West Hertfordshire Hospitals NHS Trust

Integrated Performance Report

May 2017

(April data)

West Hertfordshire Hospitals NHS
NHS Trust

West Hertfordshire Hospitals NHS Trust

Executive Summary

Safe Effective Caring

Reporting sub committees – COE and S&C

Areas of good performance

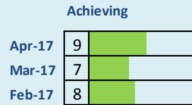
- Mortality indicators show sustained excellent performance *(pages 3 & 13)*
- No medication errors causing serious harm *(pages 4 & 18)*
- New harms, as measured through the Safety Thermometer, were better than the national average *(pages 4 & 20)*
- Clostridium difficile was better than the monthly threshold (2 cases recorded) and better than the year to date threshold (1 vs 2) *(pages 3 & 17)*

NB. the March 2017 report overstated the number of C-diffs by one case.

New to category this month:

- Patients spending 90% of their time on the stroke unit was better than the performance standard *(pages 4 & 14)*
- There were no MRSA bacteraemia *(pages 3 & 17)*

Achieving



Better than national average

Apr-17	9
Mar-17	7
Feb-17	8

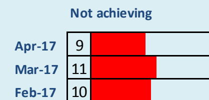
Areas requiring performance improvement

- VTE risk assessment was below threshold *(pages 4 & 19)*
- Admissions to stroke ward within 4 hours was below the performance standard *(pages 4 & 14)*
- There were 6 mixed sex accommodation breaches *(pages 3 & 21)*
- Harm free care was worse than the performance standard but better than the national average *(pages 4 & 20).*
- Complaints responded to within agreed timescales was worse than the performance threshold *(pages 3 & 15)*
- There were 11 reactivated complaints *(pages 3 & 15)*

New to category this month:

- There was one never event *(pages 4 & 17)*

Not achieving



Worse than national average

Apr-17	7
Mar-17	9
Feb-17	8

Responsive

Reporting sub committee – TEC

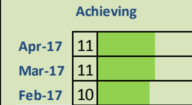
Areas of good performance

- Diagnostic wait times delivered to the performance standard *(pages 5 & 23)*
- Cancer 31 day first, 31 day subsequent surgery and drug are delivering to the performance standard (provisional) *(pages 5 & 24-25)*
- The 2WW cancer indicator achieved the performance standard (provisional) *(pages 5 & 24)*
- The 62 day GP indicator and 62 day screening indicator was provisionally better than the standard *(pages 5 & 25)*
- Hospital initiated outpatient cancellations under 6 weeks performed better than the performance standard *(pages 6 & 23)*
- The Trust did not report any patients waiting 52 weeks on an incomplete pathway *(page 5)*

New to category this month:

None

Achieving



Better than national average

Apr-17	7
Mar-17	7
Feb-17	6

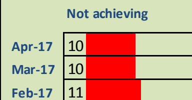
Areas requiring performance improvement

- A&E 4 hour wait performance was below standard *(pages 5 & 26)*
- Formal DToCs were below standard *(pages 6 & 27)*
- Ambulance turnaround times' performance was worse than standard *(pages 5 & 26)*
- The RTT incomplete indicator was worse than the standard *(pages 5 & 22)*
- Patients not treated within 28 days of their last minute cancellation was below standard *(pages 6 & 23)*
- The breast symptomatic cancer indicator was below standard (provisional) *(pages 5 & 24)*

New to category this month:

None

Not achieving



Worse than national average

Apr-17	6
Mar-17	6
Feb-17	7

Well led

Reporting sub committee – Workforce

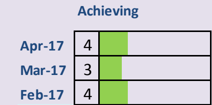
Areas of good performance

- Temporary costs and overtime as % of total pay bill was better than target *(pages 7 & 28)*
- Agency pay was better than target *(pages 7 & 28)*

New to category this month:

- Bank pay was better than target *(pages 7 & 28)*

Achieving



Better than national average

Apr-17	3
Mar-17	3
Feb-17	3

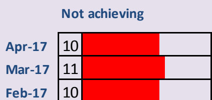
Areas requiring performance improvement

- A number of workforce indicators continue to report underperformance, including staff turnover rate, vacancy rate, appraisals and mandatory training *(pages 7 & 28-30)*
- The sickness rate was worse than target *(pages 7 & 28)*
- Friends and Family response rate for A&E was below threshold *(pages 7 & 31)*
- Inpatient FFT response rate was worse than the target *(pages 7 & 31)*
- Maternity Friends and Family response rate was worse than target *(pages 7 & 31)*

New to category this month:

None

Not achieving



Worse than national average

Apr-17	6
Mar-17	6
Feb-17	6

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. Indicators which are identified in the main pack as provisional may lead to changes to achieving/not achieving counts previous months in Executive Summary.

Indicator Summary

Domain	Indicator	Target	Feb-17	Mar-17	Apr-17	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	✔ 90.9	✔ 88.9	✔ 89.6			MD	Nov-16	Y	National	100	Nov-16		G	
	HSMR - Total (Rolling three months)	100	✔ 88.5	✔ 89.6	✔ 88.4			MD	Jan-17	Y	National	100	Jan-17		G	
	Crude Mortality Rate (Non elective ordinary)**	3.5%	✔ 3.3%	✔ 2.8%	✔ 3.1%	✔ 3.1%	3.5%	MD	Apr-17	Y	National	4.09% (East of Eng.)	Jan-17		G	
	● 30 Day Emergency Readmissions - Combined *	4.0%	✘ 7.2%	✘ 7.5%	✘ 7.6%	✘ 7.6%	4.0%	MD	Apr-17	Y	National	11.4%	2011-12		G	£ Marginal tariff reimbursement, possible penalties
	30 Day Emergency Readmissions - Elective *	n/a	2.6%	3.3%	3.3%	3.3%	n/a	MD	Apr-17	Y	National	n/a			G	£ Marginal tariff reimbursement, possible penalties
	30 Day Emergency Readmissions - Emerg *	n/a	11.4%	11.4%	11.3%	11.3%	n/a	MD	Apr-17	Y	National	n/a			G	£ Marginal tariff reimbursement, possible penalties^
	Number of patients with a length of stay > 14 days *	tbc	343	387	353	353	tbc	MD	Apr-17		Local	n/a			G	£ Reduction in reimbursement vs largely fixed costs. No penalty levied.
	Staff FFT % recommended care	tbd NHSI^	66.8%	N/A	61.5%	63.8%	tbd NHSI^	DoW	Mar-17	Y	National	n/a			G	
	Inpatient Scores FFT % positive	tbd NHSI^	94.6%	93.8%	94.7%	94.7%	tbd NHSI^	CN	Apr-17	Y	National	95.9%	Mar-17		G	
	A&E FFT % positive	tbd NHSI^	90.7%	89.2%	88.7%	88.7%	tbd NHSI^	CN	Apr-17	Y	National	87.1%	Mar-17		G	
	Daycase FFT % positive	tbd NHSI^	98.9%	99.1%	98.9%	98.9%	tbd NHSI^	CN	Apr-17	Y	National	n/a			G	
	Maternity FFT % positive	tbd NHSI^	100.0%	97.1%	93.5%	93.5%	tbd NHSI^	CN	Apr-17	N	National	96.8%	Mar-17		G	
	● % Complaints responded to within one month or agreed timescales with complainant	85%	✘ 41.1%	✘ 44.6%	✘ 54.4%	✘ 54.4%	85%	CN	Apr-17	N	Local	n/a			R	
	Complaints - rate per 10,000 bed days	tbd NHSI^	37.4	34.8	29.6	29.6	tbd NHSI^	CN	Apr-17	N	National	n/a			R	
	Reactivated complaints	0	✔ 0	✘ 10	✘ 11	11	n/a	CN	Apr-17	N	Local	n/a			R	
	● Mixed sex accommodation breaches	0	✘ 6	✘ 6	✘ 6	✘ 6	0	CN	Apr-17	N	National	29 Trusts breaching	Apr-17		G	£ Penalties from CCG. £250 per day per service user.
	● Clostridium Difficile	23	✘ 4	! 1	✔ 1	✔ 1	3	CN	Apr-17	Y	National	Nationally C-diffs down by 10.4%	Apr-Mar16 vs 17		G	£ Penalties from CCG, fines from other statutory authorities. £10,000 per case above threshold.
	MRSA bacteraemias	0	✔ 0	✘ 1	✔ 0	✔ 0	0	CN	Apr-17	Y	National	n/a			G	£ Penalties from CCG, fines from other statutory authorities. £10,000 in respect of each incidence in the relevant month.
	E. Coli Bacteraemia	tbc	2	2	1	1	tbc	CN	Apr-17	Y	National	n/a			G	

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

West Hertfordshire Hospitals NHS
NHS Trust

Indicator Summary

Domain	Indicator	Target	Feb-17	Mar-17	Apr-17	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	◆ Never events	0	✔ 0	✔ 0	✘ 1	✘ 1	0	MD	Apr-17	Y	National	n/a			G	£ Penalties from CCG, fines from other statutory authorities, prosecution^
	Serious incidents - number*	tbd NHSI^	2	2	3	3	tbd NHSI^	MD	Apr-17	Y	National	n/a			A	
	% of patients safety incidents which are harmful*	n/a	13.9%	13.5%	11.5%	11.5%	n/a	MD	Apr-17	Y	National	n/a			A	
	Medication errors causing serious harm *	0	✔ 0	✔ 0	✔ 0	✔ 0	0	MD	Apr-17	Y	National	n/a			A	
	● CAS Alerts: Number issued each month	n/a	4	1	6	6	n/a	CN	Apr-17	Y	National	n/a			A	
	CAS alerts not acknowledged within 48 hours	0	✔ 0	✔ 0	✔ 0	✔ 0	0	CN	Apr-17		National	n/a			A	
	● Harm Free Care*/**	95.0%	✘ 91.6%	✘ 91.3%	✘ 94.3%	✘ 94.3%	95.0%	CN	Apr-17	Y	National	94.1%	Apr-17		G	
	Pressure Ulcers New Harms*/**	tbd NHSI^	4	1	1	1	tbd NHSI^	CN	Apr-17	Y	National	WHHT 0.16 vs 0.9	Apr-17		G	
	Falls New Harms*/**	tbd NHSI^	1	2	0	0	tbd NHSI^	CN	Apr-17	Y	National	WHHT 0.0 vs 0.54	Apr-17		G	
	Catheter & UTI New Harms*/**	tbd NHSI^	0	4	1	1	tbd NHSI^	CN	Apr-17	Y	National	WHHT 0.16 vs 0.29	Apr-17		G	
	VTE New Harms*/**	tbd NHSI^	1	6	2	2	tbd NHSI^	CN	Apr-17	Y	National	WHHT 0.33 vs 0.37	Mar-17		G	
	● VTE risk assessment*	95.0%	✘ 90.7%	✘ 90.4%	✘ 89.5%	✘ 89.5%	95.0%	MD	Apr-17	Y	National	95.6%	Q3 2016		A	
	● Caesarean Section rate - Combined*	26.5%	✘ 30.0%	✘ 28.6%	✘ 29.5%	✘ 29.5%	26.5%	MD	Apr-17	Y	Local	26.7%	Apr15-Aug15		A	
	Caesarean Section rate - Emergency*	n/a	16.5%	14.0%	17.4%	17.4%	n/a	MD	Apr-17	Y	Local	15.3%	Apr15-Aug15		A	
	Caesarean Section rate - Elective*	n/a	13.5%	14.5%	12.1%	12.1%	n/a	MD	Apr-17	Y	Local	11.4%	Apr15-Aug15		A	
	Maternal deaths	0	✔ 0	✔ 0	✔ 0	✔ 0	0	MD	Apr-17	N	National	n/a			G	
	● Patients admitted directly to stroke unit within 4 hours of hospital arrival *	90.0%	✘ 52.6%	✘ 53.5%	✘ 58.6%	✘ 58.6%	90.0%	COO	Apr-17	Y	National	59.3%	Apr-Jul 16		G	
	Stroke patients spending 90% of their time on stroke unit *	80.0%	✘ 78.9%	✘ 69.8%	✔ 82.8%	✔ 82.8%	80.0%	COO	Apr-17	Y	National	84.0%	Apr-Jul 16		A	

* Performance may change for the current month due to data entered after the production of this report
tbd NHSI^ - threshold/target to be determined by Trust Development Agency guidance when available
** Indicators reported from NHS Safety Thermometer
NB Exception reports not provided for FFT scores
NB. Where national avg. blank - information not currently 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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◆ Red for the latest data point

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Indicator Summary

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Responsive	● Referral to Treatment - Admitted*	90.0%	✗ 69.0%	✗ 67.4%	✗ 68.3%	✗ 68.3%	90.0%	COO	Apr-17	Y	Local	75.3%	Mar-17		G	
	● Referral to Treatment - Non Admitted*	95.0%	✗ 87.5%	✗ 87.8%	✗ 89.0%	✗ 89.0%	95.0%	COO	Apr-17	Y	Local	90.3%	Mar-17		G	
	● Referral to Treatment - Incomplete*	92.0%	✗ 89.2%	✗ 90.9%	✗ 90.3%	✗ 90.3%	92.0%	COO	Apr-17	Y	National	90.3%	Mar-17		G	£ CCG penalty of £100 in respect of each excess breach above the threshold
	Referral to Treatment - 52 week waits - Incompletes	0	✗ 1	✓ 0	✓ 0	✓ 0	0	COO	Apr-17		National	1529 (all Trusts)	Mar-17		G	
	Diagnostic wait times	99.0%	✓ 99.81%	✓ 99.79%	✓ 99.23%	✓ 99.2%	99.0%	COO	Apr-17	Y	National	98.9%	Mar-17		G	£ CCG penalty of £200 in respect of each excess breach above the threshold
	● ED 4hr waits (Type 1, 2 & 3)	95.0%	✗ 77.6%	✗ 78.1%	✗ 76.6%	✗ 76.6%	95.0%	COO	Apr-17	Y	National	90.0%	Mar-17		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	COO	Apr-17	Y	National	271 (all Trusts)	Mar-17		G	£ CCG penalty £1,000 per incidence
	● Ambulance turnaround time between 30 and 60 mins	0	✗ 526	✗ 344	✗ 422	✗ 422	0	COO	Apr-17	Y	Local	n/a			R	£ CCG penalty £200 per service user waiting over 30 mins
	● Ambulance turnaround time > 60 mins	0	✗ 290	✗ 439	✗ 327	✗ 327	0	COO	Apr-17	Y	Local	n/a			R	£ CCG penalty £1,000 per service user waiting over 60 mins
	Cancer - Two week wait *	93.0%	✓ 96.8%	✓ 94.9%	✓ 93.4%	✓ 93.4%	93.0%	COO	Apr-17	Y	National	94.7%	Q4 16/17		G	£ CCG penalty breaches per qtr in excess of tolerance is £200 for each breach.
	● Cancer - Breast Symptomatic two week wait *	93.0%	✗ 88.0%	✗ 87.2%	✗ 84.0%	✗ 84.0%	93.0%	COO	Apr-17	Y	National	92.9%	Q4 16/17		G	£ CCG penalty breaches per qtr in excess of tolerance is £200 for each breach.
	Cancer - 31 day *	96.0%	✓ 97.5%	✓ 99.4%	✓ 98.4%	✓ 98.4%	96.0%	COO	Apr-17	Y	National	97.4%	Q4 16/17		G	£ 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%	COO	Apr-17	Y	National	99.2%	Q4 16/17		G	£ CCG penalty breaches per qtr in excess of tolerance is £1,000 for each breach.
	Cancer - 31 day subsequent surgery *	94.0%	✓ 100.0%	✓ 100.0%	✓ 100.0%	✓ 100.0%	94.0%	COO	Apr-17	Y	National	95.4%	Q4 16/17		G	£ CCG penalty breaches per qtr in excess of tolerance is £1,000 for each breach.
	Cancer - 62 day *	85.0%	✓ 86.1%	✓ 87.6%	✓ 91.5%	✓ 91.5%	85.0%	COO	Apr-17	Y	National	80.9%	Q4 16/17		G	£ CCG penalty breaches per qtr in excess of tolerance is £1,000 for each breach.
	Cancer - 62 day screening *	90.0%	✓ 100.0%	✓ 93.1%	✓ 100.0%	✓ 100.0%	90.0%	COO	Apr-17	Y	National	91.2%	Q4 16/17		G	£ CCG penalty breaches per qtr in excess of tolerance is £1,000 for each breach.

