	↑	53.96	↓



Note: The response rate is reported nationally for the 'birth' element only.

I was confused and disappointed when sent home first time I came in. I was really struggling to cope at home and that was probably the hardest part of labour for me to cope with.

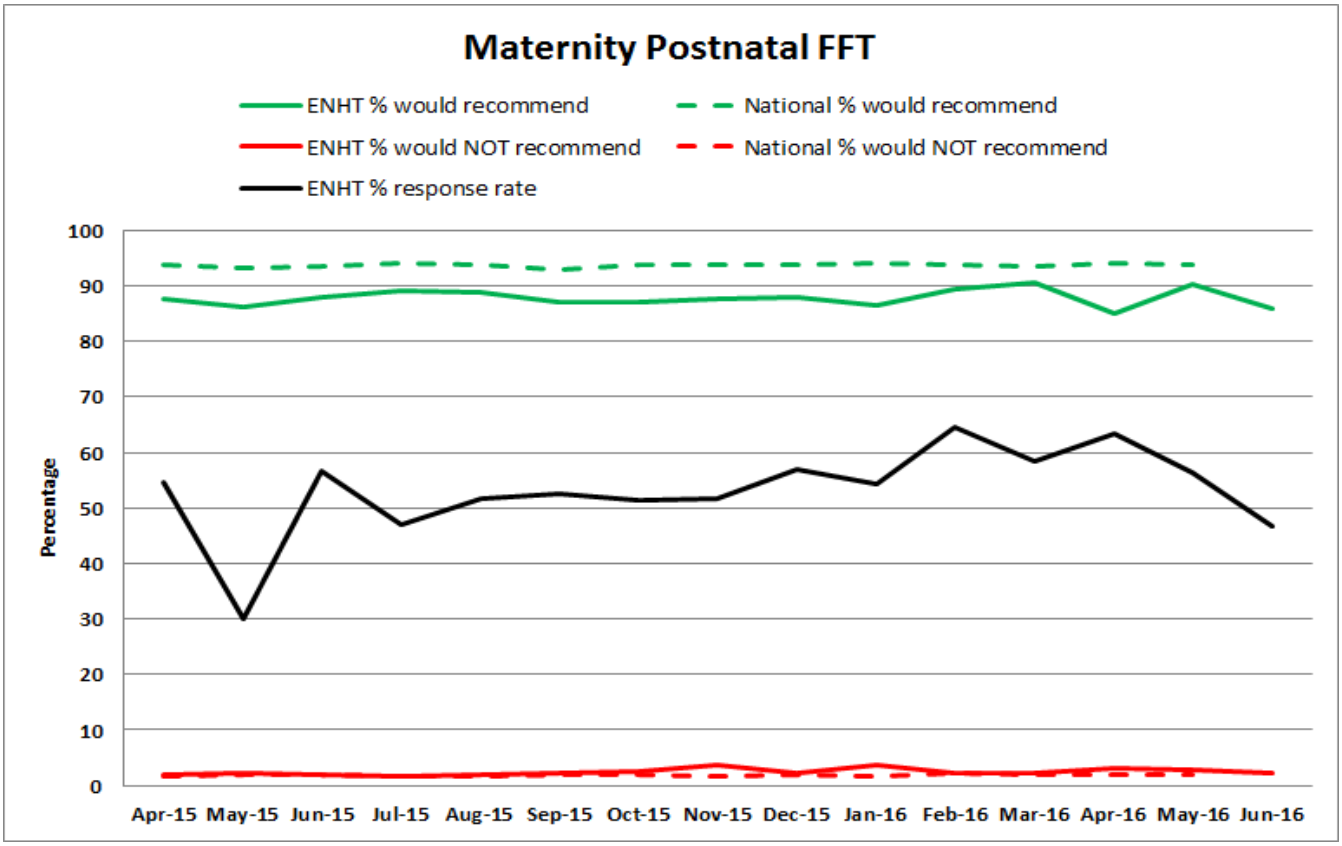
Midwife Led Unit, Jun-16

The midwives were fantastic, especially the midwife who delivered our baby who was AMAZING! She was very respectful of my birth plan, gave great advice at the right times during labour and technique to push/birth. Couldn't have done it without her.

Consultant Led Unit , Jun-16

Postnatal

	Would recommend		Would not recommend	
	%	Compared to last quarter	%	Compared to last quarter
Trust target	93%			
Q1 Apr-Jun-15	87.48	↓	2.01	↓
Q2 Jul-Sept-15	88.37	↑	2.05	↑
Q3 Oct-Dec-15	87.57	↓	2.88	↑
Q4 Jan-Mar-16	88.81	↑	2.61	↓
Q1 Apr-Jun-16	87.14	↓	2.76	↑



Transitional care meant I could be around my baby at all times, this gave me piece of mind and reassurance that baby and I were well taken care of.

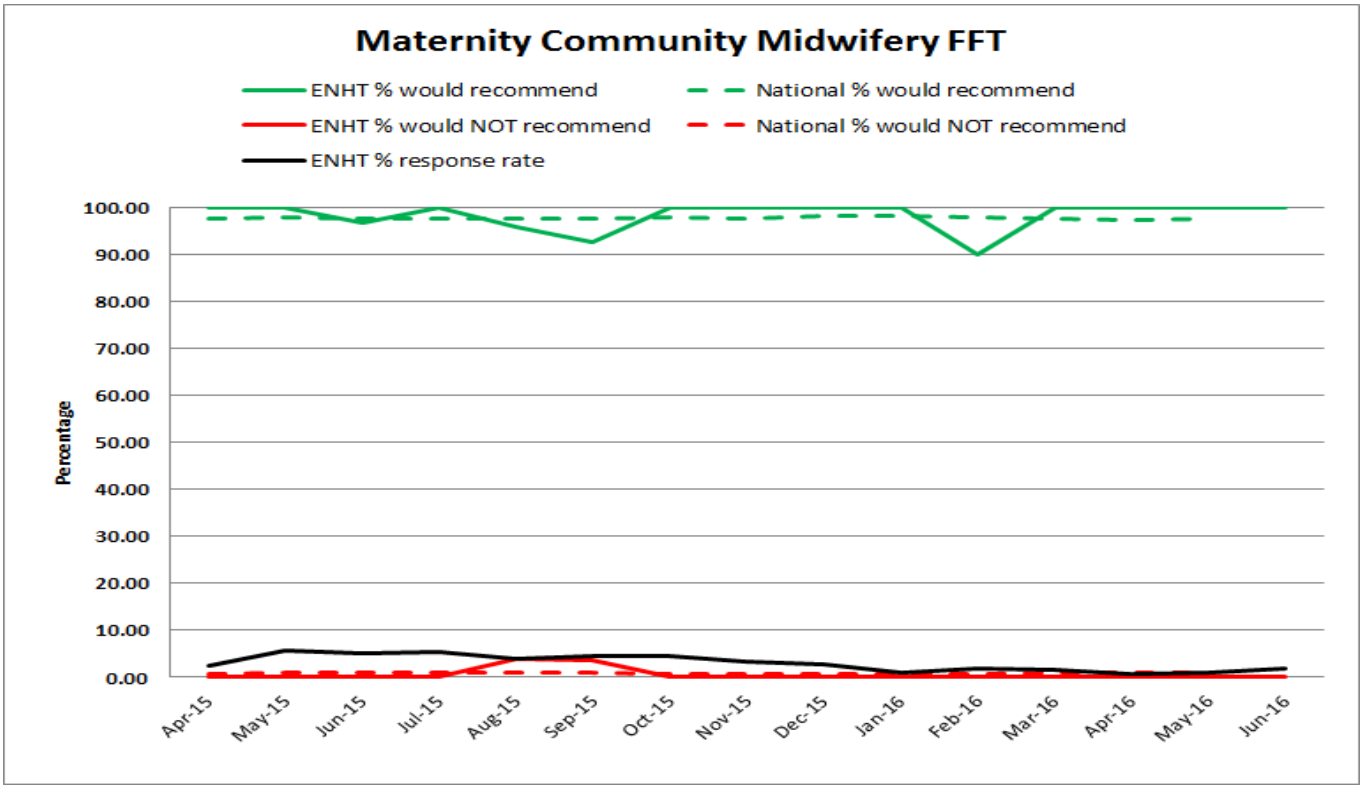
Consultant Led Unit , Jun-16

More communication on what happens when. Everyone is busy and doing a great job but no idea when can expect to return home.

Gloucester Ward, Jun-16

Community Midwifery

	Would recommend		Would not recommend	
	%	Compared to last quarter	%	Compared to last quarter
Trust target	93%			
Q1 Apr-Jun-15	98.72	↓	0	↔
Q2 Jul-Sept-15	96.47	↓	2.35	↑
Q3 Oct-Dec-15	100	↑	0	↓
Q4 Jan-Mar-16	96.0	↓	0	↔
Q1 Apr-Jun-16	100.00	↑	0	↔



Response rate for antenatal, birth, postnatal, community midwifery responses:

	Combined Response rate	
	%	Compared to last quarter
Trust target	30%	
Q1 Apr-Jun-15	24.85	↑
Q2 Jul-Sept-15	25.63	↑
Q3 Oct-Dec-15	26.24	↑
Q4 Jan-Mar-16	30.18	↓
Q1 Apr-Jun-16	27.72	↓

My experience of the midwives in training could have been better, one took my blood and really hurt me and the other couldn't answer some of my questions but I am sure that comes with experience I guess.

Community, Jun-16

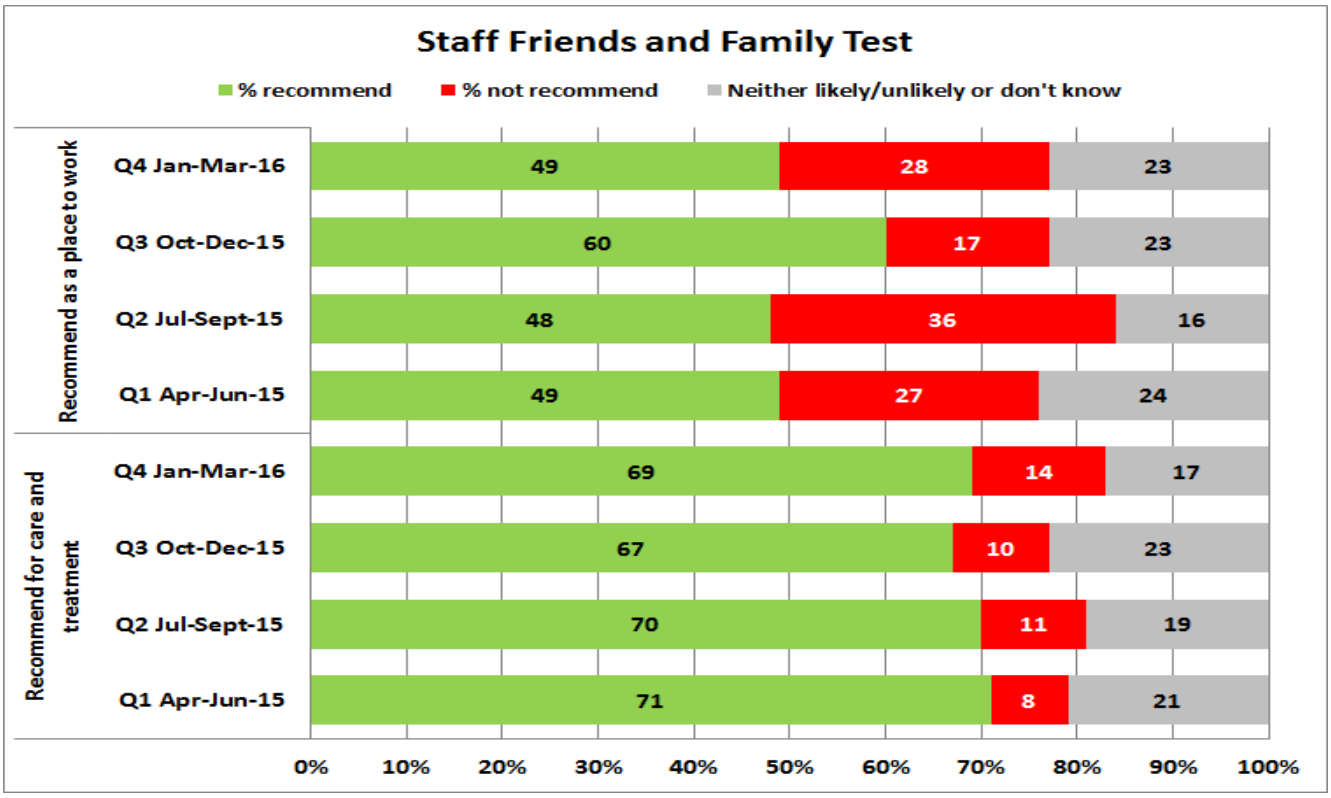
Number of patients responding to Friends and Family Test

	Inpatients/ Day Case	A&E	Outpatients	Maternity				TOTAL
				Antenatal	Birth	Postnatal	Community	
Q1 2015-16	5197	4483	8087	186	651	647	78	**19329**
Q2 2015-16	5140	4550	7794	140	732	731	85	**19172**
Q3 2015-16	4881	6449	6281	105	764	764	63	19307
Q4 2015-16	5705	6566	5755	240	804	804	25	19899
Q1 2016-17	5593	6562	7595	177	763	762	20	21472
Total	26516	28610	35512	848	3714	3708	271	99179

Breakdown of responses for Q1:

	Inpatients/ Day Case	A&E	Outpatients	Maternity				TOTAL
				Antenatal	Birth	Postnatal	Community	
Apr-16	1918	2100	2306	89	284	283	4	6984
May-16	1700	2338	2497	52	258	258	5	7108
Jun-16	1975	2124	2792	36	221	221	11	7380
Q1 TOTAL	**5593**	**6562**	**7595**	**177**	**763**	**762**	**20**	**21472**

Staff Friends and Family Test



Number of staff responding:

Q1 341/5,230 (6.5%)
Q2 314/5,332 (5.8%)
Q4 313/5,215 (6.0%)

In Q3 the FFT questions were included in the national staff survey sent to all staff; 1,700 staff responded.

NURSING & MIDWIFERY QUALITY INDICATORS: Jun-1

East and North Hertfordshire NHS
NHS Trust

All data is collated using nursing & midwifery establishment figures and inpatient wards only -RAG Rating for Patient Experience is Provisional

SUMMARY		Trust	Medicine	Surgery	Women & Children	Cancer
Beds	Total Beds	733	344	203	131	55
	Bed occupancy % (at Midnight)	85.13%	93.17%	86.45%	72.98%	58.91%
e-Roastering	% E-roster Deadline Met	87.57%	94.77%	95.75%	85.43%	77.33%
	Net Hours %	-0.46%	-0.15%	-0.93%	0.46%	-0.33%
	Net Hours Position *	-687	-94	-630	152	-27
	% of Actual Annual Leave	13.07%	11.86%	13.31%	12.41%	11.73%
Staffing	Funded WTE *	2480.44	975.31	682.21	476.08	191.03
	Actual WTE *	2054.39	739.83	579.71	429.89	164.87
	Vacancy rate %	17.18%	24.14%	15.02%	9.70%	13.69%
	RN Fill Rate (day shifts)*	96.80%	96.34%	93.94%	103.58%	98.40%
	Sickness %	5.09%	6.05%	4.33%	4.85%	5.16%
	Agency usage %	15.70%	19.30%	14.00%	8.80%	3.90%
	Bank usage %	12.40%	13.70%	9.50%	10.80%	7.40%
	Staff Appraised % (rolling 12 months)	78.30%	65.82%	82.89%	85.14%	84.15%
	Missed Breaks *	269	33	21	184	2
	Nursing Overtime	8.34	2.18	1.93	3.28	0.21
	Statutory Mandatory Training all 9 Competency %	74.26%	71.45%	75.43%	74.67%	76.54%
	Statutory Mandatory Training Overall Coverage %	89.01%	85.85%	89.70%	91.64%	90.80%
	No of shifts where staffing initially triggered Red *	180	76	35		0
	% Shifts Triggered Red in Month	6.30%	6.50%	4.86%	4.76%	0.00%
LOS	No. Delayed Discharges *	44	34	10	0	0
Patient Safety	No. Inpatient falls *	2.50	3.59	2.30	0.25	1.82
	No. Inpatient falls resulting in serious harm *	0	0	0	0	0
	No. of Hospital Acquired Pressure Ulcers *	0.14	0.19	0.16	0	0
	% News Score Completion	93.00%	94.77%	93.71%	85.00%	98.50%
	News Escalation *	93.00%	92.69%	92.23%	96.33%	100.00%
	No. Medication Reported errors *	80	28	26	7	16
	% Medication administered as prescribed	96%	96%	94%	100%	100%
	% Analgesia administered as prescribed	97%	96%	98%	83%	100%
	Intentional rounding completed*	96%	97%	95%	100%	100%
	Safety Thermometer Patients with harm *	20	14	4	0	2
	% of Compliance with Hand Hygiene	97.98%	94.43%	99.82%	100.00%	98.81%
Patient Experience	% Response to Inpatient Survey	35.84%	44.35%	49.59%	22.43%	28.01%
	Help to eat meals/Infant Feeding	91	90	88	89	98
	Enough nurses on duty	83	76	86	91	96
	Respond to call bell	72	69	74	88	90
	Pain Control	93	94	96	87	90
	Understand answers from nurses	91	89	94	94	98
	Someone to talk to about worries and fears	82	83	84	85	95
	Enough emotional support from staff	88	87	90	87	98
	Know named nurse	76	76	69	90	87
	Inpatient FFT - % of patients would recommend	96.30%	95.22%	96.75%	93.53%	100.00%
	Inpatient FFT - % of patients would not recommend	0.71%	0.92%	0.60%	1.44%	0.00%
	FFT Response Rate %	39.72%	39.87%	42.54%	28.44%	34.47%
	No.of Complaints *	85	25	28	13	6

NURSING & MIDWIFERY QUALITY INDICATORS: Jun-16

East and North Hertfordshire NHS
NHS Trust

CANCER		Ward 10	Ward 11	Michael Sobell House
Beds	**Total Beds** (Based on wards in this report)	21	18	16
	Bed occupancy % (at Midnight)	55.60%	58.00%	64.40%
e-Roastering	% E-roaster Deadline Met	66.00%	66.00%	100.00%
	Net Hours %	0.20%	-1.60%	0.40%
	Net Hours Position	5.50	-48.42	16.00
	% of Actual Annual Leave	11.80%	13.10%	10.30%
Staffing	Funded WTE	27.21	26.77	26.15
	Actual WTE	19.75	20.01	26.99
	Vacancy rate %	27.42%	25.25%	-3.21%
	RN Fill Rate (day shifts)	84.42%	100.41%	110.35%
	Sickness %	5.13%	5.00%	5.24%
	Agency usage %	8.10%	1.40%	1.80%
	Bank usage %	5.70%	7.80%	8.70%
	Staff Appraised % (rolling 12 months)	71.43%	82.35%	89.66%
	Missed Breaks	1.00	1.00	0.00
	Nursing Overtime	0.00	0.00	0.00
	Statutory Mandatory Training all 9 Competency %	75.86%	77.78%	80.00%
	Statutory Mandatory Training Overall Coverage %	91.67%	95.63%	93.49%
	No of shifts where staffing initially triggered Red	0.00%	0.00%	0.00%
	% Shifts Triggered Red in Month	0.00%	0.00%	0.00%
LOS	No. Delayed Discharges	0.00	0.00	0.00
Patient Safety	No. Inpatient falls	1.59	3.70	0
	No. Inpatient falls resulting in serious harm	0	0	0
	No. of Hospital Acquired Pressure Ulcers	0	0	0
	% News Score Completion	97.00%	100.00%	Not Applicable
	News Escalation	100.00%	100.00%	Not Applicable
	No. Medication Reported errors	4	2	4
	% Medication administered as prescribed	100.00%	100.00%	100.00%
	% Analgesia administered as prescribed	100.00%	100.00%	100.00%
	Intentional rounding completed	100.00%	100.00%	Not Applicable
	Safety Thermometer Patients with harm	0	0	2
	% of Compliance with Hand Hygiene	96.43%	100.00%	100.00%
Patient Experience	% Response to Inpatient Survey	21.21%	26.36%	52.17%
	Help to eat meals	100	95	100
	Enough nurses on duty	95	93	100
	Respond to call bell	82	88	100
	Pain Control	100	98	100
	Understand answers from nurses	100	93	100
	Someone to talk to about worries and fears	93	93	100
	Enough emotional support from staff	100	94	100
	Know named nurse	79	82	100
	Inpatient FFT - % of patients would recommend	96.00%	100.00%	100.00%
	Inpatient FFT - % of patients would not recommend	0.00%	0.00%	0.00%
	FFT Response Rate %	46.73%	13.50%	75.00%
	No.of Complaints	0	0	0

