West Hertfordshire Hospitals NHS Trust

Integrated Performance Report

January 2015

(December data)

West Hertfordshire Hospitals NHS Trust

Executive Summary

The Board is asked to note the key areas below and to refer to the indicator summaries and detailed exception reports for other areas where national/local performance has not been achieved.

Areas of Good Performance:

- Cancer 2 week wait performance has delivered to the 93% standard for the last 3 months. 96.9% for December is the best performance for the current financial year.
- Mortality indicators (SHMI and HSMR) show sustained performance improvement.
- Clostridium difficile numbers show sustained reduction through the last 3 months and represent an improvement on last year's position, with a year to-date position of 19 cases against a year-to-date trajectory of 22 cases.
- Pressure ulcer numbers are showing reductions over the last 3 months [slide 40].
- The Friends and Family score for question 2 (birth experience) at 71 for December, has shown improvement towards the target of 75 [slide 37].

Areas for Performance Improvement:

- A&E 4 hour wait (all types) performance for December was 87.5%, the lowest performance for this financial year. The year to date position is 92.8% [slide 18].
- Ambulance turnaround times increased significantly in December, with 327 ambulances taking 30-60 minutes for turnaround , from 281 in November [slides 19 & 20].
- Cancer 62 day performance was 73.2% for December (performance standard 85%) [slide 29].
- All referral to treatment indicators continue to report under the performance standards [slides 21 - 24].
- Stroke indicators show a drop in performance in December. Patients spending 90% of their time on the stroke unit has previously achieved the performance standard [slides 38 & 39].
- All workforce indicators continue to report under the performance standards [slides 14 - 17]. Staff turnover rate is 17.1% for December (performance standard 12%) [slide 14].

Indicator Summary

Data Quality RAG rating to be incorporated from March 2015

Domain	Indicator	Target	Latest three data points (Most Recent)			YTD Actual	YTD Target	Executive Lead	Month	Threshold	Trend	Data Quality RAG
Clinical Effectiveness	SHMI (Rolling 12 months)		✗ 100.2	! 97.6	✓ 93.4			MD	Apr-Mar 14	National		
	HSMR - Total (Rolling three months)		✓ 85.0	✓ 86.0	✓ 85.8			MD	Aug-14	National		
	HSMR - Elective Weekday		Data not currently available. Awaiting data from an external source.									
	HSMR - Elective Weekend											
	HSMR - Emergency Weekday											
	HSMR - Emergency Weekend											
●	Deaths in low risk conditions	0	✗ 6	✗ 3	✗ 1	✗ 13	0	MD	Aug-14	National		
	Caesarean Section rate - Elective	tbc	11.6%	8.4%	6.1%	9.7%	tbc	MD	Dec-14	Local		
	Caesarean Section rate - Emergency	tbc	18.8%	14.5%	13.9%	16.0%	tbc	MD	Dec-14	Local		
	30 Day Emergency Readmissions - Elective	tbc	3.4%	3.6%	3.7%	3.8%	tbc	MD	Dec-14	National		
	30 Day Emergency Readmissions - Emergency	tbc	10.7%	11.3%	11.1%	11.2%	tbc	MD	Dec-14	National		
	Clostridium Difficile	3	✓ 1	✓ 1	✓ 1	✓ 19	22	CN	Dec-14	National		
	MRSA bacteraemias	0	✓ 0	✓ 0	✓ 0	✗ 1	0	CN	Dec-14	National		
	MRSA screening - Elective	95.0%	✓ 98.2%	✓ 98.3%	✓ 97.9%	✓ 98.6%	95.0%	CN	Nov-14	Local		
●	MRSA screening - Emergency	95.0%	✗ 94.6%	✗ 93.3%	✗ 94.6%	✗ 94.5%	95.0%	CN	Nov-14	Local		
	Number of patients with a length of stay > 14 days	tbc	371	367	332	2,793	tbc	MD	Nov-14	Local		
	VTE risk assessment	95.0%	! 95.5%	! 96.4%	! 95.6%	! 96.2%	95.0%	MD	Nov-14	National		

Exception indicators key

- ● Red for a minimum of two data points and amber for one, out of the latest three data points
- ◆ Red for the latest data point

Data Quality RAG key

Red – Standard of data accuracy is not known, it is incomplete and inconsistent with relevant standards

Amber – Data is assumed to be complete and accurate, although there may be limitations or unresolved queries

Green – Data is complete, accurate and consistent with the standards set for the specific indicator

Indicator Summary

Domain	Indicator	Target	Latest three data points (Most Recent →)			YTD Actual	YTD Target	Executive Lead	Month	Threshold	Trend	Data Quality RAG
Workforce & Safety	● Never events	0	✗ 1	✓ 0	✗ 1	✗ 3	0	MD	Dec-14	National		
	Medication errors causing serious harm *	0	✗ 1	✓ 0	✓ 0	✗ 6	0	MD	Dec-14	National		
	Maternal deaths	0	✓ 0	✓ 0	✓ 0	✗ 1	0	MD	Dec-14	National		
	Serious incidents - number	tbc	11	5	13	140	tbc	MD	Dec-14	National		
	Serious incidents - % that are harmful	tbc	80.0%	60.0%	69.2%	79.5%	tbc	MD	Dec-14	National		
	Open CAS Alerts	tbc	10	9	11			CN	Dec-14	National		
	● Harm Free Care	95.0%	✗ 93.2%	✗ 91.2%	✗ 92.6%	✗ 92.1%	95.0%	CN	Dec-14	National		
	Staff survey - Net Promoter Score - staff who would recommend the trust as a place to work (Quarterly data)	tbc	-	27	22	25	tbc	DoW	Sep-14	National		
	Staff survey - Net Promoter Score - staff who would recommend the trust as a place to receive treatment (Quarterly data)	tbc	-	44	47	46	tbc	DoW	Sep-14	National		
	● Staff turnover rate	12.0%	✗ 17.3%	✗ 17.6%	✗ 17.1%	✗ 16.4%	12.0%	DoW	Dec-14	National		
	● Sickness rate	3.5%	✗ 3.9%	✗ 3.9%	✗ 4.2%	✗ 3.6%	3.5%	DoW	Dec-14	National		
	● Vacancy rate	5.0%	✗ 12.4%	✗ 12.0%	✗ 12.0%	✗ 12.2%	5.0%	DoW	Dec-14	National		
	● Appraisal rate	95.0%	✗ 23.4%	✗ 31.8%	✗ 33.8%	✗ 46.7%	95.0%	DoW	Dec-14	National		
	Mandatory Training	tbc	73.5%	74.3%	75.6%	73.4%	tbc	DoW	Nov-14	Local		
	% Bank Pay	tbc	6.3%	6.3%	6.2%	6.3%	tbc	DoW	Dec-14	Local		
	% Agency Pay	tbc	15.5%	14.4%	14.8%	14.9%	tbc	DoW	Dec-14	Local		
	Temporary costs and overtime as % of total paybill	tbc	21.8%	21.1%	20.1%	21.7%	tbc	DoW	Dec-14	National		

*Medication errors causing serious harm data for latest month is provisional and subject to validation

Indicator Summary

Domain		Indicator	Target	Latest three data points (Most Recent)			YTD Actual	YTD Target	Executive Lead	Month	Threshold	Trend	Data Quality RAG
Operational Effectiveness	●	A&E 4hr waits (Type 1, 2 & 3)	95.0%	✗ 91.6%	✗ 90.1%	✗ 87.5%	✗ 92.8%	95.0%	DCEO	Dec-14	National		
		A&E 12hr trolley waits	0	✓ 0	✓ 0	✓ 0	✓ 0	0	DCEO	Dec-14	National		
	●	Ambulance turnaround time between 30 and 60 mins	0	✗ 247	✗ 281	✗ 327	✗ 2,063	0	DCEO	Dec-14	Local		
	●	Ambulance turnaround time > 60 mins	0	✗ 51	✗ 41	✗ 181	✗ 434	0	DCEO	Dec-14	Local		
	●	Referral to Treatment - Admitted	90.0%	✗ 67.3%	✗ 68.9%	✗ 67.1%	✗ 70.8%	90.0%	DCEO	Dec-14	National		
	●	Referral to Treatment - Non Admitted	95.0%	✗ 86.2%	✗ 82.2%	✗ 84.1%	✗ 87.2%	95.0%	DCEO	Dec-14	National		
	●	Referral to Treatment - Incomplete	92.0%	✗ 81.0%	✗ 81.2%	✗ 81.2%	✗ 83.4%	92.0%	DCEO	Dec-14	National		
	●	Referral to Treatment - 52 week waits	0	✗ 12	✗ 23	✗ 21	✗ 67	0	DCEO	Dec-14	National		
	●	Diagnostic wait times	99.0%	! 99.0%	✗ 98.9%	✗ 98.7%	✗ 97.4%	99.0%	DCEO	Dec-14	National		
		Cancer - Two week wait *	93.0%	! 94.6%	✓ 96.7%	✓ 96.9%	✗ 89.1%	93.0%	DCEO	Dec-14	National		
	◆	Cancer - Breast Symptomatic two week wait *	93.0%	✓ 95.6%	! 93.9%	✗ 90.6%	✗ 58.2%	93.0%	DCEO	Dec-14	National		
	◆	Cancer - 31 day *	96.0%	✗ 92.2%	✓ 99.1%	✗ 93.6%	✗ 95.3%	96.0%	DCEO	Dec-14	National		
		Cancer - 31 day subsequent drug *	98.0%	✓ 100.0%	✓ 100.0%	✓ 100.0%	✓ 100.0%	98.0%	DCEO	Dec-14	National		
	◆	Cancer - 31 day subsequent surgery *	94.0%	✓ 100.0%	✓ 100.0%	✗ 88.2%	✓ 96.9%	94.0%	DCEO	Dec-14	National		
	●	Cancer - 62 day *	85.0%	✗ 66.9%	✗ 82.0%	✗ 73.2%	✗ 78.9%	85.0%	DCEO	Dec-14	National		
		Cancer - 62 day screening *	90.0%	✓ 100.0%	✓ 100.0%	✓ 100.0%	✓ 93.3%	90.0%	DCEO	Dec-14	National		

*Cancer data for latest month is provisional and subject to validation

Indicator Summary

Domain	Indicator	Target	Latest three data points (Most Recent)			YTD Actual	YTD Target	Executive Lead	Month	Threshold	Trend	Data Quality RAG
Operational Effectiveness	◆ Mixed sex accommodation breaches	0	✓ 0	✓ 0	✗ 5	✗ 5	0	CN	Dec-14	National		
	Urgent operations cancelled for a second time	0	✓ 0	✓ 0	✓ 0	✓ 0	0	DCEO	Dec-14	National		
	● Number of patients not treated within 28 days of last minute cancellation	0	✗ 2	✗ 1	✗ 2	✗ 18	0	DCEO	Dec-14	National		
	● Outpatient cancellation rate	8.0%	✗ 11.0%	✗ 11.5%	✗ 9.3%	✗ 10.8%	8.0%	DCEO	Nov-14	Local		
	Discharges between 8am and 12pm (main adult wards excl AAU)	tbc	18.9%	19.9%	23.1%	20.4%	tbc	DCEO	Dec-14	Local		
	● Electronic discharge summary sent to GP practices	90.0%	✗ 41.0%	✗ 35.5%	✗ 33.6%	✗ 37.7%	90.0%	DCEO	Dec-14	Local		
	NHS number utilisation - inpatients	99.0%	✓ 99.6%	✓ 99.8%	✓ 99.6%	✓ 99.6%	99.0%	CIO	Dec-14	Local		
	NHS number utilisation - outpatients	99.0%	✓ 99.8%	✓ 99.8%	✓ 99.8%	✓ 99.8%	99.0%	CIO	Dec-14	Local		
	Data quality of returns to HSCIC	Data not currently available.										

Indicator Summary

Domain		Indicator	Target	Latest three data points (Most Recent)			YTD Actual	YTD Target	Executive Lead	Month	Threshold	Trend	Data Quality RAG
Patient Experience	●	Friends & Family (I Want Great Care) - inpatient score	75	✗ 61	✗ 63	✗ 59	✗ 68	75	CN	Dec-14	National		
		Friends & Family (I Want Great Care) - inpatient response rate	25.0%	✓ 57.7%	✓ 53.8%	✓ 51.8%	✓ 46.7%	25.0%	CN	Dec-14	National		
	●	Friends & Family (I Want Great Care) - A&E score	75	✗ 62	✗ 54	✗ 61	✗ 62	75	CN	Dec-14	National		
	●	Friends & Family (I Want Great Care) - A&E response rate	15.0%	✗ 5.3%	✗ 8.5%	✗ 8.9%	✗ 8.4%	15.0%	CN	Dec-14	National		
	●	Friends & Family (I Want Great Care) - Maternity score - question two	75	✗ 65	✗ 74	✗ 71	✗ 67	75	CN	Dec-14	National		
		Friends & Family (I Want Great Care) - Maternity response rate - question two	15.0%	✓ 38.5%	✓ 40.5%	✓ 35.4%	✓ 24.2%	15.0%	CN	Dec-14	National		
		CQC Inpatient Survey Q68 - Overall, I had a very poor/good experience (Annual Data)	Annual data. 2014 data is expected in Spring 2015.										
	●	Patients admitted directly to stroke unit within 4 hours of hospital arrival *	90.0%	✗ 62.8%	✗ 58.3%	✗ 56.3%	✗ 66.2%	90.0%	DCEO	Dec-14	Local		
	◆	Stroke patients spending 90% of their time on stroke unit *	80.0%	✓ 88.4%	✓ 87.5%	✗ 68.8%	✓ 84.0%	80.0%	DCEO	Dec-14	Local		
	●	Hospital Acquired Pressure Ulcers - Grade 3 or 4	0	✗ 2	✗ 2	✗ 4	✗ 46	0	CN	Dec-14	Local		
		Delayed Transfers of Care (DToC)	3.5%	✓ 1.4%	✗ 3.8%	✓ 2.3%	✓ 2.1%	3.5%	DCEO	Dec-14	National		
		Number of Falls	tbc	124	86	73	713	tbc	CN	Nov-14	Local		
		% Complaints responded to within one month	tbc	47.1%	53.3%	40.6%	57.3%	tbc	CN	Nov-14	Local		
		Complaints - rate per 10,000 bed days	tbc	26.70	26.77	21.47	25.64	tbc	CN	Nov-14	National		

