West Hertfordshire Hospitals NHS Trust

Integrated Performance Report

January 2016

(December data)

West Hertfordshire Hospitals NHS Trust

West Hertfordshire Hospitals NHS Trust

Executive Summary

Safe Effective Caring

Reporting sub committee - PSQR

Performance relative to targets/ thresholds

	Achieving	Not achieving	Better than national average	Worse than national average
Dec-15	7	9	4	7
Nov-15	8	8	7	3
Oct-15	5	11	7	3

Areas of good performance

•Mortality indicators show sustained excellent performance (pages 3 and 10)
•There were no MRSA bacteraemia (pages 3 and 14)
•Patients spending 90% of their time on the stroke unit achieved the performance standard (pages 4 and 11)

New to category this month:

• There were no medication errors causing serious harm (pages 4 and 15)

Areas requiring performance improvement

• Clostridium difficile year to date total is 23 (against a trajectory of no more than 23 cases for the year) *(pages 3 and 14)*
• VTE risk assessment was below the threshold at 92.0% (noting an improvement from last month) *(pages 4 and 16)*
• There was 1 mixed sex accommodation breach *(pages 3 and 17)*
• Admission to stroke ward within 4 hours was below the performance standard *(pages 4 and 11)*
• There were 4 serious incidents recorded *(pages 4 and 15)*

New to category this month:

• There was one never event (pages 4 and 14)
Harm free care was below the performance standard (pages 4 and 17)

Executive summary

Responsive

Reporting sub committee - F&P

	Achieving	Not achieving	Better than national average	Worse than national average
Dec-15	11	9	6	7
Nov-15	11	9	5	7
Oct-15	12	8	7	5

Areas of good performance

• Diagnostic wait times delivered to the performance standard *(pages 5 and 19)*
• All cancer indicators including 62 day indicators are delivering to the performance standard (provisional) (pages 5 and 20)
• There were no RTT 52 week waits *(pages 5 and 18)*
• Patients not treated within 28 days of their 'last minute' cancelled operation achieved the performance standard (pages 6 and 19)

New to category this month:

• *None*

Areas requiring performance improvement

• A&E 4 hour wait (all types) performance was 85.2% for December *(pages 5 and 22)*
• Formal delayed transfers of care continue to report above the performance standard *(pages 5 and 23)*
• Ambulance turnaround times' performance was worse than standard *(pages 5 and 22)*

New to category this month:

• The referral to treatment incomplete indicator was below the performance standard (pages 5 and 18)
•The number of patients not treated within 28 days of last minute cancellation was below the performance standard (pages 6 and 19)

Well led

Reporting sub committee - Workforce

	Achieving	Not achieving	Better than national average	Worse than national average
Dec-15	2	10	2	1
Nov-15	4	8	3	0
Oct-15	4	8	2	1

Areas of good performance

• The percent of bank pay was better than target *(pages 7 and 24)*
• The sickness rate was better than target *(pages 7 and 24)*

New to category this month:
None

Areas requiring performance improvement

• A number of workforce indicators continue to report underperformance, including agency pay, staff turnover rate, vacancy rate, appraisals and mandatory training *(pages 7, 24 and 25)*

New to category this month:

•Inpatient Friends and Family response rate was below threshold (pages 7 and 16)
• Maternity Friends and Family response rate was better than threshold (pages 7 and 26)

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 the national average relate to only those indicators where the national average was available.

West Hertfordshire Hospitals NHS Trust

Indicator Summary

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
Safe, Effective, Caring		SHMI (Rolling 12 months)	100	✓ 90.6	✓ 90.2	✓ 93.4			MD	Apr-Mar 15	Y	National	100	Apr-Mar 15	
		HSMR - Total (Rolling three months)	100	✓ 81.8	✓ 77.9	✓ 70.5			MD	Sep-15	Y	National	100	Sep-15	
		Crude Mortality Rate (Non elective ordinary)**	3.2%	✓ 2.1%	✓ 1.8%	✓ 3.1%	✓ 2.2%	3.2%	MD	Dec-15	Y	National	2.5% (East of Eng.)	Sep-15	
	●	30 Day Emergency Readmissions - Combined *	4.0%	✗ 7.4%	✗ 6.9%	✗ 7.5%	✗ 7.4%	4.0%	MD	Dec-15	Y	National	11.4%	2011-12	
		30 Day Emergency Readmissions - Elective *	n/a	3.8%	3.2%	3.9%	3.6%	n/a	MD	Dec-15	Y	National			
		30 Day Emergency Readmissions - Emerg *	n/a	10.5%	10.0%	10.2%	10.4%	n/a	MD	Dec-15	Y	National			
		Number of patients with a length of stay > 14 days *	tbc	352	313	366	3088	tbc	MD	Dec-15		Local			
		Staff FFT % recommended care	tbd TDA^	57.5%	63.1%	61.2%	61.9%	tbd TDA^	DoW	Sep-15	Y	National			
		Inpatient Scores FFT % positive	tbd TDA^	94.2%	94.0%	94.5%	94.2%	tbd TDA^	CN	Dec-15	Y	National	95.7%	Nov-15	
		A&E FFT % positive	tbd TDA^	95.2%	95.3%	95.1%	94.6%	tbd TDA^	CN	Dec-15	Y	National	86.9%	Nov-15	
		Daycase FFT % positive	tbd TDA^	97.9%	99.3%	97.8%	98.0%	tbd TDA^	CN	Dec-15	Y	National			
		Maternity FFT % positive	tbd TDA^	95.6%	94.2%	94.4%	94.3%	tbd TDA^	CN	Dec-15	N	National	96.3%	Nov-15	
		% Complaints responded to within one month or agreed timescales with complainant	tbd TDA^	32.4%	37.7%	23.3%	43.5%	tbd TDA^	CN	Dec-15	N	Local			
		Complaints - rate per 10,000 bed days	tbd TDA^	41.9	28.4	26.8	36.9	tbd TDA^	CN	Dec-15	N	National			
	●	Mixed sex accommodation breaches	0	✗ 7	✗ 3	✗ 1	✗ 35	0	CN	Dec-15	N	National	38 Trusts breaching	Nov-15	
	●	Clostridium Difficile	1	! 2	✗ 6	! 1	✗ 23	7	CN	Dec-15	Y	National			
		MRSA bacteraemias	0	✗ 1	✓ 0	✓ 0	✗ 1	0	CN	Dec-15	Y	National			

* 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

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

West Hertfordshire Hospitals NHS NHS Trust

West Hertfordshire Hospitals NHS Trust

Indicator Summary

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
Safe, Effective, Caring	◆	Never events	0	✓ 0	✓ 0	✗ 1	✗ 2	0	MD	Dec-15	Y	National				G
		Serious incidents - number*	tbd TDA^	5	7	4	55	tbd TDA^	MD	Dec-15	Y	National				A
		Serious incidents - % that are harmful*	n/a	80.0%	100.0%	0.0%	60.0%	n/a	MD	Dec-15	Y	National				A
		Medication errors causing serious harm *	0	✓ 0	✗ 1	✓ 0	✗ 3	0	MD	Dec-15	Y	National				A
	●	Open CAS Alerts	0	✗ 8	✗ 9	✗ 9	✗ 9	0	CN	Dec-15	Y	National				A
	◆	Harm Free Care	95.0%	✗ 94.4%	✓ 96.0%	✗ 94.1%	✗ 94.0%	95.0%	CN	Dec-15	Y	National	94.2%	Dec-15		G
		% New Harms (Safety Thermo - New/All Harms)	tbd TDA^	28.1%	30.4%	22.9%	29.2%	tbd TDA^	CN	Dec-15	Y	National				G
		Pressure Ulcers New Harms	tbd TDA^	2	3	1	31	tbd TDA^	CN	Dec-15	Y	National	WHHT 0.18 vs 0.93	Dec-15		G
		Falls New Harms	tbd TDA^	1	1	3	16	tbd TDA^	CN	Dec-15	Y	National	WHHT 0.53 vs 0.56	Dec-15		G
		Catheter & UTI New Harms	tbd TDA^	1	1	1	17	tbd TDA^	CN	Dec-15	Y	National	WHHT 0.17 vs 0.30	Dec-15		G
		VTE New Harms	tbd TDA^	5	2	3	28	tbd TDA^	CN	Dec-15	Y	National	WHHT 0.34 vs 0.36	Dec-15		G
	●	VTE risk assessment*	95.0%	✗ 88.5%	✗ 93.4%	✗ 92.0%	✗ 91.0%	95.0%	MD	Dec-15	Y	National	95.9%	Q2 2015		A
	●	Caesarean Section rate - Combined*	26.5%	✗ 31.6%	✗ 30.8%	✗ 37.3%	✗ 30.5%	26.5%	MD	Dec-15	Y	Local	26.7%	Apr15-Aug15		A
		Caesarean Section rate - Emergency*	n/a	20.6%	19.7%	21.9%	19.2%	n/a	MD	Dec-15	Y	Local	15.3%	Apr15-Aug15		A
		Caesarean Section rate - Elective*	n/a	11.0%	11.1%	15.4%	11.3%	n/a	MD	Dec-15	Y	Local	11.4%	Apr15-Aug15		A
		Maternal deaths	0	✗ 1	✓ 0	✓ 0	✗ 2	0	MD	Dec-15	N	National				G
	●	Patients admitted directly to stroke unit within 4 hours of hospital arrival *	90.0%	✗ 62.3%	✗ 69.7%	✗ 74.1%	✗ 63.3%	90.0%	DCEO	Dec-15	Y	National	58.7%	Apr-Jun 15		G
		Stroke patients spending 90% of their time on stroke unit *	80.0%	✗ 75.5%	✓ 93.9%	✓ 88.9%	✓ 83.5%	80.0%	DCEO	Dec-15	Y	National	82.6%	Apr-Jun 15		A

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tbd TDA^ - threshold/target to be determined by Trust Development Agency guidance when available
NB Exception reports not provided for FFT scores

Exception indicators key
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◆ Red for the latest data point

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Indicator Summary

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
Responsive	●	Referral to Treatment - Admitted*	90.0%	✗ 74.5%	✗ 75.5%	✗ 75.7%	✗ 73.7%	90.0%	DCEO	Dec-15	Y	Local	82.5%	Nov-15	
	●	Referral to Treatment - Non Admitted*	95.0%	✗ 90.7%	✗ 90.1%	✗ 91.0%	✗ 91.0%	95.0%	DCEO	Dec-15	Y	Local	93.0%	Nov-15	
	◆	Referral to Treatment - Incomplete*	92.0%	✓ 92.3%	✓ 92.1%	✗ 90.3%	✗ 91.5%	92.0%	DCEO	Dec-15	Y	National	92.4%	Nov-15	
		Referral to Treatment - 52 week waits - Incompletes	0	✓ 0	✓ 0	✓ 0	✗ 4	0	DCEO	Dec-15		National	834 (all Trusts)	Nov-15	
		Diagnostic wait times	99.0%	✓ 99.8%	✓ 99.9%	✓ 99.8%	✓ 99.7%	99.0%	DCEO	Dec-15	Y	National	98.4%	Nov-15	
	●	ED 4hr waits (Type 1, 2 & 3)	95.0%	✗ 86.6%	✗ 88.4%	✗ 85.2%	✗ 89.4%	95.0%	DCEO	Dec-15	Y	National	91.4%	Nov-15	
		ED 12hr trolley waits	0	✓ 0	✓ 0	✓ 0	✓ 0	0	DCEO	Dec-15	Y	National	32 (all Trusts)	Nov-15	
	●	Ambulance turnaround time between 30 and 60 mins	0	✗ 454	✗ 345	✗ 491	✗ 3,052	0	DCEO	Dec-15	Y	Local	WHHT 29.2% vs EEAS 14.1%	Dec-15	
	●	Ambulance turnaround time > 60 mins	0	✗ 114	✗ 64	✗ 116	✗ 758	0	DCEO	Dec-15	Y	Local	WHHT 6.0% vs EEAS 2.6%	Dec-15	
		Cancer - Two week wait *	93.0%	✓ 97.8%	✓ 97.0%	✓ 98.1%	✓ 96.2%	93.0%	DCEO	Dec-15	Y	National	93.5%	Q2 15/16	
		Cancer - Breast Symptomatic two week wait *	93.0%	✓ 98.9%	✓ 100.0%	✓ 97.2%	! 93.0%	93.0%	DCEO	Dec-15	Y	National	92.4%	Q2 15/16	
		Cancer - 31 day *	96.0%	✓ 99.2%	✓ 98.7%	✓ 97.4%	✓ 98.5%	96.0%	DCEO	Dec-15	Y	National	97.6%	Q2 15/16	
		Cancer - 31 day subsequent drug *	98.0%	✓ 100.0%	✓ 100.0%	✓ 100.0%	✓ 100.0%	98.0%	DCEO	Dec-15	Y	National	99.6%	Q2 15/16	
		Cancer - 31 day subsequent surgery *	94.0%	✓ 100.0%	! 94.1%	✓ 100.0%	✓ 97.0%	94.0%	DCEO	Dec-15	Y	National	95.8%	Q2 15/16	
		Cancer - 62 day *	85.0%	✓ 85.4%	✗ 84.1%	✓ 90.5%	✓ 87.6%	85.0%	DCEO	Dec-15	Y	National	82.1%	Q2 15/16	
		Cancer - 62 day screening *	90.0%	! 90.0%	✗ 88.0%	✓ 91.3%	✓ 94.5%	90.0%	DCEO	Dec-15	Y	National	93.9%	Q2 15/16	

