West Hertfordshire Hospitals NHS Trust

Integrated Performance Report

May 2016

(April data)

West Hertfordshire Hospitals NHS Trust

Executive Summary

West Hertfordshire Hospitals NHS Trust

Safe Effective Caring

Reporting sub committee - PSQR

Performance relative to targets/ thresholds

	Achieving	Not achieving	Better than national average	Worse than national average
Apr-16	8	8	8	8
Mar-16	9	7	8	8
Feb-16	8	8	8	8

Areas of good performance

•Mortality indicators show sustained excellent performance (*pages 3 and 12*)
•There were no MRSA bacteraemia (*pages 3 and 16*)
•There were no medication errors causing serious harm (*pages 4 and 17*)

New to category this month:

• Clostridium difficile year to date total is 0 (against a trajectory of no more than 23 cases for the year) *(pages 3 and 16) – NB c-diff was better than the monthly trajectory for March but worse than the full year trajectory. As a result, the classification category has moved to 'good performance'*

Areas requiring performance improvement

• VTE risk assessment was below the threshold *(pages 4 and 18)*
• Admission to stroke ward within 4 hours was below the performance standard *(pages 4 and 13)*
• There were 4 serious incidents recorded *(pages 4 and 17)*
•There were 6 mixed sex accommodation breaches *(pages 3 and 20)*
• Patients spending 90% of their time on the stroke unit was below the performance standard (*pages 4 and 13*)

New to category this month:

• Harm free care was worse than the performance standard (pages 4 and 19) and below the national average

Responsive

Reporting sub committee - F&P

Executive summary

	Achieving	Not achieving	Better than national average	Worse than national average
Apr-16	8	12	6	9
Mar-16	9	11	6	9
Feb-16	8	12	7	7

Areas of good performance

• Diagnostic wait times delivered to the performance standard *(pages 5 and 22)*
• All cancer standards are delivering to the performance standard (provisional) , with the exception of 31 day first and subsequent surgery (*pages 5 , 22 and 23*)

New to category this month:

• The breast symptomatic indicator was above the performance standard (provisional) (*pages 5 and 23).*

Areas requiring performance improvement

• A&E 4 hour wait (all types) performance was below standard *(pages 5 and 25)*
• Formal delayed transfers of care continue to report above the performance standard *(pages 6 and 26)*
• Ambulance turnaround times' performance was worse than standard *(pages 5 and 25)*
•The referral to treatment incomplete indicator was below the performance standard (*pages 5 and 21*),
•The number of patients not treated within 28 days of last minute cancellation was below the performance standard (*pages 6 and 22)*
The 31 day subsequent surgery indicator was below the performance standard *(pages 5 , 23 and 24)*

New to category this month:

• The cancer 31 day first indicator was below the operational standard *(pages 5 , 23 and 24)*
• There were two RTT 52 week waits *(pages 5 and 21)*

Well led

Reporting sub committee - Workforce

	Achieving	Not achieving	Better than national average	Worse than national average
Apr-16	5	7	6	4
Mar-16	4	8	6	4
Feb-16	4	8	4	6

Areas of good performance

•Temporary costs and overtime as % of total paybill was better than target (*pages 7 and 27)*
• The Maternity Friends and Family response rate was better than target *(pages 7 and 29)*
• The sickness rate was better than target *(pages 7 and 27)*

New to category this month:

• The percent of bank pay was better than target *(pages 7 and 27)*

Areas requiring performance improvement

• A number of workforce indicators continue to report underperformance, including, staff turnover rate, vacancy rate, appraisals and mandatory training *(pages 7, 27 and 28),*
•Friends and Family response rates (excluding Maternity) were below threshold (*pages 7 and 29*)

New to category this month:

• The Staff Friends and Family response rate was worse than target *(pages 7 and 27*)

NB. Indicators achieving relate only to where targets have been set - as seen on the indicator summary. Ratings showing the number of indicators better or worse than

West Hertfordshire Hospitals NHS Trust

Indicator Summary

West Hertfordshire Hospitals NHS Trust

Domain		Indicator	Target	Latest three data points (Most Recent)			YTD Actual	YTD Target	Executive Lead	Month	Included in Detailed Reports	National / Local	National avg.	National avg. Period	Trend	Data Quality RAG	Financial impact
Safe, Effective, Caring		SHMI (Rolling 12 months)	100	✓ 93.4	✓ 95.5	✓ 94.1			MD	Nov-15	Y	National	100	Nov-15		G	
		HSMR - Total (Rolling three months)	100	✓ 81.1	✓ 83.8	✓ 82.8			MD	Jan-16	Y	National	100	Jan-16		G	
		Crude Mortality Rate (Non elective ordinary)**	3.3%	✓ 2.8%	✓ 3.2%	✓ 2.6%	✓ 2.6%	3.3%	MD	Apr-16	Y	National	3.2% (East of Eng.)	Feb-16		G	
●		30 Day Emergency Readmissions - Combined *	4.0%	✗ 6.8%	✗ 6.9%	✗ 6.3%	✗ 6.3%	4.0%	MD	Apr-16	Y	National	11.4%	2011-12		G	£ Marginal tariff reimbursement, possible penalties
		30 Day Emergency Readmissions - Elective *	n/a	3.6%	3.4%	2.8%	2.8%	n/a	MD	Apr-16	Y	National	n/a			G	£ Marginal tariff reimbursement, possible penalties
		30 Day Emergency Readmissions - Emerg *	n/a	9.7%	10.1%	9.6%	9.6%	n/a	MD	Apr-16	Y	National	n/a			G	£ Marginal tariff reimbursement, possible penalties^
		Number of patients with a length of stay > 14 days *	tbc	360	362	383	383	tbc	MD	Apr-16		Local	n/a			G	£ Reduction in reimbursement vs largely fixed costs. No penalty levied.
		Staff FFT % recommended care	tbd TDA^	61.2%	N/Av	68.0%	64.0%	tbd TDA^	DoW	Mar-16	Y	National	n/a			G	
		Inpatient Scores FFT % positive	tbd TDA^	94.8%	93.0%	93.2%	93.2%	tbd TDA^	CN	Apr-16	Y	National	95.7%	Mar-16		G	
		A&E FFT % positive	tbd TDA^	95.7%	88.4%	92.3%	92.3%	tbd TDA^	CN	Apr-16	Y	National	83.5%	Mar-16		G	
		Daycase FFT % positive	tbd TDA^	99.8%	98.1%	99.7%	99.7%	tbd TDA^	CN	Apr-16	Y	National	n/a			G	
		Maternity FFT % positive	tbd TDA^	93.1%	95.5%	94.2%	94.2%	tbd TDA^	CN	Apr-16	N	National	96.5%	Mar-16		G	
		% Complaints responded to within one month or agreed timescales with complainant	tbd TDA^	69.6%	48.7%	33.8%	33.8%	tbd TDA^	CN	Apr-16	N	Local	n/a			G	
		Complaints - rate per 10,000 bed days	tbd TDA^	26.6	37.9	28.4	28.4	tbd TDA^	CN	Apr-16	N	National	n/a			G	
●		Mixed sex accommodation breaches	0	✗ 3	✗ 4	✗ 6	✗ 6	0	CN	Apr-16	N	National	44 Trusts breaching	Mar-16		G	£ Penalties from CCG. £250 per day per service user.
		Clostridium Difficile	3	✓ 2	✓ 2	✓ 0	✓ 0	3	CN	Apr-16	Y	National	Nationally C-diffs down by 1.32% April to February	Apr - Mar15 vs 16		G	£ Penalties from CCG, fines from other statutory authorities. £10,000 per case above threshold.
		MRSA bacteraemias	0	✓ 0	✓ 0	✓ 0	✓ 0	0	CN	Apr-16	Y	National	n/a			G	£ Penalties from CCG, fines from other statutory authorities. £10,000 in respect of each incidence in the relevant month.

* Performance may change for the current month due to data entered after the production of this report
** Crude mortality threshold UCL upper control limit (2 standard deviations from mean)
tbd TDA^ - threshold/target to be determined by Trust Development Agency guidance when available
NB. Where national avg. blank - information not currently available

^Calculation of emergency re-admissions penalty – Re-admission rate is applied to the value of all admitted activity. 25% of this is then applied on the basis that this proportion is avoidable.

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 – 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
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West Hertfordshire Hospitals NHS Trust

Indicator Summary

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Safe, Effective, Caring		Never events	0	✓ 0	✓ 0	✓ 0	✓ 0	0	MD	Apr-16	Y	National	n/a			G	£ Penalties from CCG, fines from other statutory authorities, prosecution^
		Serious incidents - number*	tbd TDA^	2	4	4	4	tbd TDA^	MD	Apr-16	Y	National	n/a			A	
		% of patients safety incidents which are harmful	n/a	14.0%	17.0%	14.5%	14.5%	n/a	MD	Apr-16	Y	National	n/a			A	
		Medication errors causing serious harm *	0	✗ 1	✓ 0	✓ 0	✓ 0	0	MD	Apr-16	Y	National	n/a			A	
	●	Open CAS Alerts	0	✗ 5	✗ 4	✗ 1	✗ 1	0	CN	Apr-16	Y	National	n/a			A	
	◆	Harm Free Care	95.0%	✗ 94.2%	✓ 95.1%	✗ 93.3%	✗ 93.3%	95.0%	CN	Apr-16	Y	National	93.9%	Apr-16		G	
		% New Harms (Safety Thermo - New/All Harms)	tbd TDA^	21.6%	19.4%	19.5%	19.5%	tbd TDA^	CN	Apr-16	Y	National	n/a			G	
		Pressure Ulcers New Harms	tbd TDA^	4	2	4	4	tbd TDA^	CN	Apr-16	Y	National	WHHT 0.32 vs 1.0	Apr-16		G	
		Falls New Harms	tbd TDA^	0	3	0	0	tbd TDA^	CN	Apr-16	Y	National	WHHT 0.48 vs 0.6	Apr-16		G	
		Catheter & UTI New Harms	tbd TDA^	3	1	1	1	tbd TDA^	CN	Apr-16	Y	National	WHHT 0.16 vs 0.3	Apr-16		G	
		VTE New Harms	tbd TDA^	1	0	3	3	tbd TDA^	CN	Apr-16	Y	National	WHHT 0.00 vs 0.4	Apr-16		G	
	●	VTE risk assessment*	95.0%	✗ 91.2%	✗ 89.9%	✗ 90.8%	✗ 90.8%	95.0%	MD	Apr-16	Y	National	95.5%	Q3 2015		A	
	●	Caesarean Section rate - Combined*	26.5%	✗ 30.2%	✗ 30.2%	✗ 29.0%	✗ 29.0%	26.5%	MD	Apr-16	Y	Local	26.7%	Apr15-Aug15		A	
		Caesarean Section rate - Emergency*	n/a	19.6%	19.6%	21.0%	21.0%	n/a	MD	Apr-16	Y	Local	15.3%	Apr15-Aug15		A	
		Caesarean Section rate - Elective*	n/a	10.6%	10.6%	7.9%	7.9%	n/a	MD	Apr-16	Y	Local	11.4%	Apr15-Aug15		A	
		Maternal deaths	0	✓ 0	✓ 0	✓ 0	✓ 0	0	MD	Apr-16	N	National	n/a			G	
	●	Patients admitted directly to stroke unit within 4 hours of hospital arrival *	90.0%	✗ 39.1%	✗ 40.0%	✗ 51.9%	✗ 51.9%	90.0%	DCEO	Apr-16	Y	National	59.8%	Oct-Dec 15		G	
	●	Stroke patients spending 90% of their time on stroke unit *	80.0%	✗ 56.5%	✗ 71.4%	✗ 70.4%	✗ 70.4%	80.0%	DCEO	Apr-16	Y	National	84.4%	Oct-Dec 15		A	

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tbd TDA^ - threshold/target to be determined by Trust Development Agency guidance when available

^Recovery of cost of procedure or episode plus any additional charge incurred for corrective procedure or care in consequence to the event.

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Responsive	●	Referral to Treatment - Admitted*	90.0%	✗ 68.1%	✗ 70.6%	✗ 66.7%	✗ 66.7%	90.0%	DCEO	Apr-16	Y	Local	80.7%	Mar-16		G	
	●	Referral to Treatment - Non Admitted*	95.0%	✗ 87.9%	✗ 89.5%	✗ 88.7%	✗ 88.7%	95.0%	DCEO	Apr-16	Y	Local	92.6%	Mar-16		G	
	●	Referral to Treatment - Incomplete*	92.0%	✗ 91.6%	✗ 89.7%	✗ 88.6%	✗ 88.6%	92.0%	DCEO	Apr-16	Y	National	91.5%	Mar-16		G	£ CCG penalty of £100 in respect of each excess breach above the threshold
	◆	Referral to Treatment - 52 week waits - Incompletes	0	✓ 0	✓ 0	✗ 2	✗ 2	0	DCEO	Apr-16		National	865 (all Trusts)	Mar-16		G	
		Diagnostic wait times	99.0%	✓ 99.9%	✓ 99.96%	✓ 99.9%	✓ 99.9%	99.0%	DCEO	Apr-16	Y	National	98.3%	Mar-16		G	£ CCG penalty of £200 in respect of each excess breach above the threshold
	●	ED 4hr waits (Type 1, 2 & 3)	95.0%	✗ 74.1%	✗ 73.6%	✗ 79.2%	✗ 79.2%	95.0%	DCEO	Apr-16	Y	National	87.3%	Mar-16		G	£ CCG penalty of £120 in respect of each excess breach above the threshold (cap off 8% of attendances)
		ED 12hr trolley waits	0	✓ 0	✓ 0	✓ 0	✓ 0	0	DCEO	Apr-16	Y	National	350 (all Trusts)	Mar-16		G	£ CCG penalty £1,000 per incidence
	●	Ambulance turnaround time between 30 and 60 mins	0	✗ 452	✗ 429	✗ 467	✗ 467	0	DCEO	Apr-16	Y	Local	WHHT 25.1% vs EEAS 16.0%	Mar-16		R	£ CCG penalty £200 per service user waiting over 30 mins
	●	Ambulance turnaround time > 60 mins	0	✗ 372	✗ 513	✗ 276	✗ 276	0	DCEO	Apr-16	Y	Local	WHHT 23.5% vs EEAS 8.4%	Mar-16		R	£ CCG penalty £1,000 per service user waiting over 60 mins
		Cancer - Two week wait *	93.0%	✓ 94.2%	! 93.1%	✓ 95.2%	✓ 95.2%	93.0%	DCEO	Apr-16	Y	National	94.7%	Q4 15/16		A	£ CCG penalty breaches per qtr in excess of tolerance is £200 for each breach.
		Cancer - Breast Symptomatic two week wait *	93.0%	✗ 87.9%	✗ 91.6%	✓ 94.9%	✓ 94.9%	93.0%	DCEO	Apr-16	Y	National	93.6%	Q4 15/16		A	£ CCG penalty breaches per qtr in excess of tolerance is £200 for each breach.
	◆	Cancer - 31 day *	96.0%	✓ 99.2%	✓ 100.0%	✗ 95.0%	✗ 95.0%	96.0%	DCEO	Apr-16	Y	National	97.5%	Q4 15/16		A	£ CCG penalty breaches per qtr in excess of tolerance is £1,000 for each breach.
		Cancer - 31 day subsequent drug *	98.0%	✓ 100.0%	✓ 100.0%	✓ 100.0%	✓ 100.0%	98.0%	DCEO	Apr-16	Y	National	99.2%	Q4 15/16		A	£ CCG penalty breaches per qtr in excess of tolerance is £1,000 for each breach.
	◆	Cancer - 31 day subsequent surgery *	94.0%	✓ 100.0%	✗ 93.8%	✗ 90.9%	✗ 90.9%	94.0%	DCEO	Apr-16	Y	National	95.3%	Q4 15/16		A	£ CCG penalty breaches per qtr in excess of tolerance is £1,000 for each breach.
		Cancer - 62 day *	85.0%	✓ 85.9%	✓ 86.9%	✓ 88.0%	✓ 88.0%	85.0%	DCEO	Apr-16	Y	National	82.1%	Q4 15/16		A	£ CCG penalty breaches per qtr in excess of tolerance is £1,000 for each breach.
		Cancer - 62 day screening *	90.0%	✗ 83.3%	✓ 100.0%	✓ 100.0%	✓ 100.0%	90.0%	DCEO	Apr-16	Y	National	91.9%	Q4 15/16		A	£ CCG penalty breaches per qtr in excess of tolerance is £1,000 for each breach.