*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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Responsive		Urgent operations cancelled for a second time	0	✔ 0	✔ 0	✔ 0	✔ 0	0	COO	Apr-17	Y	National	n/a			G	
	●	Number of patients not treated within 28 days of last minute cancellation	0	✘ 2	✘ 2	✘ 3	✘ 3	0	COO	Apr-17	Y	National	10 (avg. all Trusts)	Q4 16/17		G	
	●	Delayed Transfers of Care (DToC)*	3.5%	✘ 8.3%	✘ 7.2%	✘ 7.2%	✘ 7.2%	3.5%	COO	Apr-17	Y	National	6.0%	Feb-16		G	£ Marginal tariff reimbursement, possible penalties
		Delayed Tranfers of Care (DToC) beddays used in month	0	1,372	1,638	1,538	1,538	0	COO	Apr-17	Y	National	n/a			G	£ Marginal tariff reimbursement, possible penalties
	●	Outpatient cancellation rate	8.0%	✘ 11.2%	✘ 12.4%	✘ 12.9%	✘ 12.9%	8.0%	COO	Apr-17	Y	Local	n/a			G	
		Outpatient cancellation rate within 6 weeks^	5.0%	✔ 3.9%	✔ 4.7%	✔ 4.9%	✔ 4.9%	3.0%	COO	Apr-17	Y	Local	n/a			G	
	●	Patient initiated cancellations (all)		11.9%	12.0%	13.2%	13.2%		COO	Apr-17	Y	Local				G	
		Hospital + Patient initiated cancellations (all)		23.1%	24.4%	26.2%	26.2%		COO	Apr-17	Y	Local	n/a			G	

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

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

**DToC benchmark estimated by total delayed patients nationaly as percentage of occupied general and accute beds*

Exception indicators key

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Indicator Summary

Domain		Indicator	Target	Feb-17	Mar-17	Apr-17	YTD Actual	YTD Target	Executive Lead	Month	Included in Detailed Reports	National / Local	National avg.	National avg. Period	Trend	Data Quality RAG	Financial impact
Well Led	●	Staff turnover rate (rolling 12 months)	12.0%	✗ 16.4%	✗ 16.5%	✗ 16.4%	✗ 16.4%	12.0%	DoW	Apr-17	Y	National	13.5% (Beds and Herts orgs)	Dec-15		G	
		Staff turnover rate (rolling 3 months)	12.0%	✗ 14.0%	✗ 15.0%	✗ 15.1%	✗ 15.1%	12.0%	DoW	Apr-17	Y	National	13.5% (Beds and Herts orgs)	Dec-15		G	
		% staffleaving within first year (excluding medics and fixed term contracts)		18.6%	18.7%	19.7%	19.7%		DoW	Apr-17	Y	National	n/a			G	
	●	Sickness rate	3.2%	✗ 3.7%	✗ 3.5%	✗ 3.4%	✗ 3.4%	3.2%	DoW	Apr-17	Y	National	3.8% (EoE orgs)	Dec-15		A	£ Payments made to staff for nil productivity
	●	Vacancy rate	9.0%	✗ 13.1%	✗ 12.5%	✗ 13.0%	✗ 13.0%	9.0%	DoW	Apr-17	Y	National	11% (local survey)	Dec-15		G	£ Costs saved in short term for nil productivity
	●	Appraisal rate (non-medical staff only)	95.0%	✗ 74.6%	✗ 73.2%	✗ 73.3%	✗ 73.3%	95.0%	DoW	Apr-17	Y	National	85% (local survey)	Dec-15		G	
	●	Mandatory Training	95.0%	✗ 86.5%	✗ 89.1%	✗ 87.7%	✗ 87.7%	95.0%	DoW	Apr-17	Y	Local	86% (local survey)	Dec-15		G	
		% Bank Pay**	10.0%	✓ 8.4%	✗ 10.5%	✓ 9.3%	✓ 9.3%	10.0%	DoW	Apr-17	Y	Local	n/a			G	£ Costs at established rates rather than premium
		% Agency Pay**	10.0%	✓ 10.0%	✓ 8.0%	✓ 9.7%	✓ 9.7%	10.0%	DoW	Apr-17	Y	Local	11.4% (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%	✓ 18.9%	✓ 18.9%	✓ 19.4%	✓ 19.4%	22.6%	DoW	Apr-17	Y	National	n/a			G	£ Premium payments of various types vs established rates
		*Temporary costs and overtime as % of total paybill** (Excl. unfunded beds)*		✓ 5.0%	✓ 6.7%	✓ 8.4%	8.4%		DoW	Apr-17	Y	National	n/a			G	£ Premium payments of various types vs established rates
	●	Inpatient FFT response rate	54.0%	✗ 19.1%	✗ 21.6%	✗ 19.3%	✗ 19.3%	54.0%	CN	Apr-17	Y	National	26.1%	Mar-17		G	
	●	A&E FFT response rate	20%	✗ 3.8%	✗ 3.1%	✗ 3.1%	✗ 3.1%	20.0%	CN	Apr-17	Y	National	12.9%	Mar-17		G	
		Daycases FFT response rate	tbd NHSI^	33.4%	38.5%	26.0%	26.0%	tbd NHSI^	CN	Apr-17	Y	National	n/a			G	
	◆	Staff FFT response rate	50%	✗ 16.2%	N/A	✗ 15.7%	✗ 14.7%	50%	DoW	Mar-17	Y	National	n/a			G	
		Staff FFT % recommended work	tbd NHSI^	57.4%	N/A	58.5%	57.5%	tbd NHSI^	DoW	Mar-17	Y	National	n/a			G	
	●	Maternity FFT response rate	38%	✗ 19.2%	✗ 18.2%	✗ 28.2%	✗ 28.2%	38%	CN	Apr-17	N	National	24.4%	Mar-17		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 NHSI^ - threshold/target to be determined by Trust Development Agency guidance when available
NB. Exception reports not provided for FFT scores ** Trajectory set as target
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 – 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

Finance (Overview)

Financial Overview as at 30 April 2017

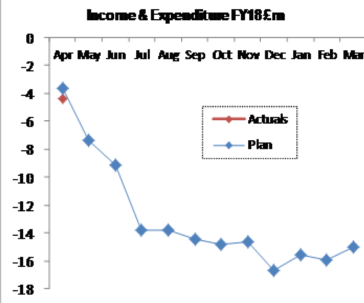
Month 1 Income & Expenditure

£m	Plan	Actual	Variance
Surplus (Deficit)	(3.7)	(4.4)	(0.8)

Statutory / Regulatory Duties

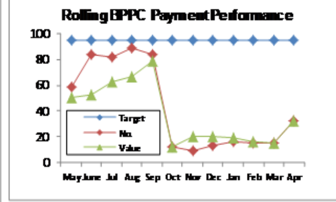
Breakeven	The Trust has a deficit plan of £15m for FY18.	R
CRL	The Trust has not exceeded its Capital Resource Limit.	G
EFL	The Trust has managed spend within its External Financing Limit.	G
10 Days' Cash	Cash at 30/04/17 equated to 6 days' spend	R
BPPC	Month 1 performance - 33% by number and 33% by value (95% target)	R

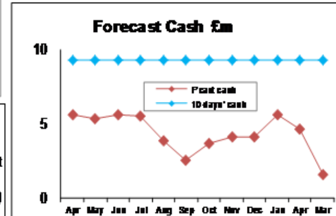
Financial Risk Rating	FY18	R

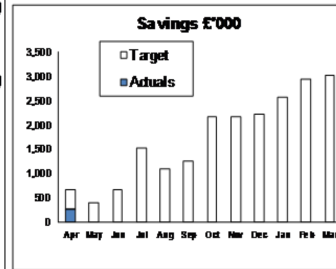


FY18 Month 1 Variance by Division

	£m	% Budget
Medicine	(0.1)	(3)
Unscheduled Care	(0.7)	(4)
Surgery	0.2	1
Women's	(0.2)	(1)
Clinical Support	0.1	2
Estates & Facilities	0.1	0
Corporate	0.3	1
Other	(0.3)	
Total	(0.8)	







Savings and outlook for FY18

Savings achieved at £0.3m in Month 1 vs plan of £0.4m, i.e. projects costed vs actual delivery). The 2017/18 Trust savings target is £21.9m in order to achieve a control total of £15.0m. Of this amount, £13.7m has so far been assigned to divisions, and of this over 60% has been identified.

Forecast for the year is still to achieve the control total, with a number of risk areas identified and mitigation underway.

Statutory duties

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

Financial risks remain high but underlying controls are strong. Recovery actions ensured that, excluding readmission credits and STF adjustments, the Trust's control total was achieved.

Operational performance

Control total of £15.0m deficit received and accepted by the Trust. Deficit of £4.4m in April (£0.7m adverse to plan) reflects a100% CQUIN assumption alongside an income environment that was more challenging than expected due to the impact of several non-standard working days in April (i.e. weekends and bank holidays).

Finance (I&E)

Statement of Comprehensive Income (I&E)

	2017/18 FY Budget	Month 1 (April) Budget	Month 1 (April) Actual	Month 1 (April) Var	Prior Year Actual
Volumes					
Elective	42,806	3,509	3,433	(76)	3,378
Non elective	49,525	5,232	4,888	(344)	3,687
Outpatient	433,803	37,137	33,447	(3,690)	34,009
A&E	117,791	9,656	9,574	(82)	9,384
NHS REVENUE	**£000's**		**£000's**	**£000's**	
Elective	55,461	4,507	4,374	(133)	4,235
Non elective	100,978	8,278	7,889	(389)	7,555
Outpatient	70,139	5,662	5,297	(366)	5,682
A&E	16,032	1,314	1,256	(58)	1,156
Critical care	13,781	1,130	1,412	282	1,247
Other NHS revenue	42,978	3,523	3,454	(69)	3,242
TOTAL NHS REVENUES	**299,369**	**24,414**	**23,682**	**(732)**	**23,117**
Private Patients	259	22	22	1	19
Other non-NHS clinical income	11,306	587	568	(18)	83
TOTAL Non NHS Clinical	**11,565**	**608**	**590**	**(18)**	**101**
Education & Training	8,576	715	721	6	703
Other Revenue	15,110	1,221	1,350	129	1,245
Income savings	-	-	-	-	
TOTAL OTHER REVENUE	**23,686**	**1,936**	**2,071**	**136**	**1,948**
NET HOSPITAL REVENUE	**334,620**	**26,958**	**26,344**	**(614)**	**25,167**

Operational performance

NHS income was £732k below plan, with a favourable variance in Critical Care (£282k due to increased activity) partially responsible for larger adverse variances in Non-Elective (£389k) and Outpatient (£366k).

A number of areas have been re-purposed to deal with activity fluctuations (e.g. CDU into major illness area, WCOB to children's ward), in addition to short-term delays (e.g. cardiology expansion, endoscopy unit, in-month launch of new CT / MRI).

Other income (mainly car park income) was £129k favourable in month 1.

Engagement with Commissioners

- Contractual HVCCG activity continues to form the bulk of all income (small areas of block contract).
- CQUIN management involves formal monitoring and regular operational controls, assuming 100% achievement at this stage.
- Final FY17 income remains under discussion.

Outlook for FY18

The income profile was set at a level which may have been too challenging given the number of bank holidays and weekends in April. Re-assessment of income still allows for achievement of annual plan.

Finance (I&E)

Statement of Comprehensive Income (I&E)

	2017/18 FY Budget	Month 1 (April) Budget	Actual	Var	Prior Year Actual
Permanent / Bank Staff	223,523	18,743	17,376	1,367	15,976
Agency	6,362	511	1,860	(1,349)	2,605
Unidentified pay savings	(10,882)	(108)		(108)	
TOTAL PAY	**219,002**	**19,146**	**19,236**	**(89)**	**18,581**
Drugs	21,579	1,710	1,799	(88)	1,700
Clinical services	32,579	2,658	2,511	148	2,510
Non-clinical services	71,930	6,234	6,344	(110)	5,654
Unidentified non-pay savings	(6,348)	(22)		(22)	
TOTAL NON-PAY	**119,740**	**10,580**	**10,653**	**(73)**	**9,864**
EBITDA	**(4,123)**	**(2,769)**	**(3,545)**	**(776)**	**(3,278)**
Depreciation & Amortisation	8,500	709	667	42	667
Interest	1,545	130	143	(13)	107
Dividends Payable	872	73	73	-	183
Surplus / (Deficit)	**(15,040)**	**(3,681)**	**(4,428)**	**(747)**	**(4,234)**

Operational performance

Pay costs were £0.1m adverse in month (Medical £0.3m adv & Other Clinical £0.2m adv, offset by Non-Clinical £0.3m adv). Focus on agency management to continue agency cost trend established in FY17.

Non-pay costs were £0.1m adverse in month – Services largely on plan, and an overspend of £0.09m on drugs is under investigation.

[Further detail is given in the main Finance Report.]

CIP schemes

CIP schemes are a combination of expenditure and income, as well as transformational schemes.

The FY18 agency spend target of £17.0m is a £9.5m reduction on FY17 outturn, and therefore represents a significant challenge to the Trust, particularly as much of the reduction is expected to be counted under CIP.

All cross-cutting CIP themes are closely monitored through formal meetings and operational actions. Targets must be met, alongside other important schemes, in order to avoid greater financial difficulties for the Trust, the success of which will depend on Trust-wide efficiency schemes alongside consistently implemented ideas from all.

Outlook for FY18

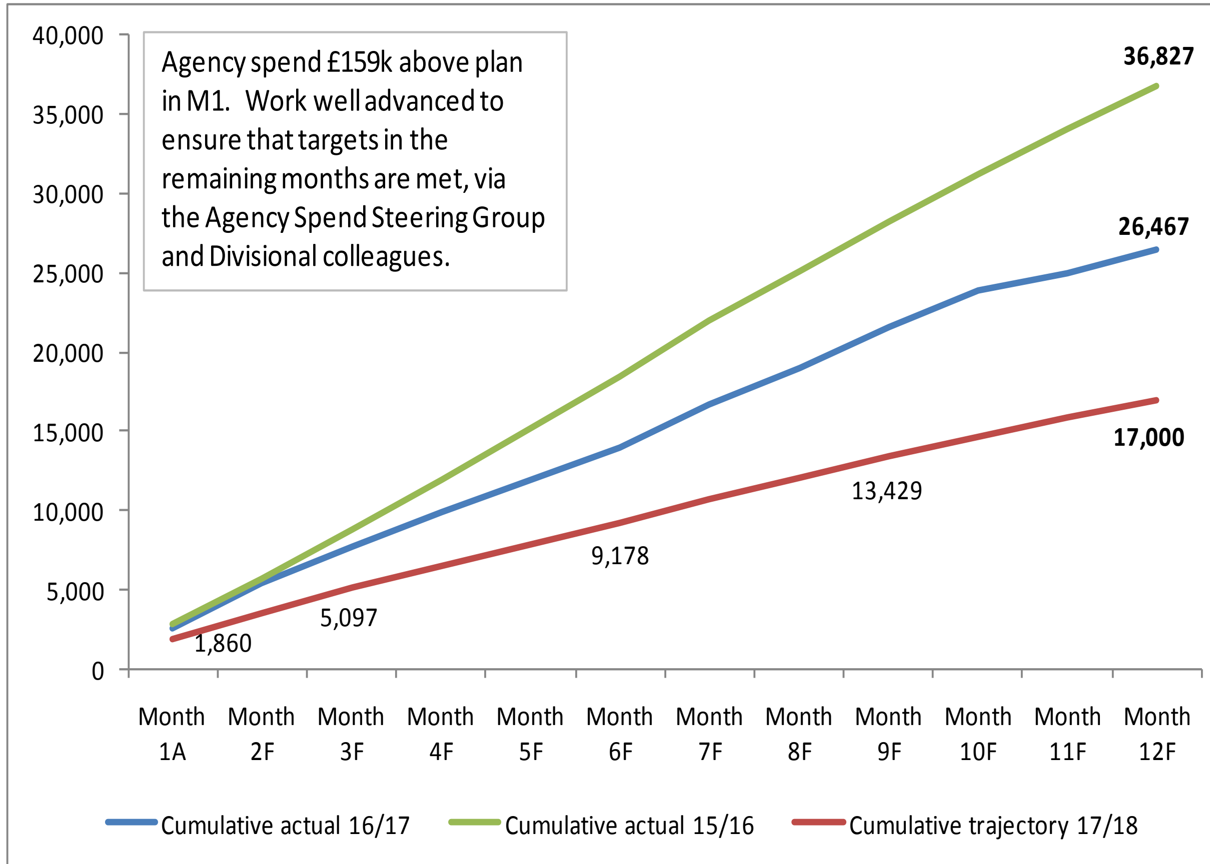
The full year forecast remains within the control total, noting likely variations up and down the I&E statement as CIPs are identified and operational changes managed.