*Stroke data for latest month is provisional and subject to validation

Indicator Summary

Domain	Indicator	Target	Latest three data points (Most Recent →)			YTD Actual	YTD Target	Executive Lead	Month	Threshold
		£000s	£000s	£000s	£000s					
Financial Viability	Bottom line Income & Expenditure position – forecast against plan	-14,000	-14,000	-14,000	-14,000			DoF	Dec-14	National
	Bottom line Income & Expenditure position – year to date actual against plan	-11,092	-10,626	-13,018	-15,222			DoF	Dec-14	National
	Actual efficiency recurring- forecast against plan	13,400	9,018	7,758	5,163			DoF	Dec-14	National
	Actual efficiency recurring - year to date against actual plan	8,230	2,147	2,627	3,110			DoF	Dec-14	National
	Actual efficiency non-recurring- forecast against plan		982	2,242	1,655			DoF	Dec-14	National
	Actual efficiency non -recurring - year to date against actual plan		498	663	998			DoF	Dec-14	National
	Forecast underlying surplus/deficit against plan	-14,000	-21,500	-21,500	-27,500			DoF	Dec-14	National
	Forecast year end charge to capital resource limit	23,508	23,508	19,540	19,540			DoF	Dec-14	National
	Is the Trust forecasting permanent PDC for liquidity purposes?	30,200	22,700	22,700	14,000			DoF	Dec-14	National
	Cumulative I&E surplus or deficit		-10,626	-13,018	-15,222			DoF	Dec-14	National
	Month's I&E surplus or deficit		-1,000	-2,393	-2,203			DoF	Dec-14	National
	Cumulative EBITDA margin (%)		-1.8%	-2.2%	-2.6%			DoF	Dec-14	National
	NHS income variance (%)		-3.0%	-2.9%	-4.5%			DoF	Dec-14	National
	Year on year change in income		14,504	15,376	14,215			DoF	Dec-14	National
	Year on year change in pay costs		10,718	11,307	11,869			DoF	Dec-14	National
	Year on year change in non pay costs		12,987	12,703	11,403			DoF	Dec-14	National
	Year on year change in capital spend		-7,171	-8,466	-5,791			DoF	Dec-14	National
	Capital spend as a % of annual CRL.		16.3%	22.2%	29.1%			DoF	Dec-14	National
	Continuity of services risk rating		Data not received	Data not received	Data not received			DoF	Dec-14	National
	Liquidity ratio		1	1	1			DoF	Dec-14	National
	Capital servicing capacity		1	1	1			DoF	Dec-14	National
	NHS clinical income per consultant PA		8	Data not received	Data not received			DoF	Dec-14	National
	Outstanding loans value		10,393	10,393	10,393			DoF	Dec-14	National
	Debtor days		29	32	37			DoF	Dec-14	National
	Creditor days		48	49	48			DoF	Dec-14	National
	Purchase order compliance		4.0%	3.0%	3.0%			DoF	Dec-14	National
	% of turnover saved in month		2.4%	2.5%	3.7%			DoF	Dec-14	National
	Forecast savings as % of turnover		3.1%	3.2%	3.2%			DoF	Dec-14	National
	% of forecast savings classified RED		38.0%	39.1%	32.7%			DoF	Dec-14	National

Exception Reports

Deaths in Low Risk Conditions

Indicator	Executive Lead	Clinical Lead	Operational Lead
Deaths in low risk conditions	MD		

Current Month is Aug-14		Year to Date	
Actual	Target	Actual	Target
✖ 1	0	✖ 13	0
Number of months not achieving target (in current financial year)			0 out of 5

August is the latest information available from Dr Foster. No updates to the data from the previous month's report.

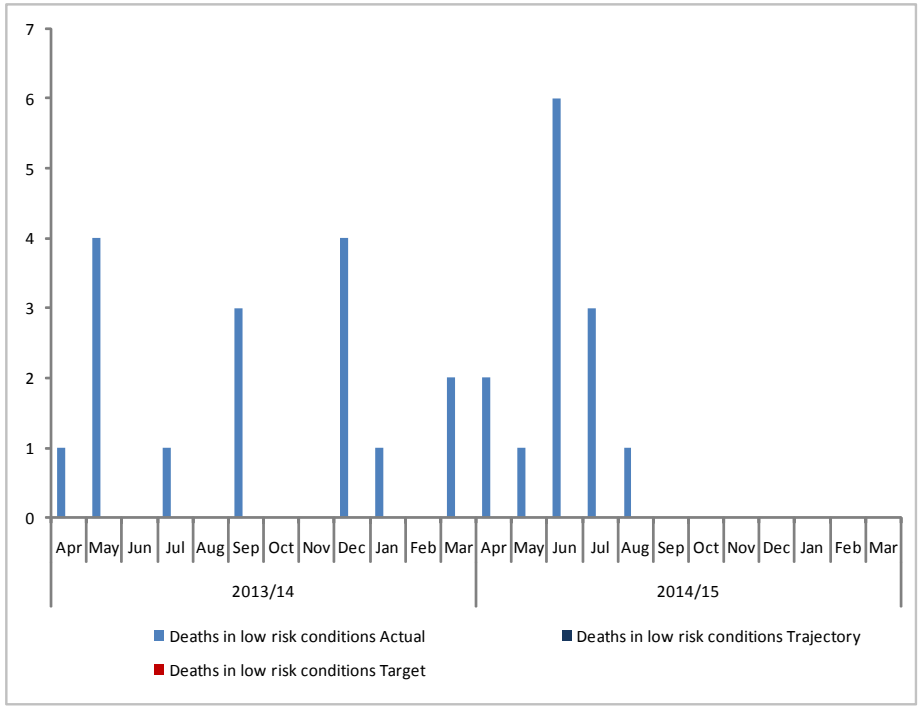
Indicator Description

Deaths from low risk conditions where patients would normally survive. There is a significant time delay in data publication.

Description of Risk

Death in low risk conditions are not expected and need scrutiny when they happen. Mortality notes audit is to be undertaken by the clinical lead and divisional director. Findings fed back to the clinical teams and to the mortality review group. Coding is based on why a person was in hospital, not why they died. Accurate discharge summaries are important.

Immediate Actions	Date
1. All deaths audited through M&M meetings	In place
2. Patient details being reviewed and audited to check data quality and coding	In place
3. Findings from audits to be spread through divisional group meetings	In place
4. Executive monitoring via mortality review group undertaken monthly	In place
5. Review of detailed breakdown of cases to be undertaken	In place
6	
7	
8	



Actions to achieve target and deliver sustainability

Timely receipt of information to ensure mortality is being properly represented internally and externally. Doctors' discharge forms and death certificates to be overseen by senior consultants. Actual coding of death including complex differential diagnosis are to be checked and agreed with senior consultants to ensure accuracy within the coding. Raising awareness and training amongst clinicians to support accurate and clear patient case note documentation.

MRSA Screening - Emergency

Indicator	Executive Lead	Clinical Lead	Operational Lead
MRSA screening - Emergency	CN		

Current Month is Nov-14		Year to Date	
Actual	Target	Actual	Target
✗ 94.6%	95.0%	✗ 94.5%	95.0%
Number of months not achieving target (in current financial year)			7 out of 9

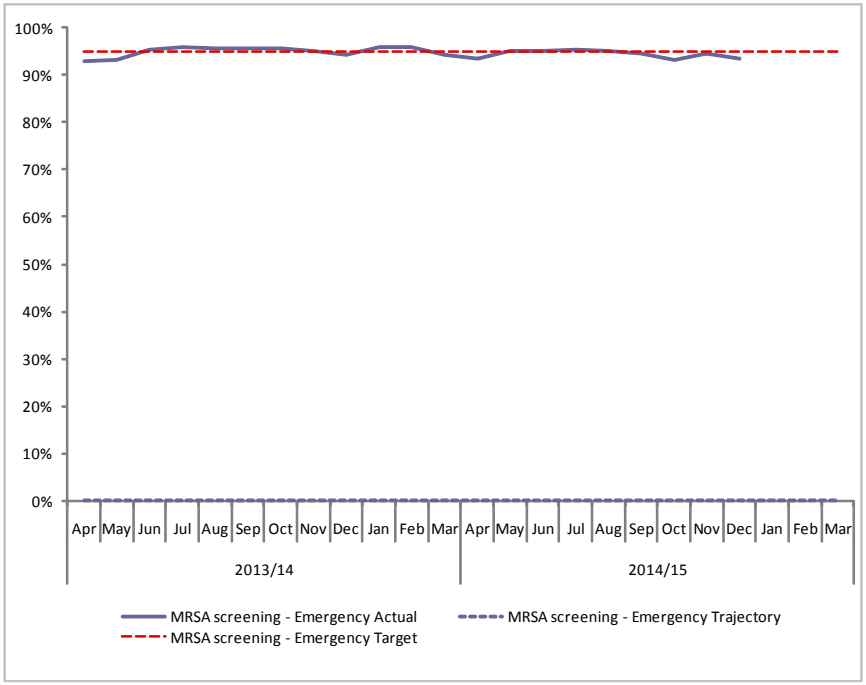
Indicator Description

Percentage of emergency admissions that are screened for MRSA.

Description of Risk

MRSA is often carried on the skin. Screening patients and treating them helps reduce the chance of patients developing an MRSA infection or passing an infection on to other patients.

Immediate Actions	Date
1 No immediate actions.	
2 Reviewed at the monthly Infection, Prevention & Control panel	
3 Assurance is provided through the Quality & Safety report and Infection Control report at Patient Safety, Quality & Risk Committee. The report was tabled at the 6 January 2015 meeting.	



Actions to achieve target and deliver sustainability

Never Events

Indicator	Executive Lead	Clinical Lead	Operational Lead
Never events	MD		

Current Month is Dec-14		Year to Date	
Actual	Target	Actual	Target
✗ 1	0	✗ 3	0
Number of months not achieving target (in current financial year)			0 out of 9

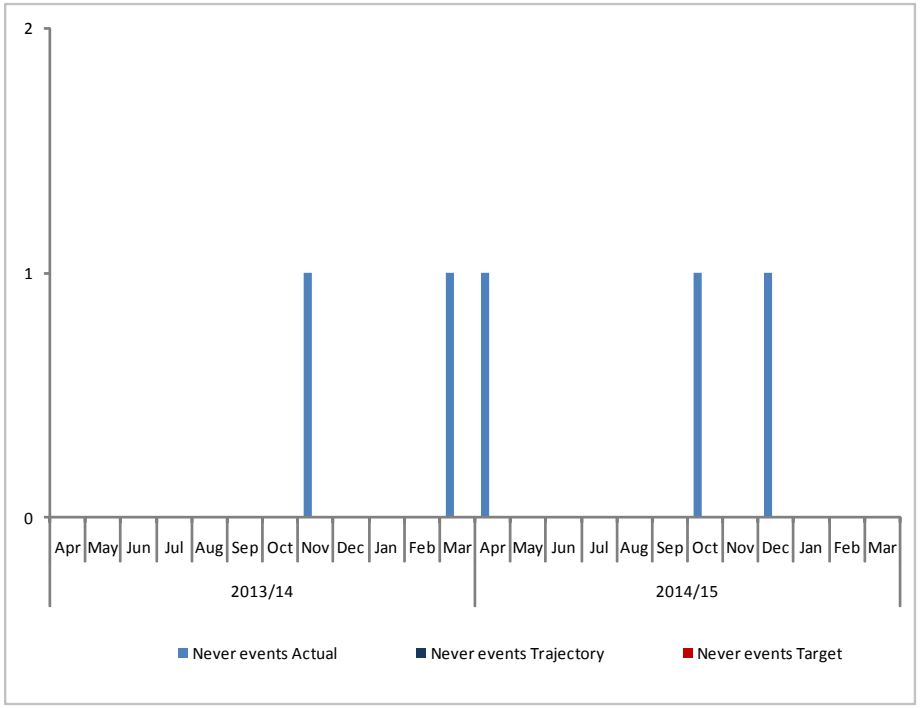
Indicator Description

Number of never events recorded in period. Never events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have

Description of Risk

All never events are serious incidents which need scrutiny since they are largely preventable if available preventable measures have been implemented.

Immediate Actions	Date
1. Investigation commenced, led by ITU nurse with support from surgical division and midwife.	
2	
3	
4	
5	
6	
7	
8	



Actions to achieve target and deliver sustainability

Reported never event of retained swab currently being reviewed.

Harm Free Care

Indicator	Executive Lead	Clinical Lead	Operational Lead
Harm Free Care	CN		

Current Month is Dec-14		Year to Date	
Actual	Target	Actual	Target
✗ 92.6%	95.0%	✗ 92.1%	95.0%
Number of months not achieving target (in current financial year)			9 out of 9

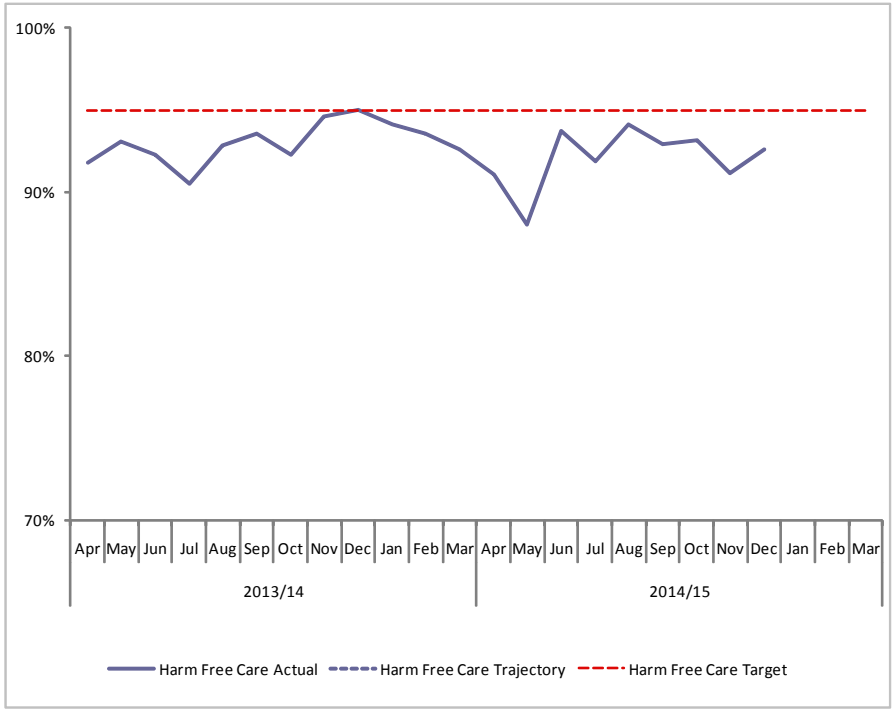
Indicator Description

Data is sourced from the Safety Thermometer, a snapshot of the condition of a large number of patients, reporting on falls, catheter UTI, pressure ulcers and Venous Thromboembolism (VTE).

Description of Risk

The safety thermometer is a point prevalence survey (one day) to give and indication of the level of harm free care through the organisation. Other metrics are collected on a more regular basis to ensure delivery of harm free care in relation to falls, catheter usage, pressure ulcer care and VTE identification and management.

