East and North Hertfordshire NHS Trust
Trust Board Part 1

7 March 2018 14:00 - 7 March 2018 15:30

AGENDA

#	Description	Owner	Time
1	Chair's Opening Remarks	Chair	
2	Declaration of Interests		
3	Questions from the Public Members of the public are reminded that Trust Board meetings are meetings held in public, not public meetings. However, the Board provides members of the public at the start of each meeting the opportunity to ask questions and/or make statements that relate to the work of the Trust. Members of the public are urged to give notice of their questions at least 48 hours before the beginning of the meeting in order that a full answer can be provided; if notice is not given, an answer will be provided whenever possible but the relevant information may not be available at the meeting. If such information is not so available, the Trust will provide a written answer to the question as soon as is practicable after the meeting. The Secretary can be contacted by email (jude.archer@nhs.net), by telephone (01438 285454), by fax (01438 781281) or by post to: Company Secretary, Lister Hospital, Coreys Mill Lane, Stevenage, Herts, SG1 4AB. Each person will be allowed to address the meeting for no more than three minutes and will be allowed to ask only one question or make one statement. However, at the discretion of the Chair of the meeting, and if time permits, a second or subsequent question may be allowed. Generally, questions and/or statements from members of the public will not be allowed during the course of the meeting. Exceptionally, however, where an issue is of particular interest to the community, the Chairman may allow members of the public to ask questions or make comments immediately before the Board begins its deliberations on that issue, provided the Chairman's consent thereto is obtained before the meeting.		
4	Apologies for Absence		
5	Minutes of Previous Meeting For approval 5. Minutes from 10 January 2018 Part I - AMENDE... 5	Chair	
6	Matters Arising and Actions Log For information 6. Actions Log - Board Part 1 - January 2018.pdf 15	Chair	
7	Annual Cycle For information 7. Board Annual Cycle 2017-18.pdf 17	Company Secretary	

#	Description	Owner	Time
8	Chief Executive's Report For discussion 8. CE Board Report - March 2018.pdf 23	Chief Executive	
9	Strategy		
9.1	Trust Strategy and Objectives 2018/19 For discussion 9.1 Trust Strategy and Objectives 2018 19.pdf 27	Director of Strategy	
9.2	Mount Vernon Clinical Strategy For decision 9.2 Mount Vernon Cancer Centre Clinical Strategy.... 33	Director of Strategy / Divisional Chair Cancer Services	
9.3	Risk Management Strategy and Board Assurance Framework For approval 9.3 a) Approach to Risk Management.pdf 49 9.3 b) Appendix 1 - Risk Management Strategy.pdf 53	Director of Strategy	
10	Finance and Performance Committee Report For discussion 10. FPC Report to Board (4) NS final draft.pdf 65	Chair of FPC	14.15
10.1	Finance Report - Month 10 For discussion 10.1 Finance Report Month 10 (Part i).pdf 69	Director of Finance	
10.2	Performance Report For discussion 10.2 - Performance Report.pdf 77	Chief Operating Officer	
10.3	Workforce Report For discussion 10.3 - Workforce Report M10.pdf 89	Chief People Officer	

#	Description	Owner	Time
11	Risk and Quality Committee Report For discussion [P] 11 RAQC Report to Board - 27.02.2018 FINAL.pdf 117	Chair of RAQC	14:45
11.1	Learning from Deaths For discussion [P] 11.1. Learning from Deaths Report.pdf 123	Medical Director	
12	Data pack For information [P] Data Pack.pdf 149 [P] 12- Floodlight Scorecard.pdf 191	All Directors	
13	Part II The Trust Board resolves that under Standing Order 3.17(i) representatives of the press and other members of the public be excluded from the remainder of this meeting, having regard to the confidential nature of the matters to be transacted, publicly which would be prejudicial to the public interest.		15:45-18:00
13.1	Commercial-in-confidence		
13.2	Governance Matters		
13.3	Personnel Matters		
14	Date of next meeting: 2 May 2018 - The New QEII		

EAST AND NORTH HERTFORDSHIRE NHS TRUST

Minutes of the Trust Board meeting held in public on Wednesday 10 January 2018 at 2.00pm at the New QEII Hospital, Welwyn Garden City

Present:	Mrs Ellen Schroder	Non-Executive Director (Chair)
	Mr Bob Niven	Non-Executive Director
	Mr John Gilham	Non-Executive Director
	Mrs Alison Bexfield	Non-Executive Director
	Ms Val Moore	Non-Executive Director
	Mr Jonathan Silver	Non-Executive Director (Designate)
	Mr Nick Carver	Chief Executive Officer
	Mr Martin Armstrong	Director of Finance
	Mr Michael Chilvers	Medical Director
	Ms Rachael Corser	Director of Nursing
	Ms Bernie Bluhm	Interim Chief Operating Officer
In attendance from the Trust:	Ms Kate Lancaster	Director of Strategy
	Mr Tom Simons	Chief People Officer
	Ms Jude Archer	Company Secretary
	Ms Katie Martin	Corporate Governance Assistant
In attendance external to the Trust:	Mr Justin Jewett	Member of Public
	Kim Handel	CQC
	Hannah Cattell	CQC

18/001 CHAIR'S OPENING REMARKS

18/001.1 Mrs Schroder welcomed the visitors from the CQC to the meeting. She also welcomed both Mrs Rachael Corser, and Mr Michael Chilvers into their new roles as Director of Nursing and Medical Director.

18/001.2 It was noted that this would be the last Board meeting that Mrs Alison Bexfield would attend. Mrs Bexfield was thanked for everything she had done for the Trust in the last ten years.

18.001.3 It was acknowledged that Mr Johnathan Silver will step up as a full Non-Executive Director, and take over from Mrs Bexfield as Chair of the Audit Committee.

18/002 DECLARATIONS OF INTEREST

18/002.1 There were no declarations of interest.

18/003 QUESTIONS FROM THE PUBLIC

18/003.1 *How are the non-executive directors feeling about the progress that ENHERTS Trust have made towards achieving the 62 day Cancer Pathway, and which best practices are being used from PAH to achieve improvement?*

18/003.2 Mrs Schroder responded to this with reference to the performance report. She commented on the sharp fall back in June being disproportionate, and the impact of the new measures being taken on improving the 62 day rate. For example, the October number was higher than earlier in the year, clearly evidencing how the Trust is seeing patients more quickly. It was recognised that the Trust had not hit their trajectory and this was not where the Trust or Board wanted to be. However, improvement plans were in place focusing on changes and stabilisations, and breaches by trauma groups.

18/003.3 With regards to PAH, Mrs Schroder highlighted how the Trust has reviewed and learnt from their practices but that direct performance comparisons were not possible. She explained that MVCC is tertiary and holds a different group of cancer patients meaning it is harder for them to hit their targets as they accept referrals from other hospitals. This inevitably results in our number of cancer patients being significantly higher than PAH and more complex.

18/003.4 The Interim Chief Operating Officer emphasised the close connection between the Trust, and other acute cancer providers to ensure best practice is shared between the organisations. She stated the open dialogue of what has worked for other Trusts such as 2WW appointment scripts and STT pathways at PAH has meant that learning is extremely real as we can adopt and build similar practices in order to improve.

In summary

- ENHT are part of the regional cancer collaborative and are working widely with other acute cancer provider to ensure that best practice is shared across the region.

- ENHT have introduced a 2WW appointment script that is used when booking patients on a suspected cancer referral pathway. This script is similar to that being used at PAH and advises the patient that they have been referred on an urgent suspected cancer pathway, therefore it is essential that the GP has informed the patient of this prior to making the referral. The Trust is working closely with the CCG and all patients are being provided with a leaflet from CRUK by the GP explaining the need to make themselves available for a short notice appointment.

- In addition as per the actions implemented at PAH the trust has reducing the C&B polling times for the 4 timed tumour site pathways with the intention of trying to offer patients an appointment within the first week of the 2week wait standard. This is a new development and will require more time before an effective evaluation can be considered.

- Equally, ENHT aim to streamline the Lung, Colorectal, Prostate and Breast pathways in line with national best practice guidelines. Shared learning from PAH has demonstrated that that the Straight to test (STT) pathway alongside further pathway adjustments has enabled PAH to reduce their Lung Cancer pathway by circa 14 days; the Trust will be adopting a similar practice. The "one stop" service in place for patients on a prostate pathway at PAH has also enabled them to streamline their Urology pathways in line with national best practice guidance. Our teams at ENHT aim

to adopt a similar approach within our pathways.

- Both Cancer Leads at PAH and ENHT work closely together and continue to share best practice between the organisations. Both Leads often meet with their GP Lead and STP Project Manager together to steer and implement the operational agenda of the STP.

18/004 APOLOGIES FOR ABSENCE

18/004.1 There were no apologies for absence.

18/005 MINUTES OF THE PREVIOUS MEETING

18/005.1 The Board reviewed and approved the draft minutes of the previous meeting.

18/006 MATTERS ARISING AND ACTIONS LOG

18/006.1 The Board reviewed and noted the actions log with the following comments:

- 18/006.2: Social Care Funding - assurance was provided that the funding has been important, and is being spent on what we want it to be spent on in order to support the Trust. Mrs Schroder questioned what happens when the funding stops in April, the Interim Chief Operating Officer confirmed we have and will continue to deliver when the funding comes to an end.

- 18/006.3: Vascular Surgery Hub - the business case is in progress. Mr Niven asked if there was a timetable for this. The Director of Strategy responded by explaining that we are awaiting input from finance and activity data from West Herts, but will be pushing in the next two weeks.

18/007 ANNUAL CYCLE

18/007.1 The annual cycle was noted.

18/008 CHIEF EXECUTIVE'S REPORT

18/008.1 The Chief Executive delivered the Chief Executive's Report, highlighting the following items:

- The Chief Executive gave thanks to Mrs Alison Bexfield for her contributions to the Trust over the last ten years which were greatly appreciated.
- The Chief Executive welcomed the newcomers, and noted that we are nearing the end of recruitment for the Executive team which was significant for the organisation.
- The Chief Executive also gave thanks to all the staff for their tremendous efforts, and going beyond to provide high quality care in a time when the Trust is faced with high peaks of activity and massive winter pressures.
- The national staff survey results will be published in February 2018. An online workshop for feedback has been launched with the responses being balanced, constructive and focussed on how improvements can be made.
- Great achievement for Lister's Respiratory Department as the

service was rated in the top 5% for review and discharge by the Royal College of Physicians. Also, following an audit of the Lister's Multiple Pregnancy Team, the service has been rated as exceptional by the Twins and Multiple Births Association.

- The Ambulatory Care Team at the New QEII hospital has received a Purple Star award from Hertfordshire County Council for their work in improving services for people with learning disabilities. The Chief executive specifically highlighted that we need to be making sure we follow the Purple Star award in other specialities, and into the Lister hospital.
- The Trust's international nurses have achieved 97% pass rate in their exams against the national average of 60%.

18/008.2 The Board noted the latest Floodlight Dashboard. The Director of Finance however advised that the numbers are not the most recent.

FINANCE AND PERFORMANCE

18/009 FPC report to board

18/009.1 The Board received the report of the Finance and Performance Committee meeting held on 20 December.

18/009.2 Mr Swift highlighted cancer underperformance and discussions on how to get to the target by March with the means of an underlying action plan. He reported that the Committee received a comprehensive review on how to address ED performance and patient flow, detailing that the 7 initial work streams were being refined into 3 key work streams. Mr Swift clarified that part of the work would be to explore options for providing an ambulatory emergency care service in ED.

18/009.3 Mr Swift reported the Committee was encouraged with regards to the Lorenzo Stabilisation plan. It was noted that NHS Digital were positive regarding the Trust's actions to date, and considered the plan could be successfully executed if focus was given to the three core priorities.

18/009.4 The Director of Finance was clear that income had improved in month 8. He also indicated that activity was better than previous months with Outpatient activity increased to the highest level of 2017/18, and day case activity throughput higher in November. Despite an increase in pay expenditure, a significant element of this was expected to be non-recurrent. The Director of Finance advised that the Trust's activity and cost improvement programme in regards to Outpatients has faced challenges since the implementation of Lorenzo.

18/010 Finance Report Month 8

18/010.1 The Director of Finance delivered the Month 8 Finance Report. Key points to be noted included:

- The Trust reported a £1.4m deficit in month, bringing the year to date position to a £19.3m deficit. This represents a £1.1m adverse variance against the original plan in month, after removing the impact of STF funding.
- As a result of the adverse year to date variance, the Trust

has assumed that it will not be eligible for STF funding in Q2 and Q3.

- There was a significant increase in pay expenditure in month, partially due to some pay arrears as well as increasing costs to support Operational management and Lorenzo.
- CIP performance during November was poor compared with plan, but was broadly in line with forecast.
- The SLA income in month has had a positive benefit from the refresh of M7 income of £132k.
- The Trust continues to report significant under performance against its SLA plan. This variance now totals £9.0m for year to date M8.

18/010.2 Mrs Schroder encapsulated the £9.0m variance on SLA activity and scrutinised the possibility of over projecting growth. The Director of Finance was of the view that the estimates on growth were reasonable, but did acknowledge that estimates are actually reducing due to the change in patient and financial pathways. Mrs Schroder asked if this pattern would continue for the next year also. The Director of Finance responded to this by reassuring the Board that there is a 2 year planning cycle in place to reduce uncertainty, and with the launch of the new planning guidance, this risk will be reviewed.

18/010.3 Mrs Schroder observed the £12.1m savings and perceived it to be a fantastic achievement by Month 8, praising the efforts and management of Finance. The Director of Finance welcomed the positive message, and proposed that the inherent benefits due to the changes needs to continue to flow back into the organisation.

18/010.4 Mr Gilham asked in relation to the new models of care and relevant discussions with commissioners, how the benefit is being shared. The Director of Finance replied that better internal forums with commissioners, and the enhancement of business skills in relation to new models of care is allowing this sharing to take place. The Interim Chief Operating Officer reinforced this, identifying that the redesign and relocation of assessment units is enabling us to move forward, but a lot of work still needs to be done.

18/010.5 Mr Gilham questioned the shortfall in income nearly doubling in radiology in Month 8. The Director of Finance stated that this was something he would investigate in more detail.

18/011 Performance Report Month 8

18/011.1 The Interim Chief Operating Officer introduced the Month 8 Performance Report. Key points to note included:

- RTT- Following migration to Lorenzo, the Trust is unable to report November's performance against the RTT standard. Dialogue is continuing with NHS Improvement to establish timescales for return to reporting and currently seeking to report in March for February's performance.
- 4 Hour Performance- November's performance against the four hour standard was 81.796% with Nerve Centre continuing to pose operational challenges for reporting, showing that ED's performance continues to be high risk. Also, due to the winter pressures this has been difficult to maintain, with vulnerable individuals and urgent cases taking

priority, but the Trust has opened 46 additional beds to support capacity.

- 62- day Cancer Performance- the Trust did not achieve the 62 day performance standard and acknowledged that this was not acceptable. However, there are indications of consistent and sustained performance against the two week GP referral to first outpatient performance, as well as the waiting list profile remaining consistent with a sustainable recovery. Assurance was given of a comprehensive action plan to support the improvement plan.
- Stroke Performance-The total thrombolysis rate for confirmed strokes sits at 6.3%. However, very few patients are eligible for thrombolysis which explains why the numbers are so low.
- Diagnostics Performance-The Trust has not been able to report the DMO1 Performance in November as a consequence of moving to Lorenzo. Actions in place as part of the Lorenzo stabilisation plan to return to reporting as soon as possible.

18/011.2 Mr Niven enquired if there could be opportunities in relation to skill mix of staff we will need, in order to deliver the ED service which could improve performance. The Interim Chief Operating Officer indicated that this is being supported in the redesign of the emergency care and acute medical care pathway / model work over the six month period.

18/011.3 Mr Gilham recognised the potential risk that if performance targets are missed the number of serious incidents and compromises to patient safety are likely to increase. The Medical Director confirmed the slight increase in serious incidents at the end of the last year. However, he suggested that if prioritising care of vulnerable individuals continues, the risk will be mitigated as a much as possible. This continues to be monitored.

18/011.4 Mrs Schroder reinforced Mr Gilham's concerns, querying whether the cancer breaches have uncovered real patient harm. The Interim Chief Operating Officer provided assurance to this by replying that the Trust has not seen any patient harm to date. Processes are in place and clinical validation continues.

18/011.5 The Medical Director commented on the Trust performing above and beyond considering the winter pressures, with external partners also being very supportive. Mrs Schroder agreed with this, and suggested that the Trust needs to keep pulling together to maintain this level of performance.

18/012 Workforce Report Month 8

18/012.1 The Chief People Officer delivered the Month 8 Workforce Report. Key highlights were:

- Temporary staffing- The monthly agency ceiling target was achieved in month 8 with agency spend under by £104k. The Trust is under the ceiling target by £2,561k, year to date therefore continuation of this work will ensure that the target is achieved by year end. The operational challenge of how the shared bank could be expanded is being reviewed.
- Resourcing- positive movement in regards to vacancy rates as by the end of November 2017 it stood at 8.2%, with specific emphasis on medical staff. There was a net increase

of 40.47 WTE in post in November bringing the Trust to within 41.87 WTE of the year-end target.

- Staff retention- In November 2017 the turn-over rate was at 13.02%, putting the Trust 0.85% away from the in month target and 1.02% away from the end of year target. Concerns' surrounding the turn-over targets has led to the NHSI Retention Improvement Programme which will re-set the target for the next 12 months.
- Capability of leaders- The new Leadership, Management and Coaching development Pathway launches this month. This pathway will utilise up to date blended learning in order to deliver effective training to managers and embed a strong leadership culture.

18/012.2 Ms Moore opened the discussion focussing on the lowered agency spend. She challenged whether or not the strategies for achieving this had been exhausted. The Chief People officer explained that the success around recruitment is still progressing, emphasising the International piece to show that we are still seeing benefits from the strategies and work implemented.

18/012.3 Ms Moore further probed whether or not there is a link between lowered agency spend and patient quality. The Chief People officer provided confidence that the shared work on temporary staffing would enable that translation to come through; the construction and flexible model should improve patient care and quality. He elaborated that the next step would be focussing on hotspots.

18/012.4 Mr Niven commented on staff retention, and whether there were any trends amongst the reasons for leaving that we could tackle. The Chief People Officer welcomed this issue, informing the Board that there is a clear trend in the form of 'work/life balance' and 'other'. He underlined that the Trust is endeavouring to tackle this by running focus groups and more face-to-face exit interviews. Mrs Schroder noted the efforts, but provided criticism detailing the Trust needs an initiative to stop individuals making the decision to leave initially.

18/012.5 Mr Niven enquired about indications of likely take up and sustainment, for the Leadership Management and Coaching pathway within the Trust due to the winter pressures it has been experiencing. The Chief People Officer remained positive and optimistic that it will be engaged with, and embedded in the organisation as the winter pressures begin to ease.

RISK AND QUALITY

18/013 Risk and Quality Committee Report

18/013.1 Mr Gilham presented the RAQC Committee report. Key highlights included:

- Nursing Establishment Review- detail of the methodology of the review was included in the report. The proposed changes in principle and recommendations were recommended for approval by the Trust Board.
- BAF Discussion- Capacity and Demand - the Trust has commissioned an external company to undertake capacity and demand modelling. Work is taking place to look at improving patient flow at the ED front door; remains a key

area of risk and could be improved.

- End of Life Care- RAQC had received a presentation from the Clinical Lead. The achievement of the Butterfly project and work taken place in relation to carer support. Identified challenge of the STP decision not to adopt the RESPECT model. The team are looking to share feedback from relatives and carers in order to further engage divisions regarding end of life experiences.
- Emergency Preparedness Quarterly Update- the Division Executive Committee has given approval for a full time role for EPRR.
- SI Reports- There have been 56 SIs in total for 2017 year to date. There were currently no Root Cause Analysis reports overdue to the CCG and no outstanding clarifications.

18/014 Nursing Establishment Review

18/014.1 The Director of Nursing emphasised that the funding establishments are entirely appropriate, and made the Board aware that all ten recommendations have been accepted by RAQC. She noted the success of the Trainee Associate Nurse Pilot, commenting on how our 17 TNA's are progressing well and have completed their first external placement for a period of four weeks. The Director of Nursing also recognised the success of the Enhanced Nursing Care Team, detailing real positive patient benefit in the form of falls reduction, higher level of care for vulnerable patients and reduced length of stay. The mental health enhanced care will be reviewed in December with a view for uplift in the team to support the mental health demand. She also highlighted that development of the Non Ward Based Nursing Project has been significant, with the achievement of being within the financial contribution target of £12k per month.

18/014.2 Ms Moore expressed support for the approach and methodology used for the review which gives confidence to the Board, but queried how the nursing quality indicator on falls was used. The Director of Nursing suggested that monitoring the falls trend and picking this up on the wards, as well as encouraging the safe mobilisation of fallers provides the extra support that vulnerable patients need.

CHARITY TRUSTEE COMMITTEE REPORT

18/015 CTC Report to Board

18/015.1 The Board reconvened as the Corporate Trustee of the Charity. Mr Niven presented the summary report, explaining that the Committee agreed to pilot the process and form in relation to accessing charitable funds for education and training. He detailed that the committee did not reach a decision on approvals for expenditure over £5,000 due to quality of the application paperwork received by the Charity Management Team and these would be reviewed again at the next meeting.

18/015.2 With regards to the Charity Finance Report, Mr Niven suggested that the Trust is on track for its income expenditure. Finally, it was noted that the Charity action plan to ensure compliance with the new General Data Protection Regulation has been implemented and is

making progress against the required timeline.

18/016 Charity Strategy

18/016.1 The Board (as Corporate Trustee) was presented with the Charity Strategy. The Director of Strategy encapsulated the core of the Strategy to be stepping up ambition and professionalisation for the charity, in order to achieve greater alignment between the Trust and the Charity. The Director of Strategy expanded on this, highlighting transformation within fundraising and looking at opportunities, specifically for more internal awareness and planned charitable contributions is extremely important for development.

18/016.2 The Chief Executive articulated the potential for Charity fundraising from £1.5 million to £3 million over a scalable period would make a real difference. Mrs Schroder agreed that it would be a significant help for the Trust and our patients. Ms Moore identified the issue that the Charity does not capitalise to the extent that it could and questioned the way forward with regards marketing. The Director of Strategy responded by communicating that a branding solution which brings relevance to both the local community, and national foundations is needed to resolve this inherent weakness and would be part of the delivery plan underpinning the strategy.

18/016.3 Mrs Schroder recognised the risk of the Charity having a lack of internal awareness and reputation within the hospital. The Director of Strategy acknowledged this and advised that this is clearly an area to work on.

18/017 DATA PACK

18/017.1 The Board noted the data pack.

There being no further business the Chair closed the meeting at 3.45pm.

Ellen Schroder
Trust Chair

January 2018

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

Agenda item: 6

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

Meeting Date	Minute ref	Issue	Action	Update	Responsibility	Target Date
26 July 2017	17/125.2	Social Care Funding	Once each quarter provide a briefing to Board on the progress with workstreams regarding the additional H&SC funding as part of the Performance Report.	**November 2017:** Verbal update to be provided at the meeting. **January 2018:** See minutes of 1 November Board meeting (paragraph 17/193.1) for details of discussion regarding this action. Update to be provided at January Trust Board meeting.	Chief Operating Officer	November 2017 January 2018
6 Sept 2017	17/161.2	Vascular Surgery Hub	Develop a business case in order to ensure a high level of service and to provide assurance.	**January 2018:** In progress – awaiting input from finance team/West Hertfordshire .	Director of Strategy	January 2018 • Review April 2018

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

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

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

Board Annual Cycle 2017-18

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Strategic Review & Financial recovery Plan (TBC)			*x (draft recovery plan)	*x (final recovery plan)				*x (final recovery plan) (awaiting confirmation of date / timeline of final submission)				
Sustainability and Transformation Plan (STP) (Part 2 new standing item)				x		x		x		x		x
Other Items												
Audit Committee												
Annual Audit Letter				x								
Annual Report and Accounts(Trust), Annual Governance Statement and External Auditor's Report		x										
Audit Committee TOR and Annual Report				x								
Quality Account and External Auditor's Report			x									
Raising Concerns at Work				x								x
Review of SO and SFI								x				
Charity Trust Committee												
Charity Annual Accounts and Report								x				
Charity Trust TOR and Annual Committee Review						x						
Finance and Performance Committee												

Board Annual Cycle 2017-18

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Draft Floodlight Indicators and KPIs				x								
Financial Plan inc CIPs and Capital Plan *(subject to change as dependant on national timeline)*							*x		*x			x
FPC TOR and Annual Report			x									
IM&T strategy review										X (revised timescale to be agreed)		
Market Report		x						x				
Market Strategy Review (TBC)												
Risk and Quality Committee												
Adult Safeguarding and L.D. Annual Report		x										
Detailed Analysis of Staff Survey Results	x											
Board Assurance Framework and review of delivery of objectives												x
Equality and Diversity Annual Report and WRES.				X				X (Considered at Trust Board in July)				
GMC National Training Survey *(subject to change as dependant on national release)*								X (reported in RAQC Report at Oct Board Development)				
Health and Safety Strategy Review				x								
Improving Patient Outcomes Strategy				x								
Mortality (Learning from Deaths)	x			x				x				x

Board Annual Cycle 2017-18

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Nursing and Midwifery Strategy Review								X (due to be considered at RAQC in January 2018)				x
Nursing Establishment Review				x						x		
Patient Experience Strategy Review				X (RAQC/ Data Pack)								
Nursing - PQAF / Education report								x				
RAQC TOR and Annual Review				x								
Research and Development Annual Review			X (RAQC)									
Responsible Officer Annual Review				X (RAQC)								
Safeguarding Children Annual Review				x								
Serious Incidents Report (Part 2)				x				x		x		
University Status Annual Report												Q1 2018
Shareholder / Formal Contracts												
ENH Pharma (Part 2) [iii]				x								x
tPP (Part 2)	x	x	x	x		x		x		x		

Board Annual Cycle 2017-18
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[i] The Data Pack will include the Friends and Family Test, Statutory and Mandatory Training Exception Report, Health and Safety Indicators, Nursing Quality Indicators, Finance Data, Performance Data, CQC Outcomes, Workforce Data, Safer Staffing Data and Infection Prevention and Control Data.
[ii] The FPC Report will include the Committee Report, the Finance Report, Performance Report and Workforce Report for the month.
[iii] To include the Annual Governance Review in July

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

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

East and North Hertfordshire NHS
NHS Trust

Chief Executive's Report

March 2018

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1. Corporate Update

Winter Pressures

January and February have been busy months as winter pressures continue. Our winter pressure wards 7AN and 7AS remain open to support the additional demand on beds and in January we took additional steps to provide further capacity for unscheduled care admissions by stopping elective orthopaedic surgery and utilising our ring fenced beds.

The additional bed base is increasing our demand on nursing and medical staffing and the response of our staff has been tremendous. The commitment of staff to support colleagues and work additional hours to ensure our patients are safe and comfortable is inspiring. The winter months are demanding on our staff and we know from previous years that the winter pressures are likely to continue through to the end of March.

This winter, the Nursing, Admission and Infection Prevention and Control Teams have together successfully minimised the impact of seasonal viral gastroenteritis by the prompt recognition of symptomatic patients, appropriate placement of patients, taking pre-emptive limited but effective actions such as the closure of bays. Such actions have prevented significant ward outbreaks and no ward closures have been required.

CQC Inspection Preparations

We have now received formal notification from the Care Quality Commission (CQC) of the next inspection of our services. Our previous comprehensive inspection was in October 2015 where we received a Trust rating of 'requires improvement' with some services and sites rated 'good'. A follow up unannounced inspection of our Emergency Department and Children's Inpatient Services took place in May 2016, where substantial improvements were noted in these areas.

The CQC inspection is now split into two phases and will occur annually. There will be an unannounced inspection of our core services across our sites and it is anticipated that this will occur during March 2018. This will be followed by an announced Well Led Inspection which is scheduled to take place 23-25 April 2018. We are supporting our staff to prepare for the inspection of their area and share what they are proud of and the quality improvements they have made and those they have planned.

During February our CQC inspectors have facilitated a number of focus groups for our staff to attend and share their experiences of working at the Trust. So far over 300 of our staff have supported these, with a further day scheduled at the New QEII

on 5 March 2018.

NHS Improvement will also by undertaking the new ‘use of resources’ assessment on the Trust on 11 April 2018. This assessment is designed to improve understanding of how effectively Trust are using their resources – including finance, workforce, estates and facilities, technology and procurement – to provide high quality care for patients. This assessment will generate a separate report and will be published by the CQC.

Lorenzo Stabilisation

The stabilisation of the Trust in relation to Lorenzo and Nerve Centre is progressing with a stabilisation approach, a top level plan agreed and a stabilisation steering committee in place. Funding discussions are ongoing with NHS England, NHS Improvement, and NHS Digital. An implementation partner has been selected (Channel 3) after formal bids and supplier interviews. Resources are expected start to arrive on site in early March.

2. Our Staff

Congratulations to Dr Shahid Khan, Consultant in Elderly Care who has been appointed Associate Dean, Health Education England (East). This role will include developing a medical training Initiative, offering trainee doctors from countries outside the European Union the chance to gain experience in the NHS. Shahid will also continue with his current role at the Trust as director of medical education and associate medical director.

Congratulations also to Nikhil Vasdev who has received confirmation of full financial support for the Cytokine Study, AirSeal System in robotic Urology with Lister Hospital leading the study.

Trust Consultant Stephen Tai has received a Certificate of Excellence award from healthcare review website iWantGreatCare. The awards are presented regularly to clinicians in the country across a number of different specialties - including GPs and nurses.

Finally, Trust Consultant and Royal Navy reservist Liz Turner recently passed the Officer Initial Naval Training programme and has been promoted to Surgeon Lieutenant Commander. She was presented with her rank slides by Deputy Commander Maritime Reserves Colonel Jeff Moulton.

Diabetic Screening Team Amongst the Best Performers in England

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

The service, which sees patients locally at a number of centres across east and north Hertfordshire, including in Stevenage, Welwyn Garden City and Hertford, was rated the best in the country for seeing patients with proliferative diabetic retinopathy within four weeks of receiving their positive screening results. They also ranked second in England for the uptake of screening, with 91% of patients offered an appointment attending. The team was also recognised for giving 99.7% of patients their screening results within three weeks of their appointment.

East and North Hertfordshire NHS Trust

Agenda Item:9.1

TRUST BOARD PART 1 – MARCH 2018

East and North Hertfordshire NHS Trust's Strategy Update

PURPOSE	To present for final approval an update on progress against objectives for the Trust's strategy 2017/18 and the final version of the Trust's Plan on a Page 2018/19 following sign off from DEC and the Strategic Programme Board. Approved objectives will be embedded with the performance review framework for 2018-19 and divisional and corporate progress reported on a quarterly basis against the primary measures (now included in the plan).
PREVIOUSLY CONSIDERED BY	**DEC. Presented to Board Development February 2018**
Objective(s) to which issue relates *	[X] 1. **Keeping our promises about quality and value** – embedding the changes resulting from delivery of Our Changing Hospitals Programme. [X] 2. **Developing new services and ways of working** – delivered through working with our partner organisations [X] 3. **Delivering a positive and proactive approach to the redevelopment of the Mount Vernon Cancer Centre.**
Risk Issues (Quality, safety, financial, HR, legal issues, equality issues)	Draft objectives are intended to support the Trust's response to key operational, clinical and strategic risks.
Healthcare/ National Policy (includes CQC/Monitor)	NHS Five Year Forward View
CRR/Board Assurance Framework *	[X] **Corporate Risk Register** [ ] **BAF**

ACTION REQUIRED *

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

DIRECTOR:	Director of Strategy
PRESENTED BY:	Director of Strategy
AUTHOR:	Director of Business Development & Partnerships
DATE:	2 March 2018

East and North Hertfordshire NHS Trust's Strategy Update

1. Overview

This paper presents, for final approval:

- progress against objectives for the Trust's strategy 2017/18
- the final version of the Trust's Plan on a Page 2018/19

2. Progress against objectives for the Trust's strategy 2017/18

The Trust is part way through our strategy for 17/18 and has reviewed progress against objectives to date. These are attached at appendix 1.

3. Trust's plan on a page 2018/19

The Plan on a Page 2018/19 (appendix 2) has been developed following feedback from previous DECs and the Strategic Programme Board. Approved objectives will be embedded with the performance review framework for 2018-19 and divisional and corporate progress reported on a quarterly basis against the primary measures (now included in the plan).

4. Trust's new five year plan

The Trust has commenced planning for the development of a new five year strategy which will be supported by insight from staff and substantiated by specialty-level clinical strategies. A presentation has been shared with Divisions to communicate to their teams the Trust's plans and how individuals can participate. The strategy team will support Divisions with this.

5. Conclusion

The Board is asked to:

- note the achievements to date against the 2017/18 strategy
- consider and approve the proposed measures for the 2018/19 strategy
- to note the commencement of engagement with Divisions for development of the Trust's new five year strategy.

Appendix 1: Progress against objectives for the Trust's strategy 2017/18

Appendix 2: Trust's Plan on a Page 2018/19

TRUST PLAN ON A PAGE 2017/18

East and North Hertfordshire NHS Trust

Our vision: To be amongst the best for clinical outcomes, patient experience and financial sustainability

Our strategic aims	Our strategic objectives	Primary measure of success	Achievements to date 17/18

Delivering our promises on value and quality	…by improving patient experience	• *achieve milestones in Patient & Carer Experience Strategy*
		• *achieve milestones in Engagement Strategy*
			Key successes:
			• The Trust continues to maintain a consistently high inpatients' Friends and Family score throughout 2017/18, with above national-average participation
			  • October 2017 97.01%
			  • November 2017 96.35%
			  • December 2017 97.87 %
			  • January 2018 97.20%
			• We have extended visiting hours to support patients and their families and improve the patient experience
			• Purple Stars for supporting people with learning disabilities have been earned by the Diabetic eye screening team and the ambulatory care team at the New QEII
			• Our annual general meeting (AGM) in July 2017 attracted over 300 delegates returning a 90% satisfaction rating
			• In collaboration with Health Education East of England we delivered the Trust's second annual work experience week at the Lister hospital for 74 local school pupils
			• The Lister's multiple pregnancy team has been rated as 'exceptional' by the Twins and Multiple Births Association (TAMBA), in recognition of a decrease in the number of women delivering their second twin through caesarean section after giving birth to the first naturally. The rate has fallen from 17% to 3%

	…by improving patient outcomes	• *achieve milestones in the Improving Outcomes Patient Strategy* • *achieve milestones in the Research* Strategy	**Key successes:** • Hospital-acquired pressure ulcers are at an all-time low. In 2017 there were just 31 cases reported across the whole 12 months • It has been six years since the Trust recorded the most severe form of pressure ulcer • e-Obs (Nerve Centre) commenced on wards • We are exceeding our target for the number of research participants to studies which are adopted to the national Institute for Health Research Portfolio. For April 2017 – December 2018 we recruited 1,803, 9% ahead of our year to date expectation of 1,655. • The Trust is now in the top 50 research active hospitals in the country (annual National Institute for Health Research activity league table) • SHMI is stable at 102; crude mortality continues to benchmark well when Michael Sobel House (hospice) is excluded from the figures. **On-going challenges:** • Whilst rolled out e-Obs there is further opportunity to embed
	…by securing financial recovery – transforming our services	• *deliver 17/18 and 18/19 agreed control totals* • *deliver underpinning CIP* • *implement the Trust Lorenzo PAS system during 2016/17* • *improve financial and operational decision making* • *deliver Phase 2 Our Changing Hospitals Transformation Programme*	**Key successes:** • Delivered 85% of CIP target through Transforming Our Hospitals programme • Lorenzo implemented September 2017 • Financial and operational decision-making strengthened by Qlikview • New systems and processes being embedded around business planning **On-going challenges:** • Agreed control total unlikely to be met • Phase 2 of Our Changing Hospitals delayed due to financial position
	…by developing our organisational culture and ensuring our staff are supported and engaged	• *achieve milestones within the People Strategy* • *achieve milestones within the Culture Change Programme* • *achieve milestones in Leadership and Management Strategy* • *achieve milestones in Health & Wellbeing Strategy*	**Key successes:** • LEND embedded as Trust leadership model via quarterly sessions with staff • Leadership, Management and Coaching Development Pathway in place to update staff skills • Health and Wellbeing programme supporting our staff to be well **On-going challenges:** • Initial feedback from Staff Survey suggests deterioration. Ability to have early review has enabled action plans to be developed
	…by transforming our services to deliver consistent improvements in access to care and quality of the care that our patients receive	• *achieve and sustain delivery of all constitutional standards* • *achieve consistent Good CQC ratings across all services and sites*	**Key successes:** • Commencing work on redesign of non-elective pathway • Changes made at Lister's emergency department mean that 80% of ambulances are now turned around within the overall national 30-minute standard, compared to around 10% previously **On-going challenges:** • Lorenzo has impacted our reporting ability and measurement of access standards • Continue to struggle to meet 4 hour target – not met in over 12 months. January performance was 82.03%. • Working on GP streaming at front door • Still not achieving cancer 62 day target however started making improvements Dec / Jan to achieve 80% trajectory planned for March

TRUST PLAN ON A PAGE 2017/18

Our vision: To be amongst the best for clinical outcomes, patient experience and financial sustainability

East and North Hertfordshire NHS Trust

Our strategic aims	Our strategic objectives	Primary Measure of Success	Achievements to date 17/18
New ways of caring	…by developing and redesigning our workforce to respond to recruitment challenges and support new models of care	• achieve milestones within People Strategy • finalise and implement Multi-professional Education strategy • achieve University Trust status	**Key successes:** • Electronic rostering rolled out to all staff • Nursing Associate role implemented • University status awaiting sign off from Department of Health **On-going challenges:** • Achievement of staffing levels on wards
	…by transforming our services to support and deliver STP plans	• *work with partners to redesign patient-centred pathways that facilitate keeping patients out of hospital including full participation in the STP work streams harness benefits from developing back office & support services at scale across ENHT and PAH* • *reduce unwarranted variation*	**Key successes:** • The Trust has established an outreach frailty service, supporting local care homes, and daily frailty clinics to help keep patients out of hospital • A new telemedicine service in diabetes and endocrinology allows hospital consultants to engage directly with their GP colleagues, to identify those patients who would benefit most from an early review of their care • Unwarranted variation has been reduced through review of chest pain, community acquired pneumonia and frailty pathways with STP colleagues • Options are being explored to work more closely with Princess Alexandra Hospital on medicines management and pharmacy **On-going challenges:** • Pace of STP delivery
	…by developing and delivering sustainable specialist services across the STP	• *deliver the renal sustainability strategy* • *further develop seven day services and strengthen clinically fragile services by working collaboratively with partners* • *review capacity and demand and transform service models to deliver more efficient and cost effective pathways*	**Key successes:** • Renal project team established and at options appraisal phase • Vascular hub project and clinical teams established and reviewing data for clinical and financial appraisals **On-going challenges:** • Financial constraints continue to impact on ability to deliver at pace
Develop the Mount Vernon Cancer Centre	…by securing a positive future for the Mount Vernon Cancer Centre (MVCC)	• *commence delivery of the clinical service strategy for MVCC* • *secure the Trust's interest in the site to facilitate future development* • *deliver rolling Linac replacement programme aligned with clinical strategy* • *achieve milestones in Research Strategy*	**Key successes:** • Linac replacement on track; proposals for satellite radiotherapy unit being re-costed • Investigated and evaluated finding a suitable clinical and academic partner for Mount Vernon to support long term ambition • Recently signed Memorandum of Understanding with UCLH **On-going challenges:** • Estate at Mount Vernon Cancer Centre is in poor condition • Discussions with The Hillingdon Trust are on-going to secure a long term solution

TRUST PLAN ON A PAGE 2018/19 DRAFT v9

East and North Hertfordshire NHS Trust

Our vision: To be amongst the best for clinical outcomes, patient experience and financial sustainability

Our strategic aims	Our strategic objectives	Primary Measure of Success	Our priorities to deliver our objectives
Delivering our promises on value and quality	…by improving patient experience	*Through FFT – maintain inpatients' FFT "would recommend" score above 97%*	• We will increase the number of patients recommending care at the Trust • We will engage staff, patients and stakeholders in the development of the new five year strategy. • We will improve patients' experience of discharge from our hospitals
	…by improving patient outcomes	*HSMR and SHMI - remain in the "as expected" range*	• We will reduce avoidable harm to patients including roll out e-obs across medical teams and relevant sites • We will continue to reduce mortality • We will stabilise and optimise the use of Nerve Centre and Lorenzo
	…by securing financial recovery – transforming our services	*Meet Control Total (TBC)*	• We will confirm and deliver the 2018/19 financial control total • We will embed a revised performance management framework
	…by developing our organisational culture and ensuring our staff are supported and engaged	*Staff Survey – improve engagement score (TBC once released); FFT – improve staff who "would recommend care at Trust" score from 47% to 55%*	• We will develop and deliver an action plan that responds to our staff survey • We will refresh the culture change programme with a focus on embedding a strong leadership culture • We will demonstrate Board leadership of LEND • We will deliver a new Leadership, Management & Coaching Development pathway
	…by transforming our services to deliver consistent improvements in access to care and quality of the care that our patients receive	*Meet national Access Standards: 95% 4 hr ED target; 85% first treatment within 62 days; RTT – no patients waiting over 52 weeks*	• We will redesign the acute medical model to ensure that every patient who is an emergency admission is seen by a consultant < 14 hours of admission • We will reinvigorate and embed the SAFER process on all our wards • We will adopt best practice timed pathways for patients with suspected or confirmed cancer • We will implement plans to recover elective waiting lists following the stabilisation of Lorenzo and work to improve our RTT performance
New ways of caring	…by developing and redesigning our workforce to respond to recruitment challenges and support new models of care	*Meet targets for vacancy (<6%) and turnover rates (<10%)*	• We will further reduce the vacancy rate in the Trust • We will further develop our relationship with the University of Hertfordshire and increase staff and patient participation in research
	…by transforming our services to support and deliver STP plans	*STP plans*	• We will continue to develop frailty services to enable patients to be cared for outside of hospital where appropriate • We will optimise outcomes and experience for people receiving end of life care • We will work with other organisations to develop or procure collaborative , sustainable support services in Pathology, Pharmacy, Radiology, Estates and Therapies • We will develop a new 5 year strategy for the Trust for commence from 2019/20
	…by developing and delivering sustainable specialist services across the STP	*Delivery of renal strategy and stroke KPIs (maintain A grade)*	• We will secure the future of the Luton & Dunstable satellite renal unit • We will continue to improve our Stroke services • We will develop plans for a vascular surgery network across Hertfordshire and West Essex, with a vascular centre at Lister
Develop the Mount Vernon Cancer Centre	…by securing a positive future for the Mount Vernon Cancer Centre (MVCC)	*By meeting targets set out in MVCC Clinical Strategy (62 day target; achieve whole cancer centre quality accreditation)*	We will finalise and implement the MVCC Clinical Strategy in order to: (Note: to be confirmed on 2 March following Divisional Board approval of MVCC clinical strategy) • Deliver innovative, high quality and efficient services • With partners, transform how care is provided • Harness patient views and technology to transform the environment in which we deliver care • Attract and retain high quality, expert staff supported by a culture to learn and thrive

Our values: We put our PATIENTS FIRST we strive for excellence and continuous IMPROVEMENT; we VALUE everybody; we are OPEN and honest; we work as a TEAM

Agenda Item: 9.2

TRUST BOARD – 7 MARCH 2018

MOUNT VERNON CANCER CENTRE – CLINICAL STRATEGY

PURPOSE	To present for consideration and approval the final draft clinical strategy for the Mount Vernon Cancer Centre (MVCC) for 2018/19 – 2021/22.
PREVIOUSLY CONSIDERED BY	This final draft has been electronically signed off by the Cancer Divisional Board (due to cancellation of the Divisional Board meeting on Thursday 1st March) and will be formally ratified at the rescheduled Divisional Board on 8th March.
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)	
Healthcare/ National Policy (includes CQC/Monitor)	
CRR/Board Assurance Framework *	☐ **Corporate Risk Register** ☐ **BAF**

ACTION REQUIRED

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

DIRECTOR:	Director of Strategy
PRESENTED BY:	Director of Strategy and Divisional Chair, Cancer
AUTHOR:	Director of Business Development and Partnerships
DATE:	5th March 2018

TRUST BOARD

7 MARCH 2018

MOUNT VERNON CANCER CENTRE – CLINICAL STRATEGY

1. Purpose of paper

The purpose of this paper is to present for consideration and approval the final draft clinical strategy for the Mount Vernon Cancer Centre (MVCC) for 2018/19 – 2021/22.

2. Background

The Strategy Team has been working with the leadership of MVCC over the last year to support them with the development of a new clinical strategy which will enable it to respond to a wide range of key drivers that it is currently facing.

In recognition of these drivers, the Trust Board has also been encouraging the Cancer Centre to develop a clinical and academic partnership with another tertiary cancer centre in order to further enhance their ability to address key challenges in relation to workforce, research and development, service transformation and operational performance. This piece of work culminated in a Memorandum of Understanding being signed by the Trust and University College London Hospital NHS Foundation Trust in November 2017 in which the organisations agree to enter into a clinical and academic partnership. The Collaboration Board held its first meeting in February this year and was encouraged by the level of engagement and dialogue between clinical teams that was already taking place. This collaboration will be one of a number of key mechanisms that will be used to support delivery of the new clinical strategy for the cancer centre.

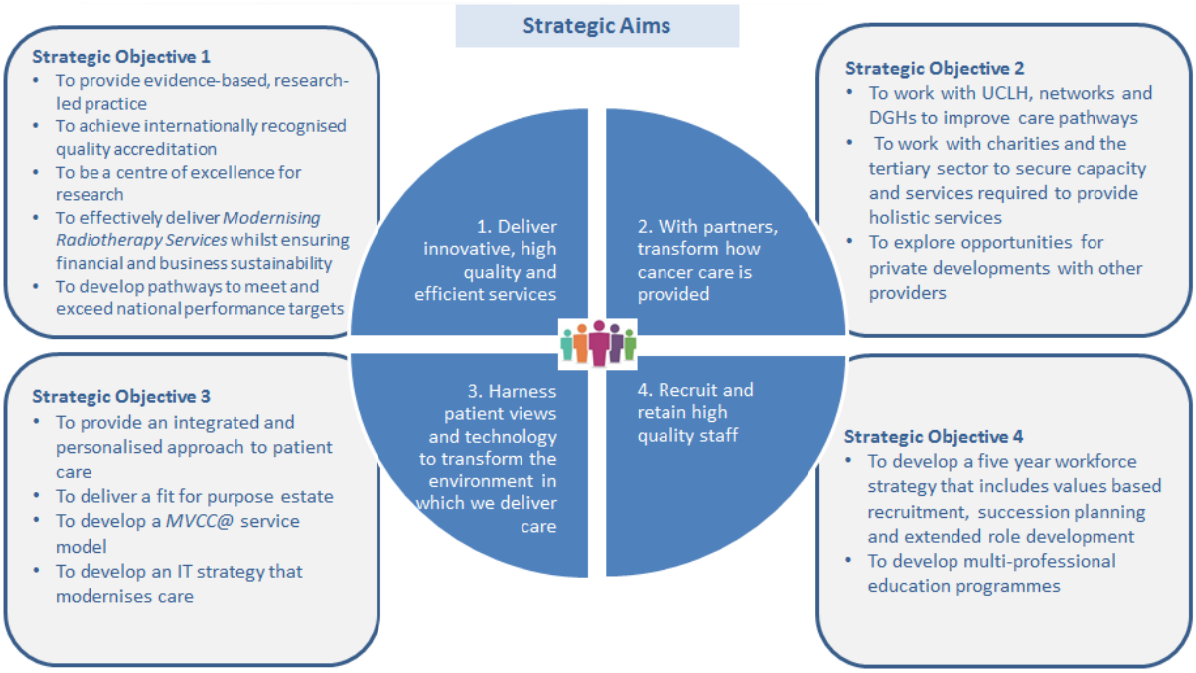
3. Clinical Strategy

At their last meeting in January 2018, the Trust Board received an update on work to develop a new, ambitious, deliverable clinical strategy for MVCC. Since that time, a further strategy workshop has been held with the MVCC multi-disciplinary attended by Nick Swift, the MVCC link non executive director. The outputs of this session have further informed the priorities and actions within the draft clinical strategy.

The Divisional Chair has led the further development of the clinical strategy within the Division and it has been shared with the Medical Director, Directors of Nursing and Strategy and the Associate Director – Research and Development for comment before being approved by the Cancer Division Board.

The final draft strategy confirms four strategic aims for the Cancer Centre; these have been amended slightly following the Progress Report provided to the January meeting of the Trust Board. The final strategic objectives are depicted in Figure 1 below.

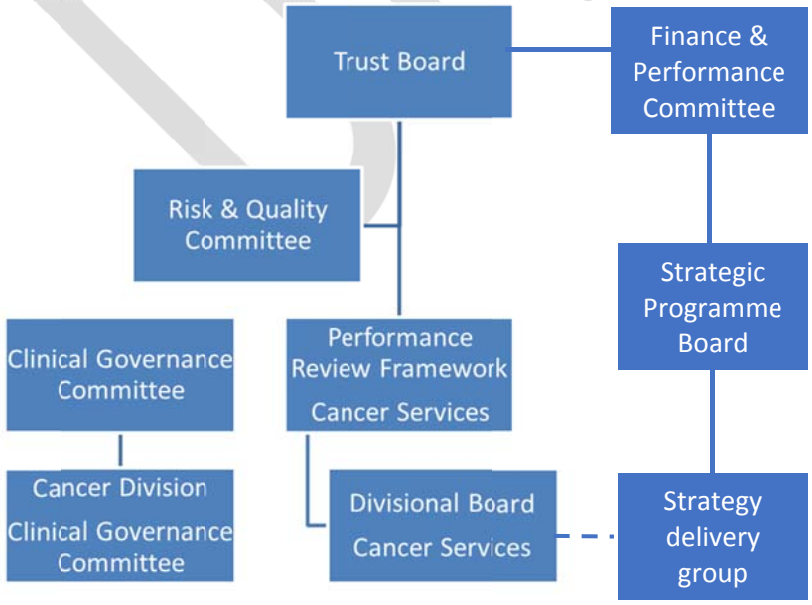
Figure 1: MVCC clinical strategy – reframed draft strategic objectives



The clinical strategy is attached at Appendix 1.

A strategy delivery group is being established from April 2018 to support and drive the delivery of the strategy. It is proposed that this group will report via the Strategic Programme Board and through the Finance & Performance Committee. In addition, the Trust Board will receive reports on a quarterly basis summarising progress with delivery of the Trust's annual objectives, which reflect the priorities in the MVCC clinical strategy.

Figure 2: Governance – MVCC Clinical Strategy Implementation



4. Recommendations

The Trust Board is asked to:

Note the positive engagement from the multi-disciplinary team at MVCC in the development and refinement of the final strategy.

Consider and approve the final draft clinical strategy (Appendix 1) for the MVCC, for implementation from 2018/19.

Appendix 1: Mount Vernon Cancer Centre – Clinical Strategy

MVCC clinical strategy Final_v2.ppt

Director of Business Development and Partnerships

26 February 2018

To be amongst the best...

East and North Hertfordshire NHS
NHS Trust

Mount Vernon Cancer Centre Strategy

2018 - 2023

5th March 2018

Introduction

This **strategy** sets out how we plan to develop and improve services over the next five years; so that we continue to deliver high quality, innovative cancer care.

The **development** of the strategy has taken place over recent months, with the full involvement of the staff at MVCC. It reflects a series of discussions that began in 2016 and builds on a 'Phase 1' strategic review approved by the East and North Hertfordshire NHS Trust Board in early 2017. The review and early strategy work considered a number of drivers for strategic change, including the need, over time, for significant investment in estates, infrastructure and equipment.

The strategy development **process** has reflected analysis of current and recent performance; the broader technological and service environment for modern, effective cancer care; national NHS strategies for cancer, likely intentions of commissioners and the changing nature of non-surgical cancer care.

During the process, some key strategic steps have been taken, notably the clinical and academic **partnership** agreed with University College Hospital NHS Foundation Trust (UCLH).

The scope of the clinical strategy includes radiotherapy; radiotherapy physics, bioengineering, nuclear medicine, brachytherapy; systemic anti-cancer therapies; and supportive and palliative care. Some core services are delivered in partnership with the Lynda Jackson Macmillan Centre; Michael Sobell House and Centre (specialist palliative care services); and the Paul Strickland Scanner Centre. Research and teaching are also in scope.

The strategy will frame operating plans and the development of the partnership with UCLH. As such it sets, in broad terms, organisational, team and individual priorities, implementation plans and potential business cases.

Overview of clinical services

Mount Vernon Cancer Centre (MVCC) offers a range of non-surgical cancer services to a catchment population of 2 million. The area encompasses Hertfordshire, South Bedfordshire, North and West London, East Berkshire and South Buckinghamshire. There are a also a number of national and international referrals.

MVCC is situated in Northwood, in the London borough of Hillingdon. Since 2004 MVCC has been part of East and North Hertfordshire NHS trust (ENHT). The estate, operated by Hillingdon Hospitals NHS Foundation Trust (HHT) is a mix of old and modern buildings but with many in poor repair unsuitable for modern patient care.

MVCC is a provider of radiotherapy, brachytherapy and systemic anti-cancer therapies such as chemotherapy and immunotherapy, for adult patients. It is not a provider of cancer surgery. MVCC sits within a network of hospitals, acting as a 'hub' for radiotherapy; and providing systemic anti-cancer therapies in various district general hospitals (DGH) or at the MVCC site for those therapies that cannot be offered in DGH settings.

Radiotherapy is delivered by seven linear accelerators and one CyberKnife and a brachytherapy suite. There is a chemotherapy suite with 20 chairs and two inpatient wards providing specialist cancer care that can not be provided in local DGHs an inpatient hospice that provides support to patients experiencing symptoms from their cancer and for end of life care, an outpatients department that is attached to the John Bush supportive care unit which provides acute oncology support 24 hours, 7 days a week. Some services are provided through service level agreements with THH and others including non-NHS providers on site.

We put PATIENTS first; we strive for continuous IMPROVEMENT; we VALUE everybody; we are OPEN and honest; we work as a TEAM

Vision and strategic aims

The **vision** for MVCC is ***to be a world class Cancer Centre*** with a recognised national and international brand which delivers innovative cancer treatments, through world class, expert, teams.