NURSING & MIDWIFERY QUALITY INDICATORS: Jun-16

East and North Hertfordshire NHS Trust

Dialysis		Dialysis Unit Bedford (stations, not beds)	Dialysis Unit Harlow (stations, not beds)	Dialysis Unit L and D (stations, not beds)	Dialysis Unit Lister (stations, not beds)	Dialysis Unit St Albans (stations, not beds)
Beds	**Total Beds** (Based on wards in this report)	Not Applicable	Not Applicable	Not Applicable	Not Applicable	Not Applicable
	Bed occupancy % (at Midnight)	Not Applicable	Not Applicable	Not Applicable	Not Applicable	Not Applicable
e-Roastering	% E-roaster Deadline Met	100.00%	100.00%	100.00%	100.00%	100.00%
	Net Hours %	-2.40%	-0.80%	-0.70%	-0.90%	-0.40%
	Net Hours Position	-77.62	-27.00	-37.75	-64.00	-16.20
	% of Actual Annual Leave	10.90%	7.36%	12.70%	6.60%	10.20%
Staffing	Funded WTE	Not Applicable	Not Applicable	Not Applicable	Not Applicable	Not Applicable
	Actual WTE	Not Applicable	Not Applicable	Not Applicable	Not Applicable	Not Applicable
	Vacancy rate %	Not Applicable	Not Applicable	Not Applicable	Not Applicable	Not Applicable
	RN Fill Rate (day shifts)	Not Applicable	Not Applicable	Not Applicable	Not Applicable	Not Applicable
	Sickness %	Not Applicable	Not Applicable	Not Applicable	Not Applicable	Not Applicable
	Agency usage %	11.10%	0.00%	0.00%	8.30%	0.00%
	Bank usage %	10.90%	8.00%	10.90%	15.80%	12.90%
	Staff Appraised % (rolling 12 months)	Not Applicable	Not Applicable	Not Applicable	Not Applicable	Not Applicable
	Missed Breaks	0	2	0	3	0
	Nursing Overtime	Not Applicable	Not Applicable	Not Applicable	Not Applicable	Not Applicable
	Statutory Mandatory Training all 9 Competency %	Not Applicable	Not Applicable	Not Applicable	Not Applicable	Not Applicable
	Statutory Mandatory Training Overall Coverage %	Not Applicable	Not Applicable	Not Applicable	Not Applicable	Not Applicable
	No of shifts where staffing initially triggered Red	Not Applicable	Not Applicable	Not Applicable	Not Applicable	Not Applicable
	% Shifts Triggered Red in Month	Not Applicable	Not Applicable	Not Applicable	Not Applicable	Not Applicable
LOS	No. Delayed Discharges	Not Applicable	Not Applicable	Not Applicable	Not Applicable	Not Applicable
Patient Safety	No. Inpatient falls	0	0	1	0	0
	No. Inpatient falls resulting in serious harm	0	0	0	0	0
	No. Medication Reported errors	0	0	0	0	0
	No. of MRSA bactareamias					
	% Enviroment audit					
	% Compliance with RDC					
	% of Compliance with Hand Hygiene	100.00%	98.69%	100.00%	100.00%	98.84%
	No. patients had KT/V measured					
	No. patients had KT/V1.2					
	No. patients non-concordant					
	% patients with RDC					
	No. patients doing 5 or more tasks in shared care					
	No . of patients using exercise bike					
Patient Experience	Target no of Renal outpatient surveys					
	Total no of Renal Outpatient Surveys undertaken					
	% Response to Renal outpatient survey					
	Did staff do what you wanted in order to help you?	100.00	98.00	97.00	97.00	95.00
	Staff to talk to about any worries and fears?	100	90	84	89	90
	Staff caring	100.00	98.00	97.00	92.00	100.00
	Who to contact if you were at home	100.00	90.00	89.00	100.00	90.00
	Enough privacy when discussing	95.00	91.00	91.00	89.00	95.00
	Meet cultural needs	98.00	91.00	90.00	87.00	100.00
	Involved in decisions	98.00	87.00	94.00	92.00	98.00
	Unit clean	98.00	98.00	94.00	93.00	94.00
	Toliets clean	97.00	93.00	88.00	89.00	81.00
	Staff professional (uniforms)	100.00	100.00	100.00	100.00	98.00
	Staff washing hands	100.00	98.00	98.00	100.00	98.00
	Prevention of infection	100.00	98.00	99.00	100.00	100.00
	Identity confirmed	85.00	93.00	98.00	100.00	86.00
	Medication side effects	100.00	72.00	81.00	67.00	69.00
	HD patients FFT - % recommend					
	HD patients FFT - % not recommend					
	No of Complaints	0	0	0	0	0

NURSING & MIDWIFERY QUALITY INDICATORS: Jun-16

East and North Hertfordshire NHS Trust

Medicine		7AN	Acute Medical Unit (AMU) - Ward	Acute Cardiac Unit (Lister)	Ashwell (AAU)	Barley	Pirton	SSU	6A	6B	10B	9A	9B	11A
NURSING & MIDWIFERY	**Total Beds** (Based on wards in this report)	14	24	34	28	22	20	28	30	25	30	30	30	29
	Bed occupancy % (at Midnight)	95.20%	82.60%	97.00%	99.30%	95.60%	77.80%	83.60%	96.90%	97.30%	96.40%	96.00%	94.60%	93.30%
e-Roastering	(%) E-roster Deadline Met	100.00%	100.00%	100.00%	100.00%	100.00%	66.00%	100.00%	100.00%	66.00%	100.00%	100.00%	100.00%	100.00%
	Net Hours %	0.70%	0.60%	-0.10%	1.40%	-0.60%	-0.10%	-2.60%	-0.90%	-1.00%	0.20%	-1.50%	1.80%	0.20%
	Net Hours Position	8.83	24.15	-5.33	57.25	-12.00	-1.77	-113.26	-25.83	-48.19	9.23	-62.02	66.63	9.00
	% of Actual Annual Leave	12.70%	10.70%	16.60%	9.60%	11.50%	9.80%	13.60%	9.70%	14.20%	10.20%	14.30%	8.60%	12.70%
Staffing	Funded WTE	18.60	62.52	54.68	31.66	30.08	41.86	35.28	36.26	39.24	33.72	35.12	35.12	35.12
	Actual WTE	8.79	47.56	48.42	26.79	13.96	26.52	30.83	21.99	36.65	22.51	26.93	24.33	28.30
	Vacancy rate %	52.74%	23.93%	11.45%	15.38%	53.59%	36.65%	12.61%	39.35%	6.60%	33.24%	23.32%	30.72%	19.42%
	RN Fill Rate (day shifts)	78.96%	100.96%	101.93%	108.75%	90.30%	84.71%	100.38%	91.54%	104.28%	97.61%	98.45%	98.26%	96.34%
	Sickness %	4.10%	7.19%	5.31%	4.29%	1.27%	4.15%	8.65%	12.74%	12.32%	11.12%	4.13%	5.03%	3.35%
	Agency usage %	Not Provided	25.10%	15.60%	29.30%	33.50%	19.60%	15.50%	34.30%	13.60%	22.90%	26.30%	25.80%	21.90%
	Bank usage %	Not Provided	19.50%	14.00%	14.10%	19.30%	13.20%	13.80%	9.60%	10.30%	12.90%	9.00%	9.70%	16.10%
	Staff Appraised % (rolling 12 months)	66.67%	53.13%	41.46%	94.12%	53.85%	76.19%	80.00%	41.67%	48.39%	66.67%	90.00%	56.25%	57.14%
	Missed Breaks	0	0	20	0	2	0	1	0	5	4	0	0	1
	Nursing Overtime				0.21			0.04	0.02			0.15		
	Statutory Mandatory Training all 9 Competency %	69.23%	62.50%	65.85%	69.44%	75.00%	73.68%	64.71%	59.38%	59.02%	75.00%	85.29%	70.27%	74.36%
	Statutory Mandatory Training Overall Coverage %	86.96%	80.95%	85.45%	88.62%	78.33%	77.29%	86.76%	80.89%	69.23%	83.96%	95.40%	90.06%	91.94%
	No of shifts where staffing initially triggered Red	5	0	6	9	9	14	1	11	6	6	8	1	0
	% Shifts Triggered Red in Month	5.56%	0.00%	6.67%	10.00%	10.00%	15.56%	1.11%	12.22%	6.67%	6.67%	8.89%	1.11%	0.00%
LOS	No. Delayed Discharges	2	0	2	3	8	0	1	2	1	6	2	4	3
Patient Safety	No. Inpatient falls	2.38	5.56	1.96	4.76	1.52	3.33	5.95	1.11	1.33	5.56	4.44	4.44	2.30
	No. Inpatient falls resulting in serious harm	0	0	0	0	0	0	0	0	0	0	0	0	0
	No. of Hospital Acquired Pressure Ulcers	0	0	0	1.19	0	0	0	1.11	0	0	0	0	0
	% News Score Completion	100.00%	100.00%	100.00%	78.00%	85.00%	90.00%	100.00%	93.00%	96.00%	95.00%	100.00%	100.00%	95.00%
	News Escalation	94.00%	95.00%	100.00%	73.00%	75.00%	100.00%	100.00%	89.00%	100.00%	95.00%	100.00%	89.00%	95.00%
	No. Medication Reported errors	0	2	2	0	0	0	1	2	2	5	0	1	3
	% Medication administered as prescribed	95.00%	100.00%	95.00%	74.00%	100.00%	100.00%	100.00%	89.00%	100.00%	100.00%	100.00%	100.00%	100.00%
	% Analgesia administered as prescribed	93.00%	95.00%	90.00%	83.00%	100.00%	100.00%	100.00%	93.00%	100.00%	100.00%	100.00%	100.00%	100.00%
	Intentional rounding completed	100.00%	100.00%	79.00%	91.00%	95.00%	100.00%	100.00%	100.00%	100.00%	91.00%	100.00%	100.00%	100.00%
	Safety Thermometer Patients with harm	1	0	0	3	0	0	0	1	0	1	4	4	0
	% of Compliance with Hand Hygiene	100.00%	100.00%	86.67%	74.19%	Not Provided	100.00%	95.41%	87.50%	100.00%	100.00%	100.00%	90.91%	98.48%
Patient Experience	% Response to Inpatient Survey	129.03%	37.21%	44.57%	12.70%	22.22%	32.76%	42.01%	19.05%	48.44%	40.82%	83.78%	44.23%	72.16%
	Help to eat meals	87	100	83	100	100	88	89	95	76	82	100	78	86
	Enough nurses on duty	64	75	93	81	81	100	80	56	71	60	65	76	86
	Respond to call bell	63	78	75	81	48	87	65	67	74	61	73	67	64
	Pain Control	86	94	96	100	100	97	93	92	93	88	100	100	88
	Understand answers from nurses	83	100	90	94	75	95	93	77	85	89	97	89	84
	Someone to talk to about worries and fears	66	91	72	100	83	91	75	79	75	74	100	79	92
	Enough emotional support from staff	75	87	86	100	88	100	87	82	84	69	98	84	89
	Know named nurse	65	63	89	75	38	89	72	75	87	85	94	57	97
	Inpatient FFT - % of patients would recommend	83.87%	95.65%	94.29%	100.00%	85.19%	100.00%	92.13%	91.67%	90.63%	100.00%	100.00%	100.00%	100.00%
	Inpatient FFT - % of patients would not recommend	6.45%	0.00%	2.86%	0.00%	0.00%	0.00%	1.12%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
	FFT Response Rate %	68.09%	18.40%	17.95%	51.16%	81.82%	37.25%	46.84%	62.07%	32.99%	42.00%	18.92%	50.85%	63.92%
	No.of Complaints	0	2	0	1	1	1	2	1	0	2	0	1	0

NURSING & MIDWIFERY QUALITY INDICATORS: Jun-16

East and North Hertfordshire NHS Trust

	Surgery	Critical Care	Swift	5A	5B	7B	8A	8B	11B
NURSING & MIDWIFERY QUALITY	**Total Beds** (Based on wards in this report)	19	25	30	30	30	30	30	15
	Bed occupancy % (at Midnight)	68.90%	82.70%	89.70%	81.00%	87.40%	91.80%	100.00%	89.30%
e-Roastering	% E-roaster Deadline Met	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	66.00%	100.00%
	Net Hours %	-4.30%	0.30%	0.70%	-1.30%	0.70%	0.60%	-3.10%	-1.00%
	Net Hours Position	-542.92	12.48	26.28	-47.97	27.93	18.85	-91.55	-33.57
	% of Actual Annual Leave	10.80%	11.80%	14.20%	15.50%	11.90%	11.30%	12.70%	18.30%
Staffing	Funded WTE	99.97	35.67	37.21	39.82	35.20	37.69	37.69	29.76
	Actual WTE	95.23	24.95	30.44	27.10	27.77	27.59	25.26	24.49
	Vacancy rate %	4.74%	28.44%	18.19%	31.94%	19.71%	26.80%	32.98%	17.71%
	RN Fill Rate (day shifts)	100.00%	87.89%	91.80%	92.27%	90.85%	97.51%	93.94%	97.24%
	Sickness %	2.17%	3.81%	3.84%	4.39%	12.70%	3.15%	5.08%	6.99%
	Agency usage %	0.00%	7.50%	24.50%	19.30%	20.00%	26.10%	34.20%	10.40%
	Bank usage %	1.40%	20.40%	9.90%	19.50%	12.30%	8.30%	2.70%	17.60%
	Staff Appraised % (rolling 12 months)	96.30%	75.00%	89.29%	96.15%	46.15%	76.92%	64.71%	85.71%
	Missed Breaks	1	5	1	3	5	2	0	4
	Nursing Overtime	0.46							
	Statutory Mandatory Training all 9 Competency %	76.61%	70.45%	64.71%	81.58%	64.58%	85.29%	69.44%	71.79%
	Statutory Mandatory Training Overall Coverage %	90.38%	86.98%	89.06%	94.57%	88.80%	95.83%	90.37%	90.40%
	No of shifts where staffing initially triggered Red	2	6	5	3	5	0	12	2
	% Shifts Triggered Red in Month	2.22%	6.67%	5.56%	3.33%	5.56%	0.00%	13.33%	2.22%
LOS	No. Delayed Discharges	0	0	5	4	1	0	0	0
Patient Safety	No. Inpatient falls	0	4.00	0	3.33	2.22	3.33	2.22	2.22
	No. Inpatient falls resulting in serious harm	0	0	0	0	0	0	0	0
	No. of Hospital Acquired Pressure Ulcers	0	0	0	1.11	0	0	0	0
	% News Score Completion	Not Applicable	100.00%	81.00%	100.00%	100.00%	90.00%	95.00%	90.00%
	News Escalation	Not Applicable	100.00%	93.60%	100.00%	100.00%	93.00%	69.00%	90.00%
	No. Medication Reported errors	8	4	4	1	0	1	4	0
	% Medication administered as prescribed		94.00%	90.00%	95.00%	96.00%	85.00%	100.00%	100.00%
	% Analgesia administered as prescribed		100.00%	93.00%	100.00%	100.00%	100.00%	100.00%	95.00%
	Intentional rounding completed		100.00%	100.00%	100.00%	92.00%	70.00%	100.00%	100.00%
	Safety Thermometer Patients with harm	1	1	1	1	0	0	0	0
	% of Compliance with Hand Hygiene	100.00%	100.00%	100.00%	100.00%	100.00%	98.59%	100.00%	100.00%
Patient Experience	% Response to Inpatient Survey		47.67%	36.73%	69.49%	51.67%	47.27%	43.48%	59.62%
	Help to eat meals/Infant Feeding	50	83	88	96	92	100	97	94
	Enough nurses on duty	100	92	90	62	82	88	74	98
	Respond to call bell	100	75	77	54	66	82	57	84
	Pain Control	100	94	91	98	93	98	91	100
	Understand answers from nurses	100	91	93	90	94	97	88	95
	Someone to talk to about worries and fears	100	84	76	97	73	86	72	82
	Enough emotional support from staff	100	88	90	96	87	89	80	90
	Know named nurse		52	67	63	72	87	54	89
	Inpatient FFT - % of patients would recommend		90.00%	100.00%	95.65%	94.32%	98.41%	96.08%	95.45%
	Inpatient FFT - % of patients would not recommend		0.91%	0.00%	0.00%	2.27%	0.00%	0.00%	0.00%
	FFT Response Rate %		61.11%	60.71%	69.70%	46.32%	60.58%	45.54%	49.62%
	No.of Complaints	1	0	1	1	0	1	2	0

NURSING & MIDWIFERY QUALITY INDICATORS: Jun-16

East and North Hertfordshire NHS
NHS Trust

Women and Children		CLU	Dacre	Gloucester	MLU	Bluebell	Neonatal Unit	7A
NURSING & MIDWIFERY QUALITY	**Total Beds** (Based on wards in this report)	10	21	27	8	20	20	16
	Bed occupancy % (at Midnight)	100.00%	55.90%	100.00%	32.10%	63.30%	58.70%	93.60%
e-Roastering	% E-roaster Deadline Met	66.00%	66.00%	66.00%	100.00%	100.00%	100.00%	100.00%
	Net Hours %	0.90%	2.80%	0.70%	0.80%	-0.10%	1.00%	-2.90%
	Net Hours Position	93.83	61.75	30.86	30.84	-1.85	81.09	-144.40
	% of Actual Annual Leave	12.60%	7.50%	11.20%	13.70%	15.00%	12.70%	14.20%
Staffing	Funded WTE	72.85	19.08	37.11	21.36	31.68	65.76	37.56
	Actual WTE	75.91	16.96	28.36	25.07	25.80	55.77	35.90
	Vacancy rate %	-4.20%	11.11%	23.58%	-17.37%	18.56%	15.19%	4.42%
	RN Fill Rate (day shifts)	104.15%	116.67%	111.25%	103.07%	91.36%		95.01%
	Sickness %	1.34%	8.15%	12.73%	10.60%	6.92%	5.88%	4.22%
	Agency usage %	4.20%	19.20%	7.70%	14.30%	26.30%	0.00%	9.50%
	Bank usage %	6.30%	9.80%	14.90%	8.40%	12.60%	16.50%	8.20%
	Staff Appraised % (rolling 12 months)	90.00%	100.00%	96.67%	79.17%	63.16%	92.45%	92.31%
	Missed Breaks	134	9	5	22	7	0	7
	Nursing Overtime					0.05	0.96	
	Statutory Mandatory Training all 9 Competency %	75.44%	91.67%	82.50%	69.57%	65.79%	80.82%	78.26%
	Statutory Mandatory Training Overall Coverage %	94.16%	99.30%	95.37%	88.47%	85.80%	95.65%	90.22%
	No of shifts where staffing initially triggered Red	0	0	0	0	24	3	3
	% Shifts Triggered Red in Month	0.00%	0.00%	0.00%	0.00%	26.67%	3.33%	3.33%
LOS	No. Delayed Discharges	0	0	0	0	0	0	0
Patient Safety	No. Inpatient falls	0	0	0	0	0	0	0
	No. Inpatient falls resulting in serious harm	0	0	0	0	0	0	0
	No. of Hospital Acquired Pressure Ulcers	0	0	0	0	0	0	0
	% News Score Completion	Not Applicable	Not Provided	100.00%	Not Applicable	55.00%	Not Applicable	100.00%
	News Escalation	Not Applicable	Not Provided	100.00%	Not Applicable	100.00%	Not Applicable	89.00%
	No. Medication Reported errors	0	2	1	0	1	2	1
	% Medication administered as prescribed	100.00%	Not Provided	Not Provided	100.00%	Not Provided	100.00%	100.00%
	% Analgesia administered as prescribed	100.00%	Not Provided	Not Provided	100.00%	Not Provided	33.00%	100.00%
	Intentional rounding completed	Not Applicable				Not Provided	Not Provided	100.00%
	Safety Thermometer Patients with harm	Not Applicable				Not Applicable	0.00	0.00
	% of Compliance with Hand Hygiene	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Patient Experience	% Response to Inpatient Survey	23.64%				4.78%	20.45%	41.25%
	Help to eat meals/Infant Feeding	84				94	94	83
	Enough nurses on duty	94				95	Not Applicable	83
	Respond to call bell	Not Applicable				100	Not Applicable	75
	Pain Control	88				89	Not Applicable	84
	Understand answers from nurses	95				100	90	90
	Someone to talk to about worries and fears	94				85	Not Applicable	77
	Enough emotional support from staff	84				100	89	73
	Know named nurse	Not Applicable				100	94	76
	Inpatient FFT - % of patients would recommend	Not Applicable				100.00%	100.00%	91.51%
	Maternity FFT - % of patients would recommend - Antenatal	97.22%				Not Applicable		
	Maternity FFT - % of patients would recommend - Birth	95.02%				Not Applicable		
	Maternity FFT - % of patients would recommend - Postnatal	85.97%				Not Applicable		
	Maternity FFT - % of patients would recommend - Community Midwifery	100.00%				Not Applicable		
	Inpatient FFT - % of patients would not recommend	Not Applicable				0.00%	0.00%	1.89%
	Maternity FFT - % of patients would not recommend - Antenatal	0.00%				Not Applicable		
	Maternity FFT - % of patients would not recommend - Birth	2.26%				Not Applicable		
	Maternity FFT - % of patients would not recommend - Postnatal	2.26%				Not Applicable		
	Maternity FFT - % of patients would not recommend - Community Midwifery	0.00%				Not Applicable		
	Inpatient FFT Response Rate %	Not Applicable				9.89%	44.00%	61.31%
	Maternity FFT Response Rate % - Combined	22.89%				Not Applicable		
	No.of Complaints	0	0	2	0	2	3	0

NURSING & MIDWIFERY QUALITY INDICATORS: Jun-16

East and North Hertfordshire NHS Trust

Assessment Wards		AMUA	CDU	CAU	SAU
NURSING & MIDWIFERY QUALITY	Spaces				
	Thruput				
e-Roastering	% E-roaster Deadline Met	100.00%	See ED for details	See Paeds ED for details	100.00%
	Net Hours %	-0.90%	See ED for details	See Paeds ED for details	-2.60%
	Net Hours Position	-38.53	See ED for details	See Paeds ED for details	-77.52
	% of Actual Annual Leave	17.40%	See ED for details	See Paeds ED for details	13.60%
Staffing	Funded WTE				
	Actual WTE				
	Vacancy rate %				
	RN Fill Rate (day shifts)	94.87%	See ED for details	See Paeds ED for details	88.61%
	Sickness %				
	Agency usage %				6.00%
	Bank usage %				19.60%
	Staff Appraised % (rolling 12 months)				
	Missed Breaks	1	See ED for details	See Paeds ED for details	1
	Nursing Overtime				
	Statutory Mandatory Training all 9 Competency %				
	Statutory Mandatory Training Overall Coverage %				
	No of shifts where staffing initially triggered Red	2	See ED for details	See Paeds ED for details	3
	% Shifts Triggered Red in Month	2.22%	See ED for details	See Paeds ED for details	3.33%
LOS	LOS from arrival in assessment area				
Patient Safety	No. falls	1	0	0	0
	No. falls resulting in serious harm	0	0	0	0
	% News Score Completion	100.00%	Not Provided	60.00%	Not Provided
	News Escalation	100.00%	Not Provided	Not Provided	Not Provided
	Falls risk assessment	0.00	0.00	0.00	0.00
	Anderson / PU risk assessment	Not Provided	Not Provided	Not Provided	Not Provided
	Record Keeping Total	69.00%	Not Provided	Not Provided	Not Provided
	Intentional rounding	100.00%	Not Provided	Not Provided	Not Applicable
	% of Compliance with Hand Hygiene	97.14%	Not Provided	100.00%	100.00%
Patient Experience for those discharged	% Response to Survey	3.52%	0.30%	0.00%	16.34%
	Wait to see a doctor	72	34	Not Applicable	41
	Understand treatment	94	50	Not Applicable	84
	Information	100	63	Not Applicable	72
	Understand answer to ?	93	Not Applicable	Not Applicable	85
	Privacy for discussion	Not Applicable	Not Applicable	Not Applicable	Not Applicable
	Danger signals	100	Not Applicable	Not Applicable	66
	Who to contact	83	Not Applicable	Not Applicable	67
	FFT - % of patients would recommend				
	FFT - % of patients would not recommend				
	FFT Response Rate %				
	No.of Complaints	2	1	0	0

