

Executive Summary: At a Glance Performance Assessment June 2012



N.B. The current assessment of risk against key metrics will differ in some instances as the main colour is the dominant acheivement. This is due to the summaryincorporating a broad assessment of risk. West Hertfordshire Hospitals



NHS Trust

Executive Summary

Following discussion at the Board Seminar in June, the Performance Report is in a new format. It includes a local dashboard and one provided by CHKS that compares the Trust with an agreed peer group. The Executive Summary will now focus on exception reporting. Where appropriate the individual schedules have comment boxes to provide additional information.

Key Performance Indicators:- this now provides performance data for current and the previous 5 months together with a forecast outturn. The 62 day Cancer target for referral to screening was not met due to one patient deferring their screen for one month for personal reasons. Some 16 patients chose not to see a consultant within 14 days of referral for breast symptoms. In an effort to improve patient choice further an additional clinic has been put in place for Tuesday afternoons.

A and E:- the Service continues to be under significant pressure, although for June achieved 96.3% for the 4-hour target. However, the numbers leaving without treatment and median waits for treatment increased, some of which is a coding issue, this is being investigated.

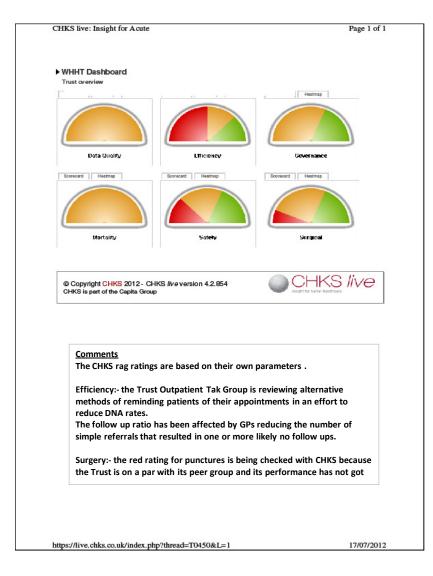
Nursing Quality Indicator Scorecard:- discussions are on-going with the nursing team to finalise this and ensure there is no duplication with reports that they currently submit to the Board.

Contracting:- The Trust has admitted 749 more patients than were planned in the first quarter which in turn has generated both significantly increased revenue but also attendant costs. The increase in elective patients is partially due to the need to ensure that all specialties were treating within 18 weeks as per the national standard. Whilst at the end of March the Trust had met this target overall, it had not achieved it at specialty level (ENT, Orthopaedics, Pain and Gynaecology). As a result additional theatre lists have been run and patients outsourced and treated by our clinicians in the local private sector. Whilst there has been an increase of 34 non-elective patients treated, this does not reflect the true position. Overall the Trust has treated more than 400 emergency patients than planned for but fewer Maternity. This has created significant bed pressures for the Trust and the emergency workload continues unabated. The Trust make a large loss on emergency over performance as we are only paid at a marginal tariff of 30%. We continue to review with out host PCT in an attempt to agree a change in contract terms.

The overall impact is a contract income of £1.687m over plan (3.02%).

CQUIN:- THE Trust can earn 2.5% additional funding should it meet specific CQUIN targets to an agreed trajectory. In 2011-12, the Trust achieved 90% overall and is expecting to perform as well, if not better in 2012-13. For most of the targets, the first quarter is about planning etc and this is underway.

Jan Filochowski July 2012



Site time period:	Jan 2012 to Jun 2012	Peer time period:	Jan 2012 to Jun 2012	
Description	Change	Value Current Period	Value Previous Period	Rating
Average Length of Stay (Spell)	Current period is 1% worse than previous period.	2.6	2.6	Amber
Delayed discharges (index)	Current period is 9% worse than previous period.	8.5%	7.8%	Green
Outpatient DNA Rate	Current period is 10% worse than previous period.	8.9%	8.1%	Red
Outpatient New to Follow-up Ratio	Current period is 0% better than previous period.	1: 2.9	1: 2.9	Red