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Responsive		Urgent operations cancelled for a second time	0	✓ 0	✓ 0	✓ 0	✓ 0	0	DCEO	Apr-16	Y	National	n/a			G	
	●	Number of patients not treated within 28 days of last minute cancellation	0	✗ 3	✗ 10	✗ 13	✗ 13	0	DCEO	Apr-16	Y	National	11 (avg. all Trusts)	Q4 15/16		G	
	●	Delayed Transfers of Care (DToC)*	3.5%	✗ 4.4%	✗ 6.6%	✗ 6.1%	✗ 6.1%	3.5%	DCEO	Apr-16	Y	National	6.0%	Feb-16		G	£ Marginal tariff reimbursement, possible penalties
	●	Outpatient cancellation rate	8.0%	✗ 12.1%	✗ 14.6%	✗ 12.9%	✗ 12.9%	8.0%	DCEO	Apr-16	Y	Local	n/a			G	
		Outpatient cancellation rate within 6 weeks^	5.0%	4.4%	5.5%	5.3%	5.3%		DCEO	Apr-16	Y	Local	n/a			G	

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Well Led	●	Staff turnover rate (rolling 12 months)	12.0%	✗ 16.3%	✗ 15.6%	✗ 15.9%	✗ 15.9%	12.0%	DoW	Apr-16	Y	National	16.0% (Beds and Herts orgs)	Oct-15		G	
		Staff turnover rate (rolling 3 months)		14.3%	13.5%	14.6%	✗ 14.6%	0.0%	DoW	Apr-16	Y	National	16.0% (Beds and Herts orgs)	Oct-15		G	
		% staffleaving within first year (excluding medics and fixed term contracts)		15.2%	14.4%	14.4%	14.4%	0.0%	DoW	Apr-16	Y	National	n/a			G	
		Sickness rate	3.5%	✗ 3.5%	✓ 3.3%	✓ 3.1%	✓ 3.1%	3.5%	DoW	Apr-16	Y	National	4.1% (Beds and Herts orgs)	Oct-15		R	£ Payments made to staff for nil productivity
	●	Vacancy rate	5.0%	✗ 11.8%	✗ 11.4%	✗ 13.5%	✗ 13.5%	5.0%	DoW	Apr-16	Y	National	11% (local survey)	Sep-15		G	£ Costs saved in short term for nil productivity
	●	Appraisal rate (non-medical staff only)	95.0%	✗ 65.3%	✗ 70.3%	✗ 74.2%	✗ 74.2%	95.0%	DoW	Apr-16	Y	National	73% (local survey)	Sep-15		G	
	●	Mandatory Training	100.0%	✗ 84.3%	✗ 85.6%	✗ 86.0%	✗ 86.0%	100.0%	DoW	Apr-16	Y	Local	85% (local survey)	Sep-15		G	
		% Bank Pay**	6.6%	✓ 6.2%	✗ 6.8%	! 6.5%	! 6.5%	6.2%	DoW	Apr-16	Y	Local	n/a			G	£ Costs at established rates rather than premium
		% Agency Pay**	16.0%	✓ 15.4%	✓ 15.3%	✓ 14.0%	✓ 14.0%	15.4%	DoW	Apr-16	Y	Local	10.5% (local survey)	Dec-15		G	£ Costs at premium rates rather than established
		Temporary costs and overtime as % of total paybill** (Inc. unfunded beds)	22.6%	! 22.0%	! 22.5%	✓ 21.1%	✓ 21.1%	22.0%	DoW	Apr-16	Y	National	n/a			G	£ Premium payments of various types vs established rates
	◆	*Temporary costs and overtime as % of total paybill** (Excl. unfunded beds)*		✓ 16.0%	✓ 16.0%	N/Av	N/Av	16.0%	DoW	Apr-16	Y	National	n/a			G	£ Premium payments of various types vs established rates
	●	Inpatient FFT response rate	54.0%	✗ 48.6%	✗ 39.1%	✗ 41.3%	✗ 41.3%	54.0%	CN	Apr-16	Y	National	24.1%	Mar-16		G	
	●	A&E FFT response rate	20%	✗ 3.5%	✗ 4.7%	✗ 4.9%	✗ 4.9%	20.0%	CN	Apr-16	Y	National	12.0%	Mar-16		G	
		Daycases FFT response rate	tbd TDA^	44.0%	49.6%	53.1%	53.1%	tbd TDA^	CN	Apr-16	Y	National	n/a			G	
	◆	Staff FFT response rate	50%	✗ 20.8%	N/Av	✗ 16.9%	✗ 16.9%	50%	DoW	Mar-16	Y	National	n/a			G	
		Staff FFT % recommended work	tbd TDA^	58.4%	N/Av	57.0%	57.4%	tbd TDA^	DoW	Mar-16	Y	National	n/a			G	
		Maternity FFT response rate	38%	✓ 44.7%	✗ 35.3%	✓ 48.6%	✓ 48.6%	38%	CN	Apr-16	N	National	23.0%	Mar-16		G	

*Perfomance for current month may change due to data entry post production of this report

*Medication errors causing serious harm data for latest month is provisional and subject to validation. Temporary costs and overtime performance is provisional for the current month

tbd TDA^ - threshold/target to be determined by Trust Development Agency guidance when available

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West Hertfordshire Hospitals NHS Trust

Finance

Financial Overview as at 30 April 2016

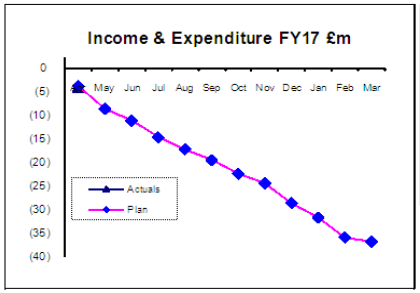
Month 1 Income & Expenditure

£m	Plan	Actual	Variance
Surplus (Deficit)	(3.9)	(4.2)	(0.3)

Statutory Duties

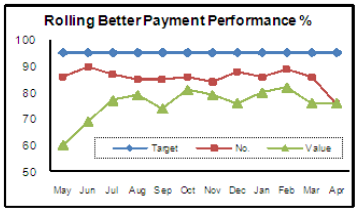
Breakeven	The Trust's plan is to deliver a deficit position in FY17.	R
CRL	The Trust has not exceeded its Capital Resource Limit.	G
EFL	The Trust has managed spend within its External Financing Limit.	G
10 Days' Cash	Cash at 30/04/16 equated to 6 days' spend	R
BPPC	Month 1 performance -76% by number and 76% by value (95% target)	R

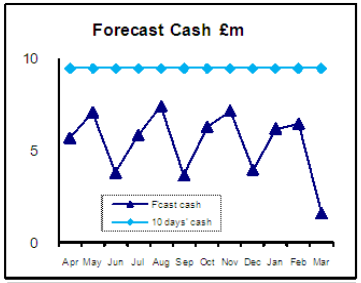
	M1
Financial Risk Rating	1

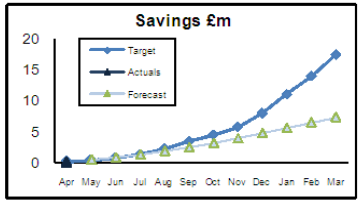


M1 Variance by Division

	£m	% Budget
Medicine	(0.2)	(10)
Unscheduled Care	(0.3)	(44)
Surgery	(0.0)	(4)
Women's	(0.1)	(5)
Clinical Support	0.0	7
Estates & Facilities	0.0	0
Corporate	0.0	0
Other	0.2	
Total	**(0.3)**	







Savings and outlook for FY17:

Savings achieved at close to plan for Month 1, albeit at a purposely low level pending the impact of largely-recruited PMO.

FY17 target of £17.5m is challenging, with more than half identified at this time, with those that have been identified being risk-assessed and delivery-assisted by the PMO.

Statutory duties:

Reliant on cash support from DH/TDA, but within borrowing and capital expenditure limits.

Financial risks remain high but underlying controls are strong, and alongside agreed recovery actions (embedded within FY17 plan) will strengthen the Trust's position in future months.

Operational performance:

Month adverse to plan by £0.3m, with FY17 forecast of £36.9m deficit (= plan) still intact.
CQUIN management much improved on FY16 with agreed divisional targets and plans to implement.
Contract penalties under discussion, with indicative numbers giving some cause for concern. Update to follow.

Finance

Statement of Comprehensive Income (I&E)

	April Budget	April Actual	April Var	Prior Year Actual	Full Year Budget
Volumes					
Elective	3,329	3,378	49	3,448	43,424
Non elective	4,286	3,687	(599)	4,163	50,043
Outpatient	33,521	34,009	488	33,504	455,425
A&E	9,750	9,384	(366)	8,948	114,839
	£000's	£000's	£000's	£000's	£000's
NHS REVENUE					
Elective	4,177	4,235	58	4,104	53,910
Non elective	8,106	7,555	(551)	7,421	94,668
Outpatient	5,670	5,682	13	5,484	73,614
A&E	1,207	1,156	(52)	1,110	14,220
Critical care	1,146	1,247	101	1,104	13,347
Other NHS revenue	3,241	3,242	1	2,964	40,234
TOTAL NHS REVENUES	**23,547**	**23,117**	**(430)**	**22,186**	**289,994**
Private Patients	26	19	(7)	90	307
Other non-NHS clinical income	118	83	(35)	100	1,415
TOTAL Non NHS Clinical	**144**	**101**	**(42)**	**190**	**1,723**
Education & Training	722	703	(19)	707	8,658
Other Revenue	1,187	1,245	58	1,302	11,629
Income savings	62	-	(62)	-	2,641
TOTAL OTHER REVENUE	**1,970**	**1,948**	**(22)**	**2,009**	**22,928**
NET HOSPITAL REVENUE	**25,661**	**25,167**	**(495)**	**24,384**	**314,645**

FY17 outturn / FY17 plan

FY17 expected income growth is factored into the Annual Planning assumptions, and agreement was reached with HVCCG and others on contractual terms. Small areas of block contract, but otherwise activity-related reimbursement.

CQUIN management is more robust than in previous years, including identification, monitoring and verification of achievement and associated risks.

Penalties will be an issue during the year, and discussions are ongoing with the CCG around how / if they should be levied and mitigated.

Operational performance:

NHS income for the month was £430k below plan in the month (£480k excluding high cost drugs), broken down by: £551k below in admitted non-elective care (incl. £138k in maternity), £58k above in admitted elective care, A&E attendances £52k below, critical care income £101k above, 'other' income £45k above.

Activity-based under-performance in maternity (i.e. lower than planned births) is a cause for concern, having been partially offset by acknowledged issues in budget phasing (i.e. partly working itself out over the course of the year). Management issues in the division on the way to being resolved, and will assist with a resolution.

Finance

Statement of Comprehensive Income (I&E)

	April Budget	April Actual	April Var	Prior Year Actual	Full Year Budget
Permanent / Bank Staff	18,045	15,976	2,068	14,809	225,417
Agency	758	2,605	(1,847)	2,772	8,861
Unidentified pay savings	(23)		(23)		(8,425)
TOTAL PAY	**18,780**	**18,581**	**199**	**17,580**	**225,853**
Drugs	1,712	1,700	11	1,379	18,026
Clinical services	2,601	2,510	91	2,359	31,039
Non-clinical services	5,476	5,654	(177)	6,787	68,915
Unidentified non-pay savings	(10)		(10)		(4,613)
TOTAL NON-PAY	**9,778**	**9,864**	**(85)**	**10,524**	**113,368**
EBITDA	**(2,897)**	**(3,278)**	**(381)**	**(3,722)**	**(24,576)**
Depreciation & Amortisation	625	667	(42)	667	7,500
Interest	79	107	(28)	44	1,307
Dividends Payable	293	183	110	325	3,518
Surplus / (Deficit)	**(3,894)**	**(4,234)**	**(340)**	**(4,756)**	**(36,900)**

Operational performance:

The FY17 plan of a £36.9m deficit is significantly different to the agreed control total of £17.3m. This plan acknowledges likely slippage against the control total, also putting S&TF funding of £12.0m at risk. The plan has been submitted to NHSI and a formal response is awaited.

The Trust continues to progress prudent planning for FY17, and the Finance & Performance Committee monitors progress against this plan.

CIP schemes

The FY16 agency cost run rate of approx £37m compares with £25m FY17 target, noting the likely need to reduce gross agency costs by more than £12m to make a sufficient contribution to the FY17 savings target.