West Hertfordshire Hospitals NHS Trust

Finance (Agency)

Agency spend trajectory

	Month 1A	Month 2A	Month 3A	Month 4A	Month 5A	Month 6A	Month 7A	Month 8A	Month 9A	Month 10A	Month 11A	Month 12A
Cumulative trajectory 16/17	2,605	5,416	7,655	9,846	11,966	14,038	16,669	18,972	21,593	23,881	25,007	26,501
Cumulative plan 16/17	2,788	5,139	7,353	9,554	11,590	13,575	15,404	17,251	19,060	20,855	22,633	24,406
Cumulative actual 15/16	2,772	5,712	8,744	11,930	15,236	18,418	21,978	25,157	28,255	31,149	34,046	36,827
Months trajectory 16/17	2,605	2,811	2,239	2,191	2,120	2,072	2,631	2,303	2,621	2,288	1,126	1,494
Months plan 16/17	2,788	2,351	2,214	2,201	2,036	1,985	1,829	1,847	1,809	1,795	1,778	1,773
Months actual 15/16	2,772	2,940	3,032	3,186	3,306	3,182	3,561	3,179	3,098	2,894	2,898	2,780



Green – 2015/16 £36.8m, large proportion of pay costs n agency spend; agency caps and other measures implemented in-year

Blue – 2016/17 £26.5m, a >£10m decrease on 2015/16 but still a high proportion of pay spend compared to peers.

Red - This year, where we needed to be in order to achieve target expenditure of £17.0m. First month results are slightly higher than planned, and plans are under development / being implemented to maximise the chances of achieving Q1 and full year targets.

Detailed reports

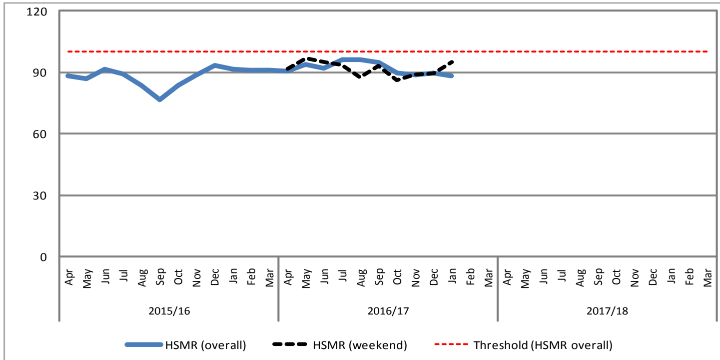
Safe, effective, caring

Reporting sub committee - S&C & COEC

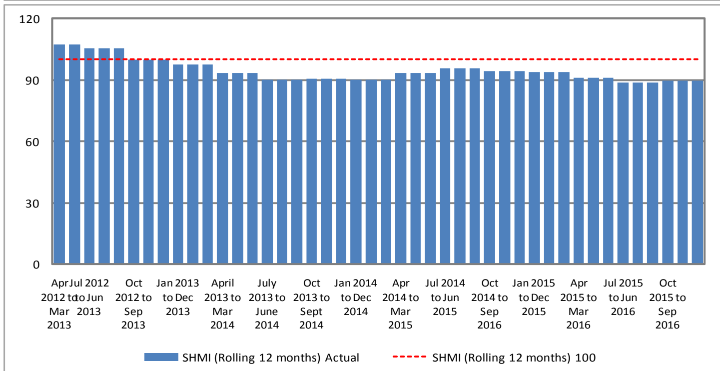
Executive lead	Clinical lead	Operational lead
*Dr Mike Van der Watt Tracey Carter		

Performance relative to targets/ thresholds		
	Achieving	Not achieving
Apr-17	4	4
Mar-17	3	5
Feb-17	4	4

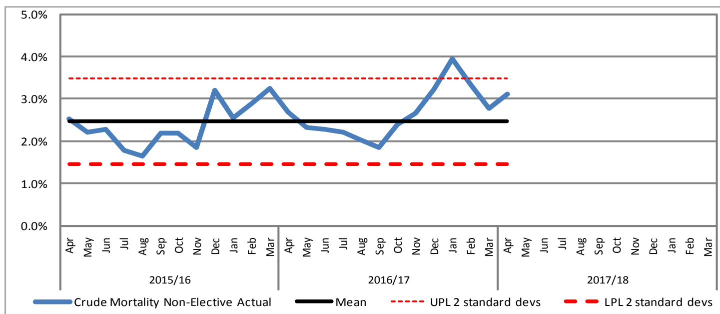
Hospital Standardised Mortality Ratio (HSMR)*



Summary Hospital Mortality Indicator*



Crude mortality rate (non-elective)*



Hospital mortality indices continue to demonstrate sustained 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). The Trust is 1 of 6 within the Shelford peer group of 11 that sit within the 'lower than expected' range

For the most recent 12 month period (February 2016 to January 2017, the Trust's HSMR of 91.3 was in the 'lower than expected' range.

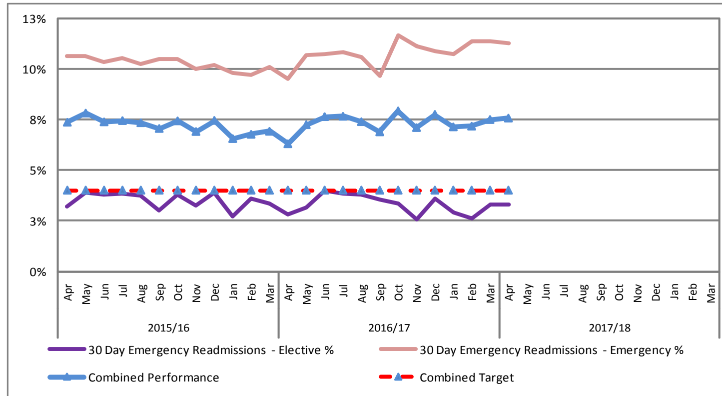
For the full year 2015/16 WHHT had the 13th lowest HSMR out of 136 non specialist trusts nationally, placing the Trust in the top 10% when compared across England. Within the East of England region, the Trust has the third lowest HSMR.

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

The Summary Hospital Mortality Indicator's (SHMI) latest statistics for October 2015 to September 2016) was 89.56 and 'as expected' (band 2).

The Trust continues to hold monthly divisional Mortality Review meetings and a bi-monthly Trust wide Mortality Review, chaired by the Medical Director.

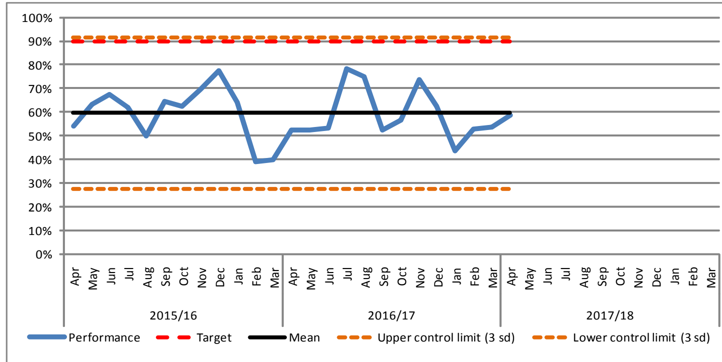
% Emergency re-admissions within 30 days following an elective or emergency spell*



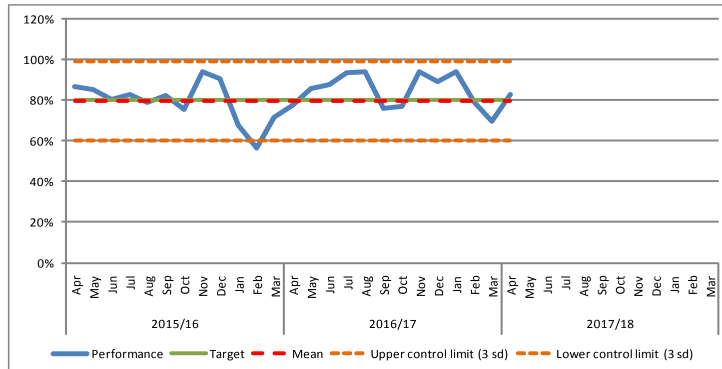
Emergency Readmissions
Combined emergency readmission rates, including both emergency and elective admissions have remained at a similar level to the previous month. The indicator includes all patients with more than one admission to the hospital within a period of 30 days, regardless of whether the second admission was related.

Within the Trust's Unscheduled Care Transformation Programme there is a work stream directly related to reducing readmissions. This is being led by the divisional director.

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)

Stroke
During April Stroke performance has shown some improvement from the previous month.

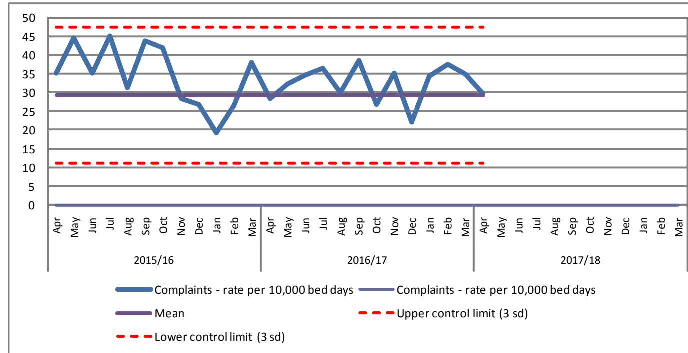
Emergency pressures continue to impact on access to the Stroke Unit within 4 hours, with an improvement in performance of 60.9% in April.

The number of stroke patients spending 90% of their stay in the Stroke Unit increased to 80.28%.. Availability of ring fenced capacity is highlighted daily at the operational meetings to ensure focus on this standard is maintained .

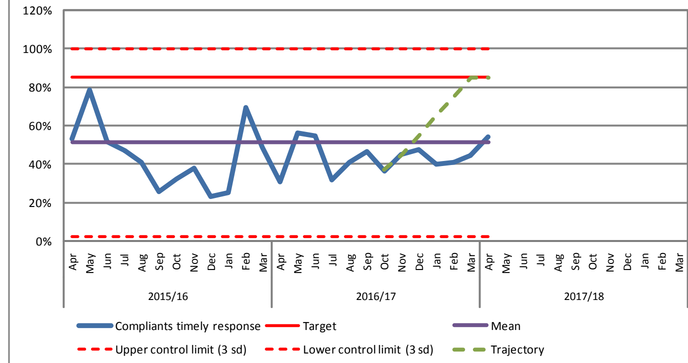
For the last SSNAP reporting quarter (August–November 16) 62.4% of patients reached the stroke unit within 4 hours. This was higher than the national average of 58.5%.

For the same reporting quarter (August–November 16) SSNAP results continue to be rated an overall "A". The next SSNAP quarterly reporting results to teams are due in June.

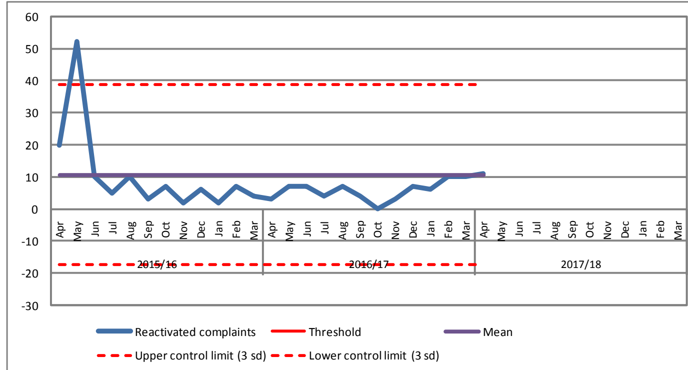
Complaints - rate per 10,000 bed days



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



Number of reactivated complaints



Complaints rate per 10,000 bed days

56 new complaints were received in April, of which 27% relate to Unscheduled Care (USC), 25% relate to Surgery, Anaesthetics and Cancer (SAC), 18% relate to Women's and Children (WACS), 14% relate to Clinical Support, 9% relate to environment, 5% relate to Medicine. There were no complaints for the corporate division. This month, the most common theme was: all aspects of clinical care (27%), attitude of staff (14%), communication (14%) . The Trust upheld 33 complaints, partially upheld 8 and 14 were not upheld.

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

This month 54% of complaints were responded to on time (trajectory 85%). 57 complaints were due for response during April; 31 were responded to on time. 51 responses were sent in total. There continues to be a focus on improving the quality of complaint investigations and responses. Consistent application of validation of response times has improved data quality, resulting in a more accurate performance measure. Complaints responded to on time, by division, is as follows

	February	March	April
Trust wide	41%	45%	54%
Medicine	85%	60%	80%
USC	12%	27%	47%
SAC	38%	45%	59%
WACS	67%	50%	33%
Environment* **	100%	50%	50%
CSS	100%	25%	50%
Corporate	0%	50%	100%

Performance timescales continue to be monitored weekly. Work is ongoing to ensure that the target for responding to 85% of complaints within one month or agreed timescales is achieved. This includes, but is not limited to:

•New deadlines for LRMs and policy update on performance figures .
•Focus on complaints response times at Divisional Performance Review Meetings
•Support from Corporate Complaints Team to complete complaint responses
•Telephoning complainants in the first 3 days of their complaint
•New system of triaging to provide better recommendations to resolve complaints

11 complaints were reactivated in April. This is in keeping with an increase in reactivated complaints since January. No themes can be identified following a more thorough review.

N/A denotes – no complaints capable of being replied to this month.
***The Environment division altered its approach to responding to complaints and will be telephoning complainants at an early stage in a complaint to address their concerns.

Intentionally blank

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Reporting sub committee - S&C & COEC

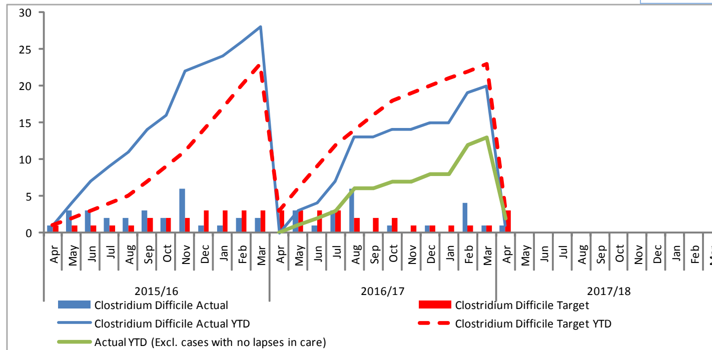
Executive lead	Clinical lead	Operational lead
*Dr Mike Van der Watt Tracey Carter		

Performance relative to targets/ thresholds

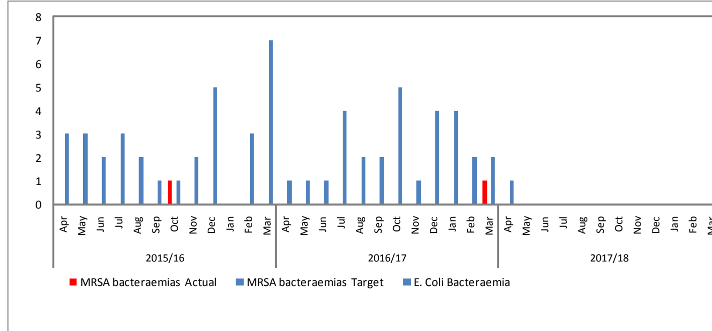
	Achieving	Not achieving
Apr-17	2	4
Mar-17	4	2
Feb-17	3	3

West Hertfordshire Hospitals NHS
NHS Trust

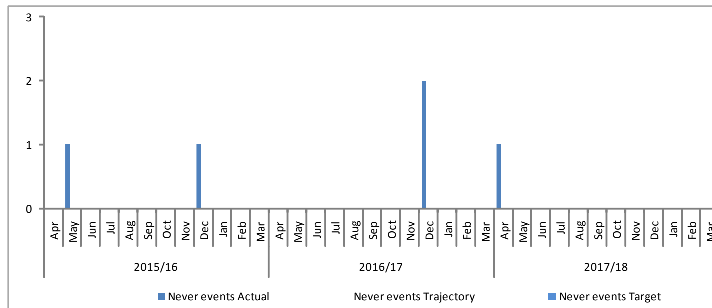
Clostridium Difficile



MRSA bactaraemias and E. Coli Bacteraemia



Never events*



Clostridium difficile Infection (CDI)

The target ceiling for WHHT apportioned CDI is 23. 1 case was reported in April. Thorough investigation (Root Cause Analysis) of this case was undertaken by the IPCT (Microbiologist, antimicrobial pharmacist and IPCN) together with the Clinical team (Consultant, ward manager and matron). The investigation outcome was that this was an unavoidable case.