Report WHHT Das Hogard > Safety

Report: WHHT Dashboard > Efficiency

Sie time period:	Jan 2012 to Jun 2012	Peer time period:	Jan 2012 to Jun 2012	
Description	Change	Value Current Period	Value Previous Period	Rating
% of patients with a fractured neck offernur that went to theathe within				
24hours for repair of the fractured	Current period is 21% better than			
femur	previous period.	78.00%	84.50%	Green
	Current period is 28% better than			
Complication Rate Attributed	previous period.	0.72%	1.0096	Amber
	Current period is 13% better than			
Cornclication Rate Treated	previous period.	1.7036	2.00%	Amber
	Current period is 27% better than			
Decubitus ulcer	previous period.	3,80%	5 20%	Red
Emergency readmissions within 28				
days of discharge following hip	Current period is 24% better than			
fracture	previous period.	12:90%	17.10%	Amber
	Current period is 32% better than			
Potential in hospital falls	previous period.	0.1136	0.1896	Green
Rate of caesarieshis action	Current period is 3% worse than			
deliveries	previous period.	28/60%	27,80%	Red
	Current period is 1% worse than			
Readmissions 30 Davs	previous period.	4.90%	4,9096	Green

Report WHHT Das hooard > Surg Hierarchy: Trust overview	Cal		
Site time period:	Jan 2012 to Jun 2012	Peer time period:	Jan 2012 to Jun 2012

Description	Change	Value Current Period	Value Previous Period	Rating
% of patients with a fractured neck of femurithat went to theatre within				
24hours for recail of the fractured	Current period is 21% better than			
formur	provisus period.	79.00%	64,50%	Green
C. I.	Current period is 0% better than	10.00 //	0 10000	
Accidental ouncture or laceration	previous period.	0.3586	0.35%	Red
	Current period is 28% better than		0.0010	
Complication Rate Attributed	crevicus period.	0.7286	1.00%6	Amber
Deaths in hospital within 30 days of				
emergency admission for hip	Current period is 22% worse than			
fracture	previous period.	7,20%	5.90%	Amber
	Current period is 18%6 better than			
Misadventure rate	previous period.	0.1196	0.14%	Amber
	Current period is 25% better than			
Post operative wound intection	previous period.	0.06%6	0.88%	Green
Rates of deaths in hospital within 30	Current period is 46% better than			
days of Elective surgery	previous period.	0.01%	0.02%	Oreen
Rates of deaths in hospital within 30	Current period is 14% worse than			
dats of Non-electives uncerv	previous period.	1.7096	1.50%	Amber