Key **drivers for change** for MVCC, requiring a strategic response, are:

1. **The need for a modernised, fit for purpose estate**
2. **The changing aspect of Cancer treatment and patient support**
3. **New and changing cancer treatments and technologies, in radiation therapies and in systemic anti-cancer therapies**
4. **Workforce pressures in particular professions**
5. **Ensuring financial and business sustainability**
6. **The national policy of stronger networks between cancer care providers**
7. **An increased need for support to rising numbers of cancer patients**

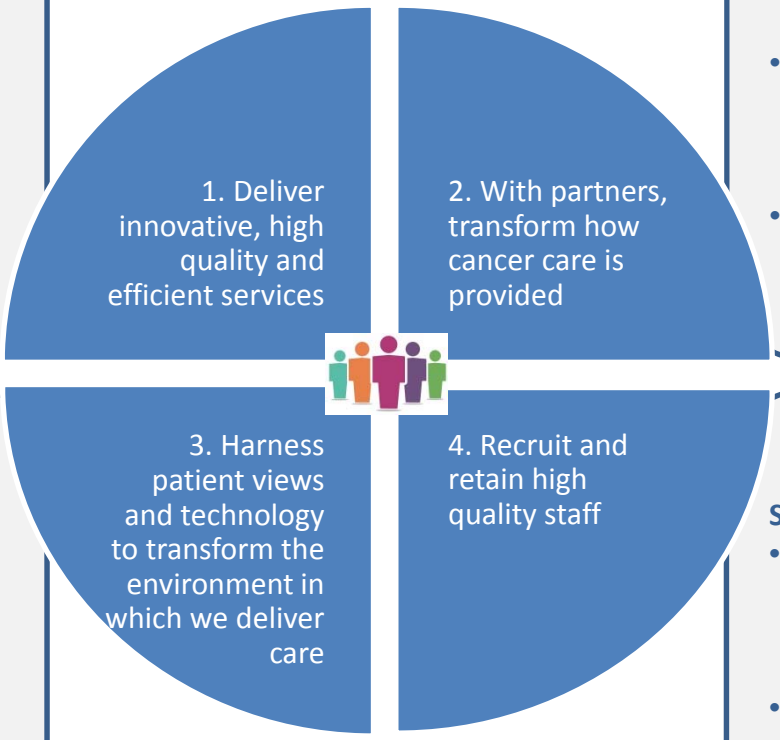
Specific **strategic aims**, to address the drivers for change and to strengthen and develop MVCC are:

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

Strategic Aims

Strategic Objective 1
- To provide evidence-based, research-led practice
- To achieve internationally recognised quality accreditation
- To be a centre of excellence for research
- To effectively deliver *Modernising Radiotherapy Services* whilst ensuring financial and business sustainability
- To develop pathways to meet and exceed national performance targets

Strategic Objective 2
- To work with UCLH, networks and DGHs to improve care pathways
- To work with charities and the tertiary sector to secure capacity and services required to provide holistic services
- To explore opportunities for private developments with other providers



Strategic Objective 3
- To provide an integrated and personalised approach to patient care
- To deliver a fit for purpose estate
- To develop a *MVCC@* service model
- To develop an IT strategy that modernises care

Strategic Objective 4
- To develop a five year workforce strategy that includes values based recruitment, succession planning and extended role development
- To develop multi-professional education programmes

The deliverables over the strategic period 2018 – 23 are set out in more detail in the following pages

Our strategic aims	Our strategic objectives	Our priorities to deliver our objectives
Deliver high quality, safe, efficient & innovative services	…by providing evidence-based, research-led practice	In 2018/19, we will: • agree a sustainable model of care for end of life • benchmark KPI and clinical outcomes against agreed reference hospitals to deliver best practice and efficiency • develop robust business intelligence to support business decisions In 2019/20, we will: • further develop nurse-led clinics to support the clinical care of our patients • seek approval of our business cases to increase the CNS establishment • enhance the provision of high quality supportive, and specialist palliative care provision • agree the marketing of bio-engineering products • agree a pathway for future management of non-cancer lymphodema patients In 2020/21,we will: • redesign services to deliver an on site administrative hub
	…by achieving internationally-recognised quality accreditation	In 2018/19 • sustain cancer centre ISO 9000 quality accreditation • increase the scope of quality awards By 2021-23 we will: • be seen as a centre of excellence for all solid tumours • be seen as regional experts for radionuclides and radiation protection
	…by becoming a centre of excellence for research	In 2018/19, we will: • agree and implement a MVCC research plan to increase the number of people who participate in cancer research to 900 • explore ways of providing explicit time in job plans for research • explore building on existing and future University links (both Brunel and UCLH) • continue expanding the Clinical Research Fellow posts at MVCC via the R&D charitable fund (with the recent inclusion of the John Bush legacy) • strengthen the Supportive Oncology Research Team in their 25th Anniversary year In 2019/20 we will: • conduct a review of current clinical trial pharmacy capacity and the funding of research • increase the number of applications prepared and submitted for external funding sources to 5 a year • have a written agreement with Brunel University to further strengthen the existing relationship • have an accredited portfolio of education which recognises the importance of work related learning, theoretical knowledge, and research In 2021-23 we will: • be an established research partner of at least one University, with joint academic posts • be recognised as an internationally important centre for cancer research

Our strategic aims	Our strategic objectives	Our priorities to deliver our objectives
Deliver high quality, safe, efficient & innovative services	…by effectively delivering *Modernising Radiotherapy Services* whilst ensuring financial and business sustainability	In 2018/19, we will: • seek to secure investment for software upgrades to optimise Linac treatment • establish ourselves within the new radiotherapy network as a provider of treatment for all solid tumours In 2019/20 we will: • seek approval of our business cases to ensure an effective equipment replacement programme of our Linear accelerators In 2021-23, we will: • submit a business case to provide in-house brachytherapy theatres By 2023, we will: • submit a business case to provide a linac-based stereotactic service
	…by developing pathways to meet and exceed national performance targets	In 2018/19, we will: • implement best practice pathways for lung, urology and colorectal, to meet cancer waiting time targets • redesign the booking and scheduling process for chemotherapy to optimise access to this service • develop an in-reach central venous access device (CVAD) team • submit a business case to secure investment for software upgrades to optimise Linac treatment In 2020/21,we will: • implement best practice timed pathways for ENT and Gynaecology tumours • develop an outreach CVAD service • Ensure all patients have access to a CNS

Our strategic aims	Our strategic objectives	Our priorities to deliver our objectives
With partners, transform how cancer care is provided	…by working with UCLH, networks and DGHs to improve care pathways	In 2018/19 we will: • contribute equally to the UCLH (radiotherapy, ambulatory and R&D) partnership • contribute to the Harefield (critical care, ICD patients, ECHOs and complex lines) collaboration • ensure robust management of SLA's with NHS and non NHS partners • in conjunction with primary care partners, deliver action plans for timed cancer pathways In 2019/20 we will: • explore future relationships with the Christie In 2020/21 we will: • contribute to shared procurement pathways with partners to reduce costs and improve efficiency • explore potential opportunities to develop the MVCC@ concept to enhance and provide MVCC services in different locations in line with referral patterns and market share, to include satellite radiotherapy services In 2021-23 we will: • increase the number of phase 1 and 2 trials offered to our patients • have academic appointments with partner organisations • ensure that MVCC is a recognised leader by a presence at national and international conferences
	…by working with charities and the tertiary sector to provide holistic services	In 2018/19 we will: • work in partnership with Paul Strickland Scanner Centre to procure future cancer diagnostic services • work with Michael Sobell House to deliver palliative and end of life care • strengthen our relationship with Macmillan in order to support further development at MVCC In 2020/21 we will: • develop the education environment that supports delivery of the education board requirement with the post graduate charity • work with Macmillan to initiate the support worker pilot project • work with Macmillan and Herts Valley CCG on the Neuro rehabilitation pathway project • work with the Teenage Cancer Trust to support the infrastructure and environment for young adult services
	…by exploring opportunities for private developments with other providers	In 2018/19 we will: • achieve the CE mark for template biopsies to support external sale In 2019/20 we will • agree a marketing strategy to promote the MVCC brand and services • market bioengineering products • explore provision of radiation protection to local dental practices for income generation • explore private development opportunities with relevant stakeholders

Our strategic aims	Our strategic objectives	Our priorities to deliver our objectives
Harness patient views and technology to transform the environment in which we deliver care	…by providing an integrated and personalised approach to patient care	In 2018/19 we will: • Develop a means for effective outward communication to our stakeholders • undertake a listening event to determine patient views on changes (including environmental and technological factors) to improve care • establish PMO support to scope the out patient department (OPD) flow and redesign • implement e-HNA to deliver patient focused care plans In 2019/20 we will: • implement the key actions that come out of the patient listening event, with development of business cases as required • implement the key actions from the OPD scoping exercise
	…with a fit for purpose estate	In 2018/19 we will: • prepare a business case for investment in local estates and contract lead for MVCC to ensure estates risk and SLA issues are properly addressed. • agree and sign a lease agreement with HHT In 2019/20 we will: • agree and implement an effective estates and SLA management service In 2020/21 we will: • ensure the MVCC environment will match the high standard of clinical care delivered by the cancer services • redesign the reception and out patient environment in line with the findings of the OPD scoping exercise.
	…by developing a *MVCC@* networked service model across the catchment	In 2019/20 we will: • roll out the development of integrated models of care across acute, community and home care provision
	…by implementing an IT strategy that supports modern care processes	In 2018/19 we will: • establish a self check-in kiosk for cancer OPD services • develop and implement a proposal to reinstate VPN access for West Herts pathology results • implement electronic transcription services • Implement an electronic referral system across the whole centre • secure IT support on site with development of a local IT strategy In 2019/20 we will: • create electronic patient information hubs • create digital apps to support patient information

Our strategic aims	Our strategic objectives	Our priorities to deliver our objectives
Attract and retain high quality, expert staff supported by a culture to learn and thrive	…by developing a five year workforce strategy that includes values based recruitment, succession planning and extended role development	In 2018/19 we will: • embed values-based recruitment and on-boarding for all senior staff • develop a cohesive medical workforce • reduce vacancies and improve retention in line with ENHT targets • optimise attendance on leadership development programme (LEND) for all senior staff • review the divisional workforce to release capacity to grow research, leadership and extended operating hours • scope the new model hospital programme for administrative staff at MVCC • ensure greater integration of clinical voices in the business functions of the division • employ an ANP for the John Bush supportive care unit In 2019/20 we will: • promote a nursing culture and encourage nurses to maximise their potential through degree, masters, doctoral programmes, journal publications and conferences • implement and embed the new model hospital programme for admin staff at MVCC • have an accredited portfolio of education which recognises the importance of work related learning, theoretical knowledge, and research In 2020/21: • embed a cultural shift to acknowledge that MVCC delivers cross site care for cancer through a divisional governance framework and communications strategy By 2021-23 we will: • seek to extend the number of practice practitioners across all tumour sites
	……by developing multi-professional education programmes that meet the needs of our staff and the local community	In 2018/19 we will: • establish a multi disciplinary education board In 2019/20 we will: • have an accredited portfolio of education which recognises the importance of work related learning, theoretical knowledge, and research • modernise the education environment in line with local need • market specialist educational programmes to meet local demand • work with Macmillan to support our ambitions for education projects. In 2020/21 we will: • market specialist educational programmes to other providers with agreed commercial income stream By 2021-23: • aim to have founded a cancer education academy

Implementing the clinical strategy

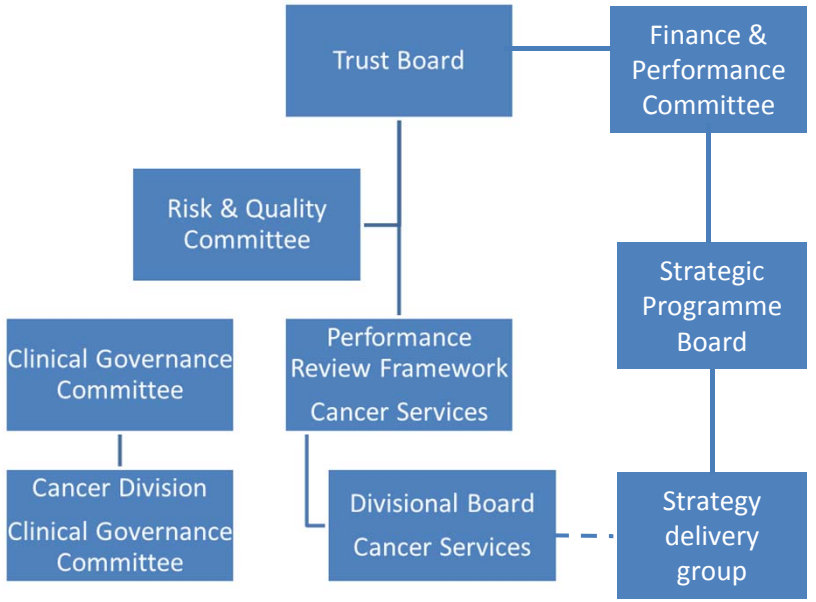
We will demonstrate **delivery** of the strategy by tracking the milestones set out in the previous pages, and reviewing the way progress has been made with the Cancer Division and its leadership team, through the strategy delivery group. We will undertake a **formal review** of the strategy at year three, and report this to the ENH Board.

We will ensure that staff and stakeholders **understand** the clinical strategy and plans for its implementation. We will **work closely** with referring hospitals and clinicians, primary care, and our partners to drive forward the necessary changes in pathways, protocols, workforce, etc. The division plans to initiate a quarterly strategic board to monitor progress of this five year strategy

We will prepare business plans for the MVCC service and its component parts. Business cases will be developed for key investments. They will sit within the **strategic framework** that this strategy provides.

The clinical strategy will be underpinned by existing **Trust enabling strategies** including *Improving Clinical Outcomes*, *Patient & Carer Experience*, *People*, *Research & Development* and *IM&T* as well as by new strategies to be developed during Year 1, including *Quality* and *Estates*.

The governance arrangements for the implementation of this clinical strategy are summarised below.



Agenda Item: 9.3

TRUST BOARD PART 1 - 7 MARCH 2018
APPROACH TO RISK MANAGEMENT

PURPOSE	This paper aims to update the Audit Committee on the work to refresh and develop the Trust's current approach to the management of risk, including the development of a risk management strategy and a Board Assurance Framework.
PREVIOUSLY CONSIDERED BY	**DEC and Executive Committee** **Also due to be considered by the Audit Committee prior to the Board meeting.**
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)	• The Trust's risks in relation to the delivery of services and care to patients are minimised, that the wellbeing of patients, staff and visitors is optimised and that the assets, business systems and income of the Trust are protected • The implementation and ongoing management of a comprehensive, integrated Trust-wide approach to the management of risk is based upon the support and leadership offered by the Trust Board
Healthcare/ National Policy (includes CQC/NHSI)	CQC Well Led Domain Single Oversight framework
CRR/Board Assurance Framework *	☐ **Corporate Risk Register** ☐ **BAF**

ACTION REQUIRED *

For approval	x	For decision	
For discussion	x	For information	

DIRECTOR:	Chief Executive
PRESENTED BY:	Chief Executive
AUTHOR:	Executive Team
DATE:	6 March 2018

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

INTRODUCTION

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

This paper aims to update the Audit Committee on the work to refresh and develop the Trust's current approach to the management of risk, including the development of a risk management strategy and a Board Assurance Framework.

BACKGROUND

Risk is an inherent part of the delivery of healthcare. We manage risk at East and North Hertfordshire NHS Trust to facilitate the provision of safe health services of the highest possible standard to our patients. We do this by:

- Employing best practice in clinical care and Infection Control
- Ensuring patient safety is paramount
- Ensuring all patients are treated with privacy and dignity
- Ensuring that resources are used effectively
- Supporting all staff to realise their full potential

Achievement of objectives is subject to uncertainty, which gives rise to threats and opportunities. Uncertainty of outcome is how risk is defined. Risk management includes identifying and assessing risks and then responding to them.

RISK MANAGEMENT STRATEGY

Attached at **Appendix 1** is the new Risk Management strategy, the strategy identifies the accountability arrangements, the resources available and provides guidance on what may be regarded as acceptable risk within the organisation.

The aim of the risk management strategy is to set out the Trust's vision for managing risk. Through the management of risk, the Trust seeks to minimise, though not necessarily eliminate, threats, and maximise opportunities.

The strategy seeks to ensure that:

- The Trust's risks in relation to the delivery of services and care to patients are minimised, that the wellbeing of patients, staff and visitors is optimised and that the assets, business systems and income of the Trust are protected
- The implementation and ongoing management of a comprehensive, integrated Trust-wide approach to the management of risk is based upon the support and leadership offered by the Trust Board

The objective of the Risk Management Strategy is to promote an integrated and consistent approach across all parts of the organisation to managing risk.

The Risk Management strategy will be supported by a Risk Management procedure which aims to provide all staff with a step-by-step guide to the identification, escalation and management of risk on a daily basis. This procedure is currently in development and will be presented to the Audit committee for consideration and approval.

Supporting the delivery of the Risk Management Strategy will be a comprehensive training and awareness programme for all Trust staff and this Programme will also be brought to the Audit Committee for consideration and approval.

A key instrument in the effective management of risk (both clinical and non-clinical) will be the appointment of Risk and Quality leads within each Division. These individuals, along with the existing Divisional leadership team, will be responsible for the management of risk, staff awareness and appropriate escalation of risk within each division.

BOARD ASSURANCE FRAMEWORK

Following the Risk Management Board Development session led by RSM in December 2017, the Board agreed to develop a refreshed Board Assurance Framework (BAF). The well led framework requires the Boards of all provider organisations to ensure that there is an effective and comprehensive process in place to identify, understand, monitor and address current and future risks and the *BAF* brings together in one place all of the relevant information on the risks to the delivery of the *board's* strategic objectives.

Attached at **Appendix 2** is the newly refreshed BAF for the Committee's consideration.

Once agreed, the BAF will be presented to the Board of Directors for its discussion and consideration at each Board meeting held in public.

Through their attendance at monthly Divisional Performance meetings and other fora, Executive Directors will determine if new risks require to be added to the BAF. Each month Executive Risk Owners will review the risks on the Board Assurance Framework ensuring that:

- The appropriate controls and assurance on controls are developed;
- Assigned actions from the prior period have been delivered;
- The scoring of each risk is considered.

The complete product of this review will then be considered and discussed each month by the Executive Committee before being presented to the Board of Directors.

Each identified BAF risk is assigned to a Board Assurance Committee for monitoring. The committees will be responsible to monitoring the risks assigned to their committee on a regular basis taking a 'deep-dive' approach when necessary and asking for regular reports from the Executive risk owner.

ACCOUNTABILITY FRAMEWORK

Over recent months an Accountability Framework has been developed to support the effective monitoring and delivery of key performance indicators. The Framework which is currently with Divisions for their input will be supported by monthly performance meetings with each division where teams will report on a balanced scorecard which will include range of measures to support the effective management of quality, patient experience, access targets, financial performance and risk. The Accountability Framework will be brought to the Board for its approval.

RECOMMENDATIONS

The Audit Committee is asked to:

- Approve the current draft risk management strategy and delegate authority to the Executive to finalise and disseminate the document to all staff.

- Note the development of a risk management procedure to support the delivery of the strategy

- Note that regular reports on the delivery of the risk management strategy and procedure will be brought to the audit committee

- Approve the internal audit team to evaluate the approach to and delivery of risk management, bringing a report on its effectiveness to the Audit Committee

- Discuss and approve the newly developed Board Assurance Framework format and approach recommending the approach to the Board of Directors

- Discuss and approve the process for the management of risks on the Board Assurance Framework

East and North Hertfordshire NHS Trust

Risk Management Strategy

2018-2019

Written by: Rachael Corser
Director of Nursing

Approved by: Audit Committee

…… Chairman

…… Date

Ratified by: Board of Directors

…… Chairman

…… Date

Scope
The management of risk management applies to all Trust staff, contractors, volunteers, students, locums, agency and staff employed with honorary contracts.

Equality Impact Assessment
This document has been reviewed in line with the Trust's Equality Impact Assessment guidance and no detriment was identified. This policy applies to all regardless of protected characteristic - age, sex, disability, gender-re-assignment, race, religion/belief, sexual orientation, marriage/civil partnership and pregnancy and maternity.

Dissemination and Access
This document is intended for all Trust staff and can only be considered valid when viewed via the East & North Hertfordshire NHS Trust Knowledge Centre (Intranet). If this document is printed in hard copy, or saved at another location, you must check that it matches the version on the Knowledge Centre.

Associated Documentation
NHSI Single Oversight Framework
Risk Management procedure
Performance Management Framework
Board Assurance Framework
Corporate Risk Register
Divisional Risk Registers
Service/Department Risk Registers
Standing financial instructions, Scheme of delegation and authorisation from the board of directors, Standing orders from the board of directors

Monitoring compliance with and the effectiveness of this document
Monitoring of compliance with this strategy will be undertaken by the Trust's audit committee, and assurance will be sought through an annual review of the risk management system and the internal auditor's report on the effectiveness of the system of internal control.

Review
This document will be reviewed within 1 year of issue.

Key Messages

- East and North Hertfordshire NHS Trust (The Trust) Board understands that activities associated will the provision of healthcare and hospital services can incur risks, some of which cannot be easily avoided.

- The Trust is committed to having a risk management culture that underpins and supports the work of the Trust and the improvement of patient care and safety and the safety of our staff, patients and visitors.

- This strategy and policy aims to describe firstly a consistent and integrated approach to the management of all risk across the Trust and secondly a commitment to the improvement of risk management through the organisation.

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1. STRATEGY STATEMENT

The board of directors is committed to the active management of risk, providing better care and a safer environment for patients, staff and other stakeholders.

The Trust recognises that the provision of healthcare and the activities associated with the treatment and care of patients, employment of staff, maintenance of Trust sites and managing finances incur risks.

The Trust recognises the need to ensure there are proactive systems in place to effectively identify and manage its risks with the aim of protecting patients, staff and members of the public as well as its assets.

2. PURPOSE

This risk management strategy aims to provide the framework and outline the processes needed to support the Trust in delivering its strategic and other objectives by identifying and managing risks.

The Trust aims to ensure that the effective management of risk an integral part of everyday management by having comprehensive risk management systems in place with clear responsibility and accountability arrangements throughout the Trust.

The approach to risk management includes clinical and non-clinical risk and aims to ensure that risk management is clearly and consistently integrated and not managed in silos. By achieving this we can:

- Keep our patients, staff and visitors safe and ensure high standards of patient care
- Protect the reputation and assets and finances of the Trust
- Anticipate changing internal and external circumstances and respond by adapting and remaining resilient
- Remain compliant (as a minimum) with health and safety regulations, insurance, accreditation and legal requirements.

We can do this by:

- Demonstrating the application of risk management principles in all activities of the Trust
- Clearly defining the roles, responsibilities and reporting lines within the Trust for risk management
- Making sure all staff understand the importance of effective risk management
- Maintaining a comprehensive register of both clinical and non-clinical risks and reviewing the same on a periodical basis
- Ensuring effective controls are in place to mitigate the risk and rectify gaps in control
- Ensuring effective and documented procedures exist for the control of risk and provision of suitable information, training and supervision
- Ensuring the Trust has appropriate Business Continuity arrangements in place

3. RISK APPETITE

Risk appetite is ‘the amount of risk that an organisation is prepared to accept, tolerate, or be exposed to at any point in time.’ (HMT Orange Book definition 2005) It can be influenced by personal experience, political factors and external events.

It is important that the Trust knows what its risk appetite is to ensure the organisation is not exposed to risk taking which exposes the organisation to a risk it cannot tolerate.

The Trust will periodically review its appetite for, and attitude to, risk updating these where appropriate. This includes the setting of risk tolerances at the different levels of the organisation, thresholds for escalation and authority to act, and evaluating the organisational capacity to handle risk.

This will lead to the generation of a risk appetite statement which defines the Board's appetite for risk in relation to each of the strategic objectives and risks throughout the organisation will be managed within the Trust's stated risk appetite.

On an annual basis the Trust will publish via its website its risk appetite statement to cover the following areas:

- Quality/ outcomes
- Finance
- Compliance/ regulation
- Reputation

4. TYPES OF RISK

Risks are adverse events that may happen, which if they were realised, could stop the Trust achieving its objectives or negatively impact upon its success.

Risks to patients

The Trust adopts a systematic approach to clinical risk assessment and management recognising that safety of patients is at the centre of all good health care.

In order to deliver safe, effective, high-quality services, the Trust will encourage staff to work to minimise risk to patients as much as possible.

Organisational risks

The Trust endeavours to establish a positive risk culture within the organisation, where unsafe is not tolerated and where every member of staff feels empowered to identify and correct/escalate system weaknesses.

The Trust aims to minimise risk to the delivery of services whilst maximising performance in line with value for money.

A programme of risk assessments will be conducted throughout the Trust to support the generation of a positive risk culture.

Reputational risk

Opportunistic risks

Where new opportunities arise for the Trust in relation to providing new services or new projects, it is important that this is only considered in relation to the Trust's stated and agreed risk appetite.

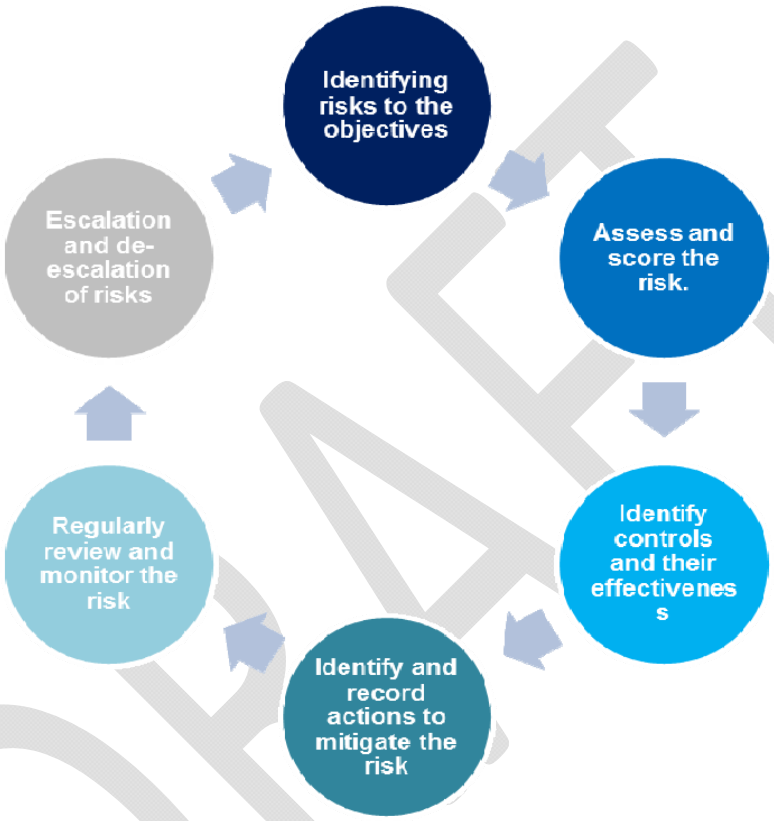
Financial risks

Risks which impact on the Trust's financial performance, these may include procurement risks, contractual risks and risks to the correct application of the Standing Orders and Standing Financial Instructions.

5. RISK MANAGEMENT PROCESS

A structure approach to the management of risk must be taken regardless of whether it is clinical or non-clinical in nature. Risks are identified, assessed and controlled and, where appropriate, escalated or de- escalated through the governance mechanisms of the Trust.

Risk management cycle
The Trust's risk management cycle includes:



6. RISK MANAGEMENT GOVERNANCE

There are different operational levels involved in the governance of risk in the Trust:

- Board of Directors
- Executive team
- Divisional management teams

Risk management by the Board of Directors is underpinned by a number of systems of control through the following three mechanisms.

- **The board assurance framework (BAF)** sets out the strategic objectives of the Trust, identifies risks in relation to each strategic objective along with the controls in place and assurances available on their operation. The BAF is then used to drive the Board of Directors meeting agendas.

- **The corporate risk register (CRR)** is the corporate high-level operational risk register used as a tool for managing risks and monitoring actions and plans against them. Used correctly it

demonstrates that an effective risk management approach is in operation within the Trust.

- **Divisional Risk Registers** are maintained by the Divisional Quality Manage on behalf of the division.

- **Corporate Services risk registers will cover risks from corporate areas such as nursing, strategy, finance, estates, workforce and IT** are maintained by an identified lead on behalf of the directorate

- **The annual governance statement** is signed by the chief executive as the accountable officer and sets out the organisational approach to internal control. This is produced at the end of the financial year and scrutinised as part of the annual accounts process.

  Additionally, the Audit Committee and other board sub-committees exist to provide assurance of the robustness of risk processes and to support the board of directors.

  Each division will have a management forum where risk is discussed, including their risk register, actions, and any required escalation. The Nursing and Medical Directors will support the oversight of the divisional risk registers through monthly risk clinics.

7. RISK MANAGEMENT ACTIVITIES

The Trust risk management activities are a part of its overall commitment to effective clinical governance and patient safety. The risk management approach is underpinned by additional Trust policies supported by on-going training including:

- Risk management procedure
- Management of Serious Incidents (SIs) procedure (CP 180)
- Adverse Incident Reporting and Investigation Policy (CSEC 049)
- Serious incidents investigation guidelines
- Management of Health and Safety at Work Policy (mhsw)
- Health and safety risk assessments
- Complaints and Concerns Policy (CSEC 008)
- Information Security policy and Records Management Policy (IG 002)
- Management of Safety Alerts Procedure (CP 256)
- Business Continuity Plan
- Capability Policy
- All policies and procedures associated with healthcare acquired infections
- Violence and Aggression Policy (viol&agg)
- Safeguarding Adults from Abuse Policy (CSEC 021)
- Safeguarding Children Policy (CSEC 046)
- Management of financial risk and risks to the internal control environment through the application of the SFIs.

The Trust's systems of internal control are based on its on-going risk management programme that aims to:

- Identify principal risks to the achievement of goals set out in the annual plan
- Evaluate the nature and extent of risks
- Manage all risks effectively, efficiently and economically
- Enable the completion of the annual governance statement

8. DELIVERING THE STRATEGY

The strategic element of this risk management strategy and policy will be delivered by focusing on key themes of activity, linked to the Trust's strategic objectives.

Executive directors, senior management teams and departmental/ operational managers within the Trust will:

- Be clear about the Trust's quality priorities and strategic objectives
- Promote awareness and understanding of the benefits of proactive risk management, and develop a positive risk and patient safety culture
- Manage risk through their own area by identifying, assessing, controlling, monitoring and reviewing risks. Ensuring the controls and action plans are fully implemented
- Distribute and disseminate, to their teams results of complaints, incidents, serious incidents, audits and lessons learned
- Support compliance with appropriate legislation and standards including national risk management standards and CQC requirements

The Trust will:

- Ensure corporate ownership and accountability throughout the organisation of risk management and the need to mitigate risk along with the mechanisms for reporting and sharing learning across the organisation
- Promote and support the development and implementation of risk management strategies and policies in general practice
- Provide training and on-going support to ensure that all risks are reported and that all staff are aware of mechanisms to report incidents and near misses
- Ensure that all staff receive training in conducting health and safety risk assessments
- Establish and implement a plan to develop and strengthen the organisation's risk management culture

Risk management specialists

The Trust has risk management specialists who possess and maintain appropriate qualifications and experience sufficient to ensure that competent advice is available to staff. The specialists are responsible for creating, reviewing and implementing policies, procedures, protocols and guidelines for the effective control of risk. Key risk management leads for the Trust are as follows:

The **Company Secretary** is the corporate governance lead for the organisation and supports the Board directors in carrying out their responsibilities for risk management and takes the lead, on behalf of the board of directors, for maintaining the board assurance framework.

The **Head of Quality and Patient Safety** is the quality governance lead for the Trust and is responsible for the Trust risk management strategy Risk Register Policy and incident management policy, including serious incidents. The Head of Quality and Patient Safety is accountable to the Medical Director / Director of Nursing and is responsible for promoting and ensuring the implementation of Trust-wide systems and processes to enable the Trust to meet its requirements in relation to clinical governance and risk, up to and including the Trust's corporate risk register.

The Patient Safety **Manager** is responsible for supporting the implementation of the Trust risk management strategy and policy and supporting procedures in conjunction with the Patient Safety Facilitator. The Patient Safety Manager is accountable to the Head of Quality and Patient Safety and is responsible for promoting and supporting the implementation of Trust-wide systems of governance and risk. This includes establishing dynamic risk management systems and processes that form an integral part of routine organisational and departmental activity.

Trust risk management specialists:

Specialist/ advisor
Caldicott Guardian
Chief Pharmacist/Accountable Person Controlled Drugs
Director for Infection Prevention and Control (DIPC)
Head of Quality and Patient Safety
Safety and Security Manager
Legal Services Manager
Head of Complaints and PALS
Information Governance Manager
Designated Individual Human Tissue Act Officers
Emergency Planning Liaison Officer
Fire Safety Officer
Lead Biomedical Scientist/Laboratory Manager Cellular Pathology
Local Counter Fraud Specialist
Local Security Management Specialist (LSMS)
Responsible Person, Legionella
Senior Information Risk Owner (SIRO)
Waste Manager

9. RESPONSIBILITIES AND ACCOUNTABILITIES

All who work at the Trust have a responsibility for the delivery of high-quality, safe care.

The following sections cover the roles of particular individuals or groups.

All staff

- Staff should have an awareness and understanding of the risks that affect patients, visitors, and staff
- Line managers will encourage staff to identify risk
- Staff will be identified to own the actions to tackle risks
- There will be proactive and frequent communication between staff, stakeholders and partners
- Staff have access to comprehensive risk guidance and advice
- Risk assessment and management – risks are assessed and acted upon to prevent, control, or reduce them to an acceptable level. Staff have the freedom and authority, within defined parameters, needed to take action to tackle risks, escalating them where necessary
- The process for managing risk is routinely reviewed to ensure continual improvement
- Measuring performance - exposure to risk is measured with the aim of reducing this over time. The culture of risk management is also measured and improved where applicable.

Risk lead

All corporate areas, divisions, programme and project teams must have an identified risk lead. The risk lead will be responsible for:

- Consulting with teams to identify and assess risks and determine mitigating actions
- The on-going maintenance of a risk register for their area of Trust business
- Ensuring risk registers undergo regular review and quality assurance
- Promoting the Risk Management Policy and procedure and best practice within their area of Trust business
- Communicating changes to the risk management strategy and risk register policy to staff within their area of the Trust
- Sharing information and knowledge on risks within their area of Trust business, directorate and those on the corporate risk register through membership of the clinical governance monitoring committee; and
- Being the key contact for the Patient Safety Department on the management of risk and compliance with this strategy and policy.

Risk owner
All risks will have an identified risk owner recorded on the Trust's DATIX system. The risk owner is responsible for ensuring the risk is managed and monitored to ensure controls and further actions are in place to mitigate the risk. It is the responsibility of the risk owner to escalate risks where appropriate in line with local governance arrangements.

Action owner
All risks have action owner(s) to whom the risk owner delegates responsibility for ensuring the delivery of a task or activity that will help mitigate the identified risk, and to provide regular reporting on progress.

Patient Safety Team
The Patient Safety Team supports the organisation and the board of directors by providing a risk management function that facilitates and monitors the implementation of effective risk management practices by operational management, and assists risk owners in defining the target risk exposure, and in reporting adequate risk-related information throughout the organisation. Specifically, the department supports all areas of the Trust to produce risk reports in an agreed format to facilitate ward to board governance and where necessary, escalation, of risks. The department also supports executive management of risk by managing the corporate risk register and reviewing the wider Trust risk register to provide assurance on the compliance with the risk management strategy and Risk Register Policy. The department also provides support and guidance to the Trust's corporate office in the maintenance of the Trust BAF, ensuring a clear relationship between BAF risks identified by the board (top down) and those recorded in the Trust risk register (bottom up).

In addition to its central risk management function, the department also provides a compliance and assurance function providing positive assurances as well as monitoring specific risks to non-compliance with regulatory quality and safety standards defined by the Health and Social Care Act 2012 and its associated regulations. The Patient Safety Department's role will not be limited to this regulatory framework alone.

Health and safety risk assessments
Risks for inclusion on the risk register can be identified from a number of sources including audits, incidents/ near-misses, inspections, complaints, enforcement action and health and safety risk assessments.

All areas of the Trust must proactively carry out health and safety risk assessments on their activities, processes, workplaces, equipment and people at particular risk. Health and safety risk assessments are important because they help to identify and adequately address hazards and risks in order to prevent harm. Where a risk has been identified as a result of a health and safety

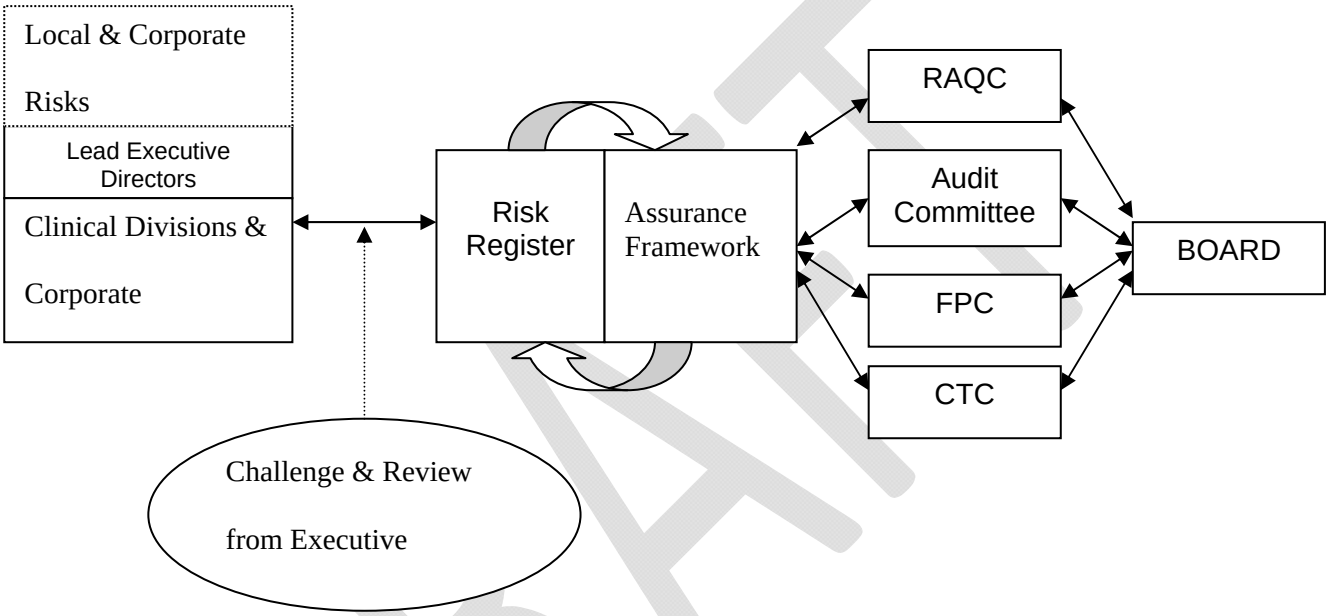
risk assessment, which is unable to be controlled to as low as reasonably practicable, the risk must be entered onto the risk register.

10. ASSURANCE FRAMEWORK

Assurance structures

Assurance of achievement, weaknesses in delivery and key risks to the delivery of Trust objectives are reported through the assurance committees of the board. The Trust assurance committees receive detailed reports to inform them of all significant risk exposures, material changes to risks and progress with milestones. The Trust assurance committees are responsible for providing assurance on the management of corporate risks to the board of directors and are identified at appendix .

An overview of the assurance process is illustrated below.



11. TRAINING

Training plan and support

To support the successful implementation and embedding of the risk management strategy and risk policy a plan for training across the organisation is required. This plan will cover all staff including the Board of Directors who will receive training every two years, to ensure that the requirements for understanding and discharging duties in relation to risk management at board level is reviewed and refreshed, thereby maintaining compliance with nationally agreed policy and practice.

The Trust's Executive Committee ensures monitoring arrangements are in place to review the overall effectiveness of the delivery of risk management training for board members and senior managers. Where such monitoring identifies deficiencies, recommendations will be agreed and an action plan developed and changes implemented accordingly.

12. RISK MANAGEMENT PROCEDURE

This risk management strategy is underpinned by a comprehensive risk register policy which describes the process for effectively identifying, assessing, evaluating and monitoring all Trust risks whether they are clinical or health and safety related.

The process by which risks are operationally managed at East & North Hertfordshire NHS Trust can be found in the Risk Register Policy on the Trust's Knowledge Centre.

Agenda Item: 10

TRUST BOARD PART 1 – 7 MARCH 2018

FINANCE AND PERFORMANCE COMMITTEE – 28 February 2018
EXECUTIVE SUMMARY REPORT

PURPOSE	To present to the Board Development meeting the report from the Finance and Performance Committee (FPC) meeting of 28 February 2018
PREVIOUSLY CONSIDERED BY	N/A
Objective(s) to which issue relates *	☑ 1. **Keeping our promises about quality and value** – embedding the changes resulting from delivery of Our Changing Hospitals Programme. ☐ 2. **Developing new services and ways of working** – delivered through working with our partner organisations ☐ **3. Delivering a positive and proactive approach to the redevelopment of the Mount Vernon Cancer Centre.**
Risk Issues (Quality, safety, financial, HR, legal issues, equality issues)	Key assurance committee reporting to the Board Financial risks as outlined in paper
Healthcare/National Policy (includes CQC/Monitor)	Potential risk to CQC outcomes Key statutory requirement under SFIs, SOs. Healthcare regulation, DH Operating Framework and other national performance standards
CRR/Board Assurance Framework *	☐ **Corporate Risk Register** ☑ **BAF**

ACTION REQUIRED *

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

DIRECTOR:	CHAIRMAN OF FPC
PRESENTED BY:	CHAIRMAN OF FPC
AUTHOR:	CORPORATE GOVERNANCE ASSISTANT/COMPANY SECRETARY
DATE:	FEBRUARY 2018

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FINANCE AND PERFORMANCE COMMITTEE – 28 February 2018

EXECUTIVE SUMMARY REPORT TO TRUST BOARD – 4 April 2018

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

The following core attendees were present:
Nick Carver (Chief Executive), Jude Archer (Company Secretary), Martin Armstrong (Director of Finance), Kate Lancaster (Director of Strategy). Mike Chilvers (Medical Director), Bernie Bluhm (Interim Chief Operating Officer), Tom Pounds (Deputy Chief People Officer), Scott Sommerville, (Stabilisation Director),

DECISIONS MADE UNDER DELEGATED AUTHORITY:

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

OTHER MATTERS CONSIDERED BY THE COMMITTEE:

Financial Recovery
Reports received:

- Finance Report Month 10
- Financial Improvement Plan Update
- Operating Plan and Draft Budget 2018/19
- CIP Development update 2018/19
- Finance Risk Register update
- Cyber Attack – funding request pro-forma

The FPC considered the Finance Report for month 10. The Trust reported a £0.7m deficit in month, bringing the year to date position to a £23.8m deficit. This represented a £1.2m variance against the original plan in month. In terms of SLA income, the Trust is significantly behind forecast for January. This is exacerbated in month because of reduction in elective activity due to operational pressures which required the re-focussing of resources. Furthermore, there has been an increase in pay expenditure in month due to the additional capacity required for winter pressures. Non- pay was largely within forecast, although there continues to be shortfalls in achieving the desired reductions in discretionary spend. The non-pay position includes the impact of transferring £2.5m of expenditure to capital for the stabilisation of the Lorenzo system. The Director of Finance noted that NHSi have agreed a £3.0m increase to the capital resourcing limit to enable this to take place. In relation to CIP performance and delivery, the Trust is £2.7m adverse to plan thereby continuing to fall short of target.

The end of year forecast has been revised on the assumption that the underlying trends continue. Although support for the Lorenzo system in terms of funding from NHSi and NHSE continues to be pursued and operational scrutiny on spend and working to delivery of activity plans remains in place.

The Committee received the first draft of the Operating Plan and Draft Budget for 2018/19. It was reported that our target control total for 2018/19 is a deficit of £12.3m, before STF funding of £14.4m. This will require a year on year improvement of around £13m. The revenue base for next year appears to include reasonable assumptions on activity growth, and a relatively flat pricing tariff consisting of inflation less a required efficiency improvement. The Committee discussed the current assumptions, the impact of Lorenzo, the SLA and contract challenges, cost challenges and assumptions and key risks. The final plan is due for approval and submission in April 2018. For further discussion in Board Part II.

The PMO Director gave an update on CIP Development for 2018/19. The main areas focussed upon were: 2017/18 FYE, Divisional Schemes, Model Hospital and Speciality Data Packs. With regards to the model hospital, it was reported that there is a £9.3m opportunity. Similarly, in relation to data packs there is a £7m opportunity. A recurrent theme was the opportunity to improve both quality and money through initiatives such as GIRFT. Further work is required to ensure Divisions and service lines are engaged and realise the importance of delivery.

The Committee noted the Financial Risk Register and Cyber Attack papers.

Performance
Reports received:

- Performance Report Month 10
- ED Deep Dive

The Deputy Director of Operations provided an update regarding performance. Following the migration to Lorenzo, the Trust remained unable to report January's performance against the RTT standard. Following discussions with NHSI and further assessment of our current position, the Trust is unlikely to return to reporting for 6-9 months. It was highlighted that the 'new' PTL report will 'go live' in the second week of March. Cancer performance for December was 80.5% post breach sharing against a trajectory of 70.6% which is evidence of progress. However, it is forecast that January's performance will drop and be close to the trajectory which is a typical seasonal pattern. The Trust has also achieved the 31 day diagnosis to 1st definitive treatment and 2 week GP referral to 1st Outpatient appointment standards.

The ED 4 hour performance was 82.03%, but the department has seen an increase in attendances at peak periods. These peaks in demand have exceeded our capacity creating periods of significant pressure within ED and other areas of the hospital which has resulted in an 'exit block' occurring. This has meant that the Trust declared OPEL 3&4 at several points during January and February. The Deputy Director of Operations informed the committee that operational challenges have continued to impact upon delivery.

The Clinical Director and Head of Nursing for the Emergency Care Pathway presented a deep dive of ED to the FPC. It was noted that generally the Lister site sees category 1-5 patients whilst the QEII site sees category 3-5 patients. The main challenges to ED performance are workforce with the current high vacancy rate particularly for Consultants and Middle Grades, attendance peaks creating significant pressures and breaches, overcrowding, nerve centre issues and changes in demographics. A detailed review was provided covering the actions from the Model Hospital work streams. The main improvement plans for consideration were captured to be enhancing clinical and operational leadership, undertaking an audit for appropriate ambulance conveyancing and triage to ED areas and reviewing the demand and capacity to match with peak levels.

Lorenzo Stabilisation / Optimisation
Reports received:

- Lorenzo Stabilisation Plan
- Data Quality and Clinical Coding Update
- Floodlight Scorecard Month 10

The FPC received an update on the Lorenzo Stabilisation Plan. The plan has been endorsed by NHSi and an external supplier has been commissioned to provide expertise on how to implement stabilisation swiftly. They are due to commence with the Trust in the next week.

The Stabilisation Director gave reference to steering committee meetings and informed the FPC that he has committed to drawing up an information pack. This will include details on reporting in addition to compliance and volume reports. It was noted that this is something that will evolve as we move through various parts of the organisation. It was agreed that the Stabilisation Director will inform the FPC of the outcomes of from future steering group meetings to ensure progress.

The Committee noted the Data Quality and Clinical Coding Update, as well as the Floodlight Scorecard for Month 10.

Strategy / Workforce
Reports received:

- Workforce Report Month 10
- Market Report

The FPC received the month 10 Workforce Report. The monthly agency ceiling target continues to be achieved with agency spend under by £434k, continuing with positive variance on control total. The Trusts vacancy rate of 8.5% is the second lowest compared to local benchmarked trusts. However, there are areas where we can do better and a robust improvement plan is in place to address this.

The staff survey results had now been received although these are not yet published. It was noted they are disappointing, however, this has been acted upon quickly with online staff survey workshops, innovative technology solutions to provide a crowd sourcing platform. The Deputy Chief People Officer

explained that efforts are being put into analysing workshop outputs in order to enable the creation of survey actions plans with the staff. A detailed report will be provided to the next FPC and Board. It was noted that a focus on organisation culture and staff engagement continues with LEND sessions for Spring 2018 launched and new 'Workforce Skills for Leaders' module to launch next month.

With regards to workforce efficiency, there are a number of work streams that require significant work to ensure that we have got the right size workforce and enable successful delivery. Additionally, it was revealed that the flu target has been achieved since January, 70%.

The Market Intelligence Report was noted with awareness that more information on market share will feed into the overall report in future.

The Director of Strategy provided an update on strategy development and working to create a new vision for the organisation.

Nick Swift
Committee Chair

28 February 2018

Agenda Item: 10.1

TRUST BOARD PART 1 –7 MARCH 2018

FINANCE REPORT MONTH 10

PURPOSE	To set out the Trust's financial position for Month 10.
PREVIOUSLY CONSIDERED BY	FPC
Objective(s) to which issue relates *	☑ 1. **Keeping our promises about quality and value** – embedding the changes resulting from delivery of Our Changing Hospitals Programme. ☐ 2. **Developing new services and ways of working** – delivered through working with our partner organisations ☐ **3. Delivering a positive and proactive approach to the redevelopment of the Mount Vernon Cancer Centre.**
Risk Issues (Quality, safety, financial, HR, legal issues, equality issues)	Financial risks are described in the main report
Healthcare/ National Policy (includes CQC/Monitor)	
CRR/Board Assurance Framework *	☐ **Corporate Risk Register** ☑ **BAF**

ACTION REQUIRED *

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

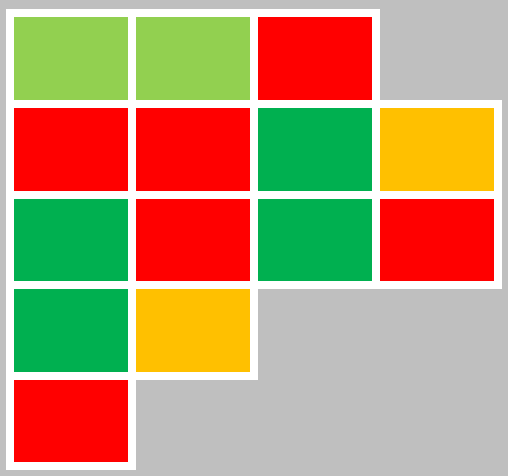
DIRECTOR:	Director of Finance
PRESENTED BY:	Director of Finance
AUTHOR:	Director of Finance
DATE:	March 2018

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

* tick applicable box

East and North Hertfordshire NHS
NHS Trust

Finance Report



Month 10 - 2017/18

Mth 10 Finance Report - Commentary

EXECUTIVE SUMMARY

- SLA Income achievement continues to fall short of plan, and is significantly behind forecast for January. This is exacerbated in month because of the cancellation of elective activity owing to operational pressures.
- CIP delivery is falling short of target
- Pay spend was above forecast in month, which was mainly due to the opening of additional unplanned emergency winter capacity.
- Non-pay was also within forecast, although there continues to be a shortfall in achieving desired reductions in discretionary spend.

KEY MONTH 10 ISSUES

- The Trust reported a £0.7m deficit in month, bringing the year to date position to a £23.8m deficit. This represents a £1.2m adverse variance against the original plan in month, after removing the impact of STF funding.
- As a result of the adverse year to date variance, the Trust has assumed that it will not be eligible for STF funding after Q1.
- A year end forecast, and monthly phasing, was presented within the last finance digest. An update to this forecast, including the month 10 results, will be presented separately.
- The month 10 reported position has been adversely impacted by a reduction in elective activity/income necessitated by operational pressures which required the re-focusing of resources. This has been exacerbated by the additional costs incurred owing to the requirement to open additional, unplanned, capacity.
- The non pay position includes the impact matching £2.5m of expenditure to capital for the stabilisation of the Lorenzo system . This treatment has been discussed and agreed with NHSI who have agreed a £3.0m increase to the Capital resourcing limit (CRL) to enable this to take place.

EXCEPTIONAL ITEMS

- The normalised I & E run rate analysis within the report presents exceptional items.
- The M10 reported position assumes that the Trust will not receive any STF funding after quarter one.
- £0.7m of additional costs have been incurred in the month in relation to the stabilisation of Lorenzo. However, as reported above, there has been a £2.5m transfer to capital in month to reflect costs incurred for the year to date, above plan, for the stabilisation of the Lorenzo system.
- The reported position includes an adverse impact of £1,501k on income for the cancellation of elective patients in January due to operational/bed pressures.

Mth 10 Finance Report - Commentary

SLA INCOME PERFORMANCE

- Trust continues to report significant under performance against its SLA plan. This adverse variance now totals £12.7m for the year to date at month 10. The material drivers of the shortfall are detailed below:

Issue	Impact
Reduced Elective Activity - DC & EL	£2.3m
Non-elective - reduced volume & casemix	£2.6m
Outpatient activity below plan	£3.6m
Reduced Maternity Antenatal bookings	£1.0m
Cyber Attack - reduced activity	£0.7m

- The Trust has seen a recovery of the level of Outpatient activity during month 10. The level of activity has returned to levels delivered in M8. However, this is still far below the YTD plan.
- Day case throughput has increased significantly compared to M9. However, Elective activity throughput dipped again following a drop month 9.
- Non Elective inpatient activity saw an increase in discharged spells M10, resulting in the second highest level of activity seen all year. Non Elective is now just under 1,000 spells below plan, equating to £2.6m in financial underperformance. This is an improvement over previously reported positions.
- The volume and income associated with WLI activity has reduced materially compared with prior years. However, separate analysis within the report demonstrates that the impact on the Trust financial bottom line is minimal given the small contribution generated by this activity i.e. reduced income is offset by reduced cost.

DIVISIONAL FINANCIAL PERFORMANCE

- Medicine, Surgery and W&C Divisions all report significant YTD adverse variances against budgets. In all cases this is largely driven by under performance on SLA income/activity.
- In month all Clinical Divisions, with the exception of Cancer Services Division, have an adverse variance owing to low activity in the month.
- The IT and Information departments now show a positive variance in the month owing to the transfer to capital of Lorenzo stabilisation costs.