*RTT and cancer performance for latest month is provisional and subject to validation
NB. Where national avg. blank - information not currently available

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West Hertfordshire Hospitals NHS NHS Trust

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Indicator Summary

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
Responsive		Urgent operations cancelled for a second time	0	✓ 0	✓ 0	✓ 0	✓ 0	0	DCEO	Dec-15	Y	National				G
	◆	Number of patients not treated within 28 days of last minute cancellation	0	✗ 3	✓ 0	✗ 6	✗ 39	0	DCEO	Dec-15	Y	National	6 (avg. all Trusts)	Q2 15/16		G
	●	Delayed Transfers of Care (DToC)	3.5%	✗ 6.4%	✗ 3.7%	✗ 6.1%	✗ 6.1%	3.5%	DCEO	Dec-15	Y	National				G
	●	Outpatient cancellation rate	8.0%	✗ 10.7%	✗ 10.3%	✗ 10.8%	✗ 11.0%	8.0%	DCEO	Dec-15	Y	Local				G
		Outpatient cancellation rate within 6 weeks^		3.2%	3.4%	3.6%	3.3%		DCEO	Dec-15	Y	Local				G

^ Excluding cancellations to provide earlier appointments, where patients have died and appointments made in error)

NB. Where national avg. blank - information not currently available

Exception indicators key

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West Hertfordshire Hospitals NHS Trust

Indicator Summary

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
Well Led	●	Staff turnover rate	12.0%	✗ 16.8%	✗ 16.4%	✗ 16.9%	✗ 17.0%	12.0%	DoW	Dec-15	Y	National			
		% staffleaving within first year (excluding medics and fixed term contracts)				15.6%			DoW	Dec-15	Y	National			
		Sickness rate	3.5%	✓ 3.5%	✓ 3.4%	✓ 3.5%	✓ 3.3%	3.5%	DoW	Dec-15	Y	National			
	●	Vacancy rate	5.0%	✗ 15.5%	✗ 13.8%	✗ 14.2%	✗ 15.2%	5.0%	DoW	Dec-15	Y	National			
	●	Appraisal rate (non-medical staff only)	95.0%	✗ 59.3%	✗ 60.3%	✗ 63.1%	✗ 63.1%	95.0%	DoW	Dec-15	Y	National			
	●	Mandatory Training	100.0%	✗ 83.6%	✗ 83.3%	✗ 85.4%	✗ 82.9%	100.0%	DoW	Dec-15	Y	Local			
		% Bank Pay**	6.6%	✓ 5.5%	✓ 5.6%	✓ 5.8%	✓ 6.1%	5.5%	DoW	Dec-15	Y	Local			
	●	% Agency Pay**	16.0%	✗ 19.4%	✗ 17.5%	✗ 17.0%	✗ 17.5%	19.4%	DoW	Dec-15	Y	Local			
	●	Temporary costs and overtime as % of total paybill**	22.6%	✗ 25.2%	✗ 23.2%	✗ 23.1%	✗ 23.9%	25.2%	DoW	Dec-15	Y	National			
	◆	Inpatient FFT response rate	54.0%	✓ 55.7%	✓ 59.7%	✗ 50.0%	✗ 53.7%	54.0%	CN	Dec-15	Y	National	25.1%	Nov-15	
	●	A&E FFT response rate	20%	✗ 12.6%	✗ 14.6%	✗ 7.6%	✗ 10.4%	20.0%	CN	Dec-15	Y	National	13.1%	Nov-15	
		Daycases FFT response rate	tbd TDA^	45.0%	59.3%	38.4%	47.9%	tbd TDA^	CN	Dec-15	Y	National			
	●	Staff FFT response rate	50%	✗ 17.9%	✗ 13.0%	✗ 20.8%	✗ 16.9%	50%	DoW	Sep-15	Y	National			
		Staff FFT % recommended work	tbd TDA^	49.4%	56.3%	58.4%	57.6%	tbd TDA^	DoW	Sep-15	Y	National			
	◆	Maternity FFT response rate	38%	✓ 53.9%	✓ 46.9%	✗ 34.5%	✗ 36.2%	38%	CN	Dec-15	N	National	23.4%	Nov-15	

*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

Exception indicators key

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◆ Red for the latest data point

Data Quality RAG key

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Indicator Summary

Domain	Indicator	Target	Latest three data points (Most Recent →)			YTD Actual	YTD Target	Executive Lead	Month	National / Local
		£000s	£000s	£000s	£000s					
Financial Viability	Bottom line Income & Expenditure position – forecast against plan	0	-29,229	-29,229	-32,800			DoF	Dec-15	National
	Bottom line Income & Expenditure position – year to date actual against plan	0	-27,264	-29,905	-34,469			DoF	Dec-15	National
	Actual efficiency recurring- forecast against plan	0	8,381	8,591	8,120			DoF	Dec-15	National
	Actual efficiency recurring - year to date against actual plan	0	4,006	4,763	5,669			DoF	Dec-15	National
	Actual efficiency non-recurring- forecast against plan	0	7,219	7,009	3,880			DoF	Dec-15	National
	Actual efficiency non -recurring - year to date against actual plan	0	2,167	2,444	2,902			DoF	Dec-15	National
	Forecast underlying surplus/deficit against plan	0	-29,251	-29,251	-29,251			DoF	Dec-15	National
	Forecast year end charge to capital resource limit	0	4,008	4,389	4,811			DoF	Dec-15	National
	Is the Trust forecasting permanent PDC for liquidity purposes?	0	32,000	0	0			DoF	Dec-15	National
	Cumulative I&E surplus or deficit	0	-27,264	-29,905	-34,469			DoF	Dec-15	National
	Month's I&E surplus or deficit	0	-2,625	2,640	-4,564			DoF	Dec-15	National
	Cumulative EBITDA margin (%)	0.0%	-11.1%	10.8%	-11.4%			DoF	Dec-15	National
	NHS income variance (%)	0.0%	-0.7%	-0.7%	-0.9%			DoF	Dec-15	National
	Year on year change in income	0	-7,916	-8,001	-5,858			DoF	Dec-15	National
	Year on year change in pay costs	0	-8,062	-9,251	-10,636			DoF	Dec-15	National
	Year on year change in non pay costs	0	-7,980	370	-2,749			DoF	Dec-15	National
	Year on year change in capital spend	0	178	52	-880			DoF	Dec-15	National
	Capital spend as a % of annual CRL.	0	18.56%	20.30%	28.98%			DoF	Dec-15	National
	Continuity of services risk rating	0	0	0	0			DoF	Dec-15	National
	Liquidity ratio	0	1	1	1			DoF	Dec-15	National
	Capital servicing capacity	0	1	1	1			DoF	Dec-15	National
	NHS clinical income per consultant PA	0	0	0	0			DoF	Dec-15	National
	Outstanding loans value	0	31,371	34,121	36,721			DoF	Dec-15	National
	Debtor days	0	29	28	29			DoF	Dec-15	National
	Creditor days	0	56	56	55			DoF	Dec-15	National
	Purchase order non compliance	0	1.00%	1.00%	1.00%			DoF	Dec-15	National
	% of turnover saved in month	0.0%	5.67%	4.08%	4.75%			DoF	Dec-15	National
	Forecast savings as % of turnover	0.0%	3.91%	3.90%	3.91%			DoF	Dec-15	National

Detailed reports

Safe, effective, caring

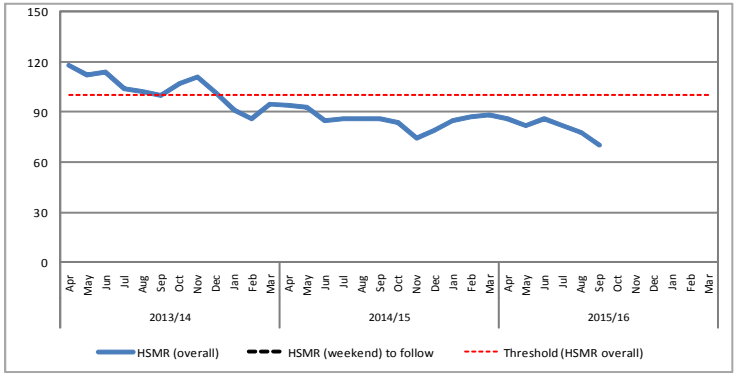
Reporting sub committee - PSQR

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

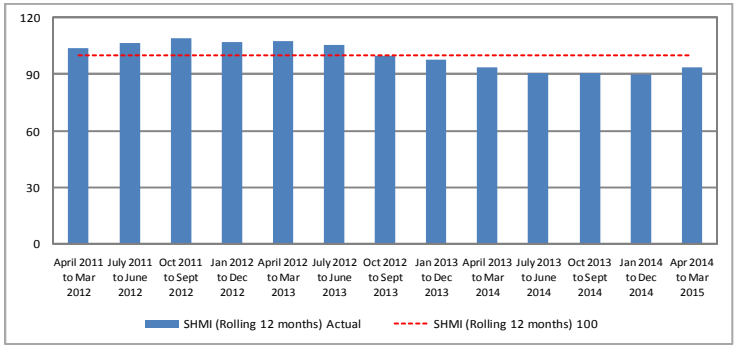
Performance relative to targets/ thresholds		
	Achieving	Not achieving
Dec-15	5	1
Nov-15	5	1
Oct-15	4	2

West Hertfordshire Hospitals NHS
NHS Trust

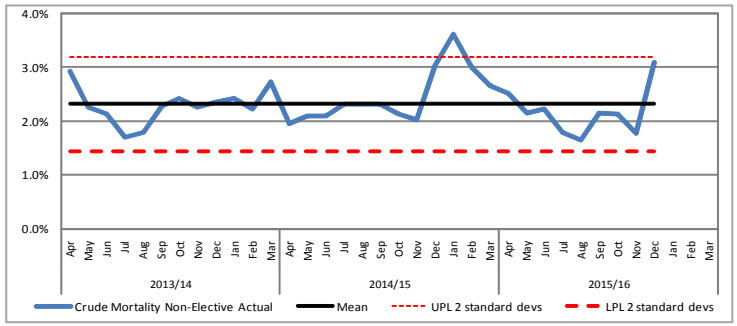
Hospital Standardised Mortality Ratio (HSMR)*



Summary Hospital Mortality Indicator*



Crude mortality rate (non-elective)*



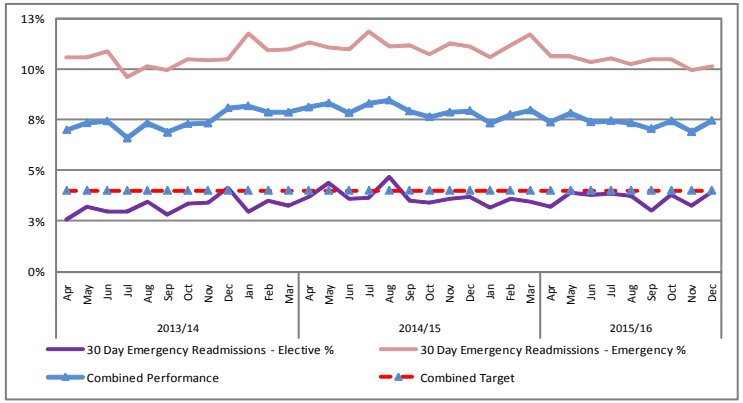
Hospital mortality indices continue to sustain improvements. The trust has gone from being in the bottom decile (2013) to being in the top performing quartile within the Hospital Standardised Mortality Ratio (HSMR). Within the region, the Trust is one of seven (out of 17 trusts nationally) with a 'lower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

HSMR emergency weekday vs weekend has no significant difference for emergency admissions. Both are significantly lower than expected. There were no diagnosis groups attracting significantly higher than expected deaths.