Key Performance Indicators



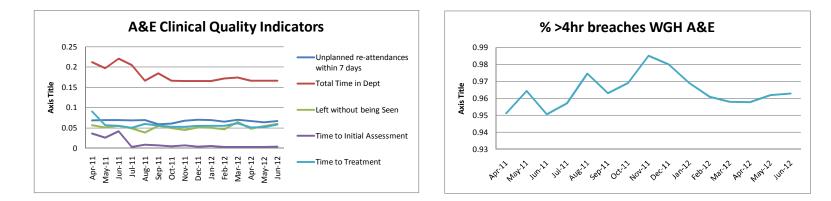
6 Month Trend

										Movement		
										from last		
		TARGET	Jan-12	Feb-12	Mar-12	Arp-12	May-12	Jun-12	YTD	period	Forecast outcome	Comments
Cancer												
	31 Day maximum wait for 2nd or subsequent treatment 62 Day max wait between 2WW referral and 1st	>=96%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%		100%	
	treatment	>=85%	87.30%	96.10%	88.10%	89.50%	87.10%	94.30%	90.40%		90%	
	62 day maximum wait from referral from screening to 1st		07.5070	50.1070	00.1070	05.5070	07.1070	5115070	50.1070		50%	
	treatment	>=90%	100.00%	81.80%	100.00%	100.00%	100.00%	87.50%	94.88%	•	95%	One patient
	62 day wait from referral from consultant upgrade to 1st											
	treatment	>=85%	no data	80.00%	100.00%	100.00%	100.00%	no data	95.00%	* *	95%	
	14 day max wait from 2WW referral to 1st appointment	>=93%	98.50%	98.50%	97.50%	98.20%	97.80%	96.70%	97.87%		96%	
	14 day max wait from urgent referral with breast		50.5070	50.5070	57.5676	50.2070	57.0070	50.7070	5710770			
	symptoms to 1st appointment	>=93%	93.90%	91.90%	90.00%	92.60%	96.40%	82.20%	91.17%	•	93%	Patient choice
	Cancer - 31 dat maximum wait from decision to treat to											
	1st treatment (all cancers)	>=96%	100.00%	98.20%	98.80%	100.00%	97.70%	98.70%	98.90%		97%	
Referral to	o Treatment Time (RTT)	1										· · · · · · · · · · · · · · · · · · ·
	Maximum time of 18 wks from point of referral in aggregate by specialty (non admitted)	>=95%	98.00%	98.20%	98.70%	97.90%	98.40%	98.20%		₽	98%	
	Maximum time of 18 wks from point of referral in	>=3378	58.00%	38.2076	58.7076	57.5076	50.4076	50.2076			5876	
	aggregate by specialty (admitted)	>=90%	91.20%	88.90%	91.30%	91.90%	92.80%	92.60%			92%	
	Admitted 95th Percentile	<=23weeks	22.86	22	22	21.49	20.07		1		21	
	Pathway incomplete - 95th Percentile	<=28weeks	15.94	16	16.4	14.96	15.27				16	
	Non-admitted 95th Percentile	<=18.3weeks	14.98	15.1	14.2	14.2	14.56				14.5	
Cancelled	Operations	10.011000	11.50	10.1	1.12	1.12	11.50				11.5	
canceneu	Breaches of 28 day readmission guarentee as a									լլ		Non-elective pressures at WGH are impacting
	percentage of cancelled operations	<=5%	7.10%	30.60%	13.80%	12.50%	0.00%	5.90%		~	5%	adversely
	percentage of cancelled operations	N=376	7.10%	50.00%	15.00%	12.50%	0.00%	3.90%			570	adversely
	VTE Assessment of admissions	100%	97.30%	98.30%	98.30%	98.40%	97.20%	94.50%			0.00/	Short-stay admissions occasionally missed
			97.30%	98.30%	98.30%							, , , ,
	Single sex accomadation breaches	Nil				0	0	0		~~~	0	
Readmissi	ions								-			
												A joint review with the PCT of 2 weeks
												readmissions has been recently undertaken. A
	Following Elective Stay					64	57	63		-		report will follow
	Following Emergency Stay	Approx 173				271	294	289		+		As above
Mortality			11/12 Q1			11/12 Q2						
	HSMR (Dr Fosters) Qtr update	<100	99			102					<100	
			Jan-12	Feb-12	Mar-12	Apr-12	May-12	Jun-12				
	SHMI (CHKS)	Trust	76	75	72	75	63	85		$\mathbf{\hat{\Gamma}}$	75	
		Peer	73	75	71	69	63	73				
	Patients receiving NOF surgery within 48 hours of						_					
	admission		88.46%	88.00%	94.29%	96.97%	96.67%	93.33%		-	96%	
	STEMI Dationts receiving anglester within 00 million											
	STEMI Patients receiving angioplasty within 90 minutes						100%				100%	
	(Door to ballon)						100%				100%	
	(Door to ballon) STEMI patientients seen by specialist						100% 8				100%	
Local Targ	(Door to ballon) STEMI patientients seen by specialist										100%	A usha la Fanananu waking agaya ia ka ing ka
Local Targ	(Door to ballon) STEMI patientients seen by specialist ets	. 2.5%		6 2007		5 2007	8	4.200/		•		A whole Economy working group is trying to
-	(Door to ballon) STEMI patientients seen by specialist ets Delayed Transfer of care - maintain at a minimum level	<=3.5%	5.60%	6.30%	5.40%	5.20%		4.20%		•		A whole Economy working group is trying to improve performance against this metric
-	(Door to ballon) STEMI patientients seen by specialist ets Delayed Transfer of care - maintain at a minimum level Stroke Care - Patients that have spent >90% of their stay		5.60%				8			↓	3.50%	
-	(Door to ballon) STEMI patientients seen by specialist ets Delayed Transfer of care - maintain at a minimum level	<=3.5%		6.30% 81.30%	5.40%	5.20%	8	4.20% 93.20%		↓		improve performance against this metric
-	(Door to ballon) STEMI patientients seen by specialist ets Delayed Transfer of care - maintain at a minimum level Stroke Care - Patients that have spent >90% of their stay in hospital in a dedicated stroke unit		5.60%				8			₽	3.50%	improve performance against this metric There is a project group in place to determine
-	(Door to ballon) STEMI patientients seen by specialist ets Delayed Transfer of care - maintain at a minimum level Stroke Care - Patients that have spent >90% of their stay in hospital in a dedicated stroke unit Discharge Summaries - proportion sent to GPs	>=80%	5.60% 93.20%	81.30%	90.30%	85.40%	8 4.50% 86.10%	93.20%		₽	3.50%	improve performance against this metric There is a project group in place to determine how to improve this poor performance. Pilot
-	(Door to ballon) STEMI patientients seen by specialist ets Delayed Transfer of care - maintain at a minimum level Stroke Care - Patients that have spent >90% of their stay in hospital in a dedicated stroke unit Discharge Summaries - proportion sent to GPs electronocally within 24 hrs (Inpatient)		5.60%				8			 	3.50%	improve performance against this metric There is a project group in place to determine
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-	(Door to ballon) STEMI patientients seen by specialist ets Delayed Transfer of care - maintain at a minimum level Stroke Care - Patients that have spent >90% of their stay in hospital in a dedicated stroke unit Discharge Summaries - proportion sent to GPs electronocally within 24 hrs (Inpatient) Discharge Summaries - proportion sent to GPs	>=80%	5.60% 93.20% 38.40%	81.30% 34.7	90.30% 33.3	85.40% 28.30%	8 4.50% 86.10% 31.90%	93.20% 28.50%		₹ *	3.50% 90% 70%	improve performance against this metric There is a project group in place to determine how to improve this poor performance. Pilot phase started w/c 7/9/12 As above
-	(Door to ballon) STEMI patientients seen by specialist ets Delayed Transfer of care - maintain at a minimum level Stroke Care - Patients that have spent >90% of their stay in hospital in a dedicated stroke unit Discharge Summaries - proportion sent to GPs electronocally within 24 hrs (Inpatient) Discharge Summaries - proportion sent to GPs electronocally within 24 hrs (Daycases)	>=80%	5.60% 93.20% 38.40% 44.10%	81.30% 34.7 41	90.30% 33.3 40.7	85.40% 28.30% 41.10%	8 4.50% 86.10% 31.90% 34.20%	93.20% 28.50% 37.70%		₹ *	3.50% 90% 70% 70%	improve performance against this metric There is a project group in place to determine how to improve this poor performance. Pilot phase started w/c 7/9/12 As above

