

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.

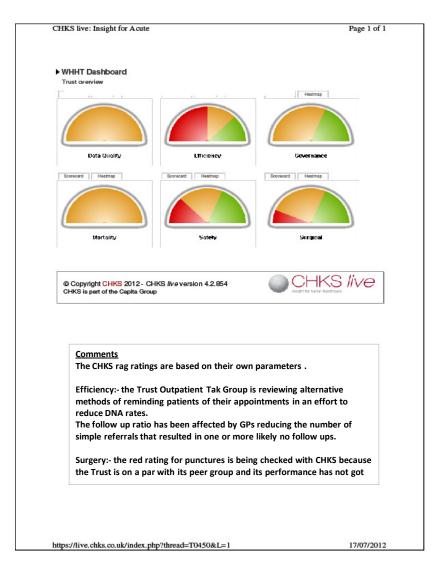
Nursing Quality Indicator Scorecard:- discussions are on-going with the nursing team to finalise this and ensure there is no duplication with reports that they currently submit to the Board.

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



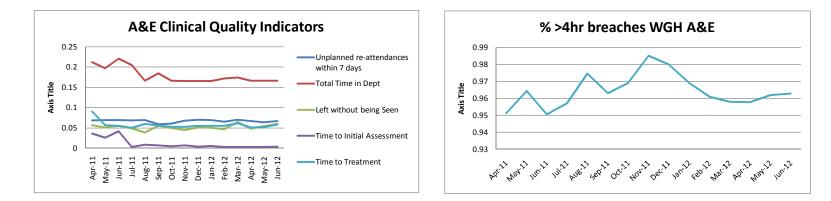
6 Month Trend

| | | | | | | | | | | 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 |
| - | (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% 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 |
| - | (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 |

West Hertfordshire Hospitals NHS

NHS Trust

| | | 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 |

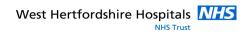
Comments:

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.

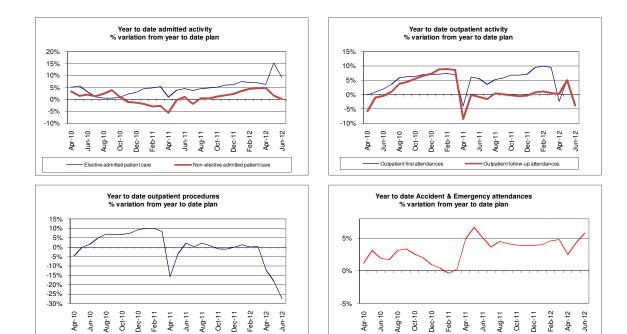


Jun-12

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:

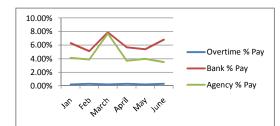
Elective admissions are 7.9% above plan. This is due to the need to run additional lists to achieve 90% admissions within 18 weeks for all specialties. This was expected to have been achieved by March but the increase in nonelective admissions from December prevented it being achieved, so the Trust needed 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.

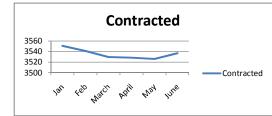
West Hertfordshire Hospitals NHS

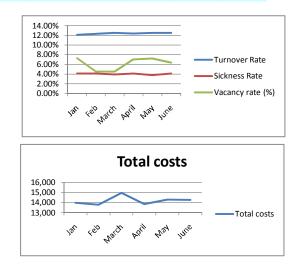
NHS Trust

| | | | | 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 | |



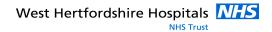




Comments:

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 | | | | | | | | | | | | | |

| - | 1- · · · · · · · · · · · | | 1 | 1 | | | | | r | | | | |
|----|--|----|--|--------|--|--------------|-------------|-----|---|------|------|------|--|
| | 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% | | | | | | | | |