NURSING & MIDWIFERY QUALITY INDICATORS: Jun-16

East and North Hertfordshire NHS Trust

Emergency Departments		ED - Lister	Paeds ED - Lister	UCC - QEII
NURSING & MIDWIFERY QUALITY INDICATOR	Time to Triage			
	Acheivement of 4hr Target			
e-Roastering	% E-roaster Deadline Met	100.00%	33.00%	
	Net Hours %	0.30%	-2.20%	
	Net Hours Position	34.72	-82.75	
	% of Actual Annual Leave	14.20%	13.80%	
Staffing	Funded WTE	147.56	38.73	
	Actual WTE	86.22	22.99	
	Vacancy rate %	41.57%	40.64%	
	RN Fill Rate (day shifts)			
	Sickness %	5.70%	5.05%	
	Agency usage %	24.90%	13.80%	
	Bank usage %	18.00%	9.30%	
	Staff Appraised % (rolling 12 months)	55.88%	8.70%	
	Missed Breaks	7	14	
	Nursing Overtime	0.11	0.30	
	Statutory Mandatory Training all 9 Competency %	71.54%	65.22%	
	Statutory Mandatory Training Overall Coverage %	89.65%	86.75%	
	No of shifts where staffing initially triggered Red	16	18	
	% Shifts Triggered Red in Month	17.78%	20.00%	
Patient Safety	No. Inpatient falls	0	0	
	No. Inpatient falls resulting in serious harm	0	0	
	% News Score Completion		88.00%	
	News Escalation		100.00%	
	No. Medication Reported errors	5	1	
	% Medication administered as prescribed			
	% Analgesia administered as prescribed			
	Intentional rounding completed			
	% of Compliance with Hand Hygiene	100.00%	100.00%	
Patient Experience	% Response to Survey	0.87%	6.38%	0.00%
	Pain Relief	93.00		
	Danger signals			
	Staff to help	97.00		
	FFT - % of patients would recommend	80.65%	91.06%	87.85%
	FFT - % of patients would not recommend	11.93%	4.07%	7.63%
	FFT Response Rate %	25.33%	0.00%	17.85%
	No.of Complaints	10	0	

PERFORMANCE DATA

Performance Report
CQC outcomes summary

East & North Hertfordshire NHS Trust :Board Performance Report (2016-17) - Month 3 DRAFT

Monitor Compliance Framework and SHA Provider Management Regime

Monitor Compliance Framework - Performance Thresholds for 2016-17

Indicator		Achieve		Under-achieve		Fail	Weighting	Area	Lead Director	Apr-16	May-16	Jun-16	Year to date
Clostridium Difficile -(profiled as 1 per month)	≤	14	≤		>	14	1	Safety	AT	3.00	2.00	2.00	7.00
MRSA	≤	0	≤		>	0	1	Safety	AT	0.00	0.00	0.00	0.00
*All Cancers: 31-day wait from diagnosis to treatment 96% (1month in arrears)	>	96%	>	-	<	96%	0.5	Quality	JW	95.9%	94.9%	Not Yet Due	95.4%
*All Cancers: 31-day wait for second or subsequent treatment - Surgery ³94% (1month in arrears)		All 3 targets met		-		1 or more target	1	Quality	JW	93.3%	100.0%	Not Yet Due	96.2%
*All Cancers: 31-day wait for second or subsequent treatment - Drug ³98% (1month in arrears)								Quality	JW	98.1%	98.3%	Not Yet Due	98.2%
*All Cancers: 31-day wait for second or subsequent treatment - Radiotherapy ³94% (1month in arrears)								Quality	JW	94.0%	94.9%	Not Yet Due	94.5%
*All Cancers: 62-day wait for first treatment - Urgent GP referral ³85% (1month in arrears)		Both targets met		-		1 or more target	1	Quality	JW	80.5%	81.6%	Not Yet Due	81.0%
*All Cancers: 62-day wait for first treatment - Consultant Screening Service ³90% (1month in arrears)								Quality	JW	100.0%	84.2%	Not Yet Due	91.4%
*Cancer 2-week wait from referral to date first seen - All cancers ³93% (1month in arrears)		Both targets met		-		1 or more target	0.5	Quality	JW	97.5%	97.4%	Not Yet Due	97.4%
*Cancer 2-week wait from referral to date first seen - Symptomatic breast patients ³93% (1month in arrears)								Quality	JW	91.6%	97.2%	Not Yet Due	94.6%
Maximum Waiting Time of 18-weeks from Referral to Treatment - Admitted	≥	90%		-	<	90%	1	Patient Experie	JW	61.88%	68.78%	69.21%	66.76%
Maximum Waiting Time of 18-weeks from Referral to Treatment - Non-Admitted	≥	95%		-	<	95%	1	Patient Experie	JW	91.31%	92.80%	92.23%	92.13%
Maximum Waiting Time of 18-weeks from Referral to Treatment - Incomplete	≥	92%		-	<	92%	1	Patient Experie	JW	92.71%	92.94%	92.63%	92.74%
A&E: Maximum Waiting Time of four hours from Arrival to Discharge or Admission	≥	95%		-	<	95%	1	Quality	JW	81.12%	84.74%	84.66%	83.58%

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

RED

AMBER

GREEN

Department of Health Operating Framework measures

Service Performance Indicators for 2016-17

Indicator		Achieve		Under-achieve		Fail	Weighting	Area	Lead Director	Apr-16	May-16	Jun-16	Year to date
RTT Delivery in all Specialties (Treatment Functions not delivered (Admitted, Non-Admitted & Incomplete Pathways)	≤	0	≤	20	>	20		Patient Exper	JW	42.00	31.00	22.00	97.00
Diagnostic Test Waiting Times (patients waiting >6-weeks for 15 key diagnostic tests)	≤	1.0%	≤	5%	>	5%		Patient Exper	JW	0.13%	0.26%	0.33%	0.24%
Post Acute Transfers at Midday	≤	12	≤	18	>	18		Quality	JW	36.00	26.00	32.00	2.00
Post Acute Transfers-Total Average Beds Blocked per Day	≤	8	≤	14	>	14		Quality	JW	15.00	13.00	16.00	15.00
MSA breaches - Numbers of unjustified breaches	≤	0.0%	≤	0.5%	>	0.5%		Patient Exper	AT	0.00	0.00	0.00	0.00
VTE Risk Assessment	≥	98.0%	≥	93%	<	93%		Safety	JM	95.50%	TBC	TBC	

Trust Clinical Efficiency KPIs

Performance Thresholds for 2016-17

Indicator		Achieve		Under-achieve		Fail	Weighting	Area	Lead Director	Apr-16	May-16	Jun-16	Year to date
DNA rate	≤	Plan	≤	Plan +1%	>	lan +1%		Productivi	JW	9.23%	8.90%	8.82%	8.81%
New to Follow-up outpatient appointment ratio	≤	1.75	≤	2.27	>	2.27		Productivi	JW	1.94	1.79	1.78	1.89
*Pre-op bed-days	≤	6.0%	≤	12.0%	>	####		Productivi	JW	3.60%	6.10%	1.80%	4.00%
OCH Bed Occupancy - Elective (latest available position)	≤	92.5%	>	92.5%	>	####		Resource	JW	73.90%	92.90%	95.40%	87.50%
OCH Bed Occupancy - Emergency (latest available position)	≤	92.5%	>	92.5%	>	####		Resource	JW	100.00%	100.00%	100.00%	100.00%
Length of Stay (Overall)	≤	4.5	≤	6	>	6		Resource	JW	3.92	3.62	3.78	3.76

Key Contract Requirements

Performance Thresholds for 2016-17

Indicator		Achieve		Under-achieve		Fail	Weighting	Area	Lead Director	Apr-16	May-16	Jun-16	Year to date
A&E Quality Indicator - Total Time in A&E (95th percentile)								Quality	JW	1.0 'Timeliness' indicator not achieved	1.0 'Timeliness' indicator not achieved	1.0 'Timeliness' indicator not achieved	1.0 'Timeliness' indicator not achieved
A&E Quality Indicator - Time to initial assessment (95th percentile)	≤	0.5			=	1	1.0 (failing 3 or more) OR 0.5 (failing 2 or less)	Quality	JW				
A&E Quality Indicator - Time to treatment decision (median)								Quality	JW				
A&E Quality Indicator - Unplanned reattendance rate	≤	1				1		Quality	JW	5.30%	5.90%	6.10%	5.80%
A&E Quality Indicator - Left without being seen	≤							Quality	JW	1.60%	1.50%	1.50%	1.50%
Ambulance Turnaround (To Apply from Q2)	≤	15 minute			>	minutes		Quality	JW	62.10%	71.90%	Not Yet Available	67.00%
Choose & Book Slot issues under 5%	<	5%	>	5 % <EoE	>	EoE Avg		Quality	JW	20.90%	Not Yet Available	Not Yet Available	20.90%
Cancelled Operations - on the day and not rebooked within 28 days	<	0.80%	≥	0.8%	>	####		Quality	JW	9.37%	0.00%	2.17%	3.70%
Readmissions following non-elective admission	≤	9%	≤	13%	>	13%		Activity	JW	7.34%	6.60%	TBC	7.10%
Admissions to a Critical Care Bed >4-hours from Decision to Admit	≥	0				>1 per mont		Quality	JW	0	0	0	0
Admissions to a Stroke Bed <4-hours from Arrival at A&E* (*Q1 – 50% pts, Q2 – 70% pts, Q3 – 90% pts, Q4 - 90% pts)	≥	90%	≥	81%	<	81%		Quality	JW	71.21%	85.00%	84.85%	80.21%

Performance Thresholds for 2016-17

Indicator		Achieve		Under-achieve		Fail	Weighting	Area	Lead Director	Apr-16	May-16	Jun-16	Year to date
Stroke Care - % of patients spending 90% of hospital stay on a specialist stroke unit	≥	80%		70%	<	70%		Local Prior	JW	91.18%	93.65%	88.57%	91.04%
Stroke Care - % patients with high risk TIA seen and scanned/treated within 24 hours	≥	63%	≥	45%	<	45%		Local Prior	JW	51.28%	70.83%	83.87%	67.02%
PPCI – 150 minute call to balloon time	≥	80%		75%	<	75%		Local Prior	JW	100.00%	100.00%	100.00%	100.00%
Two-week wait access for Rapid Access Chest Pain Clinics.	≥	98%			<	98%		Local Prior	JW	100.00%	100.00%	100.00%	100.00%
MRSA Elective screening	≥	100%	≥	99%	<	99%		Local Prior	AT	Not Yet Available	Not Yet Available	Not Yet Available	Not Yet Available
MRSA Emergency screening	≥	100%	≥	95%	<	95%		Local Prior	AT	Not Yet Available	Not Yet Available	Not Yet Available	Not Yet Available

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 conditions	Registered	Registered with conditions	Registered	Registered	Registered
Surgical Procedures	Registered	Registered	Registered with conditions			
Maternity and midwifery services	Registered with conditions	Registered		Registered		
Diagnostic and Screening procedures	Registered	Registered	Registered with conditions	Registered	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.**

Following the CQC Comprehensive Inspection in October 2015 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
  - Ensure records and assessments are completed in accordance with Trust Policy
  - 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
  - Ensure that all staff in all services complete their mandatory training

- 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
  - Ensure there is oversight and monitoring of all transfers

A number of the actions have now been completed and are being monitored to ensure they are sustained. The aim is for all actions to be delivered by end of September 2016. Progress in complying with these regulatory actions is monitored through action plans submitted to the CQC Quality Development Programme Board on a fortnightly basis and monthly Performance Management Reviews. The Quality Development Board reports to the Risk and Quality Committee.

WORKFORCE APPENDICES

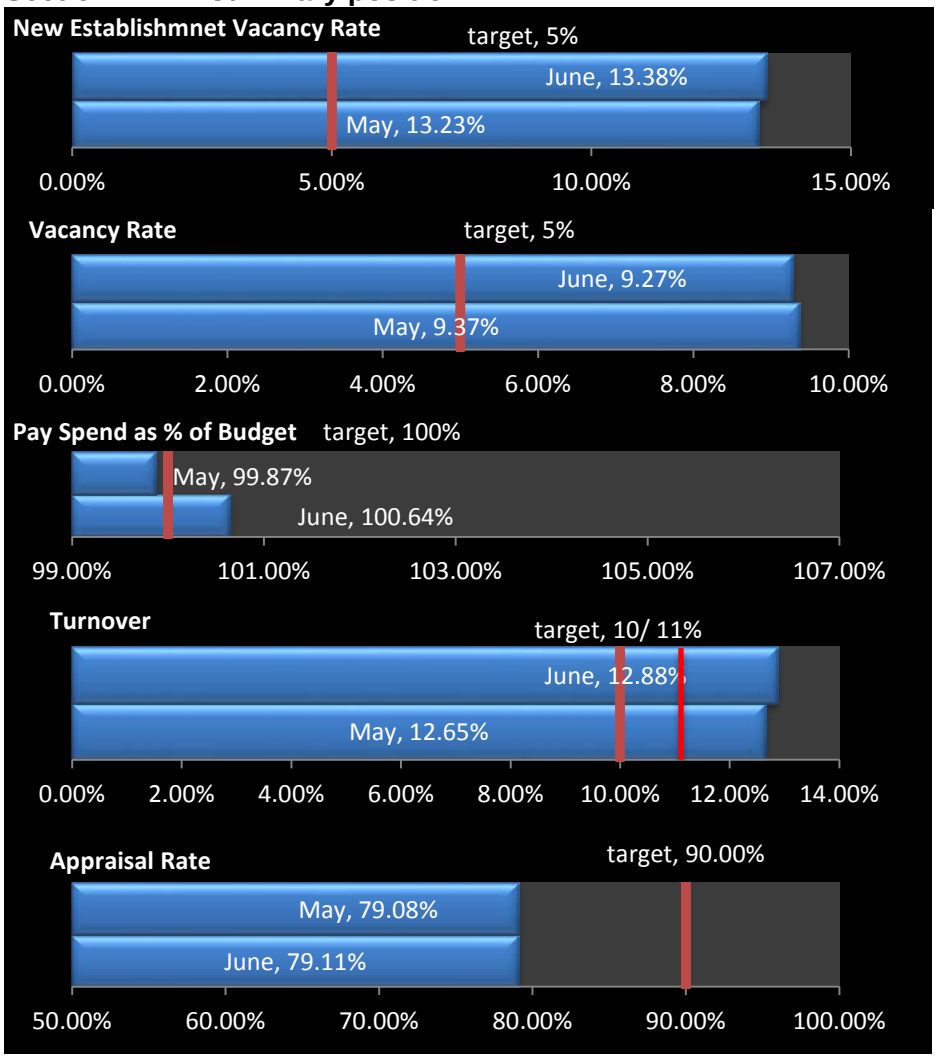
EAST AND NORTH HERTS NHS TRUST

July 2016 - Based on Month 3

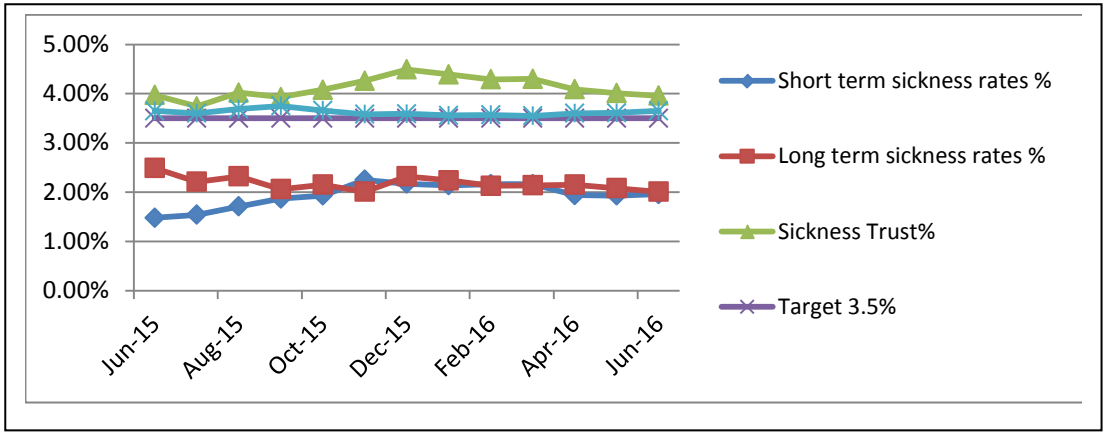
Workforce Information Report Summary

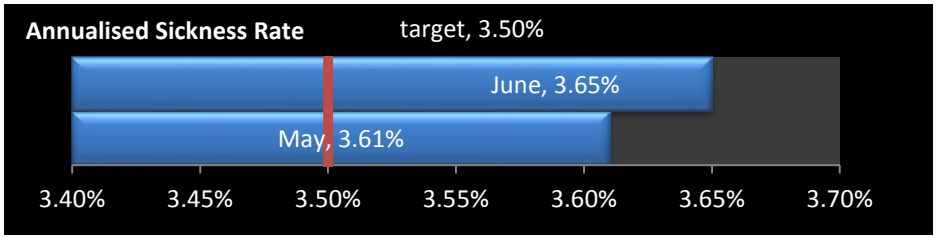
Workforce Report March 2016
(Based on data as at the end of February 2016)

Section 1: KPI summary position



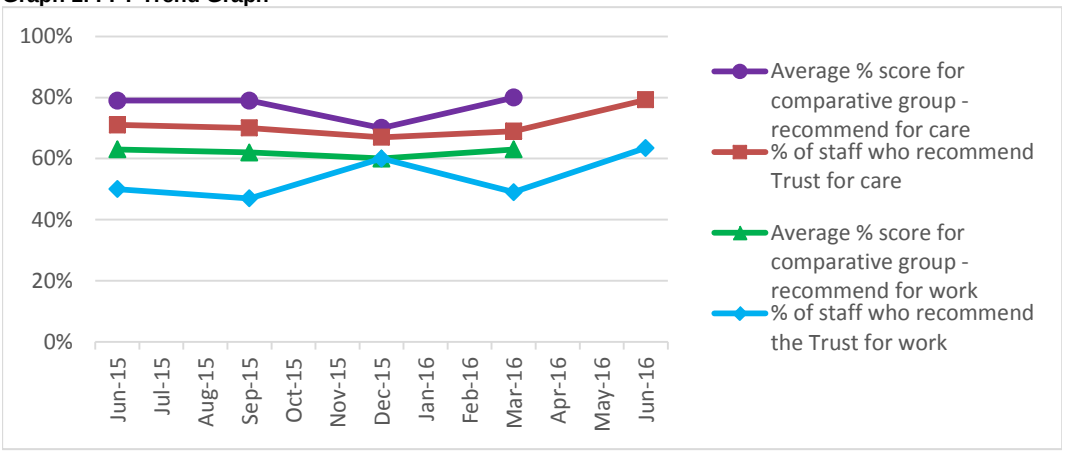
Graph 1: Sickness Rates Based On In Month Position





Section 2: Our Culture

Graph 1: FFT Trend Graph



*National benchmarks for Quarter 1 2016/17 will be published in late August 2016

Table 1: Health at Work Service core activity

Health at Work Service core activity	Average Activity 2015/16	Activity as of 31 May 2016	Activity as of 30 June 2016
Trust			
Pre Placements received	164	145	194
Manager referrals received	83	78	99
Immunisation/blood tests	554	383	348
Blood borne virus incident (sharps)	13	15	11
Return to Work plans advised	18	21	23
Self-referral advice given	17	34	24
Physiotherapy referrals	5	4	8
Use of Employee Assistance Programme	15	15	22
External			
Pre-placement	107	95	84
Manager referrals received	40	30	55
Immunisations and blood tests	341	155	137
Blood borne virus incident (sharps)	5	5	3

Section 3: Developing our people

Table 1: June 2016 Appraisal Compliance

Compliance	Done	Not Done	Not due but require review*	Grand Total	Completion Rate % June
Cancer Services	387	57	66	510	**87.16**
Clinical Support Services	497	60	123	680	**89.23**
Medicine	521	297	292	110	**63.69**
Corporate	355	91	113	559	**79.60**
Research & Development	41	21	22	84	**66.13**
Surgery	672	167	182	1021	**80.10**
Women's and Children's	435	75	108	618	**85.29**
Grand Total	**2908**	**768**	**906**	**4582**	**79.11**

Graph 1: Starters & Leavers Graph

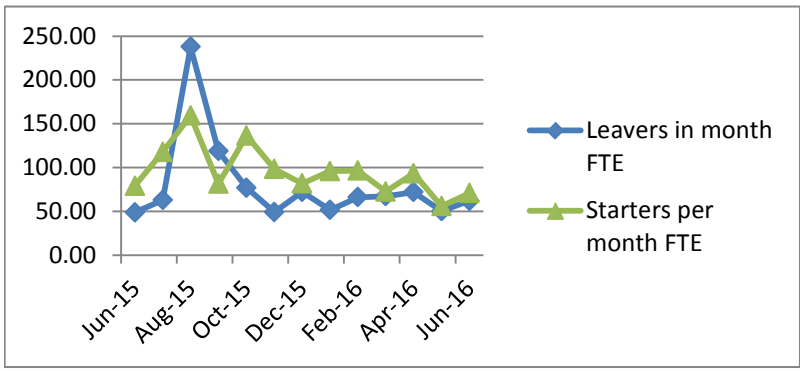


Table 2: Appraisal Compliance by Payband

Pay Band	Appraisal Completion Rate %
Band 1	73.55
Band 2	77.40
Band 3	76.89
Band 4	79.67
Band 5	77.63
Band 6	84.36
Band 7	80.18
Band 8A	81.20
Band 8B	73.08
Band 8C	90.48
Band 8D	60
Band 9	71.43
Snr Mgr Pay	52.94
Tupe	100

Table 3: Training Data

Source: ESR	Trust MTH	Surgery	Medicine	CSS	W & C	Cancer	R and D	Corporate
Statutory and mandatory training full compliance (Incl M&D)	63.83%	60.25%	58.36%	72.04%	64.26%	69.69%	71.26%	66.67%
Statutory and mandatory training average compliance (Incl M&D)	87.13%	85.59%	84.17%	90.59%	89.70%	89.86%	87.98%	87.19%