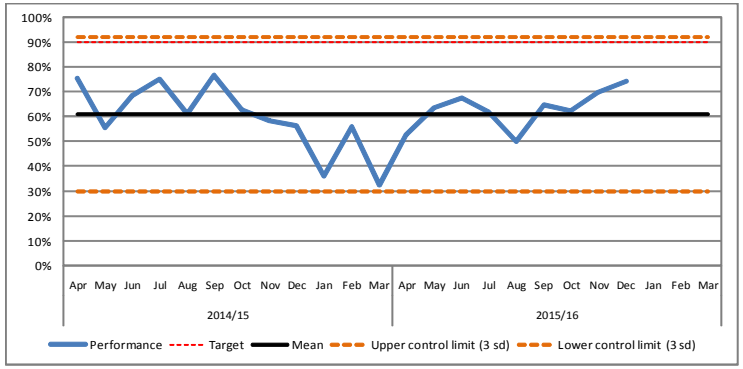
There was a peak over the winter period in crude mortality which was mirrored nationally.

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

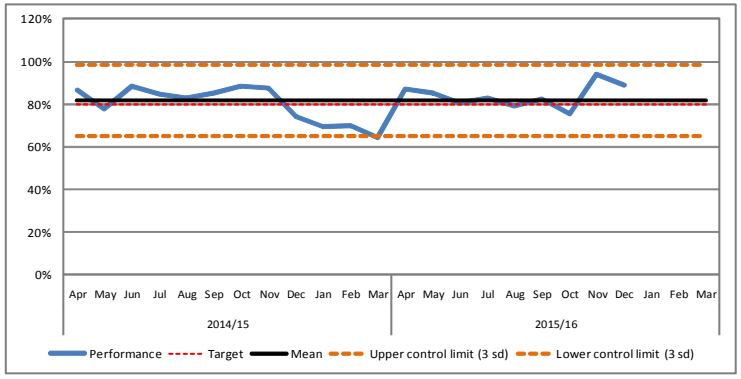
% Emergency re-admissions within 30 days following an elective or emergency spell*



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

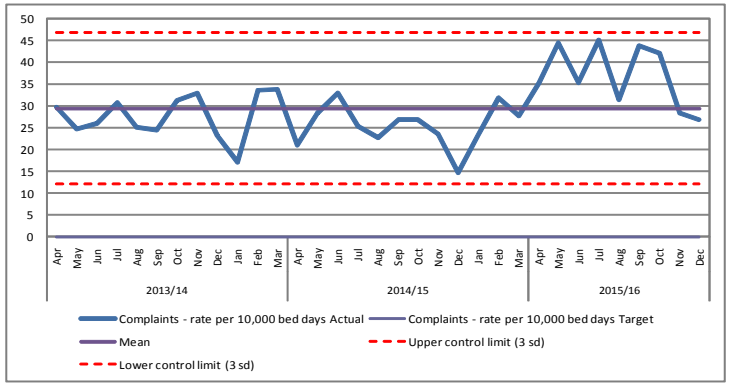
This continues to be a challenge due to:

- The high numbers of patients who present with symptoms that are atypical of a stroke
- Outlying patients on the Stroke ward (query strokes confirmed as non-strokes & neuro patients)

A short term project is underway to target improvements in this area, looking at operational policies in bed allocation and transfer of patients, and opportunities to reduce LOS on the Stroke rehab ward, as part of the ward accreditation project.

Safe, effective, caring (continued)

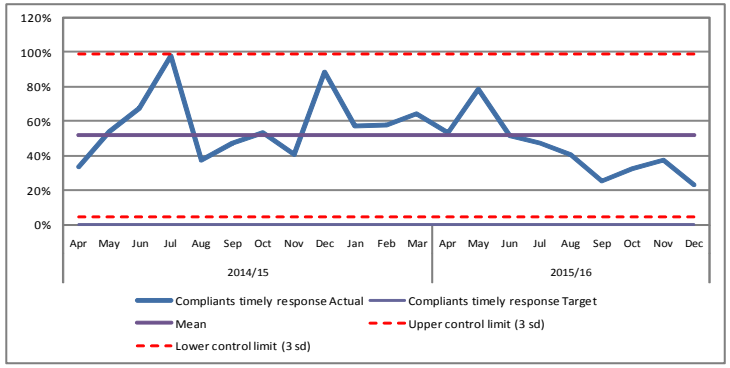
Complaints - rate per 10,000 bed days



Complaints rate per 10,000 bed days

The data from April 2015 demonstrates an increase of complaints received by the Trust. However this takes into account the changes to the way all Trust complaints are managed. Previously not all complaints were being logged centrally and 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



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

The continued work as above has resulted in a greater number of complaints being responded to within the agreed timeframe with the complainant. The progress has been maintained.

In November 2015 63% of all complaints were overdue the response date. By 11 January 2016 the figure had dropped to 42%.

Intentionally blank

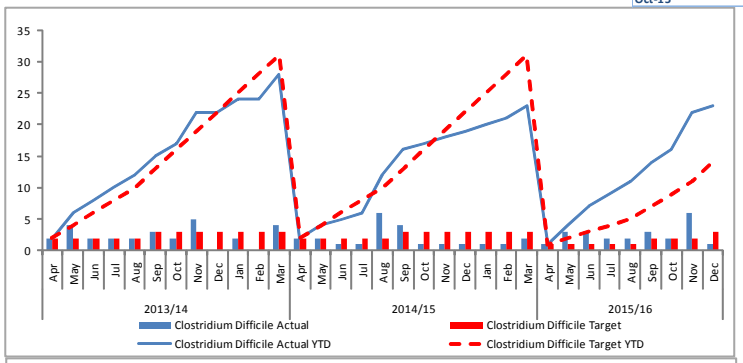
Safe, effective, caring

Reporting sub committee - PSQR

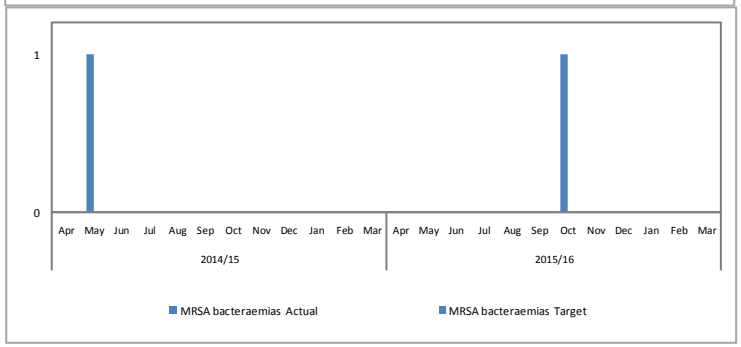
Executive lead	Clinical lead	Operational lead
*Dr Mike Van der Watt Tracey Carter		

Performance relative to targets/ thresholds	Achieving	Not achieving
Dec-15	2	2
Nov-15	2	2
Oct-15	2	2

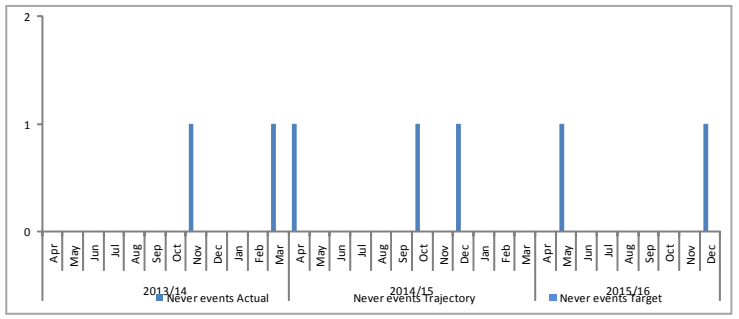
Clostridium Difficile



MRSA bactaraemias



Never events*



Clostridium difficile

The monthly trajectory for *Clostridium difficile* is 1 per month between April and August, 2 per month between September and November and 3 per month between December and March 2016. We are currently breaching our monthly target. Six cases were reported in November. Each *Clostridium difficile* case continues to be thoroughly investigated internally and externally, involving the Head of Infection Prevention Control (IPC) from the CCG in the Root Cause Analysis (RCA) meetings, for lessons learned. All learning are shared within the divisions within the Trust. In December we reported 1 case, which meant we breached our target of 23.

Targeted support audits are being undertaken by the IPC nurses on wards where a new Trust acquired Clostridium difficile Infection (CDI) case is identified until they reach a satisfactory compliance. Audits results are informing the training needed. In addition to the mandatory training, extra training and education is being delivered to all staff groups. A CDI reduction action plan has been developed this has been shared with the CCG and TDA.

MRSA bacteraemia:

One WHHT apportioned MRSA bacteraemia was reported in October.
A post infection review meeting was undertaken involving GP and CCG Head of IPC. An action plan has been generated. The learning has been shared at the January 2016 Joint Governance meeting for Medicine and Unscheduled Care. A Vascular Access nurse has been appointed and will commence 1st February 2016, will support the management of vascular devices.

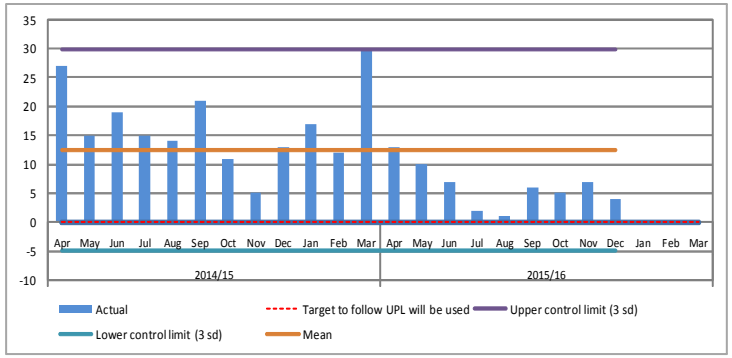
Never Events

Never events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented.

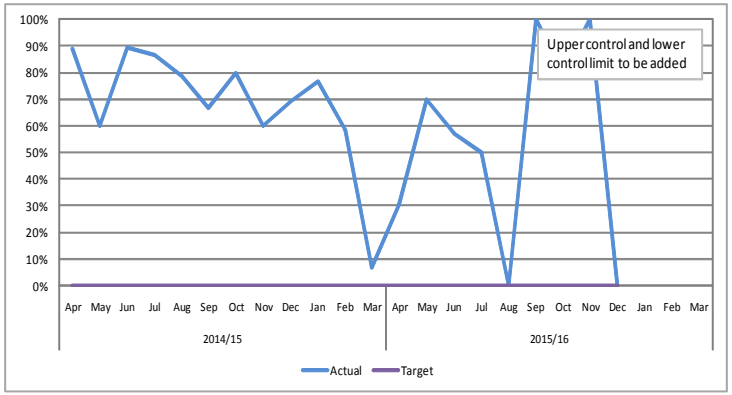
In December one never event in WACS (maternity) was reported involving a retained post procedure tampon. The investigation is in progress and is due by 16 March 2016.