YEAR ON YEAR COMPARISON

- Income levels are now showing a £4.2m increase compared to the same period in 2016/17. This is mainly due to an increase in training and education income and also winter pressure funding.
- Elective activity is 9% down on previous year, although this is partially offset by an increase in day-case activity. Whilst Non elective activity is down 3%, year on year. This is atypical compared with other local providers and the national picture.
- Both Outpatient first and follow up attendances (6% lower), as well as outpatient procedures (16% lower), are significantly below volumes delivered last year.
- Pay expenditure in 17/18 is £0.6m lower than at the same period last year. This is despite the

Mth 10 Finance Report - Commentary

PAYBILL PERFORMANCE

- The Trust reported an over spend of £1.2m against its pay budget in January, which was £0.3m higher than the revised forecast. This was mainly due to winter pressures and additional pay expenditure in Critical Care Unit and Special Care Baby Unit, which both had an increase in patient activity.
- Pay expenditure was £359k higher than in December which is mainly due to payment of bank holiday enhancements (£143k), plus additional unplanned costs of £137k for opening of additional capacity as a result of winter pressures
- As well as the £137k for higher than planned winter pressure costs, the Trust incurred £156k of winter pressures which had previously been agreed and included in the forecast.
- The agency expenditure in month of £956k, was broadly similar to the previous month, although lower than the monthly average for previous months of the financial year.
- Agency expenditure is £10.5m year to date, which is below the NHSI agency ceiling target.

CIP PERFORMANCE

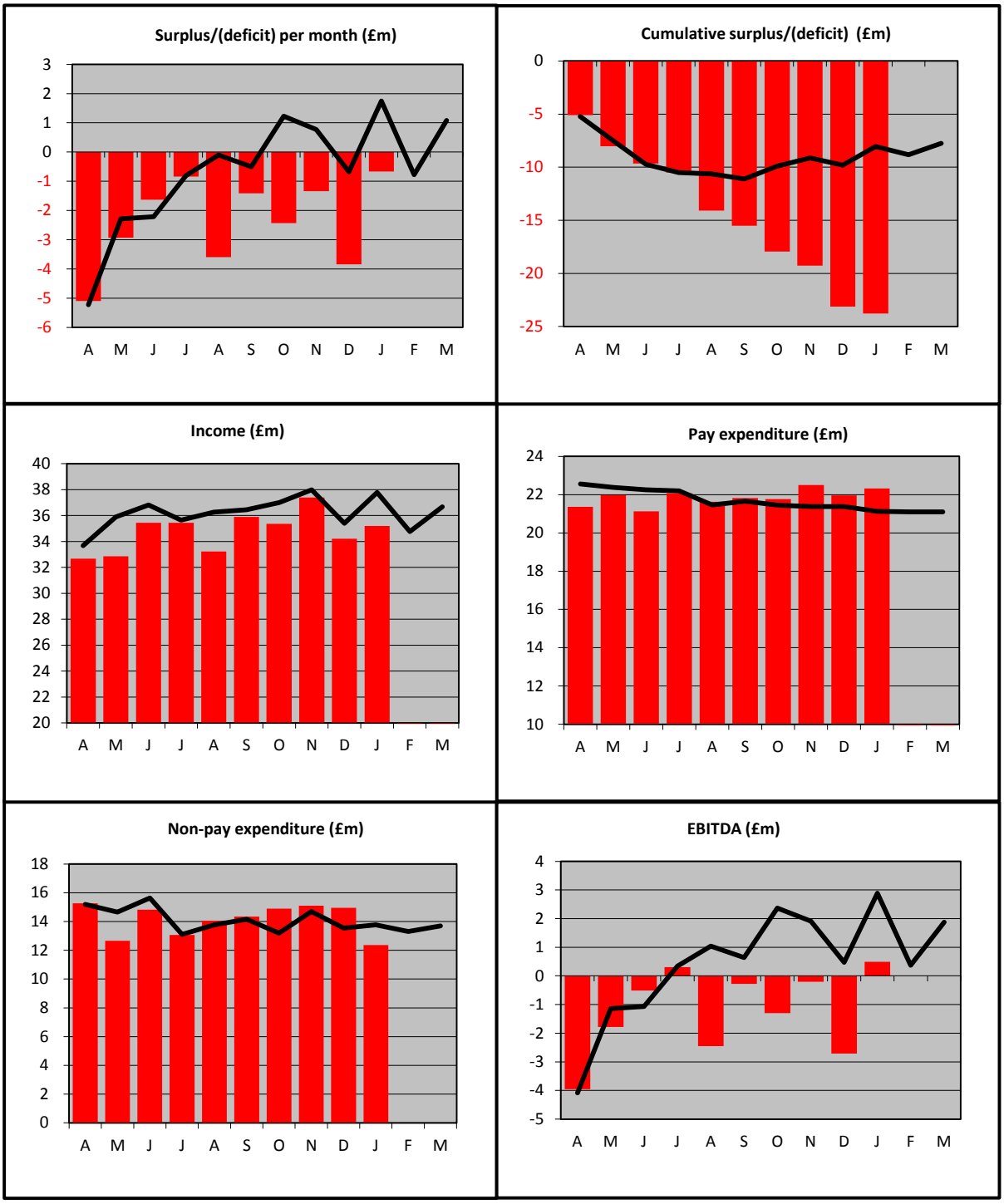
- The Trust has delivered £15.2 savings year to date against a plan of £17.9m. There is an adverse variance year to date of £2.7m.
- The overwhelming majority of the CIP overperformance is concentrated on this schemes within the 'model hospital' portfolio.
- The theatre and outpatient efficiency schemes, in particular, are not delivering to the scale anticipated, neither is the job planning scheme. There continues to be weekly information assurance meetings and CIP meetings, in an effort to secure anticipated savings for future months.

CASH, CAPITAL & BALANCE SHEET

- Non-achievement of planned levels of income and expenditure, including non-receipt of Strategic Transformation Fund monies has led to cash shortfalls, which have been, and continue to be, actively managed. The Trust has worked with NHSI on solutions to short-term borrowing requirements. However, there is a high focus on internal working capital management, including both debtor and creditor management.
- Whilst there is a requirement to restrict creditor payments to within available resources every effort will be made to reduce the risk suppliers withholding goods or services.
- The Board and FPC will continue to be apprised of the cash situation
- The Trust has obtained clearance from NHSI to capitalise a further £3.0m of appropriate Lorenzo stabilisation expenditure. Of this, £2.5m is included within the month 10 position.
- The Trust is forecasting to hit its revised capital programme.

Summary Financial Performance

	Annual Plan £m	Budget Mth £m	Actual Mth £m	Variance mth £m	Budget YTD £m	Actual YTD £m	Variance YTD £m
Income	424.2	36.6	35.2	-1.4	355.1	346.4	-8.7
Pay	-260.0	-21.1	-22.3	-1.2	-217.8	-218.6	-0.7
Non Pay	-168.7	-13.8	-12.4	1.4	-141.7	-141.5	0.2
EBITDA	-4.6	1.7	0.5	-1.2	-4.5	-13.7	-9.2
Financing Costs	-13.4	-1.1	-1.2	-0.0	-11.4	-11.4	0.0
STF Monies	10.2	1.2	0.0	-1.2	7.8	1.3	-6.5
Retained Deficit	-7.7	1.7	-0.7	-2.4	-8.0	-23.8	-15.7



Income & Expenditure Account Overview

	Annual Plan £000's	Actual £000's										Monthly Plan £000's	Monthly Actual £000's	Monthly Var £000's	Plan to Date £000's	Actual to Date £000's	Var to Date £000's
		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan						
Catering Income	1,153	90	93	81	80	32	122	103	116	98	120	96	120	23	960	937	-23
NHS Non Patient Care Income	1,931	323	144	141	207	130	201	145	258	103	199	146	199	52	1,637	1,852	214
NHS Patient Care Income	384,689	28,969	29,160	31,494	31,586	30,781	31,896	32,051	33,125	29,089	31,630	33,254	31,630	-1,624	322,178	309,781	-12,397
Other Income Category C	20,659	1,414	1,412	1,477	1,474	312	1,150	899	1,621	2,871	1,016	2,076	1,016	-1,060	16,570	13,645	-2,925
Other NHS Revenue	0	0	0	0	0	0	0	0	0	0	42	0	42	42	0	42	42
Other Patient Care Income	72	4	4	4	4	5	4	5	3	4	3	8	3	-5	57	39	-17
Private Patients	5,172	308	356	466	348	328	326	359	481	267	303	435	303	-133	4,300	3,542	-758
R&D Income	5,081	468	399	448	416	395	447	441	481	430	437	424	437	13	4,234	4,360	126
RTA Income	1,173	-39	144	205	58	91	111	109	89	113	142	98	142	44	977	1,024	47
Training & Education Income	14,441	1,135	1,136	1,135	1,269	1,150	1,642	1,258	1,228	1,237	1,297	1,245	1,297	52	12,008	12,488	480
Income Total	**434,371**	**32,672**	**32,849**	**35,452**	**35,444**	**33,224**	**35,899**	**35,369**	**37,402**	**34,213**	**35,188**	**37,782**	**35,188**	**-2,594**	**362,922**	**347,711**	**-15,211**
Admin Staff	-36,075	-2,919	-3,021	-2,701	-2,990	-2,986	-2,994	-3,052	-3,213	-2,961	-2,980	-2,994	-2,980	15	-30,098	-29,819	279
Ambulance Service Staff	10	16	-2	-2	-2	-2	-2	-2	-2	-2	-2	1	-2	-3	8	-1	-9
Ancillary Staff	-7,611	-669	-697	-668	-701	-693	-655	-651	-666	-677	-701	-625	-701	-76	-6,360	-6,779	-419
Clinical Support Staff	-15,587	-1,387	-1,349	-1,306	-1,392	-1,424	-1,349	-1,343	-1,368	-1,373	-1,413	-1,297	-1,413	-116	-12,996	-13,704	-708
Maintenance & Works Staff	-979	-70	-68	-68	-66	-69	-69	-69	-73	-68	-70	-81	-70	11	-817	-691	126
Medical Staff	-82,501	-6,889	-7,013	-6,799	-7,008	-6,941	-7,126	-7,109	-7,261	-7,142	-7,113	-6,841	-7,113	-271	-68,898	-70,400	-1,501
Nursing Staff	-81,128	-6,550	-6,672	-6,498	-6,692	-6,568	-6,563	-6,508	-6,728	-6,553	-6,837	-6,717	-6,837	-121	-67,676	-66,170	1,507
Other Staff	43	-17	-6	-1	-20	-13	-6	-14	12	4	-3	4	-3	-6	36	-63	-99
Pay Reserves	2,121	-197	-106	-24	-98	109	-82	-51	-83	-136	-92	634	-92	-726	878	-760	-1,639
Scientific Theraputic & Technical	-32,990	-2,283	-2,659	-2,665	-2,717	-2,650	-2,576	-2,539	-2,683	-2,619	-2,664	-2,769	-2,664	105	-27,460	-26,055	1,405
Senior Managers	-5,269	-387	-370	-394	-379	-388	-400	-427	-437	-429	-442	-439	-442	-3	-4,390	-4,054	336
Social Care Staff	-84	-10	-9	-10	-11	-10	-10	-6	-7	-7	-7	-6	-7	-0	-71	-86	-15
Pay Total	**-260,049**	**-21,363**	**-21,973**	**-21,135**	**-22,077**	**-21,634**	**-21,830**	**-21,770**	**-22,511**	**-21,964**	**-22,323**	**-21,132**	**-22,323**	**-1,192**	**-217,845**	**-218,581**	**-736**
Admin Expenses	-26,569	-2,720	-3,048	-2,278	-2,131	-2,105	-2,027	-2,636	-2,059	-2,269	-2,286	-1,956	-2,286	-330	-22,630	-23,560	-930
Catering	-1,805	-169	-154	-166	-155	-189	-174	-148	-175	-148	-149	-149	-149	-0	-1,507	-1,626	-118
Commissioning Expenditure	-182	-5	-7	1	-10	-5	-44	-10	-19	-14	-75	-17	-75	-59	-148	-190	-42
Drugs, Blood & Lab Consumables	-46,098	-3,773	-3,558	-4,197	-3,215	-3,984	-4,008	-3,695	-4,992	-3,997	-4,603	-4,088	-4,603	-515	-38,627	-40,021	-1,394
Energy & Utilities	-2,287	-224	-196	-127	-189	-186	-93	-175	-215	-240	-275	-187	-275	-88	-1,913	-1,919	-6
IM&T Costs	-2,920	-248	-219	-303	-240	-228	-282	-236	-187	-194	-201	-209	-201	8	-2,502	-2,338	164
Internal Recharges	-30	0	0	0	0	-0	0	0	0	0	0	-2	0	2	-25	0	25
Medical Consumables	-17,846	-1,341	-1,502	-1,448	-1,488	-1,494	-1,482	-1,540	-1,541	-1,545	-1,350	-1,484	-1,350	135	-14,877	-14,731	146
Non Pay Reserves	-3,718	-65	888	-293	17	-193	-376	-836	1,371	-256	-53	-254	-53	200	-2,302	206	2,508
P or L - Sale of Fixed Assets	700	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Property Costs	-5,145	-429	-421	-418	-472	-415	-499	-430	-473	-446	-441	-416	-441	-25	-4,312	-4,444	-133
Purch & Maint of Equip - Medical	-16,623	-1,307	-1,339	-1,380	-1,364	-1,381	-1,353	-1,337	-1,597	-1,398	-1,264	-1,316	-1,264	52	-13,931	-13,720	211
Purch & Maint of Equip - Non Medical	-1,677	-147	-125	-298	26	-69	-88	-136	-160	-5	-89	-138	-89	49	-1,400	-1,091	309
Purchase of Healthcare - Non NHS	-7,456	-553	-622	-561	-559	-607	-588	-601	-651	-814	-647	-725	-647	78	-6,250	-6,202	48
Recharges In / Out	-1,476	-117	-154	-138	-174	-135	-144	-193	-146	-144	-175	-162	-175	-13	-1,294	-1,518	-224
Services from Other NHS bodies	-20,401	-2,769	-840	-1,574	-1,468	-1,422	-1,498	-1,305	-2,997	-1,700	-1,434	-1,668	-1,434	234	-17,089	-17,008	81
Site Support Services	-14,115	-1,342	-1,268	-1,582	-1,566	-1,584	-1,650	-1,575	-1,174	-1,726	742	-906	742	1,648	-12,012	-12,726	-714
Suspense Accounts	0	-1	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Training Costs	-1,065	-53	-97	-65	-67	-49	-41	-46	-82	-64	-68	-88	-68	20	-890	-634	256
Non Pay Total	**-168,712**	**-15,260**	**-12,661**	**-14,826**	**-13,058**	**-14,045**	**-14,348**	**-14,899**	**-15,096**	**-14,959**	**-12,369**	**-13,764**	**-12,369**	**1,395**	**-141,708**	**-141,521**	**187**
Depreciation	-7,773	-648	-648	-538	-607	-607	-607	-604	-604	-604	-601	-648	-601	47	-6,477	-6,067	410
Dividend	-1,662	-168	-168	-168	-168	-168	-168	-168	-168	-168	-168	-168	-168	0	-1,677	-1,677	0
Interest Payable	-3,944	-329	-329	-421	-378	-365	-364	-364	-364	-364	-397	-329	-397	-69	-3,287	-3,674	-388
Interest Receivable	25	3	2	2	2	2	2	2	0	8	4	2	4	2	21	27	6
Financing Total	**-13,354**	**-1,141**	**-1,142**	**-1,124**	**-1,150**	**-1,138**	**-1,137**	**-1,134**	**-1,136**	**-1,128**	**-1,162**	**-1,142**	**-1,162**	**-20**	**-11,420**	**-11,391**	**29**
Grand Total	**-7,745**	**-5,093**	**-2,927**	**-1,633**	**-841**	**-3,593**	**-1,415**	**-2,434**	**-1,340**	**-3,839**	**-666**	**1,744**	**-666**	**-2,410**	**-8,050**	**-23,782**	**-15,732**

East and North Hertfordshire NHS Trust

Agenda Item:10.2

TRUST BOARD PART 1 – MARCH 2018
PERFORMANCE REPORT MONTH 10

PURPOSE	To update the Finance and Performance Committee on: • Progress against Operating Standards, Contractual standards and local performance measures.
PREVIOUSLY CONSIDERED BY	FPC
Objective(s) to which issue relates *	☑ 1. **Keeping our promises about quality and value** – embedding the changes resulting from delivery of Our Changing Hospitals Programme. ☐ 2. **Developing new services and ways of working** – delivered through working with our partner organisations ☐ **3. Delivering a positive and proactive approach to the redevelopment of the Mount Vernon Cancer Centre.**
Risk Issues (Quality, safety, financial, HR, legal issues, equality issues)	Delivery of financial, operational performance and strategic objectives, CQC ratings, Governance risk Rating, Contractual performance.
Healthcare/ National Policy (includes CQC/Monitor)	Achievement of Monitor, CQC, DH Operating Framework and other national and local performance standards.
CRR/Board Assurance Framework *	☑ **Corporate Risk Register** ☑ **BAF**

ACTION REQUIRED *

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

DIRECTOR:	CHIEF OPERATING OFFICER
PRESENTED BY:	CHIEF OPERATING OFFICER
AUTHOR:	DIRECTOR OPERATIONAL PERFORMANCE
DATE:	FEBRUARY 2018

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

***** tick applicable box

PERFORMANCE REPORT

1. Key Headlines

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

January 18 (STF) KPI Performance

RTT - 2017/18 Trajectory

	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18
	92.00%	92.00%	92.00%	92.00%	92.00%	92.00%	92.00%	92.00%	92.00%	92.00%
	92.16%	90.49%	88.93%	87.43%	85.68%	-	-	-	-	-

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

ED - 2017/18 Trajectory

	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18
	84.50%	84.60%	85.64%	87.07%	88.62%	90.19%	90.97%	91.82%	92.59%	93.44%
	89.24%	84.07%	87.53%	85.24%	85.06%	-	82.26%	81.74%	77.24%	82.03%

Cancer - 2017/18 Trajectory

	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18
	70.80%	79.56%	85.04%	84.96%	85.19%	85.00%	85.11%	85.23%	85.23%	85.23%
Pre Breach Sharing	75.00%	70.60%	64.50%	71.20%	69.30%	73.20%	76.80%	75.50%	79.70%	
Post Breach Sharing	77.90%	71.00%	66.40%	74.96%	72.20%	78.80%	79.10%	80.30%	80.50%	

January's performance is not finalised until 2nd March

2. RTT – 18 weeks

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

2.1 RTT Reporting

Following discussions with NHS Elect and further assessment of our current position the trust is unlikely to return to reporting for 6-9 months. As progress continues as part of the Lorenzo stabilisation programme this timeline will be reassessed and updates provided.

2.2 RTT PTL Reports

Since last month's update progress has been made, a new PTL has been constructed to establish a single data source for all RTT and non-RTT patient pathways. From this single data source a range of operational views can be created. The 'new' PTL is currently in technical testing and user evaluation; it is planned the report will 'go live' in the second week of March. Once the 'new' PTL has bene released it is anticipated that the resources will be deployed on developing a diagnostic PTL.

Additionally data quality continues to be an ongoing process, all of the 48,000 pathways on the incomplete PTL, as at 4th December 2017, have now been validated.

The focus of the data quality team is on:

- Validating the RTT 'clock stops' since migration

- Validating pre-migration exclusion criteria
- User error and process failures

There are also additional DQ challenges that are also being reviewed:

- Technical issues requiring Lorenzo supplier intervention
- Data warehousing processing issues
- Non-compliance with business as usual processes
- Methodology used to develop the PTL

2.3 RTT Stabilisation

Current Position

Whilst the stabilisation program begins to gather pace the impact of working with PTL that are not fit for purpose and processes that are not embedded continues to have a severe impact on operational efficiency.

- Depleted booking teams are reporting reduced efficiency of up to 50% as a result of inaccurate PTL data.
- The operational foundations of Lorenzo (access plans) are not in place.
- There is significant non-compliance with standard business processes such as clinic out-coming.
- User error is featuring as a major contributor to data quality failings

Operational and Information teams have logged over 80 data or process failings in the PTL issues log. The functional RTT PTL is validated above 18 week waits and patients should be recorded at the appropriate wait time on the incomplete PTL. The issues described above result in the patient's RTT status not being recorded correctly. This is the cause of delays and inefficiencies when tracking and booking patients. To summarise, we know how long patients have waited but in a high number of cases we cannot see what needs to happen next.

Next Planned Steps

- As stated a new PTL has been developed and is currently undergoing rigorous technical and user testing. An early March launch is planned.
- The 2,500 Access Plans from the "old" state will begin transfer to the "future" state in the first week of March.
- The focus of validation will shift from correction of errors to prevention by highlighting process failures and user errors. The training strategy will be informed by this shift. Validators will adopt a more outward looking view, supporting operational teams to improve compliance.

Requiring urgent attention

The loss of established operational processes must be addressed. Each division must plan to deliver a consistent and reliable system of booking, out-coming and tracking that supports the delivery of national standards. Capacity for this currently will significantly exceed that which is required to deliver BAU activity as many of these processes have fallen many months behind.

2.4 52 week Standard

Using the incomplete PTL from the middle of December, the trust has now confirmed that a total of 19 patients have waited over 52 weeks from referral for their first definitive treatment. At the time of writing, 7 of the patients have subsequently been treated.

A clinical harm review process will commence within the divisions and will be shared with our CCG clinical colleagues. The SI process would commence if harm was assessed to have occurred.

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

3. 4 Hour Performance

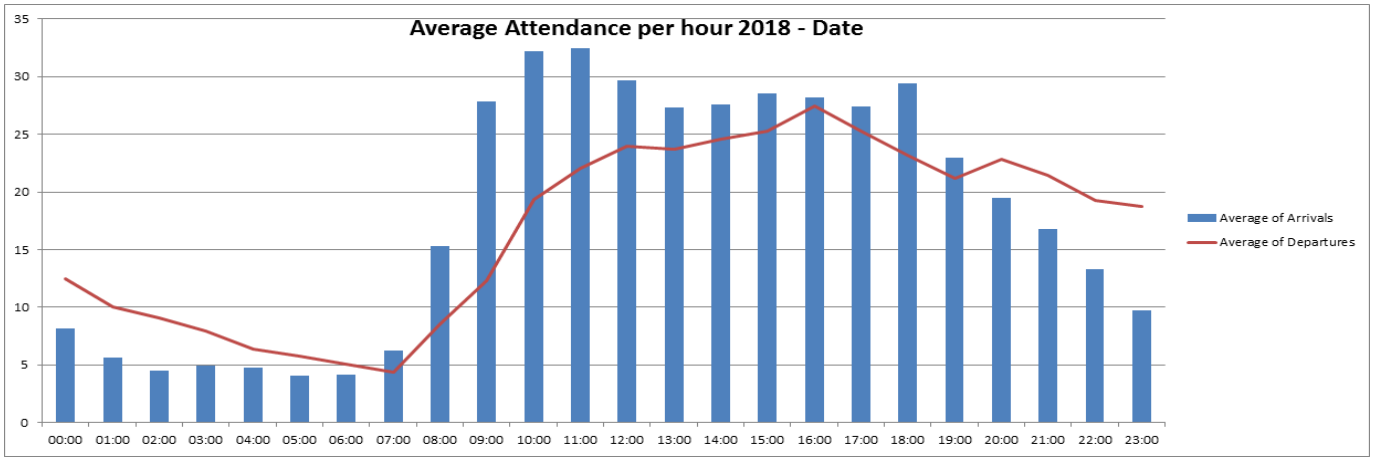
January's performance against the 4 hour standard was 82.03%, see table below. Though the total attendance numbers have remained relatively stable, the department has seen an increase in attendances at peak periods. Additionally our clinical coding suggests that the acuity of patients being treated has also increased, therefore requiring increased treatment / stabilisation time within the department.

These peaks in demand have exceeded our capacity creating periods of significant pressure within the ED, furthermore other areas of the hospital have also been pressured which has resulted in 'exit block' occurring from the ED to the assessment and ward areas.

Whilst the Trusts official delayed transfer of care (DToC) patient numbers remain low in comparison to many other organisations there has been a recent increase in the volume of medically optimised patients. This cohort do not necessarily fall within the current DToC numbers, more recently through winter months this number has on occasions exceeded 60 patients per day.

Month	% Performance	Quarterly Performance
Dec-16	85.41%	Q3 87.63%
Jan-17	83.41%	
Feb-17	83.82%	
Mar-17	83.90%	Q4 84.22%
Apr-17	89.24%	
May-17	84.82%	
Jun-17	87.53%	Q1 83.72%
Jul-17	85.24%	
Aug-17	85.06%	
Sep-17	No submission	
Oct-17	82.26%	
Nov-17	81.79%	
Dec-17	77.24%	
Jan-18	82.03%	

The graph below depicts the average number of attendances at the Trust, compared with the average number of departures. Between 09:00 and 12:00 each day, significantly more patients arrive then leave the department; this pattern continues through until the evening until 20:00 hours. During these periods the department can become over crowded as frequently patients are waiting for inpatient beds to become available. The impact is that patients wait longer to be treated and delays with ambulance handovers can occur, manifesting with patients queuing in the corridor of the ED.



The Trust continues to experience operational pressures that are impacting on Emergency Department performance. This standard should be considered more of a barometer of the pressures being experienced across the whole organisation from emergency activity and bed capacity constraints.

The Trust has declared OPEL level 3&4 at several points during January and February. OPEL 4 is the highest level of escalation requiring whole system support and intervention. During these periods of intensive emergency demand, routine planned activity is typically cancelled i.e. the only inpatient planned surgery to continue are cancer and clinically urgent cases, this impacts on those patients waiting for a 'routine' planned elective procedure and also impacts on our access performance and financial income. Additionally at OPEL 4, consideration to cancelling outpatient activity to release additional senior clinical staff to support inpatient emergency care has to be built into the Trusts response, again with the corresponding impact on patients, access performance and income.

Additionally to cancelling planned activity, extra escalation areas have also been opened to ensure that emergency patients can be safely managed. During the peaks of the pressure, the area used as the discharge lounge has been converted back into an inpatient area; this was previously a ward area. The impact is that further pressures are placed on ED as patients in beds awaiting discharge cannot be transferred to the lounge therefore adding to the exit block from ED for patients waiting an inpatient admission bed. The alternative discharge lounge facilities are not as flexible and therefore not as many patients are suitable for the lounge whilst it is located in an outpatient clinic setting.

Whilst the Trust has been under significant pressures during this quarter, our situation is not unique, it has been widely reported in the media of the pressures impacting across the wider health system and surrounding acute hospitals.

3.1 Operational Challenges to delivery

1. Delays to speciality patients being assessed within the department.
   The Trust has relaunched the professional standards regarding the responsiveness and timely assessment of patients that are referred to other specialities from the ED. This requires a behavioural and cultural change in practice which will take additional time to become fully embedded across the organisation.

2. Nerve Centre
   As part of the digital program of improvement the Trust implemented Nerve Centre (an IT system) into the ED at the same time as Lorenzo (PAS) was implemented. This has created a number of operational issues regarding the tracking and time stamping of patients to enable accurate recording and reporting of waiting times and performance against the 4 hour standard.

   Whilst significant improvements have been made and the Trust is now able to validate breaches of the standard, the organisation is still unable to adequately allocate the reasons for the breaches to specific areas / departments. This is reducing the opportunity to target areas for additional learning and remedial actions to be developed.

3. Workforce
   Over the winter period the department has also had a reduced 'fill rate' when requesting temporary workforce cover for both nursing and medical staff. The substantive staff have responded and many have worked additional hours to mitigate the impact however as this continues more staff are becoming fatigued and sickness absence levels are beginning to increase.

Medical workforce issues within ED's is a national problem, therefore the Trust has taken proactive steps to increase the diversity of the workforce overtime. An Advanced Nurse Practitioners (ANP) training program is already in progress, this will continue so that over time, years, the Trust will have access to more 'home' trained ANP's to help mitigate some of the longer term medical workforce issues.

3.2 GP Streaming

As previously reported to committee the Trust has accessed national funding to support the physical redesign of the 'front door' of the ED. On completion patients will be assessed by a registrar and potentially 'streamed' to the UCC, ambulatory care or 'hot' clinics avoiding the need for the patient to remain within the ED.

The building works is entering into the final stages and should be completed during March, at this time the building work has reduced the waiting area within the department further adding additional challenges however this is short term and the teams are managing within this constraint. Once completed in March the emergency teams are ready to implement a full GP streaming service. The standard operating procedures (SOPs) and staffing resources have been completed and identified in anticipation of the March completion date.

4. Cancer

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

Performance December 2017

Target	Goal	Threshold	2016/17	Month	Quarter 3	Year 17/18	Nat Average (Dec)	Nat Average Qtr (Q3)
Target Referrals								
Cancer Referral to 1st Outpatient Appointment	< 14 Days	93.0%	97.4%	97.6%	97.4%	97.8%	94.8%	94.9%
Referrals with Breast Symptoms (wef January 2010)	< 14 Days	93.0%	94.1%	92.3%	92.7%	93.2%	94.2%	95.1%
Cancer Treatments								
Decision to Treat to 1st Definitive Treatment for all Cancers	< 31 Days	96.0%	91.7%	96.4%	94.9%	92.4%	97.9%	97.7%
Referral to Treatment from Consultant Upgrade	< 62 Days	90.0%	75.5%	50.0%	76.9%	70.9%	88.7%	88.4%
Referral to Treatment from Screening (62 Day)	< 62 Days	90.0%	87.5%	92.3%	74.6%	68.9%	91.7%	90.7%
Second or Subsequent Treatment (Anti Cancer Drug Treatments)	< 31 Days	98.0%	95.1%	99.0%	97.6%	96.2%	99.4%	99.5%
Second or subsequent treatment (Radiotherapy Treatments)	< 31 Days	94.0%	91.9%	93.7%	90.9%	89.5%	98.0%	97.5%
Second or subsequent treatment (Surgery)	< 31 Days	94.0%	85.8%	80.8%	83.9%	86.0%	95.5%	95.6%
Urgent Referral to Treatment of All Cancers	< 62 Days	85.0%	69.3%	79.9%	77.4%	72.6%	84.0%	82.9%
Urgent Referral to Treatment of All Cancers (following breach reallocation)	< 62 Days	85.0%	72.2%	-	-	-	-	-

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

Target	Goal	Threshold	2016/17	Month	Quarter 3	Year 17/18	Nat Average (Nov)	Nat Average Qtr (Q2)

By Tumour Group										
Breast Cancer										
Decision to Treat to 1st Definitive Treatment for Breast Cancer	< 31 Days	96.0%	98.8%	100.0%	97.7%	98.3%	98.5%	98.7%		
Urgent Referral to Treatment of Breast Cancer	< 62 Days	85.0%	89.6%	91.7%	92.0%	88.8%	91.7%	94.7%		
Colorectal Cancer										
Decision to Treat to 1st Definitive Treatment for Colorectal Cancer	< 31 Days	96.0%	96.6%	100.0%	96.6%	93.2%	98.2%	98.0%		
Urgent Referral to Treatment of Colorectal Cancer	< 62 Days	85.0%	48.3%	85.7%	77.6%	58.6%	76.9%	73.5%		
Gynae Cancer										
Decision to Treat to 1st Definitive Treatment for Gynae Cancer	< 31 Days	96.0%	93.9%	100.0%	100.0%	97.9%	97.6%	97.1%		
Urgent Referral to Treatment of Gynae Cancer	< 62 Days	85.0%	61.4%	86.7%	75.7%	79.2%	80.3%	79.4%		
Haematology Cancer										
Decision to Treat to 1st Definitive Treatment for Haematology Cancer	< 31 Days	96.0%	98.3%	92.9%	97.1%	98.2%	99.6%	99.6%		
Urgent Referral to Treatment of Haematology Cancer	< 62 Days	85.0%	74.5%	62.5%	70.7%	66.7%	82.2%	80.5%		
Head and Neck Cancer										
Decision to Treat to 1st Definitive Treatment for Head and Neck Cancer	< 31 Days	96.0%	91.8%	100.0%	100.0%	92.5%	94.6%	94.5%		
Urgent Referral to Treatment of Head and Neck Cancer	< 62 Days	85.0%	49.7%	75.0%	62.1%	60.6%	63.4%	65.5%		
Lung Cancer										
Decision to Treat to 1st Definitive Treatment for Lung Cancer	< 31 Days	96.0%	96.7%	100.0%	95.5%	96.1%	98.0%	98.1%		
Urgent Referral to Treatment of Lung Cancer	< 62 Days	85.0%	56.4%	80.0%	63.3%	57.0%	75.5%	72.7%		
Sarcoma, Brain & Other Cancer										
Decision to Treat to 1st Definitive Treatment for Sarcoma, Brain & Other Cancer	< 31 Days	96.0%	96.9%	100.0%	100.0%	97.8%	98.7%	98.3%		
Urgent Referral to Treatment of Sarcoma, Brain & Other Cancer	< 62 Days	85.0%	75.0%	66.7%	60.0%	57.8%	72.3%	71.1%		
Skin Cancer										
Decision to Treat to 1st Definitive Treatment for Skin Cancer	< 31 Days	96.0%	96.7%	100.0%	98.3%	97.5%	97.6%	97.5%		
Urgent Referral to Treatment of Skin Cancer	< 62 Days	85.0%	91.4%	90.5%	95.4%	95.0%	95.5%	95.3%		
UpperGI Cancer										
Decision to Treat to 1st Definitive Treatment for UpperGI Cancer	< 31 Days	96.0%	96.5%	90.9%	94.3%	95.3%	99.1%	98.8%		
Urgent Referral to Treatment of UpperGI Cancer	< 62 Days	85.0%	73.9%	87.5%	90.0%	70.2%	74.9%	74.8%		
Urology Cancer										
Decision to Treat to 1st Definitive Treatment for Urology Cancer	< 31 Days	96.0%	73.4%	88.1%	84.4%	76.8%	96.7%	96.3%		
Urgent Referral to Treatment of Urology Cancer	< 62 Days	85.0%	58.0%	72.5%	62.4%	60.4%	81.5%	79.5%		

The Trust over achieved against the 62 day standard recovery trajectory for December, delivering 80.5% post breach sharing against a trajectory of 70.6%. At the time of writing January is currently tracking at 70.1% pre breach sharing, however January's performance does not finalise until 2nd March and is therefore subject to change as tertiary referrals can be uploaded to Open Exeter until that date. It is forecast that January's performance post breach sharing will be very close to the trajectory.

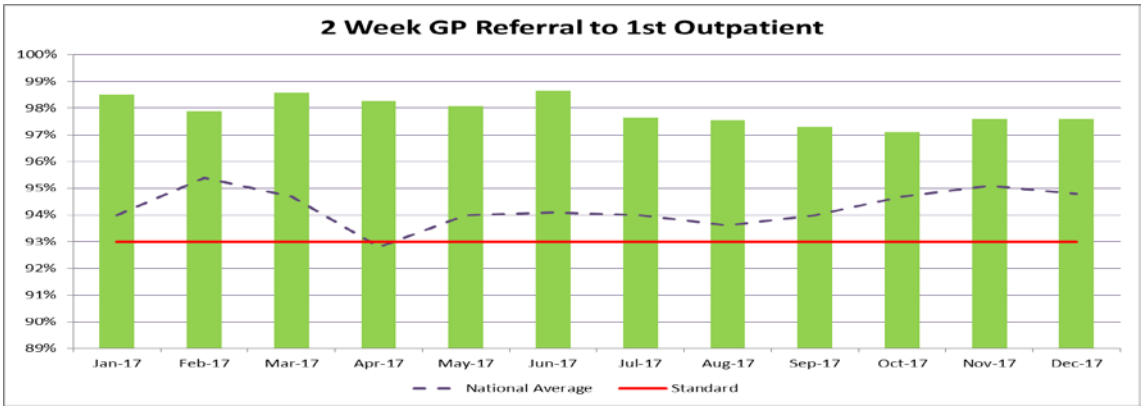
It is a typical pattern of variation for January's performance to drop as patient often elect to defer the diagnostic phase of their treatment during the Christmas and New Periods. This impact was factored into our recovery trajectory.

	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
	Finalised							Incomplete		
Pre-breach sharing	65.0%	71.0%	69.5%	73.2%	76.8%	75.5%	79.9%	70.1%		
Post-breach sharing	66.4%	74.9%	72.2%	78.8%	79.1%	80.3%	80.5%	TBC		
Trajectory							70.6%	75.2%	78.5%	81.0%

Whilst it is acknowledged that the national standards for cancer have not yet been achieved, the work to improve pathways has also had a positive impact on the Trusts 31 day diagnosis to 1st definitive treatment (all cancers) standard. ENHT achieved this standard for the second consecutive month following a period of inconsistent performance.

Standard	Threshold	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17
31 day diagnosis to 1st definitive treatment for all cancers	96%	93.80%	92.10%	93.90%	91.60%	96.30%	96.40%

Furthermore the Trust has achieved the 2 week GP referral to 1st Outpatient standard and is consistently above the national average and well as the standard for this key metric.



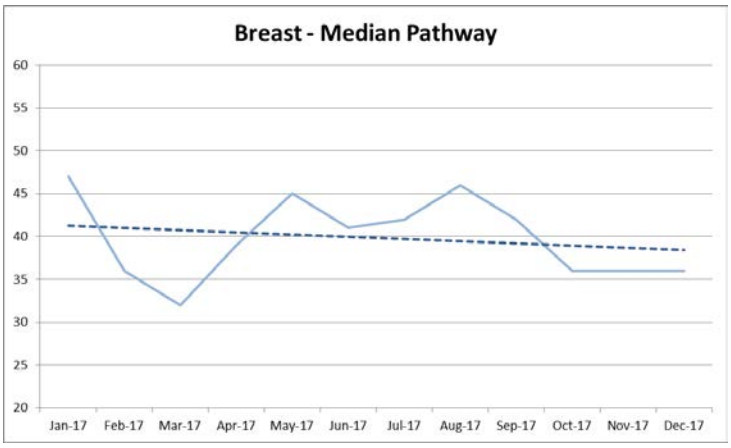
4.1 Recovery

As reported last month the trust has reforecast its recovery trajectory against the 62 day standard, expecting a return to achievement at the aggregate level in March, reported in May. Whilst improvements in administrative processes have delivered improvements in performance, a sustainable delivery is dependent on the clinical pathways being redesigned to deliver more quickly and efficiently.

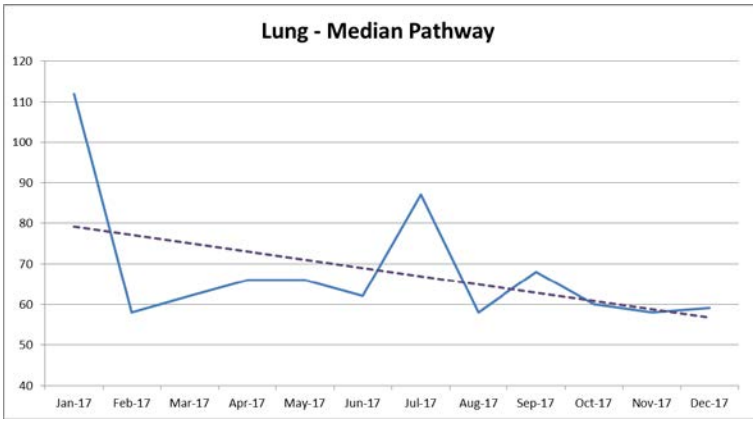
The four main tumour sites being focused on:

- Lung
- Breast
- Colorectal
- Prostate

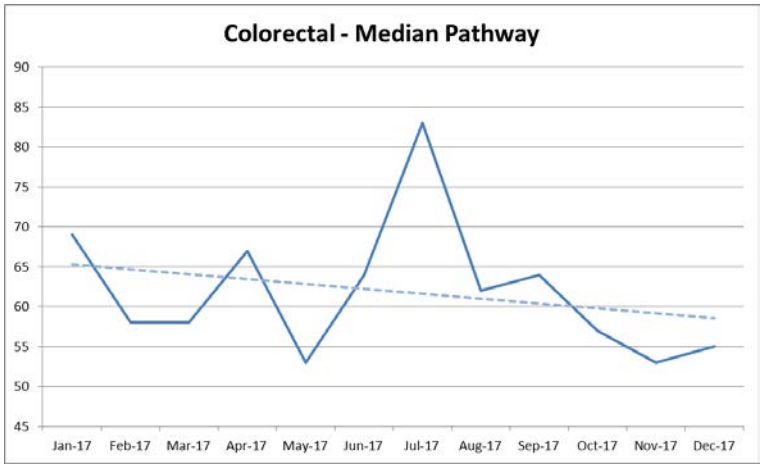
The following graphs demonstrate the median pathways for patients being treated for the four tumour sites mentioned. For the pathway to be optimal it needs to deliver a median of less than 62 days. The graphs further evidence that clinical pathways are also improving albeit that in some areas the median performance is inconsistent and needs to be much lower than 62 days as this is the median.



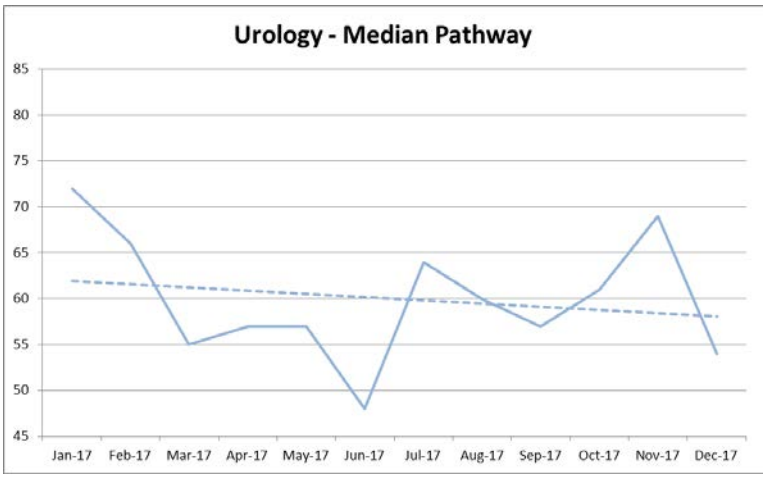
The breast pathway continues to deliver sub 62 days and is currently tracking around 36 days for the median



The lung pathway median continues to demonstrate an improvement, liner trend, the pathway has delivered a median time of 60 days for the last three months.



The Colorectal pathway is delivering a median of 58 days across the period from Jan 17 to Dec 17, although for the past three months this has been lower.



The Urology pathway median performance is more inconsistent, however across the period Jan 17 to Dec 17 is delivering a median pathway of 57 days

Shape of the Cancer Waiting list Profile

In order to achieve a sustainable performance the waiting list profile should be predominately ‘weighted’ with the majority of patients waiting in the early part of the PTL and small number over 62 days. ENHT’s cancer PTL profile:

- 42.8% (n.580) 0-14 days
- 29.3% (n.397) 15-28 days
- 13.2% (n.179) 29-43 days
- 7.4% (n.101) 44-62 days
- 7.3% (n.99) >63 days

5. Stroke

December stroke performance is the latest validated performance data.

December '17 Stroke performance

Metrics	Dec '16	Jan' 17	Feb '17	Mar '17	Apr ' 17	May '17	Jun e'17	July '17	Aug '17	Sept ' 17	Oct '17	Nov '17	Dec '17
Trust SSNAP Grade	A	A	A	A	A	A	A	A					
Stroke Discharged with AF on anticoagulants (ASI 1)	86.7%	72.2%	88.2%	91.7%	54.5%	90%	92.3%	62.5%	100%	62.5%	62.5%	66.7%	61.5%
Stroke – 4 hours direct to stroke unit from ED	76.6%	71.8%	76.4%	73.4%	82.5%	76.6%	77.6%	78.6%	71.7%	71.6%	71.2%	70.6%	78.5%
No. Confirmed Strokes in Month (figure excludes inpatient strokes & hospital transfers)	77	78	72	79	40	36	67	42	53	67	73	68	65
Stroke – 80% of patients spent 90% of time on the stroke unit	85.7%	86.9%	83.3%	92.5%	88.9%	91.4%	88.5%	88%	83.9%	88.9%	79.7%	84.9%	87.3%
Stroke – 60 min to scan from time of arrival – target 50%	47.6%	51.2%	46.2%	51.3%	52.4%	55.1%	57.5%	70%	59.6%	56.9%	51.9%	66.2%	55%
Stroke 60 mins to scan for those patients deemed urgent	86.1%	91.7%	90%	89.2%	95.2%	91.7%	90%	96.2%	92.9%	87.8%	90.9%	97.4%	72.5%
Stroke – scanned within 24 hrs (all strokes) targed 100%	98.8%	100%	98.7%	100%	100%	98.6%	100%	100%	100%	100%	100%	100%	95%
Total Thrombolysis Rate for confirmed strokes	9.9%	17.1%	7.5%	13.6%	16.2%	11.5%	13.4%	14.3%	16.7%	11.3%	6.3%	16.9%	11.4%
Stroke patients thrombolysed within 3hrs-4.5hrs	7.1%	12%	6%	9.1%	10.8%	6.6%	9%	7.1%	6.3%	4.8%	1.6%	7.7%	8.6%
Stroke – discharged with JCP – target 80%	79.2%	95.8%	100%	100%	100%	100%	100%	100%	94.7%	98%	98%	97.7%	96.2%
Stroke –discharged with ESD target 40%	36.5%	42.1%	42.4%	40%	54.5%	26.5%	48.1%	50%	33.3%	34%	35.8%	30.6%	41.5%

6. Diagnostic Standard (DM01)

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

DM01

Month	Performance	Standard
Dec-16	99.23%	99%
Jan-17	99.90%	99%
Feb-17	99.68%	99%
Mar-17	99.82%	99%
Apr-17	99.72%	99%

May-17	99.00%	99%
Jun-17	99.60%	99%
Jul-17	96.65%	99%
Aug-17	No submission	
Sep-17	No submission	
Oct-17	No submission	
Nov-17	No submission	
Dec-17	No submission	

** End of document **

Agenda Item:10.3

TRUST BOARD PART 1 – 7 MARCH 2018
Workforce & OD Board Report – Month 10

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

ACTION REQUIRED *

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

DIRECTOR:	Chief People Officer
PRESENTED BY:	Interim Deputy Director of Workforce and OD
AUTHOR:	Interim Deputy Director of Workforce and OD
DATE:	February 2018

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

***** tick applicable box

Workforce Report

FEBRUARY 2018

BASED ON MONTH 10 DATA

Key Headlines

Executive Summary

The trends for the Trust workforce report for month 10:

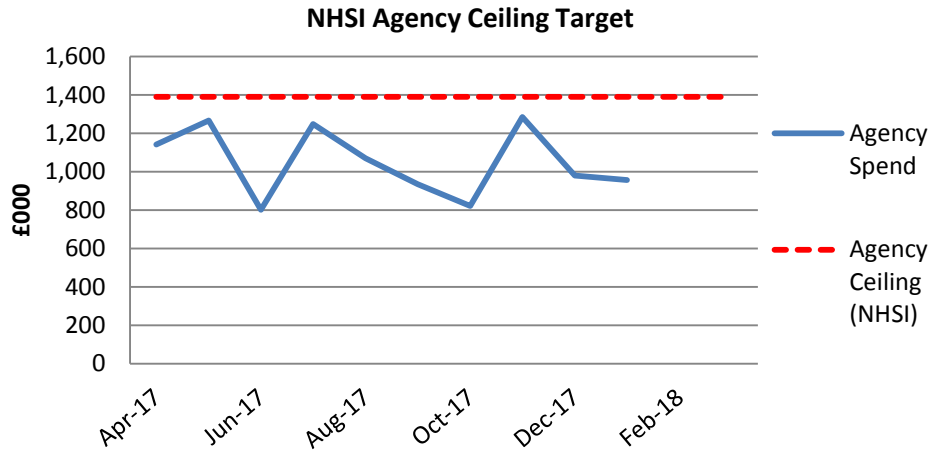
- The monthly agency ceiling target continues to be achieved in month 10 with agency spend under by £434k (variance of 31% against a national variance of 5%). Agency spend as a % of total pay cost is at 4.5% which is the second lowest in the region.
- The Trust's vacancy rate of 8.5% is the second lowest compared to local benchmarked trusts.
- The online staff survey workshops, using innovative technology solutions to provide a crowd sourcing platform, closed in late January with a participation rate of 15% against a target of 10%. Work is now underway to analyse the workshop outputs to enable the creation of survey action plans.
- Focus on organisation culture and staff engagement continues with LEND Sessions for Spring 2018 launched and new 'Workforce Skills for Leaders' module to launch next month. This continues the development model of empowerment as managers and leaders become aware and engaged in the workforce requirements of their teams.

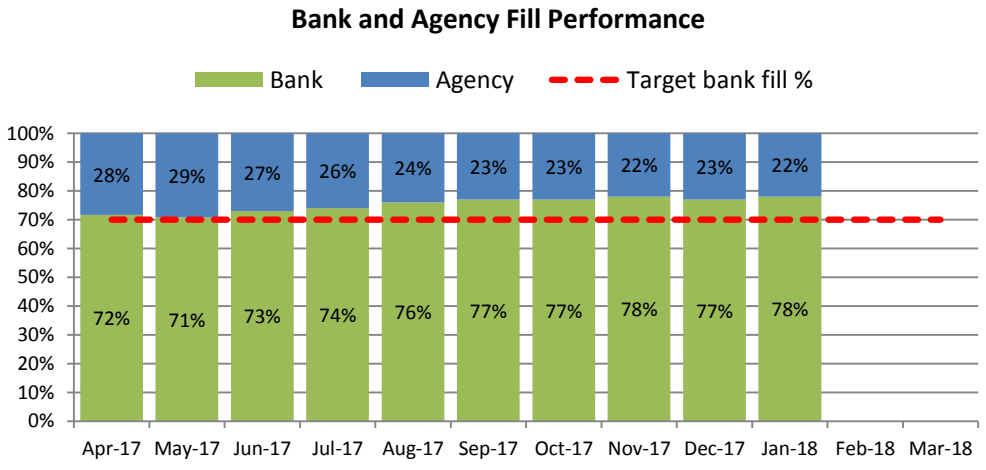
Workforce Board Report

Index

1. Temporary Staffing

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





Headlines:

The monthly agency ceiling target continues to be achieved in month 10 with agency spend under by £434k. The Trust is under the ceiling target by £3,396k FYTD with the controls in place it is expected that the Trust will remain under the target each month until the end of the financial year. New target will be set from April 2018

Based on the NHSI ceiling target, the Trust set out a plan for agency spend for each staff group. Current Month spend is below plan for all staff groups including nursing, and significantly lower when looking at year to date for all groups. All staff groups have seen an decrease in current month when compared to the last.

Spend on nursing agency has increased in month but continues at lower levels when compared to last year. Most of this increase came within Medicine and Surgery. Both of whom have had new wards open.

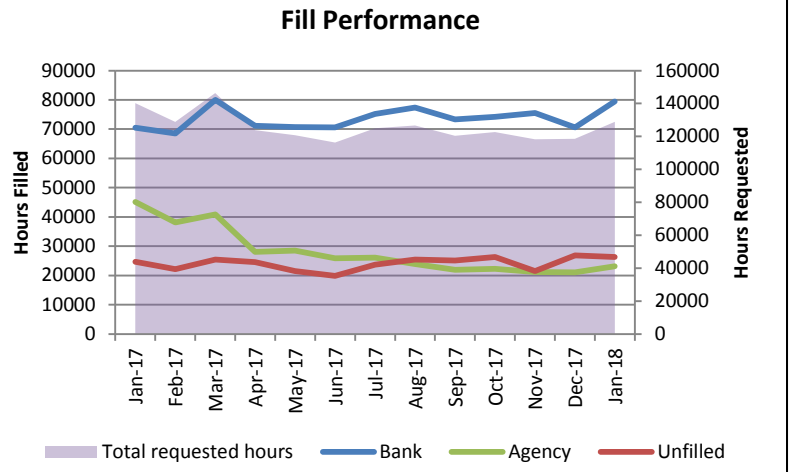
Medical Staff costs have decreased in month mostly within Women's and Children's and CSS. Within CSS Pathology lost a Haematologist, however a replacement has now been found and will impact upon February's position.

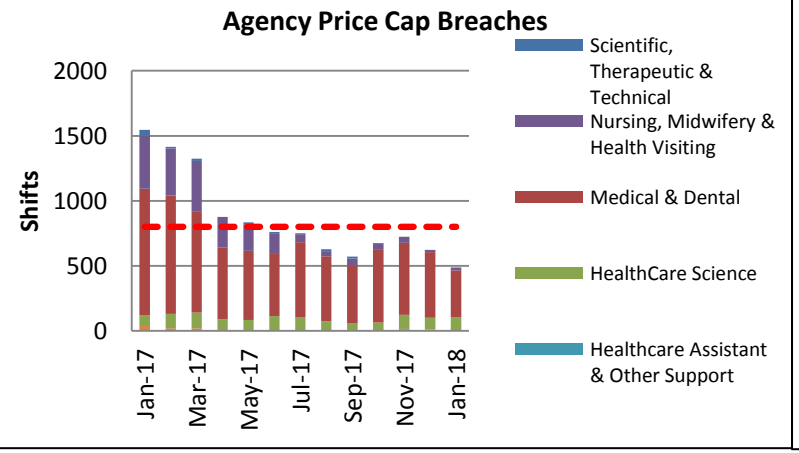
Year to date, compared to the previous year, the trust has reduced its agency shifts booked by 64%. This transition has been delivered through a comprehensive action plan focusing on key areas including agency controls, bank recruitment, regional collaboration, demand management and staff engagement.

Shared bank: With The Bank Network now embedded with three Hertfordshire Trusts, the Trust is now reviewing how this could be expanded further including a review of the software available to facilitate this. Awaiting approval for Department of Health pilot on Bank Flexible Working Pilot initiative building on the Bank Network offering.