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		TARGET	Jan-12	Feb-12	Mar-12	Apr-12	May-12	Jun-12	YTD	Movement from last period	Forecast outcome
Accident a	nd Emergency										
	Maintain 4hr maximum wait	>=95%	98.50%	98.00%	96.90%	95.80%	96.20%	96.30%	96.10%		95%
	Unplanned reattendance Rate	<=5%	6.82%	6.98%	6.91%	6.70%	6.40%	6.70%	6.60%		6%
	Left department without being seen	<=5%	4.53%	5.12%	5.04%	4.80%	5.40%	6.00%	5.40%		5%
	Time to initial assessment (95th percentile)	<=15mins	00:08	00:05	00:05	00:05	00:05	00:06	05:20		00:05
	Median time to treatment decision	<=60mins	01:19	01:19	01:28	01:14	01:15	01:24	01:17		01:00



Comments:

The activity through A and E is 6.5% above plan and 8% above the same period last year. Despite this the Trust has managed to maintain the 4 hour target. The numbers of patients recorded as leaving without treatment is above the planned level of 5%. However it has become apparent that this may be a data quality issue and further work is being done to determine if this is correct.

West Hertfordshire Hospitals

Patient Experience

Infectio	n Contro	<u>) </u>	TARGET	Jan-12	Feb-12	Mar-12	Apr-12	May-12	Jun-12	YTD	Movement from last period	Forecast outcome
	Clostridiu	m Difficile	33	2	3	3	1	2	4	7		33
	MRSA Bac	teraemia	2	0	0	0	0	0	0	0	\Rightarrow	2
	MRSA Scr	eening										
		Elective	100%	98.30%	98.50%	98.40%	98.40%	98.60%	98.70%			98.50%
		Emergency	100%	93.80%	91.70%	92.70%	93.10%	94.10%	92.80%			94%

Safety Thermometer

HA Pressure Ulcers	PU Grade 1 PU Grade 2	12 26	1 16	1 24	5 23	8 16	4 18	
Avoidable Avoidable	PU Grade 3 PU Grade 4	1	2	2	0	4	4	
		-	0	0	0	U	0	
Falls (over 65 per 100	bed days)	0.42	0.25	1	0.45	0.4	0.44	

Friends and Family Score

END DATE		Week1	Week2	Week3	Week4	Week5
		W	/c 27/05/20)12 to W/e 3	30/06/2012	
3.1 Total number of inp period (number of defined DISCI within the period)		1049	833	1013	963	992
3.2 Total number of res period (number of NPS response						
cohort in 3.1)		275	179	276	210	274
3.3 Number of promoter	s	180	106	165	134	193
4.0 Net Promoter Sc	ore					
4.1 Organisation NPS - (automatically populates f entered above)		59.63	55.3	51.81	55.23	64.59
Μ	onth Score			57.58		
ents Admitted Within 4 Hrs to Stro	Jan-12 ke Ward	Feb-12	Mar-12	Apr-12	May-12	Jun-12
	93.20%	81.30%	90.30%	85.40%	86.10%	93.20%
ous Incidents	3	4	9	5	5	7
er Events	0	0	0	0	0	0

Comments:

C-Diff in June was above the expected trajectory. If the first quarter performance was to continue, the target would not be met.