In 2015/16 there have been a total of 2 never events.

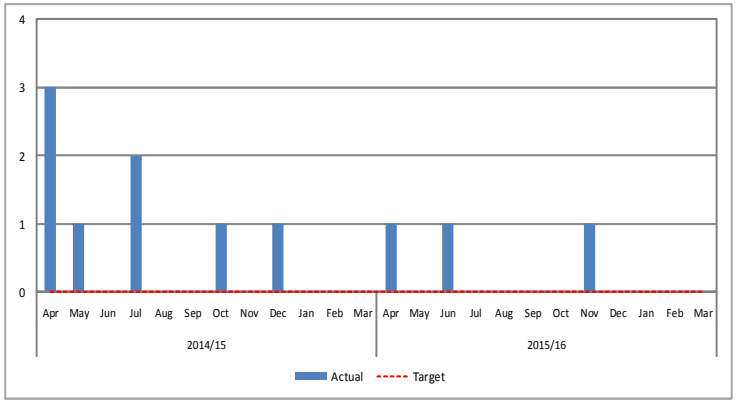
Serious incidents



% of reported patient safety incidents that are harmful



Medication errors causing serious harm*



There were 4 SIs declared in December 2015;

•The Trust has a total of 30 open SIs.

•At the end of December there were 3 RCAs overdue to go to the CCG (8 Jan 16, nil).

•15 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.

Moderate harm;
Any unexpected or unintended incident that resulted in further treatment, possible surgical intervention, cancelling of treatment, or transfer to another area, and which caused short-term harm to one or more persons.

Medication incidents causing serious harm

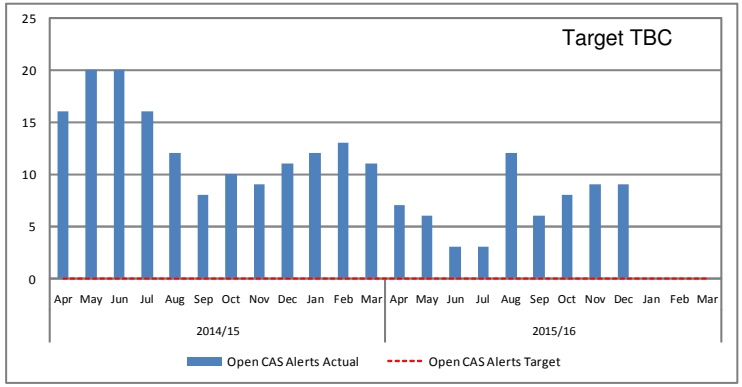
Safe, effective, caring

Reporting sub committee - PSQR

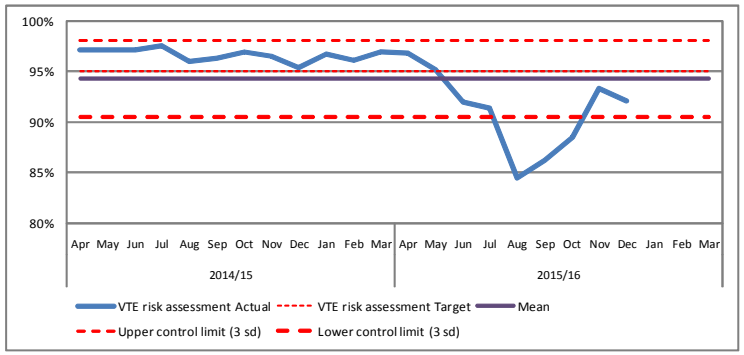
Executive lead	Clinical lead	Operational lead
*Dr Mike Van der Watt Tracey Carter		

Performance relative to targets/ thresholds	Achieving	Not achieving
Dec-15	0	4
Nov-15	1	3
Oct-15	0	4

CAS alerts outstanding and time to closure



VTE risk assessment*



Admissions to adult facilities of patients <16 years of age

to follow

CAS

Issued	Closed	Breached
7	10	0

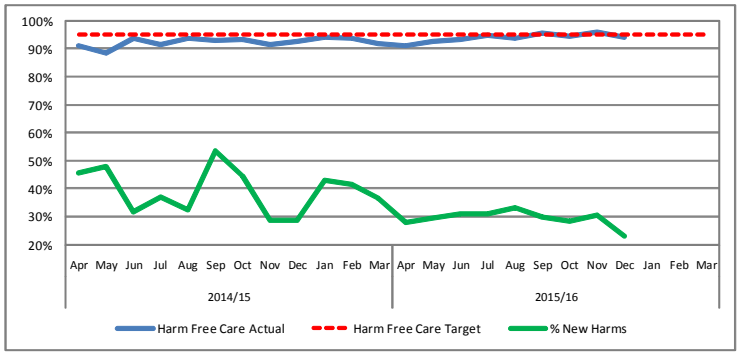
Of the 7 alerts issued in November 1 remains open and within its deadline date.

VTE

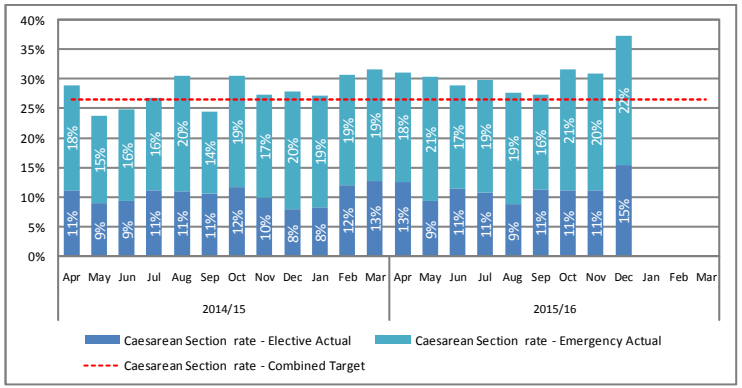
The Trust has adopted a far more rigorous approach regarding compliance with VTE, in that if the assessment has been done but is not signed, this is considered non-compliant even if the treatment / prophylaxis is prescribed.

A new policy is in place regarding VTE prophylaxis, with consultant review at post take ward rounds. The Medical Director has emphasized 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.

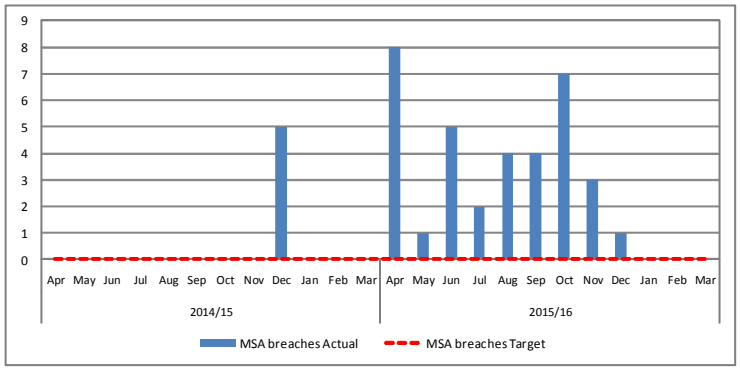
Percentage of Harm Free Care and New Harms



C-section rate



Mixed sex accommodation



Harm Free Care

In December, Harm Free Care for the Trust was 94.1%, slightly below the performance threshold of 95% and the national average of 94.2%

In December the Trust had 1 new pressure ulcer grade 2, 1 new harm with Catheter and new UTI, 3 falls with harm and 3 New VTE's. The Falls and VTE are up from Novembers data. Links have been made with the Hillingdon Trust to share good practice.

December 2015	West Herts	Luton & Dunstable	Milton Keynes	East and North Herts	Hillingdon	National average
New Pressure Ulcers	0.18	0.75	1.18	0.87	0.67	0.93
Catheter and new UTI	0.17	0.45	0	0.17	0.45	0.3
Catherisation	17.86	20.66	19.91	25.35	20.27	13.4
Falls with harm	0.53	5.88	0	0	0	0.56
New VTE's	0.34	0.30	0	0.52	0.22	0.36
Harm Free Care	94.1	94.12	93.36	96.70	94.65	94.2

Mixed sex accommodation

The mixed sex accommodation breaches occurred within ITU. In order to try to address this and reduce the incidence of MSA breaches the following actions have been taken:

ESAU

- The ESAU unit has been expanded to 2 bays since the beginning of November 2015, allowing male and female patients to be segregated and therefore MSA issue to be eliminated.

ICU

- The challenge in ICU is the layout of the unit and the lack of facility to segregate step down patients from those requiring Level 3 and Level 2 care.
- A review of the capacity versus demand within Critical Care with a view to reducing capacity to meet demand if appropriate is being undertaken.
- Inclusion of date and time of patient being ready for transfer out of ICU is on the sitrep for the operational team. Decisions are made in regard to the level of care the patients require in the morning following the Consultant rounds.

The Trust's ability to eliminate MSA breeches in Critical Care is severely compromised by the system wide issue with delayed transfers of care.

Responsive

Reporting sub committee - F&P

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

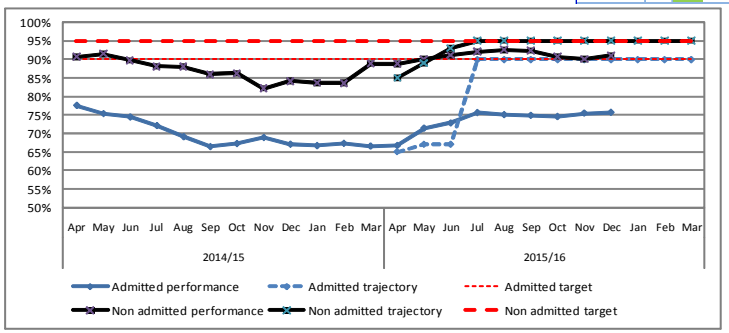
Executive lead	Clinical lead	Operational lead
Lynn Hill	Jeremy Livingstone	Jane Shentall

Performance relative to targets/ thresholds

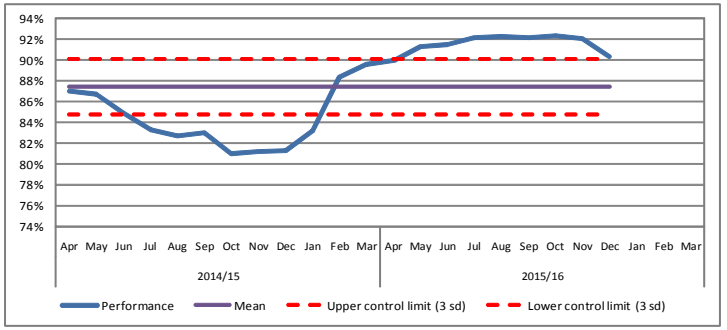
	Achieving	Not achieving
Dec-15	2	4
Nov-15	3	3
Oct-15	2	4

West Hertfordshire Hospitals NHS
NHS Trust

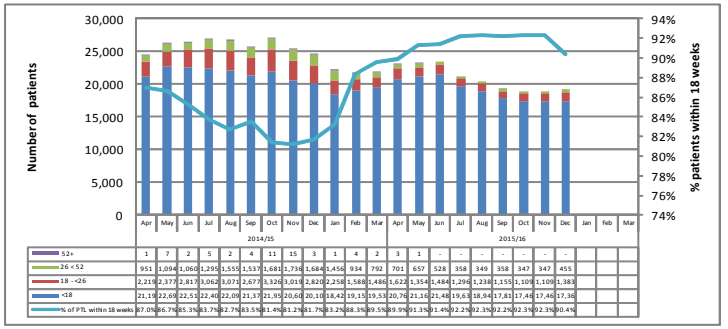
Completed pathways within 18 weeks



Incomplete pathways within 18 weeks



Incomplete pathways WL profile



RTT

WHHT undertook to achieve organisational compliance against the incomplete 92% standard for Referral to Treatment (RTT) and diagnostics by the end of Q1 2015/16. This was achieved and performance has been sustained in Q2 and to November, but was below the national standard in December. This risk has been previously identified due to the impact of the Trust's financial position on the ability to continue to run additional sessions.