Immediate Actions	Date
1 Monitored at Quality Safety Group	
2 Assurance is provided through the Quality & Safety report and Infection Control report at Patient Safety, Quality & Risk Committee. The report was tabled at the 6 January 2015 meeting.	Feb-15
3 Links to separate actions on Pressure Ulcer exception report, tabled at Patient Safety, Quality & Risk committee and Trust Leadership Executive Committee	Jan-15



Actions to achieve target and deliver sustainability

Fundamentals of care panel oversee delivery. Serious incidents are investigated as per policy. Learning from serious incidents and near misses to be further embedded throughout divisions around lessons learnt and via patient safety and quality committee.

Staff Turnover

Indicator	Executive Lead	Clinical Lead	Operational Lead
Staff turnover rate	DoW		

Current Month is Dec-14		Year to Date	
Actual	Target	Actual	Target
✖ 17.1%	12.0%	✖ 16.4%	12.0%
Number of months not achieving target (in current financial year)			0 out of 9

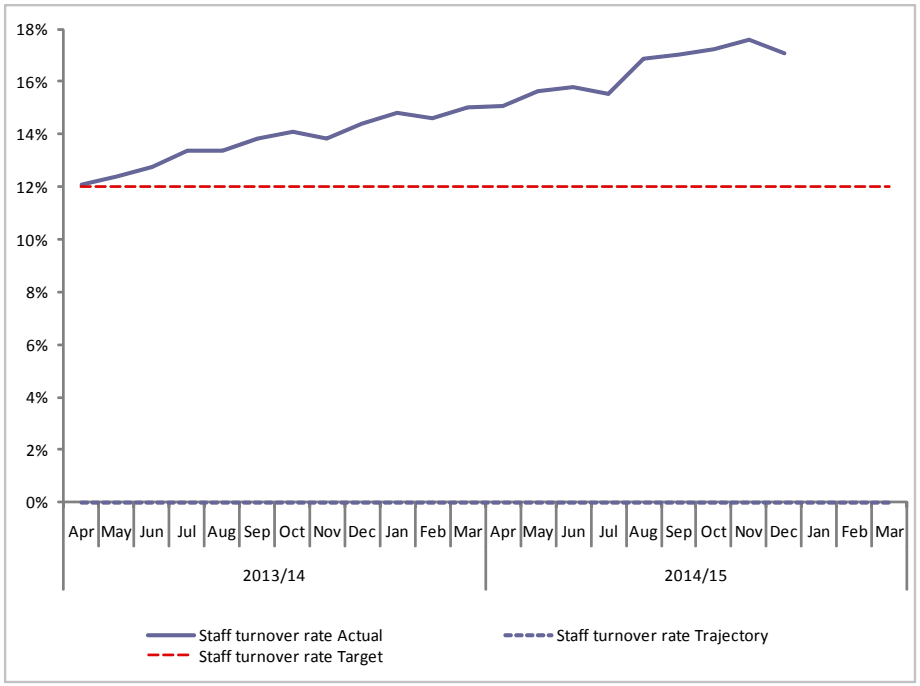
Indicator Description

Proportion of workforce leaving in a given period.

Description of Risk

Increasing labour turnover results in the Trust losing key skills, increased use of temporary staff to cover service need, and additional recruitment of staff to replace leavers.

Immediate Actions	Date
1. Divisional R&R plans now produced and being reviewed at all divisional performance meetings.	Ongoing
2. Full list of leavers to be reviewed at all divisional performance meetings.	Ongoing
3. New reporting around vacancies being produced and shared with HONs, HR BP, DoN and HRD to facilitate proactive management of existing vacancies.	Feb-15
4. External support around occupational health clearances to help alleviate current backlog being sought and changes to our standard OHS clearance procedures which would reduce time to hire being investigated.	Feb-15
5. Business case for overseas recruitment being finalised and partner to work on this project being selected.	Feb-15
6. Personalised Bank rates being introduced and all staff to be auto-enrolled onto our Bank.	Feb-15
7. Engagement plans to assure people that we are taking action around recruitment and retention being launched.	Feb-15



Actions to achieve target and deliver sustainability

It is anticipated that the current project examining reasons for high turnover should report by early January. This will help frame next steps and the production of corporate and divisional retention plans which should be in place by the end of January 2015.

Sickness Rate

Indicator	Executive Lead	Clinical Lead	Operational Lead
Sickness rate	DoW		

Current Month is Dec-14		Year to Date	
Actual	Target	Actual	Target
✗ 4.2%	3.5%	✗ 3.6%	3.5%
Number of months not achieving target (in current financial year)			4 out of 8

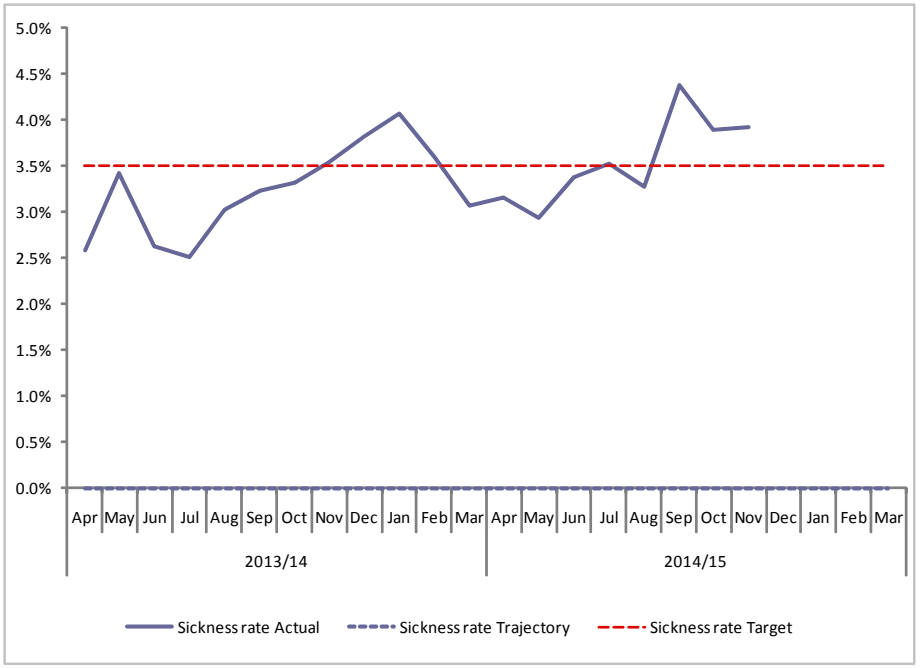
Indicator Description

Proportion of workforce absent due to sickness in a given period.

Description of Risk

High absence rates leads to diminished staff engagement, poorer patient experience and increased replacement costs. There is a lack of confidence in current reporting levels which seem low in comparison to other workforce indicators.

Immediate Actions	Date
1. Rolling out training and guidance to managers on how better to manage absence	Ongoing
2. HR BPs will be tasked with working with their divisions to produce absence management action plans	Ongoing
3. Reinstating monthly absence management meetings between HR advisers and Divisional leads	Feb-15



Actions to achieve target and deliver sustainability

Significant work is planned around absence management during 2015 which will include the review of our absence management policy, reporting of absence and a review of our occupational health service.

Vacancy Rate

Indicator	Executive Lead	Clinical Lead	Operational Lead
Vacancy rate	DoW		

Current Month is Dec-14		Year to Date	
Actual	Target	Actual	Target
✗ 12.0%	5.0%	✗ 12.2%	5.0%
Number of months not achieving target (in current financial year)			0 out of 8

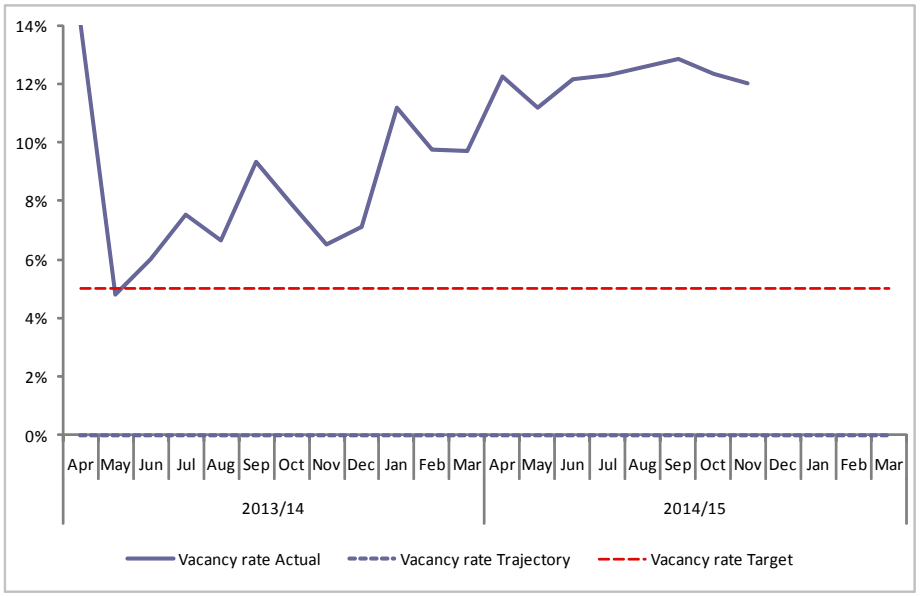
Indicator Description

Percentage of vacancies against total establishment (WTE).

Description of Risk

High vacancy rates result in leads to diminished staff engagement, poorer patient experience. increased replacement costs and loss of organisational talent.

Immediate Actions	Date
1. New processes to highlight 'inactive' vacancies to divisions to prompt activity or release	Feb-15
2. Increased numbers of Nursing and HCA recruitment events (fortnightly) with associated rolling advertisements	Ongoing
3. Job Fair attendance planned Westfield West London	Feb-15
4. Business case for overseas recruitment to be finalised	Jan-15
5. A&E Consultants engaged in process to design and develop campaign for recruitment to vacant middle grade posts	Dec-14



Actions to achieve target and deliver sustainability

Longer term the action around this area must focus upon improving retention, developing WHHT's appeal as a future employer and ensuring that our recruitment processes are able to process and recruit people as quickly as possible.

Appraisal Rate

Indicator	Executive Lead	Clinical Lead	Operational Lead
Appraisal rate	DoW		

Current Month is Dec-14		Year to Date	
Actual	Target	Actual	Target
✗ 33.8%	95.0%	✗ 46.7%	95.0%
Number of months not achieving target (in current financial year)			8 out of 8

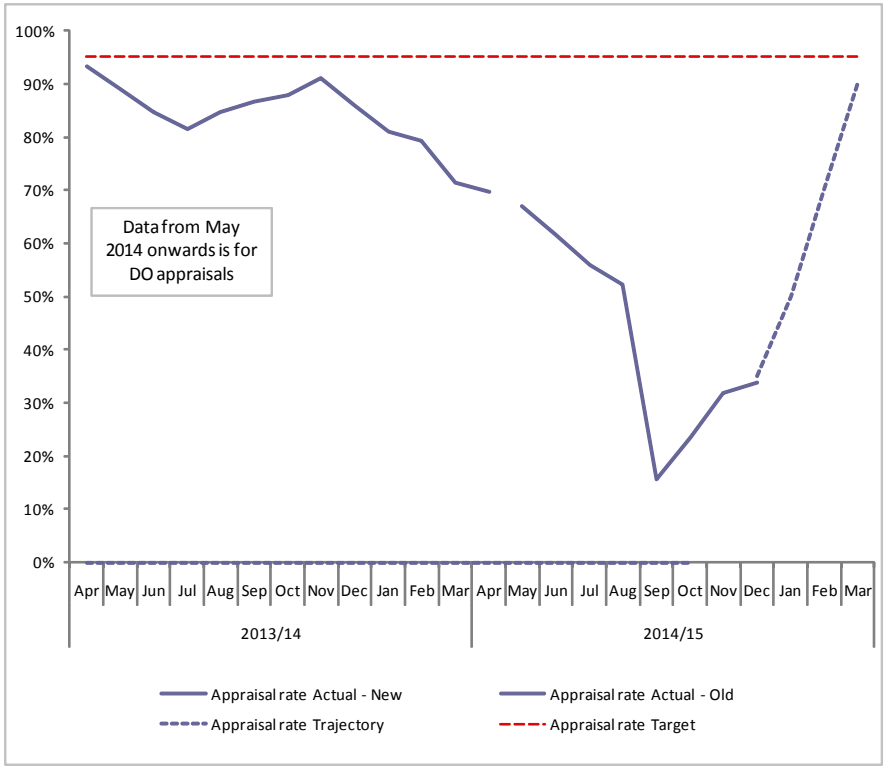
Indicator Description

Percentage of substantive staff members with an up to date appraisal recorded on ESR.

Description of Risk

Over 600 managers have received VBT training, but completion rates are very low leading to reduced engagement and potentially poor performance not being actively managed. (Important to note that the completion rates only include appraisals completed as part of the values based appraisals process with the training for this work having finished in September).

Immediate Actions	Date
1. Completion of appraisal trajectory	
2. Communications campaign to highlight good practice and encourage completion	
3. Production of divisional appraisal action plans by HR Business Partners.	
4. OD and HR Business Partners providing practical support to managers who lack confidence and/or need support with documentation	Jan-15



Actions to achieve target and deliver sustainability

Appraisal process to be established across the Trust. Monthly feedback on targets to Board and Divisions. Higher levels of appraisals indicate staff are familiar and aligned with organisation objectives and have a clear view of effective and ineffective behaviour.

A&E 4hr Waits

Indicator	Executive Lead	Clinical Lead	Operational Lead
A&E 4hr waits (Type 1, 2 & 3)	DCEO		

Current Month is Dec-14		Year to Date	
Actual	Target	Actual	Target
✗ 87.5%	95.0%	✗ 92.8%	95.0%
Number of months not achieving target (in current financial year)			7 out of 9

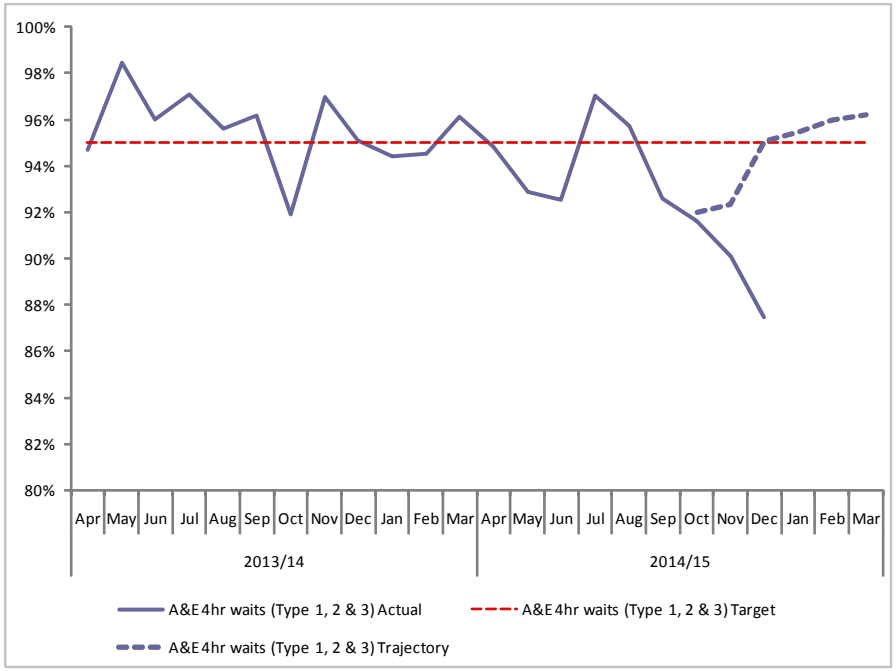
Indicator Description

Time from arrival in A&E to discharge or admission to a ward.