1b. Temporary Staffing

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





Headlines:

Fill rate improvement initiatives: The Trust has seen a prolonged period of a shortfall in clinical staff specifically for nursing (qualified and unqualified) and some areas for medics (ED and Acute medicine). This is represented in the volume of unfilled hours in December and January. The Trust has been working on a number of initiatives mitigate the shortfall. An incentive scheme for nursing staff was in place for three weeks over the holiday period an into January, this enabled a targeted approach to cover shifts with significant shortfalls. The team of 'Rapid Response' staff was increased to enable short notice deployment of staff to 'red' wards. The Trust worked with agency partners to secure greater shift coverage by offering longer term work, this process was maintain with executive sign-off only. A CSW working group has recently been launched to look at the 'end to end' experience for a bank CSW with a proposal shortly to be submitted to increase the low bank rate for this staff-group. Currently working on Easter incentive modelling (further details will be shared as appropriate)

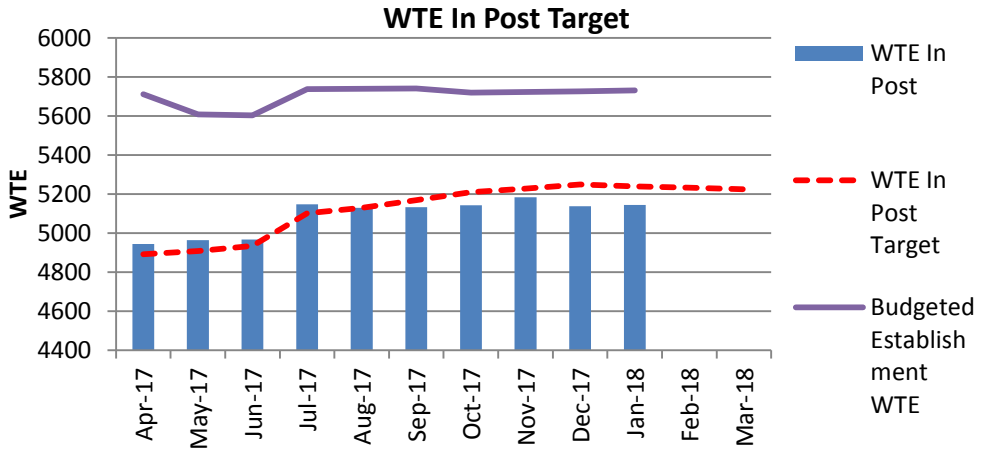
Internal Temporary Staffing Office, Doctors (TSOD): Work is ongoing with the pan London procurement group to review the Hertfordshire ceiling rates with their rates for Doctors, with a plan of achieving some standardisation across the patch. Benchmarking data shows that Hertfordshire are paying higher agency rates on average than London therefore further work is required to achieve alignment. A plan to move ED medical onto the rostering platform is underway with a launch date proposed for 1st March.

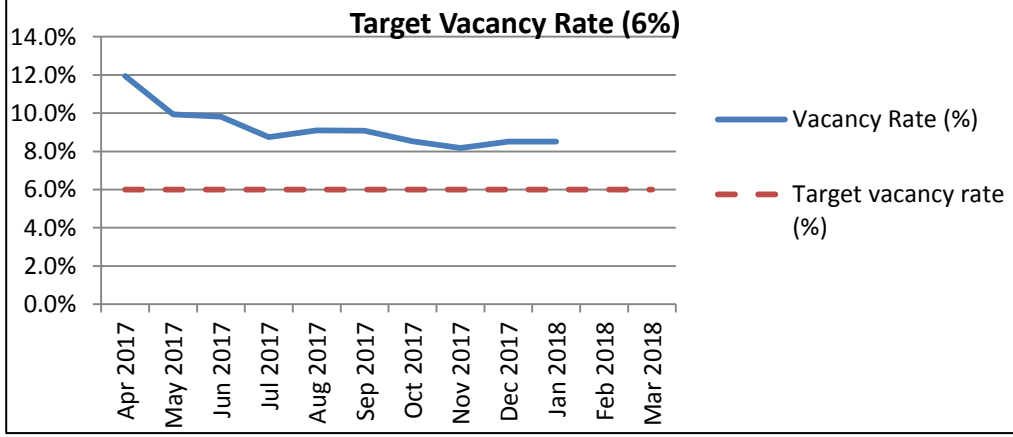
Agency Breaches: Priorities remain on reducing A&C breaches (64% for January) and Medical. Exploring Medical bank pay rates at Locum Sub Group which will incorporate Agency reduction/migration programme on rates following 'deep dive' analysis on substantive posts and Bank & Agency behaviours as to which specialities to start the reduction plan in (in collaboration with Herts Consortium). N&M account for 1% of breaches (all specialist).

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

2. Resourcing

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





Headlines:

Total WTE in post increased in January 2018 by just under 6 WTE to 5144 on December's figures. There was a total of 109 WTE starters in January against 67 WTE leavers (net increase of 42 WTE). This difference is not fully reflected in the January staff in post number due to 27 honorary contracts being removed from staff in post data.

January's reported figures means the Trust was 95.36 WTE short from the in-month recruitment target and 81.29 WTE away from the end of year target. There are currently 277.79 WTE external candidates undergoing pre-employment checks or waiting to start with the Trust. It is projected there will be an increase of new employees compared to January's new starter figures in February 2018; with a projection of 20 WTE Band 5 nurses and 18 WTE Band 2 CSWs due to be in post by February 2018.

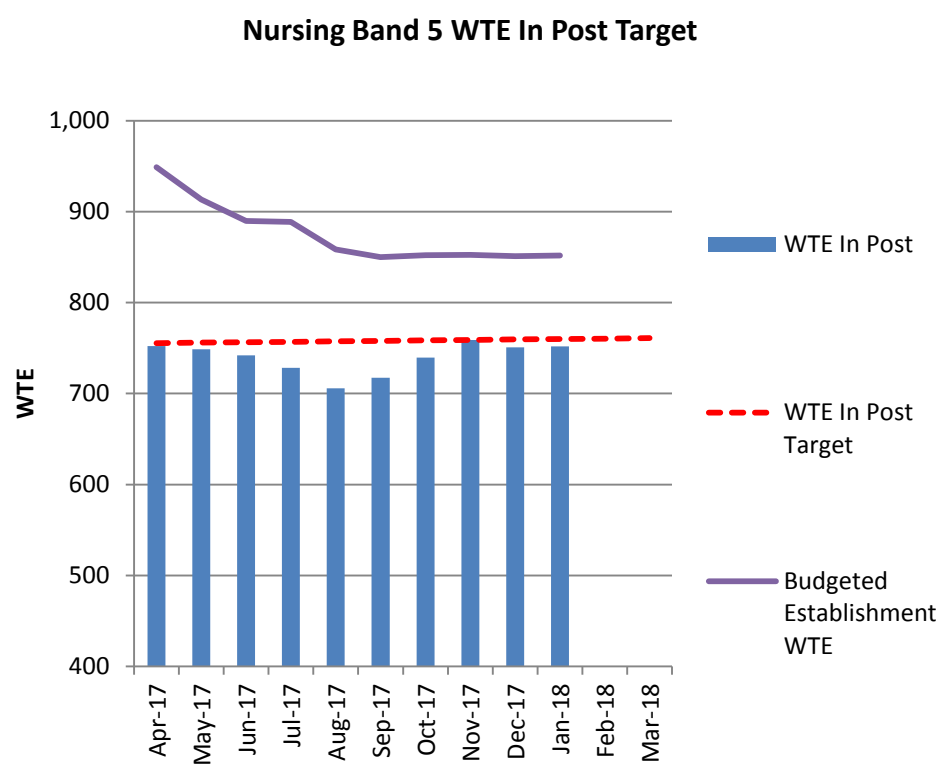
The vacancy rate at the end of January 2018 was 8.5% (478.15 WTE) and indicates positive improvement from the start of the financial year (11.9%). The vacancy rate is based on the posts actively being recruited, excluding bank and agency lines.

The Trust currently has the second lowest vacancy rate in the region at 8.5% which is only 0.4% more than the Trust with the lowest regional vacancy rate.

Current work includes a review to establish recruitment targets for the for new financial year. The re-set of recruitment targets will be supplemented by a Trust-wide Recruitment Strategy to provide the organisation with the strategic direction in which the Trust will work towards recruiting and retaining the best skilled and dedicated workforce.

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

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



Headlines:

The Band 5 nurses in post increased by 1.07 WTE in January 2018 taking the total number of Band 5 nurses to 751.81 WTE. There was a total of 24.03 WTE nurse starters in January. This meant the Trust was 8.19WTE away from the in-month target and 9.19 WTE away from the end of year target.

In order to meet the target for Band 5 recruitment the Trust would need to recruit an additional 29 WTE by March 2018; taking into consideration the average attrition of 10.0 WTE nurses leaving each month.

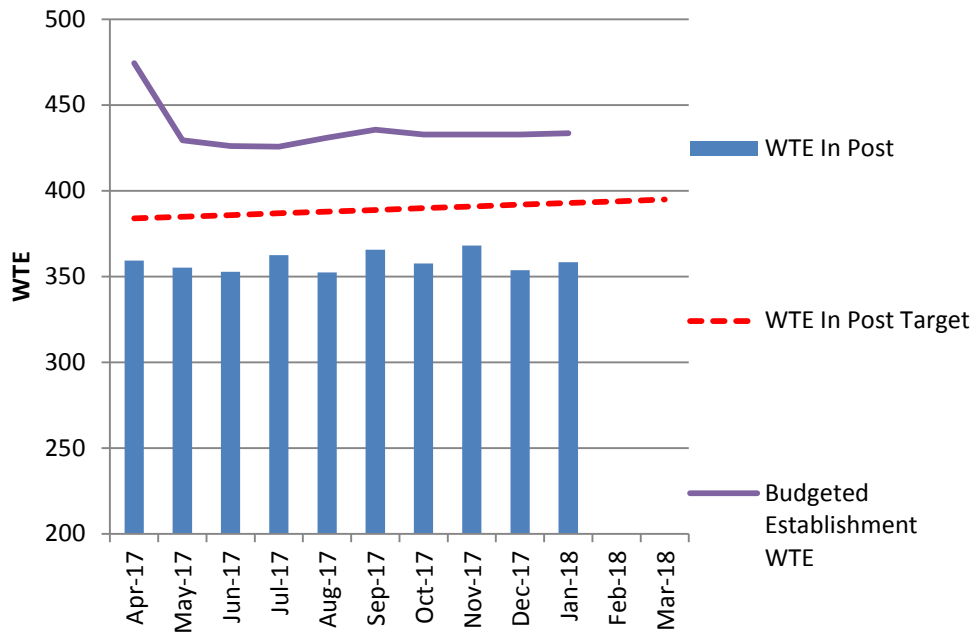
The Trust's vacant posts for Band 5 registered nurses at the end of January was 100.18WTE, this equates to a 11.75% vacancy rate; this is a positive trend compared to the end of Q3's reported vacancy rate of 13.23%.

There are currently 156.2 WTE external band 5 qualified nurse candidates undergoing pre-employment checks or awaiting to start with the Trust. The Band 5 nurse trajectory looks to have 20 WTE new starters for February 2018. The increase in Band 5 deployment is mainly attributed to international nurse recruitment.

The relaunch of the Trust's recruitment microsite and new branding for our nurse vacancies including the campaign **#nursesinherts** continues which will be using the RCN bulletin & Nursing Standard publications to increase awareness of our vacancies and Nurse Recruitment events. In addition Trust-wide Rotational Band 5 posts are being advertised as a means of attraction.

2c. Resourcing - Non-Medical CSW

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



Headlines:

The Band 2 Care Support Worker (CSW) WTE in post increased by 4.60WTE in January 2018 taking the total number to 358.27 WTE. This meant the Trust was 34.55 WTE away from the in month target and 36.55 WTE away from the end of year target. The trust now aims to recruit an additional 18.28 WTE per month until the end of the year to achieve the target.

The Trust's number of vacant posts for Band 2 CSWs at the end of January 2018 was 75.16 WTE, equating to an overall vacancy rate of 17.34% for CSWs. There are currently 30 WTE CSW candidates going through pre-employment checks. It is projected 18 WTE CSWs will commence employment in February 2018 which based on current attrition should take us to our target level.

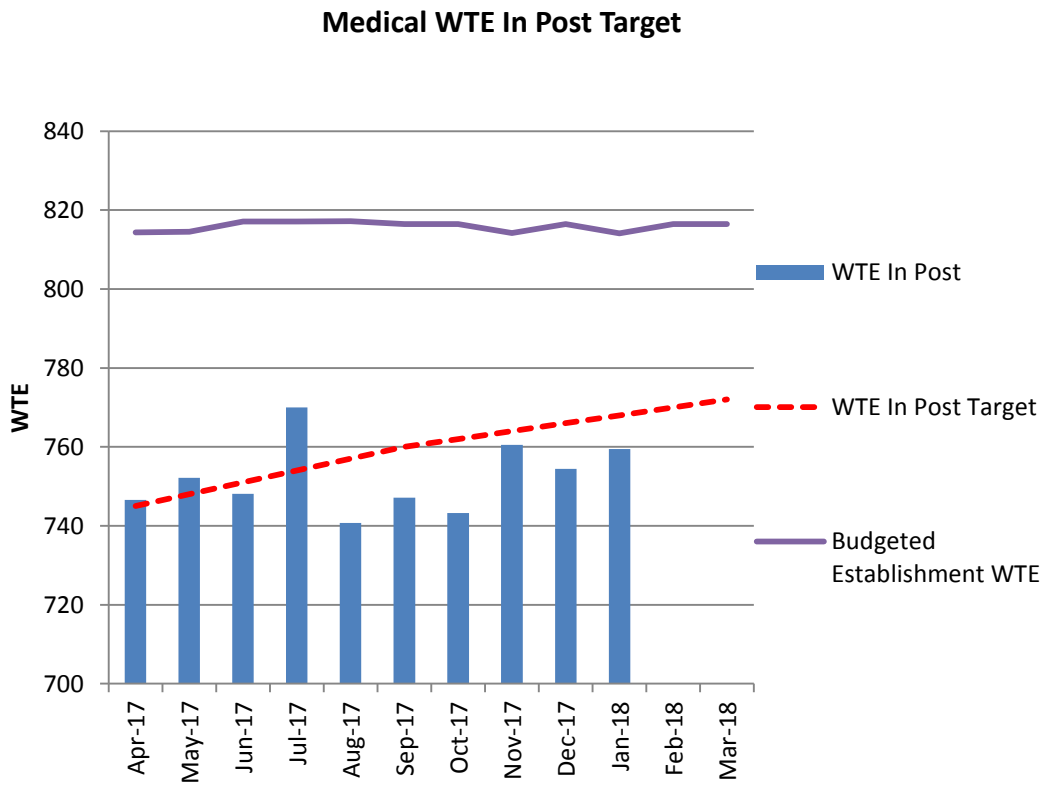
There are further assessment and recruitment events planned until the end of March 2018 with employment start dates in line with the Preparation to Practice Course which is now being scheduled every month as opposed to every 2 months.

Bespoke CSW recruitment days are to be rolled out in line with divisional recruitment plans to attract candidates for specialties. The cohort recruitment assessment days continue to be held every two weeks, to increase the pipeline. Further work is currently underway, exploring other avenues of candidate attraction and explaining the apprenticeship scheme in detail in order to determine candidate and job profile compatibility.

The CSW Working Group continues to meet and collaborate with Nursing and Temporary Staffing teams to improve attraction and retention and to establish processes between teams which will improve the overall recruitment experience.

2d. Resourcing - Medical

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



Headlines:

7.0 WTE new medical staff were appointed in January, 2.0 WTE medical staff left the Trust, giving us a net gain of 5.0 WTE on recruitment numbers. February is looking positive with 12.0 WTE new medical staff in the pipeline and 6.0 WTE scheduled to leave. The previous 6 months have been adjusted to reflect staff in post excluding staff on honorary contracts.

The Trust had an improvement trajectory of an additional 27 staff in post over 12 months. Year to date there are an additional 14 medical staff in post (9 away from in month target and 13 away from end of year target).

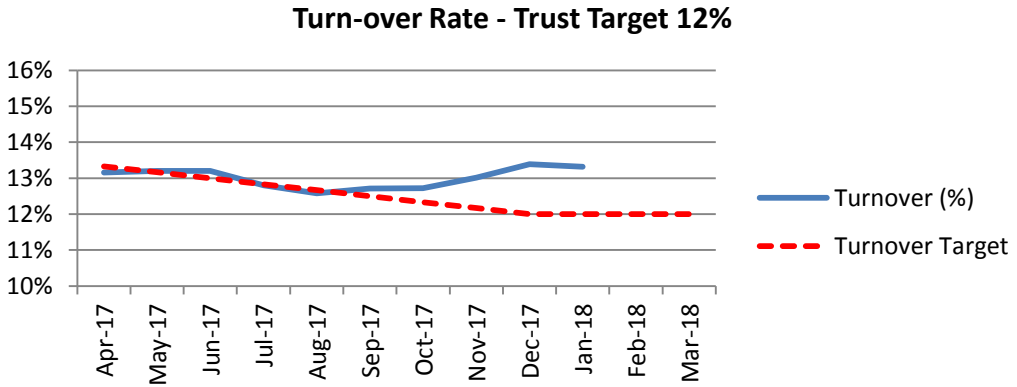
Retention of staff: Ongoing work on retention following feedback gathered from new starters and leavers required. Focus required for new starters, specifically from overseas during week 4 to 8 of starting. Staff listening events have also been suggested for Plastic Surgery and Emergency Medicine so that we can talk to the doctors in the departments to find out their experiences in the job roles to avoid high staff turnover.

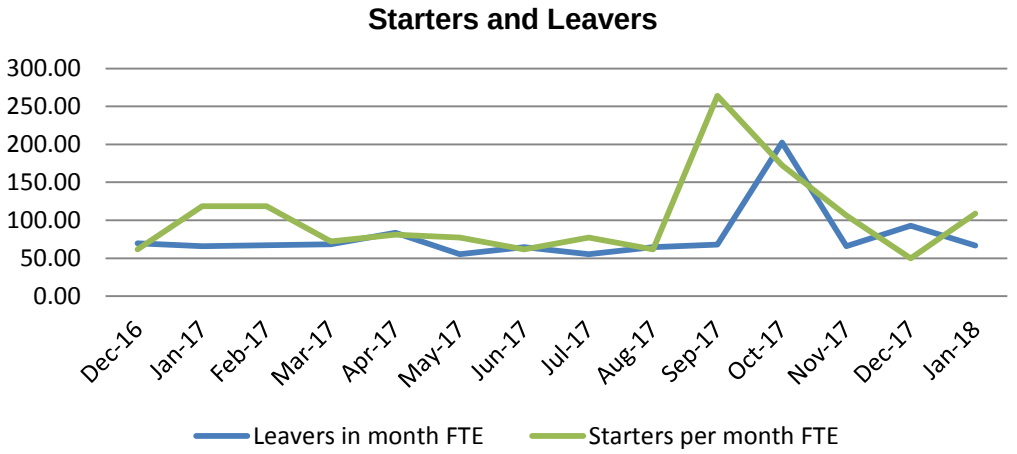
Candidate attraction: An ongoing review to look at options for an enhanced promotional video and marketing material is currently taking place. Consultant adverts are being revised to aid attraction to the post and organisation.

Threats to target: Increasingly the emphasis is on international recruitment to fill the gap in some specialties; this is an extensive process increasing the time to hire, in the month of January 5 out of 6 visa applications were rejected and the Trust is reviewing options to resolve this.

3. Staff Retention

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





Headlines:

Turnover rate decreased by 0.07% in month 10 and has moved closer to the planned target rate of 12% (dif. 1.32%). The overall turnover rate is significantly below the regional benchmark of 16.7%. In month 10 there were 26 WTE less leavers compared to the previous month.

A new plan has been devised which sets out all of the key drivers for delivery of the Trust target. The plan covers the four key areas as follows:

Improved experience of staffing levels - Improved branding and marketing, leader for international recruitment, increase bank fill rates, limit staff being moved from substantive ward. Work has already begun with an initiative starting in February known as re-set Tuesday which will ensure staff are not moved from their allocated ward to mitigate staffing shortfalls, instead cover will be provided form other non-ward based staff.

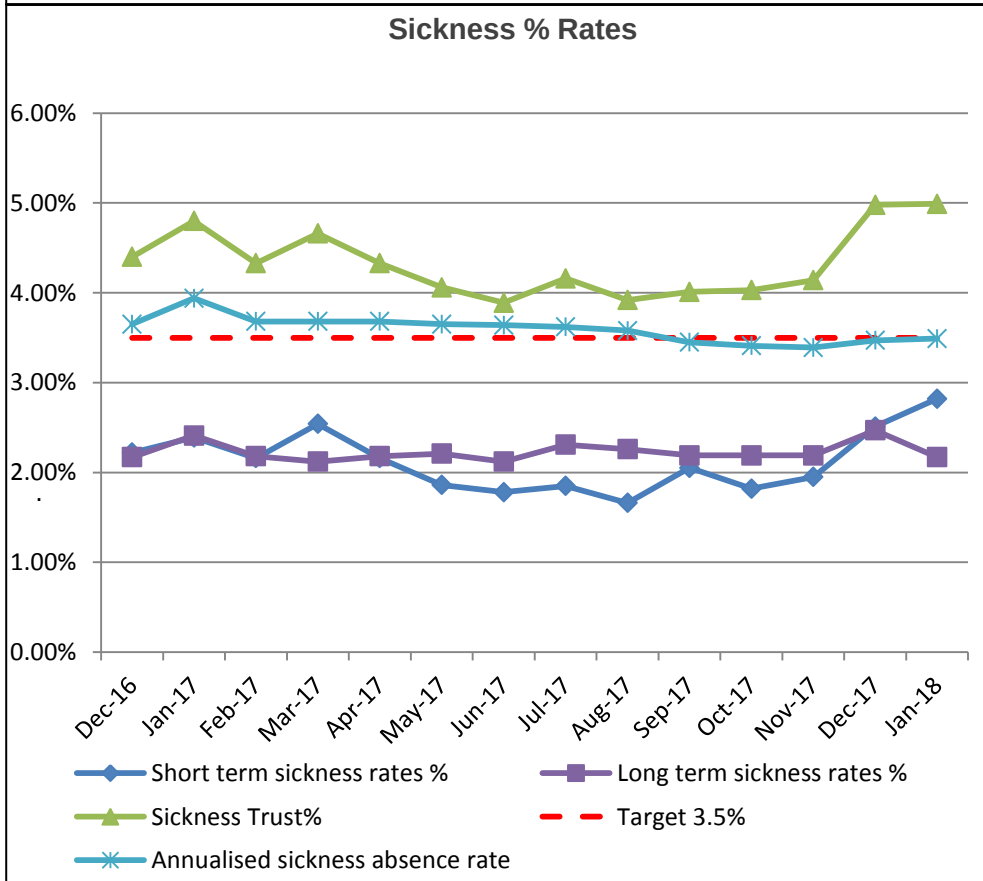
Improved clinical management and team development - Improved manager leadership capabilities, renewed recruitment and induction processes, team intervention and development. An area of focus has been maternity where work is being complete improve team dynamics creating a high performing team.

Enhanced employment offer and staff benefits - Benefits package, continuation of Flexible Working scheme, Clinical excellence accreditation. Flexible working opportunities remains one of our core offering to staff.

Improved career pathways - Explicit career pathway within and across discipline, improved internal movement opportunity for staff, improved talent management. The rotational post offer is now in place with the first cohort soon to start.

4. ER Sickness Management

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



Headlines:

Overall the annualised sickness absence rate has remained stable at 3.49%; this remains in line with the overall target of reducing the annualised absence rate down to 3.3% by the end of March 2018.

In January 2018 the in-month sickness absence rate showed a marginal increase (0.01%) to 4.99%. In both December 2017 and January 2018 the in-month sickness absence rate has been higher compared with the same period last year due to an increase in short term sickness absence. A detailed Sickness Absence Action Plan has been developed, including the launch of the revised policy, to specifically target the increasing rate of sickness absence. Actions commence in respect of the action plan with effect from March 2018.

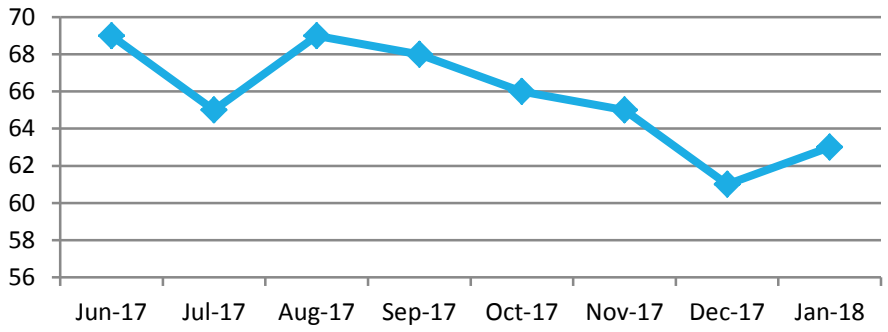
99 individuals remained absent at month end due to long term sickness absence; this figure has reduced from 134 in December 2017. The key actions that have commenced in respect of the sickness absence cost saving plan are; auto-enrolment of LTS cases, focus on hotspot areas, early intervention by Health at Work in respect of musculoskeletal and stress related sickness and direct communications with individuals reaching informal triggers in respect of STS absence.

The revised Sickness Absence Policy has now been agreed following discussion with key stakeholders and staff side colleagues. The final drafting will be approved at the Joint Negotiating Committee on 23rd February 2018. The launch of the revised policy will be supported with a range of training sessions, frequently asked questions, guidance sheets and amended template letters. It is anticipated that the number of supported / formal cases will increase as a result of the revised trigger framework; ensuring that as a Trust we are consistent and proactive in the management of sickness absence and that timely support is being provided to those individuals who are unable to maintain their attendance at work.

5. Employee Relations

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

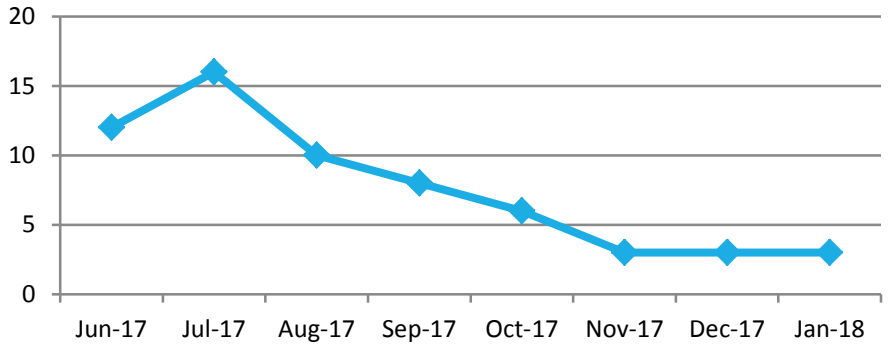
Sickness Cases



Headlines:

- The number of sickness absence cases registered with ERAS for active support increased to 63 as at the end of January 2018; the launch of the sickness absence policy has been delayed to take place with effect from March 2018. With the implementation of the new policy we are expecting case numbers to increase.
- It is anticipated that approximately 800 staff members will have reached the formal trigger of 192; a review of all cases will take place commencing March 2018.
- In addition and in accordance with the Trusts plans for reducing short term sickness absence; the ERAS team with HRBPs will be targeting hotspots areas using metrics for the highest number of staff reaching the formal trigger point. This will ensure increased awareness of the policy and will develop the HR capabilities of managers dealing with sickness absence.
- Long term sickness cases continue to be monitored and auto-enrolled with ERAS to ensure timely and consistent management action.

Bullying and Harassment Cases



Bullying and Harassment:

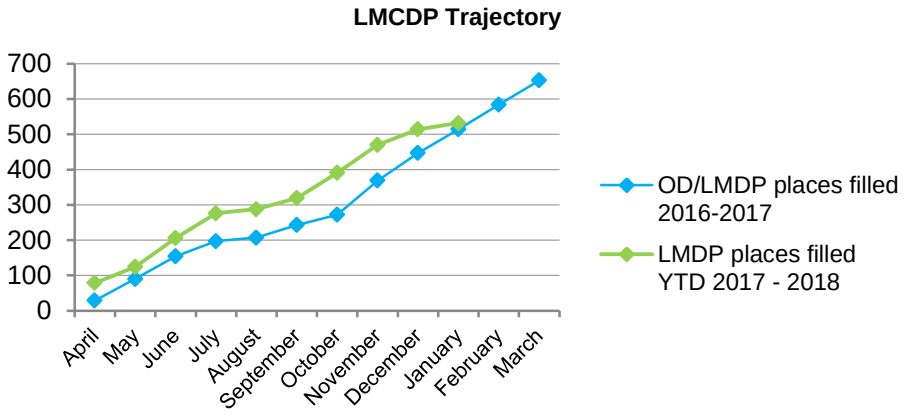
- In January, the percentage of employee relations cases based on headcount within the Trust was 1.7% which sits within the expected range of between 1% and 3%. There were 105 open cases at month end including; Sickness Absence , Grievance, Disciplinary, Capability and Appeals.
- In the last month there has been 1 new Raising Concerns Case which relates to management concerns and breaches of confidentiality. The concern is registered with ERAS and being appropriately investigated.
- There was 1 new case opened in relation to Dignity and Respect at Work; the overall number of bullying and harassment cases has remained the same.
- Work is continuing to address bullying and harassment concerns and dates are being finalised for future drop-in sessions at each of the Trust sites.
- Increased communications will commence in March 2018 in relation to the Trusts' Speak in Confidence Service; to notify staff of key changes to the service and increase overall awareness.

Policy Update:

- Managing Sickness Absence due for sign-off 23rd February 2018
- Change Management and Dignity and Respect at Work subject to review.
- Disciplinary signed off January 2018.

6. Organisational Development - Capability of leaders

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



Headlines:

LMCDP (Leadership, Management and Coaching Development Pathway) attendance figures continue to outperform the 2016 -2017 figures, despite redirection of resources to other tasks. The *Appraisal Skills for Managers* programme has now received CPD accreditation.

The Coaching as an Approach to Leadership Programme Set B (for experienced leaders) ran in January and received excellent feedback from delegates:

- **'**very enjoyable course, good group of candidates. Learnt a lot to take away and use'
- 'a course that all the workforce should attend as it will make a difference in practice'
- 'creates a level of self-awareness and empowers you to coach others'

All three cohorts of the second set of the regional *Mary Seacole Programme* are now full, with training grade doctors among the delegates for the first time. A proposal is currently with Health Education East of England regarding funding for a full evaluation of the first round of the programme which ran during 2017.

The online staff survey workshops closed in late January with a participation rate of 15% against a target of 10%. Work is now underway to analyse the workshop outputs to enable the creation of survey action plans.

The Accelerated Director Development Scheme (ADDS) selected the staff from ENHT who will attend the 2018 programme

6b. Organisational Development - Capability of leaders

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

Headlines:

LEND Sessions for Spring 2018 have been set and dates advertised. Organisational leaders have been encouraged to attend and support the their teams in attending

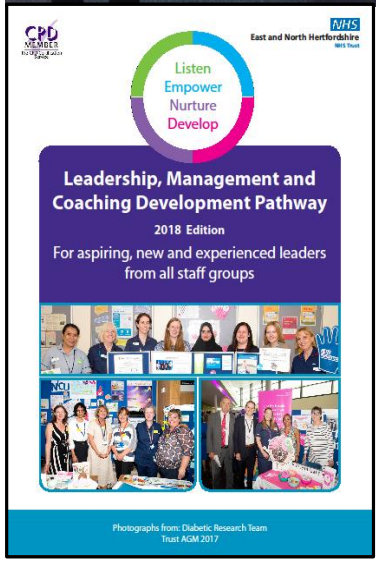
An increase in bespoke team interventions across the organisation with work in IT, Maternity, Cancer. The use of the organisational values and behaviours provide a consistent approach to all work undertaken

NEW 'Workforce Skills for Leaders' module to launch next month. This continues the development model of empowerment as managers and leaders become aware and engaged in the workforce requirements of their teams

Formal induction into the ENHT Faculty of Leadership Development will members of the organisation receiving formal recognition for their contribution – the first formal members come from Quality & Safety, PMO, Surgery and Medicine.

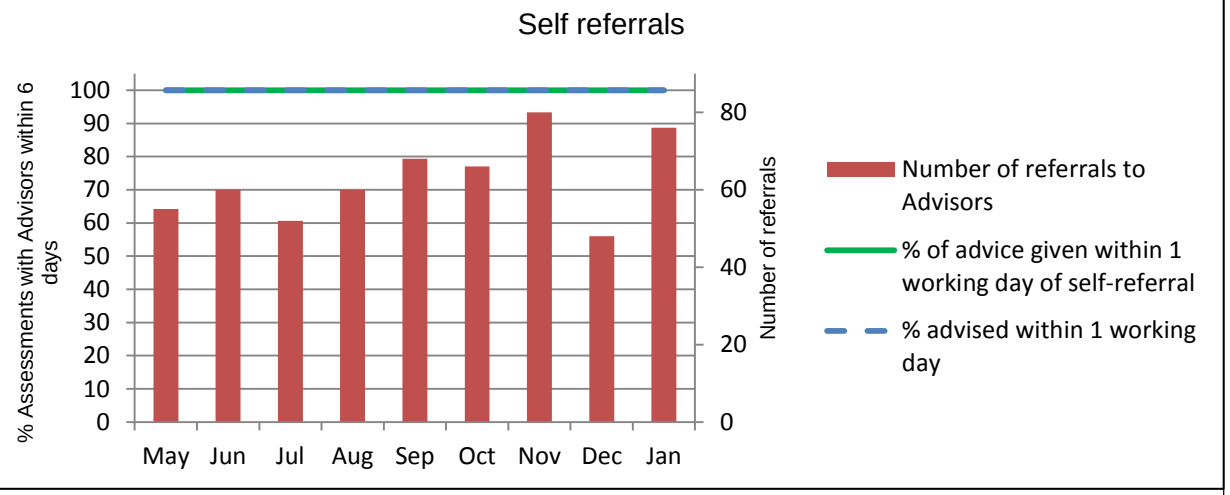
Promotion continues for the 2018-19 LMCDP programmes and bookings are healthy with feedback remaining exceptional – pathway is now used as a recruitment offer and is recommended by delegates to colleagues.

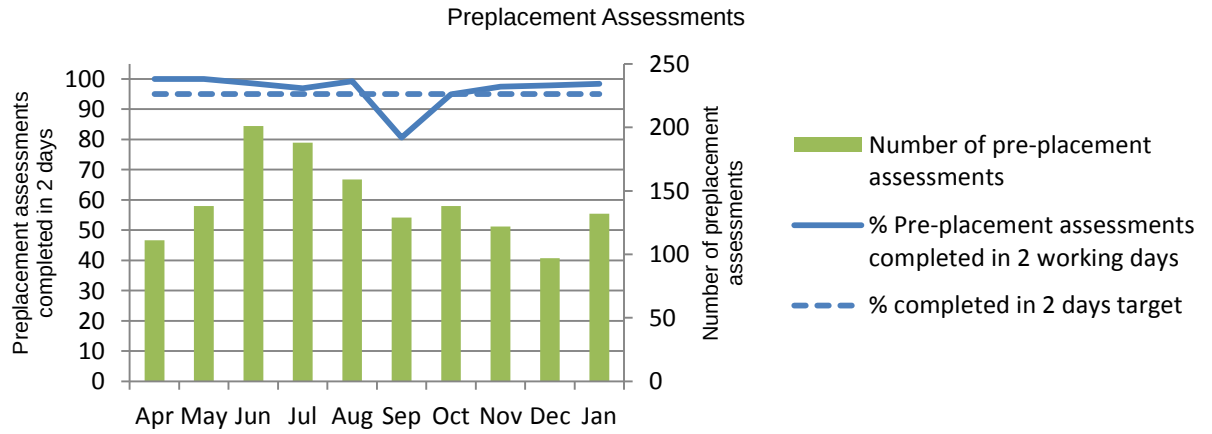
A leadership and management development workstream has commenced with UoH with the prospect of joint projects and programmes as well as access to newly emerging 'higher' apprentice programmes.



7. Staff Health and Well-being

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





Headlines:

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

In January 76 employees self-referred to Health at Work, all these staff were offered advice about strategies to optimise their health at work within 1 day of the call. The Health at Work Service have consistently been able to offer 100% of employees advice within the same day of a telephone request.

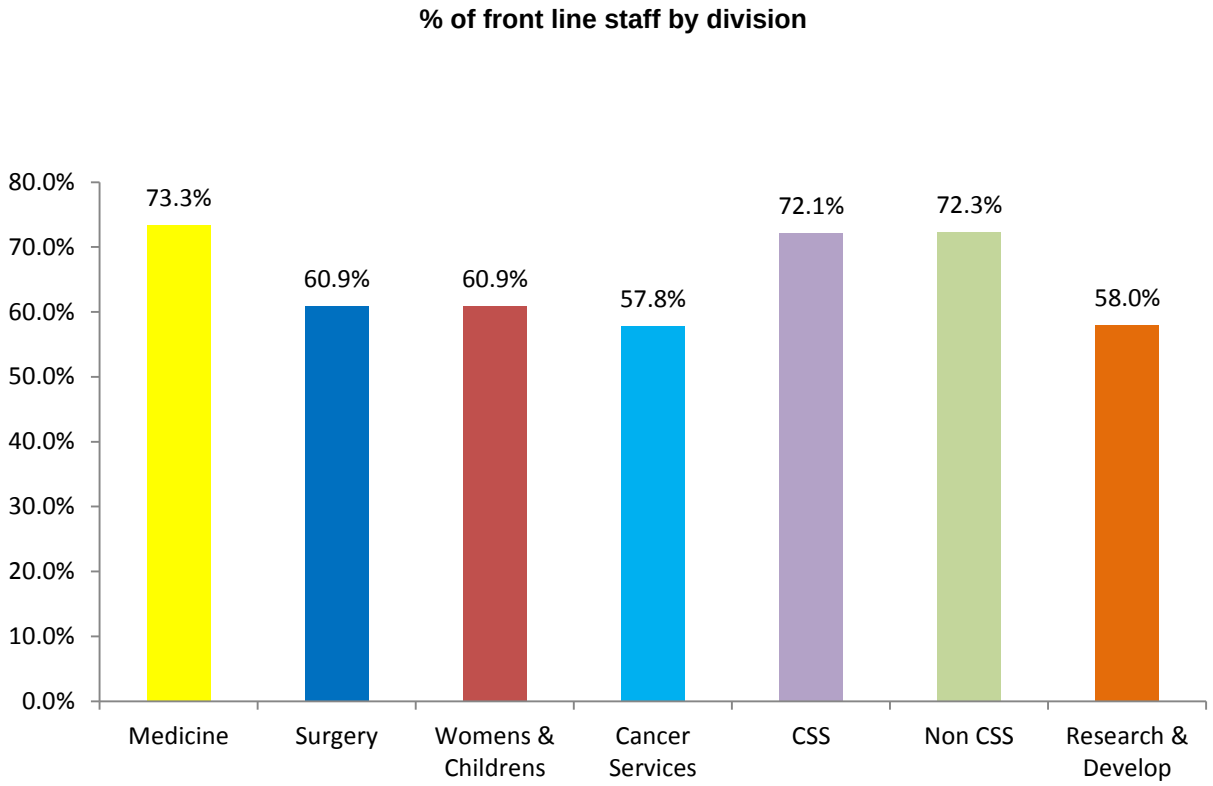
Referrals from managers have increased in January, 111 referrals were received from managers, 65.6% of employees were assessed within 6 days of the referral, this is lower than our expected standard of 95% of assessments, however a full time Senior Advisor post has now been successfully recruited to which will support the achievement of the standard.

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

132 Preplacement health questionnaires were received in January, 98.4% of pre-placement health clearances were sent within 2 working days.

7b. Staff Health and Well-being

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



Headlines:

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

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

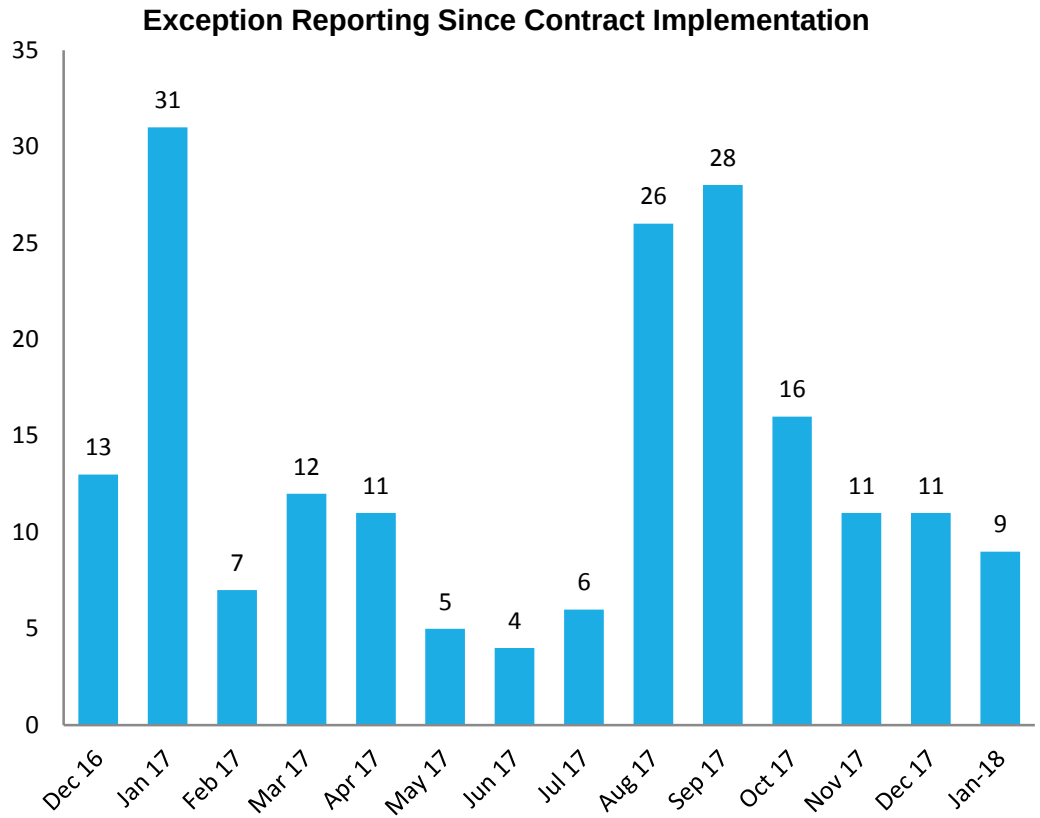
Performance: The Staff flu vaccine campaign began on the 2nd October 2017. Frontline healthcare workers play a pivotal role in helping to prevent the spread of influenza (flu) throughout the winter months. Flu immunisation is one of the most effective interventions to reduce harm from flu and pressures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

By the end of January 2990 (66.2%) frontline staff have received the vaccine, this is a 2.4% increase on last year. Drop-in clinics have been held at Lister Community Hub, and roaming clinics have been held at Mount Vernon, QEII, Hertford County, Luton and Bedford Renal Units and Lister.

In January a healthy eating event was held at the Community Hub at Lister and Mount Vernon Cancer Centre to support staff to make better lifestyles choices to improve mental and physical health. Mental health promotion events are planned for February at both Lister and Mount Vernon.

8. Medical HR: Electronic Job Planning & Exception Reporting

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



Headlines:

Electronic Job Planning:

At present the intention is not to re-publish job plans for 2018/9 round as previously planned before February 2018 due to ongoing work around the Demand and Capacity Model which will result in Team Job Planning. Once this work is complete the Electronic Job Plans will be re-published for the next round of discussions. The exception is those who have job plan changes since 2017/18 sign off who are now able to have job plans published for updating or those who have joined the Trust recently and require a job plan in place.

Exception reporting:

There was an increase in the number of exception reports following the increase of juniors on the new contract from August 2017. However the number of exceptions have reduced month on month since September.

72.38% of the reports submitted since August have been submitted by Foundation Year One Doctors primarily relating to Elderly Medicine, Urology and General Surgery. A Divisional summary is provided at Appendix 11.

9. Workforce efficiency and capacity

Strategy: To deliver more effective workforce models, within a reduced pay envelope to deliver financial stability and high quality patient care (18-19 year).

Workstreams	Outurn Budget 17-18 £	Savings fye £k
1. A&C aligned pathway - to deliver improved patient safety and qu	12-13 mill	500
2. A&C redesign of Divisional non clinical teams		400
3. Operational management redesign to reduce high cost pay enve	3-4 mill	600
4. Nursing management to increase nurse led clinics and reduce se	4-4.5 mill	325
5. Medic redesign - driven by the Model Hospital data		300
6. IM&T phase 2 to consolidate IT roles from Divisions into	1-2 mill	150
7. Consolidation of Trust teams to remove duplication and wastage	1-2 mill	100
8. Estates and Facilities - back office service improvements	3-4 mill	150
9. Corporate team redesign aligned to model hospital	6-7 mill	440
10. Therapies service review to reduce LOS and cost base	3-3.5 mill	250
Total gross savings		**3,215**
Programme Resource costs		350
Severance costs		745
Net Savings full year effect		**2,120**
Net Savings part year effect		**1,085**

The work-streams will be established as part of the WF Efficiency & Transformation Programme

(a) Addresses the issues that the trust is facing in the right sizing of the trust workforce model

(b) Redesign of service will deliver savings and improved service and care to patients

(b) Builds sustainable capability and capacity within the Trust for the mid-term.

Headlines:

As part of the Trust's Transformation programme, supporting the Model hospital agenda and development of right sizing the Trust's organisation structure, a workforce efficiency programme will develop an organisational design to align the demand, capacity and income of the Trust using the latest NHSI benchmarking data. With a purpose of designing more efficient workforce models, within a reduced pay envelope to deliver financial stability and high quality patient care. The total of the Workforce efficiency programme plan includes delivery of savings of £3,200 mill fye and £1,085 mill part year effect 2018-19, with an overall reduction in headcount.

Performance and progress: The following principles for driving Workforce Efficiency programme savings 2018-19 year:

- Technical approach to savings through the reduction of unwarranted variation
- Model Hospital data mining to identify opportunities for savings
- Benchmarking with Acute Trusts for Corporate areas e.g. Workforce
- Phased approach to mitigate risk for Lorenzo stabilisation and the CQC visit
- Hybrid option as agreed previously by Programme board, this includes a severance option

A Gateway process (weekly or bi weekly) will be in place to review:

- What has slipped/what issues arose last week?
- Main tasks and deliverables for this week?
- Forward planning for following week – what next?

10. Appendices

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1. Recruitment Data

Staff Groups	Wte in Post	Recruitable Establishment	Non-Recruitable	Vacancy	Vacancy Rate %
Admin and Clinical Support (Combined)	1710.31	1844.88	22.19	134.57	7.29%
Medical and Dental	758.46	814.96	3.04	56.5	6.93%
Nursing Qualified	1608.93	1751.97	63.46	143.04	8.16%
Nursing Unqualified	541.3	646.34	18.72	105.04	16.25%
St and T	525.05	550.37	0.66	25.32	4.60%
Total	5144.05	5608.52	108.07	464.47	8.28%

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2. ERAS Data

Source: ERAS	Total Live Cases as at 31-Dec--17	Total Live Cases as at 31-Jan--18	Surgery	Medicine	CSS	Women & Children	Cancer (inc R & D)	corporate
Headcount	5893	5907	1389	1416	923	786	658	735
Number of Disciplinary Cases (excluding medical cases) % = no of cases as % of headcount	17 (0.3%)	19 (0.3%)	3 (0.2%)	5 (0.4%)	2 (0.2%)	1 (0.1%)	5 (0.8%)	3 (0.4%)
Number of Grievances	5	5	1	2	1	0	1	0
Number of Capability cases	6	4	0	2	0	0	2	0
Number of B&H, discrimination and victimisation cases	3	3	0	0	0	0	1	2
Number of formal short term sickness cases including cases under monitoring	19	19	7	0	7	0	1	4
Number of formal long term sickness cases	42	44	12	10	8	5	3	6
Number of *MHPS cases (Medical cases)	2	2	1	1	0	0	0	0
Total number of cases in progress	94	96	24	20	18	6	13	15
Number of suspensions/medical exclusions (inclusive of over six months)	3	3	0	2	0	0	0	1
Number of suspensions lasting 6 months or longer	0	0	0	0	0	0	0	0
Number of appeals	2	1	0	0	0	0	0	1

11. Appendices

3. Medical HR

Exception Report Division Summary Since August 2017 Changeover

	No. submitted exception reports	Total Additional Hours - DECIMAL	Paid Enhanced Hours	Paid Basic Hours	Total Pay	Total TOIL Hours
Medicine Total	59	99.25	0.5	£51.75	£760.09	27.25
Complete	47	83.75	0.5	£51.75	£760.09	27.25
Pending	5	6.75			0.00	
Unresolved	7	8.75			0.00	
Surgery Total	39	155.5	3.25	£44.25	£640.81	47.75
Complete	23	95.25	3.25	£44.25	£640.81	47.75
Pending	16	60.25			0.00	
W&C Total	3	2.75	0	£1.25	£21.86	1.5
Complete	3	2.75	0	£1.25	£21.86	1.5
Grand Total	101	257.5	3.75	£97.25	£1,422.76	76.5

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4. Appraisals

Appraisal compliance

Compliance	Done	Not Done	Not due but require review*	Grand Total	Completion Rate % October
Cancer Services	379	32	75	486	92.21%
Clinical Support Services	549	58	271	878	90.44%
Medicine	748	157	217	1122	82.65%
Corporate	461	120	121	702	79.35%
Research & Development	54	15	23	92	78.26%
Surgery	717	181	168	1066	79.84%
Women's and Children's	432	94	110	636	82.13%
Grand Total	3340	657	985	4982	83.56%

Appraisal by Payband Data

Band	Done	Not Done	Not Due But require review	Grand Total	Completion rate%
Band 1	102	18	24	144	85.00%
Band 2	534	90	231	855	85.58%
Band 3	479	67	141	687	87.73%
Band 4	334	77	86	497	81.27%
Band 5	670	150	251	1071	81.71%
Band 6	645	103	130	878	86.23%
Band 7	391	80	68	539	83.01%
Band 8A	104	33	25	162	75.91%
Band 8B	31	21	7	59	59.62%
Band 8C	23	4	9	35	85.19%
Band 8D	11	5	3	19	68.75%
Band 9	2	3	4	9	40.00%
SMP	12	6	3	21	66.67%
Tupe	2		3	5	100.00%
Grand Total					83.56%

11. Appendices

5. Training

Source: ESR	Trust MTH	Surgery	Medicine	CSS	W & C	Cancer	R and D	Corporate
Statutory and mandatory training full compliance (Incl M&D)	64.65%	63.63%	59.33%	59.05%	65.60%	74.46%	74.47%	73.96%
Statutory and mandatory training overall compliance (Incl M&D)	86.08%	86.71%	84.79%	77.92%	90.37%	89.75%	89.72%	89.19%

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6. Benchmarking

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

11. Appendices

7. Exit Interview Feedback

The below shows what some of the key contributors were in employees choosing to leave the Trust:

Lack of support from Management

- Some employees stated that they left as they did not receive adequate support from management.

Family/Personal reasons

- Family/Personal reasons were cited as a factor in employee's decision to leave the Trust.

Individual Feedback: Below is just some of the feedback we have received during the past month from individuals choosing to leave.

- A band 5 left with 9 years' service. They stated the key reason was because of work pressure to achieve targets. The employee felt work is now completely target driven and that patients are just numbers. They felt that skeleton staff are expected to achieve unachievable targets.
- A band 3 left with 20 years' service due to what they described as exhaustion and stress. The employee perceived a lack of consistency and difficulty in getting anything achieved.
- A band 6 left with 1.5 years' service because of work pressures including what they described as tick box exercises and number counting meaning that they felt that they could not perform their job to the quality they would like. The employee also felt that they do not feel inspired by my management and constantly feel like a failure. They stated that there should be much more respect, opportunity and encouragement given to junior members of staff (Band 5 and below).
- A band 5 left with 14 years' service due to what they described as a lack of opportunity to progress into the next band. They stated that issues with staffing means more and more work is put onto us, therefore work/life balance is tough, car parking has been a huge issue. The employee also felt frustration at how much of their work is based on money/audits/paperwork when in fact they felt they should always be prioritising the patients.

Ongoing Actions:

- Ongoing Drop-In Sessions for Bullying and Harassment,
- Early intervention from Health at Work in relation to Work-related stress and musculo-skeletal illness.
- Review of Exit Interview Feedback – opportunity for all staff to have an Exit Interview in addition to completing the questionnaire.

East and North Hertfordshire NHS Trust

Agenda Item: 11

TRUST BOARD – 7 MARCH 2018

RISK AND QUALITY COMMITTEE – MEETING HELD ON 27 FEBRUARY 2018
EXECUTIVE SUMMARY REPORT

PURPOSE	To present to the Board the report from the RAQC meeting of 27 February 2018.
PREVIOUSLY CONSIDERED BY	N/A
Objective(s) to which issue relates *	☑ 1. **Keeping our promises about quality and value** – embedding the changes resulting from delivery of Our Changing Hospitals Programme. ☐ 2. **Developing new services and ways of working** – delivered through working with our partner organisations ☐ **3. Delivering a positive and proactive approach to the redevelopment of the Mount Vernon Cancer Centre.**
Risk Issues (Quality, safety, financial, HR, legal issues, equality issues)	Key assurance committee reporting to the Board Financial risks as outlined in paper
Healthcare/National Policy (includes CQC/Monitor)	Potential risk to CQC outcomes Key statutory requirement under SFIs, SOs. Healthcare regulation, DH Operating Framework and other national performance standards
CRR/Board Assurance Framework *	☐ **Corporate Risk Register** ☑ **BAF**

ACTION REQUIRED *

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

DIRECTOR:	CHAIRMAN OF RAQC
PRESENTED BY:	CHAIRMAN OF RAQC
AUTHOR:	CORPORATE GOVERNANCE OFFICER/ COMPANY SECRETARY
DATE:	MARCH 2018

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

RISK AND QUALITY COMMITTEE – MEETING HELD ON 27 FEBRUARY 2018

SUMMARY REPORT TO TRUSY BOARD – 7 MARCH 2018

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

The following core attendees were present:
Bernie Bluhm, Nick Carver, Michael Chilvers and Rachael Corser

The following points are specifically highlighted to the Trust Board:

Safer Staffing Report

The Committee received the latest Safe Staffing Report. The Unify submission for registered fill % increased in January with the average day fill % for registered nurses increasing from 94.1% in December to 95% in January. The Committee considered that, on the whole, the position regarding safe staffing was not significantly changed from the previous month. The Committee were informed by the Director of Nursing that processes to manage safe staffing were in place and continued to strengthen over time. It was reported that safe staffing remained a key risk and would form part of the refreshed BAF which would be considered at the next RAQC meeting. This would include detail of mitigating actions the Trust was taking. The Safe Staffing Report would also be refreshed for the next meeting to focus more exclusively on staffing, with the quality indicators currently provided in the report being considered in other reports instead.