The IPCT will review this case with a view to submitting the report to the HVCCG C.difficile panel for exclusion from contractual sanctions.

IPCT will continue with antimicrobial rounds, weekly Clostridium difficile rounds, and targeted training. There is also increased IPC support to key clinical areas.

MRSA bacteraemia (MRSAb)

The target ceiling for MRSA bacteraemia is 0 avoidable cases. In April no MRSAb was reported.

For all cases of MRSAb a Post Infection Review (PIR) is carried out. All organisations involved in the patient `s care pathway are expected to participate at the PIR and agree the possible factors that contributed to the patient`s MRSAb.

Following the case reported in March, new blood culture bottles and the connection system have now been implemented across the Trust. The blood culture policy will be reviewed.

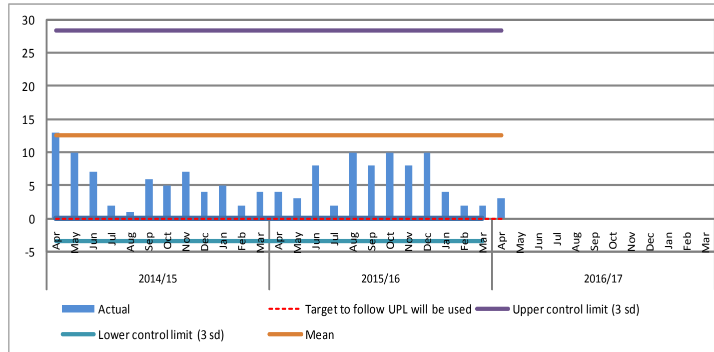
E. Coli bacteraemia (E colib)

1 case reported in April . By March 2021 there is an expectation that localE colib will be reduced by 50%. The target set for the CCG this year is a 10% reduction which equates to 36 cases. There is no target for WHHT. The wider health economy is working in partnership to reduce E.colib in Hertfordshire.

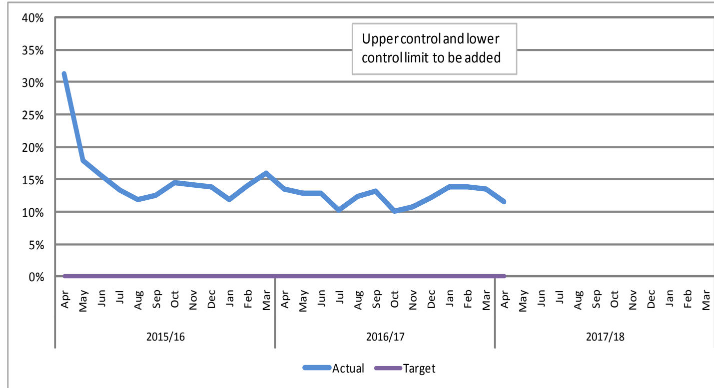
Never event

1 never event was declared in April 2017 relating to the wrong route administration of medication. A number of immediate actions were taken to prevent a similar incident occurring and the SI investigation commenced. Monitoring of the investigation and implementation of actions will be progressed in accordance with the Trust SI investigation process.

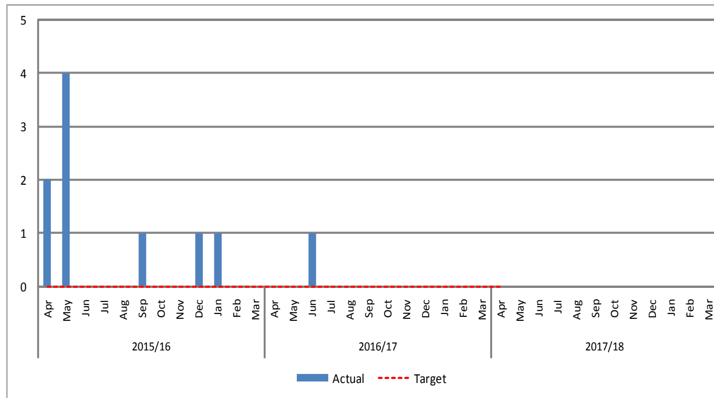
Serious incidents



% of reported patient safety incidents that are harmful



Medication errors causing serious harm*



Serious Incidents

3 Serious Incidents (SIs) were declared in April 2017, 1 more than in March 2017. April 2017s SIs were as follows:

- 1 Unscheduled Care (inpatient fall);
- 2 Unscheduled Care (medication incidents – 1 was declared as a Never Event)

At the end of April 2017 the Trust had 45 open SIs. Investigations are complete for 29 of these and they are with Commissioners pending formal closure on StEIS.

At the end of April there were 16 ongoing SI investigations. 11 were over the StEIS deadline due to the investigation not being completed;. All of the overdue SIs have a plan in place for completion.

Learning from SIs

The following actions and processes are in place to ensure learning from SIs and provide assurance that learning has taken place and changes have been implemented:

- 45 day review meetings allow the SI draft report to be discussed and challenged by the relevant clinical and management teams prior to the action plan being completed.
- Each action plan is developed, signed off and monitored by the division leading the investigation.
- The SI review group (SIRG), chaired by the Associate Medical Director, review all closed SI action plans and senior divisional representation provides assurance and evidence that actions have been implemented before the SI is formally closed internally.

There was one 45 day review meeting in April 2017.

A SIRG meeting was held on 24 April 2017; 8 action plans were closed, including the Neonatal Thematic review action plan. The next SIRG meeting is scheduled for 23 May 2017.

% of patient safety incidents which are harmful

11.4% of incidents reported in April 2017 are currently recorded as harmful, this is a decrease of just over 2% when compared to the previous month of March 2017 at 13.6%.

There were 31 incidents reported with moderate harm or above in April 2017. Of these , 18 still require harm validation and are therefore the harm level is subject to change.

Medication incidents causing serious harm

There were no medication errors causing serious harm in April 2017

Safe, effective, caring

Reporting sub committee - S&C & COEC

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

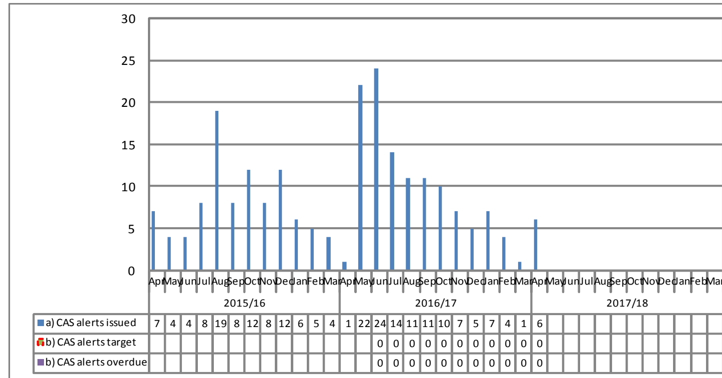
Performance relative to targets/ thresholds

	Achieving	Not achieving
Apr-17	1	4
Mar-17	1	4
Feb-17	1	4

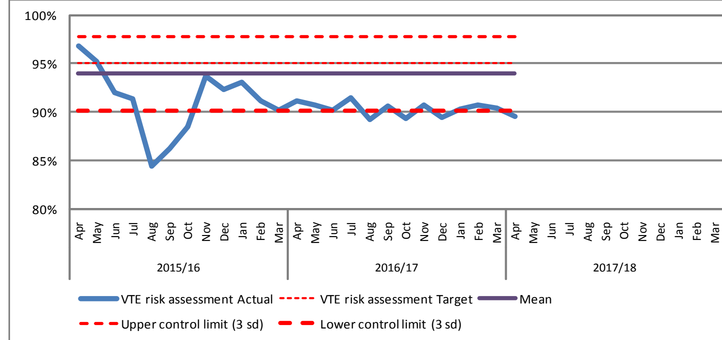
West Hertfordshire Hospitals NHS
NHS Trust

CAS alerts:

a) number issued per month (not target)
b) number where acknowledgement overdue*
(target = 0)
(Class 4: for information only and class 2: Action within 48 hours)



VTE risk assessment*



All alerts issued by CAS in April 2017 were acknowledged within the 48hr deadline.

There were 6 alerts issued in April 2017, of which 5 were Medical Device alerts which have been sent to the Divisions and Procurement and 1 Patient Safety Alert titled "Resources to", to support the safety of girls and women who are being treated with Valproate. Pharmacy are leading on this alert.

There were no breaches during April 2017 and all alerts with deadlines were closed on time.

Issued by CAS	6
Breached in month	0
Currently overdue	0
CAS alerts not acknowledged within 48hrs	0

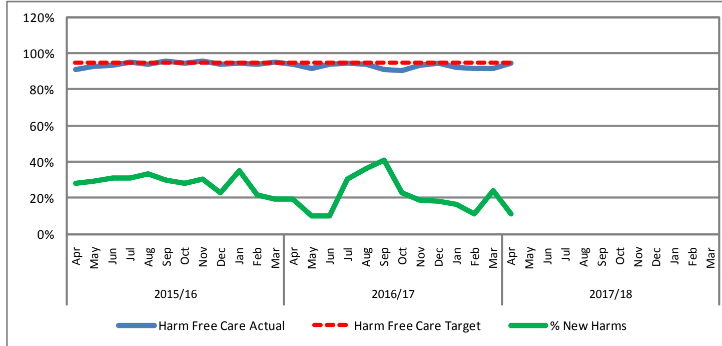
VTE

VTE risk assessment compliance remains substandard. An audit of the VTE risk assessment forms which have been classified as non-compliant has been undertaken by clinicians in order to gain understanding of the problem and to ascertain whether appropriate thromboprophylaxis was prescribed in these patients. This showed that most did receive therapy.

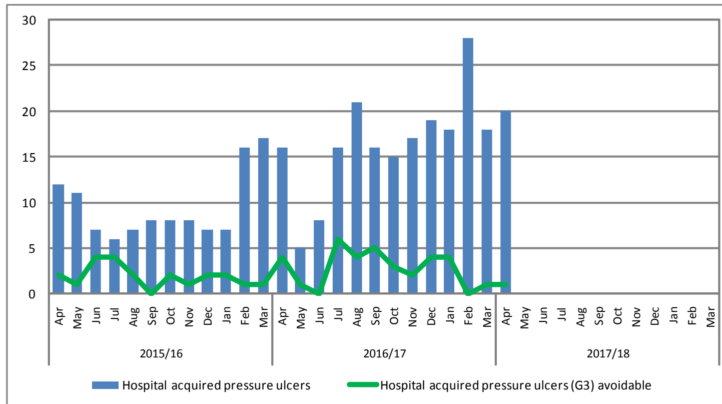
The audit criteria has now been changed following a CAG discussion.

The audit also highlighted groups of patients who should be exempt from VTE risk assessment who were previously included (patients on anticoagulation treatment, those who will be started on anticoagulants for acute coronary syndrome). A different version of the risk assessment form has been devised for patients with stroke. Areas with poor compliance will be targeted and juniors will receive regular reminders to complete VTE risk assessments.

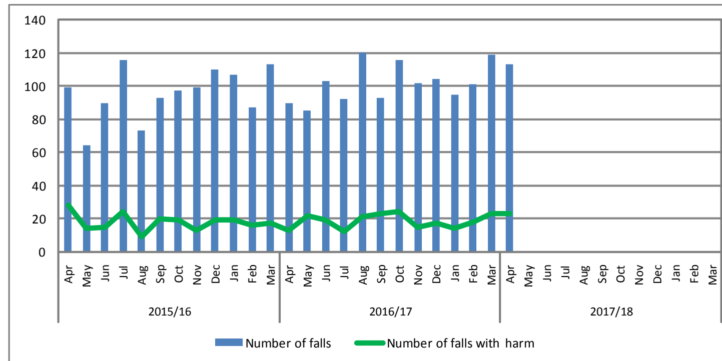
Percentage of Harm Free Care and New Harms



Hospital acquired pressure ulcers



Falls and falls with harm



Harm Free Care – Safety Thermometer

'Harm free' care is defined by the absence of pressure ulcers, harm from a fall, urine infection (in patients with a catheter) and new VTE.

In April Harm Free Care was 94.31%, above the national average of 94.05%. This includes harms acquired both inside and outside of the Trust.

New Harm Free care (harms acquired in the Trust) for April 2017 was 99.35%, better than the national average of 97.94%.

In April there was a 1 new pressure ulcers, grade 2 (same as March)
New VTE in April was 2 (an improvement from March)

April 2017 there were 8 falls all with no harm (improved from March)

Catheters and new UTI for April was 1 (an improvement from March)

The Trust remains above the national average for catheters in situ at 15.98 against the national figure of 13.36

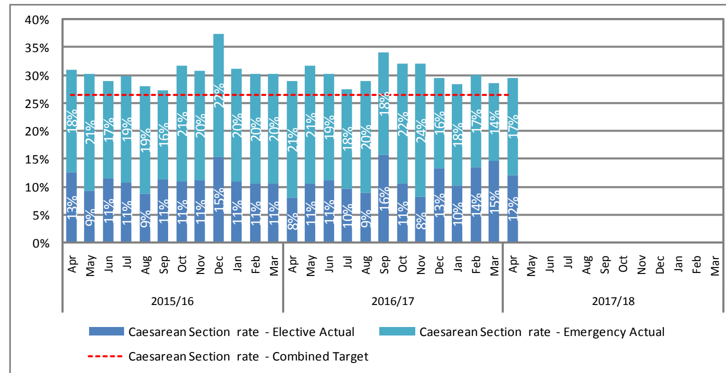
Harm Free Actions

- E-coli will be a national focus in 2017, with new tool kits to help reduce UTIs to be launched.
- New Steering group established with Urology to drive best practise with urinary catheters in conjunction with Infection Prevention and control . Data will be monitored through the group.
- VTE specialist Nurse post (secondment) from Jan 2017 focus on education, risk assessment appropriate treatment.
- National programme planned with NHSI to further reduce acquired pressure damage
- Promotion of Nutrition and Hydration week took place across the Trust 13th March – 17th March
- Medicines management quiz took place over Easter raising awareness .

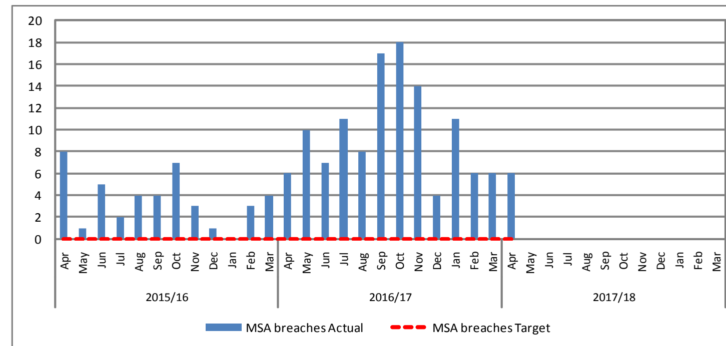
April 2017	National	WHHT	Milton Keynes	East and North	The Hillingdon
Pressure Ulcers - New	0.90	0.16	1.33	0.34	n/avail.
Catheter & New UTI	0.29	0.16	-	0.17	n/avail.
Catheters	13.36	15.93	21.24	18.21	n/avail.
Falls with Harm	0.54	-	0.22	-	n/avail.
All New VTEs	0.37	0.33	0.44	0.34	n/avail.
New Harm Free	97.94	99.35	98.01	99.14	n/avail.