All cross-cutting CIP themes are closely monitored through formal monthly meetings, and more frequent operational actions.

Cost control otherwise good, and a successful FY17 will depend on Trust-wide efficiency schemes alongside smaller but consistently implemented ideas from all staff and volunteers.

Detailed reports

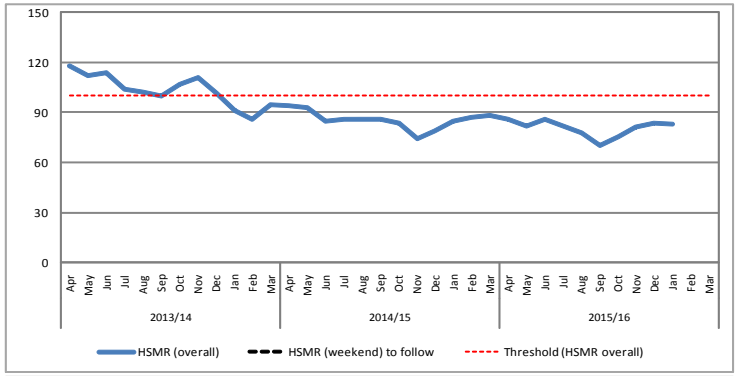
Safe, effective, caring

Reporting sub committee - PSQR

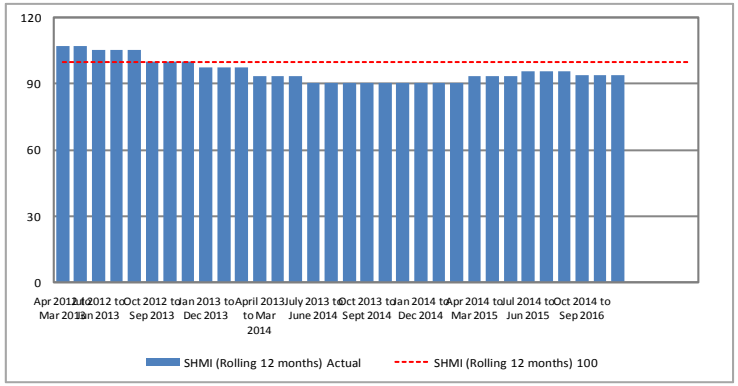
Executive lead	Clinical lead	Operational lead
*Dr Mike Van der Watt Tracey Carter		

Performance relative to targets/ thresholds				
	Achieving		Not achieving	
Apr-16	3		3	
Mar-16	3		3	
Feb-16	3		3	

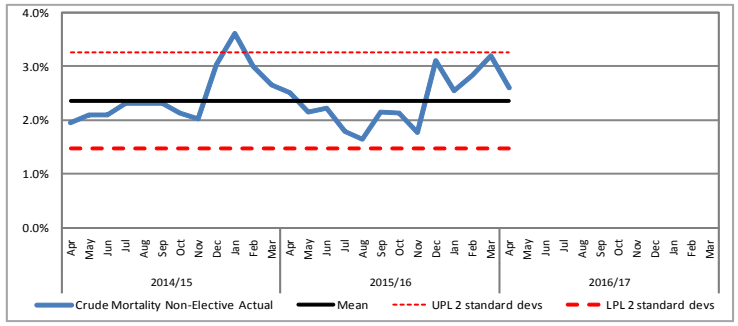
Hospital Standardised Mortality Ratio (HSMR)*



Summary Hospital Mortality Indicator*



Crude mortality rate (non-elective)*



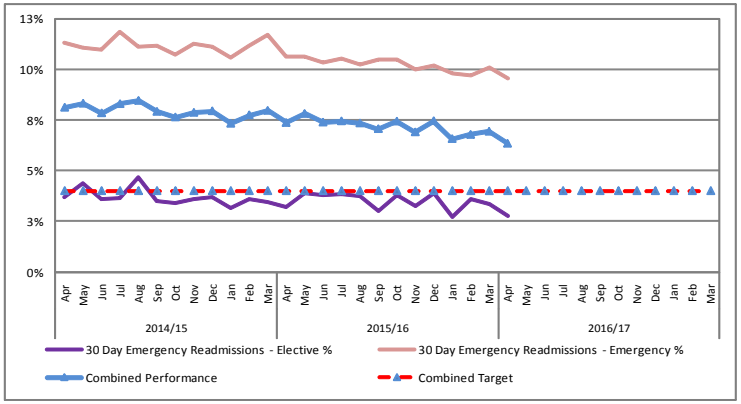
Hospital mortality indices continue to sustain improvements. The trust has gone from being in the bottom decile (2013) to being in the top performing quartile within the Hospital Standardised Mortality Ratio (HSMR). Within the region, the Trust is one of seven (out of 17 trusts nationally) with a 'lower than expected' HSMR.

HSMR emergency weekday vs weekend has no significant difference for emergency admissions. Both are significantly lower than expected.

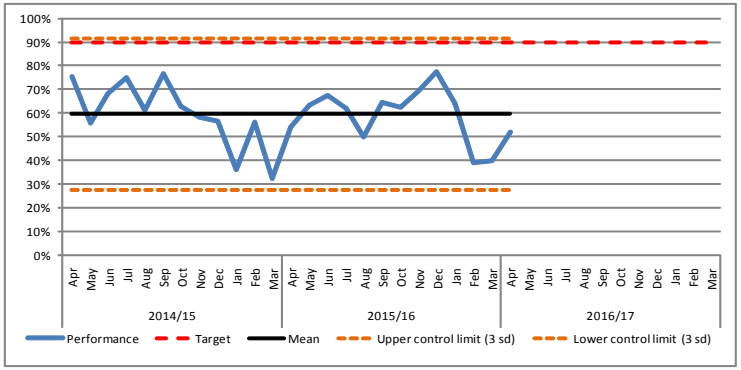
There was a peak over the winter period in crude mortality which was mirrored nationally.

The Summary Hospital Mortality Indicator (SHMI) is as expected. The Trust continues to hold Mortality Review meetings monthly, with CCG participation.

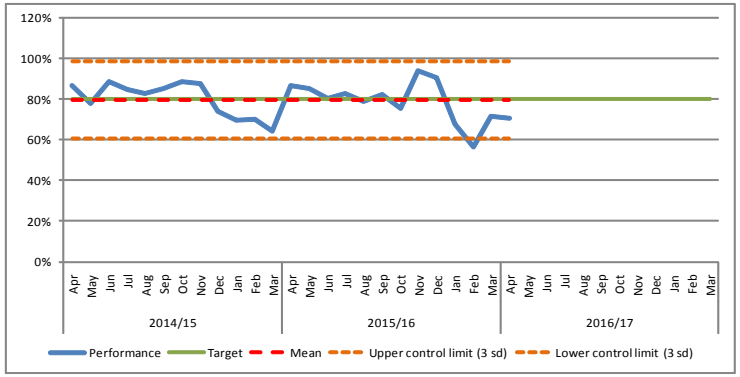
% Emergency re-admissions within 30 days following an elective or emergency spell*



Patients admitted directly to stroke unit within 4 hours of hospital arrival*



Stroke patients spending 90% of their time on stroke unit*



Stroke 60 mins, stroke care and STeMI 150 mins* (to follow)

Emergency Readmissions

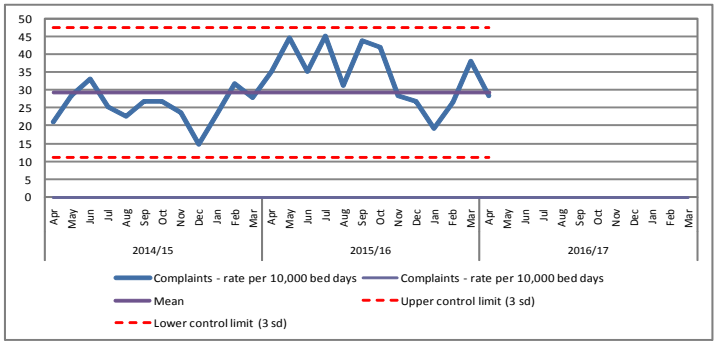
Emergency Readmission rates have dropped since Q4 of last year, however an audit process has been put in place, which is being led by the consultants in Unscheduled Care and Medicine divisions.
The notes of readmitted patients will be reviewed and assessed for additional insight into how and why these patients could have been prevented from being readmitted.
The initial results of audits in Unscheduled Care suggest a significant proportion of patients could not have been prevented from re-admittance, however the audit results will be assessed appropriately when completed.
A standardised audit approach for readmissions has now been agreed and a consultant led review of readmitted patients will be initiated in the coming weeks.

Stroke

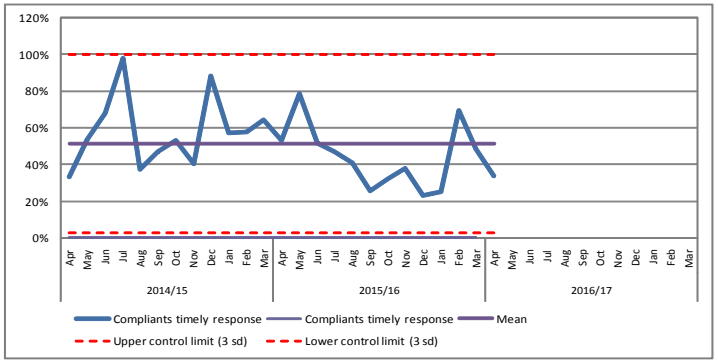
April saw an improvement in the performance for stroke patients being admitted to stroke unit within 4 hours of hospital arrival, although there is still much to do. Work has begun with the specialty and operational teams to review pathways of repatriated patients minimizing the impact on stroke bed capacity. Additionally, both teams are looking at increasing the awareness and visibility of outlying stroke patients, aiming for patients to get to a specialist stroke bed as soon as possible, once available.

The SSNAP results for the October to December quarter were released April 2016. The Trust's combined level was an "A" meaning as a team, the Trust is in the top tier of the 215 hospitals contributing to SSNAP.

Complaints - rate per 10,000 bed days



% Complaints responded to within one month or agreed timescales with complainant



Complaints rate per 10,000 bed days

The Trust has seen a decrease of complaints per 10,000 bed days between March and April. For the same period in 2014/15 the Trust experienced an increase in complaints. Total number of complaints are higher than the previous year.

Previously not all complaints were being logged centrally on the Datix database . With new pathways, process and policy; a thorough validation of the data base was undertaken which has resulted in live accurate and up to date information at all times through Datix.

% Complaints responded to within one month or agreed timescales with complainant

With a focus on ensuring that agreed timescales are adhered to, further work continues with the corporate complaints team and the divisions to ensure timely responses and to address overdue complaints.

Across the Trust as a whole, average compliance stands at around 46% (non-compliance was 74%, 51% and 72% respectively in Q4).

Significant improvement has been made across the Corporate (inc. Finance), Environment and Unscheduled Care divisions who have maintained performance with an average of 20% of their complaints overdue at closure since Q2.

Further work is necessary in relation to complaints received by the Trust's Surgical, Medicines and WACS divisions, whose average performance remains at over 50% of complaints responses being sent past their deadline. Operational pressures and annual leave commitments towards the end of Q4 have impacted on some divisions' ability to address complaints.

Assistance is being provided to assist WACS in the administration of its complaints by the Lead Nurse for Resolution who works closely with the quality assurance midwife. The new complaints advisor has been charged with addressing performance in WACS. The Head of Litigation & Claims, SIs, Complaints and PALS and complaints manager are meeting with every division to discuss response times as a permanent item on the agenda.

Intentionally blank

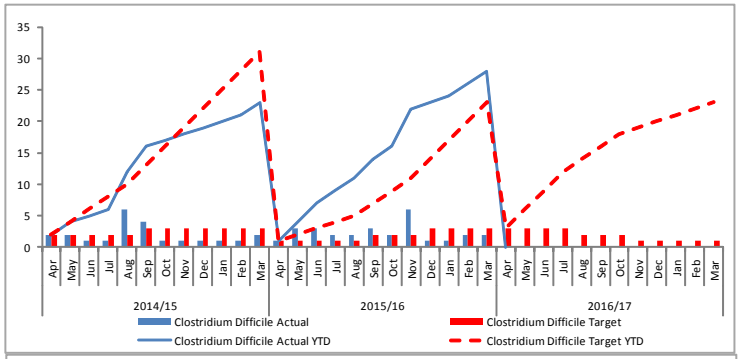
Safe, effective, caring

Reporting sub committee - PSQR

Executive lead	Clinical lead	Operational lead
*Dr Mike Van der Watt Tracey Carter		

Performance relative to targets/ thresholds	Achieving	Not achieving
Apr-16	2	4
Mar-16	2	4
Feb-16	1	3

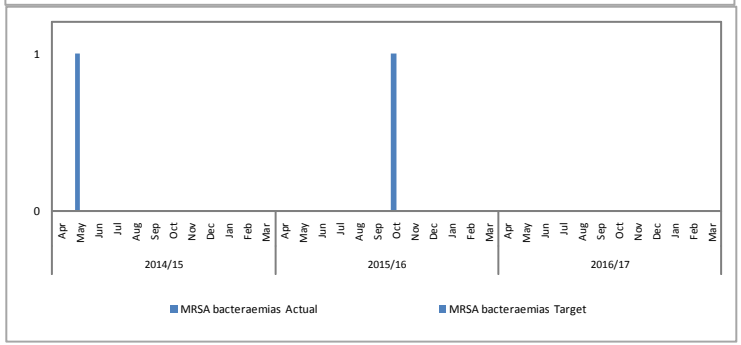
Clostridium Difficile



***Clostridium difficile* Infection (CDI)**

The target ceiling for WHHT apportioned CDI is 23. The monthly target is 3 from April to July, 2 from August to October then 1 per month from November to March 2017. In April the were no CDI cases reported.

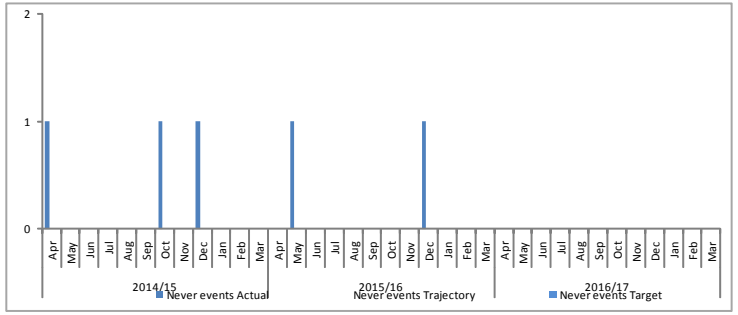
MRSA bactaraemias



MRSA bacteraemia:

The target ceiling target for MRSA bacteraemia is zero avoidable cases. In April we reported no cases of MRSA bacteraemia.