Refreshed Approach to Risk Management

The Committee received a verbal update regarding the refreshed approach to risk management. Actions being taken included the introduction of risk clinics to support consistency of scoring and to support informed decision making. It was agreed that additional scrutiny of the process would be beneficial and the Committee was pleased to hear that part of the new system would include the requirement for assurance to be provided that actions were being reviewed. The Committee were informed that work was taking place to finalise the Trust's new Risk Management Strategy. A new Risk Report would be presented to the next RAQC meeting and developed over the coming months.

Operating Plan

The RAQC received the draft Operating Plan 2018/19. The report would also be considered at FPC and would be reviewed and revised prior to the Board meeting on 7 March. The Committee discussed the importance of ensuring that quality remained a core element of the plan and emphasising the message that quality improvements could lead to financial benefits. In particular the importance of the plan facilitating the removal of unwarranted clinical variation and avoidable delays in treatment through for example the implementation of the Getting it Right First Time (GIRFT) guidance throughout the Trust was encouraged.

Outcomes:

Divisional Presentation – Surgery and Critical Care

The Committee received a presentation regarding surgery and critical care services at the Trust. The presentation covered an overview of the current position, the complaints process, details of learning arising from SIs and incidents, details of top risks and a look at the areas of focus for the year ahead. The Committee discussed capacity utilisation with the Division and use of WLIs, risks relating to capital equipment and potential opportunities through the GIRFT programme.

Maternity Dashboard

The Head of Midwifery and the Clinical Governance Coordinator for Women's Services presented the Maternity Dashboard. The report would be provided to RAQC on a monthly basis, with any issues escalated as required. The dashboard presented performance in the year to date against a number of metrics and assisted with the monitoring of maternity services performance and governance to provide assurance regarding the quality and safety of the maternity unit. The Committee noted a discrepancy between an indicator in the Maternity Dashboard and the CQC Insight dashboard. It was agreed that this should be reviewed.

Update on Patient Survey Results

The Director of Nursing presented a report which informed the RAQC of the Trust's 2017 Inpatient survey results from Picker and the CQC 2017 Maternity survey results. Regarding the Picker survey, the Trust's performance had improved on the 2016 survey in several areas, though there were still a number of questions where the Trust compared less favourably to other trusts. The results were not yet formally published. Regarding the Care Quality Commission survey, the Trust primarily scored 'about the same' as other trusts, though there were some areas where the Trust scored 'worse' than would be expected. Actions would be taken to address the issues identified and would be reported through the Patient Experience Committee. It was noted that discharge related questions were an area where the Trust needed to look to make improvements. Compliance with the Red to Green programme was therefore a key indicator for the RAQC to monitor. Discharges would be a key quality priority for the year ahead.

Learning Disability Update

The Committee received an update regarding progress in relation to the completion of actions arising from the investigation into an SI involving a patient with Learning Disabilities. The Committee also discussed the Trust's approach to continuous quality improvement more broadly and whether current systems were designed to help with reducing risk. The Committee acknowledged the update and emphasised the importance that actions taken by the Trust management needed to be based on approaches which embedded compliance to best practice.

Workforce Report

The RAQC received the latest Workforce Report. Key headlines from the report included good performance in terms of agency spend and the Trust's vacancy rate (at 8.5%) being the second lowest compared to local benchmarked trusts. The Committee also received an update on staff sickness and actions being taken following the staff survey. There was some discussion regarding the budgeted establishment WTE figure and also regarding the link between feedback from staff on the ground and the data provided in the report.

Medical Recruitment Plan Quarterly Update

The Committee noted the report which provided an update on progress on the medical recruitment strategy.

Information Governance Report

The Committee received the IG Report. The report provided an update on information governance matters including preparation for the new General Data Protection Regulation (GDPR), the Information Governance toolkit and IG audit outcomes and actions. It was proposed than an exception report regarding preparation for GDPR be provided for RAQC on a monthly basis in the run up to the GDPR coming into effect on 25 May. The Committee were also informed of two recent IG related Serious Incidents. These would be investigated

in line with the standard SI procedure and actions taken where necessary. They had also been reported to the ICO.

Medical Devices Annual Report
The Committee noted the Medical Devices Annual Report for 2016/17.

Stethoscope Outliers Report
The Interim Chief Operating Officer provided an update on the outliers identified at the previous meeting:
Maternity outlier – Neonatal readmissions – The outlying position was primarily as a result of a coding issue.
Number of patients not treated within 28 days of last minute cancellation due to non-clinical issues – This figure had increased recently and there would be a push to improve performance in this area.
Average length of stay for emergency admissions for ambulatory care sensitive conditions – There was already a programme of work in place around improving the services at the front door of the hospital.
BADs day case rate – This outlier was primarily as a result of current issues with recording outpatient procedure activity.

Clinical Governance Strategy Committee Report
The Committee noted the Clinical Governance Strategy Committee Report. The key elements highlighted by the Medical Director were the CGSC's discussions regarding the risk register and the update provided at the CGSC regarding the patients safety alert in relation to NG tubes.

Risk Discussion Avoidable Variation
The Medical Director presented a report regarding themes from an analysis of incidents and claims where the subject related to assessment delay / failure. The report identified four main themes that emerged across both incidents and claims. The Committee noted the findings of the report.

The following reports were noted by the Committee:

1. **CQC Insight Dashboard and Inspection Update**
   The Committee noted the CQC Insight dashboard and inspection update. The Trust's composite indicator in the latest edition was -2.2 which was a declining position from last month's report. However, it was noted that the dashboard had not been released until late last week and a revised CQC guidance and methodology had been used in this edition. The new guidance and methodology would be reviewed further to understand the Trust's declining score.

2. **Infection Prevention and Control Report**
   The Committee noted the latest Infection Prevention and Control Report. Regarding MRSA bacteraemias, the year to date position was 1 Trust allocated case (target 0 cases to year end). Regarding cases of C.Difficile, the year to date position was 22 reported cases, of which 9 had been provisionally accepted by the CCG Appeals Panel for exemption against financial sanctions and 3 had been provisionally accepted. The Trust ceiling target was 11 cases to year end.

3. **Emergency Preparedness Update**
   The Committee noted the update that was provided regarding emergency preparedness. It was also noted that progress was being made with regard to recruitment to the emergency preparedness post.

4. **Clinical Ethics Group Annual Report**
   The Committee noted the Clinical Ethics Group Annual Report. The report provided an update on the work of the Clinical Ethics Group over the last year and objectives for 2018-19.

5. **Floodlight Scorecard**
   The Committee noted the Floodlight Scorecard.

John Gilham
March 2018

East and North Hertfordshire NHS Trust

Agenda Item: 11.1

TRUST BOARD – 7 MARCH 2018

Learning from Deaths Report

PURPOSE	To provide the Board with an update on mortality and learning from deaths
PREVIOUSLY CONSIDERED BY	Elements considered by the Trust Mortality Surveillance Group (Clinical Governance Committee), RAQC in January 2018
Objective(s) to which issue relates *	☑ 1. **Keeping our promises about quality and value** – embedding the changes resulting from delivery of Our Changing Hospitals Programme. ☑ 2. **Developing new services and ways of working** – delivered through working with our partner organisations ☐ **3. Delivering a positive and proactive approach to the redevelopment of the Mount Vernon Cancer Centre.**
Risk Issues (Quality, safety, financial, HR, legal issues, equality issues)	As identified in the report
Healthcare/ National Policy (includes CQC/Monitor)	CQC Compliance
CRR/Board Assurance Framework *	☐ **Corporate Risk Register** ☑ **BAF**

ACTION REQUIRED *

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

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

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

***** tick applicable box

1. BACKGROUND

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

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

Further information on the key metrics, developments and current risks summarised on this page can be found in Appendix 1. The full learning from deaths report with a more in-depth study of mortality issues follows in Appendices 1-3.

2. KEY METRICS

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

Metric	Result
Crude mortality	Crude mortality is 1.57% for the 12 month period to November 2017 compared to 1.65% for the latest 3 years.
HSMR (data period Sep 16 – Aug 17, as Sep 17 not available)	HSMR for the 12 month period is **96.18** and is statistically **'as expected'.**
SHMI (data period Jul16 -Jun17)	SHMI for the 12 month period is 102.14: **'as expected band 2'.**
HSMR – Peer comparison	E&NH is ranked 6th (out of 16) in the East of England Peer group compared to 5th out of 16 in the last report.

3. DEVELOPMENTS

- Second report of information and data mandated by the National Guidance on Learning from Deaths published by the National Quality Board in March 2017
- Presentations on mortality improvement and reviews made to NHS I and joint meeting of Royal College of Physicians and Surgeons
- Attendance at Learning from Deaths event with the Secretary of State
- SHMI has remained stable within the 'as expected band'.

4. CURRENT RISKS

Table 2 below summaries key risks identified:

Risks	Report ref (Mitigation)
Acumen tool – Deaths in hospital and ED Deaths reports still in UAT	1.3
Data submission/reporting: post Lorenzo issues	1.4
Gastroenterology – operational issues/elevated HSMR for specialty of discharge	1.6.5
Cardiology – elevation of AMI HSMR	1.6.7
Slow progress with 7 day service	1.8.2
Coding capability	1.9
Reduced frequency of the Rolling Half Days to discuss mortality reviews	1.10.2
Mortality Review Process – need for significant development of IT tool	1.10/1.10.2

Appendix 1

LEARNING FROM DEATHS – DETAILED UPDATE JANUARY 2018

1.1 Introduction

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

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

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

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

1.2 Mortality indicators

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

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

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

1.3 Crude Mortality

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

data is currently not available. The expectation is that this will be accessible again shortly. However for information only, provisional UAT data (User Acceptance Testing) for September 2017 to November 2017 has been used in the preparation of this report.

Dr Foster is now comparing performance of crude mortality and reports that the average national crude inpatient mortality (for ordinary admissions excluding day cases) is 1.4% and 1.5% within the region. This compares to 1.7% within ENHT.

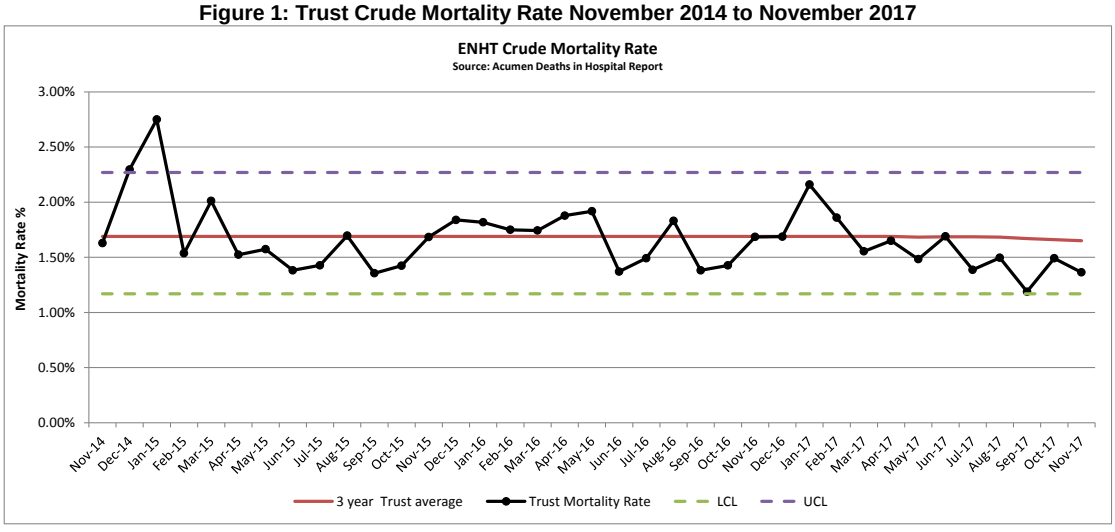
Dr Foster's Mortality Comparator also provides the ability to benchmark the Trust's performance against other non-specialist acute providers. The latest available information is provided below.

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

	ENHT	Non-specialist acute providers
All deaths	3.56	3.3
In-hospital deaths	2.49	2.35
Post discharge deaths	1.08	0.95

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

Figure 1: Trust Crude Mortality Rate November 2014 to November 2017



The 3 year average rate for crude mortality shown in figure 1 above is 1.65%.

Table 2 below provides the data for deaths, discharges and the crude mortality rate for the latest rolling year from December 2016 to November 2017 (1.57%) together with the current financial year 'YTD' position.

Table 2: Trust Crude Mortality November 2016 to November 2017

	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	YTD 17/18
Trust Deaths	149	138	187	152	137	126	122	142	124	142	120	156	147	1079
Trust Discharges	8841	8177	8657	8170	8814	7635	8227	8401	8939	9493	10098	10459	10778	74030
Trust Mortality Rate	1.69%	1.69%	2.16%	1.86%	1.55%	1.65%	1.48%	1.69%	1.39%	1.50%	1.19%	1.49%	1.36%	1.46%

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

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

1.4 Hospital Standardised Mortality Ratio (HSMR)

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

Due to problems with the creation of the August to September 2017 SUS data (Secondary Uses Service) (this was the first post-Lorenzo), the Trust missed the 18 October 2017 submission deadline by one day. As a result there is no ENHT data showing on Dr Foster for the month of September 2017 and the ENHT August 2017 data has not been refreshed.

Consequently the latest available 12 month period for HSMR contained in this report is September 2016 to August 2017. Subsequent SUS data has been submitted on time. When Dr Foster refreshes in January this should show both September and November data for the Trust.

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

The Trust’s HSMR position for the last twelve months to August 2017 was **96.18.** The Trust’s position relative to its East of England peers is 6th (out of 16) and can be viewed in Appendix 3.

1.4.1 HSMR Performance

One of the strengths of the HSMR model is the ability to review the calculations for individual months and for units of analysis within a Trust. HSMR at the Trust is reviewed at both Trust level and for each Division against appropriate thresholds and

reported on the Trust Board Performance Report showing rolling 12 month performance. Table 3 shows Trust and Divisional monthly HSMR performance RAG rated against internal targets.

1.4.2 HSMR Trends

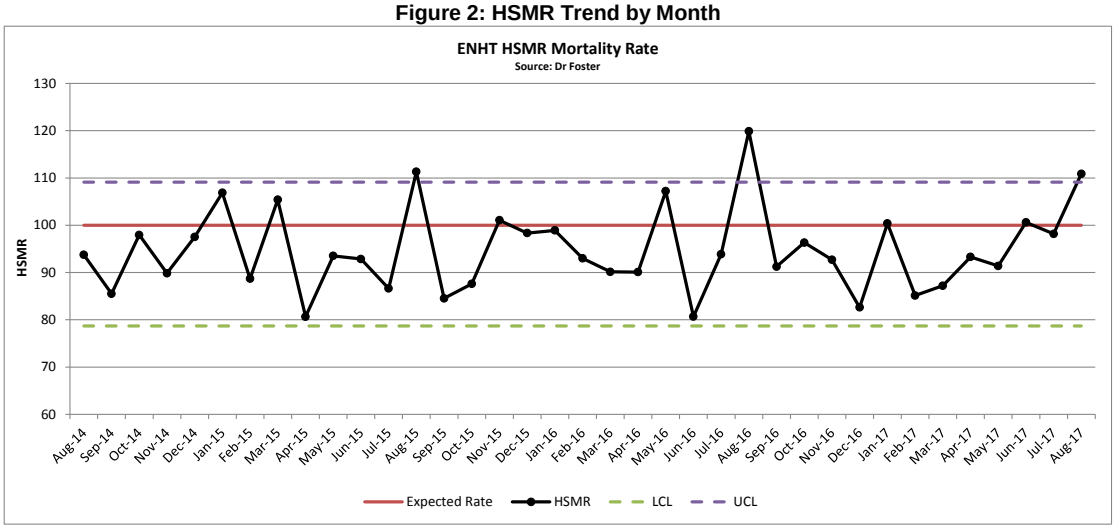
Table 3: Monthly Trust and Divisional HSMR Sep16 –Aug17

	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Rolling 12M
Cancer	83.74	69.83	153.67	89.12	86.04	148.48	126.38	105.19	117.52	90.94	81.24	61.35	109.99	101.06
CSS	0.00	0.00	208.59	0.00	0.00	139.47	0.00	0.00	0.00	0.00	0.00	0.00	0.00	46.56
Medicine	126.94	99.30	91.09	99.01	81.15	98.82	87.47	90.99	90.24	93.34	102.39	103.08	111.27	95.12
Surgery	76.79	49.70	90.58	87.09	153.26	123.76	108.17	52.15	109.73	83.12	129.56	130.25	109.86	102.78
Women & Children	231.00	0.00	174.92	0.00	127.37	312.06	0.00	0.00	0.00	0.00	0.00	0.00	0.00	45.46
Trust	**118.58**	**90.52**	**97.86**	**96.05**	**89.16**	**105.85**	**91.89**	**87.97**	**94.22**	**91.16**	**101.30**	**98.11**	**110.60**	**96.18**

Source: Dr Foster Healthcare Intelligence Portal

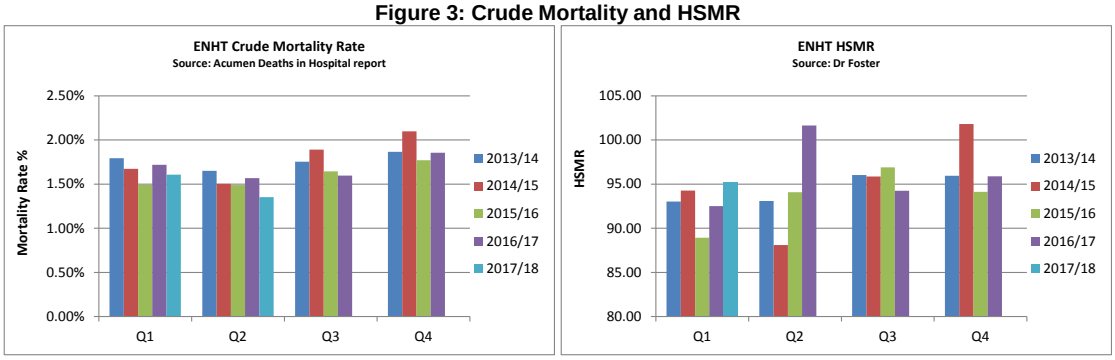
The monthly Trust-level HSMR is shown in Figure 2.

Figure 2: HSMR Trend by Month



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

Figure 3: Crude Mortality and HSMR



1.4.3 HSMR Outliers

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

Table 4: HSMR Negative Outlier September 2016 to August 2017

	Relative Risk	Observed Deaths	Expected Deaths	"Excess" Deaths
Acute Myocardial Infarction	143.90	57	40	17
Cancer of rectum and anus	168.30	20	12	8
Septicaemia (except in labour)	12121	132	109	23

Source: Dr Foster Healthcare Intelligence Portal

While the verbal debrief following the Invited Service Review by the Royal College of Physicians indicated that there were no concerns regarding cardiology mortality, the detailed report is still awaited. Recent changes to Sepsis Coding guidelines came into effect on 1 April 2017. These have affected HSMR levels and are currently under review by the Classifications Department. As there is no obvious/expected reason for the elevated HSMR for Cancer of rectum and anus a Coding review of the underlying cases has been instigated.

1.4.4 CQC CUSUM Alerts

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

1.4.5 Key Quality Measures

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

Table 5: Key Quality Measures September 2016 – August 2017

	Trust Total	Elective	Non-Elective
HSMR	96.2	106.8	96.0
Length of Stay	92.8	87.4	93.7
Readmissions within 28 days	108.8	113.9	107.7

Source: Dr Foster Healthcare Intelligence Portal

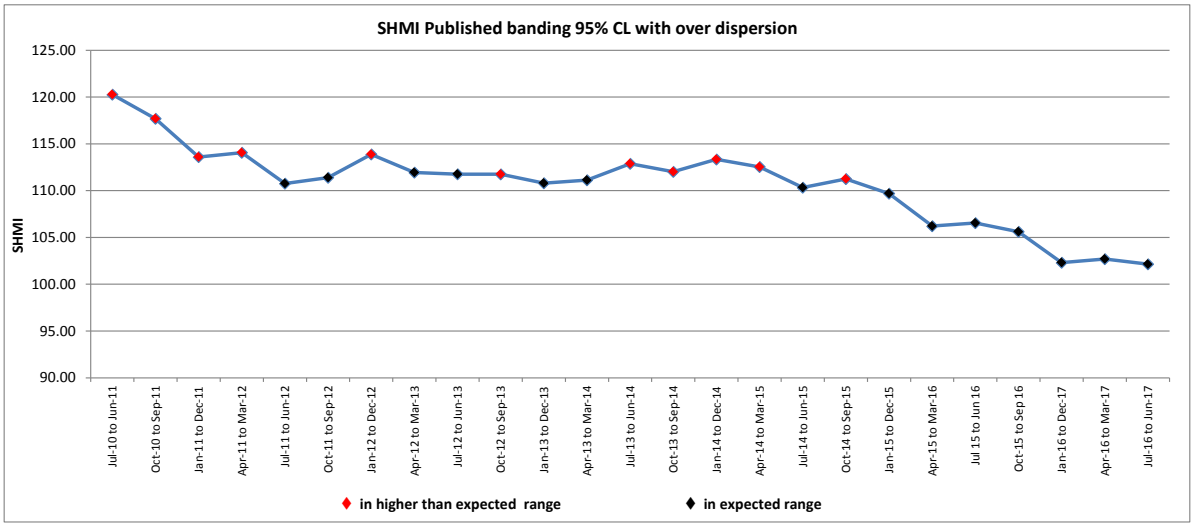
HSMR mortality continues to show a good level of performance, falling within the 'as expected' band, and length of stay has remained consistently below the expected levels, meaning that overall we discharge patients sooner than expected for our case mix. Readmissions have remained relatively unchanged and continue to be above the national average.

1.5. Summary Hospital Mortality Indicator (SHMI)

SHMI alongside HSMR can be a powerful benchmarking tool. Historically the methodological differences between these two models have provided challenges for the Trust. However, over recent months the difference between these 2 indicators has narrowed down to around 8 points. The remaining discrepancy is partly accounted for by 7-day provision of palliative care services and in addition the Trust remains in a small minority that include a hospice.

Following consistent improvements in SHMI, the latest rolling 12 month period to June 2017 has shown the Trust's position remaining stable with a marginal decrease from 102.3 to 102.1. As figure 4 demonstrates this represents an 18.1 point reduction since our first SHMI was reported for the period July 2010 to June 2011.

Figure 4: Trust SHMI July 2010 to June 2017



1.5.1 SHMI Mortality Triangulation

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

The five diagnoses resulting in the highest number of deaths during this period are Pneumonia, Acute Cerebrovascular Disease (which includes stroke), Septicaemia (except in labour) and Shock, Congestive Heart Failure and Urinary Tract Infections, Congestive Heart Failure.

Table 6: SHMI Diagnosis Groups with highest death rate Jul16-Jun17

CCS Group	Spells	Observed Deaths	Expected Deaths	SHMI	SHMI Performance Change
Pneumonia	1832	366	332.44	110.10	▲
Acute cerebrovascular disease	909	164	163.44	100.34	▼
Septicaemia (except in labour), Shock	632	118	112.27	105.11	▼
Congestive heart failure, nonhypertensive	575	97	85.45	113.52	▼
Urinary tract infections	1651	87	95.69	90.92	▲

Source: NHS Digital

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

Table 7: SHMI Diagnosis Groups with highest excess Jul16-Jun17

Diagnosis group	Spells	Excess Deaths	Latest SHMI (Jul16-Jun17)	Previous SHMI (Apr16-Mar17)	SHMI Performance Change
Pneumonia	1832	34	110.10	116.5	▲
Acute myocardial infarction	635	18	137.72	134.2	▼
Chronic obstructive pulmonary disease and bronchiectasis	899	17	128.55	128.0	▼
Congestive heart failure, nonhypertensive	575	12	113.52	107.8	▼
Intestinal obstruction without hernia	206	10	163.32	128.8	▼

Source: NHS Digital

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

1.6 Specific Actions to Address High Mortality Conditions

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

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

- The Integrated Community Respiratory Service has been fully established since May 2017. It works closely with Acute Chest Team to prevent admission and support early discharge. There has been a reduction in COPD admissions of 14.9% for the CCG in the last 6 months
- The Community team continues to work with GPs to highlight frequent attenders and support early discharge from hospital. There has been an audit in the Stevenage locality showing good cooperation between the different teams and resulting reduction in spend
- The telephone advice line has been stopped and replaced with the e-mail advice line (respconsultants.enh-tr@nhs.net) which is open to GPs and practice nurses
- Fortnightly the team inputs into target days with consultants going out to GP practices which has been working well.

The respiratory service is still not fully established in terms of consultant numbers, being one individual short. Despite this the service is maintained due to cross cover.

In the latest release, there have been improvements in SHMI in five of the seven respiratory diagnosis groups. Of note is that the remaining two diagnosis groups saw only marginal increases in SHMI.

Reviews have demonstrated the challenges associated with the accurate coding of a number of respiratory conditions including Pneumonia and Respiratory Failure. Work in this regard remains ongoing.

Table 8: Respiratory Service SHMI Data

Diagnosis group	Observed Deaths	Excess Deaths	Latest SHMI (Jul16-Jun17)	Previous SHMI (Apr16-Mar17)	SHMI Performance Change
Pneumonia	366	332	110.10	116.5	▲
Chronic obstructive pulmonary disease and bronchiectasis	75	58	128.55	128.0	▼
Aspiration pneumonitis, food/vomitus	62	71	87.71	93.9	▲
Acute bronchitis	35	44	80.09	90.6	▲
Respiratory failure, insufficiency, arrest (adult)	25	21	117.31	117.2	▼
Pleurisy, pneumothorax, pulmonary collapse	14	18	76.43	104.2	▲
Other upper respiratory infections…	6	12	48.64	55.2	▲

Source: NHS Digital

1.6.2 Acute Chest Team (Post CQUIN)

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

1.6.2.1 Seven Day Respiratory Service

As previously indicated we now look at mortality indicators relating to the specific respiratory diagnosis groups within the respiratory basket to try to assess the impact of moving to a seven day service.

Table 9 below shows that while HSMR has remained in the “as expected” range, significant reductions have been achieved in the majority of respiratory diagnosis groups compared to the previous 12 month period. This improvement had been expected, but took longer to materialise than had been anticipated. Recent recognition of the team has included a short listing in the Nursing times award and being heralded as one of the leading Trusts in the RCP national audit.

Table 9: Respiratory Service HSMR Data

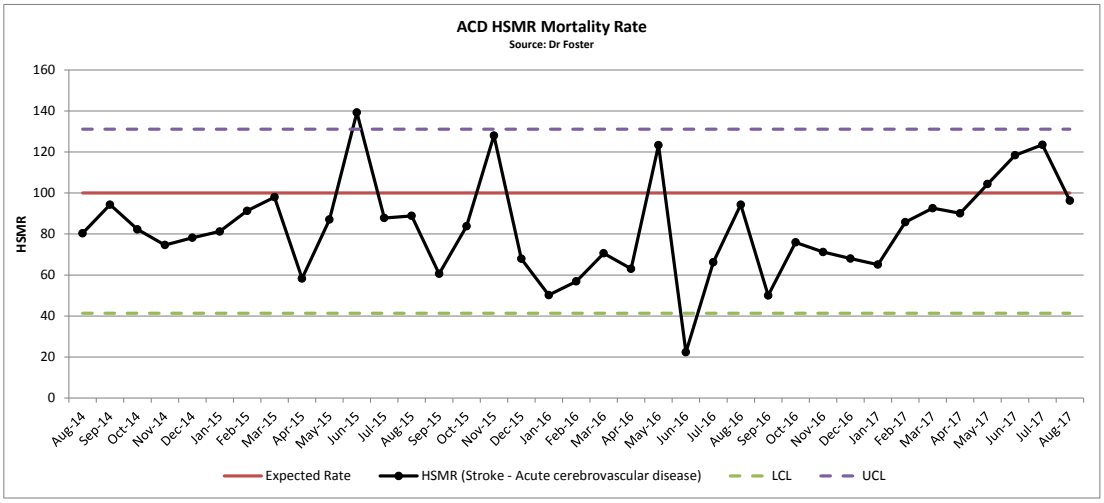
Diagnosis group	Sep-15 to Aug-16 HSMR	Sep-16 to Aug-17 HSMR	HSMR Performance Change
All	105.6	95.8	▲
Acute bronchitis	110.9	65.1	▲
Aspiration pneumonitis food/vomitus	95.2	77.5	▲
Chronic obstructive pulmonary disease and bronchiectasis	116.7	92.5	▲
Other lower respiratory disease	99.4	92.0	▲
Other upper respiratory disease	116.0	91.5	▲
Pleurisy pneumothorax pulmonary collapse	115.2	56.2	▲
Pneumonia	103.4	104.5	▼
Respiratory failure insufficiency arrest (adult)	128.0	98.9	▲

Source: Dr Foster (Benchmark month: Jun 2017)

1.6.3 Acute Cerebrovascular Disease (Stroke)

Stroke SHMI had been a cause for concern, rising to 124.08 for the period January 2015 to December 2015. However, SHMI releases in September and December 2016 saw significant falls in SHMI to 101.67 and 85.3 respectively. Although the latest release to June 2017 has seen an increase to 100.3 this is still a significant improvement on the 2015 position. As Dr Foster’s Mortality Comparator has yet to refresh with the June 2017 release, it is not yet known whether this is within the ‘as expected’ range. The HSMR fell to 73.3 (lower than expected range) for the rolling year to March 2017. The value for 12 months to August 2017 has seen it rise to 87.05, within the ‘as expected’ range.

Figure 5: Acute Cerebrovascular Disease HSMR by Month



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

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

1.6.4 Sepsis

1.6.4.1 Sepsis CQUIN

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

Table 10: Sepsis Key CQUIN Data 2017-2018

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

The Q3 results show setbacks in performance in relation to both screening and time to treatment. The Sepsis Group meeting on 17 January, attended by representatives from ED, wards, ICU and other trusts, sought to better understand the underlying issues.

It has been noted that while NerveCentre provides more information about when vital signs deteriorate, it does not evidence sepsis screening outside adult ED or provide sufficient information regarding escalation. The feasibility of appropriate development to the system is being investigated.

In line with the above, activity for the final quarter of the year will focus on training (both regarding appropriate use of new systems and identification/escalation of sepsis patients), integration and development of supporting systems together with liaison with peer trusts who are currently achieving better results than ENHT.

1.6.5 Gastroenterology

Following previously elevated mortality, Gastroenterology mortality has been monitored closely both via the mortality review process and regular monitoring of Dr Foster. HSMR for Gastroenterology as the speciality of discharge has shown a slight increase since my last report from 153.03 to 158.2 (both above expected range) for the rolling year to August 2017. The Service continues to investigate anomalies in its drive to improve the accuracy of coding especially for general medical cases.

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

1.6.6 Acute Kidney Injury

The sustainability of the Service remains in jeopardy due to the lack of a long term contract for the AKI specialist nurse which makes planning for service development in the medium to long term very challenging.

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

- For the time period April to August 2017, Dr Foster reported HSMR to be significantly elevated for acute and unspecified renal failure. The AKI team has worked closely with the Head of Coding to review the underlying cases. This investigation identified an issue regarding the coding of deaths due to AKI which has now been rectified
- For the 12 months prior to this, ending February 2017, HSMR had reduced to 92.5. This represented a marked improvement to the years prior to the inception of the AKI team in February 2016. The Trust's performance is well place among East of England peers (5th out of 16)
- The AKI team has also been trialling submission to the Renal Registry's national AKI reporting service
- The AKI service has been challenged by a loss of AKI e-reporting due to the implementation of Lorenzo. Work is underway regarding the development of an AKI alert within Lorenzo and NerveCentre.

1.6.7 Cardiology

The latest HSMR for AMI for the rolling 12 months to August 2017 remains significantly elevated at 143.9. As previously reported this is at least in part due to incorrect coding. Work has remained on-going to ensure correct/consistent coding of these patients, including external liaison with the Classifications Department regarding clarification of appropriate protocols. It is anticipated that forthcoming refreshes of the Dr Foster data will see the benefit of the coding corrections.

Of note is that verbal feedback following the October Invited Service Review by the Royal College of Physicians contained no concerns regarding mortality rates. In addition Dr Foster shows HSMR for Cardiology as the Specialty of Discharge to be 116.0 for the year to August 2017 which is in "as expected" range. The formal report from the RCP is still awaited.

1.7 Update on Strategically Important Pathways

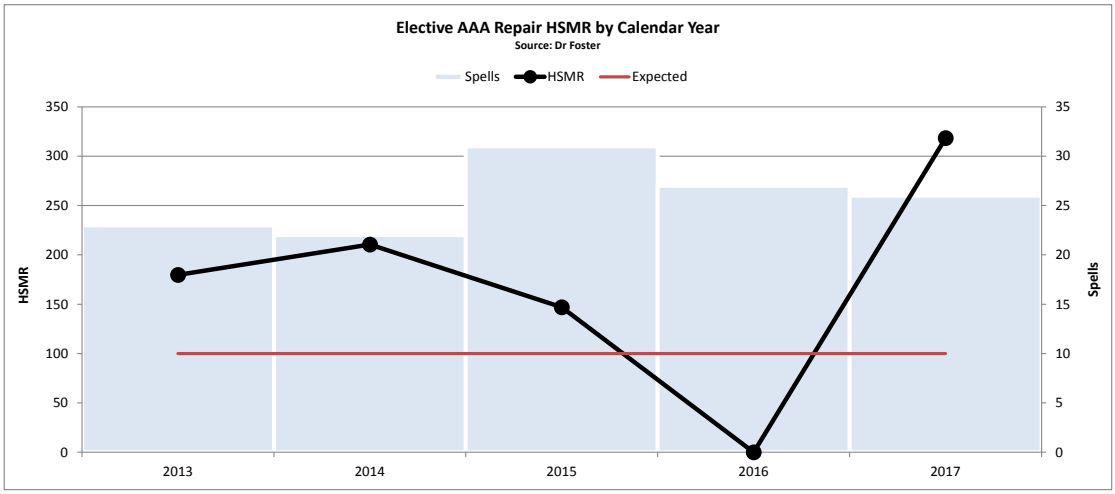
1.7.1 Elective Abdominal Aortic Aneurysm Repair (AAA)

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

Two key milestones of the development of the business case are to review and update the assumptions in the submitted bid and to develop clinical pathways and assessing the impact of these pathways on partner organisations. Validation of the activity and cost assumptions from the bid and development of clinical pathways have taken longer than anticipated. Therefore, development of Outline Business Case (OBC) for Phases 1 and 2 by Feb 2018 will be delayed to April 2018.

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

Figure 6: Elective AAA Repair by Year



Note: data for 2017 is YTD (up to August 2017)

The spike in HSMR for the period Jan-17 to Aug-17 is the result of one death. This death was comprehensively reviewed via the Trust's mortality review process and Specialty Clinical Governance forum prior to final consideration by the Clinical Governance Strategy Committee. The Committee concluded that this was major surgery with known risks, performed by a highly experienced vascular surgeon. All appropriate consenting had been carried out and no failings in care were identified. It was agreed that this was an unfortunate but unavoidable death.

1.7.2 Deteriorating Patient Plan

Since February the Deteriorating Patient Plan (DPP) working group has been incorporated into the Patient Safety Committee. Current updates include:

- Mount Vernon e-Obs commencing in January 2018
- Lorenzo changes are underway to create lists of the highest acuity patients for monitoring overnight

- Root cause analysis investigation of cardiac arrest patients (covering the 24 hours prior to arrest) has commenced. Aimed at identifying poor management and learning opportunities regarding deteriorating patients the outputs will also feed into the mortality review process
- Monthly audits of delayed or omitted critical medications, using the Meridian system, commenced in December 2017. To date of 278 medication charts reviewed 10.43% of doses were shown to have been delayed by more than 2 hours or were omitted. This information will be used to inform the Trust's continued drive to improve medications administration
- There has been a national change to NEWS (NEWS2). The parameters will need to be recalculated within Nerve Centre and paper charts adjusted. The system change is in the planning stage
- Doctors' training on Nerve Centre continues to enable use of the escalation module from 10th February 2018.

1.8 Other Trust-wide reducing mortality initiatives

1.8.1 Improving Patient Outcomes Strategy 2015-18

The Improving Patient Outcomes Strategy 2015-18 (IPOS) which combines a strategy for clinical effectiveness and patient safety has now entered its final year. Objectives for 2017-18 have been confirmed and approved by the Clinical Governance Strategy Committee. A mid-year report was provided to the Clinical Governance Strategy Committee in December. The following table provides a RAG rating summary of performance compared to the previous year for Q1/Q2.

Table 11: IPOS Mid-Year Performance Summary 2017-18

	Q1/Q2 2017-18		Q1/Q2 2016-17	
	43	52%	35	40%
	22	27%	34	39%
	7	9%	9	10%
(information not yet available)	10	12%	10	11%

Mid-year indications are positive and compare favourably with last year's position. The final end of year report will presented to the Risk and Quality Committee.

1.8.2 Seven Day Services

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

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

When the Medical Director attended the Seven Day services day provided by NHS I in Cambridge in September it was obvious that many other Trusts, like ENHT, were struggling to make progress towards achievement of the required standards. The Trust's endeavours have been further hampered by the recent departure of our

Seven Day Services Lead. At this point in time the target of compliance with the four prioritised standards by the end of March 2018 remains extremely challenging.

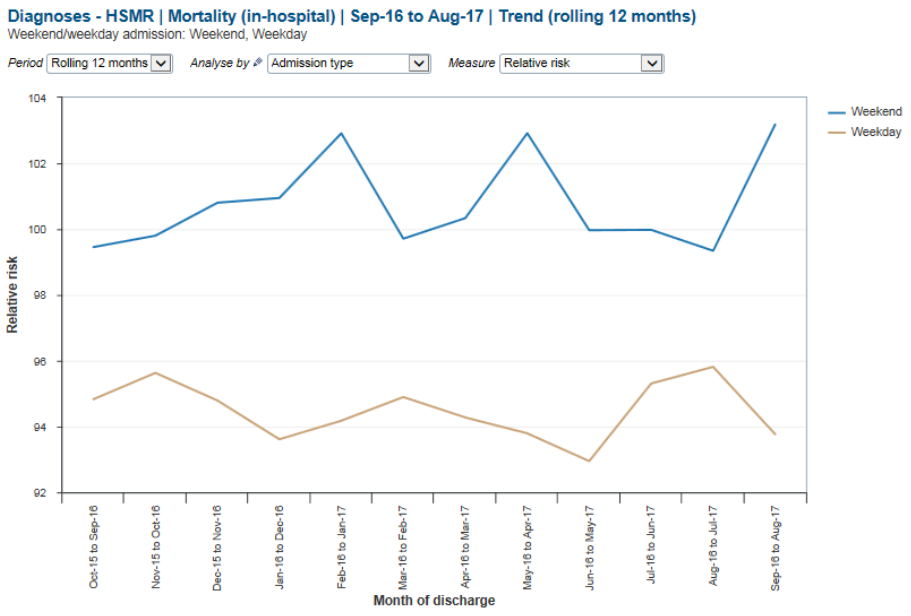
Table 12 provides headline detail of the March 2017 audit outcomes:

Table 12: 7 Day Services March 2017 Audit Summary

Standard	Requirement	ENHT Outcome	
Standard 2	Patients should be seen by a consultant within 14 hours of admission	The overall proportion of patients seen and assessed by a suitable consultant within 14 hours of admission	70%
Standard 8	All patients with high dependency needs should be seen and reviewed by a consultant TWICE DAILY (including all acutely ill patients directly transferred and others who deteriorate).	The overall proportion of patients who required twice daily consultant reviews and were reviewed twice by a consultant	98%
	Once a clear pathway of care has been established, patients should be reviewed by a consultant at least ONCE EVERY 24 HOURS, seven days a week, unless it has been determined that this would not affect the patient's care pathway.	The overall proportion of patients who required a daily consultant review and were reviewed by a consultant	90%
Standard 5	Hospital inpatients must have scheduled seven-day access to diagnostic services, typically ultrasound, computerised tomography (CT), magnetic resonance imaging (MRI), echocardiography, endoscopy, and microbiology. Consultant-directed diagnostic tests and completed reporting will be available seven days a week: Within 1 hour for critical patients and Within 12 hours for urgent patients	Are these diagnostic tests and reporting always or usually available on site or off site by formal network arrangements for patients admitted as an emergency with critical and urgent clinical needs, in the appropriate timescales	YES
Standard 6	Hospital inpatients must have timely 24 hour access, seven days a week, to key consultant-directed interventions that meet the relevant specialty guidelines, either on-site or through formally agreed networked arrangements with clear written protocols.	Do inpatients have 24 hour access to the following consultant directed interventions 7 days a week, either on site or via formal network arrangements: Critical Care, Primary Percutaneous Coronary Intervention, Cardiac Pacing, Thrombolysis for Stroke, Emergency General Surgery, Interventional Endoscopy, Interventional Radiology, Renal Replacement, Urgent Radiotherapy)	YES

Figure 7 below shows that there continues to be an intermittent widening divergence between weekday and weekend HSMR levels. The reasons for this are not fully understood. These movements in the data will continue to be monitored.

Figure 7: HSMR by Weekend/weekday admission: rolling 12 months Sep16 to Aug17



1.8.3 Care Bundles

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

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

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

1.9 Coding

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

- Continued work to clear the coding backlog
- Continued work regarding Lorenzo implementation and data amendments
- Implementation of OPCS 4.8 and new HRG 4+ grouper in April together with relevant training for the Coding team
- Coding awareness/education within the Divisions with a presentation to General Surgery at April RHD
- “The importance of coding” training and awareness to FY2 commenced 17 October 2017 and FY1 in January 2018
- Clinical Coding refresher course for all coders planned for December 2017
- IGT Audit planned for January 2018.

1.10 Learning from Deaths National Requirements

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

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

As stipulated in the last report to Committee, the fact that the guidance is detailed, in places open to interpretation and impacts on multiple Trust processes and policies, means that work will remain ongoing over the coming months to ensure we take full account of all the recommendations not only to guarantee compliance but also to gain maximum benefit from the quality improvement recommendations.

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

Table 13: Learning from Deaths: Compliance Summary

Guidance Requirement	Current Compliance Status
From April 2017 Collection of quarterly information relating to deaths, reviews, investigations and resulting quality improvement	**Compliant** Corresponding detail provided in this report at 1.10.3 below.
By the end of September 2017 Publish an updated policy detailing how the Trust responds to and learns from the deaths of patients in its care	**Compliant** Policy drafted by 30 September; ratified by the Clinical Governance Strategy Committee on 4 October and published on Trust website on 5 October.
From Q3 2017 Publish information on deaths, reviews and investigations via a quarterly agenda item and paper to its public board meeting	**Compliant** The first Learning from Deaths report to include the new mandated content was considered by RAQC in October and presented at the Board meeting on 1 November 2017, with papers subsequently published on the Trust website.
From June 2018 Publish an annual overview of the relevant information in the Trust's Quality Account, including a more detailed narrative account of the learning from deaths reviews/investigations, actions taken in the preceding year, an assessment of their impact and actions planned for the next year.	**On track for compliance** Those involved in the preparation of the Quality Account and those responsible for oversight of Mortality Surveillance are fully aware of the requirements.

Over the Autumn, presentations on mortality improvement and reviews made to NHS I and a joint meeting of Royal College of Physicians and Surgeons, together with attendance at a Learning from Deaths event with the Secretary of State, provided opportunities for discussion with other Trusts, Regulators and the Public. They also confirmed the complexity and diversity of challenges involved in the implementation of the framework across the healthcare system, the diversity of approaches being adopted by different organisations and the fact that there is a great deal of variation in how far advanced organisations are on the road to full implementation and compliance with the framework.

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

1.10.1 Learning from Deaths Policy

The new national guidance required trusts to have published a Learning from Deaths Policy on their websites, compliant with the guidance, by the end of September. Our policy was developed within this timeframe and published on the Trust's website following approval/ratification by the Clinical Governance Strategy Committee on 4

October. As further development of our Learning from Deaths framework takes place over the coming months our policy will continue to be revisited and shaped.

1.10.2 Mortality Case Record Review Process and Methodology

As indicated in the last report, following detailed consideration, including consultation with our Mortality Reviewers, a decision was made that the Trust would not adopt the Standardised Mortality Review Methodology which has been developed by the Royal College of Physicians.

Now that the post Lorenzo IT development freeze has been lifted, work is about to commence on our existing tool to develop it, taking into account the best of both the RCP and PRISM methodologies, while maintaining the core of our current format. In the meantime our existing process does allow for compliance with the new reporting regime. Our Mortality Case Record Review Policy will be updated to reflect developments as they take shape.

We have 32 trained mortality reviewers in place from across medical and surgical specialties. For the time being, Areas Of Concern (ACONs) raised following Stage 1 reviews continue to be forwarded to relevant Specialties for Stage 2 review and discussion at Directorate RHDs, with final Stage 3 consideration, including a decision regarding the avoidability of death, conducted by the Clinical Governance Strategy Committee. A review of the effectiveness of the current Stage 2 format of the process is felt to be particularly important, especially in view of the on-going uncertainly regarding the future frequency of the Specialty Rolling Half Day programme.

1.10.3 Mandated Mortality Information

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

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

In addition, for cases where Areas of Concern are raised, the current lapse in time between the death and completion of Stages 1, 2 and 3 of the review process, means that the avoidability of death score is often not being decided in the same review year. This should be borne in mind when viewing the data contained in the dashboard at Appendix 4, which only includes the conclusion details for 2017-18 deaths.

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

Work to embed the process internally is continuing. While confirmation of cases has still been achieved via reference to cases reported to the national programme, Lorenzo flag and inclusion of an LD question on the mortuary checklist, the weekly report based on coding is currently unavailable following the implementation of Lorenzo. It is hoped that this report will soon be back on line.

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

In Q2 one learning disability death has been reported. This was not an in-hospital death as the patient died in ED.

Table 14: Q2 Learning Disability Deaths

	Jul-17	Aug-17	Sep-17
Learning Disability deaths	0	1	0

This patient, who had learning difficulties and comorbidities including advanced dementia and respiratory problems, presented suffering from severe chest sepsis. The patient was extremely poorly on arrival at ED at 22:29 hours. At 22:59 a DNACPR was signed and they were attended by the Palliative Care team at 23:50. They sadly died at 01:15 the following morning. The reviewer found no cause for concern regarding the patient's care and judged this to be an unavoidable death. A copy of our review has been provided to the national LeDeR programme.

A formal mortality review has also been undertaken of the LD death which occurred in Q1 at Michael Sobel House Hospice. As indicated in the last report, this death was expected and the reviewer found no cause for concern regarding the care of the patient. A copy of this review has also been provided to the LeDeR programme.

As both of these reviews were completed after the end of Q2 they do not yet show on the dashboard provided at Appendix 4.

1.10.3.3 Severe Mental Illness Deaths

The learning from deaths guidance stipulates that Trusts must have systems in place to flag patients with severe mental health needs so that if they die in an Acute Trust setting their care can be reviewed and reported on. As indicated in our October report, when this requirement was discussed with our Rapid Assessment, Interface and Discharge mental health team (RAID) they felt the inclusion of a mental health flag on the Trust's patient administration system ran counter to moves to change attitudes towards mental health by the removal of such labelling. No clear indication was given in the national guidance regarding what definition should be attached to the term 'severe mental illness' and internal discussions continue regarding how best to comply with the guidance. In the meantime there have been no known instances of any deaths in Q2 of patients with severe mental illness.

1.10.3.4 Stillbirth, Children and Maternity Deaths

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

Our Policy includes the relevant detail and Q2 statistics are provided below:

Table 15: Q2 Stillbirth, Children and Maternity Deaths

	Jul-17	Aug-17	Sep-17
Stillbirth	0	0	2
Children	2	2	0
Maternity	0	0	0

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

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

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

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

1.10.3.5 Serious Incidents involving Deaths

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

Table 16: Q2 Serious Incidents Involving a Patient Death

Serious Incidents involving the death of a patient	Jul-17	Aug-17	Sep-17
Serious Incidents reported	0	1	1
Serious Incidents – final report approved*	2	2	1

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

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

- Ongoing SEPSIS training including escalation and appropriate and timely use of antibiotics
- Both nursing and medical staff need to ensure that the patient is aware of the very rare risk of DPD deficiency when giving patients verbal and written information
- Diagnostic error brought about by reassuring symptoms. Staff to be aware of human factors, in particular cognitive errors such as the 'framing effect' when assessing patients
- Inadequate preoperative anaesthetic review and poor documentation led to decision to perform surgery. Preoperative checks and documentation must be completed fully
- Roles of Ward Registrar and CNS team were not clear. These have been reviewed to include competencies and responsibilities and this information has been shared within the Division.

Following conclusion of investigations learning and feedback is provided to relevant Specialty Rolling Half Day clinical governance meetings for discussion and adoption of agreed actions. Inclusion of information in the Patient Safety Matters newsletter is also used to promote Trust-wide sharing of important learning and developments.

The Patient Safety Committee is responsible for ensuring that key learning and themes inform the Trust's quality improvement initiatives. A detailed Serious Incident Report is provided to the Risk and Quality Committee on a quarterly basis.

1.10.3.6 Learning from Complaints

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

Table 17: Q2 Complaints Involving a Patient Death

	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17
Complaints received relating to an in-hospital death	0	0	1	3	0	0

No patterns were identified regarding specialty, ward or patient cohort of these cases. However, all involved elements of poor communication with, or attitude towards, the patient or their family, whether it be a case of staff not listening to family, not keeping the family fully informed or showing a lack of empathy in their care of the patient. In each case the shortfall was not in clinical care, but in human interaction.

1.10.3.7 Learning from Inquests

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

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

Table 18: Q2 Inquests into a Patient Death

	Jul-17	Aug-17	Sep-17
Requests for a Report to the Coroner	5	2	5
Regulation 28: Report to Prevent Future Deaths	0	0	0

1.10.3.8 Key Issues and Themes from Mortality Reviews

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

Key themes arising from the ACONs which were concluded in Q2 are detailed below. In order to ensure all important themes and learning are made available to the Board, the detail below relates to all ACONs concluded in Q2, whether the patient's death occurred in the current year or 2016-17. Throughout the year emerging themes will

be monitored and will be used to inform quality improvement initiatives including the Improving Patient Outcomes Strategy.

- Importance of all transfers being appropriate for the patient's condition with all necessary attendant communication between Specialties taking place at an appropriate level and on a timely basis
- The need for all nursing staff to adhere to deteriorating patient and NEWS escalation protocols
- The importance of timeliness in all aspects of patient care, in particular regarding patient review and required investigations and corresponding results review
- Importance of all relevant information being documented in a timely manner
- The need for responsibility to be taken by those at all levels (nurses, junior doctors and consultants) regarding appropriate communication between teams
- The importance of forward planning by nursing staff regarding patient care/review in advance of weekend and Bank Holidays
- The importance of all appropriate preoperative investigations/checks and documentation being completed in a comprehensive manner
- Value of the mortality review process in promoting the adoption of new guidelines and development of new processes (examples in this quarter being: the adoption of Abdominal Paracentesis Guidelines for Patients with Cirrhosis and the implementation of an electronic email referral system by Gastroenterology to facilitate better inter-Specialty communication)
- Value of the mortality process in identifying learning opportunities, even in cases where no failings in care were found and where the death was considered to be unavoidable
- Value of the mortality review process in identifying pre admission concerns for consideration in the Community (cases are referred to the CCG on a monthly basis).

1.11 Summary of Key Mortality Issues

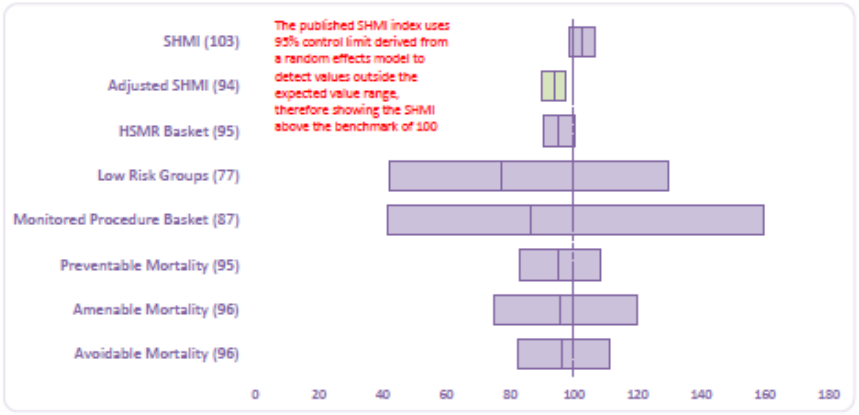
- Crude mortality is 1.57% for the latest rolling year to November 2017
- Overall HSMR performance is good at 96.18 and the Trust's overall position for the latest rolling year is 6th out of 16 trusts in East of England
- The SHMI has remained stable at 102.1
- Numerous mortality improvement initiatives as detailed in the *Improving Outcome Strategy 2015-18 (IPOS)* are in train
- Current report incorporates new national Learning from Deaths requirements
- Following publication of the new Trust Learning from Deaths Policy the focus is now on additional associated development work required to support the Learning from Deaths framework (including the development of the Trust's Mortality Case Record Review methodology/process and database)
- Mortality monitoring is on-going with regular reporting to DEC, RAQC, Board, and CCG
- Regular joint meetings are held with ENH CCG to improve mortality rates.