West Hertfordshire Hospitals NHS Trust

C-section rate



Mixed sex accommodation



Mixed sex accommodation (MSA)

All breaches occurred in ITU and were due to pressures on the emergency care pathway.

The monitoring and management of patients requiring step down from ITU is reviewed daily as part of the regular operational management meetings, with the intention of reducing where possible, the number of mixed sex accommodation breaches that occur. Advance planning for complex patients requiring side-room capacity is reviewed as part of these meetings.

The Trust policy on mixed sex accommodation is currently being reviewed.

Responsive

Reporting sub committee - F&P

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

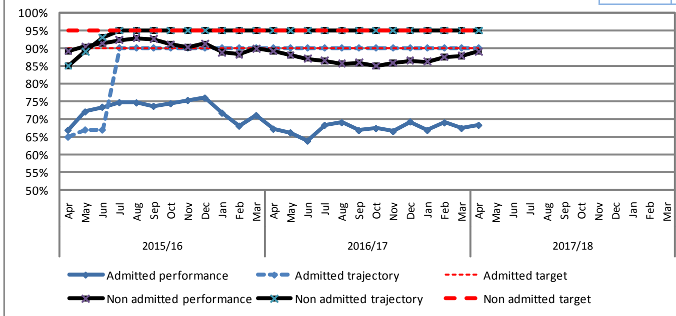
Executive lead	Clinical lead	Operational lead
Sally Tucker	Jeremy Livingstone	Jane Shentall

Performance relative to targets/ thresholds

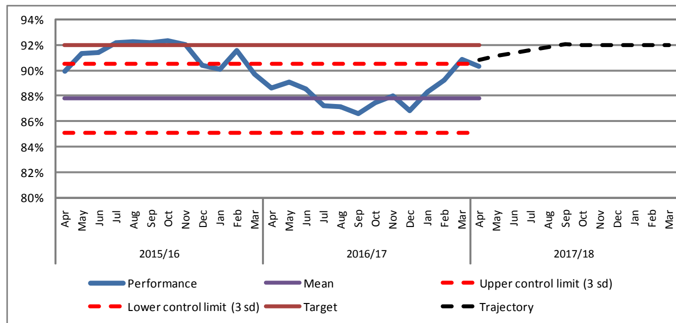
	Achieving	Not achieving
Apr-17	5	2
Mar-17	5	2
Feb-17	5	2

West Hertfordshire Hospitals NHS Trust

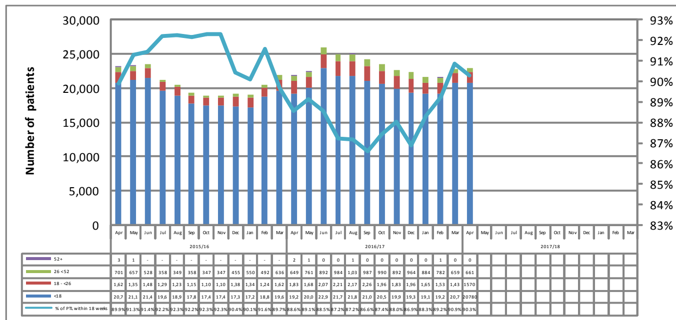
Completed pathways within 18 weeks



Incomplete pathways within 18 weeks



Incomplete pathways WL profile



RTT

Performance dipped slightly to 90.3%, largely as a result of reduced capacity and activity around the Easter break. The most recent national data available (March) shows that Trust's performance in April is equal to the national average (90.3%) with 92% achieved at RFH, L&D but not at E&NH (91.96%). The median waiting time at WHHT (ie the weeks half the patients on an RTT pathway were waiting) was better than the national position (6.1 vs 6.2 weeks) as was the 92 percentile wait time (18.9 vs 19.5 weeks).

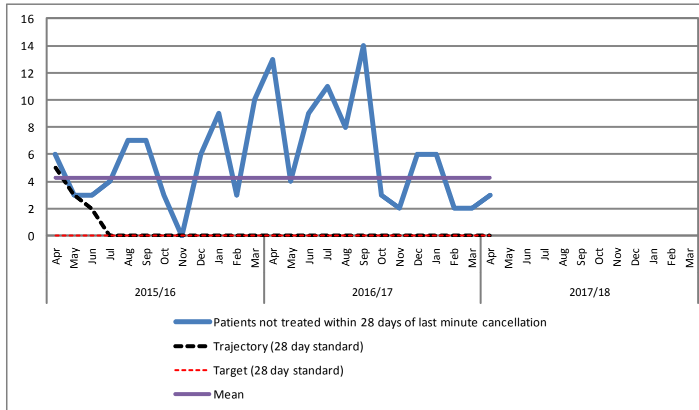
In line with overall performance, divisional level performance has reduced a little although Elective Medicine (95.5%) and WACS (96.8%) have sustained performance above 92%. Clinical Support Services (Orthotics) continue to improve at 80.6% but like Surgery (86.5%) remains below standard. The backlog currently represents 9.3% of the total PTL. Performance is in line with the recovery trajectory.

Service/Specialty Description	Backlog	Performance against 92% standard
GENERAL MEDICINE	0	100.00%
GERIATRIC MEDICINE	0	100.00%
CRITICAL CARE MEDICINE	0	100.00%
PAEDIATRIC OPHTHALMOLOGY	0	100.00%
PAEDIATRIC EPILEPSY	0	100.00%
HEPATOLOGY	0	100.00%
PAEDIATRIC CARDIOLOGY	0	100.00%
STROKE MEDICINE	0	100.00%
TRANSIENT ISCHAEMIC ATTACK	0	100.00%
MEDICAL ONCOLOGY	0	100.00%
NEONATOLOGY	0	100.00%
GYNAECOLOGICAL ONCOLOGY	0	100.00%
DIABETIC MEDICINE	1	99.06%
ENDOCRINOLOGY	4	98.58%
NEPHROLOGY	1	98.44%
BREAST SURGERY	5	98.40%
GASTROENTEROLOGY	20	98.16%
RESPIRATORY MEDICINE	14	97.63%
PAEDIATRIC DERMATOLOGY	1	97.56%
CLINICAL ONCOLOGY	1	97.44%
PAEDIATRIC UROLOGY	3	97.22%
CLINICAL HAEMATOLOGY	7	97.19%
GYNAECOLOGY	28	96.96%

Service/Specialty Description	Backlog	Performance against 92% standard
PAEDIATRICS	27	96.79%
** BLANK **	1	96.30%
PAEDIATRIC CLINICAL HAEMATOLOGY	1	96.30%
DERMATOLOGY	89	95.60%
PAEDIATRIC ENDOCRINOLOGY	2	95.00%
CARDIOLOGY	74	94.53%
PAEDIATRIC GASTROENTEROLOGY	6	93.94%
RHEUMATOLOGY	29	92.60%
ORAL SURGERY	66	91.78%
COLORECTAL SURGERY	39	91.67%
NEUROLOGY	85	90.86%
GENERAL SURGERY	160	90.59%
UROLOGY	142	88.07%
UPPER GASTROINTESTINAL SURGERY	6	86.05%
PAIN MANAGEMENT	87	85.99%
TRAUMA & ORTHOPAEDICS	545	84.85%
OPHTHALMOLOGY	356	84.58%
ENT	347	83.11%
ORTHOTICS	18	80.65%
VASCULAR SURGERY	29	79.58%
ORTHODONTICS	39	20.41%
Total	2233	90.29%

Outsourcing continues, with 47% uptake from patients. 534 patients have been treated.

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

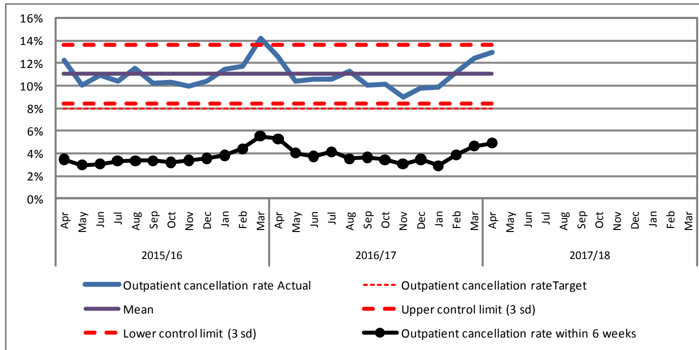


Hospital cancellations – patients not treated within 28 days of last minute cancellation

There were 3 breaches of the 28 day rebooking requirement. One patient (Oral surgery) cancelled their new admission date. The two other patients (ENT) were not offered a date within 28 days due to capacity and case mix constraints.

Hospital outpatient cancellations all and % cancelled* within 6 weeks

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

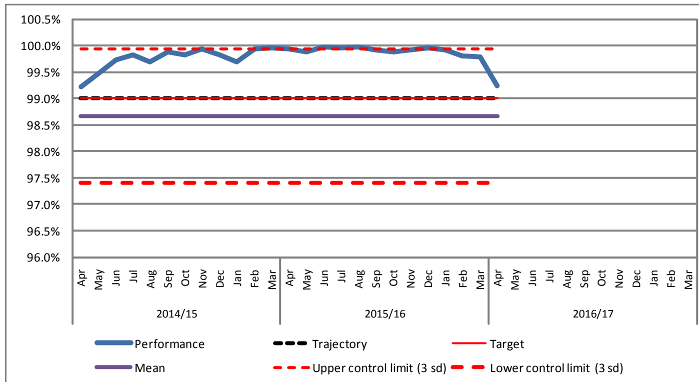


Hospital cancellations – patients cancelled within 6 weeks and overall

Short notice cancellations remained just below the Trust tolerance (5%) at 4.9% (excluding valid cancellations and patient initiated cancellations).

Total cancellations: 26.2%			
Hospital initiated		Patient initiated	
All cancellations	Under 6 weeks	All cancellations	Under 6 weeks
12.9%	4.9%	13.2%	10.1%

Diagnostics



Diagnostic wait times

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

Consistently strong performance against this standard continues and remains better than the national position, although increased demand in DEXA, Neurophysiology and Cardiology has resulted in a slight reduction in performance.

Responsive

Reporting sub committee - F&P

CWTs

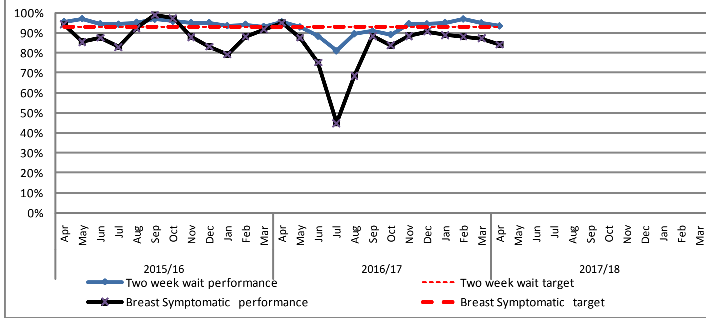
Executive lead	Clinical lead	Operational lead
Sally Tucker	Jeremy Livingstone	Jane Shentall

Performance relative to targets/ thresholds

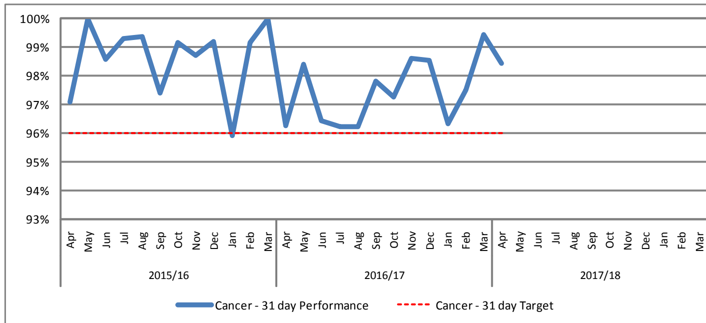
	Achieving	Not achieving
Apr-17	6	1
Mar-17	6	1
Feb-17	6	1

West Hertfordshire Hospitals NHS
NHS Trust

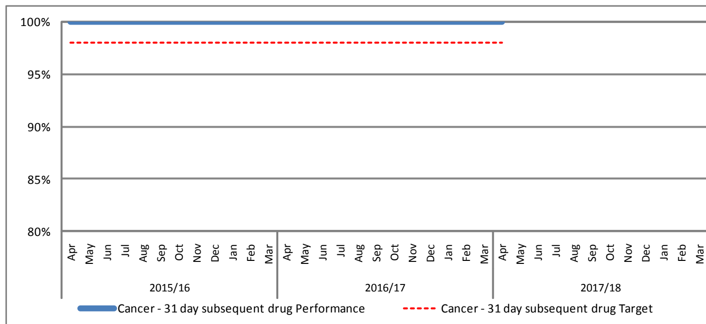
Two week standard and breast symptom two week standard



31 day standard



31 day subsequent drug standard



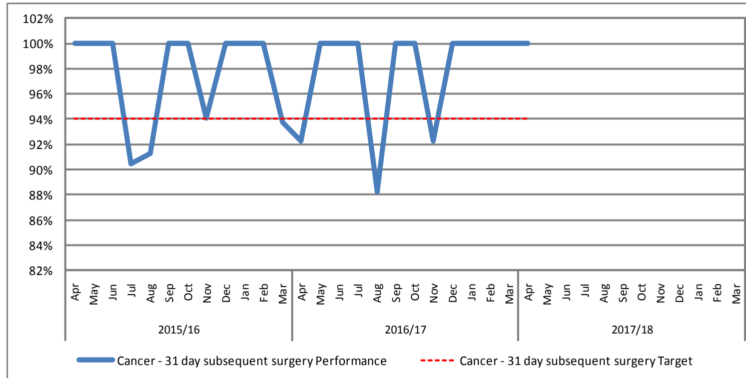
Breast symptomatic
The final position for April is non compliant at 84.0%.
A joint action plan has been drafted with the CCG to improve performance., with a range of actions in cluding creation of additional clinic capacity, targets for booking all breast symptomatic patient appointments by day 5, a letter to GP after 1st DNA or cancellation, focussed work with the 2WW booking team.