Section 4: People Performance

Table 1:Bank & Agency Spend

June 2016 position				
Total spend	**Current month**		**YTD**	
	£	**%**	**£**	**%**
Agency	2,249,695	10.50%	6,898,503.72	10.82%
Bank	1,000,716.81	4.67%	2,862,578.51	4.49%
Substantive	18,168,599.83	84.82%	54,017,004.60	84.70%
Total	**21,419,011.23**		**63,778,086.83**	
Variance against pay budget	**136,400.73**	0.64%	**187,568.56**	0.29%

Graph 1: Ledger Position V Worked WTE

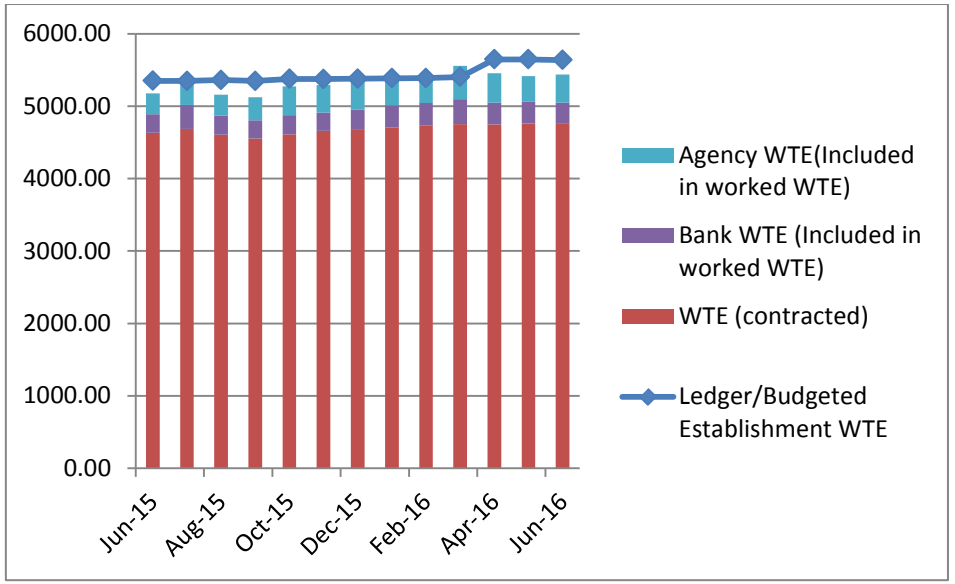


Table 2: Recruitment Data

Source: TRAC	Target	Trust Last MTH (weeks)	Trust MTH (weeks)
Time to Start: From requisition	9 weeks	8.9 weeks	8.9 weeks

approval to start date (actual/booked)			
Time to Recruit: From conditional offer to Start date (booked/actual)	2.6 weeks	2.9 weeks	3.1 weeks
Time taken for approvals: From requisition being created to requisitions authorised	2 weeks	1 weeks	0.9 weeks

Table 3: Establishment changes 16/17: Substantive Posts WTE

	Cancer division	Clinical Support division	Corporate division	Medical division	R&D	Surgery division	Womens & Childrens division	Grand Total
Adjustment	-0.4					-0.42		-0.42
Admin and estates	4.5	12.83	39.25	20.16	7.9	8.31	7.43	100.38
Medical and dental	-0.96	0.7	0	12.11	-1.46	0.42	3.2	14.01
Nursing qualified	-2.43	0.89	3.03	38.12	-0.43	13.57	-0.36	52.39
Nursing unqualified	1.96	0.37	-1	16.93	-1	11.38	2.42	31.06
St and T	6.71	-1.97	0	2.19	1.85	8.44	-0.92	16.3
ST and T unqualified	-1	-1.17		-1		1.32	-0.08	-1.93
Grand Total	**8.38**	**11.65**	**41.28**	**88.51**	**6.86**	**43.02**	**11.69**	**211.39**

Table 4: Establishment changes 16/17: Bank & Agency Posts WTE

	Cancer division	Clinical Support division	Corporate division	Medical division	R&D	Surgery division	Women's & Children's division	Grand Total
Admin and estates agency				-4.51		-4	0	-8.51
Admin and estates bank		-2.08	-2.11	0	-0.43	9.96	1.5	6.84
Agency Medical and dental						4.29		4.29
Agency nursing qualified				13.47				13.47
Bank nursing qualified	-0.51	-0.73	0	3.26	0	-0.14	5.63	7.51
Bank nursing unqualified	-0.08	0		1.2		0.44	0	1.56
St and t bank	-4	9.6		2		0		7.6
Grand Total	**-4.59**	**6.79**	**-2.11**	**15.42**	**-0.43**	**10.55**	**7.13**	**32.76**

Table 5: Benchmarking Data: Beds and Herts NHS Organisations - Vacancy, Turnover and Agency costs comparisons - Dec 2015

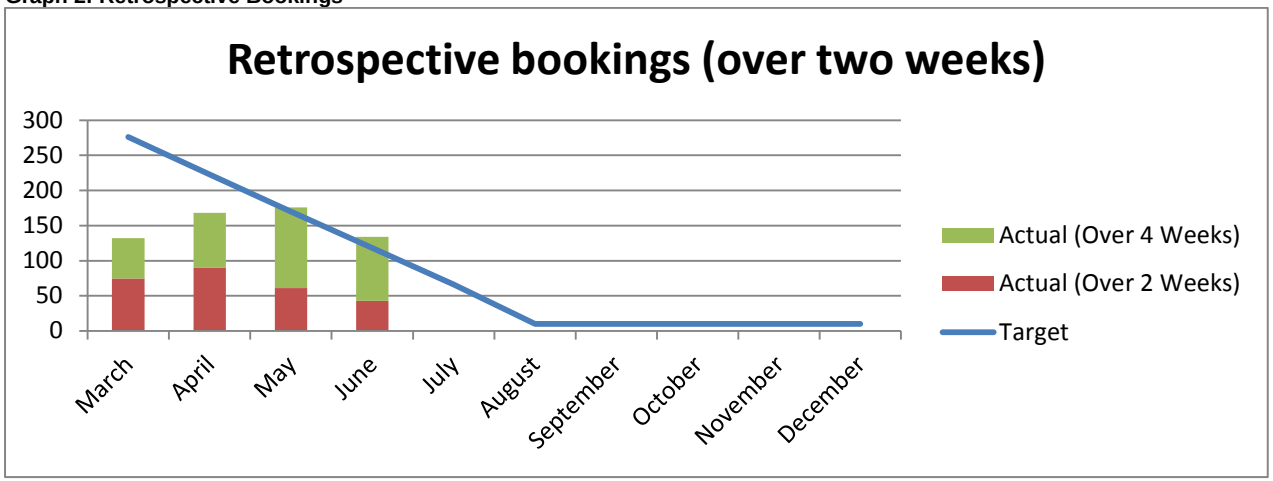
Trust	Mandatory Training Rate March 16	Mandatory Training Rate March 16	Appraisal Rate March 16	Turnover March 16	Vacancy Rate March 16	Sickness March 16	Agency March 16
Bedford Hospital	76%	76%	82%	11.20%	5.6%	4.50%	9.80%
Herts Community	92%	93%	85%	13.70%	9.3%	3.71%	
WHHT	84%	86%	71%	16.30%	11.8%	3.50%	15.30%
East & North Herts	**86%**	**86%**	**80%**	**13.10%**	**9.9%**	**3.55%**	**14.04%**
Luton & Dunstable	87%	84%	77%	15.10%	11.1%	3.31%	8.90%
HPFT	88%	88%	88%	14.50%	12.6%	4.40%	7.10%
ELF Bedford		87%	99%	16.70%	9.9%	3.90%	11.20%
ELF Luton		84%	100%	16.60%	7.5%	3.10%	13.50%
Average	**86%**	**86%**	**85%**	**14.7%**	**10%**	**3.8%**	**11.43%**

Table 6: NHSP Performance

Staff Group	Current YTD Month & Year	Net Shifts Requested	NHSP Filled Shifts	% NHSP Shift	Agency Filled Shifts	% Agency Filled Shifts	Overall Fill Rate	Unfilled Shifts	% Unfilled Shifts
Nursing & Midwifery	May 2016	9,905	4,072	41.1 %	4,167	42.1 %	83.2 %	1,666	16.8 %
	June 2016	10,059	4,124	41.0 %	4,104	40.8 %	81.8 %	1,831	18.2 %
Doctors	May 2016	1,131	448	39.6 %	464	41.0 %	80.6 %	219	19.4 %
	June 2016	92	18	19.6 %	26	28.3 %	47.8 %	48	52.2 %
Admin & Clerical	May 2016	2,412	1,335	55.3 %	967	40.1 %	95.4 %	110	4.6 %
	June 2016	2,416	1,367	56.6 %	919	38.0 %	94.6 %	130	5.4 %

Allied Health Prof, Health Care Sciences	May 2016	2,400	1,164	48.5 %	1,051	43.8 %	92.3 %	185	7.7 %
	June 2016	2,344	1,120	47.8 %	1,015	43.3 %	91.1 %	209	8.9 %

Graph 2: Retrospective Bookings



Retrospective Bookings: The graph demonstrates the planned reduction of retrospective booking based on current volumes. The plan focuses on reducing the requests that are greater than 2 weeks retrospective while ensuring the volume under 2 weeks retrospective does not increase.
** Graph represents retrospective bookings only*

Table 7: Performance, Employee Relations

Source: ERAS	Total Live Cases as at 31 May 2016	Total Live Cases as at 30 June 2016	Surgery	Medicine	CS	W & C	Cancer (inc R&D)	Corporate
Headcount	5463	5470	1318	1376	739	772	678	587
Number of Disciplinary Cases (excluding medical cases) % = no of cases as % of headcount	12 (0.2%)	13 (0.2%)	4 (0.3%)	3 (0.2%)	2 (0.3%)	1 (0.1%)	3 (0.4%)	0 (0.0%)
Number of Grievances	11	4	2	0	0	1	1	0
Number of Capability cases	12	8	3	4	0	0	1	0
Number of B&H, discrimination and victimisation cases	8	8	0	3	3	1	0	1
Number of formal short term sickness cases including cases under monitoring	102	112	13	26	21	22	24	6
Number of formal long term sickness cases	58	67	14	26	10	8	3	6

Including cases under monitoring								
Number of *MHPS cases (Medical cases)	**2**	**2**	**1**	**0**	**0**	**1**	**0**	**0**
Total number of cases in progress	**205**	**214**	**37**	**62**	**36**	**34**	**32**	**13**
Number of suspensions/medical exclusions	**4**	**4**	**2**	**0**	**0**	**0**	**1**	**1**
Number of suspensions lasting 6 months or longer								
Number of appeals	**15**	**18**	**0**	**0**	**0**	**1**	**5**	**12**

***MHPS = Maintaining High Professional Standards**

Table 8: ERAS (Exit Interview Data) Headcount 40

A. Reason of Leaving	
Enhanced Job Opportunity	4
Salary	0
Lack of challenge	4
Lack of support from Mgt	3
Career Change	4
Reason Unknown	3
Relocation	5
Retirement	4
Family/Personal reasons	1
Dissatisfaction with Mgr	1
Working Conditions	1
Further Education	10

C. Band	
1	1
2	7
3	7
4	0
5	15
6	7
7	2
8	0
9	1

B. Length of Service within the Trust	
> 12 months	7
1-5 Years	23
6-10 Years	3
11-15 Years	3
16-20 Years	1
21-25 Years	2
26-30 Years	1

D. Department	
Pharmacy	0
Health Records	0
Mount Vernon Cancer Centre	5
Facilities	1
Orthopaedics	0
Obstetrics & Gynaecology	1
Elderly Care	0
Outpatients Services	2
Surgical Specialties	3
Specialty Medicine	2
Child Health	1
Quality Control	1
Anaesthetics, Theatres, Critical Care	3
Strategic Development	0
General Surgery and Urology	2
Nursing Practice	0
Cardiology	2
Acute Medicine	3

Table 8: Exit Interview data demonstrates that 40 people left the Trust.
Table 8a: shows breakdown of different reasons as to people leaving the Trust.
Table 8b: shows their length of service within the Trust**.**
Table 8c: shows their band of service with the Trust.
Table 8d: shows their working department within the Trust.

Research and Development	0
Emergency Department	2
Renal	3
Pathology	3
Radiology	4
Finance	1
Trust Management	1

Qualititave Exit Interview Data

The following summarises the responses obtained to questions asked at exit interviews over the period of December 2015 - September 2016, and provides some analysis of the key trends identified amongst the leavers.

What factors contributed to employees decisions to leave the Trust?

Enhanced Job opportunity

Some employees stated that they left as they were offered a promotion at another Trust or were able to take up a job opportunity that would help them progress further.

People felt that there was no opportunity for them to go further in their role. Some stated that they had learnt a lot but weren't able to learn anymore from the banding they were on as well as lack off study days for further development.

Lack of support from management

Some of the reasons provided by leavers:-

- Made to work Saturdays and unable to balance work life and home life
- Poor Staffing levels and lack of support from senior management
- Lack of support from management at a time when help is needed and support with a difficult colleague

Working Conditions

- Stressful environment and the salary was not sustainable
- Poor Staffing levels
- Extremely unhappy with our work environment over the last 6months,new line manager, difficult circumstances due to inherited back log of work

Staff Group (Nursing & Midwifery)

- A band 7 nurse from Surgical Specialities left after 10 years of service because of a lack of support from management at a time she needed help and support with a difficult colleague. The employee also mentioned she rarely saw her line manager and when she did the manager had little time for her.

- A band 6 nurse from Mount Vernon Cancer Centre left after 11 years of service because of an overwhelming feeling that she was not adequate in her role. She has felt undermined in what she did and received no praise or thanks from management. The employee states that what the manager thinks is support comes across as criticism and is not constructive. The employee did not like the amount of paperwork within every aspect of the job and despite promises of clerical support being provided this never happened.

- A band 8 A from Orthopaedics left after 13 years of service because of changes to the 24 hour rota. The employee did not like conflicting priorities at work.

- A band 5 nurse from Speciality Medicine left after 26 years of service due to poor staffing levels and lack of support from senior management. '*When your area does not have its quota of staff someone is always taken from another area which is short staffed this makes a working environment which is unsafe. My area has been 10 staff down for some time making it impossible to give a high standard of care to patients. This "pinching of staff" doesn't encourage staff to do an extra bank shift to cover the ward as they know that if they provide cover they will be made to work in an area to which they are unfamiliar & inexperienced. Other contributory factors for leaving the Trust is the culture not being flexible anymore within the Trust this is why retention of skilled and experienced staff is a problem. If staff are treated poorly, undervalued and pushed until breaking point I'm not quite sure what is expected of them'.*

Staff Group (Allied Health Professionals)

- A band 2 nurse from Mount Vernon Cancer Centre left after 4.5 years of service because there were no opportunities for her to progress in her roll. She felt that she learnt a lot but wasn't able to learn anymore from her banding position. The employee states that there were a lack of study days and was stuck and couldn't do anything else. The employee did not like that there were no opportunities to progress.

- A band 3 nurse from emergency medicine left after 37.5 years of service because she felt the workload in A & E becoming too much for her.

Staff Group (Administrative & Clerical)

- A band 3 employee from Elderly care left after 1 year of service because of a stressful environment at work. The employee did not like disrespectful colleagues, stress and the feeling of not being listened to by supervisors.

- A band 6 employee from Mount Vernon Cancer Centre left after 5 years and 1 month service because of lack of opportunities, not being challenged enough in their role and when they wanted to increase hours to full time, the request was refused. The employee felt there was a lack of development opportunities as they believe they have a huge amount of skills and knowledge that were not used correctly.

- A band 4 employee from Mount Vernon Cancer Centre left after 8 years of service because they were extremely unhappy with work environment over the last 6 months. *'New line manager, difficult circumstances due to inherited back log of work. Poor team spirit and demotivated. After having been put through staff restructures many of us lost our banding which was expected and supported some of us are continually badgered into making sure we do nothing outside our new roles and other are left to continue in the old way of working due to no one wanting to tackle the difficult conversations. The whole department is demoralised and most of the senior experienced staff has left our trust due to the continuing work related issues'.* The employee did not like the constant pressure to be up to date with the back log of work inherited when the role was taken over. '*The constant negative work environments making me feel incompetent almost to a point where I was not confident to make a decision about anything*'.

- A band 5 employee from Pathology left after 25 years of service because their job had become increasingly stressful due to staff shortages . *'This had led to a stressful situation for other staff within the department as well as for me as they are required to help with my workload as well as their own".*

Staff Group (Additional Clinical Services)

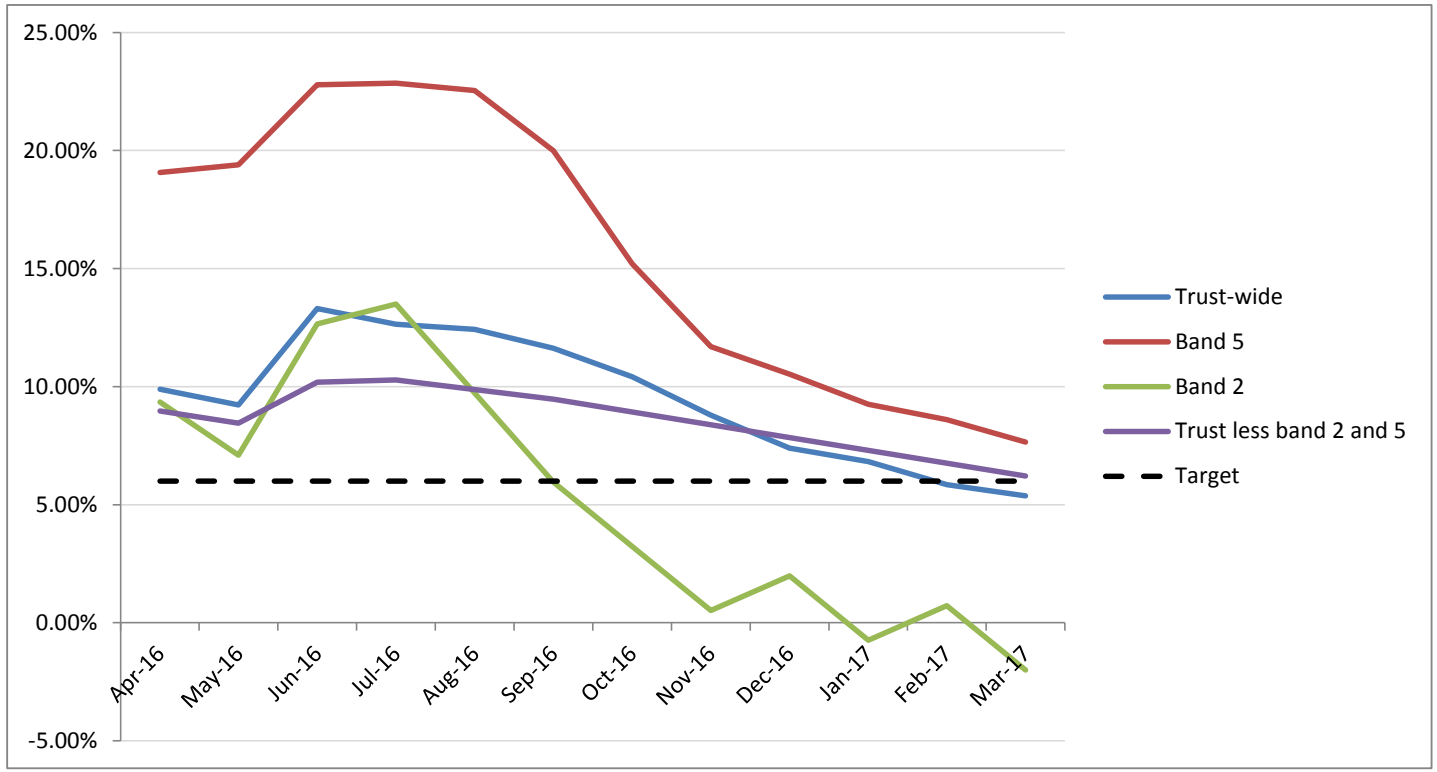
- A band 2 pharmacist left after 3 years of service. He states that he was forced to work Saturdays despite of his wife's medical conditions. The employee states that if he had been allowed to carry on not working Saturdays he would have had a happy career within pharmacy and the NHS.

Table 9: Independent contractors (excluding high value agency workers) April 2016 to end June 2016

Department	Duties	Contract Arrangements
Finance	Capital Projects Finance Lead	Anticipated contract end date is 30 September 2016.
Finance	Senior Contracts Manager	Contract extended to 31 October 2016.
Finance	Finance income capture/recovery project	Contract to 31 August 2016

Department	Duties	Contract Arrangements
Transformation Programme Office	Consultant	Ongoing for one day per week.
Information Management	EPR Programme Consultant	Contract to 30 November 2016
Information Management	Change Analyst for Pharmacy Stock Control	Contract to 18 November 2016
Information Management	EPR Project Manager	Contract to 30 November 2016
Information Management	Testing Services Consultant	Contact to 5 December 2016
Information Management	EPR Programme Manager	Anticipated contract end date is 1 October 2016.
Information Management	EPR Programme Consultant	Anticipated contract end date is 4 July 2016.
Operations	7 Day Working project Lead	Contract to 31 October 2016
Workforce & OD	ESR E-forms Project Consultants (2)	Both Contracts have now finished; one ended on 30 April 2016 and the other ended 30th June 2016.
Workforce & OD	Locum Consultant Physician in Occupational Health	Contract to be extended, to allow for substantive recruitment to post.
Workforce and OD	ADDS consultant	Contract to 30 September 2016.
Workforce and OD	ADDS Project Consultant	Contract ended on 30 June 2016.