Never events*

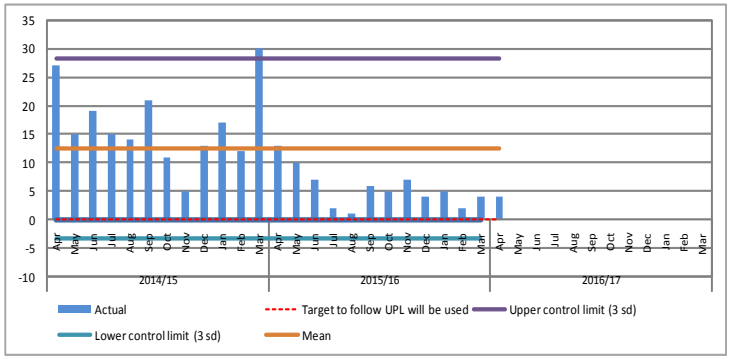


Never Events

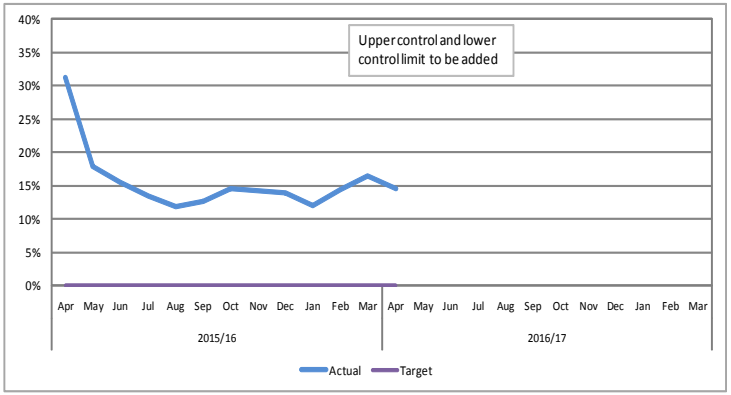
Never events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented. There were no never events recorded in April 2016.

West Hertfordshire Hospitals NHS Trust

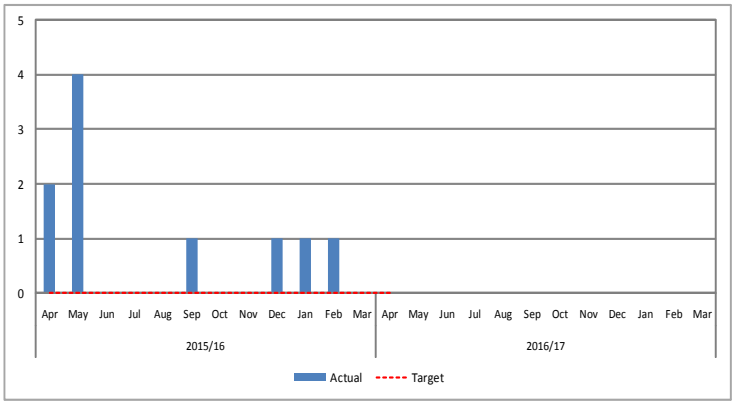
Serious incidents



% of reported patient safety incidents that are harmful



Medication errors causing serious harm*



There were 4 SIs declared in April 2016. There were 4 SIs declared in March 2016.

15 incidents were declared as divisional Root Cause Analysis (RCA) investigations.

The Trust has a total of 19 open SIs.

At the end of April there were no overdue investigations waiting to be submitted to the CCG.

There were five 45 day review meetings that took place with the relevant divisions.

There are five RCAs going through the CCG quality assurance process.

To enable learning and evidence of learning to be assured;
•45 day review meetings allow the RCA to be discussed and challenged by the relevant clinical and management teams prior to the action plan being written.
•The SI review group undertakes a deep dive for all never events and reviews all SI action plans for completion and that evidence gives assurance of actions being undertaken and that learning has taken place. The SI review group meet Bi monthly and met in April. An action log has been generated from the group meeting.

% of Patient Safety Incidents which are harmful
There were a total of 10388 patient safety incidents reported year to date with an associated harm recorded on Datix. 84.53% were no harm incidents, 9.4% were low harm, 4.75% were moderate harm, 0.59% were severe harm and 0.74% were death/catastrophic harm.

Of the severe and catastrophic harm incidents (138) 19 are still open and therefore have not yet been validated. As the investigation of the incident is closed the harm classification is confirmed.

It should be noted that these figures relate to harm as recorded on Datix and work is to take place to review the category of harm recorded on as Datix against the category of harm agreed following the investigation of the incident.

Medication incidents causing serious harm
There were no medication incidents causing serious harm reported in April 2016. A 'severe' incident was reported in January 2016 from Surgery, Anaesthetics and Cancer (SAC) which is still under investigation.

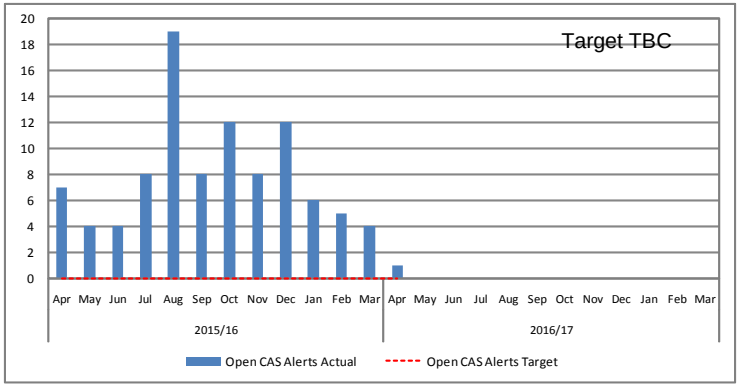
Safe, effective, caring

Reporting sub committee - PSQR

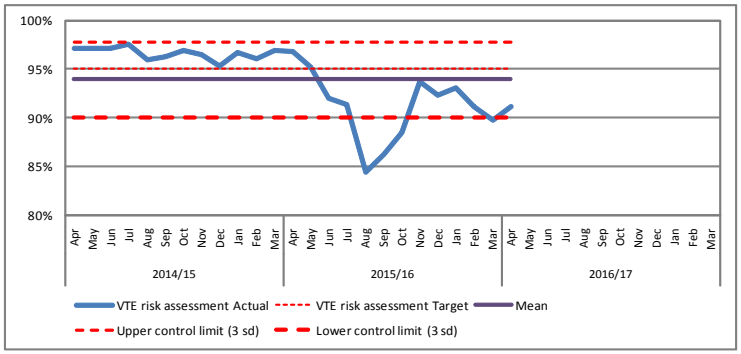
Executive lead	Clinical lead	Operational lead
*Dr Mike Van der Watt Tracey Carter		

Performance relative to targets/ thresholds		
	Achieving	Not achieving
Apr-16	1	3
Mar-16	0	4
Feb-16	1	3

CAS alerts outstanding and time to closure



VTE risk assessment*



CAS

Actions	
Open CAS alerts	15
Closed in month	4
Breached in month	1
Currently overdue	0

The breached CAS alert was a patient safety alert It was closed on 17 May 2016 . A contributory factor of the breach was waiting for Divisional assurance that all required action to ensure compliance with the alert had been taken.

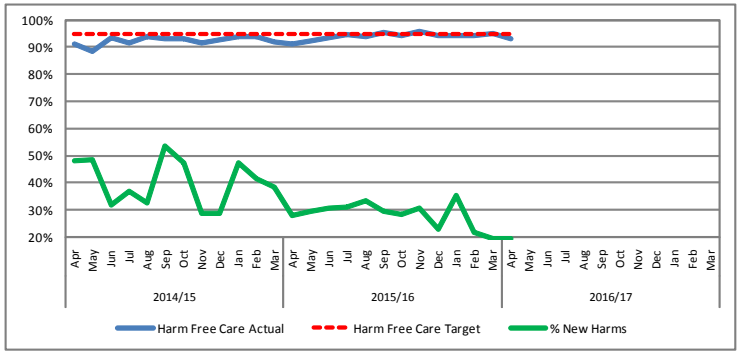
VTE

The Trust has adopted a far more rigorous approach regarding compliance with VTE, in that if the assessment has been done but is not signed, this is considered non-compliant even if the treatment / prophylaxis is prescribed.

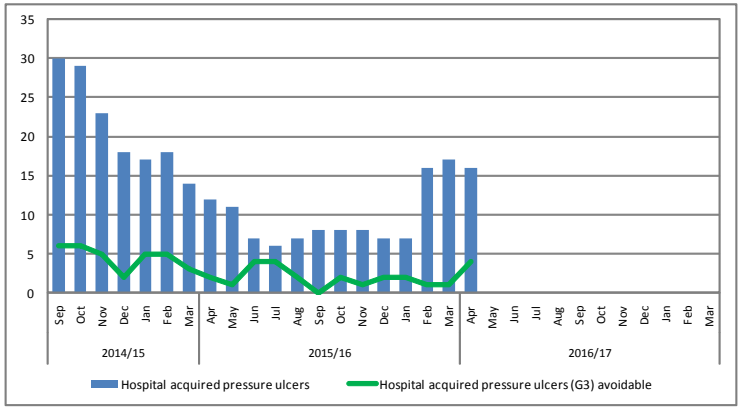
A new policy is in place regarding VTE prophylaxis, with consultant review at post take ward rounds. The Medical Director has emphasised consultants' responsibilities in ensuring this aspect of care is prescribed. It has come to light that the audit of compliance has being using local rather than national criteria, which has significantly reduced the apparent compliance rate. This has been rectified, and the reported compliance is expected to therefore increase.

A new daily ward round proforma, reminding clinicians of VTE assessment (and other measures) is being trialed, and the new ward "white boards" have a VTE check embedded.

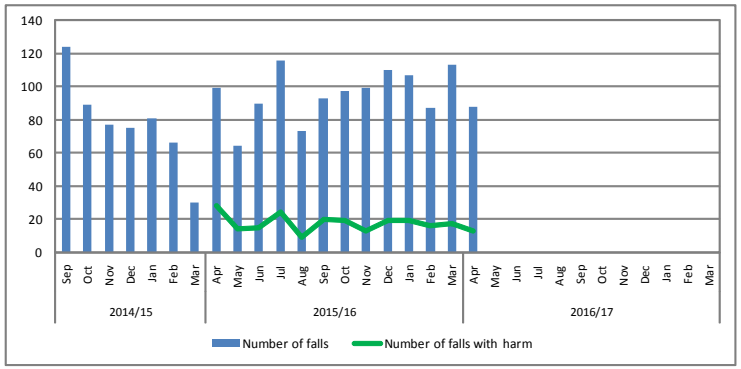
Percentage of Harm Free Care and New Harms



Hospital acquired pressure ulcers



Falls and falls with harm



Harm Free Care – Safety Thermometer

In April, Harm Free Care for the Trust was 93.3%, the national average is 93.7% .

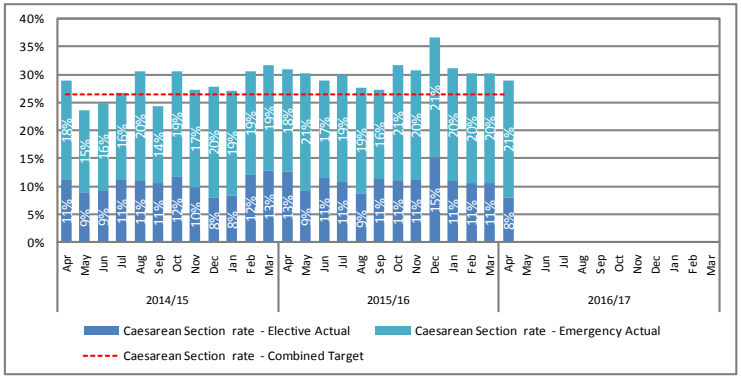
New Harm Free care for April 2016 is 98.7% which is above the national figure of 97.8%

The Trust had four new pressure ulcers grade 2 ; Two new harm with catheter and a new UTI. Six falls were recorded with no harm, Three new VTE were recorded. We are working jointly with the community to achieve further improvements across the patient pathway.

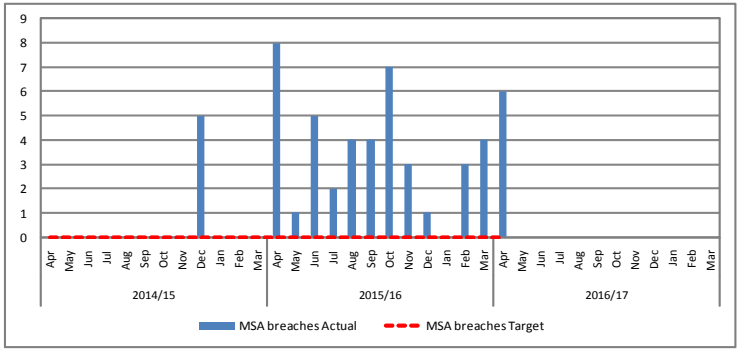
Apr16	National	WHHT	Milton Keynes	East and North	The Hillingdon
Pressure Ulcers - New	1.01	0.66	n/a	0.34	n/a
Catheter & New UTI	0.31	0.16	n/a	0.17	n/a
Catheters	13.46	18.03	n/a	21.50	n/a
Falls with Harm	0.57	-	n/a	0.51	n/a
All New VTEs	0.39	0.49	n/a	0.68	n/a
New Harm Free	97.77	98.69	n/a	98.29	n/a

NB. Data for Milton Keynes and The Hillingdon was not available for April.

C-section rate



Mixed sex accommodation



Mixed sex accommodation
All of the breaches occurred in ITU and were due to a lack of beds in ward areas.

This position is unlikely to be resolved until we have greater capacity in ward areas to transfer patients out of ITU in a more timely manner and in accordance with the RAP we agreed with HVCCG).