The RTT incomplete standard requires 92% of patients who have not received definitive treatment to be waiting under 18 weeks. The Trust's performance in December was also below the national average (92.4%).

There were no patients waiting over 52 weeks in December and the number of patients waiting over 40 weeks continues to remain at low levels.

Other improvements put in place include:

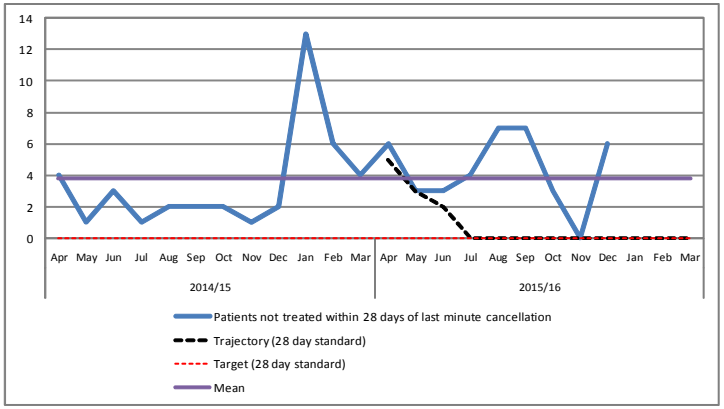
- Roll out of new clinic outcome form across the organisation commenced in November.
- Daily update on performance embedded in business as usual activities, giving current performance, number of patients to be booked from backlog and a new feature, the date in 3 weeks' time to ensure we are giving reasonable notice.
- Tool developed for Assistant Divisional Managers showing the current and future position to encourage a more forward looking approach.
- The review of the Trust's Access policy has been completed and was ratified by the Policy Review Group in November. The new Access Policy incorporates the new (Oct 15) draft guidance. Other changes include the management of DNAs and addition of icons to prompt users including the use PAS codes to make the policy user friendly.

Ongoing work

The following meetings and discussions continue to review waiting times performance, including cancelled operations and outpatient appointments.

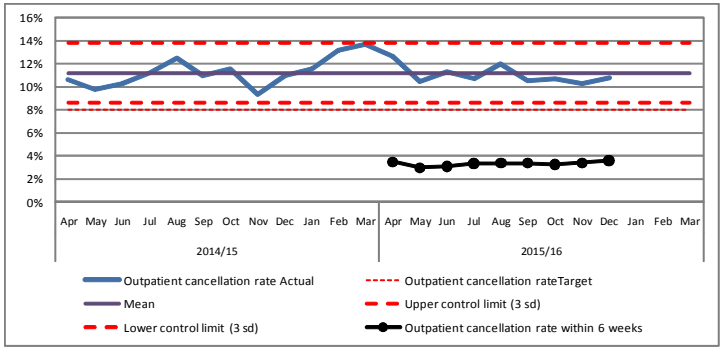
a) daily internal RTT conference call – monitoring performance very closely
b) weekly organisational level Access/performance meetings
c) weekly divisional level Access meetings (RTT)
d) patient level detailed review of PTLs by Director of Operations for Elective Care.

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

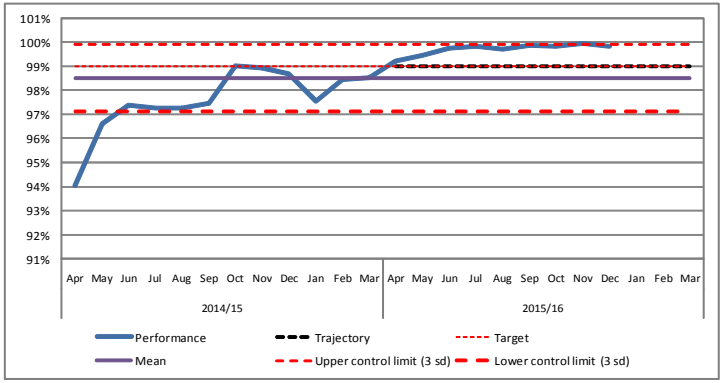


Hospital outpatient cancellations all and % cancelled* within 6 weeks

*(*excluding cancellations to provide earlier appointments, where patients have*



Diagnostics



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

There were six breaches of the 28 day readmission standard in December. All cancellations have been reviewed and it has been identified that the root causes were outside of the direct influence of the hospital. This demonstrates improvements following the introduction of the Cancelled Operations Taskforce and Remedial Action Plan where cancellation reasons frequently included hospital administration errors, and notes or lab results not being available.

Weekly access meetings review any systemic issues leading to last minute cancellations and failure to re-book within 28 days.

Ongoing work

The Cancelled Operations Task Force was formed in the summer of 2015 to address the rising rate of cancellations (clinical and non-clinical), many of which were considered avoidable. The Cancelled Operations Task Force was tasked with identifying trends in all cancellation types, understanding the reasons for cancellations and agreeing actions to improve the rate of cancellation. The group agreed a number of work streams including: Redesign of admission letters; Implementation of a missing notes escalation process; Identification of the "golden patient" – first on list; and Consultant sign off of theatre lists. Future projects include:

- Introduction of a pre-op phone call made by clinical staff to patients a week before admission (started 1/11/15).
- Day Surgery to be responsible for all day case patients, including those without an allocated bed on admission (started 1/11/15).
- Offer of same day pre-operative assessment (started 19/11/15).
- Introduction of an electronic waiting list card.

Hospital cancellations – patients cancelled within 6 weeks and overall

In December, 10.8% of outpatient appointments were cancelled by the hospital. This was above the target of 8.0%. The hospital cancellation rate by the hospital within six weeks was 3.6%. The Trust recognises that short notice cancellations can be severely disruptive where patients have booked time off from work and made other arrangements to facilitate their visit. The Trust will undertake a detailed review of all short notice hospital initiated cancellations in order to understand more clearly the reasons for the cancellations and whether there are instances of non compliance with the short notice cancellations protocol.

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. Diagnostic wait times has been delivered to the performance standard since April 2015 (nine consecutive months) and is also better than the national average of 98.4%.

Responsive

Reporting sub committee - F&P

CWTs

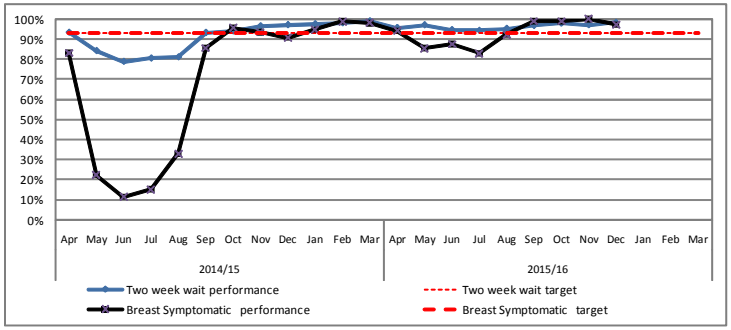
Executive lead	Clinical lead	Operational lead
Lynn Hill	Jeremy Livingstone	Jane Shentall

Performance relative to targets/ thresholds

	Achieving	Not achieving
Dec-15	7	0
Nov-15	5	2
Oct-15	7	0

West Hertfordshire Hospitals NHS Trust

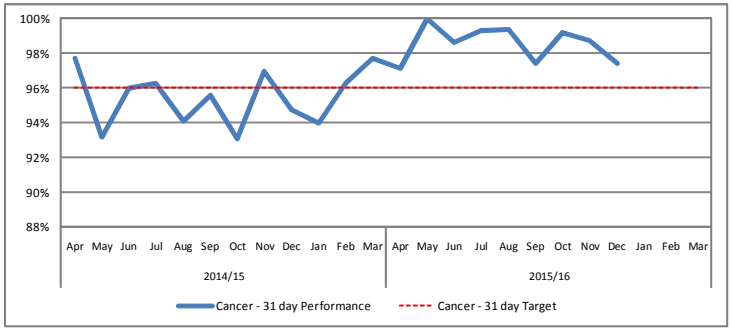
Two week standard and breast symptom two week



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.

31 day standard

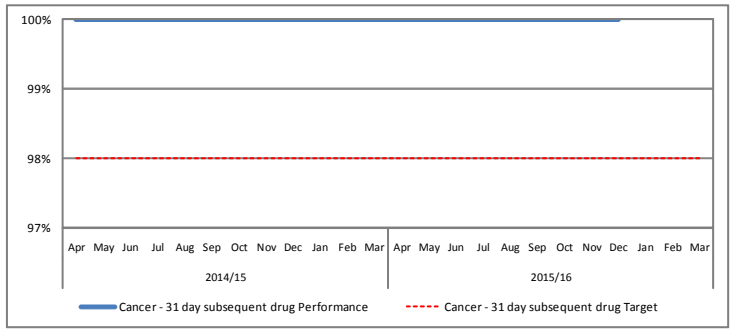


31 day first

The consolidated improvement plan now includes the main action plan, the specialty based recovery plans, the information plan and the Peer review actions. This is monitored through the fortnightly cancer improvement meeting.

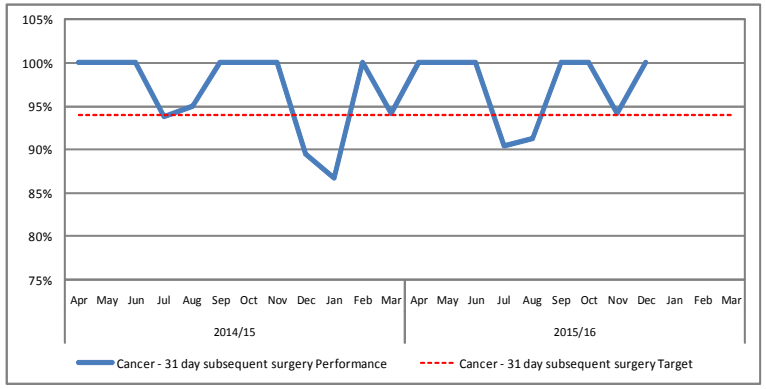
At a specialty level, a number of pathway improvements have been realised, all of which are contributing to the improvement in performance. Weekly scrutiny of the Cancer PTLs (at patient level) is well embedded, with tracking from day 0. Dedicated MRI capacity has been sourced for prostate pathway patients and pathway redesign in Urology (consultant first appointment) and Lung (straight to CT by day 5) has recently been implemented. Additional MRI capacity has been sourced from Spire Bushey to support patients on the prostate pathway.

31 day subsequent drug standard



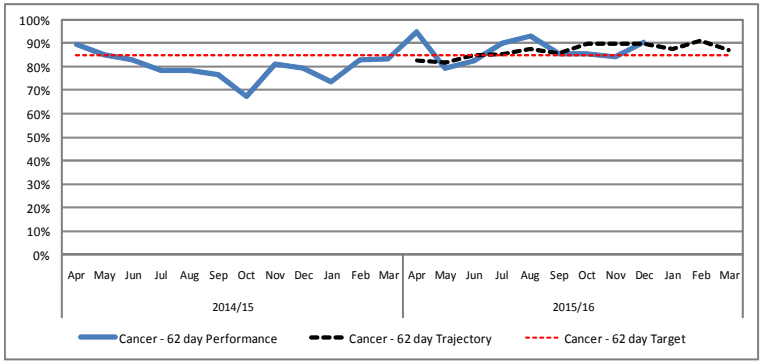
The Trust is now compliant with seven of the eight key priorities for Cancer waiting times improvements.