2ww
The provisional position for March is compliant at 93.4%
Services with breaches include
Oral Surgery, Gastroenterology, Dermatology, Thoracic, Gynaecology

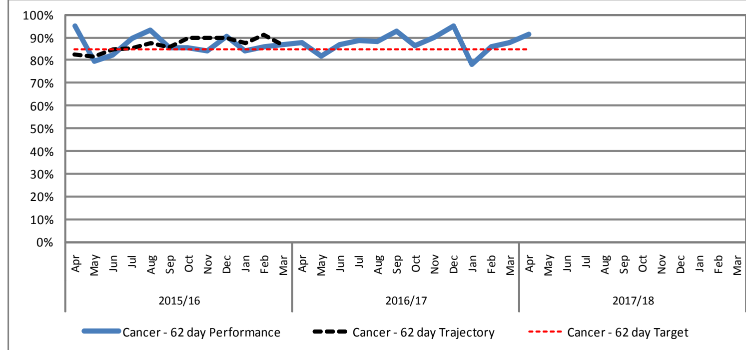
31 day first
April is compliant at 98.4% (2 skin 31 day breaches come via histology, not via co-ordinator)

West Hertfordshire Hospitals NHS Trust

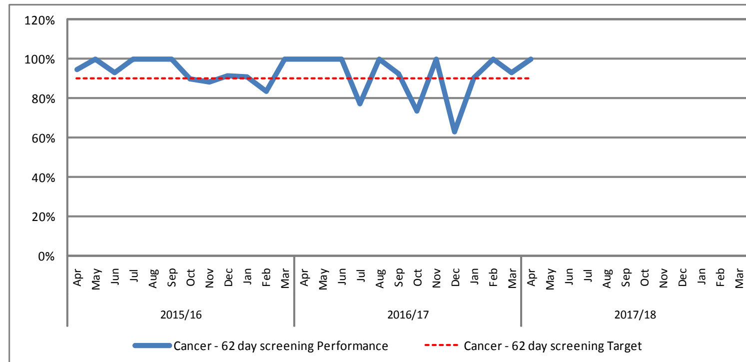
31 day subsequent surgery standard



62 day standard



62 day screening standard



62 day GP - urgent
The provisional position for April is compliant at 91.5%
There were 62.5 pathways with 5.5 breaches

- Oral - 2 pathways equating to 1 breach
- Upper GI - 2 pathways equating to 1 breach
- Haematology – 2 pathways - 1.5 breaches
- Lung – 1 pathway - 0.5 breach

Tumour site	Apr (prov.)
Breast	100
Gynaecological	100
Haematological	50
Head and Neck	0
Lower Gastrointestinal	81.8
Lung	75
Skin	100
Upper Gastrointestinal	77.8
Urological	96.3
Total	**91.5**

62 day screening – no breaches

Responsive

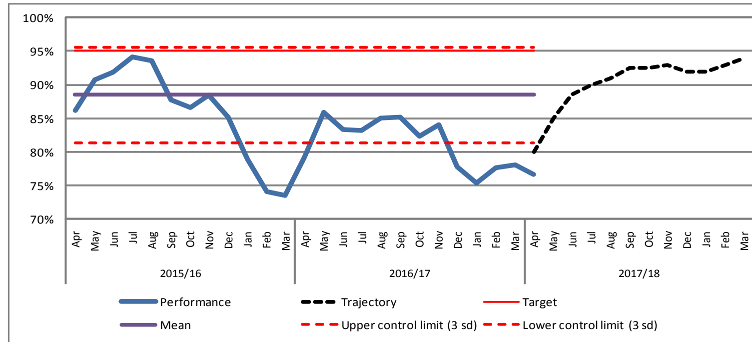
Reporting sub committee - F&P

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

Executive lead	Clinical lead	Operational lead
Sally Tucker	Dr David Gaunt	

Performance relative to targets/ thresholds	Achieving	Not achieving
Apr-17	1	4
Mar-17	1	4
Feb-17	1	4

A&E

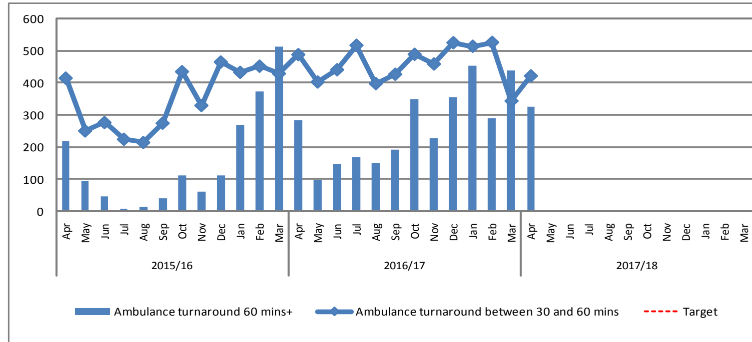


** Please note that the A&E trajectory is a working trajectory and awaiting final approval*

A&E performance in April continued on a similar trend to March with performance at 76.5%, as a result of on-going capacity issues. Performance is not in line with the revised trajectory to meet compliance. A number of immediate and future initiatives are being implemented to improve A&E flow including an increase in majors capacity, zoning to ensure dedicated medical resource to each area, extending the role of GPs in A&E and protecting assessment areas.

The focus on recovering Minors and non-admitted performance at Watford continues. Minors performance was 90.5% in April. The lead nurse for Minors is leading on a programme of actions. This includes the development of a new streaming model for walk-in patients. Performance continues to be monitored through the Emergency Department Transformation Meeting chaired by the Medical Director.

Ambulance turnaround time

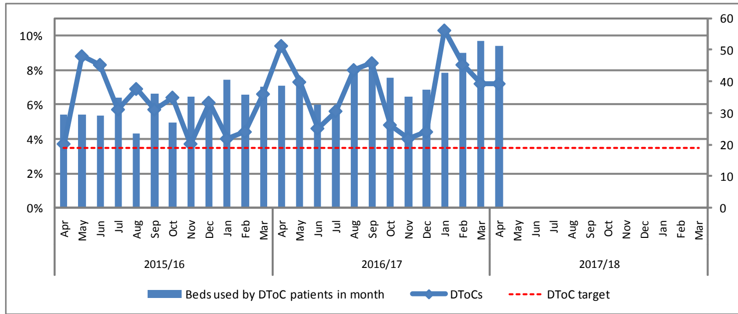


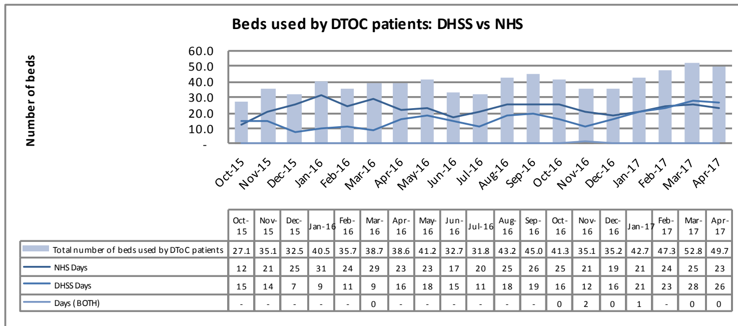
Ambulance turnaround times for those waiting over 60 minutes has improved in April following the increase in Majors capacity, by the re-use of the Clinical Decision Unit as additional Majors bays. This has reduced the occasions and length of time that patients wait in the corridor, both improving patient experience and releasing crews earlier.

An activity comparison of the current financial period with the same period last year has shown:

- Type 1 attendances are up by 5.1%,
- Ambulance arrivals are up by 2.6%,
- Admission rate from A&E (excluding ambulatory and frailty) is up by 1.5%

Delayed Transfers of Care (DToC)





	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17
Total number of beds used by DToC patients	27.1	35.1	32.5	40.5	35.7	38.7	38.6	41.2	32.7	31.8	43.2	45.0	41.3	35.1	35.2	42.7	47.3	52.8	49.7
NHS Days	12	21	25	31	24	29	23	23	17	20	25	26	25	21	19	21	24	25	23
DHSS Days	15	14	7	9	11	9	16	18	15	11	18	19	16	12	16	21	23	28	26
Days (BOTH)	-	-	-	-	-	0	-	-	-	-	-	-	0	2	0	1	-	0	0

Delayed Transfers of Care

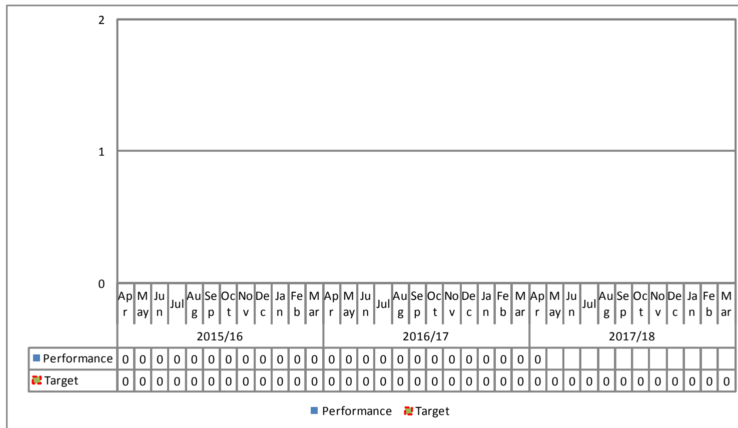
DToC patients represented 7.2% of occupied beds in April, as measured using the nationally reported method. This is based on a snapshot of the number of patients waiting at a point in time in the month, expressed as a percentage of beds.

The total beds occupied by DToC patients is therefore a more useful measure to illustrate the impact of DToC because it includes all patients waiting in the month. In April DToC patients consumed 1540 bed days, the equivalent of approximately 50 beds. There are regular audits of both DToC and other stranded patients (over 7 day length of stay) to identify issues and remove avoidable causes of delay.

Ongoing escalation to system partners via the A&E Delivery Board 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.

Streamlined processes for data monitoring and reporting have been introduced, as well as daily "live" patient monitoring with board briefings with the discharge planning nurses. Lead roles have been introduced in relation to self-funded patients, and continuing healthcare (CHC) assessments, and a number of staff have been re-allocated to different areas to tackle issues relating to a build up of referrals.

12 hour trolley waits



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
	2015/16												2016/17												2017/18											
Performance	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0											
Target	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

West Hertfordshire Hospitals NHS Trust

Well led

Reporting sub committee - Workforce

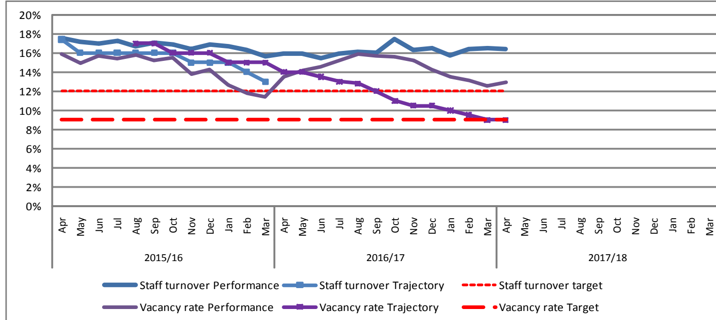
Workforce indicators - staff turnover, sickness, bank & agency, vacancy, appraisal, and mandatory training

Executive lead	Clinical lead	Operational lead
Paul da Gama		

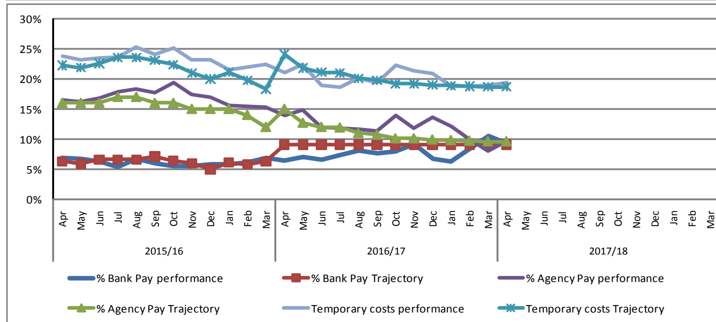
Performance relative to targets/ thresholds

	Achieving	Not achieving
Apr-17	3	4
Mar-17	2	5
Feb-17	1	6

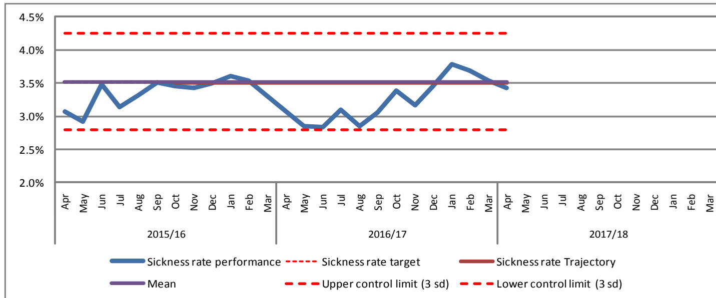
Staff turnover and vacancy rate



% bank, agency and temporary pay



Sickness rate



Turnover and Vacancies

At the end of April the overall Trust vacancy rate increased from 12.5% to 13.0%, ending a seven-month run of falling vacancies. However, staff-in-post actually rose in the month; the reason for the higher vacancy rate was an increase in the establishment of 34.8 WTEs, due to establishment re-setting for the new financial year. Had the establishment remained unchanged, the vacancy rate would have fallen slightly, to 12.3%. Within this overall figure, the Nursing & Midwifery vacancy rate also increased, from 12.2% to 14.3%; again wholly due to increased establishment. Recruitment activity has built up a large pipeline of new N&M recruits (currently 325 registered and 28 unregistered nurses), so this figure is forecast to fall again over the next few months. The 12-month rolling turnover rate remained unchanged at 16.4%; WHHT has the seventh highest turnover (out of 13) compared to Herts & Beds peers. Over the last 2 years, turnover has displayed a modest downward trend; average turnover in 2015/16 was 16.8%, whereas in 2016/17 it was 16.2%.

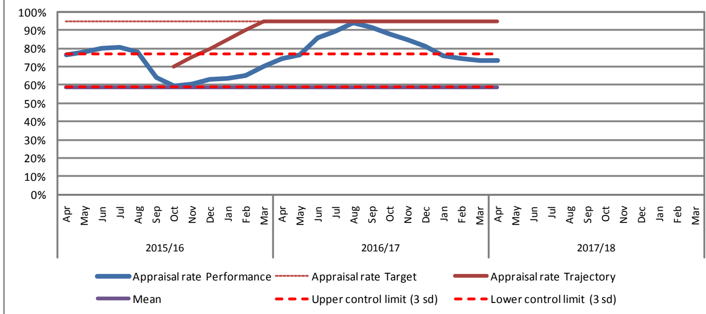
% Bank and Agency Expenditure

Having fallen considerably in March, agency spend rose in April, from £1.49m to £1.86m. April spend represented 9.7% of the overall pay-bill compared to 8.0% in March and 10.0% in February. The overall trend is falling, and agency spend reduced considerably in 2016/17 compared to 2015/16 – total spend in 16/17 being £9.64m less than in the previous year. April spend was slightly higher than the target of £1.7M in the month. Work continues to keep agency spend as low as possible via the Agency Steering Group and with Herts & Beds Partners. There is confidence that the r target maximum spend of £17m on agency in the current financial year can be achieved. Bank spend as a percentage of payroll fell from 10.5% to 9.3%.

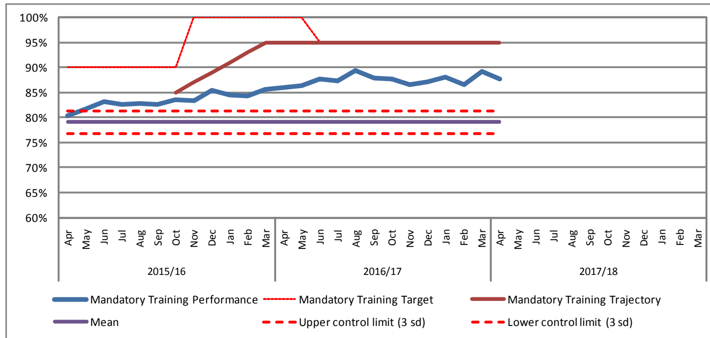
Sickness rate

The sickness absence rate fell marginally from 3.5% in March to 3.4% in April, just below target. The Trust is currently well below the Herts & Beds average, which stood at 4.5% at the end of Quarter 3. Over the last 2 years, sickness absence has remained fairly stable, fluctuating only between 3.8% and 2.8%. Average sickness absence in 2015/16 was 3.4%, whereas in 2016/17 it was fractionally lower at 3.2%.

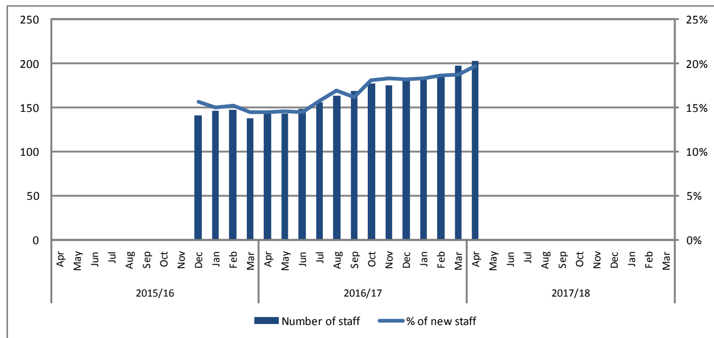
Appraisal rate
(non medical staff only)



Mandatory training



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



Appraisal – non medical staff

Appraisal rates have dropped from the peak in late September at 93%, and at the end of April the rate was 73% which has remained static from March. Current operational pressures have impacted on the number of appraisals being completed and there is a significant challenge to maintain focus and ensure appraisal dates are aligned to staff increments to further improve organisational performance. HR Business Partners are working with managers to support the transition to effective alignment of appraisals to increments and to plan the completion of outstanding appraisals over the next 3 months.