Description of Risk

Reputational, patient safety and financial risks due to the non-delivery of the four hour A&E NHS constitutional standard.

Immediate Actions	Date
1 WAD (weekend assessment and discharge team) dedicated multi disciplinary team working every weekend to facilitate discharge	In place
2 Improved monitoring and tracking processes, now including HCT, in IDT re DTOC	In place
3 Collaborative system wide working	In place
4 Implementation of Acute Hub (first stage of Unscheduled Care Programme)	In place
5 Implementation of ECIST recommendations - aligned with unscheduled care programme phasing	Dec-14
6 New breach reporting system being rolled out	Dec-14
7	
8	



Actions to achieve target and deliver sustainability

Implementation of the ECIST Whole System Review recommendations, including: WHHT to lead review and implement frailty pathway, paediatric pathway and review and improve acute discharges; system wide commitment to the appropriate use of escalation beds and for a Whole System Perfect week.

The Unscheduled Care Programme comprises six projects to re-align our clinical resources in the environment in which we see and treat patients so that we improve our response times to patients' needs and achieve better outcomes in patient care. The programme includes the following projects: patient flow, 7-day working, Children's Emergency Department/Minors streaming using Emergency Nurse Practitioners, the Emergency Surgery Assessment Unit, Gynaecology Ambulatory Care Unit and Hot Clinics.

Ambulance Turnaround Time between 30 and 60 mins

Indicator	Executive Lead	Clinical Lead	Operational Lead
Ambulance turnaround time between 30 and 60 mins	DCEO		

Current Month is Dec-14		Year to Date	
Actual	Target	Actual	Target
327	0	2,063	0
Number of months not achieving target (in current financial year)			0 out of 9

Indicator Description

Time between the time of ambulance arrival at hospital and the time the ambulance became available to respond to another call. This will include the clinical handover of the patient, time to tidy, clean and restock the ambulance ready for the next call.

Description of Risk

Reputation, patient safety and financial risks of non-delivery of the operational standard.

Immediate Actions	Date
1 Hospital based ambulance liaison officer in place	In place
2 Operations manager in A&E monitoring inbound ambulance arrivals	In place
3	
4	
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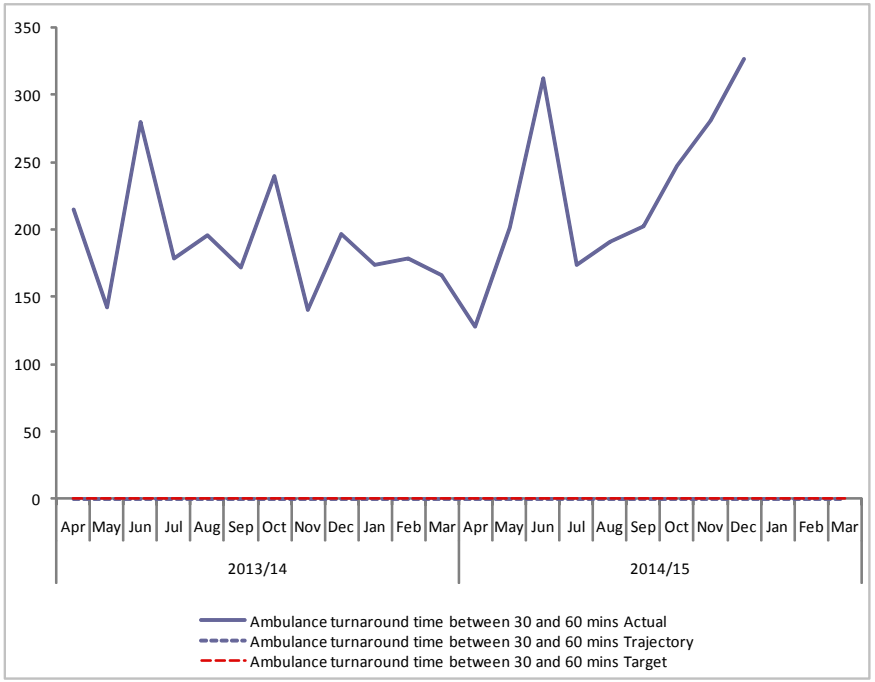
6	
7	
8	



Actions to achieve target and deliver sustainability

Ambulance Turnaround Time > 60 mins

Indicator	Executive Lead	Clinical Lead	Operational Lead
Ambulance turnaround time > 60 mins	DCEO		

Current Month is Dec-14		Year to Date	
Actual	Target	Actual	Target
✗ 181	0	✗ 434	0
Number of months not achieving target (in current financial year)			0 out of 9

Indicator Description

Time between the time of ambulance arrival at hospital and the time the ambulance became available to respond to another call. This will include the clinical handover of the

Description of Risk

Reputation, patient safety and financial risks of non-delivery of the operational standard.

Immediate Actions	Date
1 Hospital based ambulance liaison officer in place	In place
2 Operations manager in A&E monitoring inbound ambulance arrivals	In place
3	
4	
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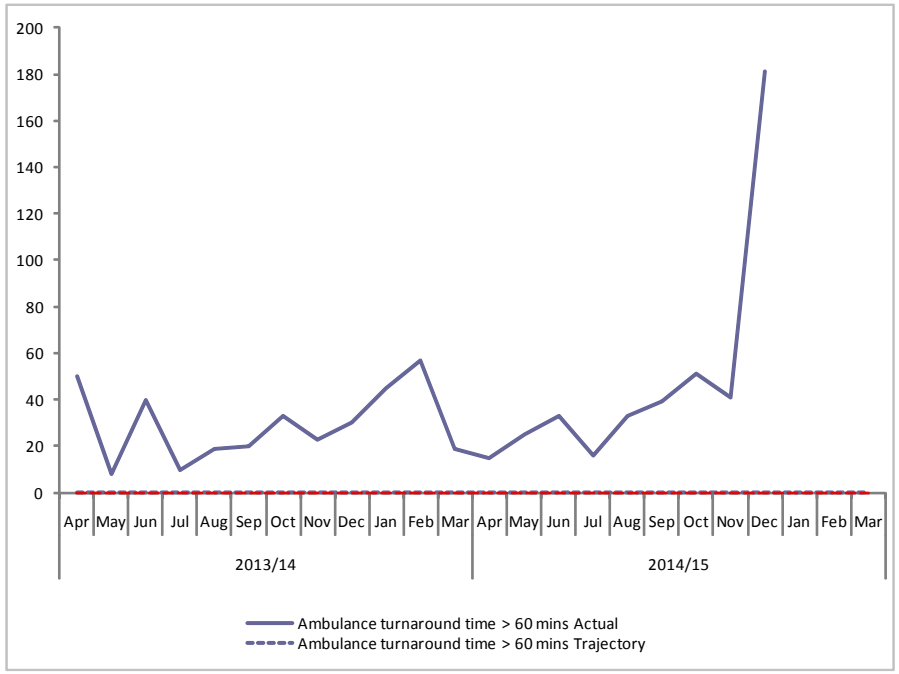


Actions to achieve target and deliver sustainability

Referral to Treatment - Admitted

Indicator	Executive Lead	Clinical Lead	Operational Lead
Referral to Treatment - Admitted	DCEO		

Current Month is Dec-14		Year to Date	
Actual	Target	Actual	Target
✗ 67.1%	90.0%	✗ 70.8%	90.0%
Number of months not achieving target (in current financial year)			9 out of 9

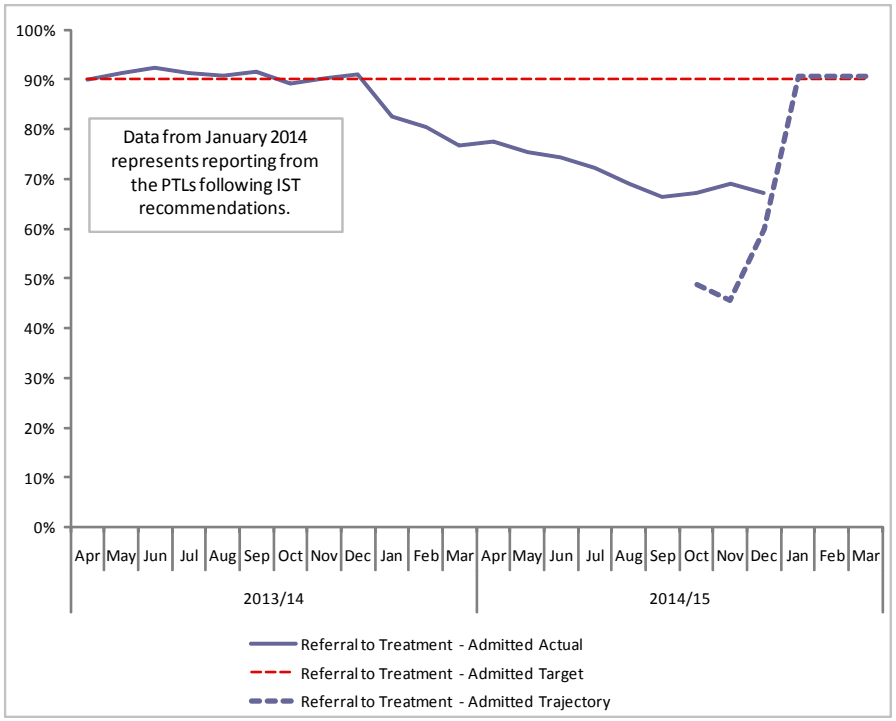
Indicator Description

Waiting times for referrals to consultant led services, timed from receipt of referral to first definitive treatment or discharge, for admitted patient pathways.

Description of Risk

Reputation, patient safety and financial risks of non-delivery mitigated by updated recovery plan including strengthened governance arrangements.
Specialty plans developed to meet required capacity. To be reviewed by Executives.
Data quality risks mitigated by full review by interim Informatics RTT Project Director and implementation of a data quality improvement plan.

Immediate Actions	Date
1. Implement new Governance arrangements (weekly monitoring and revised governance structure)	In place
2. IST review of completed specialty plans	Completed
3. Recruit to full complement of validation staff	Ongoing
4. Implement daily validation of patient pathways	Dec-14
5. Expansion of scheduling and outsourcing team	Dec-14
6. Development of prospective PTL to support scheduling and outsourcing	In place
7. Introduce new Clinic Outcome Form	In place



Actions to achieve target and deliver sustainability

Active management of progress against specialty plans and support to actions which prevent unnecessary delays and increase capacity. Actions include: increasing staffing in outpatients and pre-operative assessment to enable patient calling (to reduce DNAs); use of overtime and weekend working in outpatients; Medical Director review of all theatre lists to ensure full utilisation; and brokering of free lists. Reviewing management support to elective and patient access. Director of Operations (elective care) appointed 16/12/14.

Referral to Treatment – Non-Admitted

Indicator	Executive Lead	Clinical Lead	Operational Lead
Referral to Treatment - Non Admitted	DCEO		

Current Month is Dec-14		Year to Date	
Actual	Target	Actual	Target
✗ 84.1%	95.0%	✗ 87.2%	95.0%
Number of months not achieving target (in current financial year)			9 out of 9

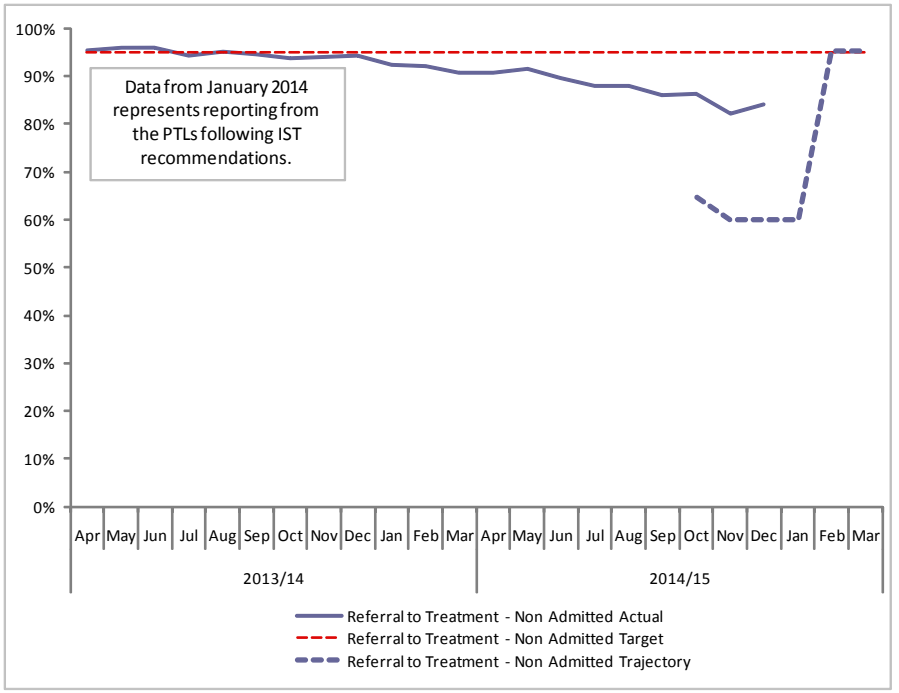
Indicator Description

Waiting times for referrals to consultant led services, timed from receipt of referral to first definitive treatment or discharge, for non admitted patient pathways.

Description of Risk

Reputation, patient safety and financial risks of non-delivery mitigated by updated recovery plan including strengthened governance arrangements.
Specialty plans developed to meet required capacity. To be reviewed by Executives.
Data quality risks mitigated by full review by interim Informatics RTT Project Director and implementation of a data quality improvement plan.