Nursing staff continue to be educated to distinguish between tissue damage caused by moisture and as a result of pressure on the skin

Net Promoter score is to be reported weekly but is fluctuating. The year end target is 60.

A comprehensive promotion that stroke patients go direct to the Stroke Unit and not AAU has significantly improved performance.



Nursing Quality Indicator Trend Scorecard DRAFT

				1 10	1.1.40		0 10		Movement from		
Nursing Indicators	Target	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Variance	previous month	Reliability of Data	Comments
Safety Thermometer		-	-					-			ST is at one point in time. Day count snapshot.
Catheter Associated UTI – care and management		0.49	0.31	0.17				-0.14	<u>لا</u>	н	
Falls in >65s resulting in harm		0.45	0.4	0.44				0.04		М	
Hospital Accuired Pressure Ulcers at Grades 2/3/4	Eliminate All Grade 2, 3 and 4 Pressure Ulcers by Dec 2012	28	28	26				-2	N	н	
VTE Assessment (of Admissions)	100.0%	94.7%	96.30%	95.8				94.8	<u>لا</u>	Н	Short stay admissions account for the failure to achieve 100%
Nutrition											
Screening and Acting on the Screening	MUST tool - not yet available	87%	79%	79%				0.0			
Protected Mealtimes		100%	100%	100%				0.0		L	
Receiving Breast Milk on Discharge-Neonates Early Expression of Breast Milk-Neonates (part of nutrition care pathway)										м	
Patient Experience											
Normal births to be 60% of the total		55%	59%	57%				-0.02	ч	?	The Trust continues to reduce caesarean sections because it is deemed to be an outlier
		% of calls								м	
Patient Experience-Neonates		per infants discharged									
PALS Contacts										L	
Infection Control											
C Diff (medicine & Surgery)	<34 in yr	1	2	4				2.00	7	Н	The Trust has exceeded its trajectory for the month
Hospital Acquired MRSA Bacteraemia	<3 in yr	0	0	0				0.00	→	Н	
Hospital Acquired MRSA Isolates		1	0	0				0.00	→	н	
MRSA Screening Elective -Test<=18weeks		98.4%	98.7%	98.80%				0.01	7		Short stay admissions account for the failure to achieve 100%
MRSA Screening Emergency - Tested <48 hours		93.1%	94.1%	92.80%				-1.30	N N		Short stay admissions account for the failure to achieve 100%
Hand Hygiene Compliance		100%	100%	100%				0.00	- 		
		100%	100%	100%				1			
Medication								-8.00		1	
Omitted Medicines		18	63	55				-8.00		L	
Pain Management											
Observational Audit										Н	
Observational Audit Paeds Early Warning Scores										н	
Paeds Early Warning Scores Personal Hygiene											
Hair/Nails/teeth											
	Workforce R/A/G(Agreed subject to testing) 5/5 = Green 3/4/5 = Amber 0-2 = Red										
Workforce Indicators											
Vacancy factors										М	
Workforce Absence								-			
Sickness – LongTermSick										M	
Sickness – ShortTermSick										M	
Maternity Leave										M L	
Fill Rates										L	
Mentorship Others										L.	
Bed Occupancy - All Wards	90.0%	82.7%	81.6%	81%				-0.9%			The Trust continues to experience significant bed pressures
Competencies *	70100	02.770	01.0/0	01/0				-0.078			The trust contained to experience againment bed pressures
Staff Morale *											
Start Motore											

Rolling 6 Months



NHS Trust

Finance Risk Ratings

									Forecast
								Risk rating	<u>rating</u>
	Metric	<u>Weight</u>	5	<u>4</u>	<u>3</u>	<u>2</u>	<u>1</u>	ytd	<u>12/13</u>
Underlying Performance	EBITDA margin %	25%	11	9	5	1	<1	3	3
Achievement of Plan	EBITDA achieved %	10%	100	85	70	50	<50	4	5
Financial Effiency	Return on assets%	20%	6	5	3	2	<-2	4	4
	I&E surplus margin %	20%	3	2	1	-2	<-2	3	3
Liquidity	Liquid ratio days	25%	60	25	15	10	<10	3	3
Overall Rating	Overall Rating							3	4

Comments:

A detailed Finance report is provided separately.