Mandatory training

Mandatory training compliance is at 88% as of end April 2017, a slight drop from 89% in March. Retained focus is required to sustain and better compliance rates. In particular the Trust is moving to more e-learning in place of classroom sessions for subjects that are knowledge based rather than practical. New starters are being asked to complete e-learning prior to commencing in post which is helping to increase compliance rates for new joiners.

Work continues towards the implementation of the new learning management system – 'ACORN' with Think Associates. As a self-serve system this will alert staff to the need to complete training in a timely way and automate many of the processes involved in logging training which should drive a step change in compliance figures.

Number of staff leaving within first year

The Trust is closely monitoring staff leavers and introduced a new exit questionnaire process to gather more intelligent data about staff reasons for leaving. The reconnect sessions continue following corporate induction, bringing new starters back together and offering an opportunity to resolve any issues and gather information to further improve staff experience in their first year in post.

Workforce BAF scorecard

Workforce Indictors - Progress Table

Progress against target - April 2017 f2

KPI	Benchmark average	Performance 12 months ago	Performance 3 months ago	Current performance	Target	Distance to target	Better / worse than 3 months ago	Remaining Progress to target needed (%)
Vacancy	12%	13.5%	13.5%	13.0%	9.0%	4.0%	↘	44%
Turnover	16%	15.9%	15.8%	16.4%	12.0%	4.4%	↗	37%
Total Sickness	3.80%	3.1%	3.8%	3.4%	3.2%	0.2%	↘	6%
Sickness Short Term		1.6%	1.8%	1.5%	1.6%	-0.1%	↘	-6%
Sickness Long Term		1.4%	1.8%	1.9%	1.6%	0.3%	↗	19%
Non-Medical Appraisal	82%	74.0%	76.0%	73.0%	95.0%	-22.0%	↘	23%
Medical Appraisal		99.0%	99.0%	99.0%	95.0%	4.0%	→	-4%
Core Skills Framework	88%	86.0%	88.0%	88.0%	95.0%	-7.0%	→	7%
Agency as a % of Paybill	8%	14.0%	12.1%	9.7%	10.0%	-0.3%	↘	-3%
Friends and Family Test	60.00%	57.0%	66.7%	59.1%	66.0%	-6.9%	↘	10%
Overall Summary								

a minus figure indicates over-performance

Key	
Achieving 80% of the target	Green
Achieving 60% to 80% of the target	Yellow
Achieving 40% - 60% of the target	Amber
Achieving 20% to 40% of the target	Brown
Achieving Under 20% of the target	Red

Overall Scoring Key	
Red	2 or more indicators Red
Green	One amber indicator, all other indicators Green
Amber	All other combinations

The Board Assurance Framework shows key workforce indicators in the context of current performance, performance 12 months and 3 months ago, Trust workforce targets, the distance to these targets and a RAG rating based on 5 scales. It also has benchmarking data taken from NHS healthcare providers in the Hertfordshire and Essex and Bedford, Luton and Milton Keynes STPs.

The RAG rating is based on distance to targets – if current performance is within 0% to 20% (or exceeds) its target then the RAG rating is green. If performance is within 60% – 80% of target then the rating is yellow. This is repeated at 20% intervals for amber and brown until performance is over 80% from the target when the RAG rating is red. If 2 indicators are rated red, then the overall rating is red. If all indicators are rated green, or one is amber then the overall rating is green. Any other combination is amber.

There are 7 indicators rated Green, with performance of 80% or over towards targets. There are 2 indicators that are within 60% to 80% of the target. Vacancies are within 40% - 60% of target, here the Trusts establishment has increased slightly at the start of the financial year and this has meant an increase in current vacancies, although the percentage rates are still lower than February. For appraisals, HRBP's are currently implementing a plan with the Divisions to ensure that the 95% is achieved. Turnover rates have maintained the current level over the last 12 months.

West Hertfordshire Hospitals NHS Trust

Safe, effective, caring

Well led

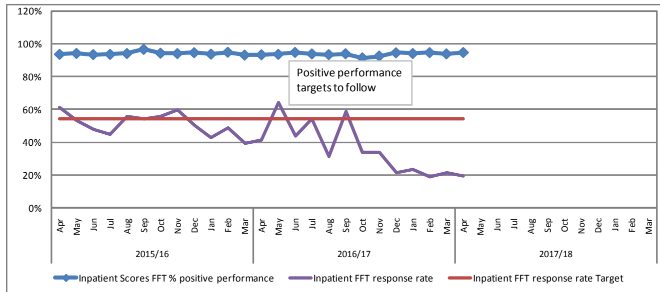
Reporting sub committees - PSQ and Workforce

Friends and family

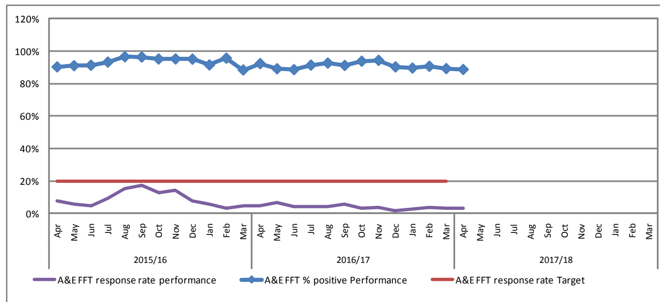
Executive lead	Clinical lead	Operational lead
Tracey Carter and Paul Da Gama		

Well led	Achieving		Not achieving	
Apr-17	0		3	
Mar-17	0		3	
Feb-17	0		3	

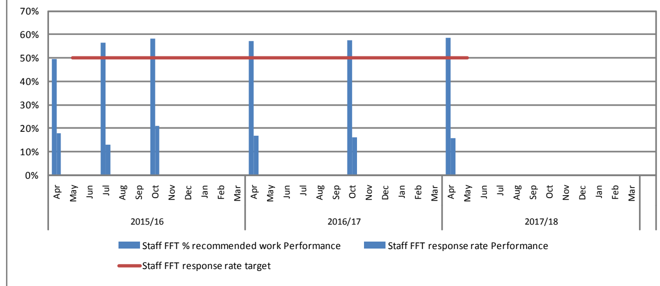
Inpatient scores (% positive and negative) and response rate



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



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



Inpatients

The overall response rate has decreased by 2.8% this month and the rate of positive response is 95.4%. The rate of negative responses has increased by 0.4% to 1.4%.

A&E

The response rate has remained the same this month however the positive response rate has reduced by 0.5% and the negative rate has reduced by 3.3% so a significant improvement. In order to understand the A&E patient experience 'first hand' and as part of the patient experience strategy actions a focus group is being planned. A free month of a text messaging service is being planned to be trialled for AE.

Maternity - Question 2

The rate of response has increased by 10% this month .
The positive rate of response was 93.5% which is a 3.9% decrease on last month.
The negative rate of response was less than 1.0% this month.

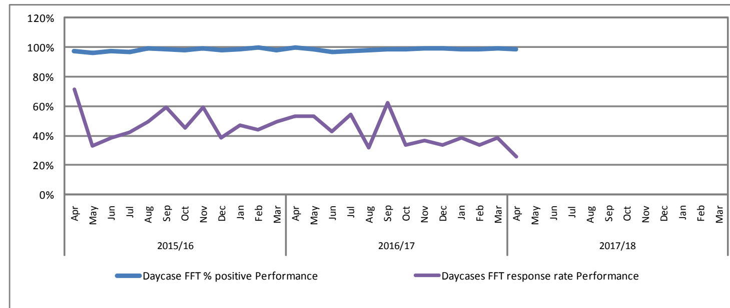
Staff

The next staff friends and family test will run at the end of June 2017.
The Staff Friends and Family Test ran from the 20 February to 10 March. There were 335 electronic (e-mail) returns and 395 paper (hard copy) returns, a total of 730 (20%).

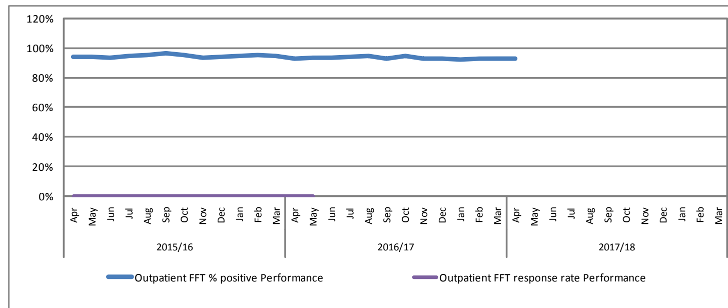
Question	Extremely Likely	Likely	Neither	Unlikely	Extremely Unlikely	Total	Engagement Score
Q1. How likely are you to recommend this Trust to friends and family if they needed care or treatment?	129	352	158	58	25	722	3.70
Q3. How likely are you to recommend this Trust to friends and family as a place to work?	106	321	161	93	42	723	3.49
Q5. I am able to do my job to a standard I am personally pleased with?	146	372	100	100	10	728	3.75
Q6. My manager asked for my opinion before making decisions which affect my work?	144	291	162	93	38	728	3.56
Q7. Over the last month I have felt that day to day issues which cause frustration and get the the way of me doing my job are resolved?	53	264	195	172	45	729	3.15
Q8. I generally feel well informed about what's going on within the Trust	94	345	174	89	30	732	3.52
Q9. I generally feel well informed about what's going on in my local place of work	119	363	134	87	28	731	3.63
Q10. I feel proud to work for WHHT	147	352	181	35	16	731	3.79
Q11. I feel proud to work within my local place of work	196	355	136	37	9	733	3.94

West Hertfordshire Hospitals NHS Trust

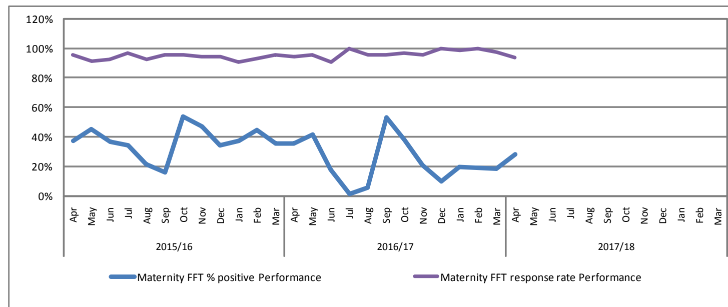
Daycases scores (% positive and negative) and response rate



Outpatient scores (% positive and negative) and response rate



Maternity (Q2) scores (% positive and negative) and response rate



Day case
The Trust is now measuring both the main DSU at SACH and also the Surgical admission lounge at WGH.

Outpatients
The total number of responses has decreased slightly on last month at 931 (March was 1100).
The positive response rate is largely unchanged at 92.7% but the negative response rate has increased by 0.6% to 2.4%.