Immediate Actions	Date
1. Implement new Governance arrangements (weekly monitoring and revised governance structure)	In place
2. IST review of completed specialty plans	Nov-14
3. Recruit to full complement of validation staff	Completed
4. Implement daily validation of patient pathways	Ongoing
5. Expansion of scheduling and outsourcing team	Dec-14
6. Development of prospective PTL to support scheduling and outsourcing	In place
7. Introduce new Clinic Outcome Form	In place
8. Review of choose and book processes	Dec-14



Actions to achieve target and deliver sustainability

Active management of progress against specialty plans and support to actions which prevent unnecessary delays and increase capacity. Actions include: increasing staffing in outpatients and pre-operative assessment to enable patient calling (to reduce DNAs); use of overtime and weekend working in outpatients; Medical Director review of all theatre lists to ensure full utilisation; and brokering of free lists. Reviewing management support to elective and patient access. Director of Operations (elective care) appointed 16/12/14

Referral to Treatment - Incomplete

Indicator	Executive Lead	Clinical Lead	Operational Lead
Referral to Treatment - Incomplete	DCEO		

Current Month is Dec-14		Year to Date	
Actual	Target	Actual	Target
✗ 81.2%	92.0%	✗ 83.4%	92.0%
Number of months not achieving target (in current financial year)			9 out of 9

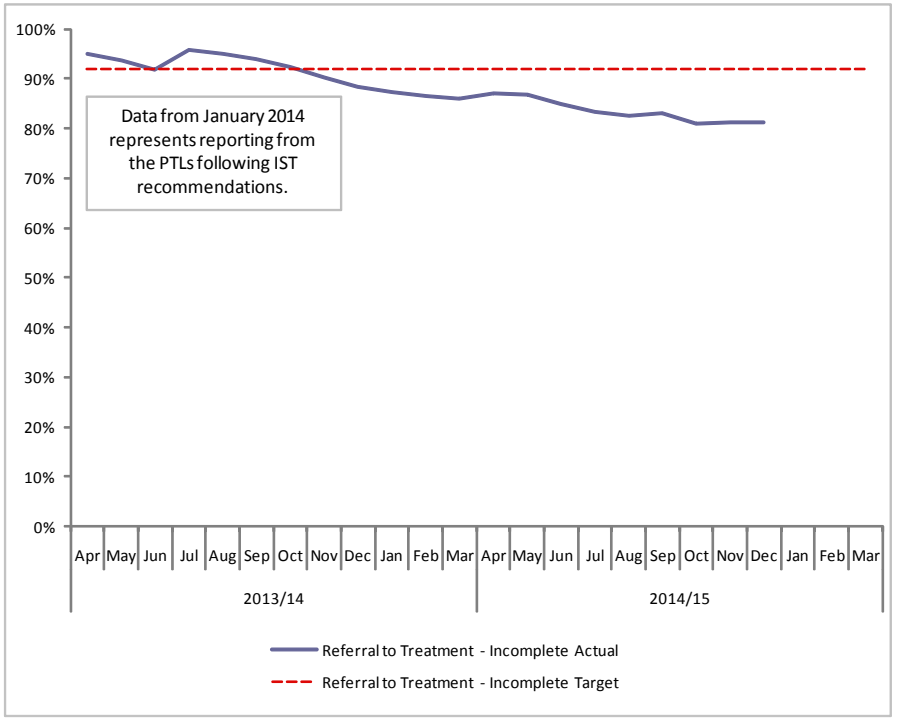
Indicator Description

Waiting times for referrals to consultant led services, timed from receipt of referral to current snapshot date, showing patients still awaiting first definitive treatment or discharge.

Description of Risk

Reputation, patient safety and financial risks of non-delivery mitigated by updated recovery plan including strengthened governance arrangements.
Specialty plans developed to meet required capacity. To be reviewed by Executives.
Data quality risks mitigated by full review by interim Informatics RTT Project Director and implementation of a data quality improvement plan.

Immediate Actions	Date
1. Implement new Governance arrangements (weekly monitoring and revised governance structure)	In place
2. IST review of completed specialty plans	Completed
3. Recruit to full complement of validation staff	Ongoing
4. Implement daily validation of patient pathways	Dec-14
5. Expansion of scheduling and outsourcing team	Dec-14
6. Development of prospective PTL to support scheduling and outsourcing	In place
7. Introduce new Clinic Outcome Form	In place



Actions to achieve target and deliver sustainability

Active management of progress against specialty plans and support to actions which prevent unnecessary delays and increase capacity. Actions include: increasing staffing in outpatients and pre-operative assessment to enable patient calling (to reduce DNAs); use of overtime and weekend working in outpatients; Medical Director review of all theatre lists to ensure full utilisation; and brokering of free lists. Reviewing management support to elective and patient access. Director of Operations (elective care) appointed 16/12/14.

Referral to Treatment – 52 Weeks

West Hertfordshire Hospitals NHS Trust

Indicator	Executive Lead	Clinical Lead	Operational Lead
Referral to Treatment - 52 week waits	DCEO		

Current Month is Dec-14		Year to Date	
Actual	Target	Actual	Target
✗ 21	0	✗ 67	0
Number of months not achieving target (in current financial year)			0 out of 9

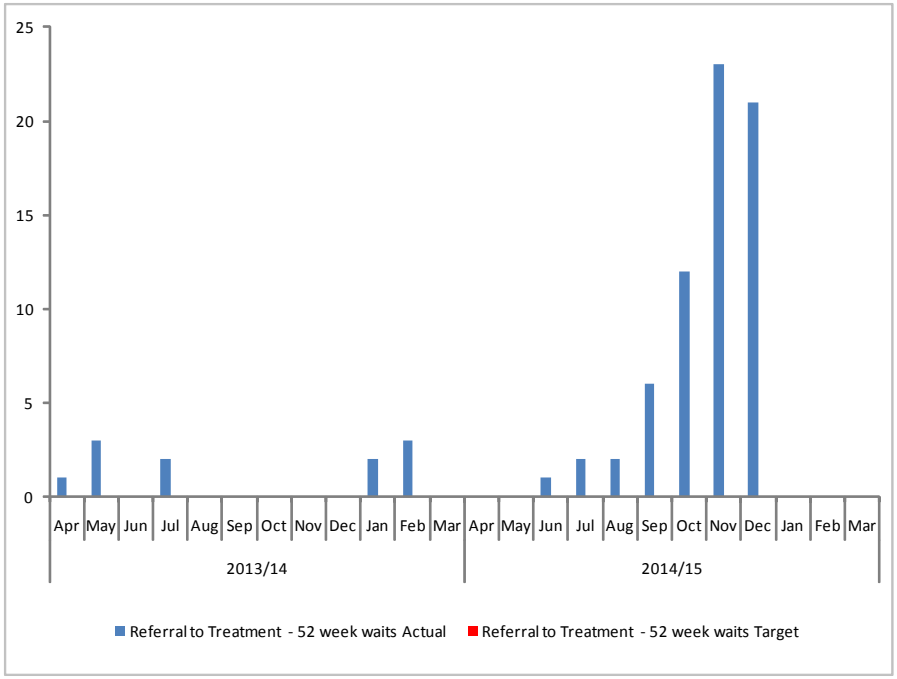
Indicator Description

Waiting time from referral to definitive treatment in excess of 52 weeks for patients.

Description of Risk

Reputational and financial due non-delivery of contractual requirement for zero 52+ week waiters. Indicator includes admitted and non admitted closed pathways over 52 weeks and incomplete pathways over 52 weeks.

Immediate Actions	Date
1. Review of all long waiters over 40 weeks at weekly Access meeting and divisional meetings	In place
2. New arrangements in place with HMP and prisoners treated in line with the Trust's Access Policy	Dec-14
3. Daily review of >52 week patients by COO	Dec-14
4. Other actions, as per completed and incomplete pathways previously listed	



Actions to achieve target and deliver sustainability

Ongoing work with prison service to support better transport services so that prison patients are able to access services at the Trust. All long waiters to be identified and escalated to ensure patients are treated as quickly as possible.

Diagnostic Wait Times

Indicator	Executive Lead	Clinical Lead	Operational Lead
Diagnostic wait times	DCEO		

Current Month is Dec-14		Year to Date	
Actual	Target	Actual	Target
✗ 98.7%	99.0%	✗ 97.4%	99.0%
Number of months not achieving target (in current financial year)			8 out of 9

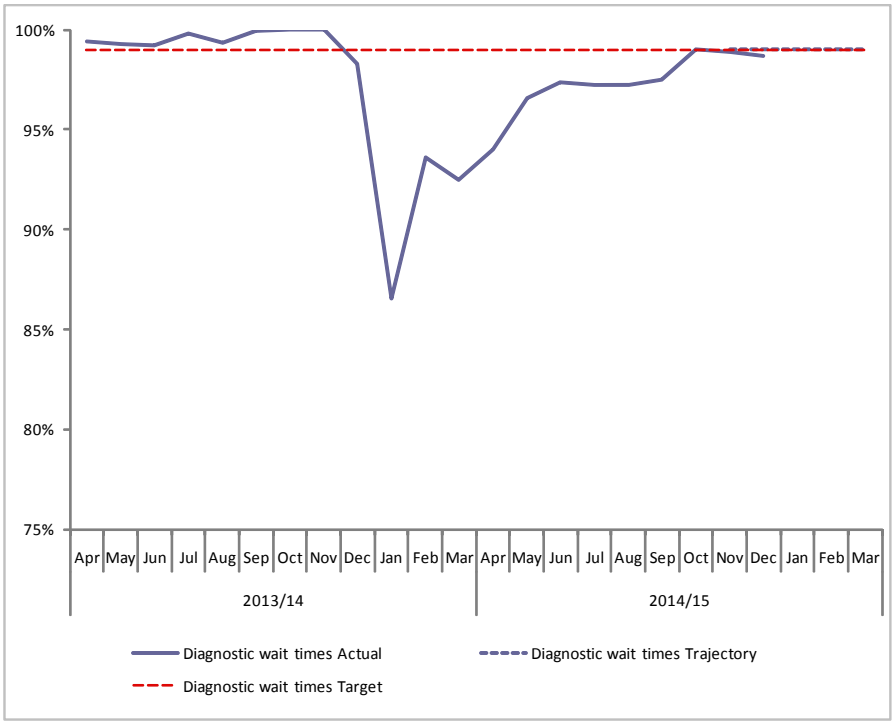
Indicator Description

Percentage of patients waiting for a diagnostic test who are seen within six weeks. There are 15 diagnostic tests in this cohort including endoscopy and imaging, but it excludes laboratory test (pathology).

Description of Risk

Diagnostic test waits at 6 weeks + risks sustainable delivery of RTT 18 week waits and cancer waits mitigated by IST supported demand and capacity work by diagnostic test to achieve 6 weeks and aim to reduce further to 4 weeks

Immediate Actions	Date
1. Forensic weekly validation	In place
2. Weekly access meetings with divisions and Information.	In place
3. Capacity and demand reviews to be re done	Jan-15
4. IST have signed off diagnostic support	Dec-14
5. Plans in place for delivery of additional diagnostic capacity needed to support 18 weeks.	Ongoing



Actions to achieve target and deliver sustainability

The diagnostic PTL will be routinely validated to identify capacity issues, and the revision of 6 weeks demand and capacity plans has commenced.

Cancer – Breast Symptomatic

Indicator	Executive Lead	Clinical Lead	Operational Lead
Cancer - Breast Symptomatic two week wait *	DCEO		

Current Month is Dec-14		Year to Date	
Actual	Target	Actual	Target
✗ 90.6%	93.0%	✗ 58.2%	93.0%
Number of months not achieving target (in current financial year)			7 out of 9

Indicator Description

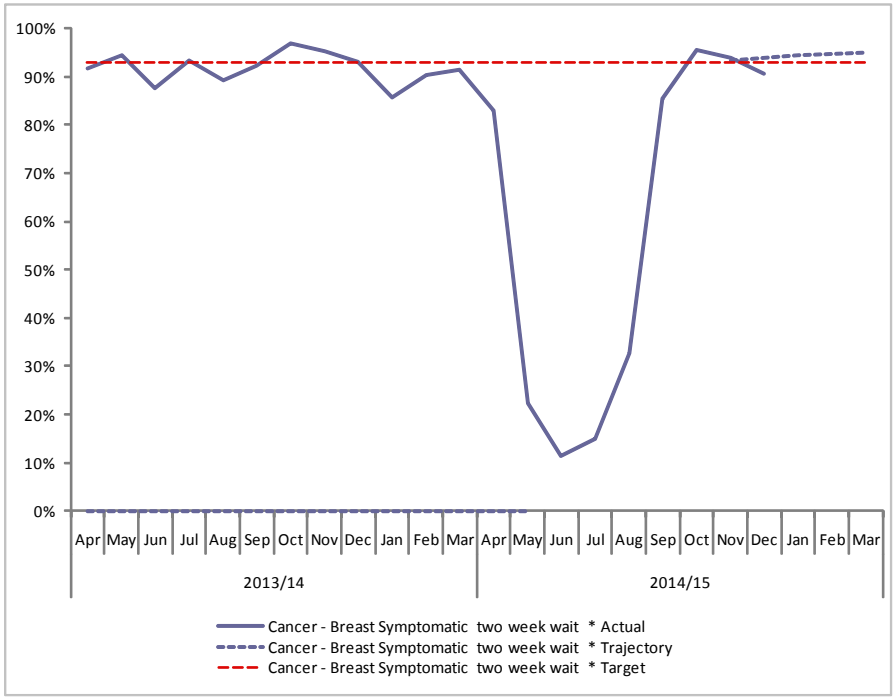
14 day target relates to patients referred from GP to hospital on a breast symptomatic pathway, timed from date of receipt of referral to first attended outpatient appointment.

Description of Risk

Patient safety, financial and reputational, due to the non-delivery of the breast symptomatic two week wait NHS constitution standard. Patient choice has been an issue in November as the Trust has had capacity to see all women in two weeks.

Risk of Cancer not being incorporated within divisional structure addressed. Cancer team now included within division of Medicine.

Immediate Actions	Date
1. Plan in place to clear backlog during September.	Complete
2. Plan in place to achieve sustainable performance in October	Complete
3. Weekly access meetings with Divisions.	In place
4. Cancer team to be incorporated into an existing division.	Complete
5. Increase patient experience of service.	In place
6. Weekly cancer project team meetings.	In place



Actions to achieve target and deliver sustainability

The trust now has capacity to offer appointments within two weeks to all patients referred on a two week pathway for breast symptoms. It is noted that some patients will elect to delay their appointment. Plan to achieve performance agreed with division. The increase of referrals (31% YTD vs same period last year) is believed to have been influenced by a recent TV programme where Breast Cancer was highlighted. Immediate action includes increased oversight and performance management of patient tracking list (PTL). Divisional directors to be informed of issues that need medical escalation. Validation work is continuing, with a focus on reviewing all symptomatic breast cancer referrals to ensure that additional capacity has been reported. Project manager appointment offered 18th December, post to commence in March 2015.