Month	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
Trust-wide	9.89%	9.23%	13.31%	12.65%	12.43%	11.63%	10.41%	8.79%	7.39%	6.83%	5.85%	5.38%
Band 5	19.07%	19.39%	22.78%	22.86%	22.54%	19.99%	15.20%	11.69%	10.52%	9.25%	8.61%	7.65%
Band 2	9.35%	7.10%	12.66%	13.49%	9.72%	5.96%	3.23%	0.51%	1.98%	-0.74%	0.72%	-2.00%
Trust less band 2 and 5	8.97%	8.46%	10.19%	10.28%	9.87%	9.47%	8.92%	8.38%	7.84%	7.29%	6.75%	6.21%
Target	6%	6%	6%	6%	6%	6%	6%	6%	6%	6%	6%	6%



Trust Vacancy Forecast

January 2016 – March 2017

Baseline 2015/16	Establishment 2016/17
Target 5% - 6%	Target 5% - 6%
Trust Vacancy Rate - 5.8% (Sept 16)	Trust Vacancy Rate - 6.28% (Feb 17)
Band 5 Nurse Vacancy Rate - 5.7% (Oct 16)	Band 5 Nurse Vacancy Rate - 7.71% (Mar 17)
Band 2 CSW Vacancy Rate - 3.13% (May 16)	Band 2 CSW Vacancy Rate - 4.11% (Oct 16)

1. Background

The attached Estimated Vacancy Predictor is presented to the Board to provide a detailed summary of recruitment activities against the establishment and vacant posts. The report represents a RAG rated forecast of the vacancy factor for Q.4 of the financial year 2015/16 and the whole financial year 2016/17. Its funded establishment is now based on a June 2016 Vacancy Workbook data, applications in the pipeline report dated 7th July 2016 and a number of variables, which have been explained below. It is imperative to point out that the report is a best estimate based on the data available at the time of producing it and a number of assumptions had to be taken into account to enable the report being completed. The report has now been updated with the most recent uplift in establishment for the year 2016/17. It does not exclude non-recruitable posts (those of less than 0.2wte). Additional 244 (211 permanent and 33 bank) wte posts have been added to the ledger in April 2016. Additional changes to the establishment have been recorded on the ledger in June 2016 and will be reflected in next month's report. It is estimated that in order to meet the target of vacancy factor between 5%-6%, an average of 78 wte new starters are required per month and the attrition should not be greater than 48 wte in each respective month.

The report consists of 4 main parts (medical staff on rotation has been excluded):

- Estimated trust – wide vacancy factor
  This part of the report is a summary of vacant posts and monthly attrition and starters (for comparison estimated and actual figures have been included to enable the resourcing team evaluating of the activities and more accurate planning going forward). The trust-wide vacancy factor has been given a RAG rating for illustration only and can be adopted based on the Board's feedback (currently vacancy up to 6% is green; vacancy between 6%-7% is amber; and vacancy above 7% is red). The estimated number of monthly starters and leavers has been calculated based on the assumptions explained in the latter part of this report, whilst the actuals are provided a month in areas based on the vacancy workbook and a list of starters and leavers for the previous month.

- Estimated vacancy factor for band 5 nurses
  This part of the report is a summary of vacant band 5 posts and monthly attrition and starters for band 5 nurses. In addition, it takes into account average monthly internal promotions (based on the last 12 months 65 moves, which equates to 5 per month). The same RAG rating has been adopted for planning. This part of the report takes into account different approaches used by the resourcing team to identify and address band 5 nursing vacancy factor. It consists of a number of recruitment campaigns undertaken to reduce vacancy (namely: ordinary UK recruitment; EU recruitment; Filipino recruitment – cohort 1 and cohort 2; and appointment of newly qualified nurses)

- Estimated vacancy factor for band 2 CSWs
  Similar to the above band 5 nursing vacancy factor, it is a summary of vacant band 2 posts and monthly attrition and starters for band 2 CSWs.

- Estimated vacancy factor for all other staff groups (excluding band 2 CSWs & band 5 nurses)
  This part of the report includes a summary for all other staff groups (excluding band 2 CSWs and band 5 nurses)

2. **Significant assumptions to be taken into account:**
   The new establishment which increased in April 2016 has affected the delivery of the trajectory and the aim to reach the vacancy Trust wide rate of 5%-6% has moved to February 2017, which is comparable to the estimated figures from June 2016 report. Without the increase of the funded establishment, the target vacancy factor of 5%-6% would still have been achieved by September/October 2016. Additional changes to the establishment have been recorded on the ledger in June 2016 and will be reflected in next month's report.

- **Trust-wide vacancy rate of 6.28% by February 2017**
  In line with the new establishment for the fy 2016/17, the trust is now on track to achieve a vacancy rate of just over 6% by February 2016. It is based on current and estimated pipeline for all staff groups. The next 3-4 months of the report include the currently available pipeline and from September 2016 takes into account assumptions, which have been explained below. Retention work, which is due to be undertaken, should help reduce the turn-over rate slightly over the next 12 months. Steady state has been assumed in this model. In June the attrition for band 5 staff nurses has been slightly higher than anticipated (11 wte as oppose to 9) and a number of internally promoted band 5 nurses remains at 4wte in a month (same as May 2016).

- **Band 5 nurse vacancy rate of 7.71% by March 2017**
  In order to estimate the band 5 nurse vacancy factor, it is imperative to remember that the pipeline is fed from a variety of sources (Filipino recruitment, EU recruitment, UK recruitment, newly qualified nurses recruitment).

  The ordinary UK recruitment have increased slightly following on from the recent introduction of the agency rate cap as well as introduction of active advertising campaigns and redesign of the cohort recruitment.

The EU recruitment has slowed down significantly due to recent changes in the NMC regulations, requiring the nurses from EU to pass IELTS (English language test) to a level 7 or above. As a consequence, all EU nurses have withdrawn from the pipeline and alternative sources are currently being explored to replace the EU candidates.

Filipino recruitment and its planning are reliant on a number of factors. It has been estimated that it takes on average 4-5 months from interview for a nurse to pass the language competency exam (this takes into account an average 1 fail per candidate); about 3 weeks to pass the CBT (computer based test – 1st part of the NMC registration); and up to 3 months for the NMC to issue the candidate with a decision letter. It is imperative to note that despite the steady continuous vacancy rate reduction between July 2016 and March 2017, operationally the trust may not see the benefits for approximately 8 weeks from the start date of the candidates. This is due to the time it takes for a candidate to complete their OSCE exam and work as a supernumerary nurse.

The trust will adopt the same approach as in the financial year 2015/16, where newly qualified nurses have been offered a streamlined recruitment process and allow the candidates to start working as band 3 CSWs awaiting their PIN numbers. This should attract a large proportion of newly qualified nurses to start their familiarisation as soon as they finished their course, without the need to await the exam board report. It is estimated that in August, September and October 2016 a total of 53 newly qualified nurses will start work in the trust. This number includes candidates from the University of Hertfordshire as well as other universities across the country. Additional 19 student midwives have been appointed recently and will be starting with the trust in September/October 2016.

Work undertaken by the trust to address the attrition and retention issues should support the organisation in a steady decrease of a number of leavers per month. It is estimated that between March 2016 and March 2017, with increase of recruitment activities, the monthly number of leavers should reduce from an estimated average of 48 to an average of 31. Following on from the evaluation of the initial retention initiatives in September 2016, the above prediction will be updated to reflect this. June 2016 saw an increase of leavers compared to May 2016. The trust will not benefit from the retention work for at least 3 months post launching the campaigns.

It has been observed that the predicted vacancy rate is off the trajectory to achieve the vacancy rate of between 5%-6%. This is due to currently available limited pipeline of candidates from within the UK and EU. Additional work has been undertaken to recover from the position over coming months and as part of the strategy, additional countries have been explored as potential source of candidates. The below needs also noting, due to its impact on the pipeline and the trajectory delivery:

- There are still delays with the Filipino nurses arrival, however 2 new agencies have been engaged in order to increase the pipeline of candidates with the IELTS. The trust has recently engaged in conversations with the POEA (Filipino overseas labour office) and Filipino agencies in order to supply nurses directly from the Philippines, without the need to go through an agent based in the UK.
- The numbers of UK candidates fluctuate from month to month, and due to the current labour market situation, candidates often drop out before completing pre-employment checks and take up posts in trusts offering High Cost Area Supplement.

- The HEE reports that almost 40% of newly qualified nurses never pursue the career in nursing, which makes the possibility of attracting sufficient numbers of applicants even more difficult.
- EU recruitment is currently under review, due to the issues with IELTS. On a positive note, the Croatian government has now started releasing the qualifications, which means that there may be a scope for additional Croatian recruitment project in the near future.
- The number of band 5 nurses leavers in June 2016 was at the same level as in May 2016 (9 wte)
- It is difficult to predict how many band 5 nurses will be promoted, which will create additional vacancy for band 5s.

- **Band 2 CSWs vacancy rate of 4.11% by October 2016**
  Taking into account most recent establishment increase for band 2 CSW posts and number of candidates in recruitment pipeline along with the redesign of cohort recruitment for CSWs, it is estimated that the vacancy rate for the said staff group will reduce to 4.11% by October 2016. It is considered to increase previously estimated steady intake of an average of 10 CSW candidates per month to 20 per month to bring the vacancy rate of below 6%. The trust should consider not to reduce the vacancy rate for CSWs to a level below 1%, as it would put additional financial pressure on the trust to accommodate the nurses awaiting full NMC registration and the PIN numbers to work as band 3 CSWs.

3. Summary

In summary, the trust is still on a trajectory of achieving a vacancy factor between 5%-6% by September 2016, in line with the establishment for the fy 2015/16. The new establishment resulted in the target being achieved by February 2017.

It is imperative to note, that despite all the recruitment activity and new starters joining the trust over the coming months, operationally, the organisation may not be able to fully benefit from the reduction of the vacant posts, as number of staff will only be able to work as fully registered member of staff some weeks after their start date (i.e. newly qualified nurses or those appointed as part of the international recruitment campaigns, who will be required to work as band 3 CSWs until their PIN number has been received).

This report will be updated monthly based on the actual figures for new starters and leavers to enable the trust more accurate operational and financial planning. Should a significant change in the considered assumptions and estimates take place, this will be reflected in the report too and any remedial actions which may need to be taken will be reported to the Director of Workforce and OD.

RISK AND QUALITY REPORTS

Safe Staffing Nursing
Infection Control

East and North Hertfordshire NHS Trust

Safe Nurse Staffing Levels

June 2016

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 June 2016.
2. To provide context for the Trust Board on the UNIFY safer staffing submission for the month of June 2016.

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	Fill rate of 97.5% for registered nurses for June	
		Care hours per Patient Day - CHPPD	Overall CHPPD is 7.8. down from 8 in May	
2.	**Staff are supported in their decision making by effective reporting.**	% of Red triggered shifts	Increase from 3.60% in May to 5.44% in June.	
		% of shifts that remained partially mitigated	17 shifts which is 0.51% out of all shifts in month. This is a reduction from May. These consisted predominantly of Late shifts	
3.	**Staffing risks are effectively escalated to an appropriate person**	Red flag reportable events and DATIX report	June demonstrated an increase in red flags raised . This correlates with an increase in red triggered shifts	
4.	**Analysis of staffing impact on quality**	Comparison of Staffing data against key quality indicators	Despite agency and vacancy rates there is no evidence to suggest an impact on patient safety	
5.	**The board are assured of safe staffing for nursing across the organisation**	The board are sited on nurse staffing issues across the organisation.	The overall RN fill fell slightly in month, resulting in an increased incident of red shifts and ward escalating staffing shortages and red flags.	

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

The following sections identify the process 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 June: 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 (%)
97.5%	**112.3%**	**100.0%**	**116.9%**

The June Unify submission for registered fill % fell slightly compared to May with the average day fill % at 97.5% for June. Care staff fill for day and night also fell, this is partially due the active patient management work carried out by the enhanced dementia support team, who provide cover for patients requiring specials only when needed, reducing the requirement for temporary staffing for an entire shift. In addition to this, escalation areas on Ashwell, 6B and ACU were utilised throughout the month, this is why some areas have RN fill % over 100%.

Summary to planned hours changes:

- **7A –** Respiratory Escalation ward has remained open since the 7th of January, both planned and actual hours are represented.
- **Swift –** Swift is now planned and funded for 24/7 cover, the planned hours have changed as a result of the service extension.

1.2 Factors affecting Planned vs Actual staffing

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

- **Escalation areas** – ACU has 4 escalation beds that are opened to enable the Trust to manage surges in activity. This proactive opening does not form part of the unit's planned hours. The overall RN fill rate on ACU was 108.6% of their planned hours. ACU the Discharge Lounge (11 occasions) and Cardiac Catheter Lab (1 occasion) at Lister were all opened to inpatients as required supporting the additional activity. In addition to the areas listed above 6B bedded 2 treatment areas, increasing capacity from 24 to 26 on the ward to support additional capacity.
- **Matrons and Specialist Nurses** - Matrons and Specialist nurses worked clinically to support wards where staffing fell below the minimum safe levels.
- **10B, 11A, 11B, 7A, 9A, 9B, and Ashwell** – Had a high number of patients requiring enhanced care which resulted in increased CSW fill.

1.3 UNIFY Care Hours Per Patient Day (CHPPD)

Following a the Carter recommendation from 1 May 2016 each Trust is required to report the number of Care Hours per Patient Day (CHPPD). This figure is calculated using the following formula:

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. This is only the second month of collecting data and therefore comparison and trends are limited. CHPPD for June has fallen slightly when compared with May's figures

Table 3 – Average Care Hours Per Patient Day

Trust wide	Care Hours Per Patient Day (CHPPD)		
	Registered midwives/ nurses	Care Staff	Overall
Total	**5.2**	**2.7**	**7.8**

CHPPD is included in our bi-annual establishment reviews and the results seen on the Unify return do fall within expected thresholds when compared to this data. A full list of CHPPD by ward can be seen in Appendix 4 of this report.

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

2.1 Daily process to support operational staffing

The daily and twice weekly look ahead meetings continue to assess and balance 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 and kept live in the operation centre and provides assurance on nurse staffing levels in the organisation.

2.2 Staffing levels and shifts that trigger red

In June the number of shifts initially triggering red increased to 181 out of 3330 compared to 124 out of 3441 shifts in May (see Table 4 below).

Table 4 – % of shifts triggering red

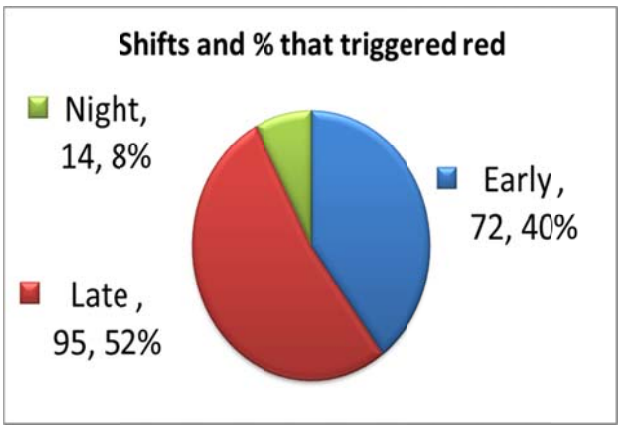
Month	% of shifts that triggered red in Month
Jun-15	1.85%
Jul-15	2.67%
Aug-15	4.89%
Sep-15	4.24%
Oct-15	5.47%
***Nov 2015**	3.00%
Dec-15	3.16%
Jan-16	4.13%
***Feb 2016**	7.10%
Mar-16	8.60%
***Apr 2016**	7.36%
May-16	3.60%
Jun-16	5.44%

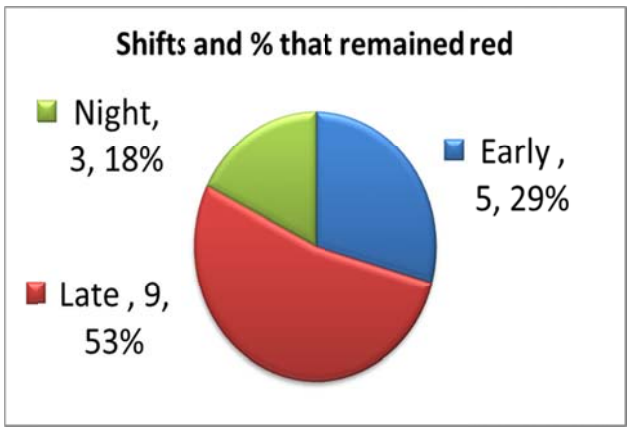
* Indicates where agency cap was implemented in November 2015, February and April 2016.

Out of the shifts triggering red, 17 of the 181 initially triggered reds (0.51%) shifts remained partially mitigated; this is a decrease from May. Shifts triggering red, and those that remained a challenge to mitigate, are explored below.

Chart 1 below shows the number and % distribution of red triggered shifts and those shifts that remained red after mitigating action was taken. This indicates that the majority of the red shifts triggered remain on the late shift.

Chart 1 – Shifts initially triggering red & remained red





A full list of all the wards with triggering red shifts can be found in Appendix 3 of this report. This shows a wider distribution of wards triggering red. Eight wards triggered red on 10% or more of the shifts in month. Red shifts are mitigated by moving staff between wards to balance staff numbers and skill mix.

Table 5 below shows the shift breakdown for each of these wards.

Table 5 – Wards triggering high number of red shifts

	INITIAL REDS				
Ward	**Early**	**Late**	**Night**	**Number of shifts where staffing initially fell below agreed levels**	**% of shifts where staffing fell below agreed levels and triggered a Red rating**
Barley	6	3	0	9	10.00
Pirton	6	8	0	14	15.56
6A	5	6	0	11	12.22
Ashwell	4	5	0	9	10.00
A&E	5	11	0	16	17.78
8B	4	7	1	12	13.33
Bluebell	11	11	2	24	26.67
Child A&E	2	12	4	18	20.00

2.3 Summary of factors affecting red triggering shifts

There are several key factors that have impacted the incidence of red shifts, these include:

- Temporary Staffing Fill – A slight decrease in overall fill rate from 85.1% to 83.9% from NHSP, resulted in an increase number of shifts triggering red and remaining a challenge to mitigate. This overall increase is further seen by the wider distribution of red triggering shifts across the wards.
- Vacancy Rate – Nurse vacancy rate at ward level remains consistent 17.18% and continues to challenge temporary staffing requirements.
- Sickness – Sickness rate remains above the 4% budget position, with June sickness recorded at 6.4% (taken from e-roster) for the inpatient wards.
- Specialling requirements
- Opening of surge capacity areas has increased temporary staffing demand
- National strategy for agency reduction restricted the use of cap.

3 Staffing risks are effectively escalated to an appropriate person

Each morning shifts that fall below minimum staffing levels are escalated to the divisional staffing bleep holder who moves to balance risk across the division. Where the division are unable to mitigate themselves this is escalated to the Nursing Service Manager to balance risk across the organisation.

3.1 Red Flags

Red flags are NICE recommended nationally reportable events that require an immediate response from the Senior Nurse Team. “Red flag events” signal to the Senior Nurse Team an urgent need for review of the numbers of staff, skill mix and patient acuity and numbers. These “red flag events” include patients not being provided with basic care requirements, such as help with visits to the bathroom, being asked about pain levels or delays in providing medicines. The Senior Nurse team considers any “red flag events” as indicators of the 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.

Chart 2 below shows the type and number of red flags raised in June. The chart shows the highest number of red flags relate to shortfall in RN time. This is an increase from the eight 'Shortfall in RN time' red flags for May. As previously mentioned, this is a new process that is embedding in the organisation but this is already showing that wards are escalating identified staffing issues using the red flag process.

Chart 2 – Red Flags by type

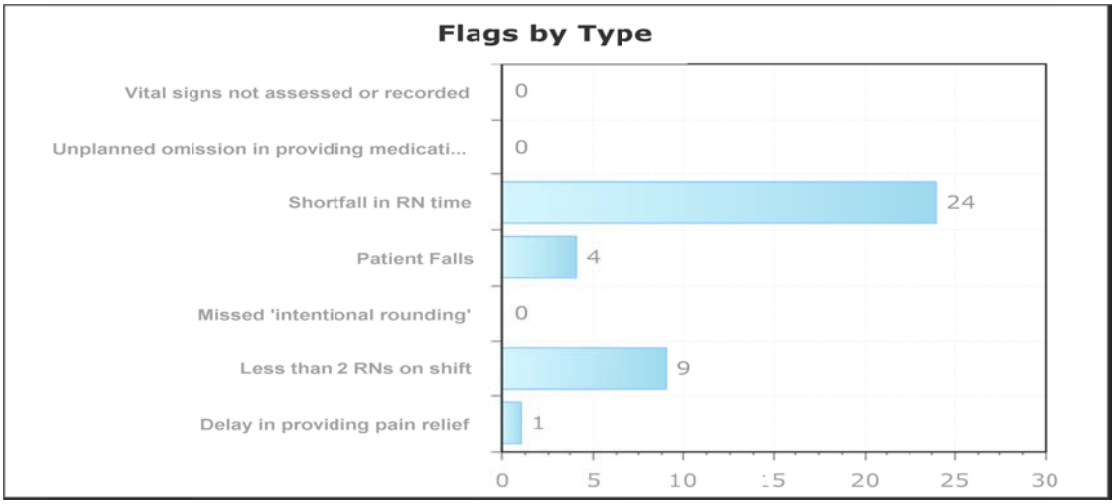
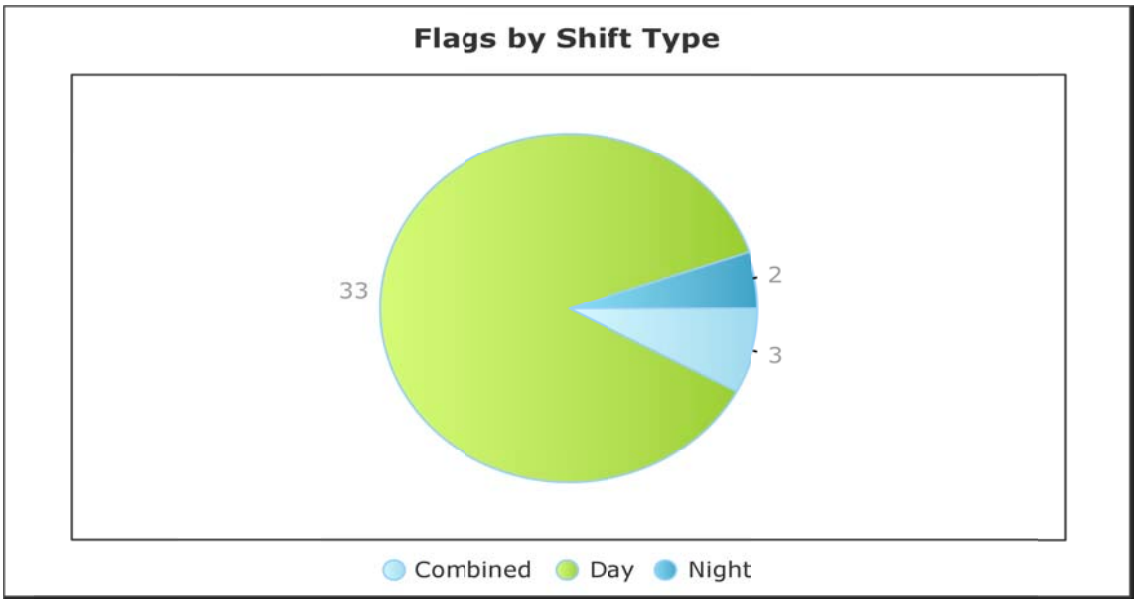


Chart 3 below indicates the red flags by shift type; both short (day) and long day (combined) shifts are worked during the day, and night shifts. The chart shows that only two red flags were raised at night. This corresponds to the low percentage of shifts that triggered red at night.