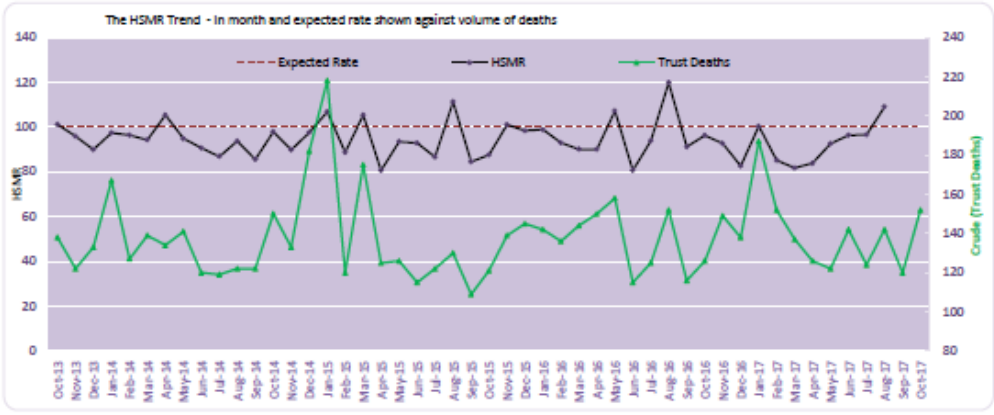
Appendix 2: Mortality Improvement Plan

Mortality Improvement Plan November 2017 update

This dashboard reports on the twelve month rolling period ending October 2017 for Crude Mortality, August 2017 for HSMR and March 2017 for SHMI.

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





Patient Safety Indicators

Period: 12 months (Sep 16 to Aug 17)

Indicator	Volume	Observed	Expected	Obs rate/k	Exp rate/k	Relative risk
Accidental puncture or laceration	72046	60	84.8	0.8	1.2	70.7
Deaths after surgery	513	54	47.2	105.3	92.0	114.5
Deaths in low-risk diagnosis groups	34065	14	18.1	0.4	0.5	77.4
Decubitus ulcer	10764	362	532.7	33.6	49.5	68.0
Infections associated with central line	17043	0	0.8	0	0.0	0.0
Obstetric trauma - caesarean delivery	1433	3	5.6	2.1	3.9	53.7
Obstetric trauma - vaginal delivery with instrument	761	35	55.3	46.0	72.6	63.3
Obstetric trauma - vaginal delivery without instrument	3016	50	95.7	16.6	31.7	52.3
Postoperative haemorrhage or haematoma	23544	20	10.2	0.8	0.4	195.4
Postoperative hip fracture	29455	3	1.8	0.1	0.1	167.0
Postoperative physiologic and metabolic derangement	19583	4	2.1	0.2	0.1	189.1
Postoperative pulmonary embolism or deep vein thrombosis	23833	62	59.0	2.6	2.5	105.1
Postoperative respiratory failure	17295	9	14.0	0.5	0.8	64.3
Postoperative sepsis	567	5	5.6	8.8	9.9	89.2
Postoperative wound dehiscence	940	3	0.9	3.2	0.9	341.0

HSMR Performance (1=lowest HSMR 16=highest HSMR)	Latest rolling period	Previous rolling period	Performance
EoE Ranking Acute providers only (Sep16-Aug17, Dr Foster)	6	5	▼

Leading Quality Indicators	Latest rolling period	Previous rolling period	Performance
Deaths in Residual Code Group (Sep16-Aug17, Dr Foster)	10	3	▼
Crude Mortality Rate (Nov16-Oct17, UAT)	1.60%	1.59%	▼
Depth of Coding vs Upper Quartile YTD (Aug17 DQ report)	4.70%	4.70%	▬
Charlson rate as index of national 2017/18	93	92	▲
Palliative Care Coding vs National FYTD	149.86%	145.22%	

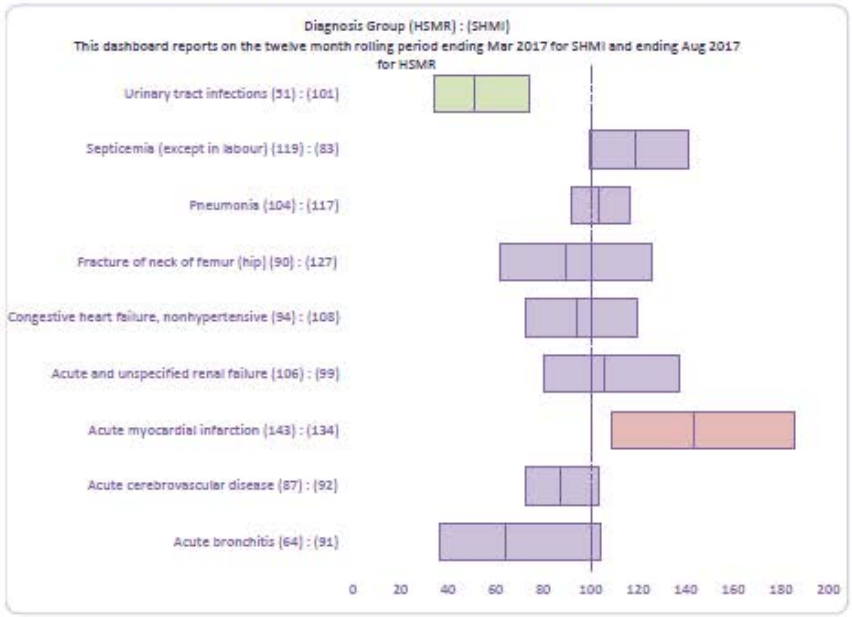
Note: SHMI figures quoted from Dr Foster Mortality Comparator

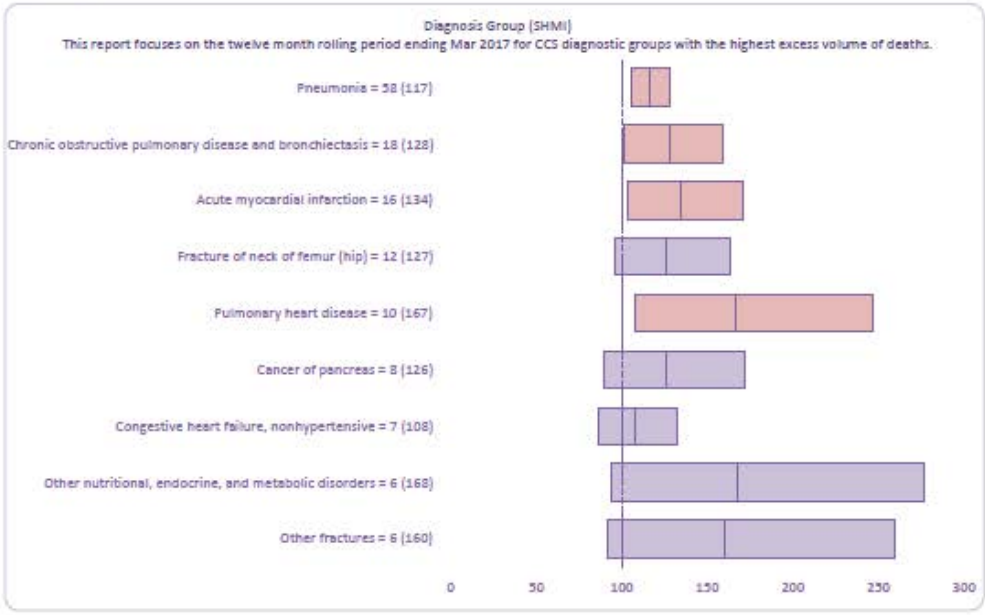
Note 2: Number of Trust Deaths for Sep 17 & Oct 17, Crude Mortality Rate for Oct16-Sep17 & Nov16-Oct17 are from the UAT version of Deaths in Hospital report
Note 3: MVCC Discharges for Aug17 to Oct17 are much higher than previous months and has impacted Crude Mortality Rate for Oct16-Sep17 & Nov16-Oct17
Note 4: Depth of Coding vs Upper Quartile YTD has not been updated, awaiting Sep17 DQ report (no estimate yet)

Mortality Improvement Plan November 2017 - v1_2

Appendix 2 (cont)

Selected Diagnosis HSMR / SHMI Report November 2017 update

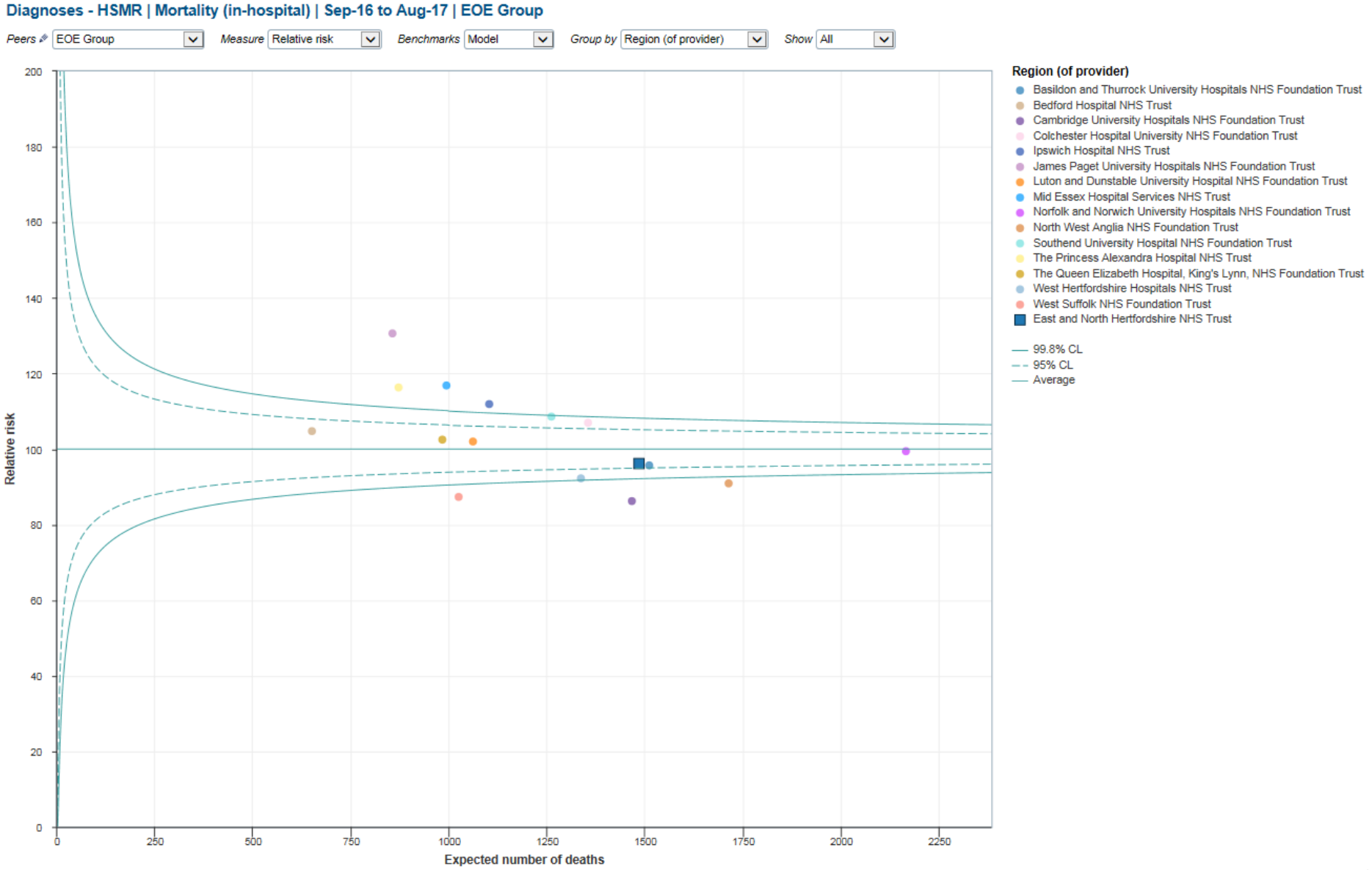




Note: SHMI figures quoted from Dr Foster Mortality Comparator

Appendix 3

HSMR by East of England Trusts: Funnel Plot
Period: September 2016 to August 2017



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

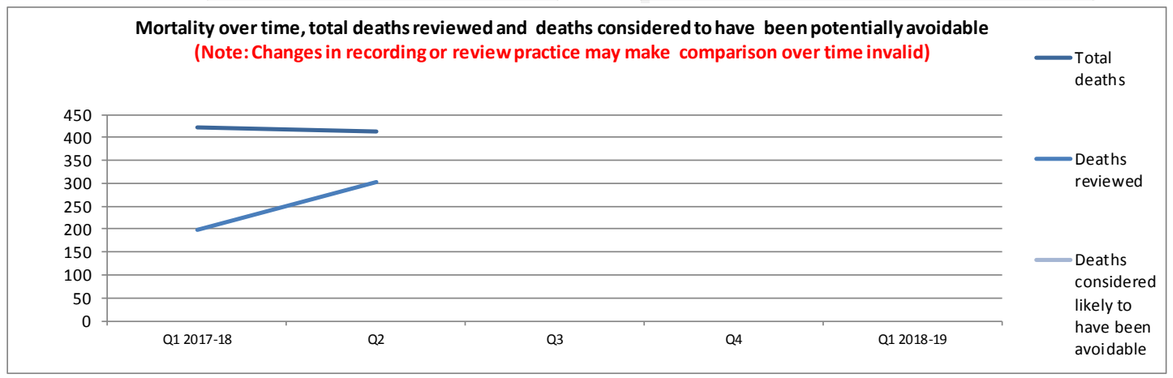
Description:
This dashboard is a tool to aid the systematic recording of deaths and learning from the care provided by East and North Hertfordshire NHS Trust and is based on the dashboard suggested by the National Quality Board in its Learning from Deaths Guidance published in March 2017. Its purpose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

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

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

Total Number of Deaths in Scope		Total Deaths Reviewed		Total Number of deaths considered to have been potentially avoidable (RCP<=3)	
This Month	Last Month	This Month	Last Month	This Month	Last Month
126	153	78	90	0	0
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
413	422	304	198	0	0
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
835	0	502	0	0	0

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



Total Deaths Reviewed by RCP Methodology Score

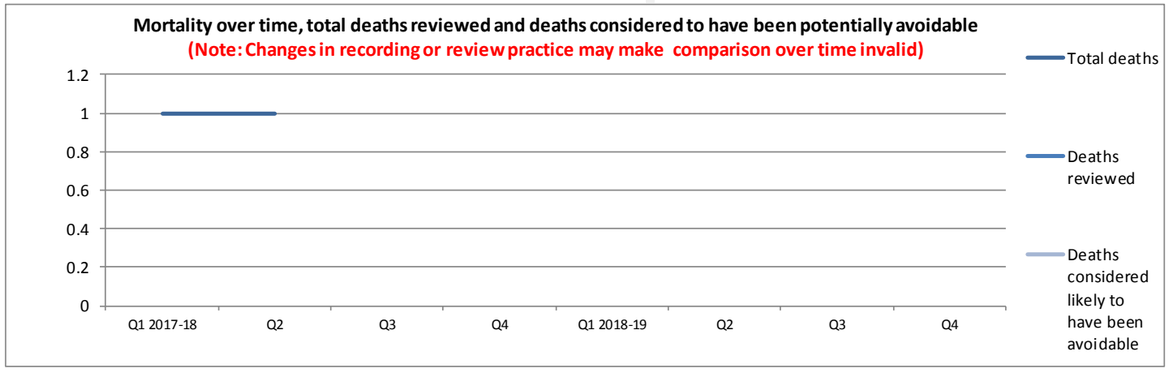
Score 1 Definitely avoidable			Score 2 Strong evidence of avoidability			Score 3 Probably avoidable (more than 50:50)			Score 4 Probably avoidable but not very likely			Score 5 Slight evidence of avoidability			Score 6 Definitely not avoidable		
This Month	0	0.0%	This Month	0	0.0%	This Month	0	0.0%	This Month	0	0.0%	This Month	1	1.3%	This Month	77	98.7%
This Quarter (QTD)	0	0.0%	This Quarter (QTD)	0	0.0%	This Quarter (QTD)	0	0.0%	This Quarter (QTD)	0	0.0%	This Quarter (QTD)	3	1.0%	This Quarter (QTD	287	99.0%
This Year (YTD)	0	0.0%	This Year (YTD)	0	0.0%	This Year (YTD)	0	0.0%	This Year (YTD)	1	0.2%	This Year (YTD)	4	0.8%	This Year (YTD)	473	99.0%

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

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

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

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



DATA PACK

Contents

1. Data & Exception Reports:

FFT

Health & Safety Indicators

Friends and Family Test - January 2018

Inpatients & Day Case	% Would recommend	% Would not recommend	Extremely Likely	Likely	Neither Likely/ Unlikely	Unlikely	Extremely Unlikely	Don't Know	Total responses	No. of Discharges	Total % response rate
5A	97.53	0.00	46	33	2	0	0	0	81	81	100.00
5B	89.29	0.00	15	10	3	0	0	0	28	44	63.64
7AN	NP	NP	0	0	0	0	0	0	0	92	0.00
7B	98.65	0.00	46	27	0	0	0	1	74	149	49.66
8A	92.59	1.85	32	18	3	1	0	0	54	86	62.79
8B	94.39	0.93	56	45	4	1	0	1	107	111	96.40
11B	100.00	0.00	16	10	0	0	0	0	26	110	23.64
Swift	95.24	0.00	65	15	3	0	0	1	84	193	43.52
ITU/HDU	100.00	0.00	9	0	0	0	0	0	9	13	69.23
Day Surgery Centre, Lister	98.45	0.39	203	51	3	0	1	0	258	440	58.64
Day Surgery Treatment Centre	98.29	0.34	243	45	4	1	0	0	293	518	56.56
Endoscopy, Lister	99.57	0.00	213	19	0	0	0	1	233	939	24.81
Endoscopy, QEII	100.00	0.00	81	5	0	0	0	0	86	298	28.86
SURGERY TOTAL	97.75	0.30	**1025**	**278**	**22**	**3**	**1**	**4**	**1333**	**3074**	43.36
SSU	76.47	5.88	7	6	3	1	0	0	17	130	13.08
AMU	97.37	0.00	33	4	1	0	0	0	38	109	34.86
Pirton	92.98	0.00	45	8	3	0	0	1	57	66	86.36
Barley	100.00	0.00	20	1	0	0	0	0	21	30	70.00
6A	100.00	0.00	13	4	0	0	0	0	17	75	22.67
6B	100.00	0.00	25	15	0	0	0	0	40	68	58.82
11A	100.00	0.00	29	8	0	0	0	0	37	68	54.41
ACU	91.67	0.00	9	2	1	0	0	0	12	121	9.92
10B	90.91	0.00	15	5	1	0	0	1	22	44	50.00
Ashwell	100.00	0.00	19	4	0	0	0	0	23	48	47.92
9B	90.48	0.00	39	18	4	0	0	2	63	63	100.00
9A	100.00	0.00	28	0	0	0	0	0	28	53	52.83
Cardiac Suite	100.00	0.00	62	6	0	0	0	0	68	129	52.71
MEDICINE TOTAL	95.94	0.23	**344**	**81**	**13**	**1**	**0**	**4**	**443**	**1004**	44.12
10AN Gynae	96.67	0.00	20	9	1	0	0	0	30	67	44.78
Bluebell ward	90.57	0.00	29	19	5	0	0	0	53	183	28.96
Bluebell day case	100.00	0.00	1	1	0	0	0	0	2	12	16.67
Neonatal Unit	100.00	0.00	19	0	0	0	0	0	19	45	42.22
WOMEN'S/CHILDREN TOTAL	94.23	0.00	**69**	**29**	**6**	**0**	**0**	**0**	**104**	**307**	33.88
Michael Sobell House	100.00	0.00	31	1	0	0	0	0	32	44	72.73
11	98.18	0.00	47	7	1	0	0	0	55	92	59.78
CANCER TOTAL	98.85	0.00	**78**	**8**	**1**	**0**	**0**	**0**	**87**	**136**	63.97
TOTAL TRUST	97.20	0.25	**1516**	**396**	**42**	**4**	**1**	**8**	**1967**	**4521**	43.51

Continued over …..

Inpatients/Day by site	% Would recommend	% Would not recommend	Extremely Likely	Likely	Neither Likely/ Unlikely	Unlikely	Extremely Unlikely	Don't Know	Total responses	No. of Discharges	Total % response rate
Lister	97.02	0.28	1376	382	41	4	1	8	1812	4256	42.58
QEII	100.00	0.00	62	6	0	0	0	0	68	129	52.71
Mount Vernon	98.85	0.00	78	8	1	0	0	0	87	136	63.97
TOTAL TRUST	**97.20**	**0.25**	**1516**	**396**	**42**	**4**	**1**	**8**	**1967**	**4521**	**43.51**

Accident & Emergency	% Would recommend	% Would not recommend	Extremely Likely	Likely	Neither Likely/ Unlikely	Unlikely	Extremely Unlikely	Don't Know	Total responses	No. of Discharges	Total % response rate
Lister A&E/Assesment	91.49	2.13	168	90	13	5	1	5	282	9710	2.90
QEII UCC	95.16	3.23	46	13	1	0	2	0	62	3459	1.79
A&E TOTAL	**92.15**	**2.33**	**214**	**103**	**14**	**5**	**3**	**5**	**344**	**13169**	**2.61**

Maternity	% Would recommend	% Would not recommend	Extremely Likely	Likely	Neither Likely/ Unlikely	Unlikely	Extremely Unlikely	Don't Know	Total responses	No. of Discharges	Total % response rate
Antenatal	93.33	0.00	14	14	1	0	0	1	30	471	**6.37**
Birth	97.01	0.00	161	66	5	0	0	2	234	476	**49.16**
Postnatal	89.27	1.29	131	77	19	3	0	3	233	476	**48.95**
Community Midwifery	NP	NP	0	0	0	0	0	0	0	588	**0.00**
MATERNITY TOTAL	**93.16**	**0.60**	**306**	**157**	**25**	**3**	**0**	**6**	**497**	**2011**	**24.71**

Outpatients	% Would recommend	% Would not recommend	Extremely Likely	Likely	Neither Likely/ Unlikely	Unlikely	Extremely Unlikely	Don't Know	Total responses
Lister	95.91	2.15	322	124	8	4	6	1	465
QEII	96.13	1.23	413	134	8	6	1	7	569
Hertford County	95.95	0.00	100	42	5	0	0	1	148
Mount Vernon CC	95.54	1.79	174	40	3	2	2	3	224
Satellite Dialysis	96.67	1.11	61	26	1	0	1	1	90
OUTPATIENTS TOTAL	**95.99**	**1.47**	**1070**	**366**	**25**	**12**	**10**	**13**	**1496**

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

Key Performance Indicators Reported to RAQC														
	2017/18	Financial Year 2017-18												
		April	May	June	July	August	September	October	November	December	January	February	March	Current Position YTD
Patient Incidents	RIDDOR incidents	0	0	0	0	0	0	0	0	0	0			0
	H&S public liability claims	0	0	0	0	0	0	0	0	0	0			0
	Slips, Trips & Falls (not including inpatient falls)	0	0	0	0	0	0	2	0	0	0			2
	Physical assault	0	0	0	1	0	1	0	0	0	2			4
Visitor Incidents	RIDDOR incidents	0	0	0	0	0	0	0	0	0	0			0
	H&S public liability claims	1	0	0	1	0	0	0	0	2	0			4
	Slips, Trips & Falls	2	2	4	3	4	0	2	0	3	2			22
The Workforce (Including Contractors) Incidents	RIDDOR incidents	2	3	5	4	4	2	3	2	7	3			35
	Slips, Trips & Falls	1	5	7	6	5	5	8	2	12	6			57
	Employer liability claims	0	2	1	1	0	0	1	0	2	1			8
	Sharps incidents	11	7	12	12	15	13	9	24	13	12			128
	Workplace stress	6	2	1	3	7	3	4	4	2	4			36
	Contact dermatitis/latex	0	0	0	0	0	0	0	0	0	0			0
	Musculoskeletal injuries	5	3	8	3	8	5	8	3	0	4			47
	Physical assault	4	0	10	9	12	9	6	15	11	7			83
	H & S training (Compliance) (YTD = Latest Available Position)	89%	88%	88%	87%	88%	86%	91%	91%	91%	89%			91%
	Significant workplace fires	1	0	0	0	1	0	0	0	0	0			2
	Total Staff	5514	5529	5532	5574	5562	5881	5895	5940	5893	5907			57227

Key Performance Indicators Reported to RAQC

Floodlight Health & Safety Metrics

The Rate is the percentage of incident per 1000 employees

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

H & S Indicator		Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Average monthly total
RIDDOR Incidents		2	3	5	4	4	2	3	2	7	3	0	0	35
RATE %	Red < 0.36 Amber 0.36-0.33 Green > 0.33	0.363	0.543	0.904	0.718	0.719	0.340	0.509	0.337	1.188	0.508	0.000	0.000	0.612
Slips, Trips and Falls		1	5	7	6	5	5	8	2	12	6	0	0	57
RATE %	Red <0.86 Amber 0.86 - 0.78 Green >0.78	0.181	0.904	1.265	1.076	0.899	0.850	1.357	0.337	2.036	1.016	0.000	0.000	0.996
Sharps Injuries		11	7	12	12	15	13	9	24	13	12	0	0	128
RATE %	Red < 2.56 Amber 2.56-2.33 Green > 2.33	1.995	1.266	2.169	2.153	2.697	2.211	1.527	4.040	2.206	2.031	0.000	0.000	2.237
Mgr Referrals to OH for Stress		6	2	1	3	7	3	4	4	2	4	0	0	36
RATE %	Red < 0.96 Amber 0.96-0.87 Green > 0.87	1.088	0.362	0.181	0.538	1.259	0.510	0.679	0.673	0.339	0.677	0.000	0.000	0.629
Work related Musculosketal Injuries		5	3	8	3	8	5	8	3	0	4	0	0	47
RATE %	Red < 1.11 Amber 1.11-1.01 Green > 1.01	0.907	0.543	1.446	0.538	1.438	0.850	1.357	0.505	0.000	0.677	0.000	0.000	0.821
Physical Assault		4	0	10	9	12	9	6	15	11	7	0	0	83
RATE %	Red < 1.45 Amber 1.45-1.32 Green > 1.32	0.725	0.000	1.808	1.615	2.157	1.530	1.018	2.525	1.867	1.185	0.000	0.000	1.450
Total Staff		5514	5529	5532	5574	5562	5881	5895	5940	5893	5907	0	0	57227

2. Performance Data:

CQC Outcomes Summary

Our CQC Registration and recent Care Quality Commission Inspection

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

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

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

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

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

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

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

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

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

Summary of the latest Inspection Outcome

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

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

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

3. Risk and Quality Committee Reports:

Safer Staffing

Infection Control Data

East and North Hertfordshire NHS Trust

Safe Nurse Staffing Levels

January 2018

Executive Summary

For the month of January the trust saw an increase in the % of planned vs actual hours for the inpatient wards for the unify return. Despite the increase in planned vs actual, the care hours per patient day fell in month. This is due to an increase in occupancy compared to December.

The red triggered shifts are up from 12.51% of all shifts in December to 16.21% of all shifts in January. Of the 573 shifts triggering red 7 remained unmitigated, this is an improved position from December and equates to 0.20%.

The number of patients requiring nursing care remains static, with the care hours provided also remaining relatively static from December. However the need to cover patients with mental health challenges did increase in month.

Falls with harm increased to 91, the highest number of falls over the last 12 months and an increase of 15 from December. Of these 91 falls, one resulted in a severe harm injury.

There were 3 avoidable hospital acquired pressure users, 1 more than our maximum trajectory. This took the trust over the annual trajectory due to the high number of incidents in December.

Purpose

The purpose of this report is:

1. To provide an assurance with regard to the management of safe nurse and midwifery staffing for the month of January 2018.
2. To provide a summary report of quality metrics for the month of January 2018 as indicators of patient safety.
3. To provide context for the Trust Board on the UNIFY safer staffing submission for the month of January 2018.

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.

Summary Table

No	Topic	Measure	Summary	RAG
1.	**Patient safety is delivered though consistent, appropriate staffing levels for the service.**	Unify RN fill rate	The Unify submission for registered fill % increased in January with the average day fill % for registered nurses increasing from 94.1% in December to 95.0%.	
		Care hours per Patient Day - CHPPD	CHPPD decreased from 7.1 in December to 7.0 in January.	
2.	**Staff are supported in their decision making by effective reporting.**	% of Red triggered shifts	The percentage of Red Triggered shifts increased from 12.51% in December to 16.21% in January.	
		% of shifts that remained partially mitigated	Out of the shifts triggering red, 7 of the 573 that initially triggered red (0.20%) remained only partially mitigated, compared to 0.51% in December.	
3.	**Staffing risks are effectively escalated to an appropriate person**	Red flag reportable events and DATIX report	Red flags continue to be used to escalate staffing issues in the organisation, and Datix reports investigated and reviewed.	
4.	**Patient Safety incidents**	Datix reports, Safety Thermometer report.	The monitoring of falls, pressure ulcers, safety thermometer and patient safety incidents are reviewed for the month of January	
5.	**The Board are assured of safe staffing for nursing and midwifery**	Board reports and discussion covering overview of safe staffing levels	The overall RN and CSW fill rate increased slightly due to the actual care being greater than planned as a result of escalation staffing, and a slight increase in temporary staffing agency fill. The CHPPD delivered in January has however decreased due to the increased number of patients admitted to our wards	

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

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

1.1 Unify Safer Staffing Return

The Trust's safer staffing submission has been submitted to Unify for December within the Unify data submission deadline. SafeCare has been used as the data source for patients as at 23:59 in the absence of patient data reports from Lorenzo. Table 1 below shows the summary of overall fill %, the full table of fill % can be seen in Appendix 1:

Table 1 – Overall Unify Return fill rate

Day		Night	
Average fill rate + registered nurses/midwives (%)	Average fill rate + care staff (%)	Average fill rate + registered nurses/midwives (%)	Average fill rate + care staff (%)
95.0%	87.7%	96.2%	108.4%

The Unify submission for registered fill % increased in January with the average day fill % for registered nurses increasing from 94.1% in December to 95.0%.

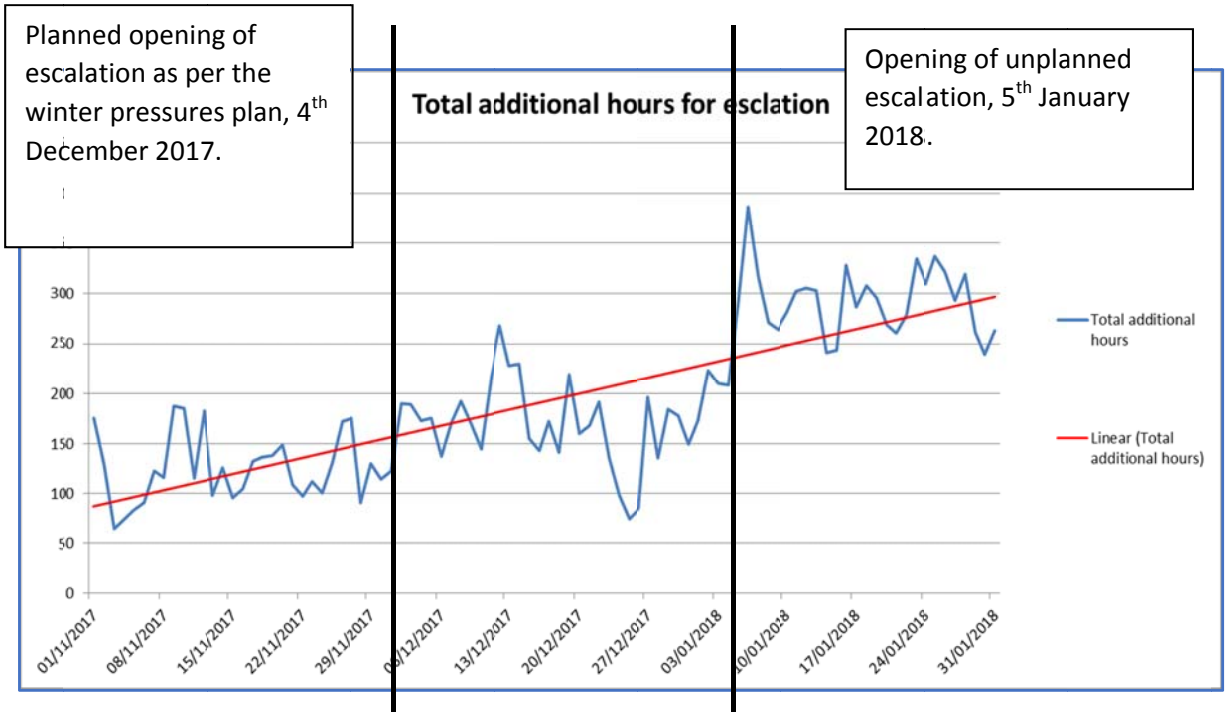
Factors affecting Planned vs. Actual staffing

Due to increased demand, the trust has opened escalation beds in line with the escalation policy. These beds have required additional staff to support safe patient care. An overview of this can be seen below:

Escalation

- Ashwell was escalated above their planned 24 beds to 28 beds for the month of January; their planned staffing level for the Unify return is reflective of their 28 bed shift plan. Staffing for additional capacity beds on Ashwell Annex (5 beds) was required for 24/31 nights in January when the ward was bedded above 28 patients. Staffing was flexed based on patient acuity and additional capacity beds. This has resulted in RN fill above planned levels (28 beds).
- A new winter pressures ward (7AN) was opened on the 3rd December. The ward was planned to be a 14 bed Surgical 23 hour stay ward, with the ward being open Monday to Saturday afternoon. The requirement for additional capacity beds led to the ward being opened 7 days a week for the whole month of January. The ward was therefore staffed above the planned requirement of RN and CSW fill as the ward did not close on a Saturday afternoon as planned.
- 6B was open to 26 patients (planned 25 beds) on 5 occasions in January. Staffing was flexed at night to support additional capacity.
- Dacre ward was staffed to support 6 beds used for Surgical and Gynae patients from the 4th January and closed on the 12th January. 10A Gynae and Dacre are above 100% fill rate as staff on these wards supported the care provided to the patients in the additional capacity beds.
- Additional staff were used in ED to support patient overflow in the entrance corridor and the opening of CDU B bay.

Chart 1 below shows the increase in hours used to staff escalation beds between November and January; it also highlights the key time lines for the planned and reactive opening of escalation beds.



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

- **Senior Nurses, Matrons and Specialist Nurses** – Senior Nurses, Matrons and Specialist nurses worked clinically to support wards where staffing fell below the minimum safe levels.
- **Our colleagues from HCT and the CCG supported the wards** with 118.5 hours of care on our wards from the 6th to the 11th January.
- **10B, 5A, 5B, 7B, 9A, 9B, Barley, Bluebell, and Pirton** – Had an increased demand for patients requiring enhanced care which resulted in an increased CSW fill in these areas. In excess of 2400 hours of care were provided by the enhanced care team, 1160 hours by bank CSWs and 175 hours by agency CSWs. A full break down of enhanced nursing care can be seen in section 2.4.
- **Dacre and 10A Gynae -** 10A Gynae and Dacre are above 100% fill rate as staff on these wards supported the care provided to outlying patients.
- **11A, 11B, 5B, 8B, AMU-A and SAU –** RN day and night fill fell below 90% in January, this is due to the increased staffing requirements due to the opening of escalation areas above the winter plan. This has depleted the overall staffing pool, and risk was balanced across the service to mitigate risk to patient safety.
- **Pirton –** RN day fill is recorded as 80.1% in January with the average occupancy of 86.07% as at the 23:59 census period. The CHPPD for the service was 6.47 compared to the service target of 6.18; this would suggest staffing was appropriate for acuity and dependency of patients on the ward. Stroke specialist nurses have also provided support for the inpatient ward to ensure patient safety.
- **Swift** – RN day fill is recorded as 75.8% in January with the average bed occupancy 67.87% as at the 23:59 census period. The CHPPD for the service was 5.95 compared to the service target of 5.02; this would suggest staffing was appropriate for acuity and dependency of patients on the ward. Due to lower planned staffing levels at night there is less flexibility to reduce staffing at night in line with occupancy.
- **Ward 11** – Care Staff fill was low in month. Registered Nurses supported where this was likely to impact on patient safety.

1.2 UNIFY Care Hours Per Patient Day (CHPPD)

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

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

This is a standard calculation indicating the number of care hours provided to each patient over a 24 hour period. The table below shows the CHPPD for January, this indicates overall CHPPD decreased from 7.1 in December to 7.0 in January.

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

Table 2 – Average Care Hours Per Patient Day

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

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

2.1 Daily process to support operational staffing

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

2.2 Staffing levels and shifts that trigger red

The number of shifts initially triggering red increased from 419 in December to 573 in January. The percentage of Red Triggered shifts increased from 12.51% in December to 16.21% in January. Table 3 below shows the % of shifts that triggered red in month.

Table 3 – % of shifts triggering red and remained red

Month	% of shifts that triggered red in Month	% of shifts that remained triggered red
Jan-17	5.32%	0.00%
Feb-17	6.40%	0.41%
Mar-17	7.44%	0.23%
Apr-17	5.91%	0.12%
May-17	6.13%	0.09%
Jun-17	6.51%	0.09%
Jul-17	8.24%	0.18%
Aug-17	8.90%	0.24%
Sep-17	10.62%	0.34%
Oct-17	12.16%	0.84%
Nov-17	9.07%	0.18%
Dec-17	12.51%	0.51%
Jan-18	16.21%	0.20%

Comparison of red triggered shifts between January 2017 and January 2018 shows an increase of 10.89% in the number of shifts triggering red in month.

Out of the shifts triggering red, 7 of the 573 that initially triggered red (0.20%) remained only partially mitigated. This is a decrease in the number of partially mitigated shifts from 17 in December. Shifts triggering red, and those that remained a challenge to mitigate, are explored below.

Due to opening of escalation areas occupancy increased in month. This contributed to the increase in red triggering shifts as additional staff resource was required for the additional capacity beds.

Chart 1 below shows the % of shifts triggering red in month and the % of shifts that remained triggered red; the % shifts triggering red has shown a linear increase. This is multifactorial and the reasons include sustained levels of vacancies, sickness, controlled use of agency and unfilled temporary staffing shifts and additional capacity beds being opened over January, both planned and unplanned. These are discussed in section 2.3.

Chart 1

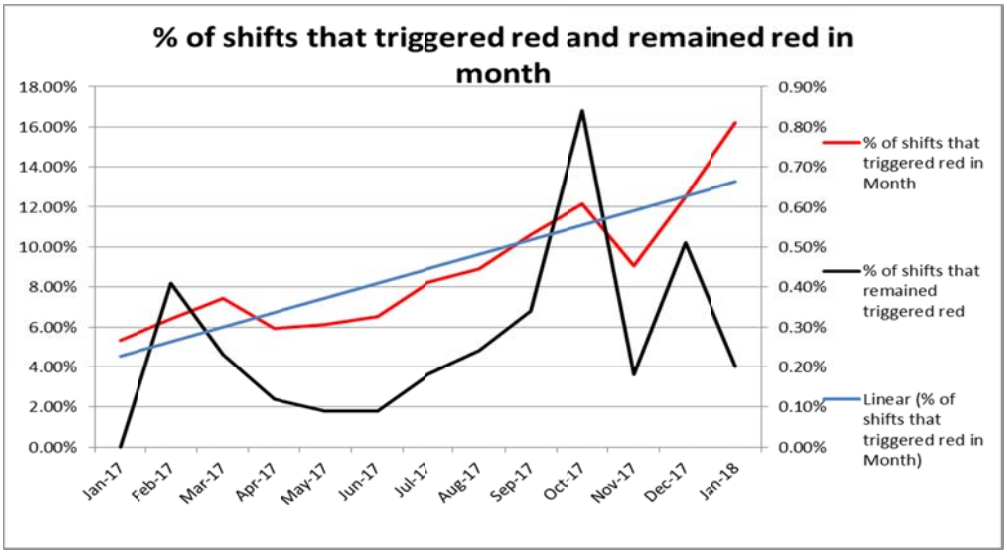
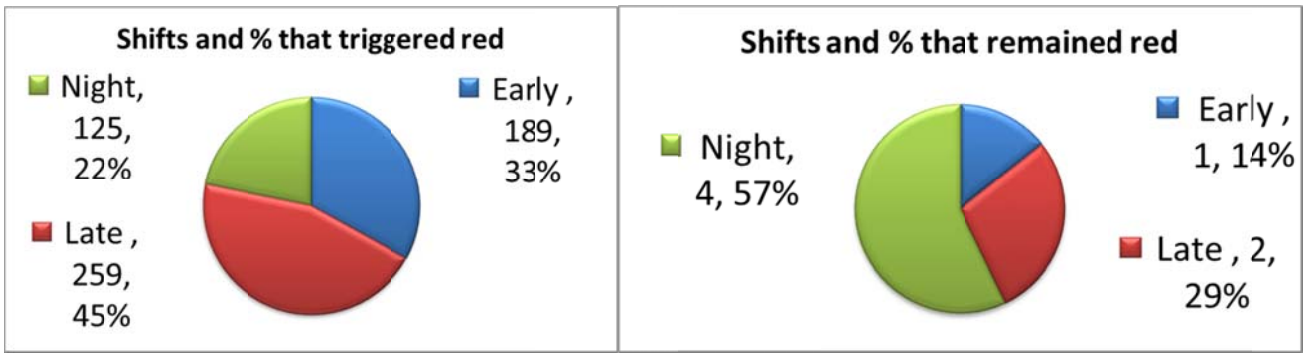


Chart 2 below shows the number and % distribution of red triggered shifts and those shifts that remained red after mitigating action was taken.

Chart 2 – Shifts initially triggering red & remained red



A list of all the shifts triggering red can be found in Appendix 3. Twenty-three wards triggered red on 10% or more of the shifts in January which is an increase from 18 wards in December.

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

Table 4 – Wards triggering high number of red shifts

	INITIAL REDS				
Ward	Early	Late	Night	Number of shifts where staffing initially fell below agreed levels	% of shifts where staffing fell below agreed levels and triggered a Red rating
Ashwell	18	18	8	44	47.31
Barley	19	16	5	40	43.01
8B	14	17	4	35	37.63
7AN	9	14	11	34	36.56
9B	13	16	3	32	34.41
7AS	7	10	14	31	33.33
10B	9	13	6	28	30.11
5B	12	11	4	27	29.03
9A	9	10	6	25	26.88
Pirton	5	16	1	22	23.66
SAU	5	10	7	22	23.66
6A	9	8	3	20	21.51
7B	4	12	4	20	21.51
10A Gynae	8	10	2	20	21.51
Swift	3	12	4	19	20.43
5A	6	4	7	17	18.28
AMU-A	2	7	5	14	15.05
ACU	5	5	3	13	13.98
SSU	2	7	3	12	12.90
8A	4	5	3	12	12.90
A&E	4	4	3	11	11.83
11B	0	5	6	11	11.83
11A	2	7	1	10	10.75

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

2.3 Summary of factors affecting red triggering shifts

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

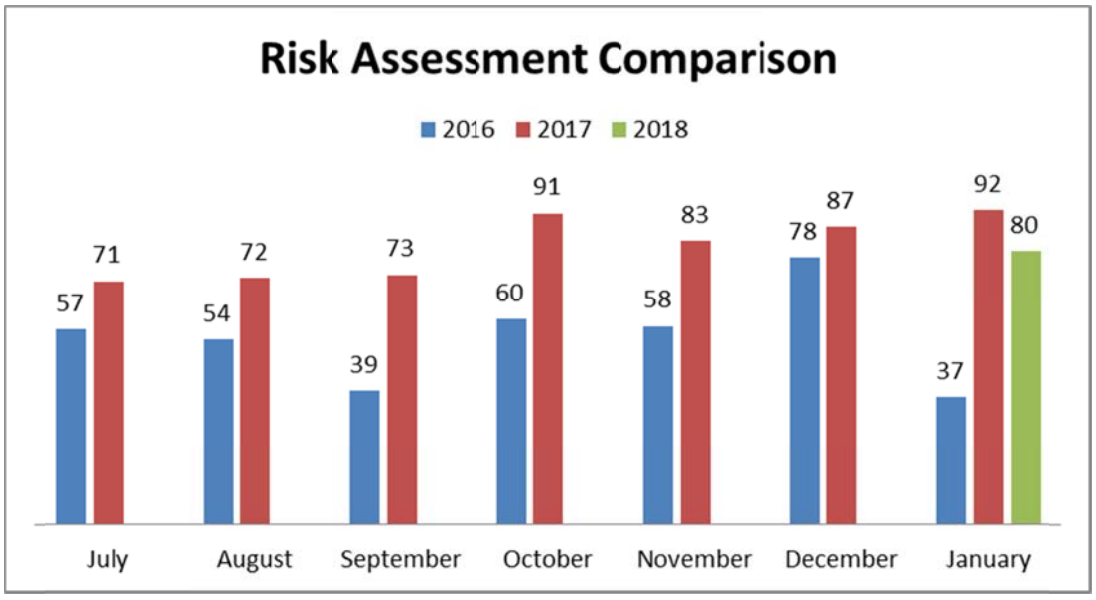
- Temporary Staffing Fill – Despite an increase in overall fill rate for temporary staffing by 0.5% from 72.1% in December to 72.6% in January, the demand increased significantly resulting in 22,394 unfilled hours. This is an increase from 20,402 unfilled hours in December. See Appendix 5.
- Sickness – The sickness rate increased from 8.1% in December to 9.2% in January (taken from e-Roster) and remains above the 4% budget position.
- Specialling requirements impact on the care hours required on a ward on a shift by shift basis. If the specialling needs are not covered this may cause the ward to trigger red

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

2.4 The Enhanced Nursing care team (ENCT)

The ENCT have streamlined the service for patients needing enhanced care and the team review the level of care requirement on each ward on a daily basis. Chart 3 shows that demand for enhanced care has decreased for the month of January with 7 less risk assessments received for enhanced care needs from the previous month. It also shows that there is a lower demand for enhanced care for the same period 2016.

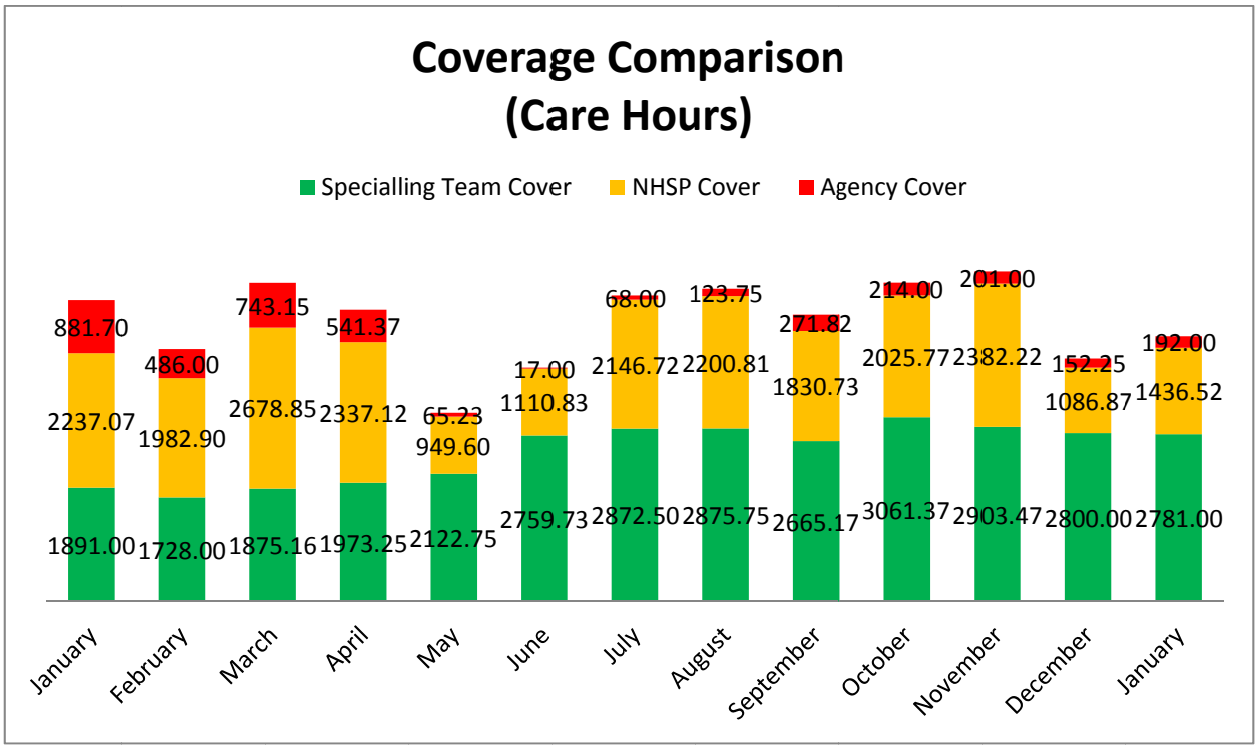
Chart 3



The Enhanced Nursing Care Team (Specialling team) continues to mitigate the risk and reduce the need to cover those patients requiring enhanced care with temporary staff, providing a higher level of care for less cost. The team has recruited 5 band 4 team leaders to manage the team out of hours and continue to streamline the service. There is ongoing band 3 recruitment to bring the team up to full establishment. The impact in terms of care hours delivered by the Specialling Team has reduced reliance on Agency staff which can be seen in the Chart 4 below. The slightly higher level of Agency used in January was due to the increase in mental health specialling. These patients require 24 hour 1-1 care so the team cannot work flexibly when providing this level of

care.

Chart 4



The ENCT review all patients requiring enhanced care on a daily basis and determine the requirement needed, reviewing behavioural charts and liaising with ward staff, patients and carers. This means that they can be flexible in the way they cover shifts working with carers and volunteers to help support the care requirement. If they are unable to support a ward with the team, the shift will be sent to temporary staffing to be filled.

The team are now working collaboratively with Hertfordshire Partnership Foundation Trust (HPFT) who have funded 1 WTE band 3 CSW. HPFT have provided training for the team to support mental health patients requiring enhanced care in our trust. Demand for enhanced care for mental health patients has seen a decrease for the month of December compared to November.

Chart 5 below shows the number of care hours that have been covered by the ENCT for mental health patients.

Chart 5

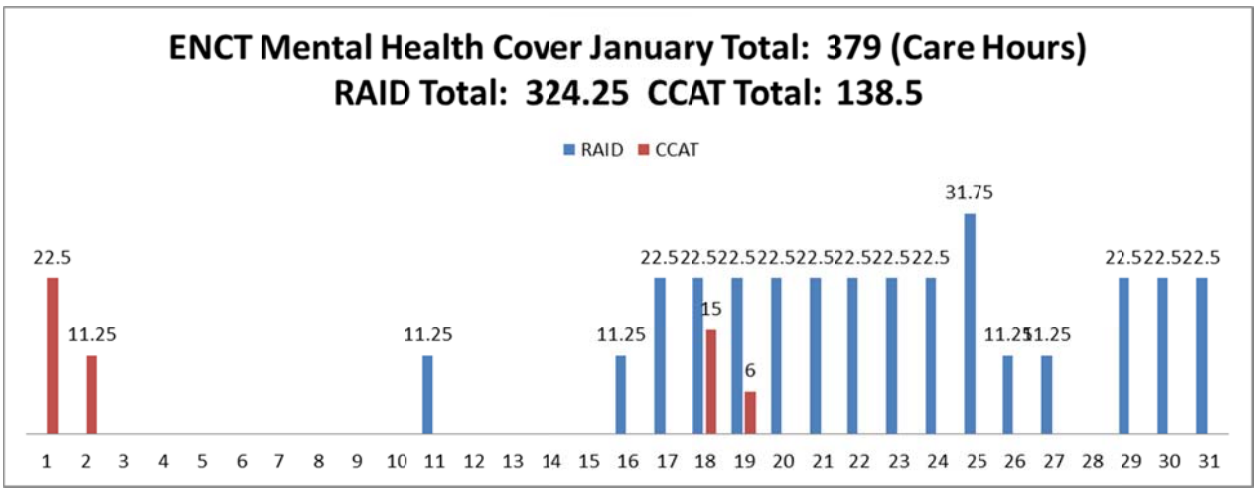
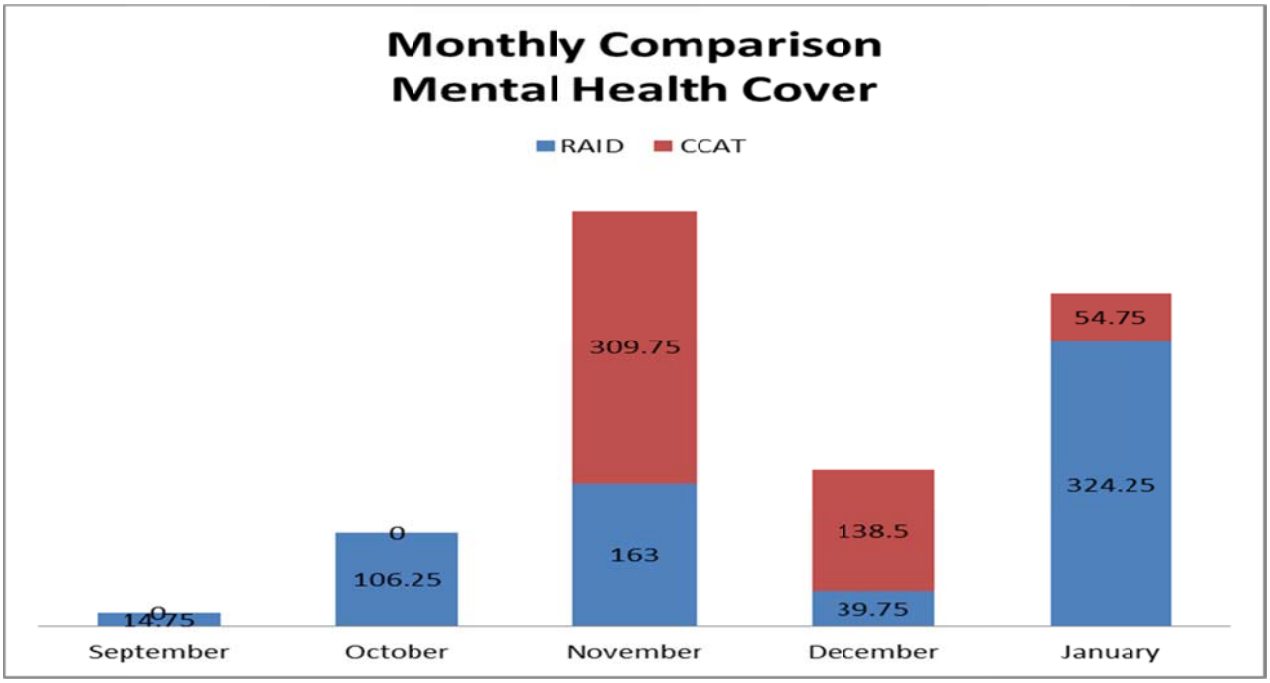


Chart 6 shows the care hours provided per month for HPFT since the project started in September 2017.