Cancer – 31 Day

Indicator	Executive Lead	Clinical Lead	Operational Lead
Cancer - 31 day *	DCEO		

Current Month is Dec-14		Year to Date	
Actual	Target	Actual	Target
✗ 93.6%	96.0%	✗ 95.3%	96.0%
Number of months not achieving target (in current financial year)			6 out of 9

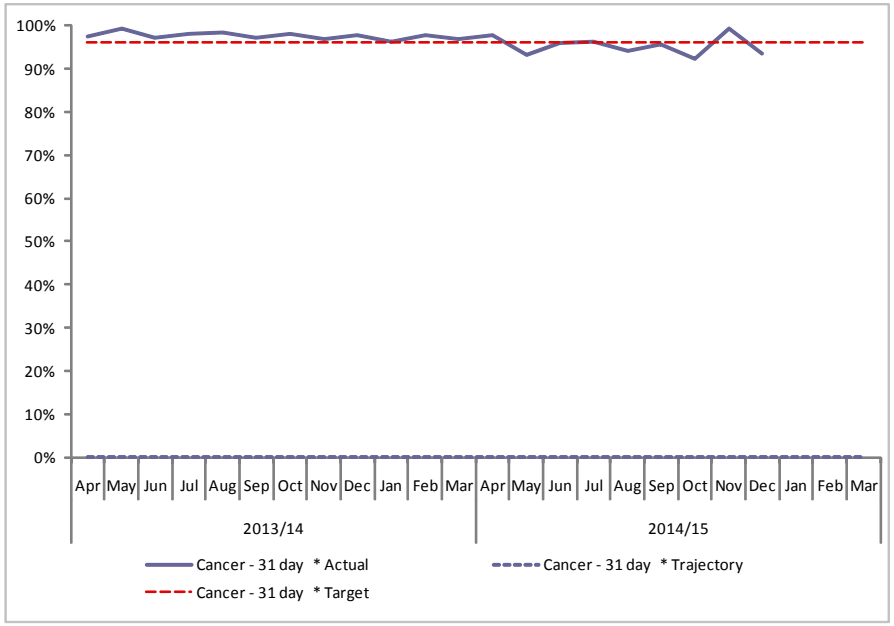
Indicator Description

31 day target relates to time from cancer diagnosis to first definitive treatment.

Description of Risk

Patient safety, financial and reputational, due to the non-delivery of the 31 day NHS constitution standard. Patient safety risk mitigated by MDT review and prioritisation. Capacity and demand imbalance risk mitigated by IST supported capacity planning for all MDTs. Routine PSA observations included in cancer waits count mitigated by operating in line with the cancer waits policy.

Immediate Actions	Date
1. Validation of all 31 day patients	In place
2. Weekly access meetings with divisions	In place
3. Cancer team to be incorporated into an existing division	Complete
4. Increase patient experience of service	In place
5. Weekly cancer project team meetings	In place
6. Detailed weekly progress reports to the Executive team	In place
7. Cancer validation team	Nov-14
8. Defined dedicated project management support	Nov-14



Actions to achieve target and deliver sustainability

Implement cancer improvement plan in response to Independent Review and IST reports. Cancer validation team in place to support accurate reporting from 2WW referral through to 31 and 62 day treatments.

Monthly monitoring of Cancer Action Plan by Executive Team. Project manager appointment offered 18th December, post to commence in March 2015.

Cancer – 31 Day Subsequent Surgery

Indicator	Executive Lead	Clinical Lead	Operational Lead
Cancer - 31 day subsequent surgery *	DCEO		

Current Month is Dec-14		Year to Date	
Actual	Target	Actual	Target
✗ 88.2%	94.0%	✓ 96.9%	94.0%
Number of months not achieving target (in current financial year)			2 out of 9

Indicator Description

Percentage of patients receiving subsequent/adjuvant treatment within a maximum waiting time of 31-days during a given period, including patients with recurrent cancer.

Description of Risk

Patient safety, financial and reputational, due to the non-delivery of the 31 day NHS constitution standard.

Immediate Actions	Date
1. Validation of all 31 day patients.	In place
2. Weekly access meetings with divisions.	In place
3. Cancer team to be incorporated into an existing division.	Complete
4.Increase patient experience of service.	In place
5. Weekly cancer project team meetings.	In place
6. Detailed weekly progress reports to the Executive team.	October
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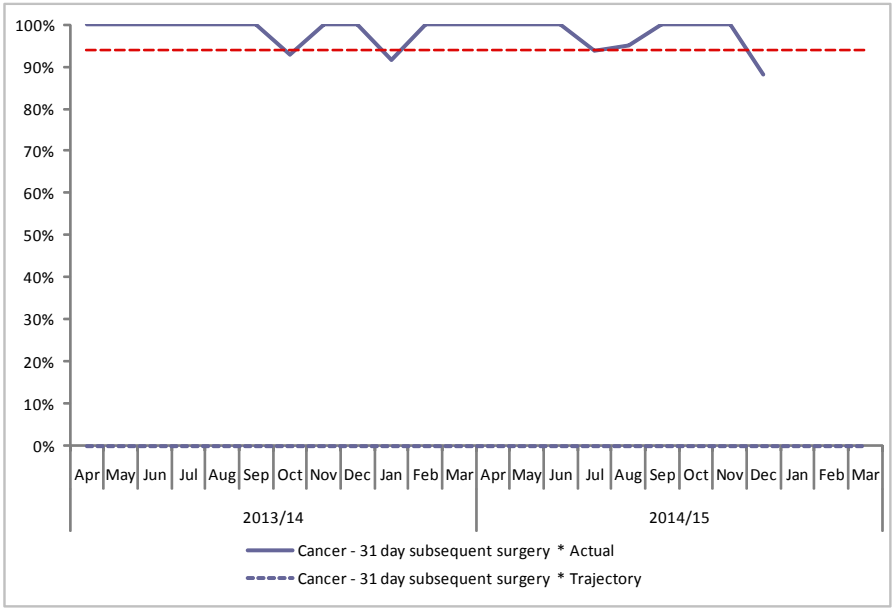


Actions to achieve target and deliver sustainability

Draft action plan being signed off focusing on:

- Scoping demand against current capacity(referrals , outpatient , POA and theatre capacity
- Mapping key stages in the process from referral to treatment to identify weakness with existing process and system and human factors (staff availability and behaviours)
- Review of 2 week wait service completed and forwarded to Cancer Team

Cancer – 62 Day

Indicator	Executive Lead	Clinical Lead	Operational Lead
Cancer - 62 day *	DCEO		

Current Month is Dec-14		Year to Date	
Actual	Target	Actual	Target
✗ 73.2%	85.0%	✗ 78.9%	85.0%
Number of months not achieving target (in current financial year)			7 out of 9

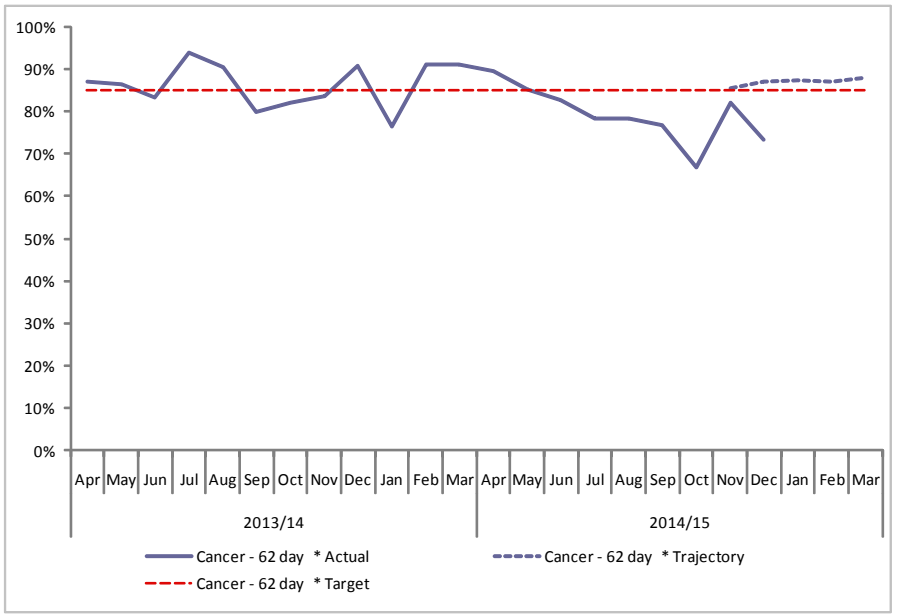
Indicator Description

62 day target relates to time from GP referral to first definitive treatment.

Description of Risk

Patient safety, financial and reputational, due to the non-delivery of the 62 day NHS constitution standard.

Immediate Actions	Date
1. Validation of all patients	In place
2. Weekly access meetings with divisions	In place
3. Cancer team to be incorporated into an existing division	Complete
4. Increase patient experience of service	In place
5. Weekly cancer project team meetings	In place
6. Cancer validation team	In place
7. Develop IST demand and capacity models by tumour site	Dec-14



Actions to achieve target and deliver sustainability

Ongoing monthly monitoring and updating of cancer improvement plan in response to Independent Review and IST reports. Cancer validation team in place to support accurate reporting from 2WW referral through to 31 and 62 day treatments. Patients on waiting lists continue to be actively managed to ensure their treatment date is within 62 days. Reintroduce breach sharing protocol with all referring organisations in order to share accountability and learnings.

Monthly monitoring of Cancer Action Plan by Executive Team. Project manager appointment offered 18th December, post to commence in March 2015.

Mixed Sex Accommodation

Indicator	Executive Lead	Clinical Lead	Operational Lead
Mixed sex accommodation breaches	CN		

Current Month is Dec-14		Year to Date	
Actual	Target	Actual	Target
✗ 5	0	✗ 5	0
Number of months not achieving target (in current financial year)			0 out of 9

Indicator Description

The number of breaches of mixed-sex accommodation.

Description of Risk

Patient dignity, financial and reputational, due to the non-delivery of the Mixed- Sex Accommodation NHS constitution standard.

Five patients in Aldenham ward were placed in a high dependency area, however one patient placed there did not meet the criteria for mixed sex accommodation in a high dependency area.

Immediate Actions	Date
1 Incident raised	Dec-14
2 Root Cause Analysis completed and actions implemented	Dec-14
3 Area reviewed and two separate single sex bays created.	Dec-14
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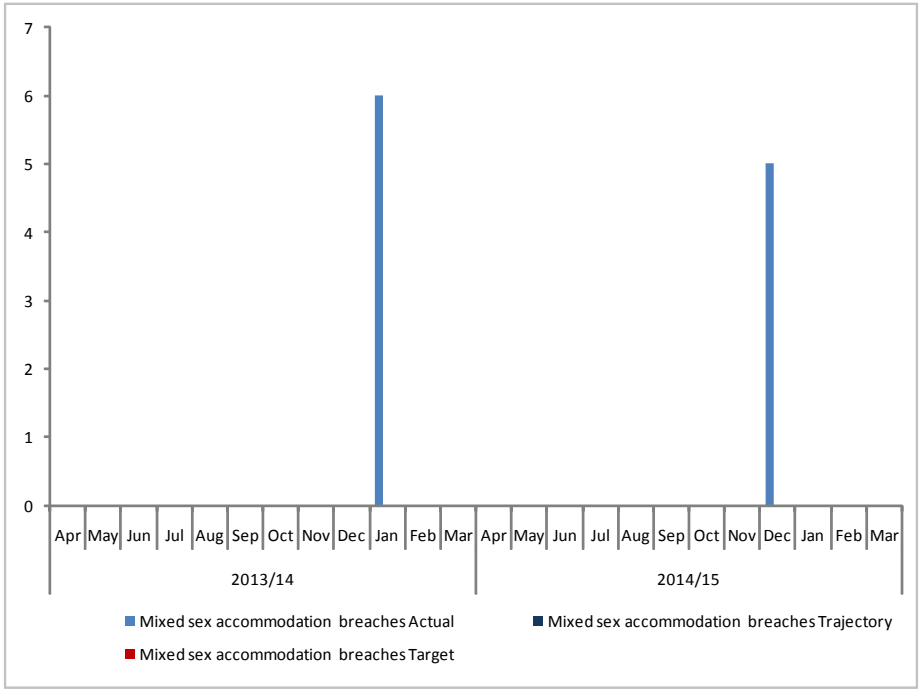

Actions to achieve target and deliver sustainability

Mixed Sex operational procedure reviewed with ward area involved to ensure patients with high dependency needs are still cared for in-ward, but now have dedicated male and female areas.

Cancelled Operations

Indicator	Executive Lead	Clinical Lead	Operational Lead
Number of patients not treated within 28 days of last minute cancellation	DCEO		

Current Month is Dec-14		Year to Date	
Actual	Target	Actual	Target
✗ 2	0	✗ 18	0
Number of months not achieving target (in current financial year)			0 out of 9

Indicator Description

Number of last minute cancelled elective operations for non clinical reasons which are not re-admitted within 28 days.

Description of Risk

Patient experience, safety and reputational risks due to the non-delivery of the 28 day standard.

Immediate Actions	Date
1. Ongoing review of breaches of the 28 day standard at weekly access meetings and implementation of any lessons learned	In place
2. Offer private sector transfer	In place
3. Forward looking at access meeting to prevent 28 day breaches	In place
4 Director of Operations (Unscheduled Care) producing regular report	Dec-14
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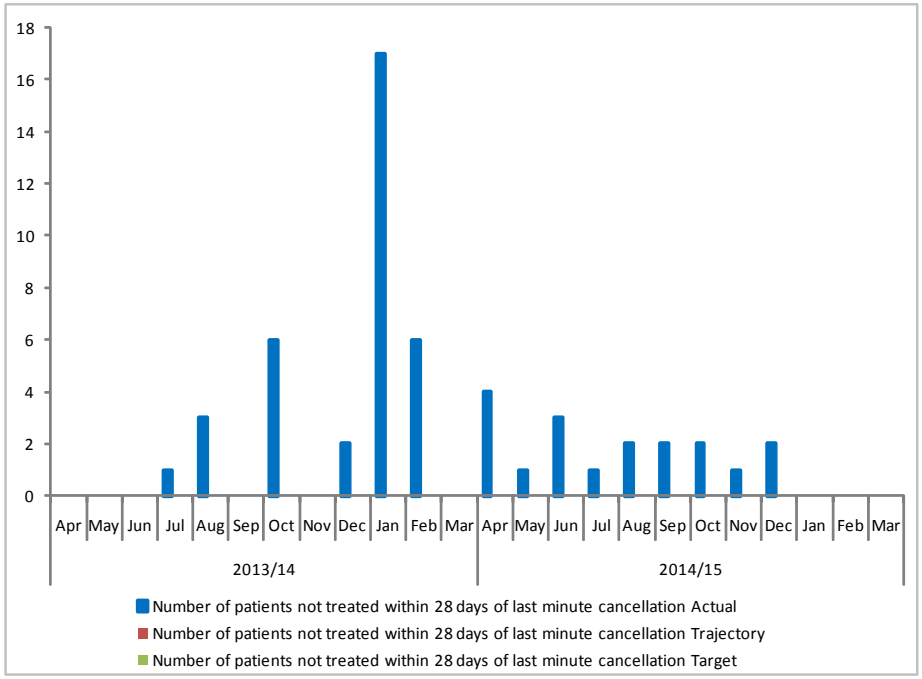

Actions to achieve target and deliver sustainability

Ongoing review of any systemic issues leading to last minute cancellations and failure to re-book within 28 days and continued active monitoring and escalation of patients through existing governance arrangements

Outpatient Cancellation Rate

Indicator	Executive Lead	Clinical Lead	Operational Lead
Outpatient cancellation rate	DCEO		

Current Month is Nov-14		Year to Date	
Actual	Target	Actual	Target
✗ 9.3%	8.0%	✗ 10.8%	8.0%
Number of months not achieving target (in current financial year)			0 out of 9

Indicator Description

Percentage of outpatient appointments that are cancelled by the hospital.