Chart 3 Red Flags Day/Night



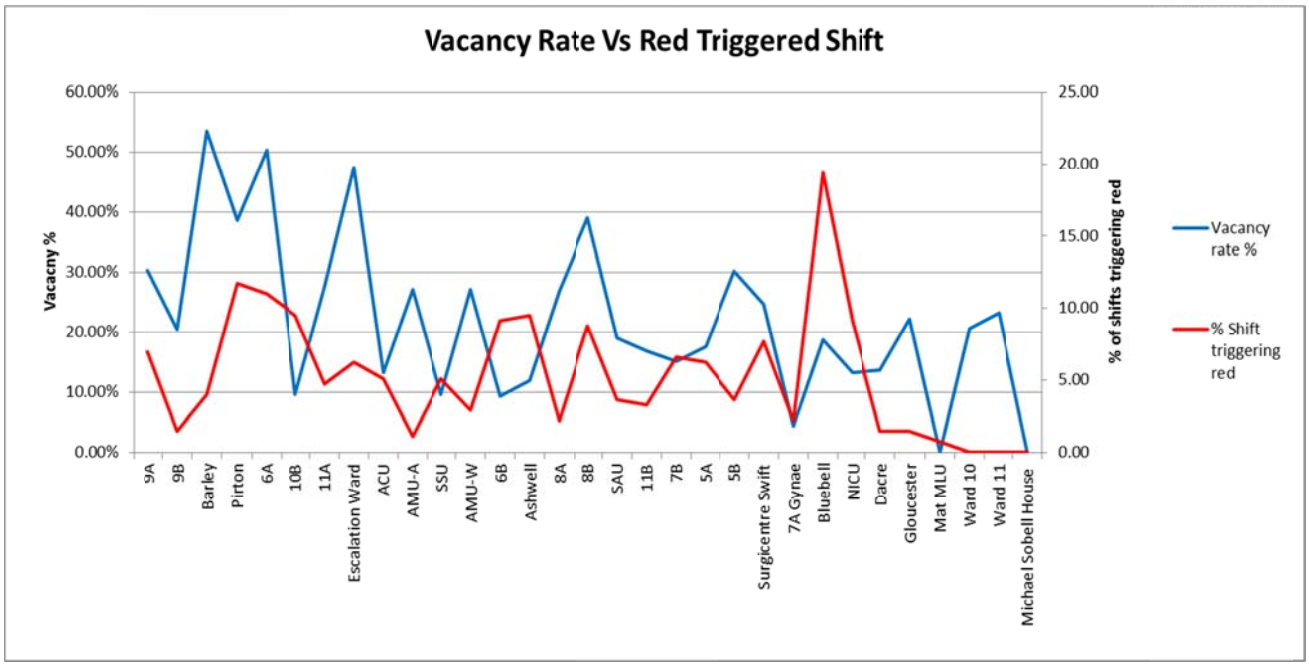
4. Analysis of staffing impact on quality

The following section looks at some staffing indicators compared to nursing quality indicators for Quarter 1. The purpose is to assess whether the impact of staffing on individual wards is impacting the care received by patients. There are a number of factors including turnover, number and acuity of patients and there are other clinical factors that must be considered along with this report. The Maternity units are not included in this report.

Chart 5 - Red Shifts vs Vacancy Rate

The chart below shows the % of red triggering shifts compared to the average vacancy rate for the last 3 months.

Chart 5



Analysis of vacancy versus shifts triggered red shows no strong correlation to wards with higher vacancy rate and wards with higher red triggered shift.

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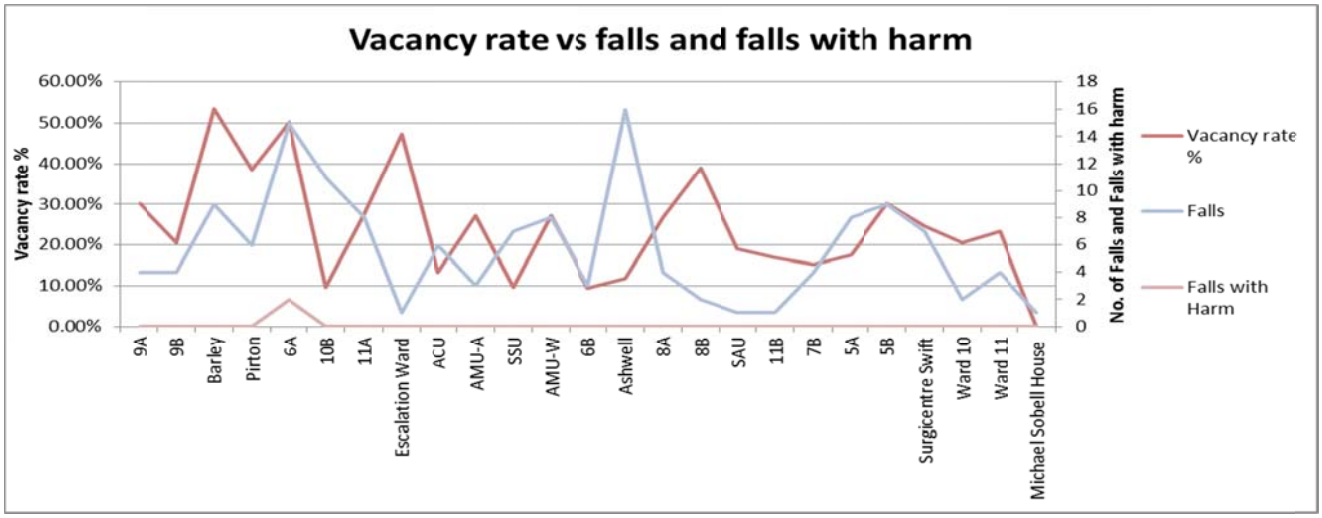
4.1 Falls

Chart 6 – Vacancy rate compared to falls and falls resulting in harm

The chart below shows the average vacancy factor for the last 3 months compared to the total number of falls and falls resulting in harm.

Chart 6

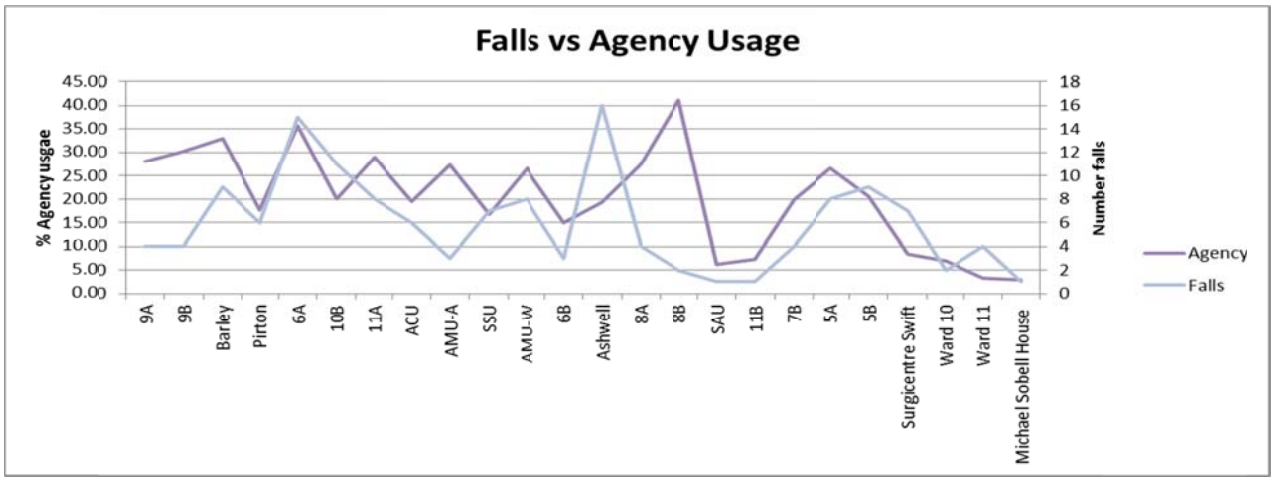


There is currently insufficient number of falls resulting in harm to draw any meaningful conclusion on the impact of vacancy rate for these areas. There is some correlation between vacancy rate and the number of falls in some areas i.e. 6A. This is not consistent on every ward and areas such as 9B have a high vacancy rate with a low number of falls. Equally Ashwell have a slightly lower vacancy rate and a higher number of falls. The complexity and acuity of patients is a key factor to consider within this analysis.

Chart 7 – Number of falls compared to % of agency usage

The chart below shows the % average agency usage over the last 3 months compared to the total number of falls for the last quarter.

Chart 7

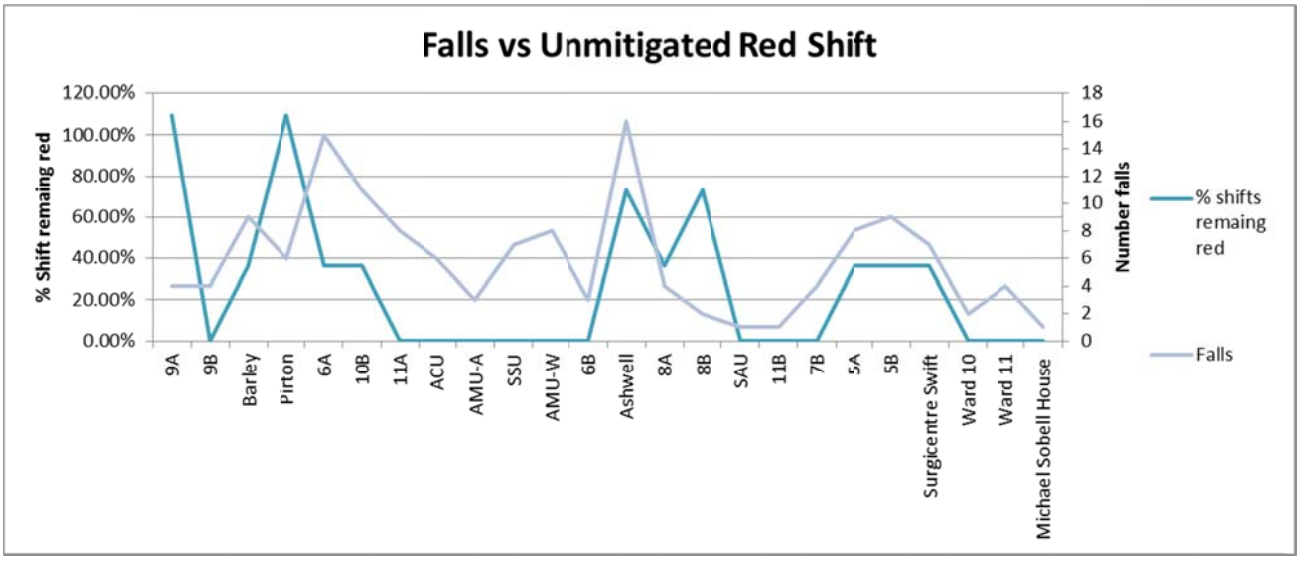


The chart shows there is no direct correlation between the % of agency use and the number of falls per ward. Although 6A had a spike in falls v agency, some areas, for example 9A, have 40% agency usage and a low number of falls. In addition to this, some wards clinical cohort will have patients with an increased risk of falls and enhanced care requirements therefore comparing 8B with Ashwell is not comparable.

Chart 8 - % of shifts that remain red compared to the number of falls

The chart below shows the % of shifts remaining a challenge to mitigate compared to the number for falls for the last 3 months.

Chart 8



Again the chart shows there is no strong correlation between the number of wards that had shifts that remained a challenge to mitigate and the number of falls over the last three months. 9A, Pirton Ashwell and 8B had the highest % of shifts than remained a challenge to mitigate. 9A had a lower number of falls possibly attributed to the enhanced dementia team presence on 9A. For example 8A and 8B had a low proportion of shifts remaining red with a higher proportion of falls.

4.2 Pressure Ulcers

The numbers of pressure ulcers within the Trust remain low and under trajectory for 2015/16, despite the reliance of temporary staff within our clinical areas. See table 4.

Table 4- Avoidable Pressure Ulcers

Month	Number
April	4
May	0
June	3

Due to the low numbers it is difficult to correlate within individual areas due to low incidence of avoidable pressure ulcers across the inpatient wards. May had zero recorded pressure ulcer in month. See table 5 below for level of harms v % of occupied bed days.

Table 5- proportion of Falls, Avoidable Pressure Ulcers and Safety Thermometer patient harms per occupied bed day

June-16	No.	% per occupied bed day
Inpatient falls	55	0.25
Falls with serious harm	0	0
Hospital acquired pressure ulcers	3	0.014
Safety Thermometer harms	20	Snap shot audit

4.3 FFT would recommend

The proportion of inpatients who 'would recommend' the inpatient ward to their friends and family remains slightly above the national average (May 2016 96.35% of inpatients would recommend ENHT compared to 95.51% nationally). The response rate from inpatients is significantly higher than the national average (May 2016 39.72% of inpatients responded to the FFT compared to 24.90% nationally). There is no correlation between wards triggering red and those achieving a lower percentage of patients who would recommend.

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

The overall RN fill rate decreased slightly in June, although fill rate remains good. The subsequent number of unfilled shifts increased for the month This is despite continued demand to cover higher than budgeted short notice sickness on the inpatient areas and the sustained use of surge capacity areas to support increasing demand. The maintenance of safe staffing levels on wards in June was supported by:

- Continued daily monitoring and ward RAG rating of staffing levels across inpatient wards
- Red Flags used to effectively escalate nationally reportable events to allow appropriate

immediate action to be taken.

- Working with cap compliant agencies
- Working with agencies to identify long line agencies to support areas with high vacancies
- Challenge and confirm culture for all additional duties being added to roster
- Controlled release of unfilled shifts to agencies
- Improved reporting and monitoring through SafeCare and Red Flag process
- Additional support provided by e-Roster, NHSP and Temporary Staffing management to assist wards with staffing challenges
- Active management and support to review staffing requirements on a daily basis for identified wards
- NSMs, Matrons, specialist nurses and the education team have supported clinically where needed.

In addition the Director of Nursing is working with a national safer staffing group reviewing the guidance.

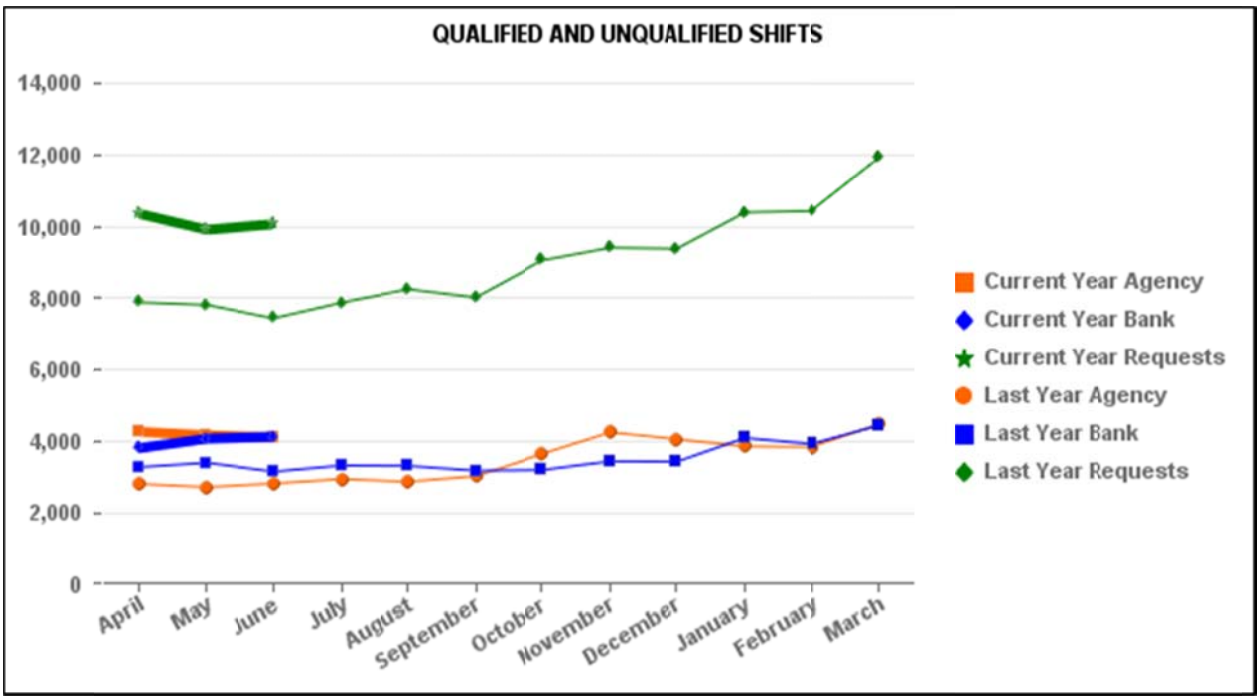
The Board are asked to note the data and supporting processes identified in this report which provide assurance of safe staffing levels in the Trust and the impact on patient safety.

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	97.6%	137.0%	95.0%	127.2%
11A	96.3%	119.2%	99.8%	163.1%
11B	97.2%	136.6%	97.5%	162.7%
5A	91.8%	98.3%	97.1%	106.7%
5B	92.3%	112.5%	94.1%	108.5%
6A	91.5%	129.4%	101.7%	106.6%
6B	104.3%	90.6%	106.4%	105.3%
7A Gynae	95.0%	107.9%	102.4%	100.5%
7B	90.8%	102.6%	98.9%	117.3%
7AN	79.0%	160.5%	100.0%	108.5%
8A	97.5%	98.6%	99.7%	110.3%
8B	93.9%	95.1%	100.9%	115.3%
9A	98.5%	149.7%	100.4%	165.2%
9B	98.3%	122.5%	99.5%	166.6%
ACU	101.9%	100.5%	115.2%	135.9%
AMU-A	94.9%	99.4%	86.1%	102.7%
AMU-W	101.0%	112.1%	101.6%	105.3%
Ashwell	108.8%	143.8%	107.2%	129.3%
Barley	90.3%	111.6%	100.3%	123.3%
Bluebell	91.4%	184.0%	104.9%	#DIV/0!
Critical Care 1	100.0%	100.0%	100.0%	100.0%
Dacre	116.7%	#DIV/0!	104.8%	#DIV/0!
Gloucester	111.3%	97.5%	100.9%	83.7%
CLU	104.1%	106.4%	103.8%	92.1%
Mat MLU	103.1%	101.1%	102.7%	112.0%
Michael Sobell House	110.4%	116.8%	99.7%	105.3%
Pirton	84.7%	118.2%	100.1%	102.2%
SAU	88.6%	81.7%	96.8%	103.1%
SSU	100.4%	110.1%	98.7%	123.2%
Swift	87.9%	95.7%	99.1%	97.6%
Ward 10	84.4%	112.7%	81.6%	#DIV/0!
Ward 11	100.4%	44.1%	84.9%	#DIV/0!
Total	**97.5%**	**112.3%**	**100.0%**	**116.9%**

Appendix 2

NHSP hours YTD report



Appendix 3

Shifts that initially triggered red in June 2016

Division	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
Medicine	Care of the Elderly	9A	5	3	0	8	8.89
		9B	0	1	0	1	1.11
	Stroke	Barley	6	3	0	9	10.00
		Pirton	6	8	0	14	15.56
	General	6A	5	6	0	11	12.22
		10B	4	2	0	6	6.67
	Respiratory	11A	0	0	0	0	0.00
		Escalation Ward	2	3	0	5	5.56
	Cardiology	ACU	2	4	0	6	6.67
	Acute	AMU-A	1	1	0	2	2.22
		SSU	1	0	0	1	1.11
		AMU-W	0	0	0	0	0.00
	Renal	6B	2	3	1	6	6.67
	DTOC / gastro	Ashwell	4	5	0	9	10.00
	ED	A&E	5	11	0	16	17.78
		UCC	0	0	1	1	1.11
Total			**43**	**50**	**2**	**95**	**6.60**
Surgery	General	8A	0	0	0	0	0.00
		8B	4	7	1	12	13.33
		SAU	1	2	0	3	3.33
	Surgical Spec	11B	0	0	2	2	2.22
		7B	2	3	0	5	5.56
	T&O	5A	3	2	0	5	5.56
		5B	1	2	0	3	3.33
		Swift	4	2	0	6	6.67
	ATCC	Critical Care 1	0	0	2	2	2.22
		ASCU	0	0	0	0	0.00
Total			**15**	**18**	**5**	**38**	**4.22**
Women's & Children	Gynae	7A Gynae	0	2	1	3	3.33
	Paeds	Bluebell	11	11	2	24	26.67
		Child A&E	2	12	4	18	20.00
		NICU	1	2	0	3	3.33
	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
Total			**14**	**27**	**7**	**48**	**6.67**
Cancer	Inpatient	Ward 10	0	0	0	0	0.00
		Ward 11	0	0	0	0	0.00
		Michael Sobell House	0	0	0	0	0.00
Total			**0**	**0**	**0**	**0**	**0.00**
		TRUST TOTAL	**72**	**95**	**14**	**181**	**5.44**

Appendix 4

Ward name	Care Hours Per Patient Day (CHPPD)		
	Registered midwives/ nurses	Care Staff	Overall
10B	3.32	2.74	6.06
11A	4.63	1.73	6.36
11B	4.22	3.78	8.00
5A	3.67	1.77	5.43
5B	3.80	2.94	6.74
6A	3.21	2.35	5.55
6B	4.35	2.70	7.05
7A Gynae	4.03	2.60	6.64
7B	3.49	1.87	5.36
7AN	4.14	2.55	6.69
8A	3.39	2.18	5.57
8B	3.92	1.89	5.81
9A	3.26	3.33	6.59
9B	3.29	3.01	6.30
ACU	5.68	2.84	8.52
AMU-A	7.50	4.59	12.09
AMU-W	5.30	3.92	9.22
Ashwell	3.43	2.90	6.33
Barley	3.92	2.86	6.78
Bluebell	8.76	1.86	10.62
Critical Care 1	24.24	1.99	26.23
Dacre	5.95	0.73	6.68
Gloucester	3.14	2.46	5.60
CLU	26.88	5.84	32.72
Mat MLU	28.73	8.22	36.96
Michael Sobell House	5.88	3.70	9.58
Pirton	5.23	3.19	8.42
SAU	5.17	2.08	7.25
SSU	4.10	2.78	6.88
Swift	3.91	2.71	6.62
Ward 10	5.69	2.34	8.03
Ward 11	7.08	1.02	8.10
Total	**5.2**	**2.7**	**7.8**