Responsive

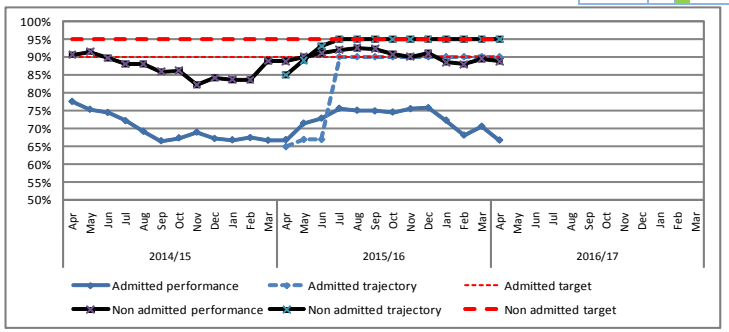
Reporting sub committee - F&P

Access indicators - RTT, diagnostics, cancelled operations and outpatient appointments

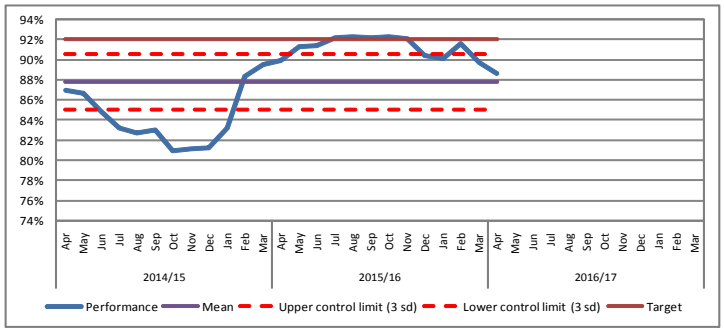
Executive lead	Clinical lead	Operational lead
Sally Tucker	Jeremy Livingstone	Jane Shentall

Performance relative to targets/ thresholds	Achieving	Not achieving
Apr-16	1	5
Mar-16	1	5
Feb-16	1	5

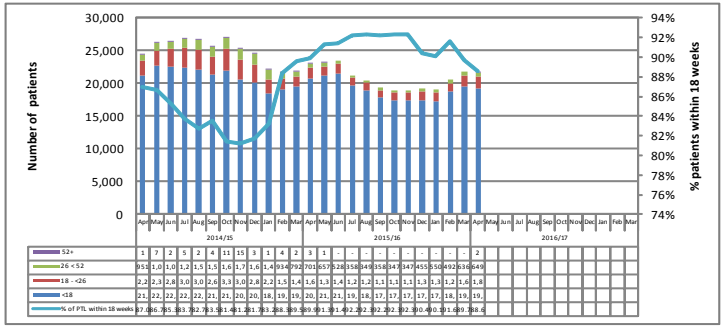
Completed pathways within 18 weeks



Incomplete pathways within 18 weeks



Incomplete pathways WL profile



RTT

The Referral to Treatment (RTT) incomplete standard requires 92% of patients who have not received definitive treatment to be waiting under 18 weeks.

Although WHHT achieved organisational compliance against the RTT standard at the end of Q1 2015/16, which was sustained through Q2 and to November, the Trust has failed to achieve the standard since December.

The Trust's performance in April was 88.6%, against a national picture of 91.5%

Prioritisation of activities in response to the junior doctors industrial action has impacted on elective admissions and outpatient attendances. Strikes occurred on 4 days in April, resulting in the loss of over 800 outpatient appointments and over 80 operations. Further infrastructure problems with theatres have also disrupted capacity although these have now been resolved.

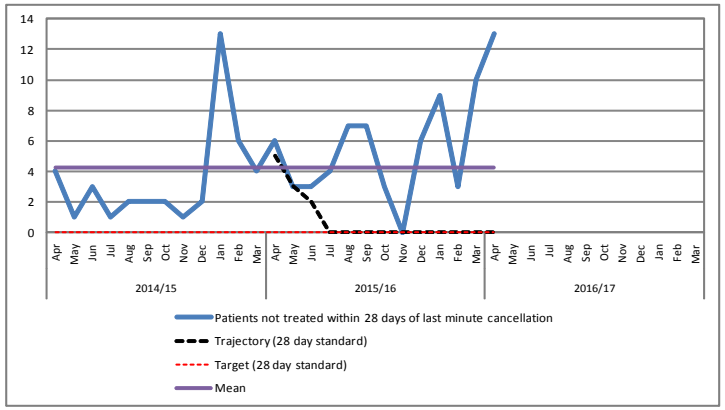
Additional theatre lists and outpatient sessions continue as part of the performance recovery plan.

There were 2 x 52 week breaches in April. One was patient choice, where the patient opted to delay treatment beyond 52 weeks. The other was also patient choice, where the patient declined the offer of surgery at an earlier date with another consultant. This patient's pathway had been closed in error much earlier and was a late entry back on to the PTL. Both patients will be treated in May. Nationally there were 865 patients in March with a wait exceeding 12 months. Locally, East and North reported four 52 week breaches in March and Milton Keynes reported three 52 week breachs.

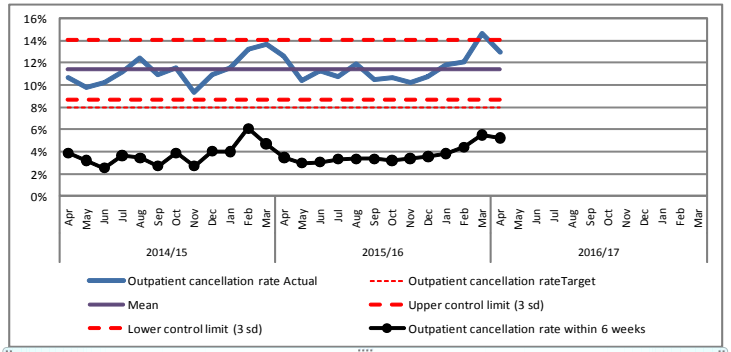
Demand continues to be a challenge in Cardiology and Pain, and the CCG has been informed that this continues to be an issue. Discussions are ongoing.

Services that are achieving 92% or above have been given a stretch target to the next percentage point to support services where compliance is an issue. Local actions are being implemented to increase activity to reduce the backlog and achieve a sustainable compliant position.

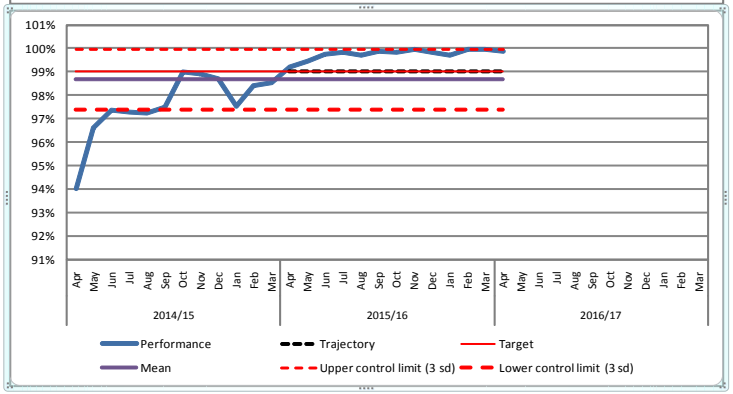
Patients not treated within 28 days of last minute cancellation and urgent operations cancelled for 2nd time



Hospital outpatient cancellations all and % cancelled* within 6 weeks *(*excluding cancellations to provide earlier appointments, where patients have*



Diagnostics



Hospital cancellations – patients not treated within 28 days of last minute cancellation

There were 13 breaches of the 28 day readmission standard in April. Review of breach reasons has identified continuing issues with scheduling practices and the availability of appropriate capacity to offer patients dates with reasonable notice and within 28 days. This was further compounded by capacity restraints resulting from the junior doctor industrial action, loss of theatre capacity and patient choice where patients declined offers at short notice.

Services have re-focussed efforts to reduce these breaches and significant improvement is anticipated over the coming months.

Hospital cancellations – patients cancelled within 6 weeks and overall

In April 12.9% of outpatient appointments were cancelled by the hospital against a target of 8.0%. The cancellation rate by the hospital within six weeks of appointment was slightly lower than the previous month, at 5.3%.

Cancellations in response to the junior doctor industrial action are included within this figure.

Analysis of hospital cancellations under 6 weeks has identified that a significant proportion do not arise from whole session cancellation and are therefore not escalated to the Director of Operations for Elective Care for authorisation prior to cancellation. Drilled down reports are to be shared with the divisions and options being considered include the removal of cancellation permissions , restricting this to a small number of staff.

Diagnostic wait times

The diagnostic waiting time standard is for 99% of patients referred for 15 diagnostic tests/procedures, should wait no longer than 6 weeks.

The strong performance against this standard has been delivered consistently since April 2015 and is better than the national position of 98.3%.

Responsive

Reporting sub committee - F&P

CWTs

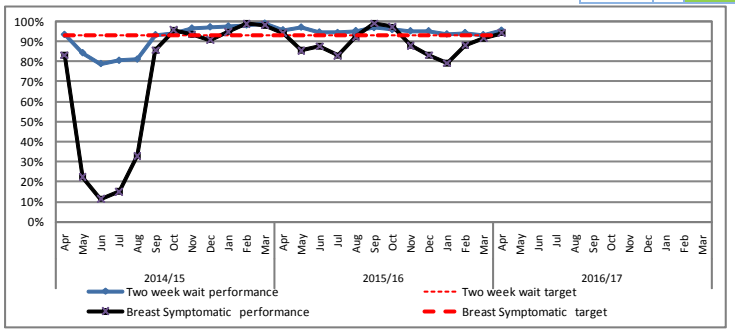
Executive lead	Clinical lead	Operational lead
Sally Tucker	Jeremy Livingstone	Jane Shentall

Performance relative to targets/ thresholds

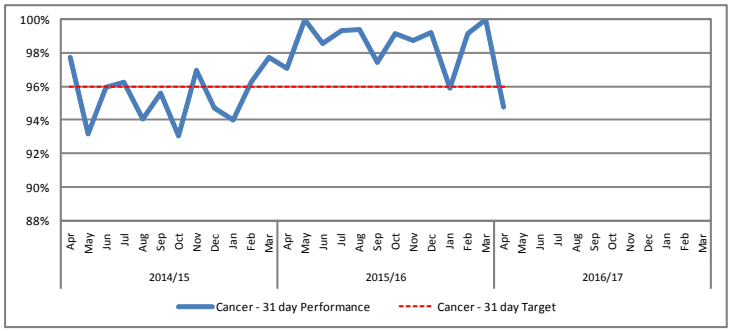
	Achieving	Not achieving
Mar-16	3	4
Feb-16	5	2
Jan-16	4	3

West Hertfordshire Hospitals NHS
NHS Trust

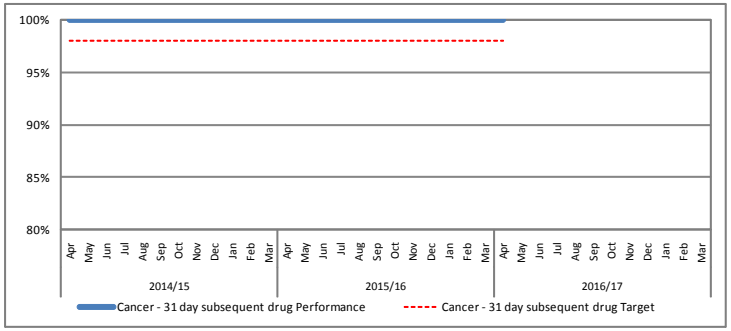
Two week standard and breast symptom two week standard



31 day standard



31 day subsequent drug standard



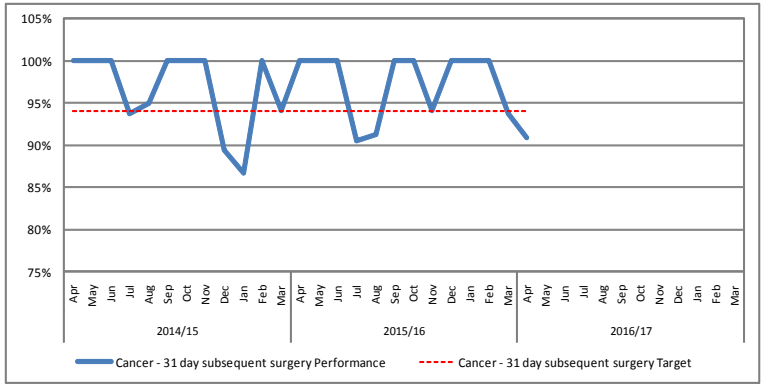
Breast symptomatic
We continue to strive for the first appointment offer within the first week and working with GPs to improve patient information and advice. The provisional position for April is complaint.

2ww
April provisional position is compliant.

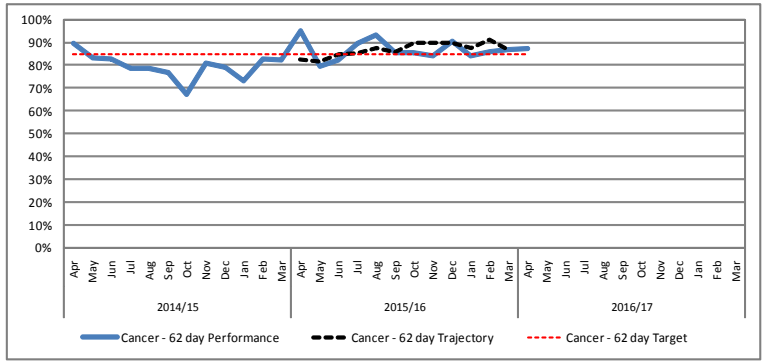
31 day first
April provisional data is non compliant currently. This is due to complex clinical pathways, patient choice and capacity .

The Trust is now compliant with seven of the eight key priorities for Cancer waiting times improvements. The outstanding action is the development of a Cancer Strategy for the organisation. This will be completed by the end of Q1 16/17. However, SOPs are in progress in a number of areas including : inter Trust referrals, imaging, PTL and tracking, note pulling and tracking, amber alerts, training, 2ww audit, histology audit, datix, storage and filing, reporting, audits, breach reporting, VTC, pathways, Consultant upgrades, 2ww pathway, screening programmes and escalation.