Description of Risk

Patient experience, safety and reputational risks due to the non-delivery of indicator.

Immediate Actions	Date
1 All hospital initiated cancellations under six weeks challenged and exceptions signed off by Divisional Manager or Divisional Director	In place
2 Enabling clearer process for annual leave to be authorised to identify impact on clinics	Jan-14
3 Reinforcement of access policy and retraining in central outpatients regarding patient initiated cancellations	Feb-14
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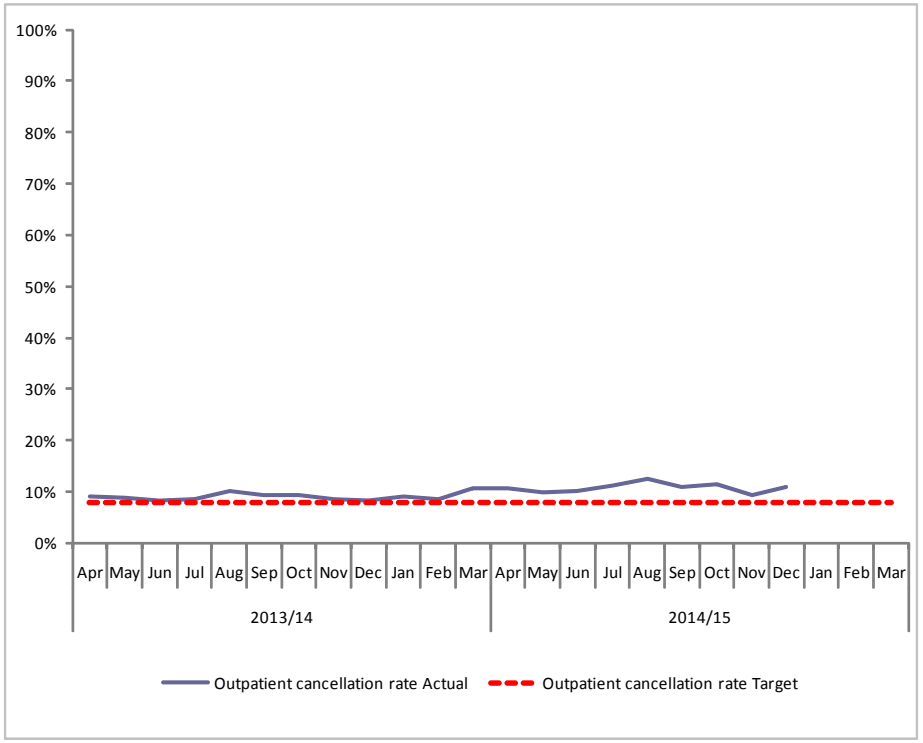

Actions to achieve target and deliver sustainability

Ongoing management of leave processes and adherence to preventing cancelations within six weeks.

Electronic Discharge Summary sent to GP Practices

Indicator	Executive Lead	Clinical Lead	Operational Lead
Electronic discharge summary sent to GP practices	DCEO		

Current Month is Dec-14		Year to Date	
Actual	Target	Actual	Target
✗ 33.6%	90.0%	✗ 37.7%	90.0%
Number of months not achieving target (in current financial year)			9 out of 9

Indicator Description

Percentage of discharge summaries that are sent electronically to GP practices. A standardised electronic discharge summary enables the continuous care of patients once they have been discharged from hospital, with consistent and relevant information in the right place, quickly.

Description of Risk

Risk to the timely provision of discharge information to GPs following a patient's discharge from hospital.

Immediate Actions	Date
1 Email functionality to be provided within the Trust Infoflex system. This required a test (server) environment to be created	Jan-15
2 Testing of functionality by Infoflex applications team	Feb-15
3 User acceptance testing by service users	Feb-15
4 Sign off user acceptance testing and go live	
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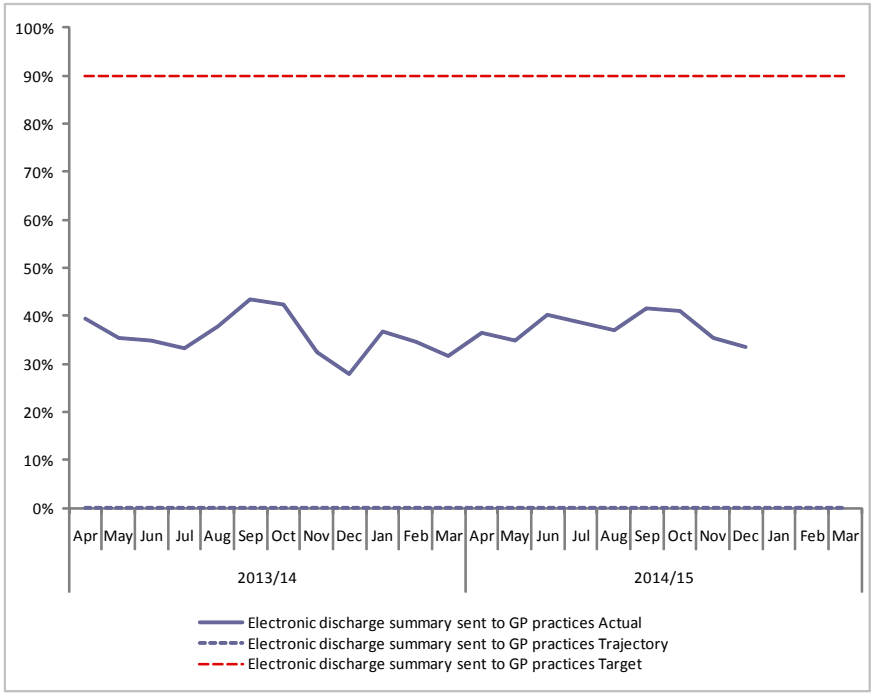


Actions to achieve target and deliver sustainability

Friends & Family – Inpatient Score

Indicator	Executive Lead	Clinical Lead	Operational Lead
Friends & Family (I Want Great Care) - inpatient score	CN		

Current Month is Dec-14		Year to Date	
Actual	Target	Actual	Target
✗ 59	75	✗ 68	75
Number of months not achieving target (in current financial year)			8 out of 9

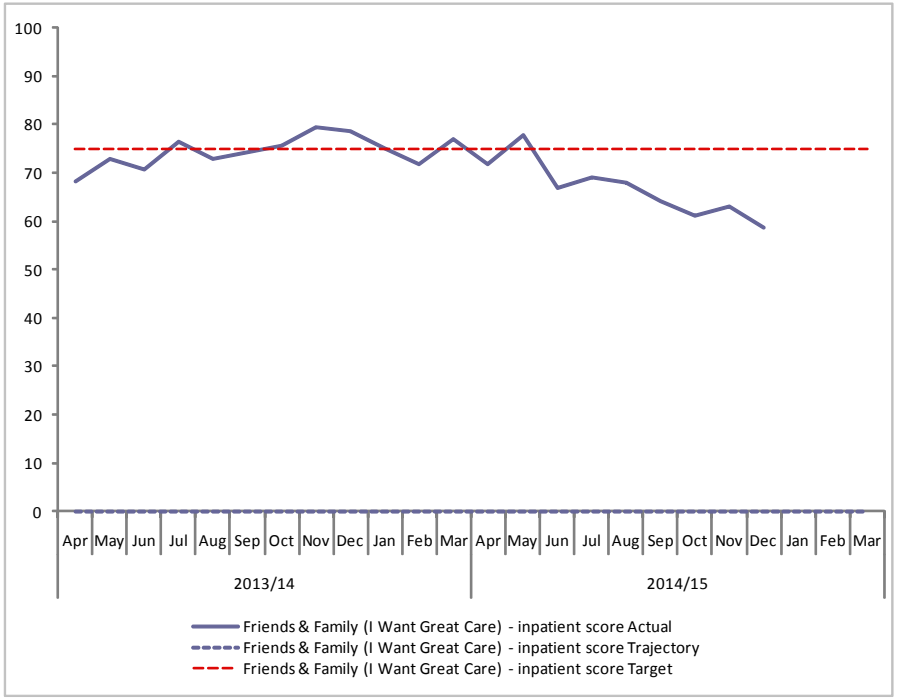
Indicator Description

The Net Promoter Score (FFT) ranges from -1-- to +100 and the closer to +100, the better. Improvement is shown by the number being positive and getting higher. This is for inpatient responses only. Data is one month in arrears due to reporting timescales.

Description of Risk

Patients need us to care and look after them to the best of our ability, in their time of need. This means our care systems and processes meets their needs in delivering NHS services. Their feedback, both formal and informal, supports reputational management in line with our strategic objectives.

Immediate Actions	Date
1 Monitored at Quality Safety Group	Ongoing
2 Assurance is provided through the Quality & Safety report at Patient Safety, Quality & Risk Committee. The report was tabled at the 6 January 2015 meeting.	



Actions to achieve target and deliver sustainability

Set up a review process of the patient feedback with actions. Implementation of ward dashboard and monitoring through monthly divisional performance reviews.

Friends & Family – A&E Score

Indicator	Executive Lead	Clinical Lead	Operational Lead
Friends & Family (I Want Great Care) - A&E score	CN		

Current Month is Dec-14		Year to Date	
Actual	Target	Actual	Target
✗ 61	75	✗ 62	75
Number of months not achieving target (in current financial year)			8 out of 9

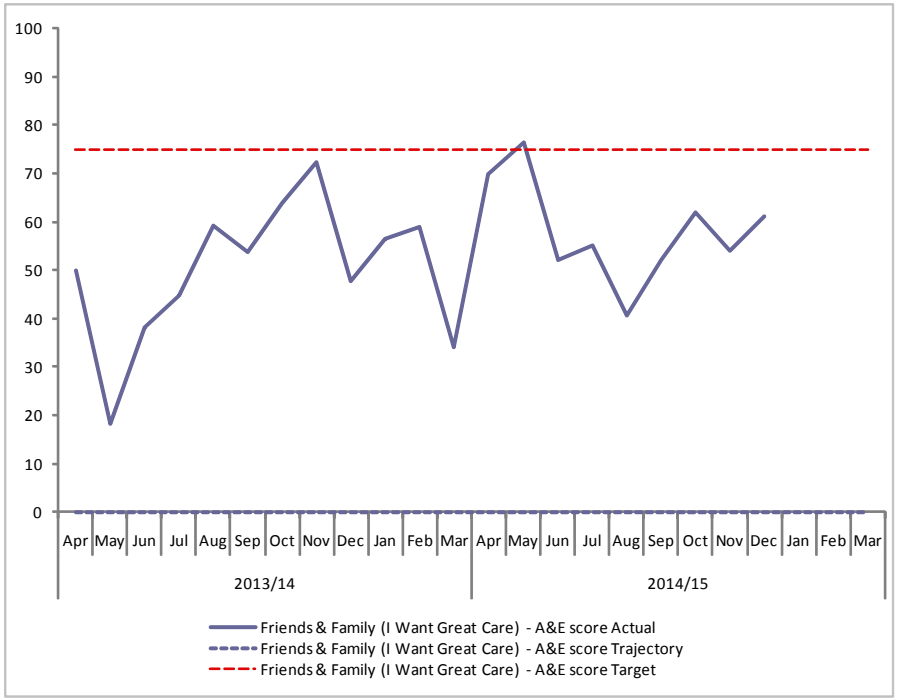
Indicator Description

The Net Promoter Score (FFT) ranges from -1-- to +100 and the closer to +100, the better. Improvement is shown by the number being positive and getting higher. This is for A&E responses only. Data is one month in arrears due to reporting timescales.

Description of Risk

Patients need us to care and look after them to the best of our ability, in their time of need. This means our care systems and processes meets their needs in delivering NHS services. Their feedback, both formal and informal, supports reputational management in line with our strategic objectives.

Immediate Actions	Date
1 Monitored at Quality Safety Group	Ongoing
2 Assurance is provided through the Quality & Safety report at Patient Safety, Quality & Risk Committee. The report was tabled at the 6 January 2015 meeting.	



Actions to achieve target and deliver sustainability

Set up a review process of the patient feedback with actions. Implementation of ward dashboard and monitoring through monthly divisional performance reviews.

Friends & Family – A&E Response Rate

Indicator	Executive Lead	Clinical Lead	Operational Lead
Friends & Family (I Want Great Care) - A&E response	CN		

Current Month is Dec-14		Year to Date	
Actual	Target	Actual	Target
✗ 8.9%	15.0%	✗ 8.4%	15.0%
Number of months not achieving target (in current financial year)			8 out of 9

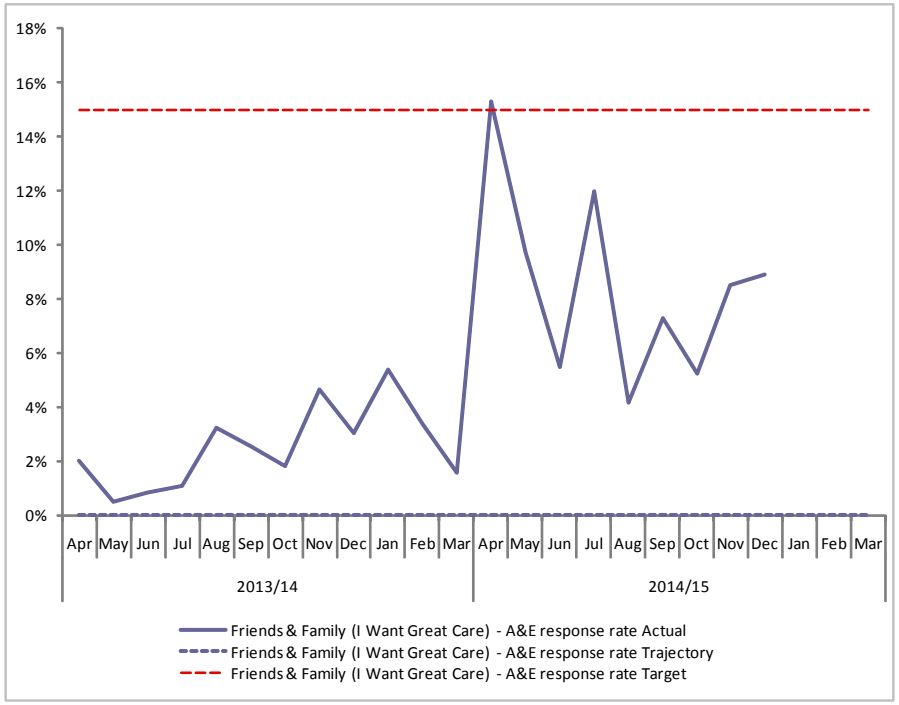
Indicator Description

The percentage of applicable A&E attendances who responded to the Friends & Family question. Data is one month in arrears due to reporting timescales.