Infection Prevention and Control Board Report Objectives & Outcomes: July 2016

Objective	Narrative	Outcome	
1. Ensure that patients presenting with an infection or who acquire an infection during their care are identified promptly and receive appropriate management and treatment to reduce the risk of transmission.	1.1 In 2016-17, the Trust has a target of 0 avoidable MRSA Bacteraemias	1.1 Trust reported 0 MRSA hospital associated bacteraemias in June. Year to date position is 0 cases.	Green
	1.2 In 2016-17, the Trust has a target of no more than 11 cases of hospital acquired *C.difficile* infection	1.2 Trust reported 2 hospital acquired *C.difficile* cases in June. Year to date position is 7 hospital acquired cases, over trajectory by 4 cases.	Red
	1.3 In 2016-17, the Trust has had 4 cases of hospital acquired MSSA bacteraemia to date (no target set)	1.3 Trust reported 0 hospital acquired MSSA bacteraemias in June. Year to date position is 4 hospital acquired cases (no target set)	Green
	1.4 In 2016-17, the Trust has had 1 case of hospital acquired E-Coli to date (no target set)	1.4 In June there was 1 case of hospital acquired E.*coli.* Year to date position is 9 hospital acquired cases (no target set)	Green
	1.7 Aim to minimise number and duration of outbreaks, eg Norovirus, through prompt identification and effective action	1.7 There were no outbreaks or periods of increased incidence in the Trust during June.	Green
	1.8 The Trust IPC Team uses ICNet for its identification, management and surveillance of HCAIs.	1.8 ICNet/TPP interface issues remain unresolved. Remedial interface support work has been commissioned but a solution has not yet been identified. Manual workaround implemented from beginning of October 2015 but some gaps in service have occurred.	Red
2. Have in place and operate effective management systems for the prevention and control of HCAI	2.1 The Trust carries out mandatory Surgical Site Surveillance of infection rates for Total Knee Replacement, Total Hip Replacement and Fractured Neck of Femur Repair	2.1 The Trust has been identified as an outlier for 2014-15, particularly for Knee Replacement. Figures for 2015-16 show an overall improvement but further work is being undertaken to reduce infection rates in line with national benchmarks.	Amber
3. Have and adhere to appropriate policies and protocols for the prevention and Control of HCAI	3.1 Fortnightly peer audits of High Impact Interventions to focus on aspects of clinical care (target over 95% for all areas). To identify good practice and any actions required will be put in place	3.1 Compliance figures for High Impact Interventions in June were above 95% with the exception of IV Devices Continuing Care (89.12%), Renal Environment (90.49%) and MRSA Screening (94.83%)	Amber
4. Ensure that vaccination is provided for patients and staff at risk of exposure to TB	4.1 Due to national BCG vaccine shortages, only highest risk categories are currently able to receive vaccination. All remaining stock has expired but MHRA have extended validity for 6 months to end August 2016.	4.1 HCT have given notice that provision of vaccination service for babies (highest risk category) will revert to the Trust. Current stock of vaccine sufficient for several weeks only. Health@Work are continuing to screen and risk assess all new staff but vaccination is not routinely available at present.	Red

ICNet / TPP issues

Daily alert organism reports are being received by the IP&C Team for manual processing, pending the resolution of TPP/ICNet interface issues. However, some gaps in the interim manual reporting system have been identified, causing further concern about the ongoing lack of TPP/ICNet compatibility. ICNet has been commissioned to work with TPP to resolve the interface issues but a workable solution has not yet been identified. The situation is on the Risk Register and has been escalated at Director level.

Clostridium difficile

In 2015-16, the Trust breached the ceiling of 11 cases by 5 cases. Appeals have been accepted by CCG for 2 of these cases where there were no lapses in care and therefore these cases will not incur financial sanctions.

The ceiling for 2016-17 remains at 11 cases. The Trust has reported 7 cases to the end of June 2016, over trajectory by 4 cases year to date. All of these cases have been in the Division of Medicine. There is no evidence of cross-transmission having occurred. Main findings from RCAs are that patients were isolated appropriately but there were some delays in sending stool samples for testing. 3 cases are currently being appealed. A copy of the *C.difficile* Reduction Action Plan is attached to this report (Appendix 1)

PHE Immunisation Workshops

On 29 June, PHE presented two Immunisation Awareness Workshops and an information stall at Lister Hospital, facilitated by the IP&C Team. This was part of a pilot scheme aimed at increasing vaccination uptake among staff, and encouraging staff to take opportunities to remind patients of the benefits of vaccination. Feedback from the initial workshops was very positive and PHE have offered to provide further sessions later in the year.

Antimicrobial Stewardship

Antibiotics Point Prevalence Survey 2016

The Trust has registered to participate in the national point prevalence survey on healthcare associated infections and antimicrobial use. The survey will take place in October 2016 and several members of staff have attended preparatory training.

Antimicrobial CQUIN

Antimicrobial resistance (AMR) has risen alarmingly over the last 40 years and inappropriate and overuse of antimicrobials is a key driver. The number of new classes of antimicrobials coming to the market has reduced in recent years, and between 2010 and 2013 total antibiotic prescribing in England increased by 6%. Widespread antimicrobial resistance raises the prospect of reduced treatment options for life-threatening infections and standard surgical procedures could become riskier.

An AMR CQUIN aims to reduce total antibiotic consumption, measured as defined daily doses (DDDs) per 1000 admissions, as well as to obtain evidence of antibiotic review within 72 hours of commencing an antibiotic. The CQUIN has two parts, the first aimed at reducing total antibiotic consumption and certain broad-spectrum antibiotics and the second focussed on antimicrobial stewardship and antibiotic review within 72 hours.

Part 4a - Reduction in antibiotic consumption per 1,000 admissions

There are three parts to this indicator:
1. Total antibiotic consumption as measured by Defined Daily Dose (DDD) per 1,000 admissions
2. Total consumption of carbapenem as measured by Defined Daily Dose (DDD) per 1,000 admissions
3. Total consumption of piperacillin-tazobactam as measured by Defined Daily Dose (DDD) per 1,000 admissions

Milestones:
Reduction of 1% or more in total antibiotic consumption, carbapenem consumption and piperacillin-tazobactam against the baselines

Part 4b - Empiric review of antibiotic prescriptions

Measured by number of antibiotic prescriptions reviewed within 72 hours as a percentage of number of antibiotic prescriptions included in the sample.

Milestones:
Q1: Perform an empiric review for at least 25% of cases in the sample
Q2: Perform an empiric review for at least 50% of cases in the sample
Q3: Perform an empiric review for at least 75% of cases in the sample
Q4: Perform an empiric review for at least 90% of cases in the sample

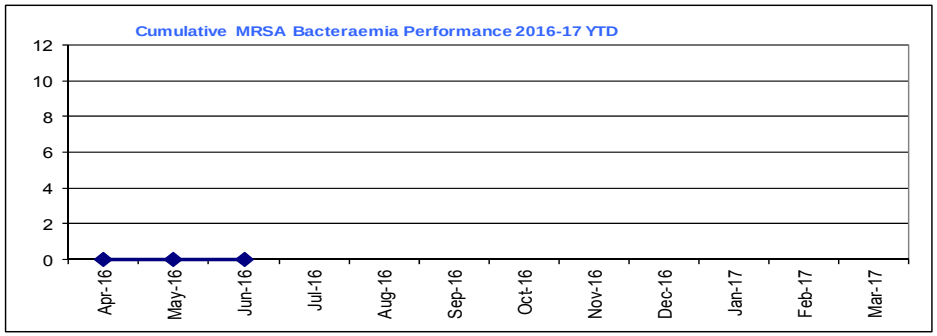
Performance – Q1 April-June 2016

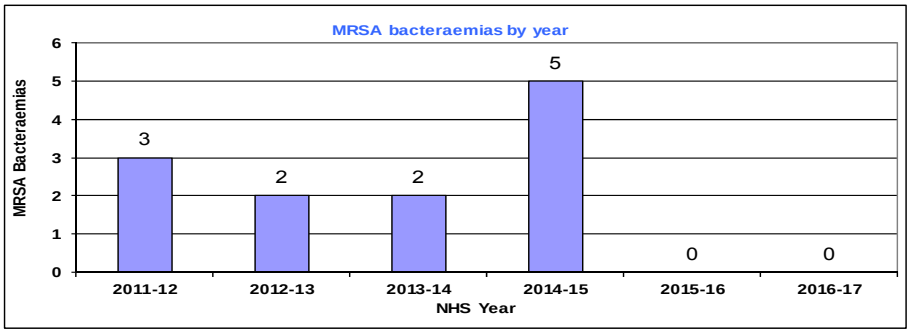
CQUIN criteria	Target	Trust position – Q1
CQUIN 4a	↓ 1% or more in total antibiotic consumption against the baseline	↓ 15%
CQUIN 4a	↓1% or more in carbapenem against the baseline	↑ 12%
CQUIN 4a	↓ 1% or more in piperacillin-tazobactam against the baseline	↓ 23%
CQUIN 4b	Perform an empiric review for at least 25% of cases in the sample	73%

Action Summary

- Grand Round 15/9/16
- Screen savers
- Education for nurses and pharmacists
- Four times weekly AMS ward rounds
- PHE Point prevalence audit
- Introduction of Procalcitonin test
- Monthly tracking of data

MRSA BACTERAEMIA – POST 48 HRS





MRSA bacteraemia by Division

Division	YTD 2015-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	YTD 2016-17
Cancer	0	0	0	0										0
Medicine	0	0	0	0										0
Surgical	0	0	0	0										0
Women & Children	0	0	0	0										0
Grand Total	0	0	0	0										0

Overview of findings from MRSA bacteraemia PIRs

An MRSA bacteraemia was identified in a patient admitted via the Emergency Department in June. This case has not been allocated to the Trust but an internal PIR meeting has taken place to gather relevant information for the CCG investigation.

MRSA – PHE Benchmarking Data (May 2016)

Public Health England

MRSA

Count of trust PIR assigned cases per month

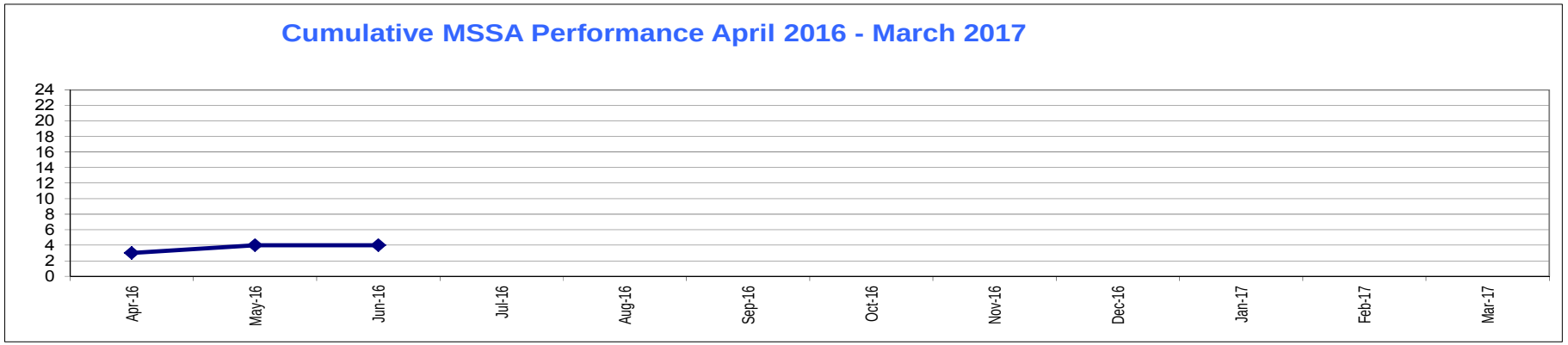
Trust Code	Acute Trust Name	Trajectory	2016									2017			Total
			April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	
RDD	Basildon & Thurrock University Hospitals NHS Foundation Trust	N/A	0	0											0
RC1	Bedford Hospitals NHS Trust	N/A	0	0											0
RGT	Cambridge University Hospitals NHS Foundation Trust	N/A	0	0											0
RDE	Colchester Hospitals University NHS Foundation Trust	N/A	1	0											1
RWH	East & North Hertfordshire NHS Trust	N/A	0	0											0
RQQ	Hinchingbrooke Health Care NHS Trust	N/A	0	0											0
RGQ	Ipswich Hospital NHS Trust	N/A	0	0											0
RGP	James Paget University Hospitals NHS Foundation Trust	N/A	0	0											0
RC9	Luton & Dunstable Hospital NHS Foundation Trust	N/A	0	0											0
RQ8	Mid Essex Hospital Services NHS Trust	N/A	0	0											0
RD8	Milton Keynes Hospital NHS Foundation Trust	N/A	0	0											0
RM1	Norfolk & Norwich University Hospitals NHS Foundation Trust	N/A	0	0											0
RGM	Papworth Hospital NHS Foundation Trust	N/A	0	0											0
RGN	Peterborough & Stamford Hospitals NHS Foundation Trust	N/A	0	0											0
RQW	Princess Alexandra Hospital NHS Trust	N/A	0	0											0
RAJ	Southend University Hospital NHS Foundation Trust	N/A	0	0											0
RCX	The Queen Elizabeth Hospital King's Lynn NHS Trust	N/A	0	0											0
RWG	West Hertfordshire Hospitals NHS Trust	N/A	0	0											0
RGR	West Suffolk Hospitals NHS Trust	N/A	0	1											1
	East of England Total	**N/A**	**1**	**1**											**2**
	England Total	**N/A**	**3**	**8**											**11**

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

Trust Code	Acute Trust Name	Trajectory	2016									2017			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
RC1	Bedford Hospitals NHS Trust	N/A	0.00	0.00											0.00
RGT	Cambridge University Hospitals NHS Foundation Trust	N/A	0.00	0.00											0.00
RDE	Colchester Hospitals University NHS Foundation Trust	N/A	6.30	0.00											3.10
RWH	East & North Hertfordshire NHS Trust	N/A	0.00	0.00											0.00
RQQ	Hinchingbrooke Health Care NHS Trust	N/A	0.00	0.00											0.00
RGQ	Ipswich Hospital NHS Trust	N/A	0.00	0.00											0.00
RGP	James Paget University Hospitals NHS Foundation Trust	N/A	0.00	0.00											0.00
RC9	Luton & Dunstable Hospital NHS Foundation Trust	N/A	0.00	0.00											0.00
RQ8	Mid Essex Hospital Services NHS Trust	N/A	0.00	0.00											0.00
RD8	Milton Keynes Hospital NHS Foundation Trust	N/A	0.00	0.00											0.00
RM1	Norfolk & Norwich University Hospitals NHS Foundation Trust	N/A	0.00	0.00											0.00
RGM	Papworth Hospital NHS Foundation Trust	N/A	0.00	0.00											0.00
RGN	Peterborough & Stamford Hospitals NHS Foundation Trust	N/A	0.00	0.00											0.00
RQW	Princess Alexandra Hospital NHS Trust	N/A	0.00	0.00											0.00
RAJ	Southend University Hospital NHS Foundation Trust	N/A	0.00	0.00											0.00
RCX	The Queen Elizabeth Hospital King's Lynn NHS Trust	N/A	0.00	0.00											0.00
RWG	West Hertfordshire Hospitals NHS Trust	N/A	0.00	0.00											0.00
RGR	West Suffolk Hospitals NHS Trust	N/A	0.00	8.73											4.44
	East of England Total	**N/A**	**0.35**	**0.34**											**0.35**
	England Total	**N/A**	**0.08**	**0.23**											**0.16**

Please note that rates are calculated using **all cases** for CCGs and **acute trust apportioned/assigned cases** for trusts.

MSSA BACTERAEMIA - POST 48 HRS



Hospital acquired MSSA by Division	YTD 2015-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	YTD 2016-17
Cancer	0	0	0	0										0
Medicine	6	2	0	0										2
Surgical	5	1	1	0										2
Women & Children	2	0	0	0										0
MVCC	1	0	0	0										0
Grand Total	14	3	1	0										4

Overview of findings from MSSA bacteraemia reviews

None.

MSSA – PHE Benchmarking Data (May 2016)

Public Health England

MSSA

Count of all cases identified by acute trust per month

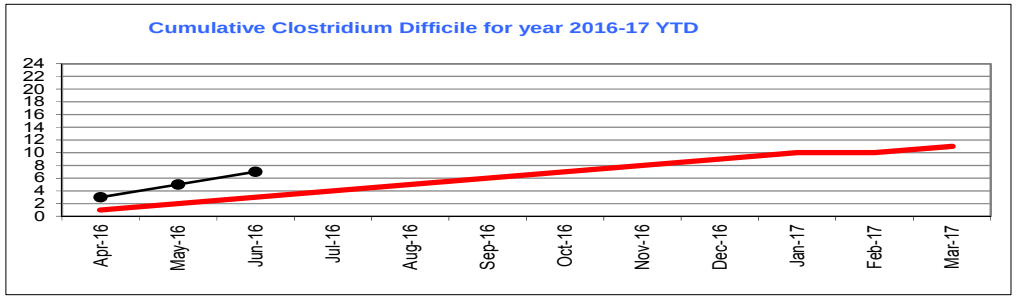
Trust Code	Acute Trust Name	Trajectory	2016									2017			Total
			April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	
RDD	Basildon & Thurrock University Hospitals NHS Foundation Trust	N/A	0	1											1
RC1	Bedford Hospitals NHS Trust	N/A	0	1											1
RGT	Cambridge University Hospitals NHS Foundation Trust	N/A	3	3											6
RDE	Colchester Hospitals University NHS Foundation Trust	N/A	2	3											5
RWH	East & North Hertfordshire NHS Trust	N/A	3	1											4
RQQ	Hinchingbrooke Health Care NHS Trust	N/A	1	1											2
RGQ	Ipswich Hospital NHS Trust	N/A	1	0											1
RGP	James Paget University Hospitals NHS Foundation Trust	N/A	1	1											2
RC9	Luton & Dunstable Hospital NHS Foundation Trust	N/A	0	0											0
RQ8	Mid Essex Hospital Services NHS Trust	N/A	2	1											3
RD8	Milton Keynes Hospital NHS Foundation Trust	N/A	2	0											2
RM1	Norfolk & Norwich University Hospitals NHS Foundation Trust	N/A	2	0											2
RGM	Papworth Hospital NHS Foundation Trust	N/A	0	1											1
RGN	Peterborough & Stamford Hospitals NHS Foundation Trust	N/A	1	0											1
RQW	Princess Alexandra Hospital NHS Trust	N/A	0	2											2
RAJ	Southend University Hospital NHS Foundation Trust	N/A	3	3											6
RCX	The Queen Elizabeth Hospital King's Lynn NHS Trust	N/A	0	2											2
RWG	West Hertfordshire Hospitals NHS Trust	N/A	1	1											2
RGR	West Suffolk Hospitals NHS Trust	N/A	0	1											1
	East of England Total	**N/A**	**22**	**22**											**44**
	England Total	**N/A**	**tbc**	**tbc**											tbc

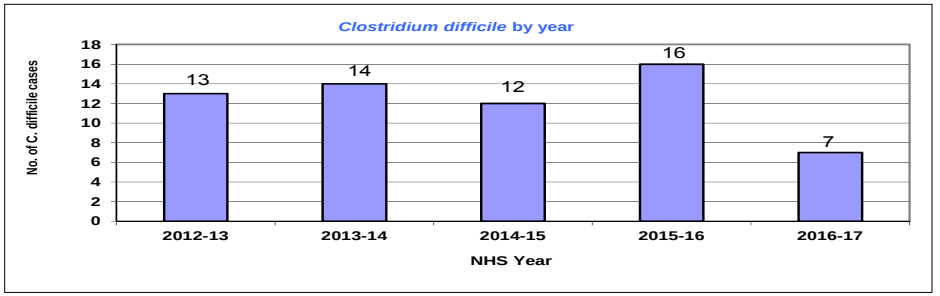
Monthly rate per 100,000 occupied bed days (acute trust apportioned cases only)

Trust Code	Acute Trust Name	Trajectory	2016									2017			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	4.99											2.54
RC1	Bedford Hospitals NHS Trust	N/A	0.00	8.74											4.44
RGT	Cambridge University Hospitals NHS Foundation Trust	N/A	11.57	11.19											11.38
RDE	Colchester Hospitals University NHS Foundation Trust	N/A	12.61	18.30											15.50
RWH	East & North Hertfordshire NHS Trust	N/A	17.04	5.50											11.17
RQQ	Hinchingbrooke Health Care NHS Trust	N/A	18.39	17.80											18.09
RGQ	Ipswich Hospital NHS Trust	N/A	6.90	0.00											3.39
RGP	James Paget University Hospitals NHS Foundation Trust	N/A	9.26	8.96											9.11
RC9	Luton & Dunstable Hospital NHS Foundation Trust	N/A	0.00	0.00											0.00
RQ8	Mid Essex Hospital Services NHS Trust	N/A	13.22	6.40											9.75
RD8	Milton Keynes Hospital NHS Foundation Trust	N/A	14.73	0.00											7.24
RM1	Norfolk & Norwich University Hospitals NHS Foundation Trust	N/A	7.02	0.00											3.45
RGM	Papworth Hospital NHS Foundation Trust	N/A	0.00	18.21											9.25
RGN	Peterborough & Stamford Hospitals NHS Foundation Trust	N/A	6.22	0.00											3.06
RQW	Princess Alexandra Hospital NHS Trust	N/A	0.00	15.09											7.67
RAJ	Southend University Hospital NHS Foundation Trust	N/A	21.05	20.37											20.71
RCX	The Queen Elizabeth Hospital King's Lynn NHS Trust	N/A	0.00	16.71											8.49
RWG	West Hertfordshire Hospitals NHS Trust	N/A	5.38	5.21											5.30
RGR	West Suffolk Hospitals NHS Trust	N/A	0.00	8.73											4.44
	East of England Total	**N/A**	**7.73**	**7.48**											**7.60**
	England Total	**N/A**	**tbc**	**tbc**											tbc

Please note that rates are calculated using **all cases** for CCGs and **acute trust apportioned/assigned cases** for trusts.