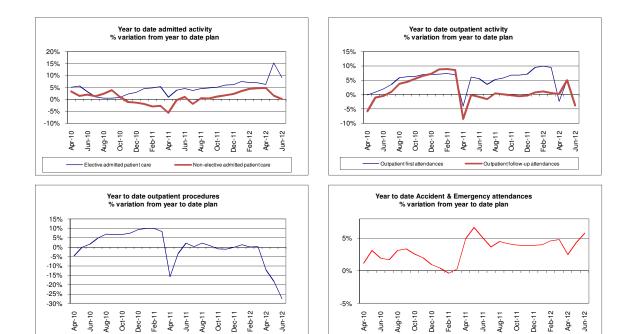


Jun-12

Contractual Risk Rating (SHA Governance Report)

Contract Performance

	YTD	YTD	Varia	ance
	Plan	Actual	Number	%
Admitted spells - elective	9,050	9,765	715	7.9%
Admitted spells - non-elective	11,458	11,492	34	0.3%
A&E Attendances	24,151	25,721	1,570	6.5%
Outpatient procedures	8,423	7,372	-1,051	-12.5%
Outpatient attendances - new	29,036	28,391	-645	-2.2%
Outpatient attendances - follow up	63,417	61,749	-1,668	-2.6%



Patients waiting	Atend May	At end June	Movement	%
IP 11+ weeks	394	381	-13	-3.3%
Diagnostics 6+ weeks	1	9	8	800.0%
OP 5+ weeks	1618	2265	647	40.0%

Comments:

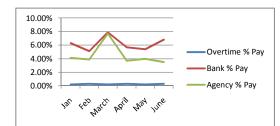
Elective admissions are 7.9% above plan. This is due to the need to run additional lists to achieve 90% admissions within 18 weeks for all specialties. This was expected to have been achieved by March but the increase in nonelective admissions from December prevented it being achieved, so the Trust needed to ctach up in the first quarter of this year. The shortfall in outpatient procedures is due to late recording and is expected to come back to planned levels.

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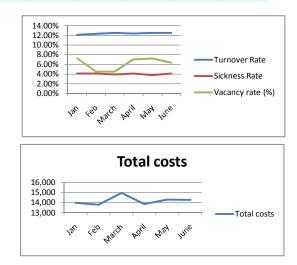
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				Work	force			
	Jan	Feb	March	April	May	June		
	WTE	WTE	WTE	WTE	WTE	WTE		
Contracted	3550.9	3541	3,529.80	3,528.50	3,525.90	3537.2		
Total costs	13,964	13,766	14,951	13,833	14,286	14,240		
Overtime % Pay	0.20%	0.30%	0.20%	0.30%	0.20%	0.30%		
Bank % Pay	6.30%	5.10%	7.90%	5.70%	5.40%	6.80%		
Agency % Pay	4.10%	3.90%	7.70%	3.70%	4.00%	3.50%		
Appraisal Rate	82%	90%	93%	93%	91%	88%		
Turnover Rate	12.10%	12.30%	12.50%	12.40%	12.50%	12.50%		
Sickness Rate	4.10%	4.10%	3.90%	4.10%	3.80%	4.10%		
Vacancy rate (%)	7.30%	4.50%	4.50%	7.00%	7.20%	6.40%		
Statutory Training	72%	74.30%	74.6	73.00%	73.00%	73.00%		
Mandatory Training	68.00%	69.90%	71.40%	73.00%	73.00%	73.00%		

Target	Data Qualit	v
	н	
	н	
	н	
	н	
3%	н	
90%	М	
	н	
<4%	н	
	М	
	М	
100%	М	



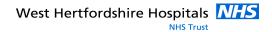




Comments:

There were 2 Bank Holidays that were part of School half-term weeks and this caused a significant rise in annual leave resulting in higher bank costs