Chart 6



3. Staffing risks were effectively escalated to an appropriate person

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

3.1 Red Flags

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

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

Chart 7 below shows the distribution of red flags by type. Total red flags raised increased from 280 red flags in December to 373 in January. This chart shows that Shortfall in Care Hours and Registered Nurse to Patient Ratio were the most commonly raised red flags. Matrons are expected to visit any ward that has raised a red flag within an hour to ensure any risk is mitigated.

Chart 7 – Red Flags raised by Type

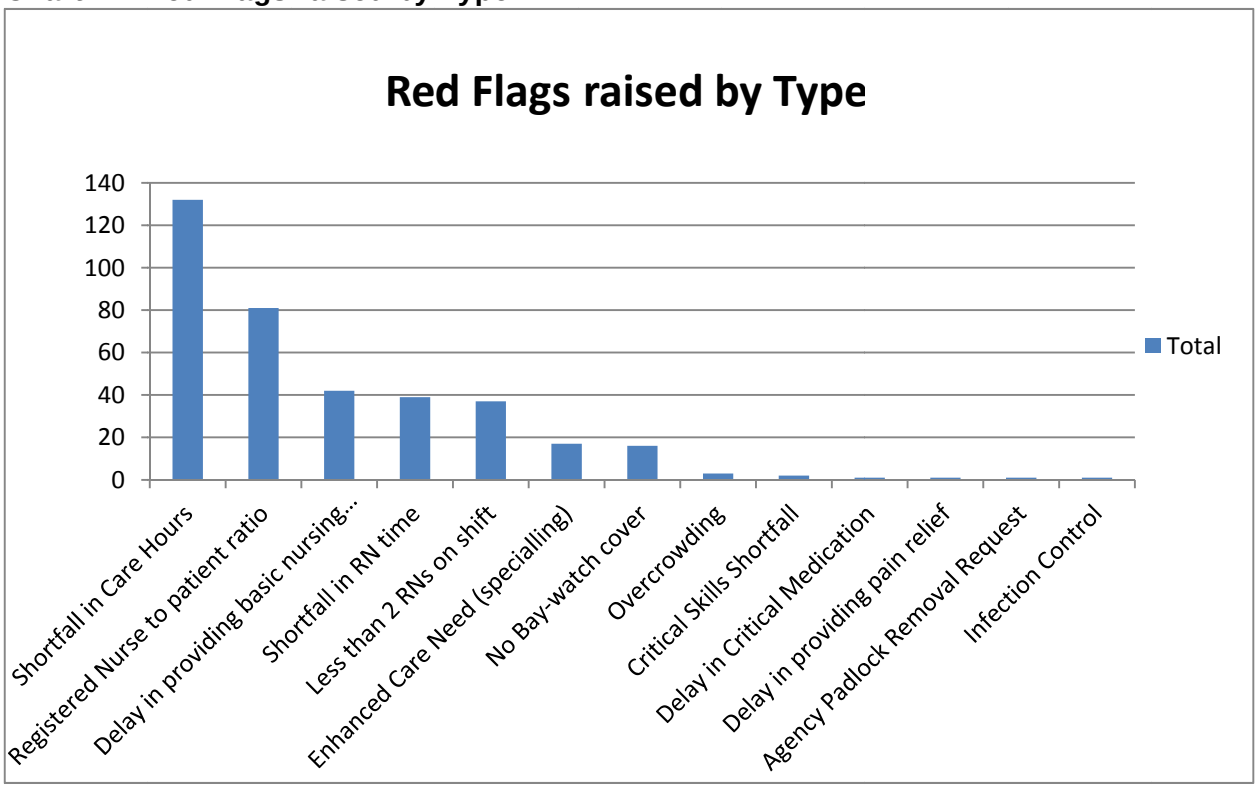
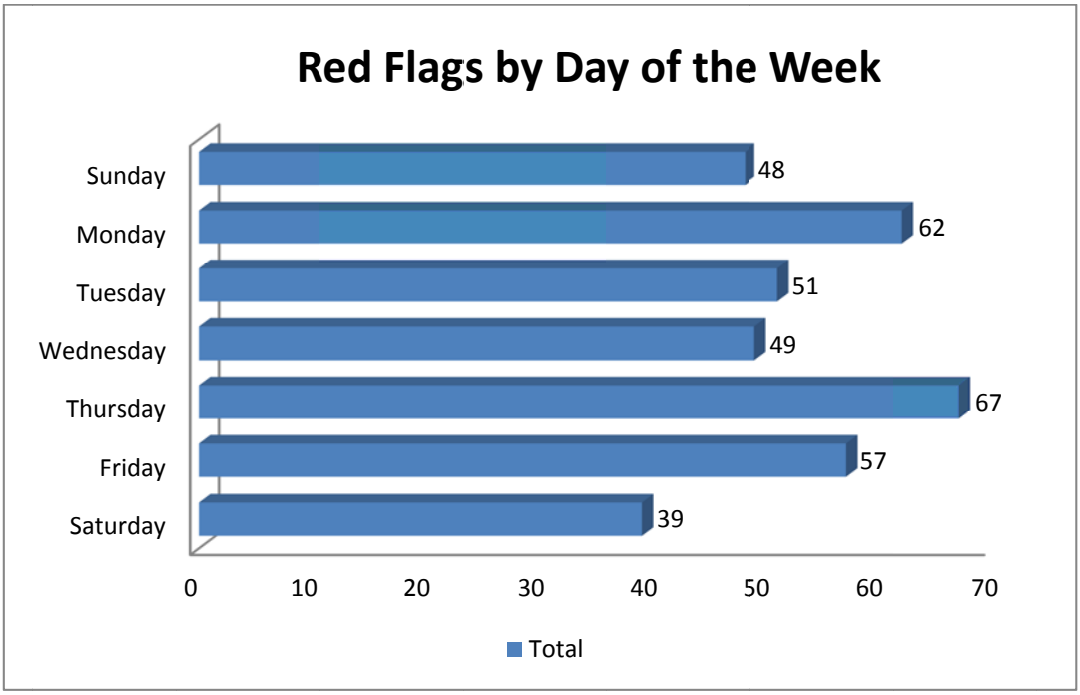


Chart 8 below indicates the red flags by day of the week; this shows that Mondays and Thursdays had the highest number of red flags raised in January. Work is ongoing to review the reasons behind the staffing challenges faced on these days of the week and is focusing on the actions required to minimise the risk accordingly.

Chart 8 - Red Flags Day of Week



4. Patient Safety incidents

4.1 Safety Thermometer

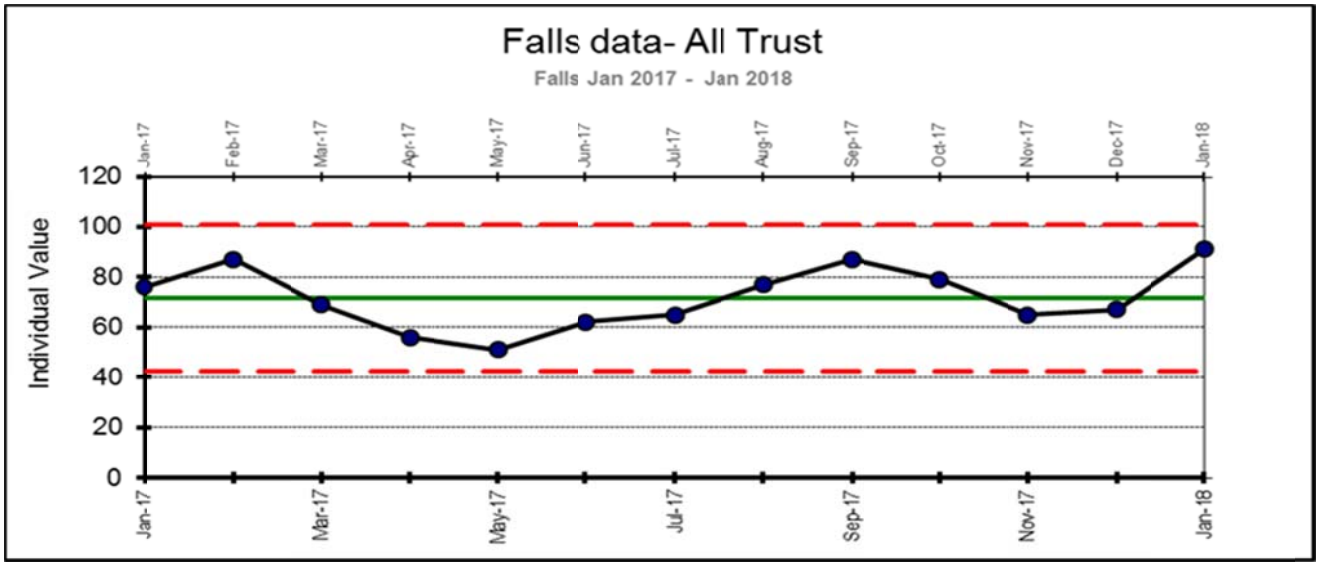
The NHS Safety Thermometer audit provides a 'temperature check' on levels of harm and enables the measurement of 'harm free care'. Harm free care is defined by the absence of pressure ulcers (community and hospital acquired), harm from a fall in hospital, urine infection (in patients with a catheter)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

Despite the increased bed capacity and higher number of patients requiring enhanced nursing care the proportion of patients with harm identified within the classic safety thermometer audit remains low. In January 2018 3.6% of patients were identified with harm (1.7% December 2017).

4.2 Falls

91 inpatient falls were recorded in January; the Trust is currently 5 incidents above the reduction trajectory set for 2017/18

Chart 9



91 inpatient falls were reported during January 2018, compared to 67 reported in December 2017 which is an increase of 24 incidents. When compared to January 2017 which reported 76 falls an increase of 15 falls. There was one severe harm incident was reported in January 2018 compared to four in January 2017. The pattern of inpatient falls occurring during January is traditionally hard to forecast and is influenced by both an increase in patient activity the opening of extra capacity areas and stresses affecting the wider health care economy, it is anticipated that inpatient falls will fall below 75 in February.

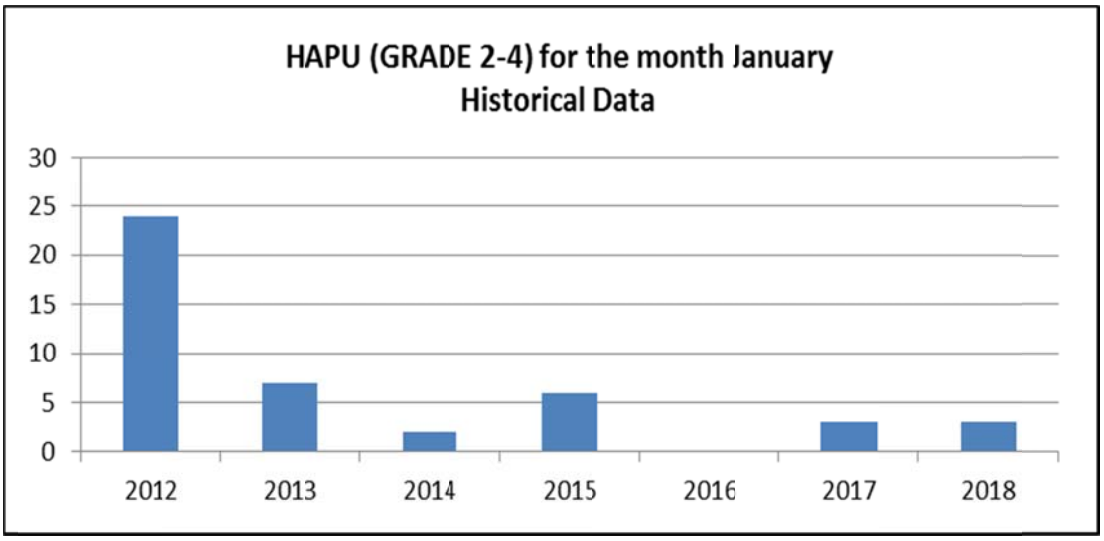
Both the medical and cancer services division are reporting a decrease in falls during 2017/18 whilst the surgical division are reporting a 16.25% increase in falls which may be due to a larger number of medical outliers on these wards.

All clinical areas are required to focus on achieving a year on year reduction in falls. The impact of safety huddles, Baywatch and the enhanced nursing care team have all had a positive impact in the reduction of falls in the trust.

Pressure Ulcers

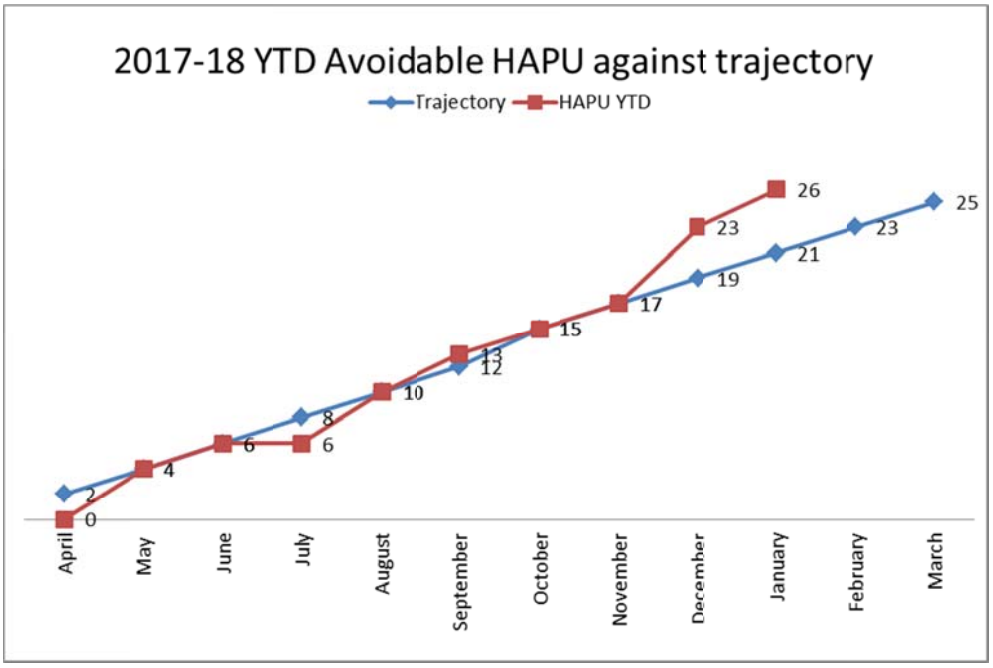
For the month of January 2018, 3 avoidable hospital acquired pressure ulcers grade 2 were recorded. The table below demonstrates the number of pressure ulcers in the month of January since 2012.In addition there were 7 hospital acquired avoidable suspected deep tissue injuries, (STDI)

Chart 10



The outcomes of the investigations suggest that the omissions were lack of documentation and pressure relieving equipment. Work is being done with the wards to improve focus on pressure ulcer prevention and completion of documentation. The tissue viability team provide monthly study days for staff to attend and are launching a new intentional rounding document which will be piloted on 8B starting in February. Chart 11 shows the trust is above the monthly position against our year end position target of 25.

Chart 11



All clinical areas are required to focus on achieving a year end reduction in pressure ulcers. The Trust has seen numbers of hospital-acquired ulcers fall dramatically over the last seven years and is now achieving one of the lowest rates in the country.

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

The overall RN and CSW fill rate increased slightly due to the actual care being greater than planned as a result of escalation staffing, and a slight increase in temporary staffing agency fill. The CHPPD delivered in January has however decreased due to the increased number of patients admitted to our wards. The maintenance of safe staffing levels on wards in January was supported by:

- Continued daily monitoring and ward RAG rating of staffing levels across inpatient wards
- Matrons review and response to Red Flag events at the three Daily Staffing meetings with mitigations fed back to the wards via SafeCare in real time
- Monthly patient acuity audits completed by Matrons, or when Acuity is in question.
- Working with cap compliant agencies
- Working with agencies to identify long line agencies to support areas with high vacancies
- Controlled release of unfilled shifts to agencies
- All controls off for the top 5 wards with the highest operational shortfall
- Additional support provided by e-Roster, NHSP and Temporary Staffing management to assist wards with staffing challenges
- The non-ward based nursing project continues to review roles and activities of non-ward based nurses, and allows for a more objective approach to meeting the clinical and organisational demands.
- Active management by the Divisional / Duty Matron and support from Matrons and Heads of Nursing within the Divisions to review staffing requirements on a daily basis for identified wards
- Divisional Heads of Nursing, Matrons, Specialist Nurses and the Education Team working clinically where needed
- The introduction of the e-Roster operational support service in the evening to cover the handover of the night shift and support the Duty Matron with the mitigation of red shifts at night
- The e-Roster team contacting all Red wards to ensure that the planned mitigations have taken place and escalate to Matrons where appropriate.

Appendix 1

	Day		Night	
Ward name	Average fill rate + registered nurses/midwives (%)	Average fill rate + care staff (%)	Average fill rate + registered nurses/midwives (%)	Average fill rate + care staff (%)
10B	92.9%	100.6%	91.1%	126.3%
11A	89.5%	90.2%	93.1%	100.6%
11B	85.2%	86.4%	99.2%	100.5%
5A	93.7%	96.8%	93.6%	180.7%
5B	89.0%	97.0%	86.5%	127.3%
6A	91.1%	80.8%	99.1%	90.9%
6B	97.7%	67.7%	103.4%	96.8%
10A Gynae	105.0%	81.2%	114.0%	110.8%
7B	93.0%	81.6%	88.2%	127.6%
7AN	118.4%	97.4%	133.5%	144.5%
8A	96.1%	88.3%	88.2%	110.7%
8B	85.5%	84.3%	85.0%	106.1%
9A	97.9%	90.8%	90.0%	125.6%
9B	92.0%	101.5%	88.8%	127.6%
ACU	92.7%	99.7%	98.4%	101.9%
AMU-A	87.9%	84.5%	88.6%	102.1%
AMU-W	100.5%	80.6%	88.1%	100.1%
Ashwell	107.3%	80.9%	119.7%	113.2%
Barley	97.7%	90.5%	96.9%	128.5%
Bluebell	97.5%	111.2%	99.7%	#DIV/0!
Critical Care 1	100.0%	100.0%	100.0%	100.0%
Dacre	113.1%	102.1%	97.3%	#DIV/0!
Gloucester	101.5%	94.5%	101.2%	90.7%
CLU	96.8%	89.3%	100.9%	96.9%
Mat MLU	103.7%	95.1%	101.5%	92.6%
Michael Sobell House	102.1%	75.8%	98.8%	106.8%
Pirton	80.1%	91.0%	93.5%	112.7%
SAU	78.9%	73.7%	99.0%	93.5%
SSU	100.6%	100.0%	94.8%	105.4%
Swift	75.8%	77.5%	79.9%	93.2%
Ward 11	101.6%	55.5%	106.2%	53.2%
Total	**95.0%**	**87.7%**	**96.2%**	**108.4%**

Appendix 2

Ward name	Care Hours Per Patient Day (CHPPD)		
	Registered midwives/ nurses	Care Staff	Overall
10B	2.82	2.67	5.49
11A	3.77	1.64	5.41
11B	3.67	2.70	6.37
5A	3.00	2.33	5.32
5B	2.99	2.71	5.70
6A	3.14	2.17	5.31
6B	3.73	2.08	5.81
10A Gynae	5.99	2.63	8.62
7B	2.95	1.66	4.60
7AN	3.65	2.48	6.14
8A	2.92	2.13	5.05
8B	2.88	1.84	4.73
9A	2.90	2.37	5.27
9B	2.87	2.30	5.16
ACU	4.31	2.27	6.59
AMU-A	5.44	3.43	8.87
AMU-W	3.88	2.90	6.78
Ashwell	2.94	2.59	5.52
Barley	3.22	2.32	5.54
Bluebell	7.48	2.18	9.65
Critical Care 1	17.74	2.35	20.09
Dacre	8.26	1.49	9.75
Gloucester	4.73	3.95	8.68
CLU	35.40	7.61	43.01
Mat MLU	27.53	8.39	35.92
Michael Sobell House	4.99	2.85	7.83
Pirton	4.05	2.42	6.47
SAU	5.87	2.42	8.29
SSU	3.50	2.42	5.93
Swift	3.48	2.47	5.95
Ward 11	5.89	1.85	7.74
Total	**4.5**	**2.5**	**7.0**

Appendix 3

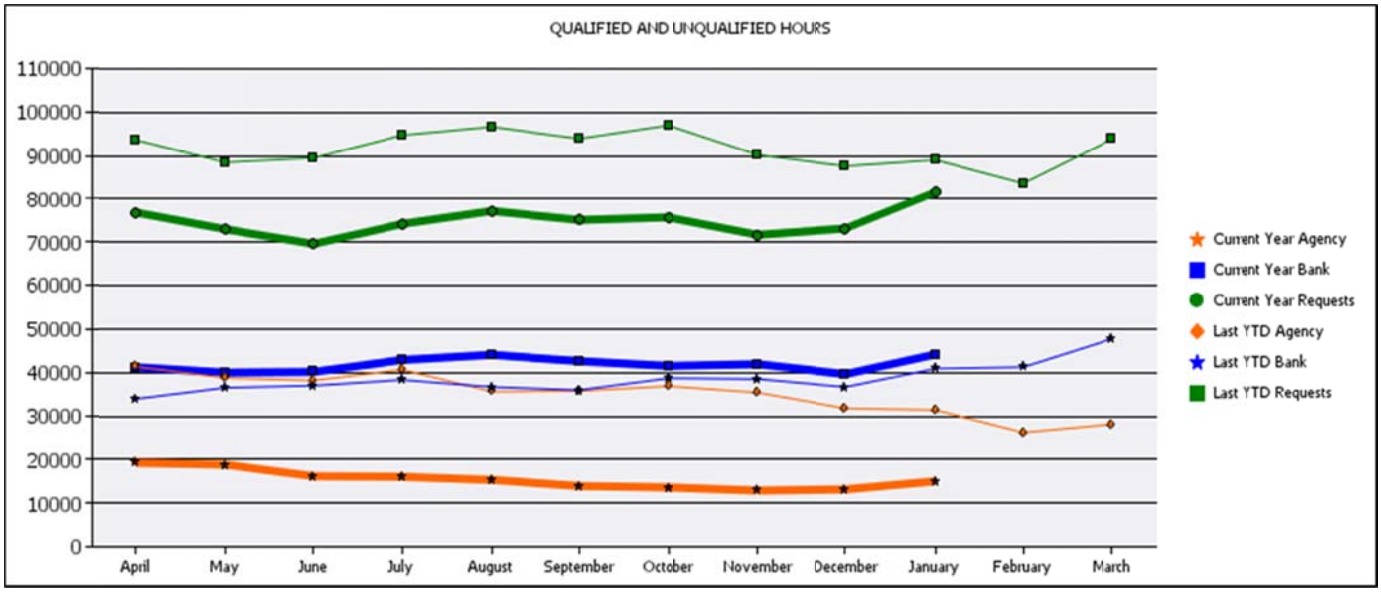
Speciality	Ward	INITIAL REDS				
		Early	Late	Night	Number of shifts where staffing initially fell below agreed levels	% of shifts where staffing fell below agreed levels and triggered a Red rating
Care of the Elderly	9A	9	10	6	25	26.88
	9B	13	16	3	32	34.41
Stroke	Barley	19	16	5	40	43.01
	Pirton	5	16	1	22	23.66
General	6A	9	8	3	20	21.51
	7AS	7	10	14	31	33.33
	10B	9	13	6	28	30.11
Respiratory	11A	2	7	1	10	10.75
Cardiology	ACU	5	5	3	13	13.98
Acute	AMU-A	2	7	5	14	15.05
	SSU	2	7	3	12	12.90
	AMU-W	2	5	1	8	8.60
Renal	6B	2	4	3	9	9.68
DTOC / gastro	Ashwell	18	18	8	44	47.31
ED	A&E	4	4	3	11	11.83
	CDU	2	2	1	5	5.38
	UCC	1	0	0	1	1.08
		111	**148**	**66**	**325**	**20.56**
General	7AN	9	14	11	34	36.56
	8A	4	5	3	12	12.90
	8B	14	17	4	35	37.63
	SAU	5	10	7	22	23.66
Surgical Spec	11B	0	5	6	11	11.83
	7B	4	12	4	20	21.51
T&O	5A	6	4	7	17	18.28
	5B	12	11	4	27	29.03
	Swift	3	12	4	19	20.43
ATCC	Critical Care 1	0	0	0	0	0.00
	ASCU	0	0	0	0	0.00
		57	**90**	**50**	**197**	**19.26**
Gynae	10A Gynae	8	10	2	20	21.51
Paeds	Bluebell	0	0	1	1	1.08
	Child A&E	6	2	1	9	9.68
	NICU	0	0	0	0	0.00
Maternity	Dacre	0	0	0	0	0.00
	Gloucester	2	3	1	6	6.45
	Mat MLU	0	2	0	2	2.15
	Mat CLU 1	4	3	0	7	7.53
		20	**20**	**5**	**45**	**6.05**
Inpatient	Ward 10	0	1	3	4	4.30
	Michael Sobell House	1	0	1	2	2.15
		1	**1**	**4**	**6**	**3.23**
	TRUST TOTAL	**189**	**259**	**125**	**573**	**16.21**

Appendix 4

Speciality	Ward	FINAL REDS				
		Early	Late	Night	Number of shifts where staffing initially fell below agreed levels	% of shifts where staffing fell below agreed levels and triggered a Red rating
Care of the Elderly	9A	0	0	0	0	0.00
	9B	0	0	0	0	0.00
Stroke	Barley	0	0	0	0	0.00
	Pirton	0	0	0	0	0.00
General	6A	0	0	0	0	0.00
	7AS	0	0	0	0	0.00
	10B	0	0	0	0	0.00
Respiratory	11A	0	0	0	0	0.00
Cardiology	ACU	0	0	0	0	0.00
Acute	AMU-A	0	0	0	0	0.00
	SSU	0	0	0	0	0.00
	AMU-W	0	0	0	0	0.00
Renal	6B	0	0	0	0	0.00
DTOC / gastro	Ashwell	0	0	1	1	1.08
ED	A&E	0	0	0	0	0.00
	CDU	0	0	0	0	0.00
	UCC	0	0	0	0	0.00
		0	**0**	**1**	**1**	**0.06**
General	7AN	0	0	0	0	0.00
	8A	0	0	0	0	0.00
	8B	0	0	1	1	1.08
	SAU	0	0	0	0	0.00
Surgical Spec	11B	0	0	0	0	0.00
	7B	0	0	1	1	1.08
T&O	5A	1	0	0	1	1.08
	5B	0	0	1	1	1.08
	Swift	0	0	0	0	0.00
ATCC	Critical Care 1	0	0	0	0	0.00
	ASCU	0	0	0	0	0.00
		1	**0**	**3**	**4**	**0.39**
Gynae	10A Gynae	0	0	0	0	0.00
Paeds	Bluebell	0	0	0	0	0.00
	Child A&E	0	0	0	0	0.00
	NICU	0	0	0	0	0.00
Maternity	Dacre	0	0	0	0	0.00
	Gloucester	0	0	0	0	0.00
	Mat MLU	0	1	0	1	1.08
	Mat CLU 1	0	0	0	0	0.00
		0	**1**	**0**	**1**	**0.13**
Inpatient	Ward 10	0	1	0	1	1.08
	Michael Sobell House	0	0	0	0	0.00
		0	**1**	**0**	**1**	**0.54**
	TRUST TOTAL	**1**	**2**	**4**	**7**	**0.20**

Appendix 5

NHSP hours YTD report



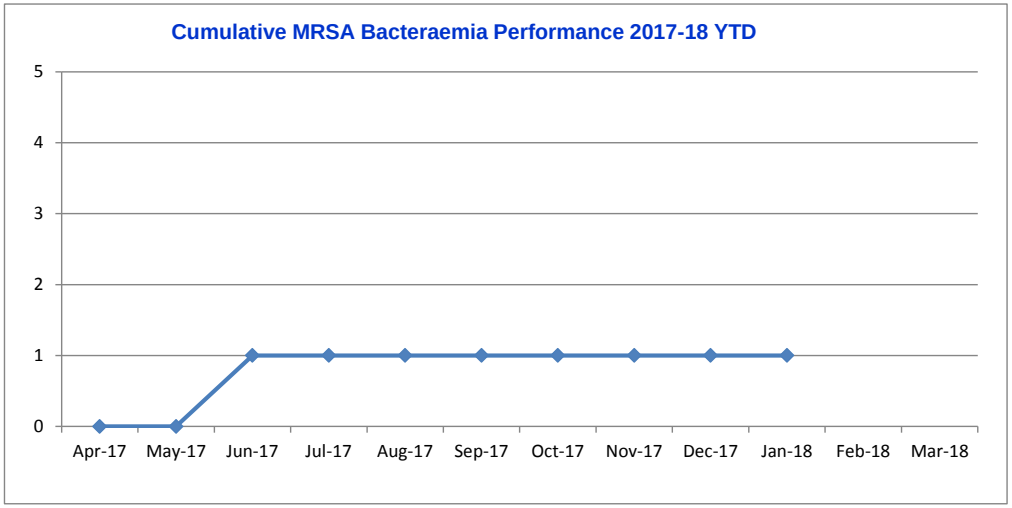
Infection Prevention and Control Board Report Objectives & Outcomes: January 2018

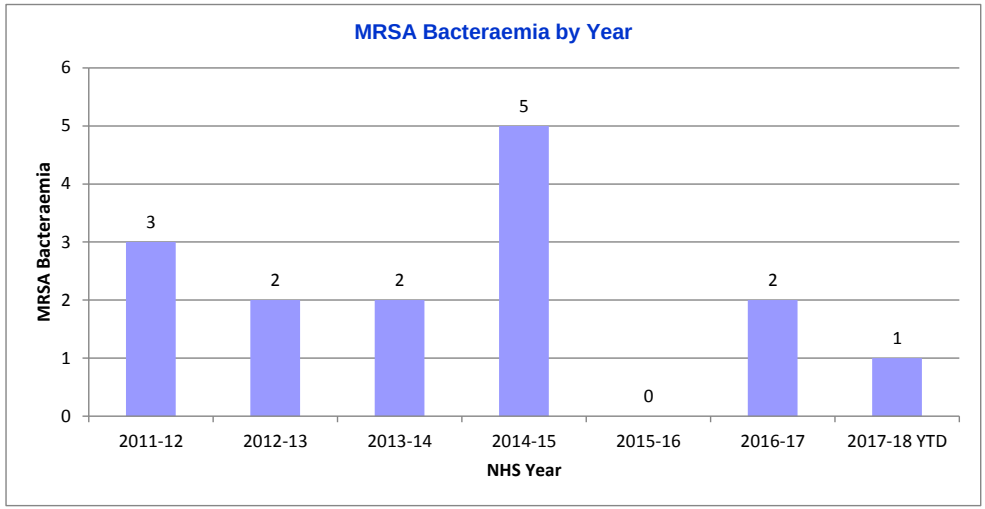
Note: RAG ratings are based on performance against set targets, previous year's performance or PHE benchmarking data, as specified.

HCAI SURVEILLANCE	MRSA bacteraemias	0 hospital associated MRSA bacteraemias in January. Year to date position is 1 Trust allocated case (target 0 cases to year end)	Red
	C.difficile	3 Trust allocated *C.difficile* cases in January. Year to date position is 22 reported cases, of which 9 have been accepted by the CCG Appeals Panel for exemption against financial sanctions and 3 have been provisionally accepted. RAG rating is based on current position for the purpose of potential financial sanctions, 10 cases against the ceiling target of 11 cases to year end. Several further cases to be appealed at the next Appeal Panel meeting in March. Recorded cases in the Trust have increased since 2016 – see September report for further details.	Amber
	MSSA bacteraemias	3 Trust allocated MSSA bacteraemias in January. Year to date position is 17 cases (no target set). RAG rating based on 17 cases in 2016-17.	Amber
	Gram negative bacteraemia: National monitoring and reduction programme for E.*coli, Pseudomonas aeruginosa, Klebsiella species*.	2 Trust associated E.*coli* bacteraemias in January Year to date position is 29 cases (no target set). RAG rating based on 35 cases in 2016-17.	Green
		0 Trust associated *Pseudomonas aeruginosa* bacteraemias in January Year to date position is 1 case (no target set). RAG rating based on Trust rate of 0.59 cases per 100,000 bed days against EoE average of 3.54 cases.	Green
		0 Trust associated *Klebsiella species* bacteraemias in January Year to date position is 7 cases (no target set). RAG rating based on Trust rate of 4.11 cases per 100,000 bed days against EoE average of 6.65 cases.	Green
	Carbapenemase Producing Organisms (CPO)	0 new inpatient cases and 2 outpatient (Paediatrics & Renal) cases identified in January. These 2 cases were identified from samples taken at another hospital following the patients' admission there. The patients' medical histories are being reviewed to assess any potential risk factors relating to their care. The 2 cases identified in December are being investigated by the Medical Division as an IRI due to the possibility of cross-transmission. Year to date position is 8 inpatient cases and 6 outpatient cases (no target set). RAG rating based on 15 cases in 2016-17.	Amber

	Outbreaks / Periods of Increased Incidence	Several cases of suspected and confirmed viral gastroenteritis and influenza were identified in January, resulting in a number of precautionary bay closures to prevent potential outbreaks. A daily report is sent to PHE detailing numbers of confirmed influenza cases and also specifying any area closures due to gastroenteritis. This report is also circulated within the Trust. The IP&C Team are also liaising several times per day with the bed management and operations teams to facilitate safe and efficient use of beds. RAG rating based on successful measures to minimise bed closures and transmission, with no outbreaks or ward closures.	Green
	Surgical Site Infection	The Trust was identified as a high outlier for 2014-15 in all 3 orthopaedic categories monitored. Figures for 2015-17 to date indicate overall improvement and are now in line with national benchmarks – see page 12 for detailed figures. RAG rating based on reduced infection rates although further work needed to sustain reductions.	Amber
CQUINs	Antimicrobial stewardship	8.4% reduction ytd (Apr-Dec 17) in total antibiotic consumption (target 2% reduction on baseline data Jan-Dec 2016). Figures for Jan 2018 to be confirmed – RAG rating based on December figures. 50.6% reduction ytd (Apr-Dec 17) in piperacillin-tazobactam (target 2% reduction on baseline data Jan-Dec 2016). Figures for Jan 2018 to be confirmed – RAG rating based on December figures. 39.9% reduction ytd (Apr-Dec 17) in carbapenems (target 2% reduction on baseline data Jan-Dec 2016). Figures for Jan 2018 to be confirmed – RAG rating based on December figures.	Green
		Review of sepsis patients on antibiotics who are still inpatients at 72 hrs. Q1: 75% of cases reviewed within 72 hrs (target 25%) Q2: 78% of cases reviewed within 72 hrs (target 50%) Q3: 93% of cases reviewed within 72 hrs (target 75%) Q4 to date: Figures to be confirmed (target 90%). RAG rating based on December figures	Green
AUDITS	High Impact Interventions (HII)	HII audit scores in January were above 95% with the exception of Intravascular Devices Insertion, Urinary Catheter Insertion & Continuing Care, Renal Environment and MRSA Screening. RAG rating based on scores exceeding 95% in 7 out of 12 categories monitored.	Amber
SURVEILLANCE PROCESSES	ICNet	Potential solutions to resolve ongoing ICNet/TPP interface issue were presented to the IM&T Strategy Board in December 2016 and an outline business case for the reinstatement of the ICNet system has been prepared and is awaiting consideration.	Closed – on Risk Register
	Infection in Critical Care Quality Improvement Programme (ICCQIP)	CCU are participating in the voluntary national surveillance programme which commenced in 2017 for blood stream infections in intensive care units, with the aim of reducing the number of such infections. Data was presented at the January TIPCC and will be presented quarterly.	Target TBC

MRSA BACTERAEMIA – POST 48 HRS





MRSA Bacteraemia by Division

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

MRSA – PHE Benchmarking Data (January 2018)

Public Health England

MRSA

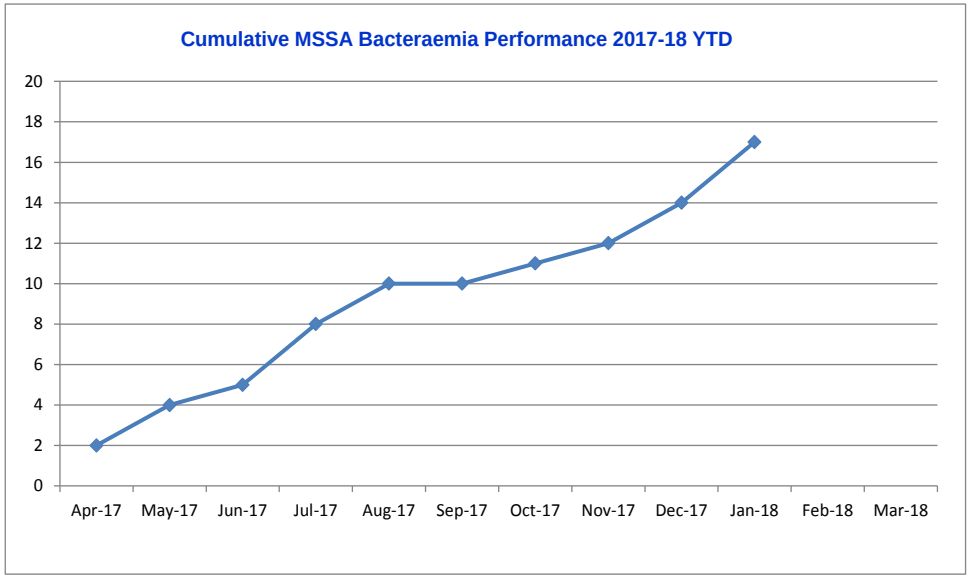
Count of trust PIR assigned cases per month

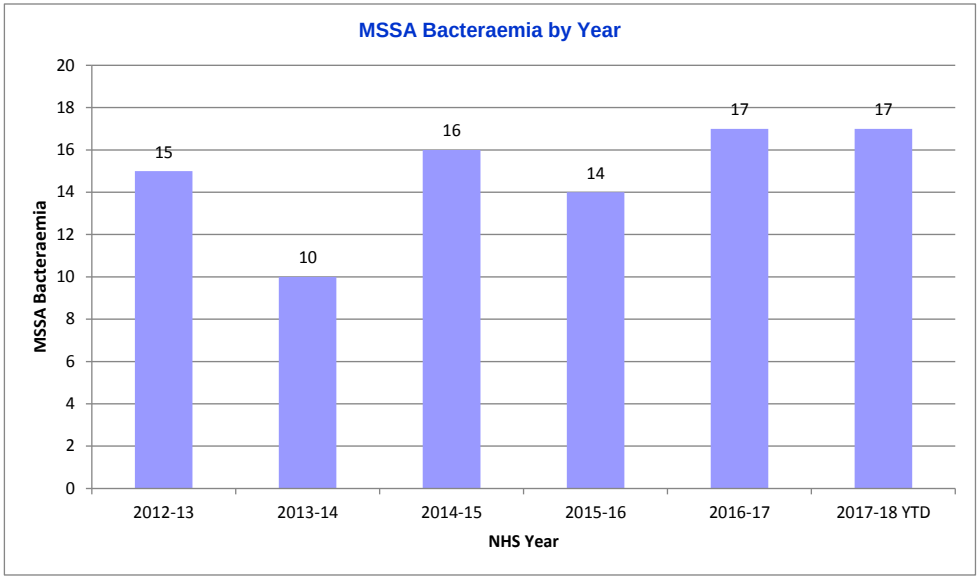
Trust Code	Acute Trust Name	Trajectory	2017									2018			Total
			April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	
RDD	Basildon & Thurrock University Hospitals NHS Foundation Trust	N/A	0	0	0	2	2	0	0	1	0	0			5
RC1	Bedford Hospitals NHS Trust	N/A	0	0	0	0	0	0	0	0	0	0			0
RGT	Cambridge University Hospitals NHS Foundation Trust	N/A	0	0	0	0	0	0	0	0	0	0			0
RDE	Colchester Hospitals University NHS Foundation Trust	N/A	0	0	0	0	0	0	0	0	2	0			2
RWH	East & North Hertfordshire NHS Trust	N/A	0	0	1	0	0	0	0	0	0	0			1
RGQ	Ipswich Hospital NHS Trust	N/A	0	1	0	0	0	0	0	0	0	0			1
RGP	James Paget University Hospitals NHS Foundation Trust	N/A	0	0	0	0	0	0	0	0	0	0			0
RC9	Luton & Dunstable Hospital NHS Foundation Trust	N/A	0	0	0	0	0	0	0	1	0	0			1
RQ8	Mid Essex Hospital Services NHS Trust	N/A	2	0	0	0	0	0	0	0	2	2			6
RD8	Milton Keynes Hospital NHS Foundation Trust	N/A	0	0	1	0	1	0	0	0	0	0			2
RM1	Norfolk & Norwich University Hospitals NHS Foundation Trust	N/A	0	0	0	0	0	0	0	0	0	0			0
RGN	North West Anglia NHS Foundation Trust	N/A	1	0	0	0	0	0	0	0	0	0			1
RGM	Papworth Hospital NHS Foundation Trust	N/A	0	0	0	0	0	1	1	0	0	0			2
RQW	Princess Alexandra Hospital NHS Trust	N/A	0	0	0	0	0	0	0	0	0	0			0
RAJ	Southend University Hospital NHS Foundation Trust	N/A	1	0	0	1	2	0	0	0	0	1			5
RCX	The Queen Elizabeth Hospital King's Lynn NHS Trust	N/A	0	0	0	0	0	0	0	0	0	0			0
RWG	West Hertfordshire Hospitals NHS Trust	N/A	0	0	0	1	0	0	0	0	0	0			1
RGR	West Suffolk Hospitals NHS Trust	N/A	0	0	0	0	0	0	0	0	0	0			0
	East of England Total	**N/A**	**4**	**1**	**2**	**4**	**5**	**1**	**1**	**2**	**4**	**3**			**27**
	England Total	**N/A**	**32**	**29**	**25**	**23**	**27**	**19**	**23**	**27**	**21**	**29**			**255**

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

Trust Code	Acute Trust Name	Trajectory	2017									2018			Total
			April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	
RDD	Basildon & Thurrock University Hospitals NHS Foundation Trust	N/A	0.00	0.00	0.00	10.44	10.44	0.00	0.00	5.39	0.00	0.00			2.64
RC1	Bedford Hospitals NHS Trust	N/A	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00			0.00
RGT	Cambridge University Hospitals NHS Foundation Trust	N/A	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00			0.00
RDE	Colchester Hospitals University NHS Foundation Trust	N/A	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	12.53	0.00			1.27
RWH	East & North Hertfordshire NHS Trust	N/A	0.00	0.00	6.01	0.00	0.00	0.00	0.00	0.00	0.00	0.00			0.59
RGQ	Ipswich Hospital NHS Trust	N/A	0.00	5.89	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00			0.59
RGP	James Paget University Hospitals NHS Foundation Trust	N/A	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00			0.00
RC9	Luton & Dunstable Hospital NHS Foundation Trust	N/A	0.00	0.00	0.00	0.00	0.00	0.00	0.00	5.99	0.00	0.00			0.59
RQ8	Mid Essex Hospital Services NHS Trust	N/A	13.62	0.00	0.00	0.00	0.00	0.00	0.00	0.00	13.62	13.62			4.12
RD8	Milton Keynes Hospital NHS Foundation Trust	N/A	0.00	0.00	7.95	0.00	7.69	0.00	0.00	0.00	0.00	0.00			1.55
RM1	Norfolk & Norwich University Hospitals NHS Foundation Trust	N/A	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00			0.00
RGN	North West Anglia NHS Foundation Trust	N/A	4.74	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00			0.48
RGM	Papworth Hospital NHS Foundation Trust	N/A	0.00	0.00	0.00	0.00	0.00	18.96	18.35	0.00	0.00	0.00			3.71
RQW	Princess Alexandra Hospital NHS Trust	N/A	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00			0.00
RAJ	Southend University Hospital NHS Foundation Trust	N/A	6.94	0.00	0.00	6.94	13.88	0.00	0.00	0.00	0.00	6.94			3.51
RCX	The Queen Elizabeth Hospital King's Lynn NHS Trust	N/A	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00			0.00
RWG	West Hertfordshire Hospitals NHS Trust	N/A	0.00	0.00	0.00	5.16	0.00	0.00	0.00	0.00	0.00	0.00			0.52
RGR	West Suffolk Hospitals NHS Trust	N/A	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00			0.00
	East of England Total	**N/A**	**1.44**	**0.35**	**0.72**	**1.44**	**1.81**	**0.36**	**0.35**	**0.71**	**1.38**	**1.04**			**0.96**
	England Total	**N/A**	**1.13**	**0.99**	**0.88**	**0.79**	**0.93**	**0.68**	**0.79**	**0.96**	**0.72**	**1.00**			**0.89**

MSSA BACTERAEMIA - POST 48 HRS





Hospital acquired MSSA Bacteraemia by Division

Division	2016-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	2017-18 YTD
Cancer	0	0	0	0	0	0	0	0	0	0	0			0
Medicine	10	0	1	0	1	0	0	1	0	0	0			3
Surgical	5	0	1	0	1	2	0	0	1	1	3			9
Women & Children	1	1	0	0	1	0	0	0	0	1	0			3
MVCC	1	1	0	1	0	0	0	0	0	0	0			2
Grand Total	17	2	2	1	3	2	0	1	1	2	3			17

MSSA – PHE Benchmarking Data (January 2018)

Public Health England

MSSA

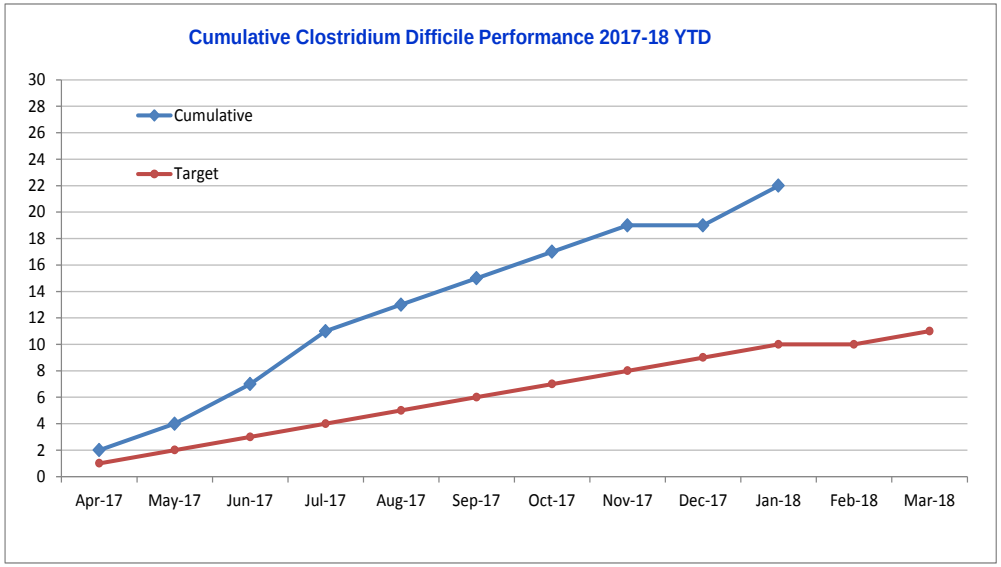
Count of all cases identified by acute trust per month

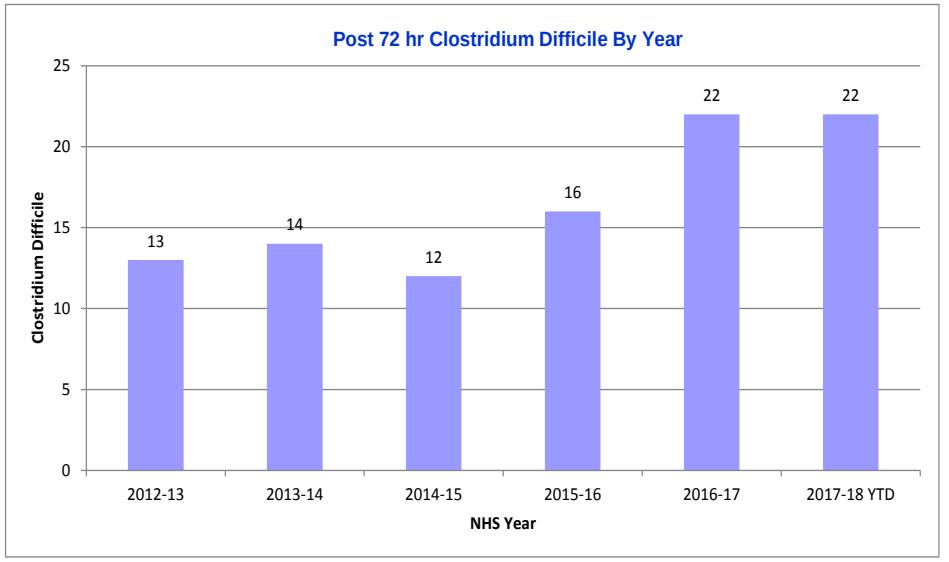
Trust Code	Acute Trust Name	Trajectory	2017									2018			Total
			April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	
RDD	Basildon & Thurrock University Hospitals NHS Foundation Trust	N/A	1	2	4	1	1	1	2	1	1	2			16
RC1	Bedford Hospitals NHS Trust	N/A	0	0	1	1	0	1	0	0	1	0			4
RGT	Cambridge University Hospitals NHS Foundation Trust	N/A	2	0	1	0	1	5	2	3	2	3			19
RDE	Colchester Hospitals University NHS Foundation Trust	N/A	1	2	2	2	2	1	0	0	2	1			13
RWH	East & North Hertfordshire NHS Trust	N/A	2	2	1	3	2	0	1	1	2	3			17
RGQ	Ipswich Hospital NHS Trust	N/A	1	0	1	0	3	1	1	0	2	4			13
RGP	James Paget University Hospitals NHS Foundation Trust	N/A	3	0	3	0	0	1	3	1	2	1			14
RC9	Luton & Dunstable Hospital NHS Foundation Trust	N/A	0	0	0	1	2	1	0	1	2	0			7
RQ8	Mid Essex Hospital Services NHS Trust	N/A	1	1	2	2	0	3	2	1	0	3			15
RD8	Milton Keynes Hospital NHS Foundation Trust	N/A	2	2	1	2	2	4	4	0	0	2			19
RM1	Norfolk & Norwich University Hospitals NHS Foundation Trust	N/A	3	1	3	4	1	0	2	0	1	0			15
RGN	North West Anglia NHS Foundation Trust	N/A	0	1	1	2	1	2	2	0	1	1			11
RGM	Papworth Hospital NHS Foundation Trust	N/A	1	2	0	0	1	2	1	1	0	0			8
RQW	Princess Alexandra Hospital NHS Trust	N/A	0	0	1	0	0	0	0	1	1	0			3
RAJ	Southend University Hospital NHS Foundation Trust	N/A	1	2	0	1	1	1	1	0	1	1			9
RCX	The Queen Elizabeth Hospital King's Lynn NHS Trust	N/A	0	1	2	1	2	1	1	1	1	1			11
RWG	West Hertfordshire Hospitals NHS Trust	N/A	3	3	1	1	1	1	1	1	1	1			14
RGR	West Suffolk Hospitals NHS Trust	N/A	0	1	1	0	1	1	0	1	3	1			9
	East of England Total	**N/A**	**21**	**20**	**25**	**21**	**21**	**26**	**23**	**13**	**23**	24			**217**
	England Total	**N/A**	**255**	**295**	**264**	**249**	**270**	**256**	**291**	**257**	**267**	**252**			**2656**

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

Trust Code	Acute Trust Name	Trajectory	2017									2018			Total
			April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	
RDD	Basildon & Thurrock University Hospitals NHS Foundation Trust	N/A	5.39	10.44	21.58	5.22	5.22	5.39	10.44	5.39	5.22	10.44			8.46
RC1	Bedford Hospitals NHS Trust	N/A	0.00	0.00	9.11	8.82	0.00	9.11	0.00	0.00	8.82	0.00			3.56
RGT	Cambridge University Hospitals NHS Foundation Trust	N/A	7.53	0.00	3.89	0.00	3.76	19.44	7.53	11.67	7.53	11.29			7.22
RDE	Colchester Hospitals University NHS Foundation Trust	N/A	6.27	12.53	12.95	12.53	12.53	6.47	0.00	0.00	12.53	6.27			8.22
RWH	East & North Hertfordshire NHS Trust	N/A	11.63	11.63	6.01	17.44	11.63	0.00	5.81	6.01	11.63	17.44			9.98
RGQ	Ipswich Hospital NHS Trust	N/A	5.89	0.00	6.09	0.00	17.67	6.09	5.89	0.00	11.78	23.56			7.73
RGP	James Paget University Hospitals NHS Foundation Trust	N/A	27.09	0.00	27.99	0.00	0.00	9.33	27.09	9.33	18.06	9.03			12.76
RC9	Luton & Dunstable Hospital NHS Foundation Trust	N/A	0.00	0.00	0.00	5.79	11.59	5.99	0.00	5.99	11.59	0.00			4.10
RQ8	Mid Essex Hospital Services NHS Trust	N/A	6.81	6.81	14.07	13.62	0.00	21.10	13.62	7.03	0.00	20.42			10.31
RD8	Milton Keynes Hospital NHS Foundation Trust	N/A	15.38	15.38	7.95	15.38	15.38	31.79	30.76	0.00	0.00	15.38			14.76
RM1	Norfolk & Norwich University Hospitals NHS Foundation Trust	N/A	10.73	3.58	11.09	14.31	3.58	0.00	7.15	0.00	3.58	0.00			5.42
RGN	North West Anglia NHS Foundation Trust	N/A	0.00	4.74	4.90	9.49	4.74	9.81	9.49	0.00	4.74	4.74			5.27
RGM	Papworth Hospital NHS Foundation Trust	N/A	18.35	36.70	0.00	0.00	18.35	37.92	18.35	18.96	0.00	0.00			14.82
RQW	Princess Alexandra Hospital NHS Trust	N/A	0.00	0.00	7.65	0.00	0.00	0.00	0.00	7.65	7.41	0.00			2.24
RAJ	Southend University Hospital NHS Foundation Trust	N/A	6.94	13.88	0.00	6.94	6.94	7.17	6.94	0.00	6.94	6.94			6.31
RCX	The Queen Elizabeth Hospital King's Lynn NHS Trust	N/A	0.00	8.46	17.48	8.46	16.92	8.74	8.46	8.74	8.46	8.46			9.40
RWG	West Hertfordshire Hospitals NHS Trust	N/A	15.47	15.47	5.33	5.16	5.16	5.33	5.16	5.33	5.16	5.16			7.29
RGR	West Suffolk Hospitals NHS Trust	N/A	0.00	8.16	8.43	0.00	8.16	8.43	0.00	8.43	24.48	8.16			7.43
	East of England Total	**N/A**	**7.54**	**6.95**	**8.98**	**7.59**	**7.59**	**9.29**	**7.96**	**4.65**	**7.96**	**8.30**			**7.68**
	England Total	**N/A**	**9.00**	**10.08**	**9.32**	**8.57**	**9.30**	**9.11**	**10.02**	**9.15**	**9.19**	**8.68**			**9.24**