CLOSTRIDIUM DIFFICILE – HOSPITAL ACQUIRED





Trajectory: Actual:

C-DIFF by Division

Division	YTD 2015-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	YTD 2016-17
Cancer	0	0	0	0										0
Medicine	12	3	2	2										7
Surgical	4	0	0	0										0
Women & Children	0	0	0	0										0
Grand Total	16	3	2	2										7

Outcomes from C.*diff* RCAs

RCAs have been held for the 2 cases in June. Findings for both cases were that there were no identified gaps in practice that might have contributed to the acquisition although there were delays in sending of samples for *C.difficile* testing.

An appeal has been submitted for 1 of the cases in 2016-17 to date, as no lapses in care were identified and the delay in obtaining a stool specimen for testing was unavoidable due to the patient having been given medication to prevent diarrhoea prior to admission.

C.DIFFICILE – PHE Benchmarking Data (May 2016)

Public Health England

Clostridium difficile

Count of acute trust apportioned cases per month

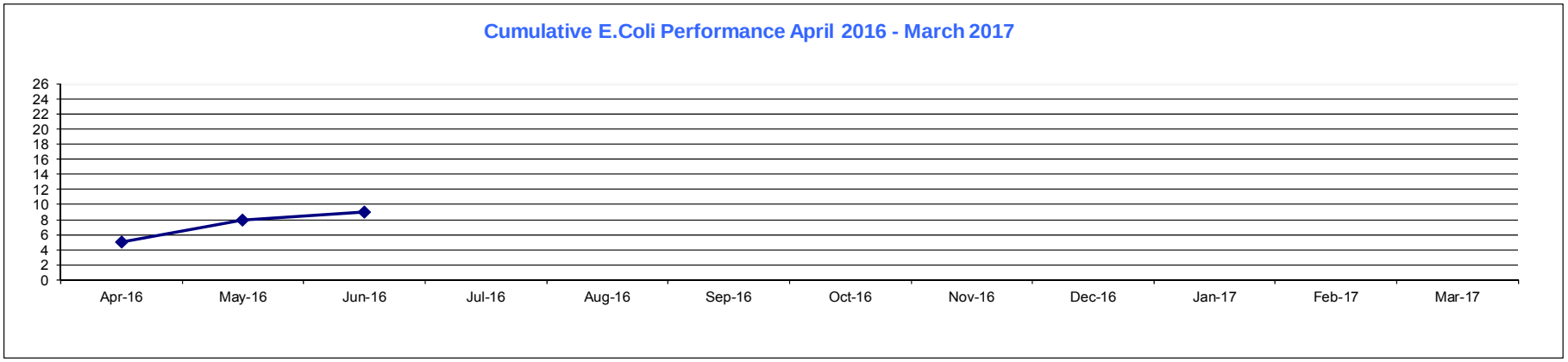
Trust Code	Acute Trust Name	Trajectory	2016 April	May	June	July	Aug	Sept	Oct	Nov	Dec	2017 Jan	Feb	Mar	Total
RDD	Basildon & Thurrock University Hospitals NHS Foundation Trust	31	0	2											2
RC1	Bedford Hospitals NHS Trust	10	1	1											2
RGT	Cambridge University Hospitals NHS Foundation Trust	49	3	1											4
RDE	Colchester Hospitals University NHS Foundation Trust	18	4	4											8
RWH	East & North Hertfordshire NHS Trust	11	3	2											5
RQQ	Hinchingbrooke Health Care NHS Trust	11	1	2											3
RGQ	Ipswich Hospital NHS Trust	18	1	7											8
RGP	James Paget University Hospitals NHS Foundation Trust	17	0	1											1
RC9	Luton & Dunstable Hospital NHS Foundation Trust	6	1	0											1
RQ8	Mid Essex Hospital Services NHS Trust	13	4	3											7
RD8	Milton Keynes Hospital NHS Foundation Trust	39	2	0											2
RM1	Norfolk & Norwich University Hospitals NHS Foundation Trust	49	4	2											6
RGM	Papworth Hospital NHS Foundation Trust	5	1	0											1
RGN	Peterborough & Stamford Hospitals NHS Foundation Trust	29	3	1											4
RQW	Princess Alexandra Hospital NHS Trust	10	2	0											2
RAJ	Southend University Hospital NHS Foundation Trust	30	0	0											0
RCX	The Queen Elizabeth Hospital King's Lynn NHS Trust	53	3	0											3
RWG	West Hertfordshire Hospitals NHS Trust	23	0	3											3
RGR	West Suffolk Hospitals NHS Trust	16	2	1											3
	East of England Total	**413**	**35**	**30**											**65**
	England Total	**4483**	**tbc**	**tbc**											**tbc**

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

Trust Code	Acute Trust Name	Trajectory	2016 April	May	June	July	Aug	Sept	Oct	Nov	Dec	2017 Jan	Feb	Mar	Total
RDD	Basildon & Thurrock University Hospitals NHS Foundation Trust	13.60	0.00	9.98											5.07
RC1	Bedford Hospitals NHS Trust	8.30	9.03	8.74											8.88
RGT	Cambridge University Hospitals NHS Foundation Trust	15.60	11.57	3.73											7.59
RDE	Colchester Hospitals University NHS Foundation Trust	9.10	25.22	24.40											24.80
RWH	East & North Hertfordshire NHS Trust	4.90	17.04	10.99											13.97
RQQ	Hinchingbrooke Health Care NHS Trust	15.60	18.39	35.60											27.14
RGQ	Ipswich Hospital NHS Trust	9.40	6.90	46.74											27.15
RGP	James Paget University Hospitals NHS Foundation Trust	13.10	0.00	8.96											4.55
RC9	Luton & Dunstable Hospital NHS Foundation Trust	3.10	5.84	0.00											2.87
RQ8	Mid Essex Hospital Services NHS Trust	7.30	26.44	19.19											22.75
RD8	Milton Keynes Hospital NHS Foundation Trust	25.80	14.73	0.00											7.24
RM1	Norfolk & Norwich University Hospitals NHS Foundation Trust	15.10	14.04	6.79											10.36
RGM	Papworth Hospital NHS Foundation Trust	7.00	18.81	0.00											9.25
RGN	Peterborough & Stamford Hospitals NHS Foundation Trust	14.40	18.65	6.02											12.23
RQW	Princess Alexandra Hospital NHS Trust	6.50	15.59	0.00											7.67
RAJ	Southend University Hospital NHS Foundation Trust	17.30	0.00	0.00											0.00
RCX	The Queen Elizabeth Hospital King's Lynn NHS Trust	38.00	25.90	0.00											12.74
RWG	West Hertfordshire Hospitals NHS Trust	10.90	0.00	15.63											7.94
RGR	West Suffolk Hospitals NHS Trust	12.50	18.05	8.73											13.32
	East of England Total	**13.70**	**12.30**	**10.20**											**11.23**
	England Total	**13.13**	**tbc**	**tbc**											**tbc**

Please note that rates are calculated using **all cases** for CCGs and **acute trust apportioned/assigned cases** for trusts.

E.COLI BACTERAEMIA – POST 48 HRS



Hospital Acquired E.Coli by Division

Division	YTD 2015-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	YTD 2015-16
Cancer	1	0	0	0										0
Medicine	17	1	1	1										3
Surgical	6	3	2	0										5
Women & Children	0	0	0	0										0
MVCC	0	1	0	0										1
Grand Total	**24**	**5**	**3**	**1**										**9**

E.COLI – PHE Benchmarking Data (May 2016)

Public Health England

Escherichia coli

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

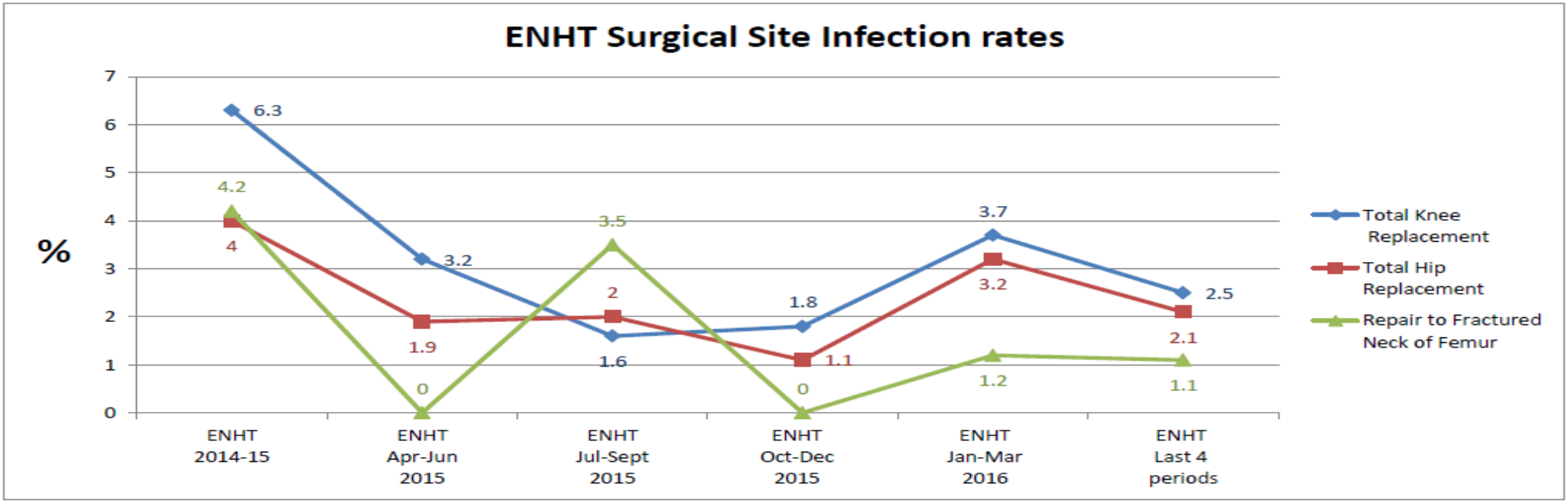
Trust Code	Acute Trust Name	Trajectory	2016									2017			Total
			April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	
RDD	Basildon & Thurrock University Hospitals NHS Foundation Trust	N/A	17	17											34
RC1	Bedford Hospitals NHS Trust	N/A	11	7											18
RGT	Cambridge University Hospitals NHS Foundation Trust	N/A	22	27											49
RDE	Colchester Hospitals University NHS Foundation Trust	N/A	20	29											49
RWH	East & North Hertfordshire NHS Trust	N/A	27	21											48
RQQ	Hinchingbrooke Health Care NHS Trust	N/A	9	9											18
RGQ	Ipswich Hospital NHS Trust	N/A	18	11											29
RGP	James Paget University Hospitals NHS Foundation Trust	N/A	13	21											34
RC9	Luton & Dunstable Hospital NHS Foundation Trust	N/A	19	18											37
RQ8	Mid Essex Hospital Services NHS Trust	N/A	21	15											36
RD8	Milton Keynes Hospital NHS Foundation Trust	N/A	16	12											28
RM1	Norfolk & Norwich University Hospitals NHS Foundation Trust	N/A	24	31											55
RGM	Papworth Hospital NHS Foundation Trust	N/A	0	1											1
RGN	Peterborough & Stamford Hospitals NHS Foundation Trust	N/A	15	15											30
RQW	Princess Alexandra Hospital NHS Trust	N/A	18	10											28
RAJ	Southend University Hospital NHS Foundation Trust	N/A	19	12											31
RCX	The Queen Elizabeth Hospital King's Lynn NHS Trust	N/A	14	11											25
RWG	West Hertfordshire Hospitals NHS Trust	N/A	11	14											25
RGR	West Suffolk Hospitals NHS Trust	N/A	9	8											17
	East of England Total	**N/A**	**303**	**289**											**592**
	England Total	**N/A**	**tbc**	**tbc**											**tbc**

Surgical Site Infection Surveillance

A Surgical Site Infection Working Group has been formed to revise and implement the Surgical Site Infection Action Plan. SSI figures for April 2015 – March 2016 show an overall reduction in infection rates, but the Trust remains an outlier in Knee Replacement and Hip Replacement. Figures for April - June 2016 are still being collated. Figures for 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 patients per quarter. It should also be noted that data was collected for 1 quarter only during 2014-15 (Oct-Dec 2014).

Surgical Site Infection Rates

Category	2011-15 National Benchmark	2014-15 ENHT	No. infections / ops	Jan-Mar 2016 ENHT	No. infections / ops	Last 4 Periods ENHT	No. infections / ops
Total Knee Replacement	**0.6%**	**6.3%**	5 / 80	**3.7%**	2 / 54	**2.5%**	6 / 238
Total Hip Replacement	**0.7%**	**4%**	4 / 101	**3.2%**	3 / 94	**2.1%**	8 / 386
Repair Fractured Neck of Femur	**1.4%**	**4.2%**	5 / 118	**1.2%**	1 / 81	**1.1%**	4 / 359



High Impact Intervention Audit Scores

High Impact Interventions	YTD 2015-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Dec-16	Jan-17	Feb-17	Mar-17	YTD 2016-17	RAG rate (Month on Month)
Hand Hygiene	95.63%	95.81%	97.16%	97.98%									96.90%	▲
Surgical Site Observation	95.32%	95.85%	96.34%	96.31%									96.17%	▼
Intravascular Devices (Insertion)	95.05%	97.63%	97.49%	95.66%									96.92%	▼
Intravascular Devices (Continuing Care)	90.70%	94.66%	93.82%	89.12%									92.51%	▼
Urinary Catheter (Insertion)	94.96%	96.69%	97.93%	97.64%									97.46%	▼
Urinary Catheter (Continuing Care)	92.50%	96.88%	97.42%	97.12%									97.16%	▼
Renal Dialysis (Continuing Care)	98.33%	95.46%	98.69%	98.18%									97.49%	▼
Ventilator (Continuing Care)	99.33%	100.00%	100.00%	100.00%									100.00%	◄
Environment (Inpatients)	96.87%	98.13%	97.52%	97.39%									97.72%	▼
Environment (Outpatients)	96.82%	96.05%	97.95%	97.54%									97.12%	▼
Environment (Renal Dialysis)	91.58%	89.41%	86.33%	90.49%									88.63%	▲
MRSA Screening Compliance	91.61%	97.05%	95.63%	94.83%									95.83%	▼

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

APPENDIX 1: Trust action plan for the reduction of Trust associated *Clostridium difficile* infections 2016/17.

The Trust has reported 16 cases of *Clostridium difficile* for the year 2015/16. This was against a ceiling of eleven cases for the year. Several of these cases were associated with the community setting but due to stool collection and *C. difficile* testing issues have been allocated to the Trust.
To address this, the following plan has been produced. The actions have been identified following a review of the root cause analysis (RCAs) and identifying themes.

Findings from the RCAs include the need to:

- Improve documented assessment of patients with diarrhoea and use of Bristol Stool Chart to assess bowel habit.
- Improve documented review of antibiotics and proton pump inhibitors
- Ensure prompt despatch of stool specimen for C. difficile testing when appropriate

Other themes included in this action plan include:

- Requirement to review patients with *C. difficile* disease
- Prompt detection of transmission of *C. difficile*
- Improve process to provide assurance of isolation within 2 hours of diarrhoea being identified
- Improve process to provide assurance for cleaning of shared equipment
- Review C. difficile diarrhoea and isolation policies to ensure alignment with national guidance.
- Documentation and communication
- Embed learning from *C. difficile* cases

Identified issue	Goal	Actions	Person Responsible	Deadline	Update. May 2016
1. Need to improve documented assessment of patients with diarrhoea.	All patients with diarrhoea to have a documented clinical assessment for infection.	Inform Nursing and Medical teams of requirement to document assessment in patient notes and audit.	IPC Lead. IPC Doctor	1st June 2016	Currently IPC team assess identified diarrhoea patients.
		To communicate Bristol stool chart recording to nursing teams (Record bowels not opened and formed stool)	IPC Lead	1st June 2016	
2. Antibiotics contribute to risk of *C. difficile* disease. Need to improve documented review of antibiotics and proton pump inhibitors.	Antibiotic stewardship in line with NICE and CQUIN targets.	See CQUIN strategy	Antibiotic Lead Pharmacist	1st August 2016	
	Documented review of PPIs and antibiotics for patients presenting with diarrhoea.	Incorporate into *C. difficile* policy	IPC Doctor/ IPC Lead	1st August 2016	
		Inform Medical teams	IPC Doctor	1st June 2016	
3. Ensure prompt despatch of stool specimen for *C. difficile* testing when appropriate	A stool sample to be sent for *C. difficile* testing immediately from patients with potential infectious diarrhoea	ICE ordering system to have prompts for C. difficile test	IPC Doctor	Completed May 2016	Completed
		To communicate ordering requirements to clinical teams.	IPC Doctor IPC Lead	1st June 2016	
4. Requirement to regularly review patients with *C. difficile* disease.	Weekly review of patients with *C. difficile* by the team consisting of the Microbiologist and IPCN	All inpatient C difficile cases are reviewed on weekly rounds by the	IPC Doctor IPC Lead Antibiotic Lead Pharmacist	May 2016	Ward rounds involving microbiologist, IPCN and antibiotic pharmacist on Tuesday and Fridays
5. Prompt detection of transmission of *C. difficile*	Signs of transmission of infection are detected early enabling precautionary interventions	Numbers of C. difficile cases in the hospital are monitored and reported.	IPC Doctor	April 2016 In Place	In place as embedded process
		Monitoring pathway of patients is part of initial review.	IPC Lead Nurse	May 2016	In place
		All *C. difficile* cases ribotyped.	IPC Doctor	Completed	IPC Doctor requests all cases to be ribotyped.
		Produce protocol following identification of 2 or more cases of C. difficile in a ward/unit within 30 days.	IPC Lead Nurse	1st July 2016	
6. Improve process to provide assurance of isolation within 2 hours of diarrhoea being identified	All patients with assessed potentially infectious diarrhoea to be isolated within 2 hrs.	Communicate isolation priority to Bed Managers, Medical and Nursing teams.	IPC Lead IPC Doctor	1st June 2016	
		Review C. difficile RCA forms for isolation information.	IPC Lead	Completed	This is already embedded practice
		Isolation audit	IPC Lead	1st July 20216	

7. Improve process to provide assurance for cleaning of shared equipment	Rigorous and consistent process to assure shared equipment is decontaminated between use.	Cleaning policy to include protocol of use for the green "I am clean" label. Meridian audit to reflect the protocol	IPC Lead/ facilities	1st August 2016	
8. Damaged surfaces of patient equipment is difficult to decontaminate to a safe standard.	Ensure all equipment are constructed of wipe-able surfaces which are intact and in a good state of repair	Replace damaged commodes.	IPC Lead	1st July 2016	Business case for purchase of forty new commodes agreed.
		Include patient equipment as part of the IPC audit programme	IPC Lead	1st September 2016	
9. Review C. difficile diarrhoea and isolation policies to ensure alignment with national guidance.	Policies for diarrhoea and C. difficile are aligned and aligned with supporting tools and national guidance with clear actions and responsibilities.	Produce and launch new policies *for C. difficile* and diarrhoea with aligned tools.	IPC Lead	1st August 2016	
10. Ensure information regarding patients' infection status is communicated to receiving departments.	Appropriate infection status is documented on ICE and transfer forms	Information to be cascaded to medical teams via the director of medical education.	Dr Topping	June 2016	
		Information to be cascaded to the link practitioners.	IPC Lead	June 2016	
		Monitor and review documentation via the datix system and audit.	Divisions/, IPC Lead	October 2016	
11. The Trust embeds learning from cases	All cases are subject to an RCA the learning from which is embedded in the organisation.	RCAs to continue. RCAs To include a statement of any identified lapses in care that lead to case/ infection.	IPC Lead	Completed	This is embedded practice
		To report actions & learning to TIPCC, CCG and Divisional Boards and put in IPC newsletter	IPC Lead/ Divisional Leads	Completed	PIR/RCA is an agenda item for TIPCC and Divisional IPC meetings

Key Performance Indicators Reported to RAQC

2016/17		Financial Year 2016-17												
		April	May	June	July	August	September	October	November	December	January	February	March	Current Position YTD
Patient Incidents	RIDDOR incidents	0	0	0										0
	H&S public liability claims	1	0	1										2
	Slips, Trips & Falls (not including inpatient falls)	0	0	1										1
	Physical assault	1	0	1										2
Visitor Incidents	RIDDOR incidents	0	0	1										1
	H&S public liability claims	0	0	0										0
	Slips, Trips & Falls	6	7	3										16
The Workforce (Including Contractors) Incidents	RIDDOR incidents	0	2	2										4
	Slips, Trips & Falls	4	2	5										11
	Employer liability claims	2	0	0										2
	Sharps incidents	8	15	11										34
	Workplace stress	4	8	3										15
	Contact dermatitis/latex	0	0	0										0
	Musculoskeletal injuries	5	2	7										14
	Physical assault	3	10	4										17
	H & S training (Compliance) (YTD = Latest Available Position)	86%	89%	87%										87%
	Significant workplace fires	0	0	0										0
	Total Staff	5301	5310	5470										5470

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-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Average monthly total
RIDDOR Incidents		0	2	2	0	0	0	0	0	0	0	0	0	4
RATE %	Red < 0.61 Amber 0.61-0.56 Green > 0.56	0.000	0.377	0.366	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.249
Slips, Trips and Falls		4	2	5	0	0	0	0	0	0	0	0	0	11
RATE %	Red < 1.28 Amber 1.28-1.18 Green >1.18	0.755	0.377	0.914	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.684
Sharps Injuries		8	15	11	0	0	0	0	0	0	0	0	0	34
RATE %	Red < 0.62 Amber 0.62-0.57 Green > 0.57	1.509	2.825	2.011	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	2.114
Mgr Referrals to OH for Stress		4	8	3	0	0	0	0	0	0	0	0	0	15
RATE %	Red < 0.62 Amber 0.62-0.57 Green > 0.57	0.755	1.507	0.548	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.933
Work related Musculosketal Injuries		5	2	7	0	0	0	0	0	0	0	0	0	14
RATE %	Red < 1.19 Amber 1.19-1.09 Green > 1.09	0.943	0.377	1.280	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.871
Physical Assault		3	10	4	0	0	0	0	0	0	0	0	0	17
RATE %	Red < 1.17 Amber 1.17-1.07 Green > 1.07	0.566	1.883	0.731	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	1.057
Total Staff		5301	5310	5470	0	0	0	0	0	0	0	0	0	16081