Description of Risk

Patients need us to care and look after them to the best of our ability, in their time of need. This means our care systems and processes meets their needs in delivering NHS services. Their feedback, both formal and informal, supports reputational management in line with our strategic objectives.

Immediate Actions	Date
1 Monitored at Quality Safety Group	Ongoing
2 Assurance is provided through the Quality & Safety report at Patient Safety, Quality & Risk Committee. The report was tabled at the 6 January 2015 meeting.	
3. To work with the relevant Head of Nursing where response rates are not being met.	
4. Review uptake with Division and Department.	Mar-15



Actions to achieve target and deliver sustainability

Set up a review process of the patient feedback with actions.

Friends & Family – Maternity Score

Indicator	Executive Lead	Clinical Lead	Operational Lead
Friends & Family (I Want Great Care) - Maternity score -	CN		

Current Month is Dec-14		Year to Date	
Actual	Target	Actual	Target
✖ 71	75	✖ 67	75
Number of months not achieving target (in current financial year)			9 out of 9

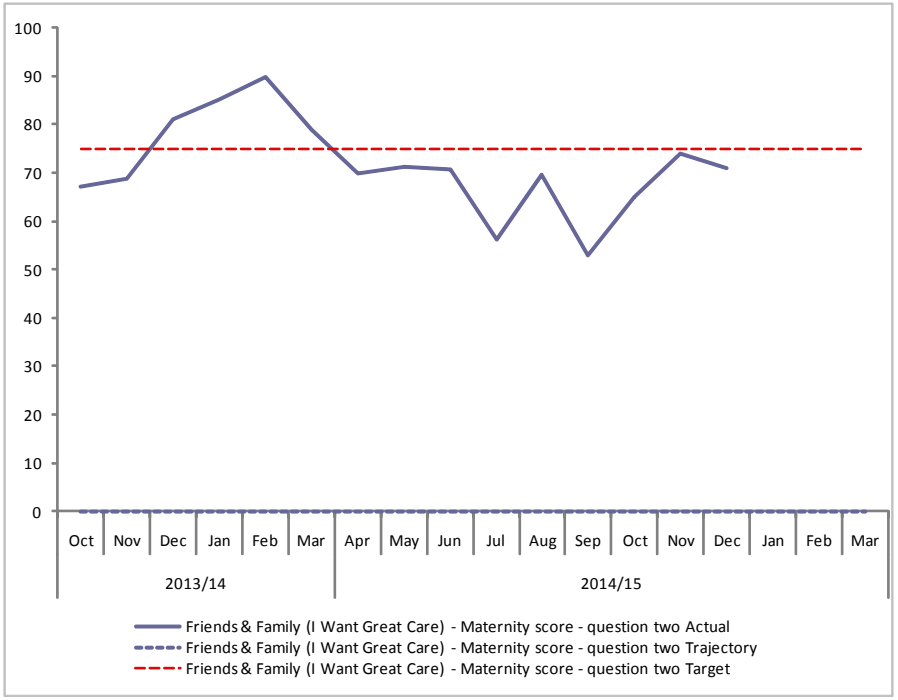
Indicator Description

The Net Promoter Score (FFT) ranges from -1-- to +100 and the closer to +100, the better. Improvement is shown by the number being positive and getting higher. This is for Maternity responses only. Data is one month in arrears due to reporting timescales.

Description of Risk

Patients need us to care and look after them to the best of our ability, in their time of need. This means our care systems and processes meets their needs in delivering NHS services. Their feedback, both formal and informal, supports reputational management in line with our strategic objectives.

Immediate Actions	Date
1 Monitored at Quality Safety Group	Ongoing
2 Assurance is provided through the Quality & Safety report at Patient Safety, Quality & Risk Committee. The report was tabled at the 6 January 2015 meeting.	



Actions to achieve target and deliver sustainability

Draft action plan finalised focussing on increase in uptake and completion of the F&F questionnaires. Implementation of ward dashboard and monitoring through monthly divisional performance reviews.

Patients admitted to stroke unit within 4 hours of arrival

Indicator	Executive Lead	Clinical Lead	Operational Lead
Patients admitted directly to stroke unit within 4 hours of hospital arrival *	DCEO		

Current Month is Dec-14		Year to Date	
Actual	Target	Actual	Target
✗ 56.3%	90.0%	✗ 66.2%	90.0%
Number of months not achieving target (in current financial year)			9 out of 9

Indicator Description

The percentage of applicable patients who are admitted to the Stroke unit within four hours of arriving, regardless of how they arrived in the hospital.

Description of Risk

Rapid assessment and provision of stroke services are linked to quality outcomes for patients.

Immediate Actions	Date
1 Implement Unscheduled Care Programme (refer to actions under A&E exception template)	In place
2. Ensure stroke ring-fenced beds are maintained. Use of beds to be approved by COO/Deputy COO.	In place
3. Patients now flagged to ED en route by ambulance crews pre-arrival	In place
4. Information and education in ED regarding stroke presentation and early identification	In place
5. COO has met with the stroke lead to formulate an immprovement plan	Dec-14
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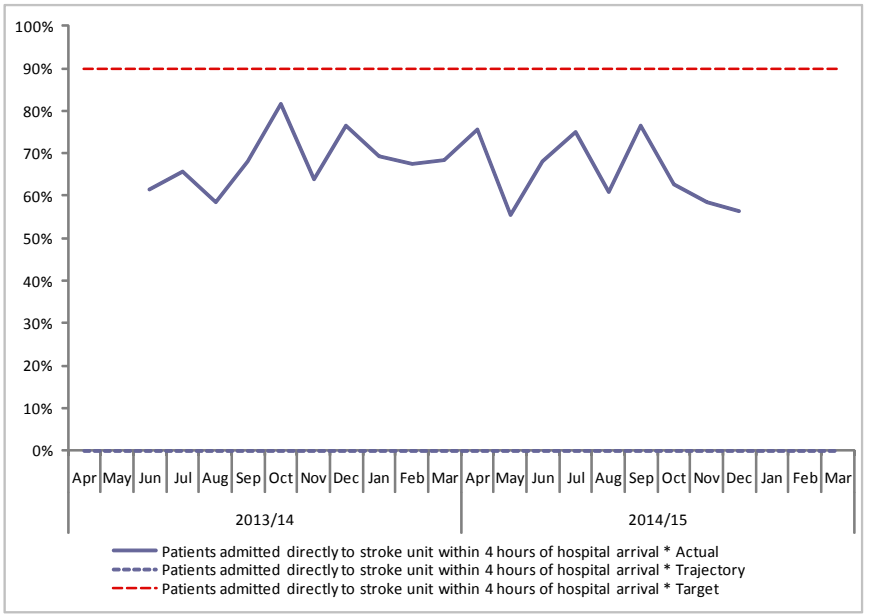

Actions to achieve target and deliver sustainability

Implementing the Unscheduled Care Programme will support improved patient flow throughout the hospital and enable faster access to the Stroke Unit for patients. The Early Supported Discharge (ESD) programme provides an improved patient experience by enabling an earlier and supportive discharge for patients that meet the criteria for this service. This will also improve patient flow and capacity within the hospital.

Stroke patients spending 90% of their time on stroke unit

Indicator	Executive Lead	Clinical Lead	Operational Lead
Stroke patients spending 90% of their time on stroke unit *	DCEO		

Current Month is Dec-14		Year to Date	
Actual	Target	Actual	Target
✗ 68.8%	80.0%	✓ 84.0%	80.0%
Number of months not achieving target (in current financial year)			1 out of 8

Indicator Description

The percentage of applicable patients who spend at least 90% of their time on the Stroke unit.

Description of Risk

Rapid assessment and provision of stroke services are linked to quality outcomes for patients.

Immediate Actions	Date
1 Implement Unscheduled Care Programme (refer to actions under A&E exception template)	In place
2. Ensure stroke ring-fenced beds are maintained. Use of beds to be approved by COO/Deputy COO.	In place
3. Patients now flagged to ED en route by ambulance crews pre-arrival	In place
4. Information and education in ED regarding stroke presentation and early identification	In place
5. COO has met with the stroke lead to formulate an immprovement plan	Dec-14
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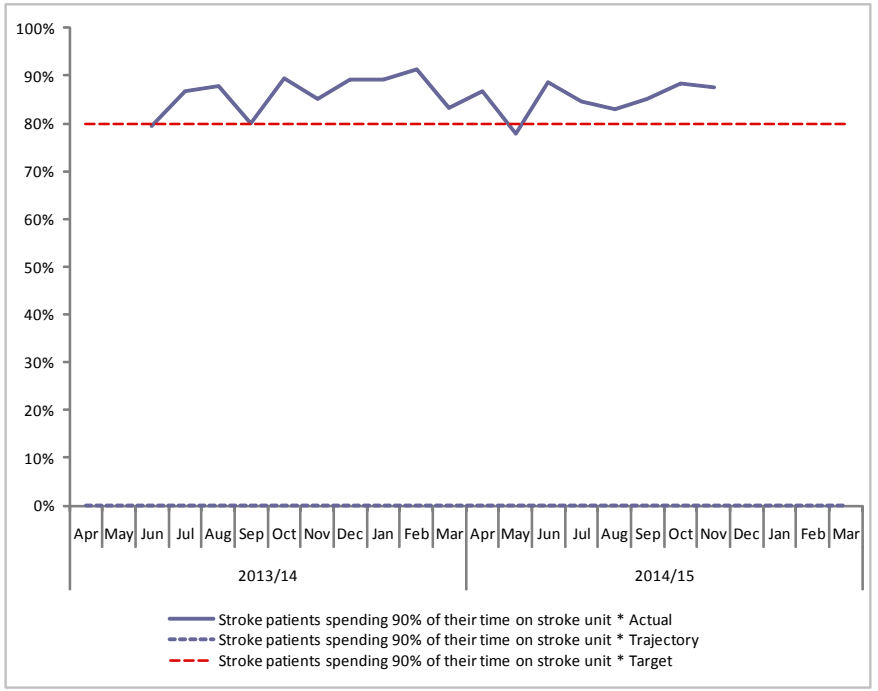


Actions to achieve target and deliver sustainability

Implementing the Unscheduled Care Programme will support improved patient flow throughout the hospital and enable faster access to the Stroke Unit for patients. The Early Supported Discharge (ESD) programme provides an improved patient experience by enabling an earlier and supportive discharge for patients that meet the criteria for this service. This will also improve patient flow and capacity within the hospital.

Hospital Acquired Pressure Ulcers – Grade 3 or 4

Indicator	Executive Lead	Clinical Lead	Operational Lead
Hospital Acquired Pressure Ulcers - Grade 3 or 4	CN		

Current Month is Dec-14		Year to Date	
Actual	Target	Actual	Target
✖ 4	0	✖ 46	0
Number of months not achieving target (in current financial year)			0 out of 9

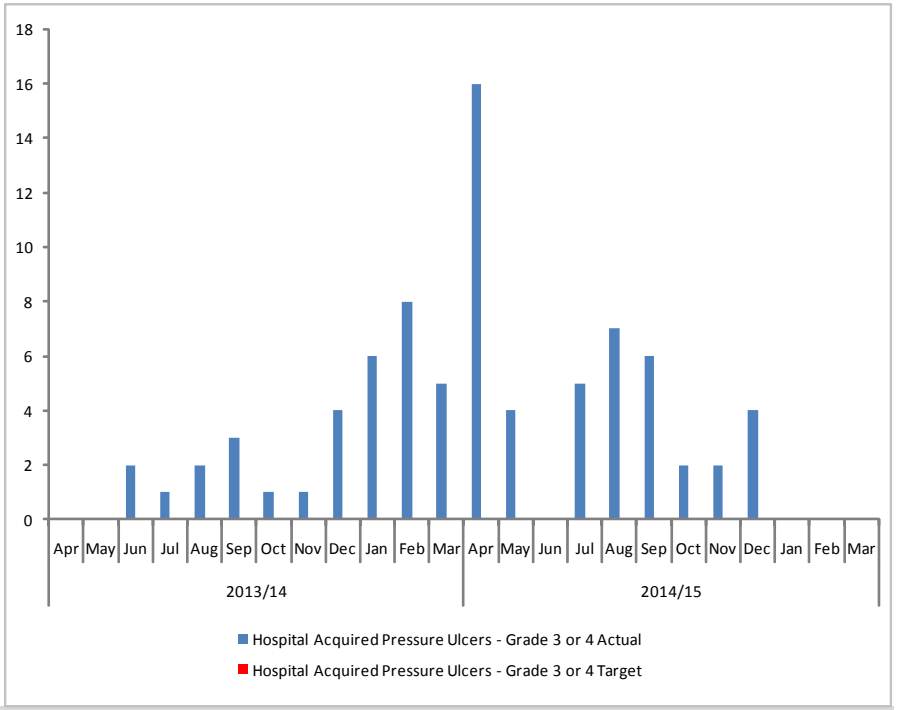
Indicator Description

The actual number of patients who have a grade three or grade four pressure ulcer in hospital during the month. Grade three pressure ulcers are when skin loss occurs throughout the entire thickness of the skin. The underlying tissue is also damaged, although the underlying muscle and bone are not. Grade four is the most severe type of pressure ulcer. The skin is severely damaged and the surrounding tissue begins to die (tissue necrosis). The underlying muscles and/or bone may also be damaged.

Description of Risk

Pressure ulcers represent a risk to the quality and experience of care due to the risk of complications from the ulcer and the time taken to heal.

Immediate Actions	Date
1. Actions outlined in Quality & Safety report	Dec-14
2. Monitored at Quality Safety Group	Ongoing
3. Assurance is provided through the Quality & Safety report at Patient Safety, Quality & Risk Committee. The report was tabled at the 6 January 2015 meeting.	Jan-15
4. Outcomes from the Pressure Ulcer Summit are to be further developed	



Actions to achieve target and deliver sustainability

Fundamentals of care panel oversee delivery. Serious incidents are investigated as per policy. Learning from serious incidents and near misses to be further embedded throughout divisions around lessons learnt and via patient safety and quality committee. Implementation of ward dashboard and monitoring through monthly divisional performance reviews.