CLOSTRIDIUM DIFFICILE – HOSPITAL ACQUIRED





Post 72 hr Clostridium Difficile by Division

Division	2016-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	2017-18 YTD
Cancer	0	0	0	0	0	0	0	0	0	0	0			0
Medicine	14	2	1	3	3	0	2	1	0	0	3			15
Surgical	8	0	1	0	1	2	0	1	1	0	0			6
Women & Children	0	0	0	0	0	0	0	0	0	0	0			0
MVCC	0	0	0	0	0	0	0	0	1	0	0			1
Grand Total	22	2	2	3	4	2	2	2	2	0	3			22

Summary of reviews of the 22 Trust allocated cases to end January:

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

C.DIFFICILE – PHE Benchmarking Data (January 2018)

Public Health England

Clostridium difficile

Count of acute trust apportioned cases per month

Trust Code	Acute Trust Name	Trajectory	2017									2018			Total
			April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	
RDD	Basildon & Thurrock University Hospitals NHS Foundation Trust	31	5	1	2	1	1	2	1	1	5	2			21
RC1	Bedford Hospitals NHS Trust	10	0	1	1	0	1	2	0	1	1	2			9
RGT	Cambridge University Hospitals NHS Foundation Trust	49	1	11	4	7	5	8	5	4	6	2			53
RDE	Colchester Hospitals University NHS Foundation Trust	18	0	3	3	1	1	2	0	1	4	3			18
RWH	East & North Hertfordshire NHS Trust	11	2	2	2*	4	2	2	1*	2	0	3			20*
RGQ	Ipswich Hospital NHS Trust	18	1	3	1	8	2	1	1	1	0	0			18
RGP	James Paget University Hospitals NHS Foundation Trust	17	0	2	3	3	1	0	2	2	0	1			14
RC9	Luton & Dunstable Hospital NHS Foundation Trust	6	1	2	1	1	1	1	1	0	1	0			9
RQ8	Mid Essex Hospital Services NHS Trust	13	8	3	2	5	7	3	2	4	5	5			44
RD8	Milton Keynes Hospital NHS Foundation Trust	39	1	0	0	1	3	0	1	0	1	3			10
RM1	Norfolk & Norwich University Hospitals NHS Foundation Trust	49	2	1	6	3	3	3	4	4	2	3			31
RGN	North West Anglia NHS Foundation Trust	40	7	4	4	4	3	8	3	6	2	1			42
RGM	Papworth Hospital NHS Foundation Trust	5	0	0	0	0	0	0	2	0	0	0			2
RQW	Princess Alexandra Hospital NHS Trust	10	1	0	1	4	0	3	0	1	0	2			12
RAJ	Southend University Hospital NHS Foundation Trust	30	5	2	4	1	3	1	1	4	7	2			30
RCX	The Queen Elizabeth Hospital King's Lynn NHS Trust	53	2	3	4	5	3	5	7	4	1	3			37
RWG	West Hertfordshire Hospitals NHS Trust	23	1	1	4	0	0	0	3	5	1	6			21
RGR	West Suffolk Hospitals NHS Trust	16	3	0	0	1	0	2	6	4	0	1			17
	East of England Total	**438**	**40**	**39**	**42**	**49**	**36**	**43**	**40**	**44**	**36**	**39**			**408**
	England Total	**2945**	**345**	**372**	**411**	**467**	**400**	**408**	**411**	**389**	**353**	**384**			**3940**

*** Figures shown for ENHT exclude 1 case in June which does not meet PHE criteria for inclusion but which is Trust associated, and also 1 case in October which is not yet shown due to a data error**

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

Trust Code	Acute Trust Name	Trajectory	2017									2018			Total
			April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	
RDD	Basildon & Thurrock University Hospitals NHS Foundation Trust	13.60	26.97	5.22	10.79	5.22	5.22	10.79	5.22	5.39	26.10	10.44			11.11
RC1	Bedford Hospitals NHS Trust	8.30	0.00	8.82	9.11	0.00	8.82	18.22	0.00	9.11	8.82	17.63			8.01
RGT	Cambridge University Hospitals NHS Foundation Trust	15.60	3.76	41.40	15.56	26.34	18.82	31.11	18.82	15.56	22.58	7.53			20.14
RDE	Colchester Hospitals University NHS Foundation Trust	9.10	0.00	18.80	19.42	6.27	6.27	12.95	0.00	6.47	25.06	18.80			11.39
RWH	East & North Hertfordshire NHS Trust	4.90	11.63	11.63	12.02*	23.26	11.63	12.02	5.81*	12.02	0.00	17.44			11.74*
RGQ	Ipswich Hospital NHS Trust	9.40	5.89	17.67	6.09	47.11	11.78	6.09	5.89	6.09	0.00	0.00			10.70
RGP	James Paget University Hospitals NHS Foundation Trust	13.10	0.00	18.06	27.99	27.09	9.03	0.00	18.06	18.66	0.00	9.03			12.76
RC9	Luton & Dunstable Hospital NHS Foundation Trust	3.10	5.79	11.59	5.99	5.79	5.79	5.99	5.79	0.00	5.79	0.00			5.27
RQ8	Mid Essex Hospital Services NHS Trust	7.30	54.46	20.42	14.07	34.04	47.65	21.10	13.62	28.14	34.04	34.04			30.25
RD8	Milton Keynes Hospital NHS Foundation Trust	25.80	7.69	0.00	0.00	7.69	23.07	0.00	7.69	0.00	7.69	23.07			7.77
RM1	Norfolk & Norwich University Hospitals NHS Foundation Trust	15.10	7.15	3.58	22.18	10.73	10.73	11.09	14.31	14.79	7.15	10.73			11.20
RGN	North West Anglia NHS Foundation Trust	tbc	33.21	18.98	19.61	18.98	14.23	39.23	14.23	29.42	9.49	4.74			20.12
RGM	Papworth Hospital NHS Foundation Trust	7.00	0.00	0.00	0.00	0.00	0.00	0.00	36.70	0.00	0.00	0.00			3.71
RQW	Princess Alexandra Hospital NHS Trust	6.50	7.41	0.00	7.65	29.62	0.00	22.96	0.00	7.65	0.00	14.81			8.97
RAJ	Southend University Hospital NHS Foundation Trust	17.30	34.71	13.88	28.70	6.94	20.83	7.17	6.94	28.70	48.60	13.88			21.03
RCX	The Queen Elizabeth Hospital King's Lynn NHS Trust	38.00	16.92	25.37	34.96	42.29	25.37	43.70	59.21	34.96	8.46	25.37			31.60
RWG	West Hertfordshire Hospitals NHS Trust	10.90	5.16	5.16	21.31	0.00	0.00	0.00	15.47	26.64	5.16	30.94			10.93
RGR	West Suffolk Hospitals NHS Trust	12.50	24.48	0.00	0.00	8.16	0.00	16.87	48.97	33.73	0.00	8.16			14.04
	East of England Total	**13.70**	**14.36**	**13.55**	**15.08**	**17.70**	**13.00**	**15.37**	**13.84**	**15.73**	**12.45**	**13.49**			**14.44**
	England Total	**13.13**	**12.18**	**12.71**	**14.51**	**16.08**	**13.77**	**14.52**	**14.15**	**13.84**	**12.16**	**13.22**			**13.71**

*** Figures shown for ENHT exclude 1 case in June which does not meet PHE criteria for inclusion but which is Trust associated, and also 1 case in October which is not yet shown due to a data error**

CARBAPENEMASE-PRODUCING ORGANISMS (CPO)

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

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

The 2 cases identified in December are being investigated due to probable cross-transmission of infection. Both cases are the same organism (*Pseudomonas aeruginosa*) with the same resistance mechanism (VIM), and both patients had previously attended the same clinic on the same day. Practices are being reviewed and the department has implemented a number of changes.

Carbapenemase-Producing Organisms - 2017-18

Division/Dept		2016-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	YTD 2017-18
INPATIENTS	Renal Ward - Lister	3	0	0	1	0	0	0	0	0	0	0			1
	Medicine	3	0	1	0	0	0	0	0	0	0	0			1
	Surgery	7	1	0	0	0	1	1	1	0	1	0			5
	W&C	0	0	0	0	1	0	0	0	0	0	0			1
	MVCC	0	0	0	0	0	0	0	0	0	0	0			0
RENAL DIALYSIS UNITS	Lister	1	0	0	0	0	0	0	0	0	0	0			0
	L&D	0	0	0	0	0	0	0	0	0	0	0			0
	Harlow	0	0	0	0	0	0	0	0	0	0	1			0
	St Albans	0	0	0	0	0	0	0	0	0	0	0			0
	Bedford	0	0	0	0	0	0	0	0	0	0	0			0
OUTPATIENTS	Lister	0	0	1	0	0	0	1	0	0	1	1			4
	QEII	1	0	0	0	0	0	0	0	0	0	0			0
	HCH	0	0	0	0	0	0	0	0	0	0	0			0
	MVCC	0	0	0	0	0	0	0	1	0	0	0			1
TOTAL (TRUST PATIENTS)		15	1	2	1	1	1	2	2	0	2	2			14

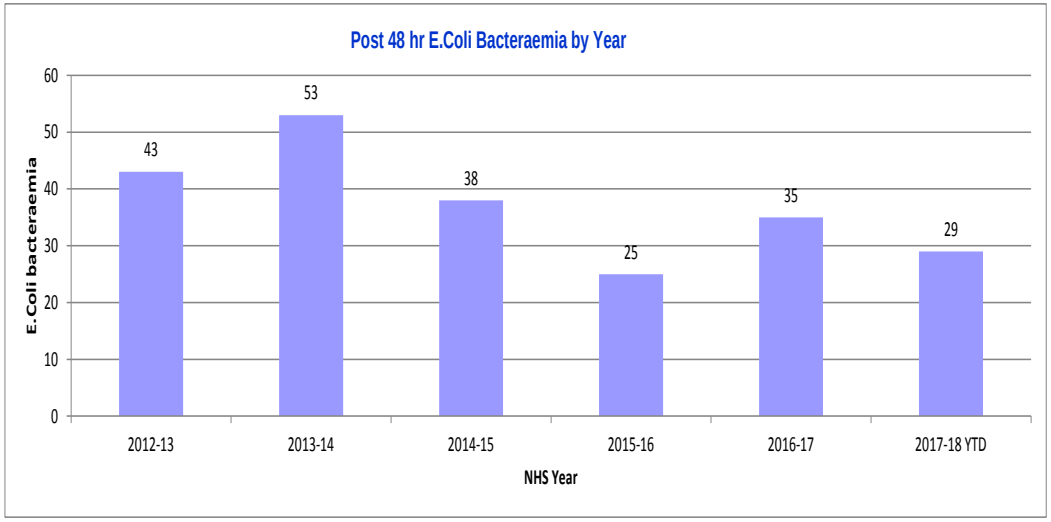
Note: The 2 cases listed in January were identified from samples taken at a different hospital, but included here as both patients are regular attenders at ENHT.

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

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

E.COLI BACTERAEMIA – POST 48 HRS

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



Hospital acquired E.Coli Bacteraemia by Division

Division	2016-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	2017-18 YTD
Cancer	0	0	0	0	0	0	0	0	0	0	0			0
Medicine	16	3	3	2	2	2	2	2	0	0	2			18
Surgical	16	1	2	1	1	0	2	1	0	0	0			8
Women & Children	1	0	2	0	0	0	0	0	1	0	0			3
MVCC	2	0	0	0	0	0	0	0	0	0	0			0
Grand Total	35	4	7	3	3	2	4	3	1	0	2			29

E.COLI – PHE Benchmarking Data (January 2018)

Public Health England

Escherichia coli

Hospital onset cases per month (sample taken later than day following admission)

Trust Code	Acute Trust Name	Trajectory	2017									2018			Total
			April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	
RDD	Basildon & Thurrock University Hospitals NHS Foundation Trust	N/A	3	3	2	4	3	7	5	5	8	2			**42**
RC1	Bedford Hospitals NHS Trust	N/A	1	3	1	0	3	0	1	2	2	1			**14**
RGT	Cambridge University Hospitals NHS Foundation Trust	N/A	13	8	7	8	11	6	10	11	3	10			**87**
RDE	Colchester Hospitals University NHS Foundation Trust	N/A	5	5	1	2	4	0	2	7	2	2			**30**
RWH	East & North Hertfordshire NHS Trust	N/A	4	7	3	3	2	4	3	1	0	2			**29**
RGQ	Ipswich Hospital NHS Trust	N/A	4	3	3	2	3	1	1	5	1	0			**23**
RGP	James Paget University Hospitals NHS Foundation Trust	N/A	1	4	3	3	1	2	2	0	3	5			**24**
RC9	Luton & Dunstable Hospital NHS Foundation Trust	N/A	2	2	3	3	0	3	3	0	2	2			**20**
RQ8	Mid Essex Hospital Services NHS Trust	N/A	2	5	5	1	1	2	5	4	4	0			**29**
RD8	Milton Keynes Hospital NHS Foundation Trust	N/A	2	2	4	4	1	1	4	1	4	2			**25**
RM1	Norfolk & Norwich University Hospitals NHS Foundation Trust	N/A	1	4	6	5	4	5	11	9	3	4			**52**
RGN	North West Anglia NHS Foundation Trust	N/A	2	4	1	4	5	5	3	4	4	6			**38**
RGM	Papworth Hospital NHS Foundation Trust	N/A	0	1	0	1	0	1	1	1	2	1			**8**
RQW	Princess Alexandra Hospital NHS Trust	N/A	2	1	2	0	2	3	4	2	1	0			**17**
RAJ	Southend University Hospital NHS Foundation Trust	N/A	3	1	2	3	2	5	3	4	4	0			**27**
RCX	The Queen Elizabeth Hospital King's Lynn NHS Trust	N/A	4	4	2	3	0	4	2	5	4	2			**30**
RWG	West Hertfordshire Hospitals NHS Trust	N/A	1	1	5	8	3	2	4	4	2	2			**32**
RGR	West Suffolk Hospitals NHS Trust	N/A	2	0	2	3	1	2	1	2	3	2			**18**
	East of England Total	**N/A**	**52**	**58**	**52**	**57**	**46**	**53**	**65**	**67**	**52**	**43**			**545**
	England Total	**N/A**	**610**	**689**	**681**	**660**	**649**	**676**	**667**	**664**	**581**	**642**			**6519**

Monthly rate per 100,000 occupied bed days (hospital onset cases only)

Trust Code	Acute Trust Name	Trajectory	2017									2018			Total
			April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	
RDD	Basildon & Thurrock University Hospitals NHS Foundation Trust	N/A	16.18	15.66	10.79	20.88	15.66	37.76	26.10	26.97	41.77	10.44			**22.21**
RC1	Bedford Hospitals NHS Trust	N/A	8.82	26.45	9.11	0.00	26.45	0.00	8.82	18.22	17.63	8.82			**12.46**
RGT	Cambridge University Hospitals NHS Foundation Trust	N/A	48.92	30.11	27.22	30.11	41.40	23.33	37.63	42.78	11.29	37.63			**33.06**
RDE	Colchester Hospitals University NHS Foundation Trust	N/A	31.33	31.33	6.47	12.53	25.06	0.00	12.53	45.32	12.53	12.53			**18.98**
RWH	East & North Hertfordshire NHS Trust	N/A	23.26	40.70	18.03	17.44	11.63	24.03	17.44	6.01	0.00	11.63			**17.03**
RGQ	Ipswich Hospital NHS Trust	N/A	23.56	17.67	18.26	11.78	17.67	6.09	5.89	30.43	5.89	0.00			**13.68**
RGP	James Paget University Hospitals NHS Foundation Trust	N/A	9.03	36.11	27.99	27.09	9.03	18.66	18.06	0.00	27.09	45.14			**21.88**
RC9	Luton & Dunstable Hospital NHS Foundation Trust	N/A	11.59	11.59	17.96	17.38	0.00	17.96	17.38	0.00	11.59	11.59			**11.70**
RQ8	Mid Essex Hospital Services NHS Trust	N/A	13.62	34.04	35.17	6.81	6.81	14.07	34.04	28.14	27.23	0.00			**19.94**
RD8	Milton Keynes Hospital NHS Foundation Trust	N/A	15.38	15.38	31.79	30.76	7.69	7.95	30.76	7.95	30.76	15.38			**19.41**
RM1	Norfolk & Norwich University Hospitals NHS Foundation Trust	N/A	3.58	14.31	22.18	17.89	14.31	18.48	39.35	33.27	10.73	14.31			**18.78**
RGN	North West Anglia NHS Foundation Trust	N/A	9.49	18.98	4.90	18.98	23.72	24.52	14.23	19.61	18.98	28.47			**18.21**
RGM	Papworth Hospital NHS Foundation Trust	N/A	0.00	18.35	0.00	18.35	0.00	18.96	18.35	18.96	36.70	18.35			**14.82**
RQW	Princess Alexandra Hospital NHS Trust	N/A	14.81	7.41	15.31	0.00	14.81	22.96	29.62	15.31	7.41	0.00			**12.71**
RAJ	Southend University Hospital NHS Foundation Trust	N/A	20.83	6.94	14.35	20.83	13.88	35.87	20.83	28.70	27.77	0.00			**18.93**
RCX	The Queen Elizabeth Hospital King's Lynn NHS Trust	N/A	33.83	33.83	17.48	25.37	0.00	34.96	16.92	43.70	33.83	16.92			**25.62**
RWG	West Hertfordshire Hospitals NHS Trust	N/A	5.16	5.16	26.64	41.25	15.47	10.66	20.63	21.31	10.31	10.31			**16.66**
RGR	West Suffolk Hospitals NHS Trust	N/A	16.32	0.00	16.87	24.48	8.16	16.87	8.16	16.87	24.48	16.32			**14.45**
	East of England Total	**N/A**	**18.67**	**20.15**	**18.67**	**20.59**	**16.62**	**18.94**	**22.48**	**23.95**	**17.99**	**14.87**			**19.29**
	England Total	**N/A**	**21.54**	**23.54**	**24.04**	**22.73**	**22.35**	**24.05**	**22.97**	**23.63**	**20.01**	**22.11**			**22.69**

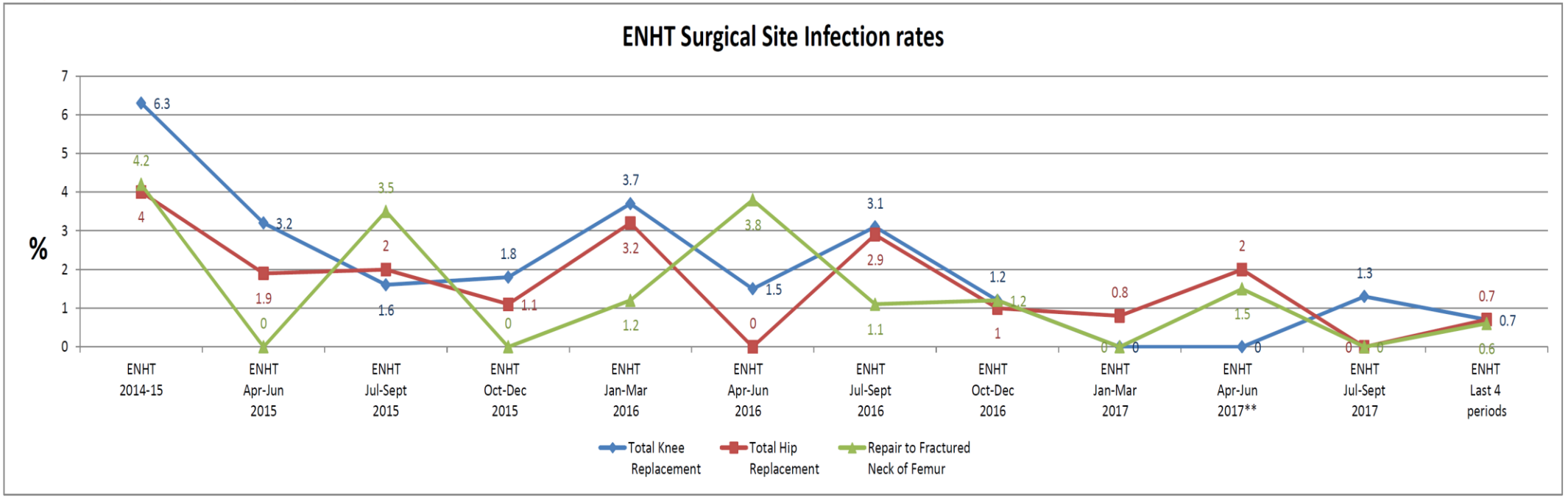
Surgical Site Infection Rates

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

Category / Quarter	Oct-Dec 14 ENHT	Apr-Jun 15 ENHT	Jul-Sept 15 ENHT	Oct-Dec 15 ENHT	Jan-Mar 16 ENHT	Apr-Jun 16 ENHT	Jul-Sept 16 ENHT	Oct-Dec 16 ENHT	Jan-Mar 17 ENHT	Apr-Jun 17 **ENHT	Jul-Sept 17 ENHT	* Last 4 periods ENHT	2012-2016 National Benchmarks
Total Knee Replacement	**6.3%**	**3.2%**	**1.6%**	**1.8%**	**3.7%**	**1.5%**	**3.1%**	**1.2%**	**0%**	**0%**	**1.3%**	**0.7%**	**0.5%**
TKR infections/ops	5 / 80	2 / 63	1 / 64	1 / 57	2 / 54	1 / 66	2 / 65	1 / 85	0 / 77	0 / 60	1 / 76	2 / 298	
Total Hip Replacement	**4%**	**1.9%**	**2%**	**1.1%**	**3.2%**	**0%**	**2.9%**	**1%**	**0.8%**	**2%**	**0%**	**0.7%**	**0.7%**
THR infections/ops	4 / 101	2 / 103	2 / 100	1 / 89	3 / 94	0 / 94	3 / 105	1 / 99	1 / 129	2 / 98	0 / 111	3 / 437	
Repair Fractured Neck of Femur	**4.2%**	**0%**	**3.5%**	**0%**	**1.2%**	**3.8%**	**1.1%**	**1.2%**	**0%**	**1.5%**	**0%**	**0.6%**	**1.2%**
#NOF infections/ops	5 / 118	0 / 93	3 / 86	0 / 99	1 / 81	3 / 80	1 / 87	1 / 82	0 / 116	1 / 68	0 / 80	2 / 346	

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

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



High Impact Intervention Audit Scores

High Impact Interventions	2016-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	YTD 2017-18	RAG rate (Month on Month)
Hand Hygiene	96.48%	96.48%	96.80%	96.44%	92.02%	94.89%	96.42%	95.49%	93.03%	93.81%	96.24%			95.22%	▲
Surgical Site Observation	93.13%	94.57%	96.46%	97.87%	97.49%	96.57%	95.85%	95.74%	96.68%	96.79%	96.41%			96.48%	▼
Intravascular Devices (Insertion)	93.58%	95.44%	96.16%	95.16%	96.05%	93.93%	94.63%	95.38%	95.00%	94.19%	94.38%			95.04%	▲
Intravascular Devices (Continuing Care)	91.65%	93.29%	94.26%	95.27%	94.42%	95.04%	95.97%	95.37%	96.23%	96.12%	95.00%			95.07%	▼
Urinary Catheter (Insertion)	96.39%	94.26%	99.31%	96.60%	97.14%	95.86%	96.85%	95.56%	95.04%	95.92%	93.98%			96.04%	▼
Urinary Catheter (Continuing Care)	93.82%	88.00%	98.63%	93.92%	97.83%	98.57%	97.56%	97.79%	95.71%	97.93%	93.90%			96.01%	▼
Renal Dialysis (Continuing Care)	96.70%	100.00%	100.00%	100.00%	100.00%	100.00%	99.67%	100.00%	100.00%	98.58%	97.62%			99.60%	▼
Ventilator (Continuing Care)	97.00%	100.00%	81.48%	100.00%	100.00%	100.00%	100.00%	100.00%	96.77%	100.00%	97.14%			97.14%	▼
Environment (Inpatients)	96.70%	96.54%	97.25%	96.74%	96.46%	95.63%	95.63%	97.04%	95.97%	96.52%	95.73%			96.37%	▼
Environment (Outpatients)	97.17%	96.96%	96.50%	97.62%	96.85%	96.29%	96.32%	95.98%	96.79%	97.94%	95.96%			96.68%	▼
Environment (Renal Dialysis)	89.24%	91.18%	93.56%	91.07%	90.39%	85.60%	86.81%	89.96%	90.84%	89.30%	89.92%			89.88%	▲
MRSA Screening Compliance	96.42%	90.25%	97.09%	95.61%	98.03%	95.69%	93.93%	97.78%	96.94%	96.09%	93.57%			95.44%	▼

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

Agenda Item: 12

TRUST BOARD – MARCH 2018
FLOODLIGHT SCORECARD MONTH 10

PURPOSE	To inform Board of performance against Key Performance Indicators for the Trust in a number of domains.
PREVIOUSLY CONSIDERED BY	Board Committees
Objective(s) to which issue relates *	[X] 1. **Keeping our promises about quality and value** – embedding the changes resulting from delivery of Our Changing Hospitals Programme. [ ] 2. **Developing new services and ways of working** – delivered through working with our partner organisations [ ] **3. Delivering a positive and proactive approach to the redevelopment of the Mount Vernon Cancer Centre.**
Risk Issues (Quality, safety, financial, HR, legal issues, equality issues)	Exception reports for red floodlight areas are covered as follows: **Stroke performance** – within Performance report to FPC and Board **Finance** – reported to FPC and Board **Workforce** – reported to FPC and Board **Clinical Outcomes** – verbal update to be provided **Clinical Efficiency** – within Performance report to FPC and Board **Patient Experience** – reported to RAQC and Board **Patient Safety** – reported to RAQC and Board **MCF/TDA Performance Framework** – performance report to FPC and Board
Healthcare/ National Policy (includes CQC/Monitor)	Measures performance against CQC and other performance standards, as well as measuring patient experience. Governance and Regulation indicators assess compliance with statutory and other mandatory standards.
CRR/Board Assurance Framework *	[X] **Corporate Risk Register** [ ] **BAF**

ACTION REQUIRED *

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

DIRECTOR:	All Directors
PRESENTED BY:	Stabilisation Director
AUTHOR:	Stabilisation Director / All Directors
DATE:	February 2018

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

***** tick applicable box

East and North Hertfordshire NHS
NHS Trust

TRUST FLOODLIGHT

DASHBOARD AND SCORECARD 2017/18

January - Month 10

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

Trust Floodlights Dashboard
January 2018 (M10)

East and North Hertfordshire NHS
NHS Trust

Report Structure

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

Trust Floodlights Dashboard January 2018 (M10)

Monthly Information, Performance and RAG Rating

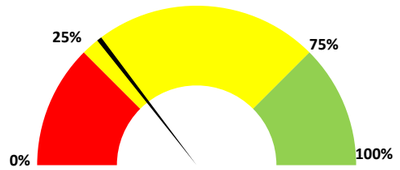
1 - Safe

Percentage of KPIs met

KPI Performance					
Improved		No Change		Declined	
	7		3		9

2- Effective

Percentage of KPIs met



KPI Performance					
Improved		No Change		Declined	
	2		2		3

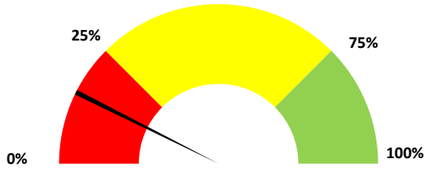
3 - Responsive - Efficiency

Percentage of KPIs met

KPI Performance					
Improved		No Change		Declined	
	1		1		4

4 - Responsive - Key Targets

Percentage of KPIs met



KPI Performance					
Improved		No Change		Declined	
	8		1		5

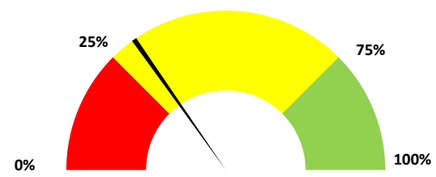
5 - Caring

Percentage of KPIs met

KPI Performance					
Improved		No Change		Declined	
	2		1		3

6 - Well-Led

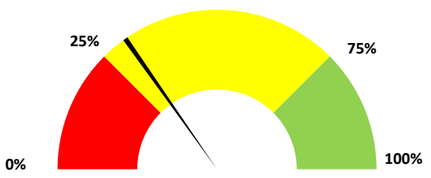
Percentage of KPIs met



KPI Performance					
Improved		No Change		Declined	
	5		4		1

7 - Financial Performance

Percentage of KPIs met



KPI Performance					
Improved		No Change		Declined	
	2		6		2

8 - Sustainability

Percentage of KPIs met

KPI Performance					
Improved		No Change		Declined	
	5		0		2

Trust Floodlights Dashboard January 2018 (M10)

Monthly Information, Performance and RAG Rating

SAFE

ID	Indicator (YTD)	Month Change
1.1	Never Events 4	
1.2	Safety Thermometer Patients with Harm 214	
1.3	Clostridium Difficile Cases 18	
1.4	MRSA Post 48 hours Cases 1	
1.5	Hospital Acquired Pressure Ulcers Grade 2 or higher 0.11	
1.6	Inpatient Falls 3.01	
1.7	Ambulance Handovers > 30 mins 1381	
1.8	Fill Rate RNs (%) 94.6	
1.9	Fill Rate RNs Unreg (%) 91.9	

EFFECTIVE

ID	Indicator (YTD)	Month Change
2.1	HSMR - 3 month lag 97.5	
2.2	SHMI - 6 month lag 102.14	
2.3	SHMI (Palliative Care Adjustment) - 6 month lag 94.5	

ADMISSIONS

2.4	Medical & Surgical Patient Outliers 85	
2.5	Number of Patients with LOS > 14 days 135	
2.6	LOS - Non Elective 3.6	
2.7	Readmissions 7.1	

RESPONSIVE-EFFICIENCY

ID	Indicator (YTD)	Month Change
3.1	New to Follow-Up Ratio 2.35	
3.2	Overnight Bed Occupancy Rate 87.3	
3.3	Pre OP bed days (elective)	
3.4	Delayed Transfer of Care 57	
3.5	Post Acute Transfer Delays	
3.6	Ward Discharges before Midday 14	
3.7	Cancelled Ops - on Day 649	
3.8	Number of Discharges from Discharge Lounge	

CARING

ID	Indicator (YTD)	Month Change
5.1	Inpatient FFT % of patients would recommend 97.2	
5.2	FFT Response Rate % 43.5	
5.3	Friends & Family Recommend Place of Care 74.4	
5.4	Complaints - % received telephone call 100.0	
5.5	% of Complaints concluded within agreed timeframe 65.4	
5.6	GP Enquiries Response Rate - Routine 55.0	
5.7	GP Enquiries Response Rate - Urgent 90.0	

WELL-LED

ID	Indicator (YTD)	Month Change
6.1	Continuity of Services Risk Rating	
6.2	Risk register	
6.3	CQC Outcomes	
6.4	NHSI Governance Risk Rating 3	
6.5	Friends & Family Recommend Place of Work 52.4	
6.6	Vacancy Rate % 8.5	
6.8	Bank Spend 9.27	
6.9	Agency Spend 4.31	
6.10	Sickness % 3.49	
6.11	Substantive Staff Turnover 13.3	
6.12	Appraisal Rate 83.56	

HEALTH & SAFETY

ID	Indicator (YTD)	Month Change
1.14	RIDDOR Incidents 0.58	
1.15	Musculosketal Injuries Reported 0.83	
1.16	Physical Assault Incidents 1.44	
1.17	Manager Referrals to OH for Stress 0.63	
1.18	Staff Slips, Trips & Falls 0.99	
1.19	Staff Sharps Injuries 2.23	

SUSTAINABILITY

ID	Indicator (YTD)	Month Change
8.1	GP referrals Received - 2WW 9866	
8.2	GP referrals Received - non 2WW 83679	
8.3	A&E Attendances 124946	
8.4	Elective Spells (PBR) 38776	
8.5	NonElective Spells 37421	
8.6	OP Attendances/Procs (Total) 383400	
8.7	Outpatient DNA Rate 9%	
8.8	Theatre Utilisation	

RESPONSIVE - KEY TARGETS

ID	Indicator (YTD)	Month Change
4.1	A&E 4 hour Target 83.9	
4.2	RTT Admitted 73.2	
4.3	RTT Non Admitted 85.5	
4.4	RTT - Open Pathways 85.7	
4.5	RTT Patients Waiting > 18 weeks 4834	
4.6 ##### 0	Diagnostic Waits < 6 weeks 98.7	
4.7	Cancer 2week Ref to Appt 97.8	
4.8	Cancer 31day : Diag 92.4	
4.9	Cancer 62day : Urgent RTT inc ITP transfers 75.5	
4.10	TIA: All Risks treatment within 24 hrs 46.2	
4.12	4 hrs direct to Stroke Unit 75.2	
4.13	90% of time on the Stroke Unit 86.7	
4.14	60 minutes to scan 88.9	
4.15	Thrombolysed within 3 hrs 7.4	

FINANCIAL PERFORMANCE

ID	Indicator (YTD)	Month Change
7.1	Capital Servicing Capacity 4	
7.2	Liquidity Ratio (days) 4	
7.3	I&E Margin 4	
7.4	Distance from financial plan 4	
7.5	Agency spend variance from ceiling 1	
7.6	Overall Finance Metric 3	
7.7	Pay Spend 100.0	
7.8	Capital Plan Trajectory 91	
7.9	CIP Plan delivered 72	
7.10	Cash Plan 163	

RESPONSIVE

ID	Indicator (YTD)	Month Change
1.10	Statutory Mandatory Training 86.08	
1.11	Safeguarding Adults Training 86.9	
1.12	Safeguarding Children Training 88.0	
1.13	Competancy Coverage 64.7	

Trust Floodlights Dashboard
January 2018 (M10)

Monthly Information, Performance and RAG Rating

1 - SAFE

ID	Indicator	Target 17-18	Target YTD	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position
1.1	Never Events	0		4	0			
1.2	Safety Thermometer Patients with Harm	336	280	214	22			
1.3	Clostridium Difficile Cases	11	10	18	0			
1.4	MRSA Post 48 hours Cases	0		1	0			
1.5	Hospital Acquired Pressure Ulcers Grade 2 or higher	0.16		0.11	0.24			
1.6	Inpatient Falls	3.17		3.01	3.71			
1.7	Ambulance Handovers > 30 mins	2604	1736	1381	393			
1.8	Fill Rate RNs (%)	90		94.6	95.0			
1.9	Fill Rate RNs Unreg (%)	90		91.9	87.7			
1.10	Statutory Mandatory Training	90		86.1	86.1			
1.11	Safeguarding Adults Training	90		86.9	86.9			
1.12	Safeguarding Children Training	90		88.0	88.0			
1.13	Competancy Coverage	85		64.7	64.7			
1.14	RIDDOR Incidents	0.56		0.58	0.51			
1.15	Musculosketal Injuries Reported	1.09		0.83	0.68			
1.16	Physical Assault Incidents	1.13		1.44	1.19			
1.17	Manager Referrals to OH for Stress	0.57		0.63	0.68			
1.18	Staff Slips, Trips & Falls	1.18		0.99	1.02			
1.19	Staff Sharps Injuries	2.00		2.23	2.03			

2 - EFFECTIVE

ID	Indicator	Target 17-18	Target YTD	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position
2.1	HSMR - 3 month lag	94		97.5				
2.2	SHMI - 6 month lag	100		102.1				
2.3	SHMI (Palliative Care Adjustment) - 6 month lag	95		94.5				
2.4	Medical & Surgical Patient Outliers	50		85				
2.5	Number of Patients with LOS > 14 days	100		135				
2.6	LOS - Non Elective	3.5		3.6	3.2			
2.7	Readmissions	7.75		7.1	6.1			

3 - RESPONSIVE - EFFICIENCY

ID	Indicator	Target 17-18	Target YTD	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position
3.1	New to Follow-Up Ratio	2		2.35	2.35			
3.2	Overnight Bed Occupancy Rate	85		87.3	88.4			
3.3	Pre OP bed days (elective)	6		3.3	4.5			
3.4	Delayed Transfer of Care	8		57	7			
3.5	Post Acute Transfer-Total Avg beds blocked	Method of Data Collection and Definition to be confirmed						
3.6	Ward Discharges before Midday	13		14.3	14.7			
3.7	Cancelled Ops - on Day	504	378	649	56			
3.8	Number of Discharges from Discharge Lounge	Method of Data Collection and Definition to be confirmed						

4 - RESPONSIVE - KEY TARGETS

ID	Indicator	Target 17-18	Target YTD	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position
4.1	A&E 4 hour Target	95		83.9	82.0			
4.2	RTT Admitted	0		73.2	70.9			
4.3	RTT Non Admitted	0		85.5	82.5			
4.4	RTT - Open Pathways	92		85.7	85.7			
4.5	RTT Patients Waiting > 18 weeks	1231		4834	4834			
4.6	Diagnostic Waits < 6 weeks	99		98.7	96.7			
4.7	Cancer 2week Ref to Appt	93		97.8	97.6			
4.8	Cancer 31day : Diag	96		92.4	96.4			
4.9	Cancer 62day : Urgent RTT inc ITP transfers	85		75.5	80.5			
4.10a	TIA: All Risks treatment within 24 hrs	100.0		46.2	45.0			
4.12	4 hrs direct to Stroke Unit	90		75.2	80.0			
4.13	90% of time on the Stroke Unit	80		86.7	87.3			
4.14	60 minutes to scan	90		88.9	72.5			
4.15	Thrombolysed within 3 hrs	12		7.4	8.7			

5 - CARING

ID	Indicator	Target 17-18	Target YTD	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position
5.1	Inpatient FFT % of patients would recommend	95		97.2	97.2			
5.2	FFT Response Rate %	40		43.5	43.5			
5.3	Friends & Family Recommend Place of Care	76		74.4	74.4			
5.4	Complaints - % received telephone call	85		100.0	100.0			
5.5	% of Complaints concluded within agreed timeframe	75		65.4	64.0			
5.6	GP Enquiries Response Rate - Routine	80		55.0	55.0			
5.7	GP Enquiries Response Rate - Urgent	95		90.0	90.0			

6 - WELL-LED

ID	Indicator	Target 17-18	Target YTD	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position
6.1	Continuity of Services Risk Rating	0		0	0			
6.2	Risk register	1		3	0			
6.3	CQC Outcomes	1		2	0			
6.4	NHSI Governance Risk Rating	4		3	0			
6.5	Friends & Family Recommend Place of Work	61		52.42	52.42			
6.6	Vacancy Rate %	10		8.5	8.5			
6.8	Bank Spend	9		9.27	9.27			
6.9	Agency Spend	7		4.31	4.31			
6.10	Sickness %	3.5		3.49	3.49			
6.11	Substantive Staff Turnover	11		13.32	13.32			
6.12	Appraisal Rate	85		83.56	83.56			

7 - FINANCIAL PERFORMANCE

ID	Indicator	Target 17-18	Target YTD	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position
7.1	Capital Servicing Capacity	1		4.0	4.0			
7.2	Liquidity Ratio (days)	1		4.0	4.0			
7.3	I&E Margin	1		4.0	4.0			
7.4	Distance from financial plan	1		4.0	4.0			
7.5	Agency spend variance from ceiling	1		1.0	1.0			
7.6	Overall Finance Metric	1		3.0	3.0			
7.7	Pay Spend	100		100.0	106.0			
7.8	Capital Plan Trajectory	90		91.0	611.0			
7.9	CIP Plan delivered	100		72.0	82.0			
7.10	Cash Plan	90		163.0	163.0			

8 - SUSTAINABILITY

ID	Indicator	Target 17-18	Target YTD	Actual YTD	Actual Month	Month Perf.	Month Change	YTD Position
8.1	GP referrals Received - 2WW			9,866	1,367			
8.2	GP referrals Received - non 2WW			83,679	8,968			
8.3	A&E Attendances	147,144	123,353	124,946	12,297			
8.4	Elective Spells (PBR)	37,060	30,740	38,776	4,023			
8.5	NonElective Spells	46,703	38,943	37,421	3,835			
8.6	OP Attendances/Procs (Total)	471,770	391,272	383,400	40,705			
8.7	Outpatient DNA Rate	8		8.9%	10.3%			
8.8	Theatre Utilisation	Method of Data Collection and Definition to be confirmed						

Key: Monthly Change

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

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

Trust Floodlights Dashboard January 2018 (M10)

Monthly Information, Performance and RAG Rating

1 - SAFE

ID	Indicator	Target 17-18	Target YTD	Actual YTD	Actual Month	Month Performance	Monthly Change	YTD Position	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12
1.1	Never Events	0		4	0				0	1	0	0	0	1	0	2	0	0		
1.2	Safety Thermometer Patients with Harm	336	280	214	22				20	24	34	20	18	21	31	14	10	22		
1.3	Clostridium Difficile Cases	11	10	18	0				2	2	3	4	2	2	2	1	0	0		
1.4	MRSA Post 48 hours Cases	0		1	0				0	0	1	0	0	0	0	0	0	0		
1.5	Hospital Acquired Pressure Ulcers Grade 2 or higher	0.16		0.11	0.24				0.000	0.188	0.100	0.000	0.241	Data not available						
1.6	Inpatient Falls	3.17		3.01	3.71				2.66	2.40	3.10	3.22	3.71	Data not available						
1.7	Ambulance Handovers > 30 mins	2604	1736	1381	393				42	94	44	43	147	199	DQ issue due to change to ARP	DQ issue due to change to ARP	419	393		
1.8	Fill Rate RNs (%)	90		95	95				96.1	96.3	95.7	94.1	93.6	92.1	92.6	96.3	94.1	95.0		
1.9	Fill Rate RNs Unreg (%)	90		92	88				104.3	94.8	91.5	93.3	91.4	92.3	86.5	90.0	87.2	87.7		
1.10	Statutory Mandatory Training	90		86.1	86.1				89.3	87.8	88.3	87.3	87.5	86.4	87.8	88.6	88.4	86.1		
1.11	Safeguarding Adults Training	90		86.9	86.9				90.5	89.2	89.5	88.2	87.5	87.0	88.7	89.8	89.2	86.9		
1.12	Safeguarding Children Training	90		88.0	88.0				91.1	89.6	90.0	88.8	88.0	87.2	89.1	90.3	90.0	88.0		
1.13	Competancy Coverage	85		64.7	64.7				66.4	64.0	64.8	64.1	64.8	63.8	65.3	65.1	66.5	64.7		
1.14	RIDDOR Incidents	0.56		0.58	0.51				0.36	0.54	0.90	0.36	0.72	0.34	0.51	0.34	1.19	0.51		
1.15	Musculosketal Injuries Reported	1.09		0.83	0.68				0.91	0.54	1.45	0.54	1.44	0.85	1.36	0.51	0.00	0.68		
1.16	Physical Assault Incidents	1.13		1.44	1.19				0.73	0.00	1.81	1.61	2.16	1.53	1.02	2.53	1.87	1.19		
1.17	Manager Referrals to OH for Stress	0.57		0.63	0.68				1.09	0.36	0.18	0.54	1.26	0.51	0.68	0.67	0.34	0.68		
1.18	Staff Slips, Trips & Falls	1.18		0.99	1.02				0.18	0.90	1.27	1.08	0.90	0.85	1.36	0.34	2.04	1.02		
1.19	Staff Sharps Injuries	2.00		2.23	2.03				1.99	1.27	2.17	2.15	2.70	2.21	1.53	4.04	2.21	2.03		

2 - EFFECTIVE

ID	Indicator	Target 17-18	Target YTD	Actual YTD	Actual Month	Month Performance	Monthly Change	YTD Position	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12
2.1	HSMR - 3 month lag	94.0		97.5					95.0	95.0	94.4	93.7	92.5	95.0	95.6	95.4	96.2	97.5		
2.2	SHMI - 6 month lag	100		102.1					n/a	n/a	102.3	n/a	n/a	102.69	102.69	102.69	102.14	102.14		
2.3	SHMI (Palliative Care Adjustment) - 6 month lag	95.0		94.5					n/a	n/a	92.9	n/a	n/a	93.82	93.82	93.82	94.50	94.50		
2.4	Medical & Surgical Patient Outliers	50		85					91	91	88	108	85	Data not available						
2.5	Number of Patients with LOS > 14 days	100		135					172	148	129	116	126	112	126	113	109	135		
2.6	LOS - Non Elective	3.5		3.6	3.2				3.8	4.0	3.8	3.6	4.1	3.3	3.8	3.3	3.1	3.2		
2.7	Readmissions	7.75		7.08	6.1				8.7	8.1	7.7	7.7	7.1	6.1	6.8	5.9	6.6	6.1		

3 - RESPONSIVE - EFFICIENCY

ID	Indicator	Target 17-18	Target YTD	Actual YTD	Actual Month	Month Performance	Monthly Change	YTD Position	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12
3.1	New to Follow-Up Ratio	2.0		2.35	2.35				2.19	2.18	2.16	2.15	2.14	2.21	2.25	2.28	2.31	2.35		
3.2	Overnight Bed Occupancy Rate	85		87.30	88.44				84.8	87.5	88.4	88.4	Data not available							
3.3	Pre OP bed days (elective)	6		3.30	4.5				4.1	2.1	2.5	4.5	Data not available					One month in arrears		
3.4	Delayed Transfer of Care	8		57	7				5	0	3	10	3	14	4	5	6	7		
3.5	Post Acute Transfer-Total Avg beds blocked	Method of Data Collection and Definition to be confirmed																		
3.6	Ward Discharges before Midday	13.0		14.3	14.7				14.5	14.0	13.2	13.0	14.3	15.3	14.5	14.5	14.5	14.7		
3.7	Cancelled Ops - on Day	504	378	649	56				46	71	157	97	74	35	71	42	56	data not available		
3.8	Number of Discharges from Discharge Lounge	Method of Data Collection to be confirmed																		

4 - RESPONSIVE - KEY TARGETS

ID	Indicator	Target 17-18	Target YTD	Actual YTD	Actual Month	Month Performance	Monthly Change	YTD Position	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12
4.1	A&E 4 hour Target	95		83.9	82.0				89.23	84.07	87.53	87.77	85.06	No Submission	80.54	81.74	77.24	82.03		
4.2	RTT Admitted	0		73.2	70.9				74.8	78.8	73.6	67.8	70.9	No Submission	No Submission	No Submission	No Submission	No Submission		
4.3	RTT Non Admitted	0		85.5	82.5				87.2	86.0	88.6	83.1	82.5	No Submission	No Submission	No Submission	No Submission	No Submission		
4.4	RTT - Open Pathways	92		85.7	85.7				92.2	90.5	88.9	87.4	85.7	No Submission	No Submission	No Submission	No Submission	No Submission		
4.5	RTT Patients Waiting > 18 weeks	1231		4834	4834				2022	2436	3191	4140	4834	No Submission	No Submission	No Submission	No Submission	No Submission		
4.6	Diagnostic Waits < 6 weeks	99		98.7	96.7				99.72	99.00	99.55	96.65	No Submission	No Submission	No Submission	No Submission	No Submission	One month in arrears		
4.7	Cancer 2week Ref to Appt	93		97.8	97.6				98.3	98.2	98.7	97.6	97.6	97.3	97.1	97.6	97.6	One month in arrears		
4.8	Cancer 31day : Diag	96		92.4	96.4				86.3	90.3	90.7	93.8	92.1	93.9	91.6	96.3	96.4	One month in arrears		
4.9	Cancer 62day : Urgent RTT inc ITP transfers	85		75.5	80.5				76.4	71.3	66.4	74.9	72.2	78.8	79.1	80.3	80.5	One month in arrears		
4.10a	TIA: All Risks treatment within 24 hrs	100.0		46.2	45.0				data not available	data not available	data not available	data not available	53.5	41.7	50.8	39.4	45.0	data not available		
4.12	4 hrs direct to Stroke Unit	90		75.2	80.0				82.5	76.6	77.6	78.6	71.7	71.6	71.2	72.1	80.0	data not available		
4.13	90% of time on the Stroke Unit	80		86.7	87.3				88.9	91.4	88.5	88.0	83.9	88.9	79.7	84.9	87.3	data not available		
4.14	60 minutes to scan	90		88.9	72.5				95.2	91.7	87.8	96.2	92.9	87.8	90.9	97.4	72.5	data not available		
4.15	Thrombolysed within 3 hrs	12		7.36	8.7				10.8	6.6	9.0	14.3	6.3	4.8	1.6	7.7	8.7	data not available		

5 - CARING

ID	Indicator	Target 17-18	Target YTD	Actual YTD	Actual Month	Month Performance	Monthly Change	YTD Position	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12
5.1	Inpatient FFT % of patients would recommend	95		97.2	97.2				96.6	97.0	97.2	97.5	97.5	97.4	97.0	96.4	97.9	97.2		
5.2	FFT Response Rate %	40		43.5	43.5				52.84	51.45	44.06	49.11	44.16	39.61	46.01	48.5	40.17	43.51		
5.3	Friends & Family Recommend Place of Care	76.0		74.4	74.4				75.0			74.4			74.4					
5.4	Complaints - % received telephone call	85		100.0	100				100	100	100	100	100	100	100	100	100	100		
5.5	% of Complaints concluded within agreed timeframe	75		65.4	64				68	74	67	53	51	77	64	64	72	64		
5.6	GP Enquiries Response Rate - Routine	80		55.0	55.0				58	74	86	89	60	74	67	65	55	One month in arrears		
5.7	GP Enquiries Response Rate - Urgent	95		90.0	90.0				100	80	100	100	18	75	80	36	90	One month in arrears		

6 - WELL-LED

ID	Indicator	Target 17-18	Target YTD	Actual YTD	Actual Month	Month Performance	Monthly Change	YTD Position	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12
6.1	Continuity of Services Risk Rating								Metric removed in September 2016.											
6.2	Risk register	1		3					3	3	2	3	3	3	3	3	3	3		
6.3	CQC Outcomes	1		2					2	2	2	2	2	2	2	2	2	2		
6.4	NHSI Governance Risk Rating	4		3					3	3	3	3	3	3	3	3	3	3		
6.5	Friends & Family Recommend Place of Work	61		52.4	52.4				46.60			52.42			52.42					
6.6	Vacancy Rate %	10		8.5	8.5				12.13	9.66	10.71	8.56	8.92	8.90	8.53	7.66	8.52	8.50		
6.8	Bank Spend	9		9.3	9.3				5.9	8.23	5.9	10.22	8.61	9.39	8.57	9.07	8.43	9.27		
6.9	Agency Spend	7		4.3	4.3				5.4	5.7	5.34	5.68	4.93	4.3	3.79	5.74	4.49	4.31		
6.10	Sickness %	3.5		3.5	3.5				3.64	3.62	3.58	3.46	3.41	3.39	3.44	3.43	3.47	3.49		
6.11	Substantive Staff Turnover	11.0		13.3	13.3				13.2	13.2	13.2	12.8	12.6	12.7	12.7	13.0	13.4	13.3		
6.12	Appraisal Rate	85		83.6	83.6				81.9	82.7	83.7	84.2	85.4	80.7	80.4	82.7	83.3	83.6		

7 - FINANCIAL PERFORMANCE

ID	Indicator	Target 17-18	Target YTD	Actual YTD	Actual Month	Month Performance	Monthly Change	YTD Position	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12
7.1	Capital Servicing Capacity	1		4	4				4	4	4	4	4	4	4	4	4	4		
7.2	Liquidity Ratio (days)	1		4	4				3	3	3	3	3	3	4	4	4	4		
7.3	I&E Margin	1		4	4				4	4	4	4	4	4	4	4	4	4		
7.4	Distance from financial plan	1		4	4				2	4	1	2	4	3	4	4	4	4		
7.5	Agency spend variance from ceiling	1		1	1				1	1	1	1	1	1	1	1	1	1		
7.6	Overall Finance Metric	1		3	3				3	3	3	3	3	3	3	3	3	3		
7.7	Pay Spend	100		100	106.0				97.0	98.0	96.0	100.0	100.0	101.0	101.0	105.0	103.0	106.0		
7.8	Capital Plan Trajectory	90		91	611.0				13	108.2	149	84	89	44	59	22	25	611		
7.9	CIP Plan delivered	100		72	82.0				122	107	120	102	61	66	81	26	48	82		
7.10	Cash Plan	90		163	163.0				146.5	131.0	135.6	124.2	117.7	253.0	138.0	142.0	480.0	163.0		

8 - SUSTAINABILITY

ID	Indicator	Target 17-18	Target YTD	Actual YTD	Actual Month	Month Performance	Monthly Change	YTD Position	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12
8.1	GP referrals Received - 2WW			9866	1367				532	649	795	870	887	1175	1322	1269	1000	1367		
8.2	GP referrals Received - non 2WW			83679	8968				7671	8537	8432	8036	7776	7584	9130	9969	7576	8968		
8.3	A&E Attendances	147,144	123,353	124946	12297				12354	12706	12835	12849	11920	12384	12824	12381	12396	12297		
8.4	Elective Spells (PBR)	37,060	30,740	38776	4023				2947	3285	3347	3553	4946	5185	3929	4229	3332	4023		
8.5	NonElective Spells	46,703	38,943	37421	3835				3691	3747	3876	3780	3675	3543	3726	3811	3737	3835		
8.6	OP Attendances/Procs (Total)	471,770	391,272	383400	40705				33886	41380	42996	39670	31341	29003	48086	43676	32657	40705		
8.7	Outpatient DNA Rate	8		9%	10.3%				7.2%	8.1%	7.5%	7.2%	8.2%	10.2%	9.5%	9.9%	11.2%	10.3%		
8.8	Theatre Utilisation	Method of Data Collection and Definition to be confirmed																		