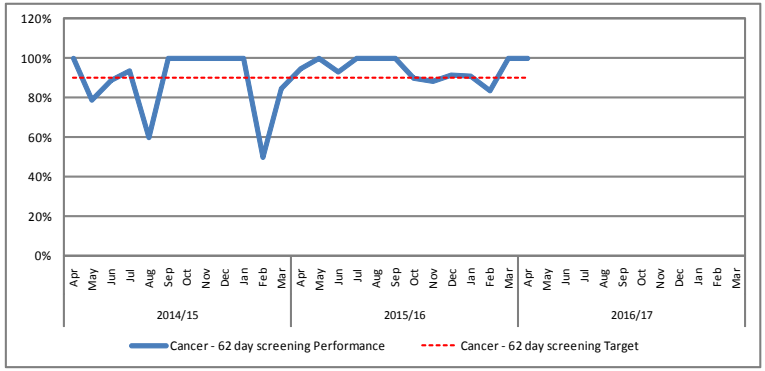
31 day subsequent surgery standard



62 day standard



62 day screening standard



31 31 day subsequent surgery
April provisional data is non compliant but still to be validated.

The **62 day GP**
Provisional position for April is 88%. There are still pathways and breaches to be validated. We are predicting a compliant position for April.

Issues in achieving compliance within tumour sites are being experienced in Colorectal, Urology, Lung. All of these services are the focus of the Cancer Improvement Programme Group.

Tumour site	April performance (provisional)
Suspected breast cancer	94.7
Suspected lung cancer	-
Suspected haematological malignancies excluding acute leukaemia	100
Suspected upper gastrointestinal cancers	92.3
Suspected lower gastrointestinal cancers	60
Suspected skin cancers	100
Suspected gynaecological cancers	70
Suspected urological cancers (excluding testicular)	75
Suspected head and neck cancers	0
Exhibited (non-cancer) breast symptoms - cancer not initially suspected	100
Total	**87.2**

The **62 day screening** standard is provisionally compliant in April.

Responsive

Reporting sub committee - F&P

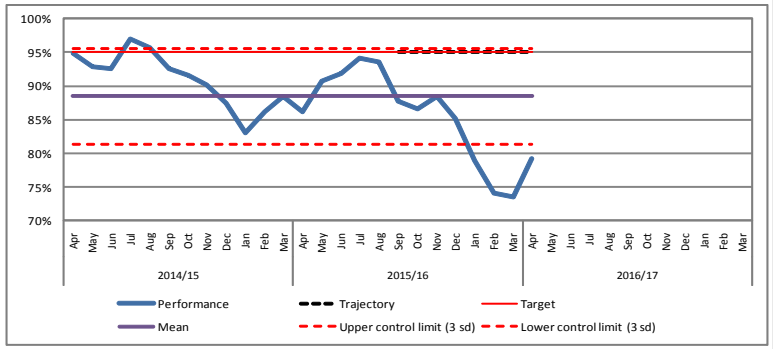
Unscheduled care indicators - A&E, ambulance turnaround and DToC

West Hertfordshire Hospitals NHS Trus

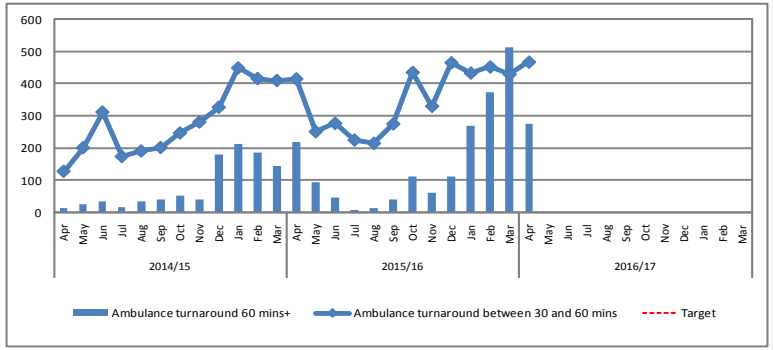
Executive lead	Clinical lead	Operational lead
Sally Tucker	Dr David Gaunt	

Performance relative to targets/ thresholds		
	Achieving	Not achieving
Apr-16	1	4
Mar-16	1	4
Feb-16	1	4

A&E



Ambulance turnaround time



A&E performance increased in April to 79.2%, whilst positive there is still much to do, The position was impacted by high numbers of type 1 attendances and beds occupied by patients whose discharge was delayed (DToC patients). Ambulance Turnaround over 60 mins improved significantly decreasing from 513 to 276, however, handovers between 30 and 60 mins increased slightly.

The Trust continues to work with ECIP and has developed an improvement programme which is governed by the Emergency Care Task Force . A programme lead for Unscheduled Care has also been appointed as part of the PMO.

Front Door Flow, including acute assessment units

The Frailty unit opened on 18th April this provides responsive, specialist care to frail older people outside of the ED environment, a joint initiative with HCT who have provided additional ring fenced bed capacity and therapy support. The service is still developing with interviews for a substantive consultant being held the end of May.

Admin support has been provided to the ED controller to support flow and a senior nurse now manages 'the board' in AAU L1 we are already seeing improved flow.

A new minors area has opened and the team are focussed on protecting this stream of patients - current minors performance is over 90%.

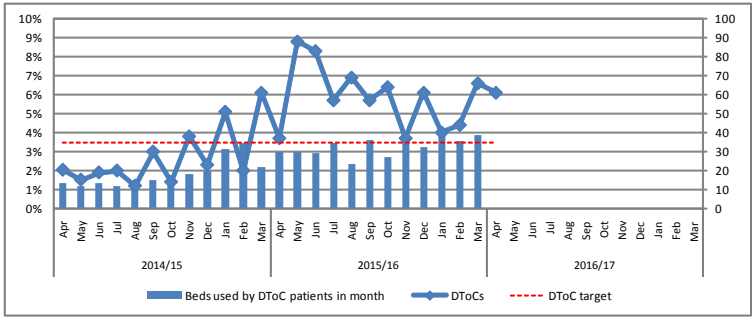
Future projects for short – medium term are Twilight Service and ring fencing of assessment space on AAU L1 .

Hospital Patient Flow

Operationally the focus is to keep assessment areas free of inpatients as far as possible this has significant impact on performance.

There is ongoing work on the wards to support timely discharge and PSAG boards are now all in place. Significant focus is also being put on discharges before midday and increasing use of discharge lounge.

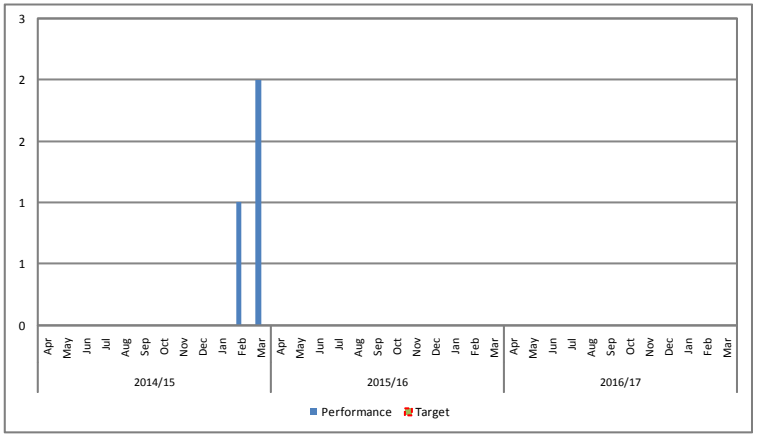
Delayed Transfers of Care (DToC)



The number of DTOCs remains a challenge for the Trust. In April, DTOC patients occupied nearly 38 beds. The national figure of the percentage of DToC can be misleading since this is based on the number of patients waiting at a point in time in the month. The total beds occupied by DToC patients is therefore a more useful measure to illustrate the impact of DToC.

Social care capacity remains a system-wide constraint to achieving target DTOC rates. The longer term development of the IDT and the links with Social Care and Community services is still being reviewed.

12 hour trolley waits



Ongoing escalation to system partners via SRG continues, with significant resource directed to generating additional capacity and improving discharge processes.

An IDT improvement plan is underway, however its impact will be marginal until capacity matches demand for onward health and social care services. The development of the discharge coordinators, including discharge planning books, standardised checklists and appropriate allocation of resource have all been identified as issues through the perfect ward projects which are now being owned by the IDT to implement.

Streamlined processes for data monitoring and reported have been introduced, as well as daily “live” patient monitoring with board briefings with the discharge planning nurses held daily. Lead roles have been introduced in relation to self-funders, and continuing healthcare (CHC) assessments, and a number of staff have been re-allocated to different areas to tackle issues of bottle necked referrals.

Well led

Reporting sub committee - Workforce

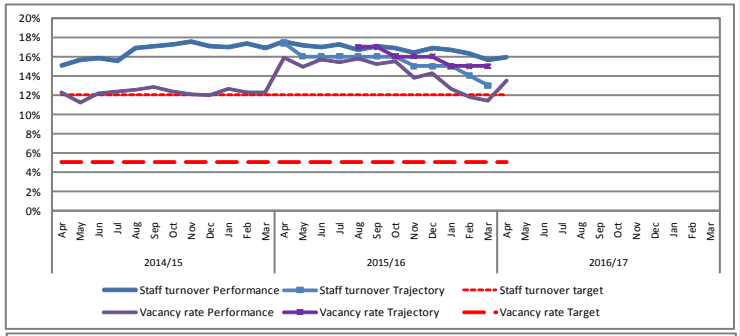
Workforce indicators - staff turnover, sickness, bank & agency, vacancy, appraisal, and mandatory training

Executive lead	Clinical lead	Operational lead
Paul da Gama		

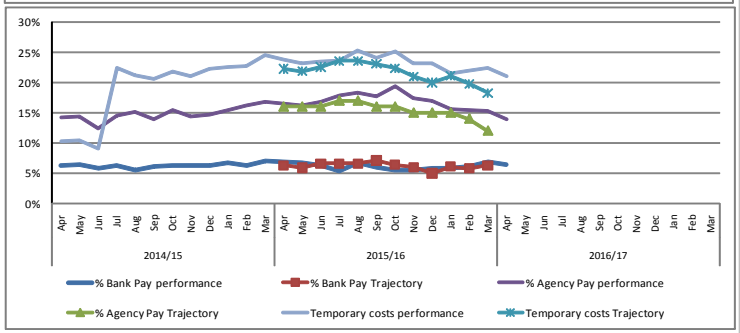
Performance relative to targets/ thresholds

	Achieving	Not achieving
Mar-16	2	6
Feb-16	3	5
Jan-16	2	6

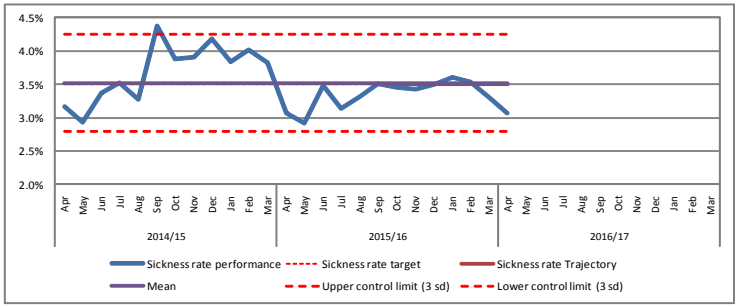
Staff turnover and vacancy rate



% bank, agency and temporary pay



Sickness rate

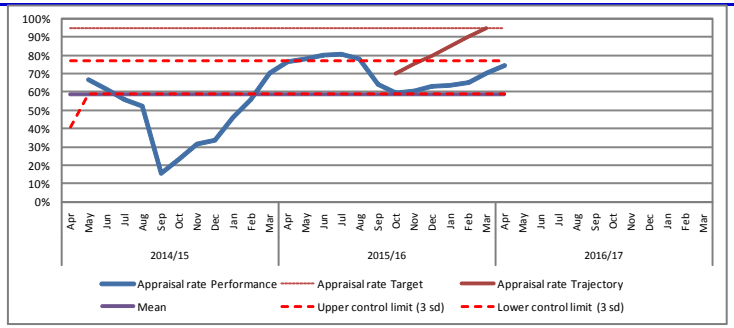


Turnover and Vacancies: At the end of April the Trust vacancy rate increased from 11.4% to 13.5%. This was purely the result of an increase in the establishment of 150 wte positions, as the 'staff-in-post' also increased by 38 wtes which would otherwise have resulted in a reduction in the vacancy rate. Despite the increase in establishment, the vacancy rate was still well below the Trust average for the first 9 months of last year, which was 15.1%, and the comparable figure for April 2015 (15.9%). Within the Trust vacancy rate, the figure for the overall nursing workforce fell from 13.9% to 12.5%, and the rate for Band 5 nurses fell particularly significantly, from 11.8% to 6.8% as a result of 40 new recruits in April. The vacancy rate for medical consultants also fell, from 6.2% to 5.8%.
The 12 month rolling turnover rate, having fallen in March from 16.3% to 15.6%, increased slightly to 15.9% in April. This is still well below the average for the first 9 months of last year, which was 17.0%, and the comparable figure for April 2015 (17.3%).

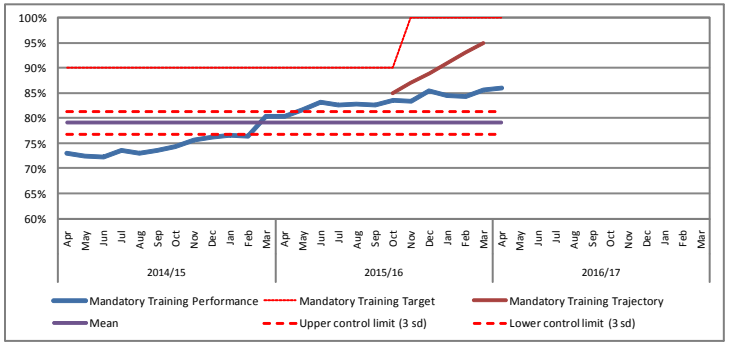
% Bank and Agency Expenditure: April saw a further noticeable reduction in agency spend as percentage of pay-bill, down to 14.0% from 15.3% in March. Spend on our bank also fell slightly to 6.5% of pay-bill in April compared to 6.8% in March; resulting in an overall fall in temporary staffing spend from 22.1% in March to 20.5% in April. We are no longer required to report separately on nursing agency expenditure; instead we have a target for overall agency spend, profiled across the year. Our April spend was below our profiled figure for the month.
The Trust continues to implement a number of steps both internally and as part of the wider NHS to limit agency spend, including the national NHS agency rate-capping. Good progress is being made in achieving the rate caps both at a local level and in partnership across Herts and Beds. As anticipated, breaches increased in April with the implementation of the final tier of the national rate caps, but these reduced noticeably in the first week of May, and we are out-performing our trajectory for breach reduction.