31 day subsequent surgery standard



31 day subsequent surgery is provisionally above the national standard in December. In addition to the review of the PTL, we have introduced weekly breach reviews and consultant sign off. The standard remains at risk due to relatively low patient volumes which mean that the standard can be missed with any more than one breach in the month.

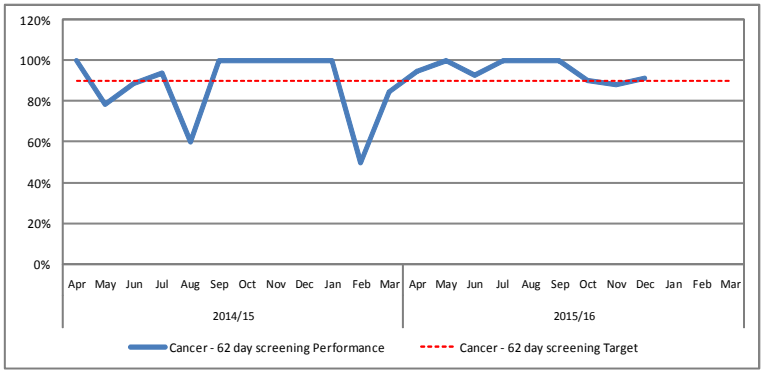
62 day standard



The **62 day GP** standard is provisionally above the national standard in December, and remains provisionally compliant for quarter 3. Issues in achieving compliance within tumour sites are being experienced in Colorectal, Urology, Lung and to a lesser extent Head & Neck. All of these services are the focus of the Cancer Improvement Programme Group.

Tumour site	Quarter 1	Quarter 2	Quarter 3
01 : Suspected breast cancer	100	100	97.3
03 : Suspected lung cancer	65.2	70.6	47.8
04 : Suspected haematological malignancies excluding acute leukaemia	75	100	100
06 : Suspected upper gastrointestinal cancers	94.7	87.5	86.2
07 : Suspected lower gastrointestinal cancers	84.8	76.1	65.5
08 : Suspected skin cancers	100	95.5	97.1
09 : Suspected gynaecological cancers	81.8	98.2	95.7
11 : Suspected urological cancers (excluding testicular)	69.7	82.6	86.2
12 : Suspected testicular cancer	-	-	100
13 : Suspected head and neck cancers	66.7	58.3	83.3
15 : Other suspected cancer	100	0	0
16 : Exhibited (non-cancer) breast symptoms - cancer not initially suspected	-	-	100
Compliance(%)	**86.3**	**89.3**	**87.3**

62 day screening standard



The **62 day screening** standard has been delivered to the performance standard in December.

Responsive

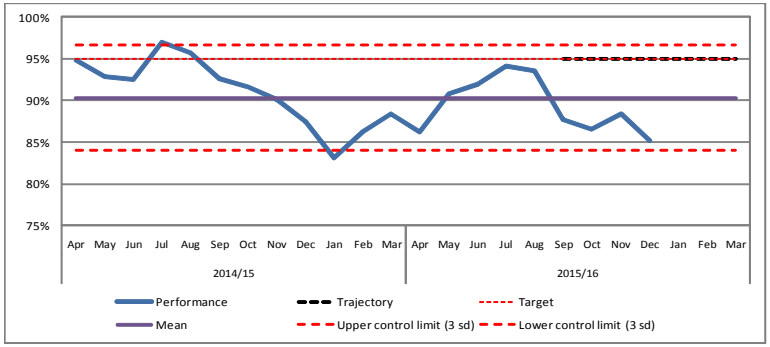
Reporting sub committee - F&P

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

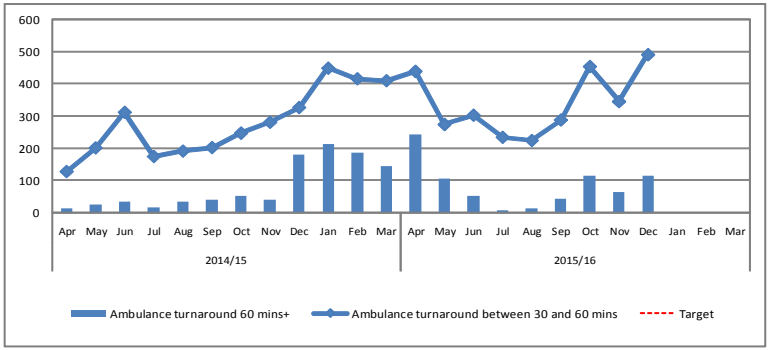
Executive lead	Clinical lead	Operational lead
Lynn Hill	Dr David Gaunt	Caroline Landon

Performance relative to targets/ thresholds	Achieving	Not achieving
Dec-15	1	4
Nov-15	1	4
Oct-15	1	4

A&E



Ambulance turnaround time



A&E performance decreased in December to 85.2%. The position was impacted by an increase in type 1 attendances and beds occupied by patients whose discharge was delayed (DToC patients). Ambulance Turnaround times deteriorated, with handover between 30-60 minutes increasing from 345 to 491 between November and December. The Trust is now working with ECIP, their report and recommendations was received in mid December. A new improvement plan has been developed which will align to the ECIP recommendations, the focus being split between front door and back door.

Winter Resilience

- Commenced frailty service in limited capacity within A&E department with plans to move to dedicated area in early March 2016
- A weekly winter planning group has been established, led by the head of operations, which includes representatives from all divisions. The project team have developed a broader action plan to implement CCG funded plans and additional schemes without significant cost implication, in order to further boost the resilience plan for 15/16.

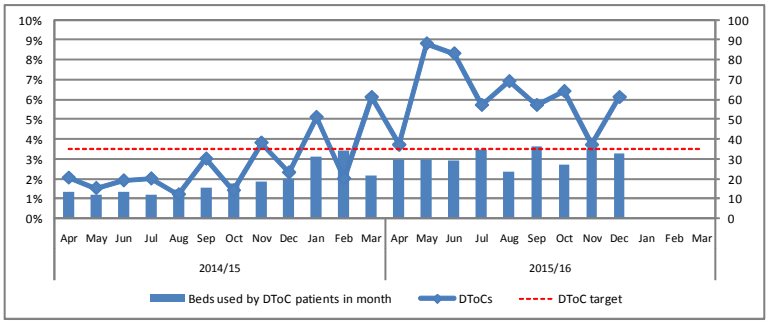
Front Door Flow, including acute assessment units

- Analysis of the impact of the single point of access implemented for GP referrals showed slight increase in the number of patients referred into Ambulatory Care, and improved control of presentation of ambulant GP patients, with the majority of patients arriving within 2 hours of referral.
- Focus is ongoing in relation to ring-fencing assessment capacity to reduce the impact of GP heralded patients in A&E
- A&E reconfiguration plans continue, with modelling outputs indicating likely performance improvement from a new minors triage process and increased CDU capacity. Modelling confirms that reconfiguring A&E alone will not be sufficient to sustain 95% performance, without concurrent improvement in flow and DTOCs.

Hospital Patient Flow

- The discharge lounge move to incorporate stretcher patients has seen an average increase of 2 patients per day, and the discharge lounge will remain in Castle
- Additional corporate nursing support has been identified to increase the pace of progress and mitigate the risks highlighted previously regarding lack of capacity to deliver improvements.

Delayed Transfers of Care (DToC)

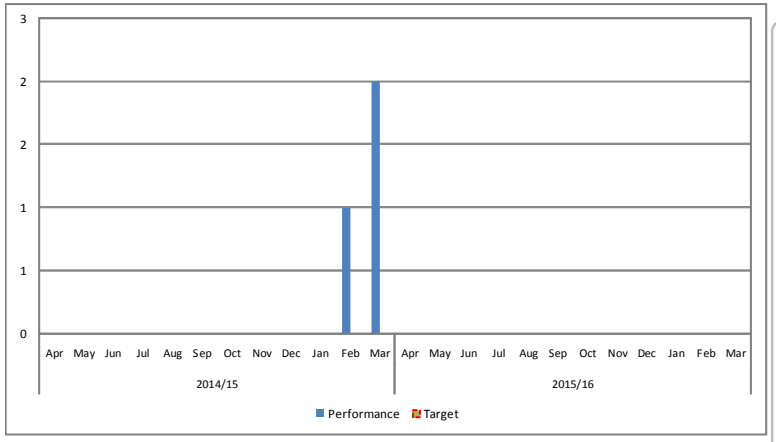


Summary issues

The number of DTOCs remains a challenge for the Trust. In December, DTOC patients occupied nearly 33 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



Immediate and additional actions

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.

The discharge lounge will be retained in its temporary location on Castle Ward to continue to accommodate patients awaiting transfer out of hospital on beds, releasing ward space earlier.

Well led

Reporting sub committee - Workforce

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

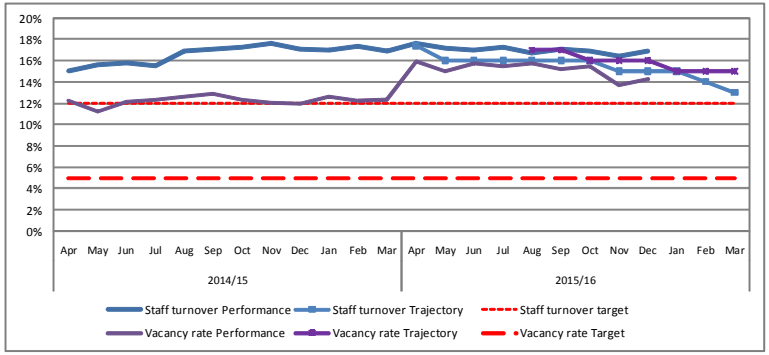
Executive lead	Clinical lead	Operational lead
Paul da Gama		

Performance relative to targets/ thresholds

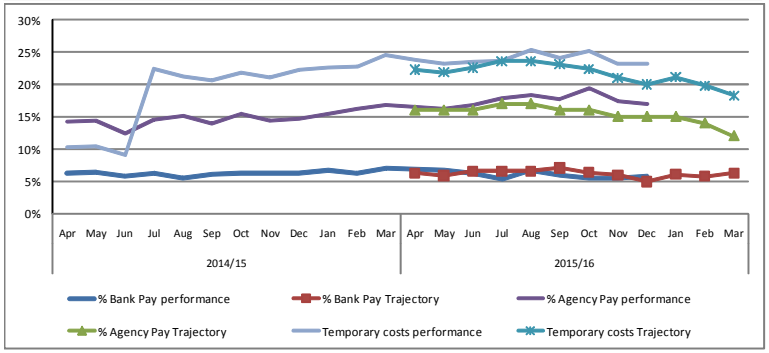
	Achieving	Not achieving
Dec-15	2	6
Nov-15	2	6
Oct-15	2	6

West Hertfordshire Hospitals NHS
NHS Trust

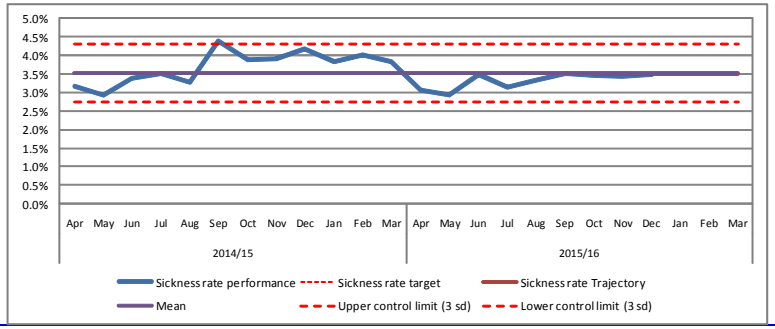
Staff turnover and vacancy rate



% bank, agency and temporary pay



Sickness rate



Turnover & Vacancy

In line with seasonal norms, there were a relatively low number of joiners in December, resulting in an overall slight increase in the vacancy rate from 13.8% to 14.2%.