West Hertfordshire Hospitals NHS Trust



Acute CQUINS

Goal no	Description of goal	Indicator number	Indicator name	Indicator weighting	Trajectory Value	Contact for Data	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13
1	% of all adult patients who have had a VTE risk assessment on admission to hospital using the clinical criteria of the national tool	1	VTE Prevention	5.00%	93%	See Procedure	99%	97%	95%									
2	The indicator is a composite, calculated from 5 survey questions. Each describes a different element of the overarching patient experience theme "responsiveness to personal needs of patients". The elements are: 1) Involvement in decisions about treatment/care, 2) Hospital staff being available to talk about worries/concerns, 3) Privacy when discussing condition/treatment, 4) Being informed about side effects of medication, 5) Being informed who to contact if worried about condition after leaving hospital.	2	Improve responsiveness to personal needs of patient	5.00%	Survey results of >68% - 30% payment >69% result - 50% payment >70% result - 70% payment >71% result - 100% payment	See Procedure							_	_			_	
3	Improve awareness and diagnosis of dementia, using risk assessment, in an acute hospital setting	3	Diagnosis of Dementia in Acute Trusts	5.00%														
	The screening of all emergency admissions of patients aged 75 and over using the "awareness question" within 72 hours of admission. This excludes day cases, patients with a stary of less than 72 hours, transfers and lective admissions as well as patients for whom the question cannot be completed within 72 hours (coma, critical illness, severe speech and language difficulties, sensory impairment, lack of translator, family or professional care giver; patients discharged with pallative care needs or significant loss of function in whom specialits referral for memory problems is inappropriate: re-admissions & frequent attenders without a diagnosis of dementia provided there is evidence of these patients having been through the FAIR process within the last 6 months).	За	Dementia case finding		90% patients screened in any 3 consecutive months	Tammi Angel	Screening tool now being devised and work on- going with clinicians and dementia nurse to embed											
	The assessment of all patients (or their carers) included in indicator 3A answering positively to the "awareness question" using an agreed dementia tool	Зb	Dementia risk assessment		90% screening in the same 3 consecutive months as 3A													
	The referral of all patients assessed as "positive" or "inconclusive" at assessment (indicator 3B)to their GP for follow up.	3c	Dementia referral		90% screening in the same 3 consecutive months as 3A and 3B													
4	Implementation of national dementia CQUIN for patients aged 60 and over following admission to hospital	4	Diagnosis of dementia in 60- 75 year olds	10.00%	75% screening in any 3 consecutive months of relevant patients aged 60-75	Sally Bashford												
5	The CQUIN will require monthly surveying all appropriate patients (as defined in the NHS Safety Thermometer guidance – any roll out to patient groups not currently included as agreed with the PCT) to collect data on four outcomes (pressure ulcers, falls, urinary tract infection in patients with catheters and VTE). A completed Safety Thermometer survey for all relevant	5	NHS Safety Thermometer	5.00%	Three consecutive quarterly submissions of monthly survey data for all relevant patients and settings using NHS Safety Thermometer will trigger full payment of the CQUIN	Sample size Pressure ulcers Falls UTI VTE	616 5.84 3.08 4.55 0.49	635 6.3 1.26 4.72 0.31	599 6.18 2 4.67 0.17									
6	Implementation of COPD care bundle; COPD discharge bundle: All patients admitted with a COPD exacerbation should be discharged with a completed COPD care bundle.	6	Improving outcomes for patients with COPD	10.00%	75% by end 2012-13, 95% by end 2013-14		sub-contracte Trust to	y discharge n ed from Barne ensure that di are followed	t Community scharge									
7		7	Net Promoter	10.00%														
	To establish the question and baseline Net Promoter Score: - For 10% of in-patient discharges for any given week The question is defined as either: "How likely is it that you will recommend this service to friends and family? Extremely likely? Likely? Neither likely nor unlikely? Olikely? Not al? Don't know?" Or "How likely is it that you would recommend this service to friends and family?" Please rate on a scale of 0 to 10 The question should be based and ten point scale approaches should be mapped to the following scoring system: Promoters = Extremely Likely P = 0:10 points Passive = Likely = 8 or 9 Detractors = Neither Likely nor Unlikely, Unlikely, Not at all, Don't know = 0 - 6 points The %age of Detractors should then be subtracted from the %age of Promoters to obtain a Net Promoter score	7a	Net Promoter - Establish question & baseline score		Demonstration that the question is established and reported for 10% of inpatient discharges, with patients surveyed at or within 48 hours of discharge	Mark Jarvis	vis 50%	45%	58%									
	Monthly Trust board minutes that clearly demonstrate reporting of patient experience including Net Promoter score (broken down to organisational, speciality and ward level), board challenge and actions relating to improvement	7b	Net Promoter - Board and Commissioner reporting		Monthly trust board minutes meeting the criteria above													