Sickness rate: Sickness is currently running at 3.1%, down from 3.4% in March. The Trust continues to run with a sickness rate slightly below peers, which was averaged 3.8% across Beds and Herts, measured in quarter 4 of 2015/16. A major review of sickness absence is ongoing. This includes auditing of local absence figures to ensure robust reporting is in place.

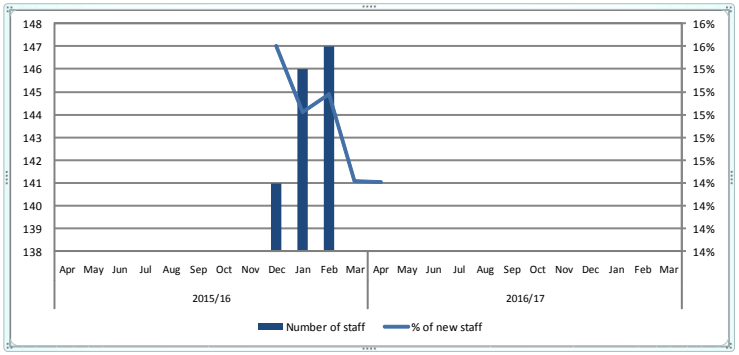
Appraisal rate
(non medical staff only)



Mandatory training



Number of staffleaving within first year (excluding medics and fixed term contracts)



Appraisal – non medical staff

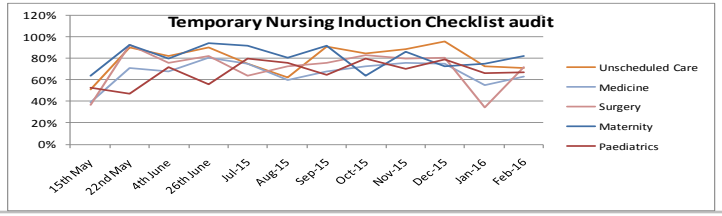
The values-based appraisal rate has increased to 75% this month and is moving in the right direction but more work is required to achieve a 95% target. The HRBP's have developed action plans with Divisional Managers to work towards the 95% target. Significant focus has been placed upon ensuring that support areas less impacted by service pressure complete appraisals which should further positively impact May's figures.

Communication has been shared to reiterate the link between appraisal completion and incremental pay awards. Training continues to be provided to managers on the new Appraisal and Pay Progression Policy and the Core Management Development Program has been rolled out for 2016 to include sessions for managers to develop their capability in relation to conducting appraisals.

Mandatory training

Mandatory training compliance has remained relatively static over last six months around 85%. The team have done significant work to enable greater access to e-learning for mandatory training and this can now be done through a web based portal using 3 clicks from the intranet home page which should positively impact figures over the next couple of months. The Trust is working with a new provider to for the Learning Management system which should enable a step change in terms of compliance as this will automate e-mail reminders to staff about the need to undertake training and signpost them to the relevant e-learning. In the short term a number of actions are being undertaken to ensure that 95% compliance is achieved by end of July. These actions include:

- E-learning material available via a weblink is being publicised via E-Update and directly face to face for managers
- Working with divisions to reduce the number of 'DNA's, currently circa 25%. Capacity of face to face training is not an issue.
- Strengthening requirement for mandatory training compliance before incremental payments are approved.
- Weekly reporting on compliance to go to divisions



Safe, effective, caring

Well led

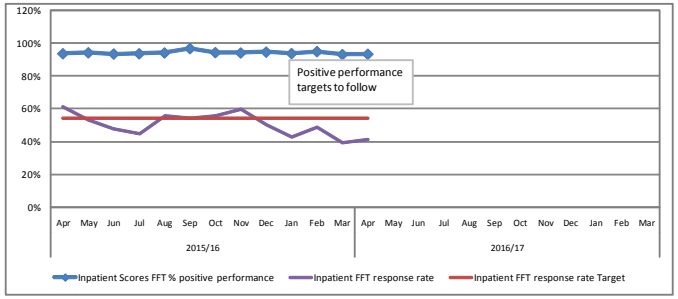
Reporting sub committees - PSQR and Workforce

Friends and family

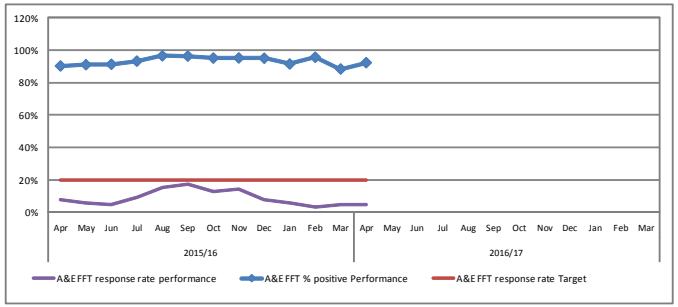
Executive lead	Clinical lead	Operational lead
Tracey Carter and Paul Da Gama		

Well led	Achieving		Not achieving	
Mar-16	0		4	
Feb-16	0		4	
Jan-16	0		4	

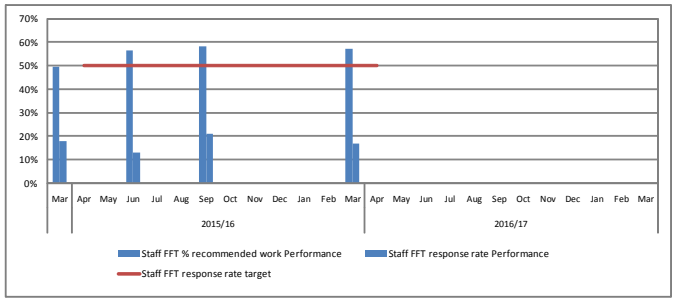
Inpatient scores (% positive and negative) and response rate



A&E scores (% positive and negative) and response rate



Staff scores (% reccommended and not recommended) and response rate



Inpatients
The overall response rate has improved this month by 2.1% to 43.6% and an improvement in the positive response rate of 0.5% is also noted.

A&E
The response rate has improved by 0.2% this month to 4.9% and there has been a more significant increase in the positive response rate of 3.9% moving from 88.4% to 92.3%. There has also been a marginal decrease in the negative response rate of 0.2% from 4.2% to 4%.

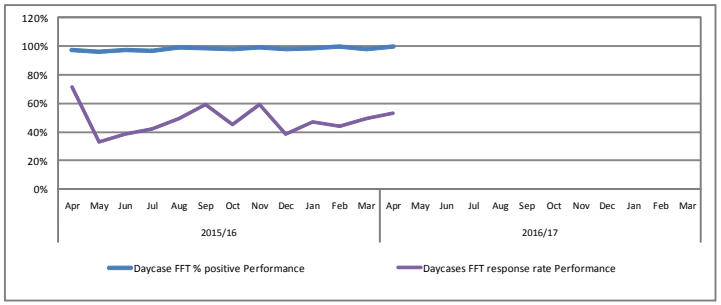
The standard operating procedure (SOP) has been developed and the trial of post discharge telephone follow up calls for minors patients has commenced; early indications are that the majority of the feedback has been positive to date.

Maternity – Question 2
Maternity has maintained performance on the response rate this month but a 1.3% drop in positive response rate is noted from 95.5% to 94.2% . The department has been 'surging' into an escalation area within the unit due to demand which may have impacted on the patient experience and account for this result.

Staff
The Staff Friends and Family Test for Q4 ran between 3 and 26 February and had been extended due to low responses. The full data has only just been received and has therefore not yet been reported on but we appear to have had a response rate of approximately 16%, less than the 20% we achieved in Q2. Results do appear to have fallen slightly since Q2 which ties in with the results from the national staff survey which took place in Q3.

The survey was available both online via a pop up box, and as a hard copy; boxes were placed at all catering facilities, and the questionnaire was promoted at health and wellbeing events throughout the month. There was a stand most lunchtimes on the Watford sites in the restaurant, offering biscuits and fruit as an incentive to complete the questionnaire.

Daycases scores (% positive and negative) and response rate



Daycase

The Trust is now measuring both the main DSU at SACH and also the Surgical admission lounge at WGH, which also has surgery patients. These are now included in the inpatient survey results.

The response rate for day cases has remained consistently high and an improving position in the positive response rate is evident.

Ward Scorecard

Areas of good performance	*Areas requiring performance improvement*	
The number of new harms this month continues to fall. **Feb –April 16** the top 5 performing clinical areas are: •1st Cleves •2nd Langley •3rd AAUP/G 3 CCU •4thStarfish •5th AAU G1 •These top 5 wards are performing well over the last 3 months across all indicators. • Langley is showing with Test your Care all indicators Green **Indicators April 16** overall green outcome indicators remain as pressure ulcers and infection control.	**Feb –April 16** the bottom 5 clinical areas are: •22nd Ridge •23rd Tudor •24th Heronsgate •25th Bluebell •26th AAU B/Y 3 Indicators Red rated areas on the Heat map are Falls and Falls with Harm. •Implementation of the Falls Campaign – All new paperwork (amended Risk booklet, Nursing Assessment •Proforma, and FALLSTOP pack) to support campaign has been received and teaching and launching during June. • Posters highlighting Falls will be displayed in clinical areas and will be in the new bedside folders for patients. **April 2016 TYC** •Overall results for adult inpatient wards is 83%, a decrease of 3 percentage points from March 2016 •For April 8 out of the 9 care indicators have decreased slightly from March. •TYC Resuscitation reported 89% (a decrease of 4 percentage points from March) •TYC Pain reported 88% a decrease of 4 percentage points from March •TYC nutrition has decreased to 67% from 72% in March 2016 •TYC Patient Observations has decreased to 79% in April from 81% March 2016.	**Comment** •Focus on Handovers with Sarratt ward using the patient documentation to demonstrate care. •. Fluid Guidelines presented to Medicines Use and Safety Panel (MUSP) in May. Training and education and roll out of new nursing documentation in June 2016 •The matrons targeting work around observations, nutrition, medication, and continence. •Safety communication –safety huddles are being undertaken on wards and improvement on handovers is being developed. •New Nursing folders with a standardised layout and content. Each area will have a folder as a resource with examples of completed paperwork . To be ordered in June • Education and rollout of new care plans on personal hygiene, mouth care and breathing/ oxygen in June • 3 clinical areas self assessing against the draft core competencies for Ward accreditation .