Despite this, and reflecting the momentum of our nursing and midwifery campaign, the overall nursing and midwifery vacancy rate fell for the fourth consecutive month, from 18.1% to 17.4%. Within this figure, the rates fell for both the registered and unregistered workforces.

Our EU overseas nurse recruitment campaign continues to progress, and to date we have:

- Interviewed: 255
- Offered: 192
- Start date agreed (excluding those who've already started): 36
- Started: 94

Having fallen for the two previous months, the turnover rate increased slightly in December from 16.4% to 16.9%.

% Bank, agency and temporary pay

December saw a further reduction in agency expenditure to 17.0% of pay-bill, compared to 17.5% in November and 19.4% in October. Overall temporary staffing spend fell to 22.9% of pay-bill compared to 23.1% following a larger fall in November. Agency expenditure dropped to £3.10m in December from £3.18 in November and £3.56m in October.

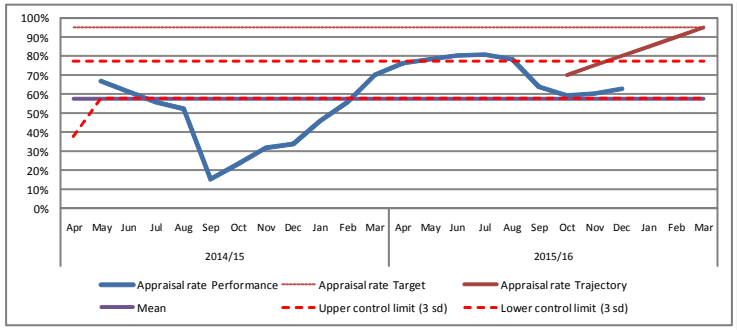
This follows a number of steps both within The Trust and the wider NHS to limit agency spend, including:

- Working with NHSP to instigate major improvement in their service and growing the Bank
- Revised stringent controls and measures in place to monitor temporary staffing spend across nursing and midwifery areas
- National NHS agency rate-capping

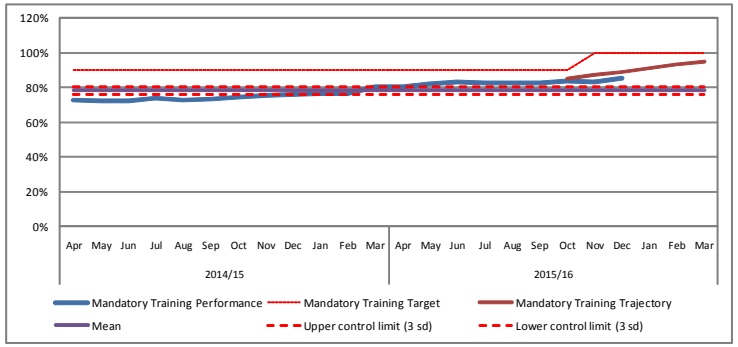
Sickness rate

Sickness is currently running at 3.5%, no change from the rate in November. The Trust continues to maintain a sickness rate slightly below its East of England peers.

Appraisal rate
(non medical staff only)



Mandatory training



Appraisal – non medical staff

The values-based appraisal rate at the end of December is 63% which is a 3% increase on last month. The HRBP's have developed action plans with the Divisional Managers to achieve the 95% target by the end of March 2016, however managers have expressed concern about the deliverability of this target whilst the Trust continues to experience significant service pressures. 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 but saw an increase from 83% to 85% in December. The increase will partly reflect the additional sessions made available in safeguarding and infection control to also ensure compliance with CQUIN targets.

Currently less than 10% of staff complete mandatory training using e-learning and so primary reliance is on classroom sessions. E-learning programmes have recently been reviewed and content used historically requires updating and this work is underway. E-learning summit has taken place and ongoing work with IT continues to develop a plan for increased and more effective e-learning and will lead to the development of a business case for funding of an improved training platform.

Due to service pressures, DNA rates is a significant issue – approximately 4000 booked attendances at classroom mandatory training have been DNAs in last year.

Remedial actions identified last month are being progressed which include:

- *Ensuring for 10 core pieces of mandatory training that TNA is complete and employees' personal records are updated to reflect what they need. To include recent revisions due to changes in legislation etc. Report against target on a monthly basis via Workforce Report.*
- *Developing trajectories to achieve 95% compliance and then stretch target to 100% compliance*
- *Establishing interim solution – pilot utilising content for e-learning developed against HEEofE Core Skills Framework and send electronically to staff with answer sheet to complete to return to Training department to confirm compliance – piloting with infection control and safeguarding which require more immediate attention due to contract targets and CQUINs*

Safe, effective, caring

Well led

Reporting sub committees - PSQR and Workforce

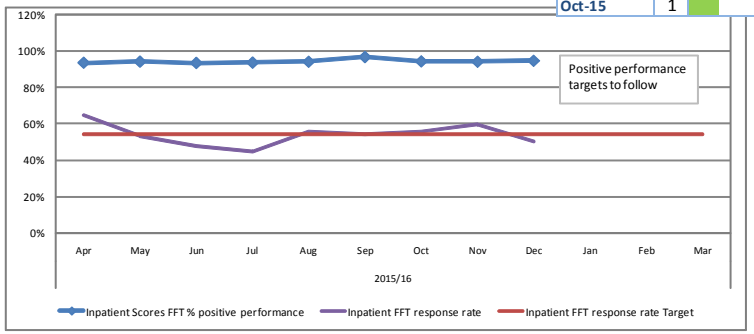
Friends and family

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

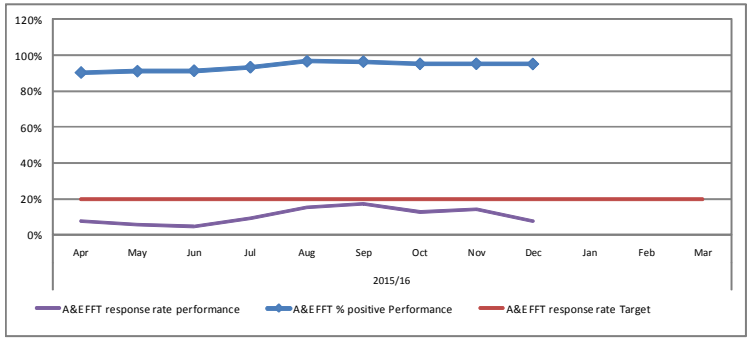
Well led	Achieving	Not achieving
Dec-15	0	4
Nov-15	1	3
Oct-15	1	3

West Hertfordshire Hospitals NHS Trust

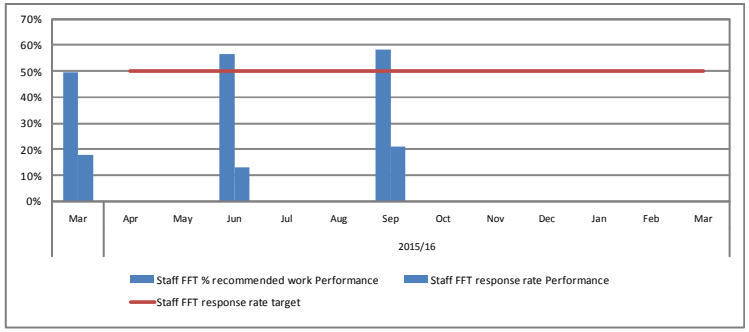
Inpatient scores (% positive and negative) and response rate



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



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



In Patients

The response rate decreased in December compared to November but the number of positive responses remained at just over 95% for both months.

Discussions with the Divisions are planned to review the response rates and where necessary agree a plan to try increase responses rates, including the use of Volunteers to promote the FFT.

A&E

A significant drop in response rate this month at 7.6% compared to November but the response rate has fluctuated all year between 7% and 15% and the positive response rate was not significantly different between the months at 95%. There was however an increase in the number of negative responses compared with November. It is not possible to ascertain the reason for this as most of the patients responding did not write any free text on the forms but it is acknowledged that December was a very challenging month for the A&E Department and this is reflected in the patient feedback.

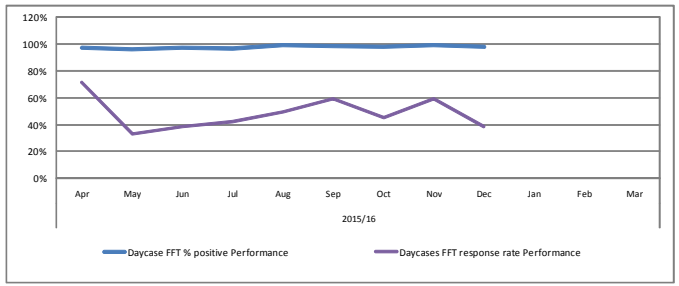
A different approach to gathering feedback from patients attending A&E is being considered with next day phone calls, similar to some other Trusts, to try to improve both response rates and patient experience.

Staff

The Friends and Family Test for quarter 2 ran between 24th August and 11th September. There was an improvement on the response rate which increased from 13% in Quarter 1 to 21% in Quarter 2. The percentage of people happy to recommend the Trust as a place for care or treatment went down by 2% to 61%. However, the percentage of people happy to recommend the Trust as a place to work increased by 2% to 58%. The HR team were all involved and allocated departments to visit and encourage to complete a survey. It was felt that this worked better than promoting the survey from the hospital restaurant every day.

The final Friends and Family test for this year will be running between 3 and 21 February and as there will be six staff benefits events taking place during that time, it is hoped that we will be able to actively encourage completion there, in addition to the online facility which will go live on 3rd February.

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.

Ward Scorecard

Areas of good performance		*Areas requiring performance improvement*	
Oct- Dec 15 the top 5 performing clinical areas are: 1st Place Simpson 2nd Starfish 3rd Langley 4th Tudor 5th AAUG1 **Indicators** Dec 2015 on heat map of wards are green Pressure ulcers as outcome indicators'. Infection control as outcome indicators. **Dec 2015** TYC medication/ storage 90% TYC Resuscitation 91% Falls 87%	**Comment** • These top 5 wards are performing well over the 3 months across all the indicators. • There 5 clinical areas are all performing well with their TYC indicators which are the process and observation indicators as well as outcome indicators for December they were 84% and above.	**Oct – Dec 15** the bottom 5 clinical areas are: 23rd place – Winyard 24th Ridge 25th Elizabeth 26th AAU BY3 27TH Sarratt **Indicators** December 2015 on the heat map of wards are red- Falls and falls with harms **Dec 2015 Red** TYC Nutrition 71% TYC Patient Observations 78%	**Comment** • These bottom 5 wards are being monitored by the matrons and Heads of Nursing. • Further performance work has been undertaken with the Medical Division to address and support these wards. New leadership is in place on Sarratt ward and programme support is in place on Winyard and AAUBY3. • Elizabeth Ward is under the leadership of the Head of Nursing in Surgery as from December 2015 • A Falls campaign was launched December targeting staff engagement. • Joint working with Community and the HarmFree Care Team • Task and Finish group looking at Fluids Charts and Hydration charts. • SKIN champions – HCA study sessions undertaken, targeted ward education and support. • The matrons have committed to improve the following indicators with targeted work around Observations – NEWS action plan ,Nutrition – related to the MUST risk assessment. • Omitted medicines – medicine summit took place in December. • Safety communication – safety huddles/ISOBAR/Folders. • Continued work and support around implementation of new nursing documentation