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	Organisations collate and review the NP score on a weekly	7c	Net Promoter - Weekly		Evidence of weekly collation and review of the Net								
	basis, commencing in Q2		reporting		Promoter Score from Q2					 	 	 	
	Achievement of either: (A) A 10 point improvement in Net Promoter score or (B) Achievement or maintenance of top quartile performance throughout 2012-13	7d	Net Promoter score - Performance Improvement		To be set and agreed using M1 data - either a 10 point improvement or achievement or maintenance of top quartile performance								
8	Using the Hospital Standardised Mortality ratio to improve quality and patient outcomes; To achieve reduced mortality rates - below 100 on average for the 2012/13 period by utilising the agreed measurement tool and through participation in the NHS Hertfordshire Hospital Mortality Review Group (HMRG) in accordance with the terms of reference (when agreed). Achieve the agreed reduction per annum and provide responses to alerts, detailed trend analyses, action plans (from WHHT and ENHTT Medical Directors), and reports on a quarterly basis. Acute HSMR reduction plan (speciality focused): Providers should review HSMR data at a speciality level. Based on the data analysis in Q, in agreement with the PCT 3 diagnosis related pathways will be selected which should be agreed with the HMRG. Evidence of implementation of these actions need to be in place by the end of Q4 and reported back to HMRG.	8	Reducing hospital mortality	10.00%	Q1: 15% - Agreement of the process of overall HSMR reduction and to participate in the HMRG in accordance with the terms of reference. Payment end of Q1. Q2: 0% Q3: 0% -unless early payment for any pathway that has been fully reviewed and action plans implemented (see Q4). Q4: 75% - Evaluation of 3 pathways to be made up as follows: 25% - For each complete evaluation of one pathway to include: 1. Identification of pathway for review 2. Benchmarking against best practice followed by an audit. 3. Development of action plans agreed by the HMRG. 4. Implementation of action plans agreed by the HMRG. 5% Overall reduction in HSMR with no single point above the upper control limit; and 4 consecutive points each less than the last (a downward trend) or an average HSMR =/<100. 5% - Report to the HMRG on how Trust will sustain work and have identified which pathways will be evaluated in 2013/14	Pathways now	agreed with	PCT					
9	To increase understand of the importance of the caring role of people with a learning disability and improve carers experience of services	9	Improving Carers Experience	10.00%									
10	Or services Proportion of patients, who, prior to discharge from the acute stroke unit, have been evaluated using 2 agreed stroke assessment tools The proposal is for these to be the "modified Rankin" scale (in line with national recommendations) and a second tool that includes more detail - possibly the Northwick Park complexity scale. These will be agreed between the provider and the Heart 8. Stroke Matowach	10	To improve outcomes for patients following a stroke	10.00%	Q1 – agreement of tools and delivery of any staff training (Heart and Stroke network will support) Q2 – completion of training & 25% patients discharged are assessed Q3 - 50% patients discharged are assessed Q4 - 80% of patients discharged are assessed and evaluation of tools carried out								
11	To improve the care of patients who are on a cancer or palliative care/pathway End of Life	11	Improving cancer care	10.00%	Following the setting of the baseline in Q1 indicators for quarters 2 & 3 will be set by the commissioner in order to support reaching at least 85% by Q4. This is in line with the expectation within NICE guidance that 85% of patients will have received an end of treatment plan and / or will be offered the opportunity to complete an advance care plan. Both holistic needs assessment targets and (for patients within the last 12 months of life) Advance Care Plan targets must be met to achieve the CQUIN.								
12	Increase the healthy lifestyle brief intervention advice given to patients by NHS staff	12	Making Every Contact Count	10.00%	Q1 - 25% for confirming the board & implementation leads, achieving staff training & submitting agreed implementation plan Quarters 2,3,4 - 25% each for giving brief intervention advice to 50% of patients and referring relevant patients to levels above.								

Speciali	ecialist Commissioning re NICU																
6	Implement routine use of specialised services clinical dashboards	6	Dashboards	20.00%		Lawry Gempton											
7	Reduce catheter related infections in low birth rate neonates	7	Infections	20.00%		Margaret Southgate											
8	Increase the percentage of preterm babies fed on mother's milk at discharge	8	Breast milk	20.00%	Last year average 27.4%	Margaret Southgate	25%	37.50%	33.50%								