Ward Scorecard

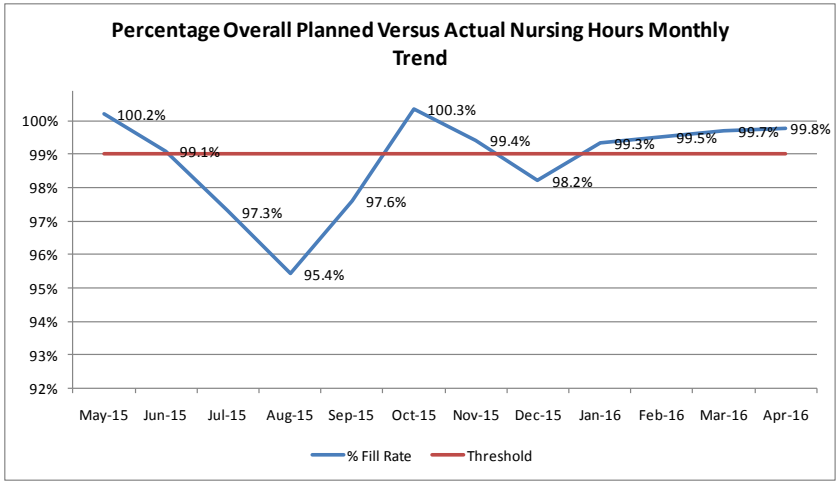
West Hertfordshire Hospitals NHS Trust

Division	Ward	April-2016															
		Matron Quality Checks/Patients	Matron Quality Checks/Staff	TYC Overall	TYC/TVN section	Pressure Ulcers	No. of Falls	Falls with Harms	Commode Audit	Hand Hygiene Audit	Hospital acquired C.diff	Hopsital acquired MRSA isolate	% Extremely Likely>90	iWGC Response >54%	Red Flag Number of shifts less than 2 RN's on shift	Red Flag Number of shifts more than 8 hours less than planned	% of Supervisory filled Hours
Unscheduled Care	AAU B/Y 3	! 86%	! 88%	✓ 93%	✓ 98%	✗ 2	✗ 12	✗ 5	✓ 100%	✗ 23%	✓ 0	✓ 0	✓ 91%	✓ 77%	✓ 0	✗ 19	✗ 62%
	AAU B1	! 87%	! 80%	! 82%	✗ 77%	✗ 1	✓ 3	✓ 0	✓ 100%	✓ 100%	✓ 0	✓ 0	✓ 100%	✓ 62%	✓ 0	✗ 2	! 86%
	AAU G1	✓ 90%	! 89%	! 84%	✗ 75%	✓ 0	✓ 1	✓ 0	✓ 100%	✓ 100%	✓ 0	✓ 0	✓ 95%	✓ 55%	✓ 0	✗ 8	✗ 33%
	AAU P1	! 87%	! 89%	✗ 78%	✗ 78%	✓ 0	✓ 3	✓ 0	✓ 100%	✓ 100%	✓ 0	✓ 0	✓ 96%	✗ 13%	✓ 0	✗ 4	! 89%
	AAU Y1	✓ 91%	! 89%	! 84%	! 84%	✓ 0	✓ 3	✗ 2	✓ 100%	✓ 100%	✓ 0	✓ 0	✓ 93%	✓ 59%	✓ 0	✗ 2	✗ 50%
	CCU/ P/G 3	! 89%	! 89%	✓ 93%	✓ 93%	✓ 0	✓ 0	✓ 0	✓ 100%	✓ 100%	✓ 0	✓ 0	✓ 94%	✓ 71%	✓ 0	✗ 7	! 86%
	A&E	! 83%	✓ 99%	✗ 63%	✗ 20%	✗ 1	✓ 1	✓ 0	✗ 67%	✓ 92%	✓ 0	✓ 0	! 87%	✗ 1%	✓ 0	✗ 15	NA
	MIU	NA	NA	✓ 96%	NA	✓ 0	✓ 0	✓ 0	NA	NA	✓ 0	✓ 0	✓ 99%	✗ 8%	✓ 0	✓ 0	NA
	UCC	NA	NA	✓ 94%	NA	✓ 0	✓ 0	✓ 0	NA	NA	✓ 0	✓ 0	! 89%	✗ 8%	✓ 0	✗ 11	NA
Medicine	Aldenham	! 87%	✓ 97%	✓ 95%	✓ 90%	✗ 1	✓ 3	✓ 0	✓ 100%	✓ 100%	✓ 0	✓ 0	✓ 93%	✓ 55%	✓ 0	✗ 4	✗ 67%
	Bluebell	NA	NA	✓ 93%	✓ 100%	✓ 0	✓ 1	✓ 0	✓ 100%	✓ 100%	✓ 0	✓ 0	✗ 75%	✗ 44%	✓ 0	✗ 32	✗ 67%
	Cassio	✓ 95%	✓ 97%	! 87%	! 75%	✓ 0	✓ 3	✓ 0	! 83%	✓ 100%	✓ 0	✓ 0	✓ 100%	✗ 34%	✓ 0	✗ 1	✓ 107%
	Croxley	✓ 94%	NA	✗ 60%	✗ 51%	✓ 0	✓ 2	✗ 1	✓ 100%	✓ 100%	✓ 0	✓ 0	✓ 91%	✗ 30%	✓ 0	✗ 5	✓ 100%
	Heronsgate	✓ 95%	NA	! 87%	✓ 97%	✓ 0	! 7	✗ 1	✓ 100%	! 81%	✓ 0	✓ 0	! 87%	✓ 71%	✓ 0	✗ 52	✓ 99%
	Oxhey	NA	NA	NA	NA	✓ 0	✓ 2	✓ 0	NA	NA	NA	NA	✗ 79%	✗ 35%	NA	NA	NA
	Red	NA	NA	! 83%	✗ 55%	✗ 1	! 5	✓ 0	✓ 100%	✓ 100%	✓ 0	✓ 0	✓ 92%	✓ 71%	✓ 0	✗ 1	! 81%
	Sarratt	✓ 95%	NA	✗ 65%	✗ 42%	✓ 0	✓ 4	✓ 0	✓ 100%	✓ 95%	✓ 0	✓ 0	! 88%	✓ 83%	✓ 0	✗ 7	! 81%
	Simpson	✓ 99%	✓ 100%	✗ 75%	✗ 48%	✓ 0	✓ 2	✓ 0	NA	✓ 100%	✓ 0	✓ 0	✓ 94%	✗ 46%	✓ 0	✗ 9	✓ 91%
	Stroke	! 86%	✓ 97%	✓ 95%	✓ 92%	✓ 0	! 5	✓ 0	! 89%	! 83%	✓ 0	✓ 0	✓ 93%	✓ 57%	✓ 0	✗ 11	! 86%
	Tudor	NA	NA	✗ 50%	✗ 36%	✓ 0	! 5	✗ 1	✓ 100%	✓ 100%	✓ 0	✓ 0	! 89%	✓ 65%	✓ 0	✓ 0	✓ 98%
	Winyard	NA	NA	✓ 93%	! 88%	✗ 2	✓ 2	✓ 0	✓ 100%	✓ 100%	✓ 0	✓ 0	✓ 92%	✓ 73%	✓ 0	✗ 4	! 79%
Surgery	Cleves	✓ 96%	✓ 98%	✓ 90%	✗ 78%	✗ 1	✓ 0	✓ 0	✓ 100%	✓ 100%	✓ 0	✓ 0	✓ 91%	✓ 72%	✓ 0	✗ 2	! 81%
	DLM	NA	NA	! 88%	! 85%	✓ 0	✓ 0	✓ 0	NA	✓ 100%	✓ 0	✓ 0	✓ 99%	✗ 42%	✓ 0	✗ 12	! 81%
	Flaunden	✓ 98%	✓ 94%	✓ 93%	✓ 97%	✗ 1	✓ 2	✓ 0	✓ 100%	✗ 70%	✓ 0	✓ 0	✓ 93%	✗ 20%	✓ 0	✗ 28	! 86%
	ICU	✓ 95%	✓ 99%	! 82%	! 82%	✗ 2	✓ 1	✓ 0	! 83%	✓ 96%	✓ 0	✓ 0	✓ 100%	✗ 22%	✓ 0	✗ 15	✓ 100%
	Langley	✓ 100%	✓ 98%	✓ 99%	✓ 95%	✓ 0	✓ 2	✓ 0	✓ 100%	! 84%	✓ 0	✓ 0	✓ 94%	✗ 42%	✓ 0	✗ 22	! 76%
	Letchmore	✓ 97%	✓ 95%	✓ 95%	✓ 100%	✗ 3	! 6	✗ 1	✓ 100%	✓ 95%	✓ 0	✓ 0	✓ 94%	✗ 36%	✓ 0	✗ 9	! 81%
	Ridge	✓ 97%	✓ 94%	✓ 90%	! 89%	✗ 1	! 5	✓ 0	✗ 67%	✓ 100%	✓ 0	✓ 0	! 90%	✓ 58%	✓ 0	✗ 18	✗ 71%
WACS	Elizabeth	✓ 97%	! 89%	! 79%	✗ 41%	✓ 0	✓ 2	✓ 0	✓ 100%	✓ 100%	✓ 0	✓ 0	! 88%	✗ 22%	✓ 0	✗ 1	! 86%
Paeds	SCBU	NA	NA	! 87%	✓ 94%	✓ 0	NA	NA	NA	✓ 100%	✓ 0	✓ 0	✓ 100%	✗ 24%	✓ 0	✗ 12	NA
	Starfish	✓ 99%	✓ 96%	✓ 100%	✓ 100%	✓ 0	NA	NA	✓ 100%	✓ 96%	✓ 0	✓ 0	✓ 100%	✗ 7%	✓ 0	✗ 21	✓ 100%
	CED	✓ 99%	✓ 96%	✓ 96%	NA	NA	NA	NA	NA	✓ 100%	✓ 0	✓ 0	✓ 96%	✗ 6%	NA	NA	NA
	Safari	✓ 100%	✓ 96%	NA	NA	✓ 0	NA	NA	NA	✓ 100%	✓ 0	✓ 0	✓ 96%	NA	✓ 0	✓ 0	✓ 131%
Maternity	Delivery Suite	NA	NA	! 83%	NA	NA	NA	NA	NA	✗ 0%	NA	✓ 0	✓ 92%	✗ 27%	NA	NA	NA
	Community	NA	NA	✓ 95%	NA	NA	NA	NA	NA	NA	NA	NA	! 86%	NA	NA	NA	NA

West Hertfordshire Hospitals NHS Trust

Safer staffing

Indicator	Performance (March)	Threshold	Trend	Forecast next month
% Nursing hours versus planned	99.8%	>95%	Upwards	>99%



Indicator by shift and skill mix	Shift	RN	Care staff
% Nursing hours versus planned	Day	94.4%	109.1%
	Night	97.5%	106.0%

What actions have been taken to improve performance

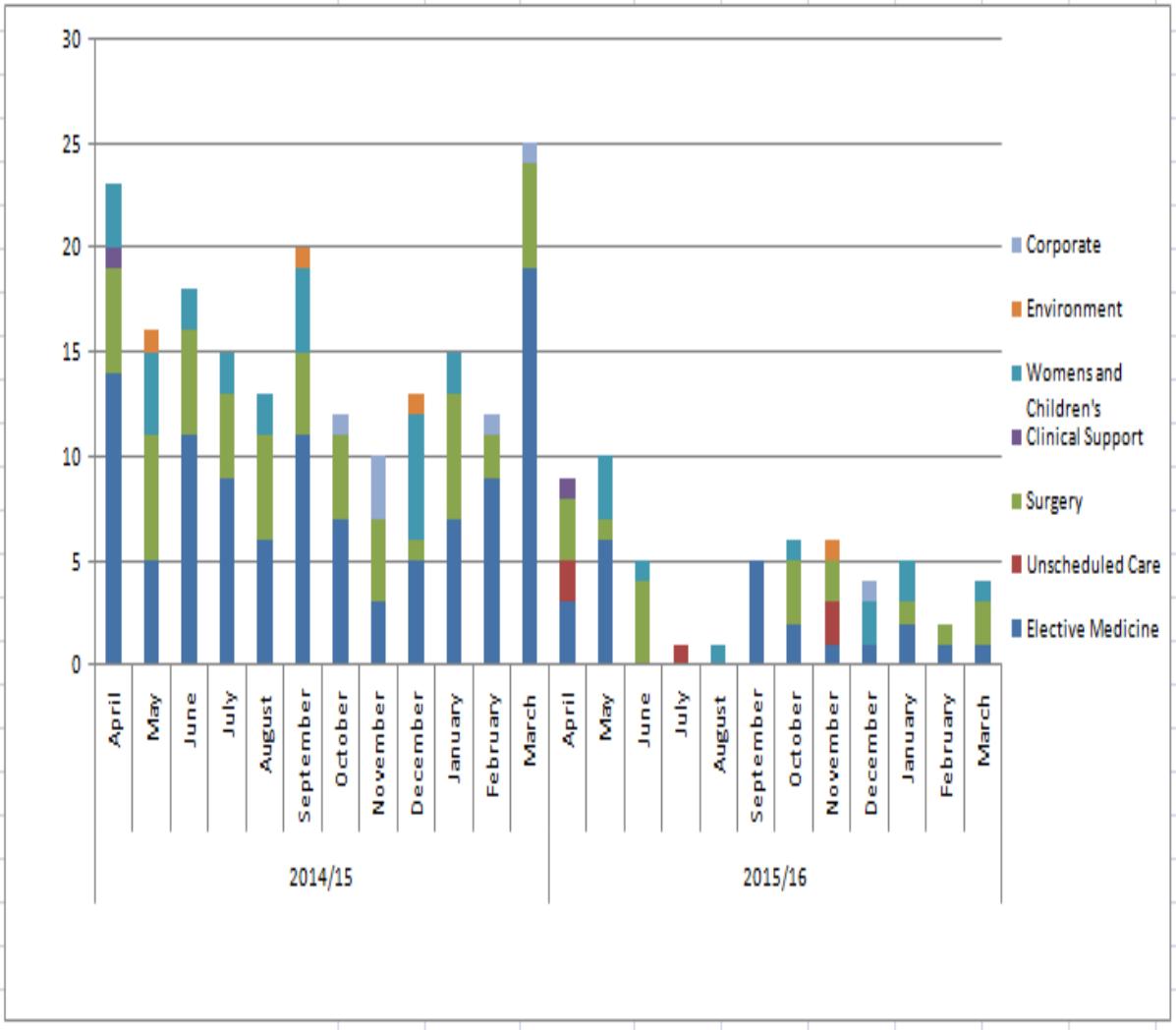
•Continued focus on recruiting and retaining new staff
• Ongoing focus on reducing reliance on high cost temporary agency
• Weekly focus on nursing and midwifery staffing, particularly around temporary usage and recruitment
•Senior nurse presence and support until 20:00 every day and working clinically
• Review of the planned RN hours has been undertaken to ensure accurate reporting of red flags. As a result there have been zero red flags reported for the number of shifts with less than 2 RNs working, and a significant improvement in the number of shifts with more than 8 hours less than planned worked
• Percentage of supervisory hours lost has continued to improve as a result of recruitment and retention.

What is causing the variance

• Overall fill rate increased in April 2016 from previous month
• Spend on nursing agency as a percentage of total nursing spend was 15% in April.
• Whilst recruitment continues temporary workers are attracted to work at night and weekends due to the enhanced payments. This will impact on the RN fill rate on day shifts.
• Skill mixing takes place, when clinically appropriate, leading to the higher number of actual HCA hours worked This is particularly noticeable for day shits.
• Use of additional HCAs above planned hours to support patients with enhanced care needs contributes to the hours worked above plan. The Trust's transitional nurses are also included in the HCA hours worked, further contributing to the positive variance in worked care staff hours.
• There were no shifts reported as red rated, as described in the Trust's safe staffing escalation policy as mitigation was put in place to address the shortfall in actual worked RN hours from planned.
• Senior sisters will work in actual worked hours to cover any unfilled shifts or support when acuity and dependency increases.
• Lower fill rate of RNs in day vs. night due to presence of other multi professional staff supplementing workforce (e.g. therapists, pharmacists and ward clerks).
• As reported previously, work to upgrade the e-roster system has commenced in April. Data cleansing of the roster information has commenced throughout April in readiness for this. A review of the red flag reporting and RAG rating of ward staffing will be completed in readiness for revised reporting requirements to include Care Hours Per Patient Day (CHPPD) from June 2016.

Patient safety – Serious incidents

Number of serious incidents



There were 8 SIs declared in March and April 2016.

•The Trust currently has a total of 19 open SIs.

•At the end of April there were no overdue investigations waiting to be submitted to the CCG.

• 10 RCAs are going through the CCG QA process.

The Trust is reporting significantly less SIs than in 2014/15; this is due to the consistent and robust way in which the national criteria for SI's is being applied in line with the focus of the new framework to 'do less better'.

To enable learning and evidence of learning to be assured;
•45 day review meetings allow the RCA to be discussed and challenged by the relevant clinical and management teams prior to the action plan being written.
•The SI review group undertakes a deep dive for all never events and reviews all SI action plans for completion and that evidence gives assurance of actions being undertaken and that learning has taken place.

Patient safety – Serious incidents

Number of serious incidents, by STEIS category

STEIS category	YTD	March April 2016
Alleged abuse of patient	3	
Adverse media coverage	1	
Confidential information leak	1	
Diagnostic incident	4	
Infection control	1	
Major incident preparedness	1	
Maternity obstetric	2	3
Medication incident	1	
Operation/treatment and consent	1	
Pressure ulcer	13	1
Slips trips and falls	2	
Surgical/invasive procedure	12	1
Treatment delay	2	
VTE incident	8	1
Incident affecting pt body after death	2	1
Suboptimal care	4	1
Total	63	8

Number of serious incidents, by action plan status

SIs	2015/16		
	Yes	No	Total
Action plans completed	1		1
Action plan confirmed closed			
Total	**1**	**0**	**1**

STEIS Category March and April 2016

STEIS Category		No
Medicine	HAPU	1
WACS	Injury following Forceps delivery	1
WACS	VTE	1
Surgery	Missed bowel Tumour	1
WACS	Neonatal Transfer	1
WACS	IUD	1
Clinical support	Mortuary Fridge Failure	1
Medicine	Unexpected death	1

Serious Incidents which have proceeded to a claim

Ref.	Claim Date	Division	Speciality
61524	16 Sept 2015	SAC	Urology
59761	28 Sept 2015	Medicine	Respiratory
89127	14 Oct 2015	Unscheduled Care	Medical
59437	04 Nov 2015	SAC	Urology
60804	20 Apr 2016	medicine	Urology