Ward Scorecard

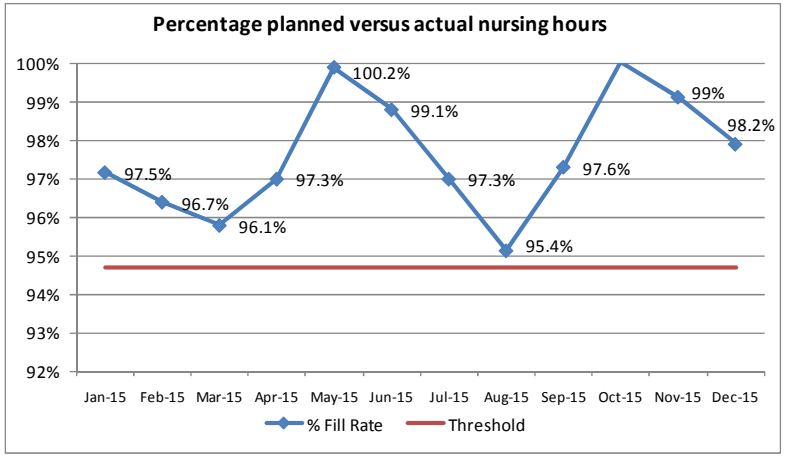
West Hertfordshire Hospitals NHS Trust

Division	Ward	December-2015																
		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 RNs on shift	Red Flag Number of shifts more than 8 hours less than planned	%of Supervisory filled Hours
Unscheduled Care	AAU B/Y 3	✓ 92%	! 88%	! 86%	! 86%	✓ 0	✓ 4	✓ 0	✓ 100%	✓ 100%	✓ 0	✓ 0	✓ 90%	✗ 32%	✗ 2	✗ 31	! 78%
	AAU B1	! 86%	! 84%	! 81%	! 88%	✓ 0	! 5	✗ 3	✓ 100%	! 84%	✓ 0	✓ 0	✓ 96%	✗ 26%	✓ 0	✗ 7	✓ 94%
	AAU G1	! 86%	! 89%	✓ 91%	✓ 95%	✓ 0	✓ 3	✗ 1	✗ 75%	✓ 96%	✓ 0	✓ 0	✓ 98%	✓ 78%	✓ 0	✗ 20	✗ 48%
	AAU P1	! 81%	! 89%	! 87%	! 80%	✓ 0	! 5	✓ 0	✓ 100%	✗ 70%	✓ 0	✓ 0	✓ 95%	✗ 46%	✓ 0	✗ 14	✗ 66%
	AAU Y1	! 84%	! 86%	✓ 94%	! 88%	✓ 0	✓ 1	✓ 0	✓ 100%	✓ 100%	✓ 0	NA	✓ 94%	✓ 61%	✓ 0	✗ 7	✗ 48%
	CCU/ P/G 3	! 87%	NA	✓ 90%	✓ 92%	✗ 1	✓ 2	✗ 1	✓ 100%	✓ 100%	✓ 0	✓ 0	✓ 96%	✓ 64%	✓ 0	✗ 6	! 87%
	A&E	NA	✓ 92%	✗ 65%	✗ 50%	✓ 0	✓ 3	✗ 1	✗ 63%	✓ 100%	✓ 0	✓ 0	✓ 94%	✗ 8%	✓ 0	✗ 22	NA
	MIU	NA	NA	! 89%	NA	✓ 0	✓ 0	✓ 0	NA	NA	✓ 0	✓ 0	NA	NA	NA	NA	NA
	UCC	NA	NA	! 84%	NA	✓ 0	✓ 0	✓ 0	NA	NA	✓ 0	✓ 0	NA	NA	✓ 0	✗ 1	NA
Medicine	Aldenham	! 87%	! 89%	✓ 94%	✓ 96%	✓ 0	✓ 2	✗ 1	✓ 94%	✓ 97%	✓ 0	✓ 0	✓ 93%	✓ 70%	✓ 0	✗ 37	✗ 61%
	Bluebell	! 80%	! 83%	✓ 94%	✓ 100%	✓ 0	! 6	✗ 1	✓ 100%	✓ 100%	✓ 0	✓ 0	✓ 100%	✗ 14%	✓ 0	✗ 58	! 81%
	Cassio	NA	NA	! 78%	! 79%	✓ 0	! 6	✗ 1	✓ 100%	✓ 100%	✓ 0	✓ 0	✓ 93%	✗ 37%	✓ 0	✗ 4	! 84%
	Croxley	✗ 78%	✓ 96%	! 88%	✓ 94%	✓ 0	! 7	✗ 2	✓ 100%	! 87%	✓ 0	✓ 0	! 82%	✗ 41%	✓ 0	✗ 7	✗ 74%
	Heronsgate	! 86%	✓ 92%	! 82%	✗ 72%	✓ 0	! 7	✗ 1	✓ 100%	! 81%	✓ 0	✓ 0	✓ 91%	✗ 37%	✓ 0	✗ 17	! 83%
	Oxhey	! 87%	! 87%	NA	NA	NA	NA	NA	NA	NA	NA	NA	✓ 96%	✓ 73%	NA	NA	NA
	Red	✓ 97%	✓ 97%	! 85%	! 80%	✓ 0	✓ 2	✓ 0	✓ 100%	✓ 100%	✓ 0	✓ 0	✓ 92%	✓ 64%	! 1	✗ 3	✗ 70%
	Sarratt	✗ 77%	✓ 97%	✗ 64%	✗ 53%	✗ 2	✓ 4	✗ 2	! 88%	✓ 100%	✓ 0	✓ 0	✓ 92%	✗ 37%	✓ 0	✗ 2	✓ 96%
	Simpson	✓ 98%	✓ 97%	✓ 93%	✓ 96%	✓ 0	✓ 3	✗ 1	✓ 100%	✓ 100%	✓ 0	✓ 0	✓ 93%	✗ 48%	✓ 0	✗ 2	✗ 74%
	Stroke	✓ 98%	✓ 97%	✓ 91%	✓ 96%	✗ 1	! 8	✗ 1	✓ 100%	✓ 91%	✗ 1	✓ 0	✓ 97%	✗ 46%	✓ 0	✗ 18	! 83%
	Tudor	NA	NA	! 84%	✗ 76%	✓ 0	! 8	✗ 1	✓ 100%	! 83%	✓ 0	✓ 0	✓ 97%	✗ 38%	✓ 0	✗ 1	✓ 91%
	Wilmyard	✓ 94%	✓ 99%	! 86%	! 89%	✗ 1	✓ 2	✗ 1	✓ 100%	✓ 100%	✓ 0	✓ 0	✓ 96%	✓ 69%	✓ 0	✗ 4	✗ 59%
Surgery	Cleves	✓ 96%	✓ 94%	✓ 95%	✓ 93%	✓ 0	✓ 1	✓ 0	✓ 92%	✓ 100%	✓ 0	✓ 0	✓ 97%	✓ 71%	✓ 0	✗ 17	✗ 35%
	DLM	! 88%	✓ 93%	✓ 90%	✗ 56%	✓ 0	✓ 1	✓ 0	NA	✓ 100%	✓ 0	✓ 0	✓ 97%	✓ 65%	✗ 4	✗ 23	✗ 65%
	Flaunden	✓ 98%	✓ 96%	! 82%	✗ 56%	✗ 1	✓ 0	✓ 0	✓ 100%	✓ 100%	✓ 0	✓ 0	✓ 91%	! 50%	✓ 0	✗ 33	✗ 65%
	ICU	✓ 91%	✓ 98%	! 83%	✓ 95%	✗ 1	✓ 0	✓ 0	✓ 100%	✓ 100%	✓ 0	✗ 1	✗ 70%	✓ 166%	✓ 0	✗ 26	✓ 100%
	Langley	✓ 100%	✓ 98%	! 88%	! 77%	✓ 0	✓ 0	✓ 0	✓ 100%	! 86%	✓ 0	✓ 0	✓ 100%	✓ 60%	✓ 0	✗ 20	✗ 74%
	Letchmore	✓ 92%	✓ 93%	✗ 71%	✗ 59%	✓ 0	✓ 3	✓ 0	! 88%	✓ 100%	✓ 0	✓ 0	✓ 98%	✗ 40%	✓ 0	✗ 37	✗ 70%
	Ridge	✓ 92%	! 88%	! 75%	✗ 72%	✓ 0	✓ 4	✓ 0	✓ 100%	✓ 100%	✓ 0	✓ 0	✓ 96%	✓ 64%	✓ 0	✗ 26	✗ 61%
WACS	Elizabeth	✓ 94%	✗ 76%	! 88%	! 83%	✓ 0	! 6	✗ 1	✓ 100%	✓ 100%	✓ 0	✓ 0	! 88%	! 50%	✓ 0	✗ 2	✗ 39%
Paeds	SCBU	✓ 100%	✓ 97%	! 84%	✓ 97%	✓ 0	NA	NA	NA	✓ 100%	✓ 0	✓ 0	✓ 100%	✓ 71%	NA	NA	NA
	Starfish	✓ 99%	✓ 99%	! 85%	✓ 100%	✓ 0	NA	NA	✓ 100%	✓ 100%	✓ 0	✓ 0	✓ 100%	✗ 22%	✗ 2	✗ 12	✓ 109%
	CED	✓ 98%	NA	✓ 92%	NA	✓ 0	NA	NA	NA	✓ 100%	✓ 0	✓ 0	NA	NA	NA	NA	NA
	Safari	✓ 100%	✓ 100%	NA	NA	✓ 0	NA	NA	NA	✓ 100%	✓ 0	✓ 0	NA	NA	NA	NA	NA
Maternity	Delivery Suite	NA	NA	✓ 90%	NA	✓ 0	NA	NA	✓ 100%	✓ 100%	✓ 0	✓ 0	NA	✗ 28%	NA	NA	NA
	Community	NA	NA	! 80%	NA	✓ 0	NA	NA	NA	NA	NA	NA	✓ 100%	NA	NA	NA	NA
Green		>=90	>=90	>=90	>=90	0	0	0	>=90	>=90	0	0	>=90	>=54	0	0	>=90
Amber		80-89	80-89	80-89	80-89	n/a	1-4	n/a	80-89	80-89	n/a	n/a	80-89	50-53	1	n/a	75-89
Red		<=79	<=79	<=79	<=79	>=1	>=5	>=1	<=79	<=79	>=1	>=1	<=79	<=49	>=2	>=1	<=74

West Hertfordshire Hospitals NHS Trust

Safer staffing

Indicator	Performance (December)	Threshold	Trend	Forecast next month
% Nursing hours versus planned	98.2%	>95%	Downwards	99%



Indicator by shift and skill mix	Shift	RN	Care staff
% Nursing hours versus planned	Day	92.0%	106.0%
	Night	97.5%	105.0%

What actions have been taken to improve performance

- 28 new nursing starters in December against 21 leavers
- Continued focus weekly on nursing and midwifery staffing, particularly around temporary usage.
- Senior nurse presence and support until 20:00 every day
- Agency ceiling agreed with Heads of Nursing across all areas.

What is causing the variance

•Maternity (ABC and Victoria wards) had a fill rate that was lower than 90% throughout December. ABC had a fill rate of 84.5%. This is an increase from last month by 31%. The senior midwife will move staff between each ward areas to ensure staffing reflects activity and the daily staffing sitrep confirms that there were no shifts reported as 'Red' throughout the same reporting period. During this time period the department had a higher than usual sickness level and the amount of compassionate leave was also high, Total % of absence in the month was 24%.

• Surgery (De La Mare , Letchmore, Cleves) has had a lower fill rate of 87.7% in this reporting period. Vacancies continue to be recruited into and additional support is to be provided for the recent overseas recruitment to this ward. Reduced elective activity throughout December meant staff could be redeployed to support areas as needed.

• The Trust work to reduce agency usage has led to a reduction in 6,611 hours (5%) of agency usage throughout December. Bank usage has remained static. This reduction in temporary staffing will result in a reduced overall fill rate, monitored through the daily sitrep.

•By the end of December the Trust was close to achieving the agency target of 12% of overall nursing spend. Surgery and unscheduled care achieved the target for the first time in December, additional surge capacity, staffed by temporary workers resulted in an overall inability to meet this target.

• Continued pressure on the urgent care pathway placed increased demand on additional staffing above planned hours to support surge capacity such as Knutsford, Ambulatory Care Unit and Children's Observations Bay.

• Whilst recruitment continues temporary workers continue to be 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

• Senior Sisters work in actual hours to fill unfilled shifts

• 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).

• There were152 price cap breaches in December, all across Specialist areas. This is the first month that this information has been collected but the information will be monitored and shared internally and externally.