Ward Scorecard April 2017

Division	Ward	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 accquired MRSA isolate	% Extremely Likely>90	FFT 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	Overall Fill Rate	Care hours per patient	Number of Alerts: Safety	Number of Alerts: Process
Alert Trigger Point		<90%	<90%	<90%	<90%	>0	>4	>0	<90%	<90%	>0	>0	<90%	<54%	>0	>1	<90%	<95%	n/a		
Number of Alerts	Process	8 / 27	3 / 27	6 / 34	6 / 29				1 / 26	5 / 32				30 / 34		30 / 33	21 / 28	9 / 29	n/a		
	Safety					10 / 36	8 / 30	14 / 30			1 / 37	1 / 36	11 / 36		0 / 33						
Unscheduled Care	AAU B/Y 3	! 87%	✓ 96%	✓ 94%	✓ 91%	✗ 8	✗ 13	✗ 3	✓ 100%	✓ 100%	✓ 0	✓ 0	✓ 100%	✗ 38%	✓ 0	✗ 27	✗ 45%	✓ 98%	7.45	3	4
	AAU B1	! 82%	✓ 93%	! 84%	✗ 67%	✓ 0	! 3	✓ 0	✓ 100%	✓ 100%	✓ 0	✓ 0	✓ 100%	✗ 14%	✓ 0	✗ 14	✓ 105%	✓ 96%	8.70	0	5
	AAU G1	! 88%	! 89%	✓ 94%	! 84%	✓ 0	! 3	✗ 1	✓ 100%	! 84%	✓ 0	✓ 0	✓ 95%	✗ 19%	✓ 0	✗ 3	! 75%	✓ 97%	8.02	1	7
	AAU P1	✓ 90%	✓ 93%	✓ 94%	✓ 91%	✓ 0	! 2	✓ 0	✓ 100%	! 84%	✓ 0	✓ 0	✓ 100%	✗ 2%	✓ 0	✗ 15	✗ 55%	! 94%	9.54	0	5
	AAU Y1	✓ 93%	✓ 90%	✓ 91%	✓ 96%	✓ 0	! 1	✓ 0	✓ 100%	ND	✓ 0	✓ 0	✓ 100%	✗ 11%	✓ 0	✗ 8	✗ 58%	! 94%	8.10	0	4
	CCU/ P/G 3	✓ 94%	✓ 100%	✓ 99%	✓ 100%	✓ 0	! 4	✗ 2	✓ 100%	✓ 100%	✓ 0	✓ 0	✓ 97%	✗ 45%	✓ 0	✗ 13	✓ 90%	✓ 99%	6.98	1	2
	A&E	✓ 91%	! 87%	✗ 70%	NA	✓ 0	! 3	✓ 0	✓ 100%	✓ 100%	✓ 0	✓ 0	! 85%	✗ 2%	✓ 0	✗ 2	NA	NA	NA	1	4
	MIU	not done	not done	✓ 95%	NA	✓ 0	✓ 0	✓ 0	NA	NA	✓ 0	✓ 0	✗ 63%	✗ 1%	✓ 0	✓ 0	NA	NA	NA	1	1
	UCC	not done	not done	✓ 95%	NA	✓ 0	✓ 0	✓ 0	NA	NA	✓ 0	✓ 0	✓ 91%	✗ 6%	✓ 0	✓ 0	NA	NA	NA	0	1
	Frailty	not done	not done	✓ 99%	✓ 100%	✓ 0	✓ 0	✓ 0	NA	✓ 100%	✓ 0	✓ 0	✓ 100%	✓ 100%	NA	NA	NA	NA	NA	0	0
Medicine	Aldenham	✓ 94%	✓ 100%	✓ 99%	✓ 99%	✗ 1	! 1	✗ 1	✓ 100%	✓ 95%	✓ 0	✓ 0	✓ 94%	✗ 32%	✓ 0	✗ 21	✗ 65%	✓ 96%	6.30	2	3
	Bluebell	✗ 76%	✓ 98%	✓ 90%	✓ 92%	✓ 0	✗ 12	✗ 2	✓ 100%	✓ 100%	✓ 0	✓ 0	✗ 67%	✗ 14%	✓ 0	✗ 58	✗ 60%	✓ 98%	11.83	3	4
	Cassio	✓ 96%	✓ 100%	✓ 97%	✓ 100%	✓ 0	✗ 6	✓ 0	✓ 100%	✓ 100%	✓ 0	✓ 0	! 88%	✓ 60%	✓ 0	✗ 14	✗ 60%	✓ 99%	5.46	2	2
	Croxley	✓ 94%	✓ 95%	✓ 93%	✓ 94%	✗ 1	! 2	✗ 2	✓ 100%	✓ 100%	✓ 0	✓ 0	✗ 0%	✗ 2%	✓ 0	✗ 2	! 80%	✓ 111%	7.37	3	3
	Heronsgate & Gade	✓ 93%	✓ 94%	✓ 94%	✓ 92%	✗ 2	✗ 10	✗ 2	✓ 100%	✓ 96%	✓ 0	✗ 1	✓ 94%	✗ 35%	✓ 0	✗ 14	✓ 114%	NA	NA	4	2
	Oxhey	! 88%	✓ 99%	✓ 98%	✓ 99%	✗ 1	! 2	✓ 0	✓ 100%	✓ 100%	✓ 0	✓ 0	✓ 100%	✗ 24%	✓ 0	✓ 0	! 85%	✓ 116%	9.30	1	3
	Red	! 88%	✓ 93%	✓ 98%	✓ 100%	✓ 0	! 3	✗ 1	✓ 100%	✓ 100%	✓ 0	✓ 0	! 89%	✓ 54%	✓ 0	✗ 3	✗ 60%	✓ 122%	7.47	2	3
	Sarratt	✓ 91%	✓ 100%	✓ 91%	! 80%	✗ 1	! 4	✗ 1	✗ 78%	✓ 100%	✓ 0	✓ 0	✓ 100%	✗ 16%	✓ 0	✗ 4	✓ 130%	✓ 105%	6.91	2	4
	Simpson	✓ 95%	✓ 97%	✓ 91%	! 84%	✓ 0	✗ 6	✗ 2	NA	✓ 100%	✓ 0	✓ 0	! 89%	✗ 46%	✓ 0	✗ 11	! 83%	✓ 104%	6.12	3	4
	Stroke	✓ 96%	✓ 97%	✓ 98%	✓ 100%	✗ 2	✗ 5	✓ 0	✓ 100%	! 85%	✗ 1	✓ 0	✓ 92%	✗ 32%	✓ 0	✗ 8	✓ 90%	✓ 102%	7.77	3	3
	Tudor	! 88%	✓ 98%	✗ 65%	✗ 42%	✗ 1	✗ 6	✗ 2	✓ 100%	! 82%	✓ 0	✓ 0	! 89%	✗ 11%	✓ 0	✗ 17	✓ 96%	✓ 102%	7.10	4	6
	Winyard	! 85%	✓ 93%	! 86%	✓ 96%	✓ 0	! 4	✓ 0	✓ 100%	✓ 100%	✓ 0	✓ 0	✓ 100%	✗ 47%	✓ 0	✗ 4	✗ 48%	✓ 133%	8.15	0	5
Surgery	Cleves	✓ 98%	✓ 100%	✓ 97%	✓ 97%	✓ 0	! 1	✓ 0	✓ 100%	✓ 100%	✓ 0	✓ 0	! 87%	✗ 36%	✓ 0	✗ 15	! 85%	✓ 100%	6.13	1	3
	DLM	✓ 95%	! 82%	✓ 98%	! 84%	✗ 1	! 1	✓ 0	NA	✓ 95%	✓ 0	✓ 0	✓ 100%	✗ 36%	✓ 0	✗ 46	✗ 50%	✗ 88%	12.40	1	6
	Flaunden	✓ 100%	✓ 99%	✓ 96%	✓ 100%	✓ 0	✗ 5	✗ 1	✓ 100%	✓ 97%	✓ 0	✓ 0	! 89%	! 51%	✓ 0	✗ 16	✗ 38%	! 92%	4.83	3	4
	ICU	✓ 99%	✓ 99%	✓ 98%	✓ 100%	✓ 0	! 1	✓ 0	✓ 100%	✓ 100%	✓ 0	✓ 0	✓ 100%	✓ 200%	✓ 0	✗ 28	✓ 100%	✓ 95%	21.84	0	1
	Langley	✓ 98%	✓ 100%	✓ 99%	✓ 100%	✓ 0	✓ 0	✓ 0	✓ 100%	✗ 69%	✓ 0	✓ 0	✓ 92%	✗ 31%	✓ 0	✗ 16	! 88%	✓ 101%	5.95	0	4
	Letchmore	✓ 99%	✓ 100%	✓ 97%	✓ 94%	✓ 0	! 4	✗ 1	✓ 100%	✓ 100%	✓ 0	✓ 0	✓ 92%	✗ 31%	✓ 0	✗ 8	✗ 65%	✓ 112%	5.76	1	3
	Ridge	✓ 97%	✓ 99%	✓ 93%	✓ 100%	✗ 1	! 3	✗ 1	✓ 100%	✓ 100%	✓ 0	✓ 0	✓ 100%	✗ 46%	✓ 0	✗ 17	✗ 25%	! 92%	5.66	2	4
	Elizabeth	✓ 94%	✓ 100%	✓ 98%	✓ 100%	✓ 0	! 1	✓ 0	✓ 100%	✓ 100%	✓ 0	✓ 0	! 87%	✗ 21%	✓ 0	✗ 17	✗ 55%	✓ 98%	5.53	1	3
Paeds	SCBU	not done	not done	✓ 91%	✓ 100%	✓ 0	NA	NA	NA	✓ 100%	✓ 0	✓ 0	✓ 100%	✗ 14%	✓ 0	✗ 42	NA	✗ 78%	11.42	0	3
	Starfish	not done	not done	! 86%	✓ 100%	✓ 0	NA	NA	✓ 100%	✓ 100%	✓ 0	✓ 0	✓ 96%	✗ 9%	✓ 0	✗ 7	✗ 68%	✗ 90%	9.02	0	5
	CED	not done	not done	✓ 95%	NA	✓ 0	NA	NA	NA	✓ 100%	✓ 0	✓ 0	✓ 91%	✗ 2%	✓ 0	✗ 28	NA	NA	NA	0	2
	Safari	not done	not done	not done	NA	✓ 0	NA	NA	NA	✓ 100%	✓ 0	✓ 0	✓ 100%	✗ 15%	✓ 0	✗ 7	✗ 68%	NA	NA	0	3
Maternity	Delivery Suite	not done	not done	not done	NA	✓ 0	NA	NA	NA	✓ 100%	✓ 0	✓ 0	✓ 90%	NA	NA	NA	NA	✗ 90%	29.48	0	1
	Katherine	not done	not done	! 86%	NA	✓ 0	NA	NA	NA	NA	NA	NA	✓ 94%	NA	NA	NA	NA	✗ 85%	5.49	0	2
Green		>=90	>=90	>=90	>=90	0	0	0	>=90	>=90	0	0	>=90	>=54	0	0	>=90	>=95	n/a		
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	90-94	n/a		
Red		<=79	<=79	<=79	<=79	>=1	>=5	>=1	<=79	<=79	>=1	>=1	<=79	<=49	>=2	>=1	<=74	<=89	n/a		

West Hertfordshire Hospitals NHS Trust

Ward Scorecard (Other/ Non Adult Inpatient) April 2017

Division	Ward	TYC Overall	TYC/TVN section	Pressure Ulcers	No. of Falls	Falls with Harms	Commode Audit	Hand Hygiene Audit	Hospital accquired C.diff	Hopsital accquired MRSA isolate	% Extremely Likely>90	FFT 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	Overall Fill Rate	Care hours per patient	Number of Alerts: Safety	Number of Alerts: Process
Alert Trigger Point		<90%	<90%	>0	>4	>0	<90%	<90%	>0	>0	<90%	<54%	>0	>1	<90%	<95%	n/a		
Number of Alerts	Process	6 / 25	0 / 2				0 / 3	0 / 11				7 / 7		5 / 7	2 / 2	4 / 4	n/a		
	Safety			0 / 9	0 / 3	0 / 3			0 / 27	0 / 27	4 / 25		0 / 7						
Unscheduled Care	A&E	✗ 70%	NA	✓ 0	! 3	✓ 0	✗ 100%	✓ 100%	✓ 0	✓ 0	! 85%	✗ 2%	✓ 0	✗ 2	NA	NA	NA	1	4
	MIU	✓ 95%	NA	✓ 0	✓ 0	✓ 0	NA	NA	✓ 0	✓ 0	✗ 63%	✗ 1%	✓ 0	✓ 0	NA	NA	NA	1	1
	UCC	✓ 95%	NA	✓ 0	✓ 0	✓ 0	NA	NA	✓ 0	✓ 0	✓ 91%	✗ 6%	✓ 0	✓ 0	NA	NA	NA	0	1
Paeds	SCBU	✓ 91%	✓ 100%	✓ 0	NA	NA	NA	✓ 100%	✓ 0	✓ 0	✓ 100%	✗ 14%	✓ 0	✗ 42	NA	✗ 78%	11.42	0	3
	Starfish	✓ 86%	✓ 100%	✓ 0	NA	NA	✓ 100%	✓ 100%	✓ 0	✓ 0	✓ 96%	✗ 9%	✓ 0	✗ 7	✗ 68%	✗ 90%	9.02	0	5
	CED	✓ 95%	NA	✓ 0	NA	NA	NA	✓ 100%	✓ 0	✓ 0	✓ 91%	✗ 2%	✓ 0	✗ 28	NA	NA	NA	0	2
	Safari	not done	NA	✓ 0	NA	NA	NA	✓ 100%	✓ 0	✓ 0	✓ 100%	✗ 15%	✓ 0	✗ 7	✗ 68%	NA	NA	0	3
Maternity	Delivery Suite	not done	NA	✓ 0	NA	NA	NA	✓ 100%	✓ 0	✓ 0	✓ 90%	NA	NA	NA	NA	✗ 90%	29.48	0	1
	Katherine	✓ 86%	NA	✓ 0	NA	NA	NA	NA	NA	NA	✓ 94%	NA	NA	NA	NA	✗ 85%	5.49	0	2
	Community	✗ 67%	NA	NA	NA	NA	NA	NA	✓ 0	✓ 0	✓ 100%	NA	NA	NA	NA	NA	NA	0	1
	ABC	✓ 93%	NA	NA	NA	NA	NA	✓ 100%	✓ 0	✓ 0	NA	NA	NA	NA	NA	NA	NA	0	0
clinical support	Radiology WGH	✓ 96%	NA	NA	NA	NA	NA	NA	✓ 0	✓ 0	✓ 100%	NA	NA	NA	NA	NA	NA	0	0
	Radiology HHGH	✓ 100%	NA	NA	NA	NA	NA	NA	✓ 0	✓ 0	✗ 75%	NA	NA	NA	NA	NA	NA	1	0
	Radiology SACH	✓ 100%	NA	NA	NA	NA	NA	NA	✓ 0	✓ 0	✓ 92%	NA	NA	NA	NA	NA	NA	0	0
	Radiology AAU	not done	NA	NA	NA	NA	NA	NA	✓ 0	✓ 0	NA	NA	NA	NA	NA	NA	NA	0	0
Medicine	Outpatient WGH	✓ 100%	NA	NA	NA	NA	NA	NA	✓ 0	✓ 0	✓ 100%	NA	NA	NA	NA	NA	NA	0	0
	Outpatient SACH	! 83%	NA	NA	NA	NA	NA	NA	✓ 0	✓ 0	✓ 91%	NA	NA	NA	NA	NA	NA	0	1
	Outpatient HHGH	✓ 98%	NA	NA	NA	NA	NA	NA	✓ 0	✓ 0	✓ 91%	NA	NA	NA	NA	NA	NA	0	0
	Endoscopy HHGH	✓ 92%	NA	NA	NA	NA	NA	✓ 100%	✓ 0	✓ 0	✓ 100%	NA	NA	NA	NA	NA	NA	0	0
	Endoscopy WGH	! 89%	NA	NA	NA	NA	NA	✓ 100%	✓ 0	✓ 0	✓ 100%	NA	NA	NA	NA	NA	NA	0	1
	Cath lab WGH	✓ 98%	NA	NA	NA	NA	✓ 100%	✓ 100%	✓ 0	✓ 0	✓ 97%	NA	NA	NA	NA	NA	NA	0	0
	Dermatology WGH	not done	NA	NA	NA	NA	NA	NA	✓ 0	✓ 0	✓ 100%	NA	NA	NA	NA	NA	NA	0	0
	Dermatology SACH	not done	NA	NA	NA	NA	NA	NA	✓ 0	✓ 0	✓ 100%	NA	NA	NA	NA	NA	NA	0	0
	Dermatology HHGH	not done	NA	NA	NA	NA	NA	NA	✓ 0	✓ 0	✓ 94%	NA	NA	NA	NA	NA	NA	0	0
	Helen Donald WGH	✓ 98%	NA	NA	NA	NA	NA	NA	✓ 0	✓ 0	NA	NA	NA	NA	NA	NA	NA	0	0
Surgery	Day surgery SACH	not done	NA	NA	NA	NA	NA	✓ 100%	✓ 0	✓ 0	✓ 99%	NA	NA	NA	NA	NA	NA	0	0
	Opthalmology WGH	✓ 95%	NA	NA	NA	NA	NA	NA	✓ 0	✓ 0	✓ 100%	NA	NA	NA	NA	NA	NA	0	0
	Pre Op HHGH	✓ 94%	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	0	0
	Theatres WGH	✓ 95%	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	0	0
	Theatres SACH	✓ 97%	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	0	0
	Theatres Delivery WGH	✓ 94%	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	0	0
	Pre Op WGH	✓ 100%	NA	NA	NA	NA	NA	NA	✓ 0	✓ 0	! 88%	NA	NA	NA	NA	NA	NA	1	0
Green		>=90	>=90	0	0	0	>=90	>=90	0	0	>=90	>=54	0	0	>=90	>=95	n/a		
Amber		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	90-94	n/a		
Red		<=79	<=79	>=1	>=5	>=1	<=79	<=79	>=1	>=1	<=79	<=49	>=2	>=1	<=74	<=89	n/a		

West Hertfordshire Hospitals NHS Trust

Ward Scorecard

The ward score card is now being ranked by Safety and Process measures . Safety measures being taken as the leading indicator

April 2017 Data
Scorecard weighting is separated into process (documentation) and safety (harm free care).

Adult Clinical areas-
- 1st ICU 0 safety and 1 process measures
- 2nd Langley and AAU Y1 - 0 safety and 4 process measures
- 3rd AAUB1 and AAUP1 0 safety and 5 process measures

Paediatric areas-
- All areas have 0 safety measures .

Adult / Maternity areas-
- 10 Clinical areas had 0 safety triggers for April 2017
- 9 have 1 safety trigger.

TYC Indicators Adult wards : April 17

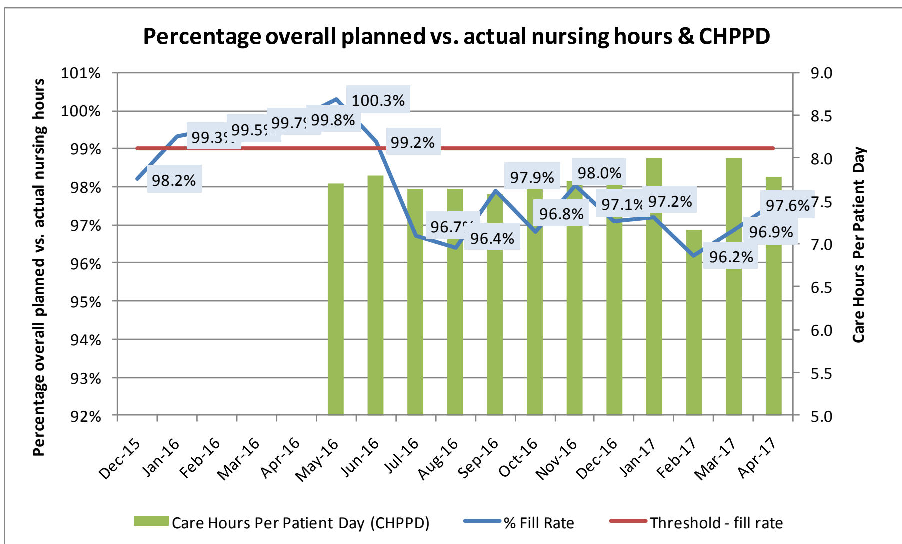
- 8 indicators are green for April (above 90%)
- 1 Amber – Nutrition at 85%
- Overall April results for adult inpatient wards is at 93 % .
- 23 out of 25 ward areas are above 90% for the overall Test Your Care scores.

Wards triggering 2 safety alerts, and if the total of safety and process alerts are greater than 7
- **Tudor - 4 safety and 6 process measures.** Safety measures: 1 pressure ulcer grade 2, 6 falls (2 with low harm), low Friends and Family extremely likely response rate for FFT. Process alerts: low overall TYC results , TVN section of TYC, Matron Quality checks for patients, hand hygiene audit , FFT response rate and 17 Red Flag shifts less than 8 hours RN planned.
- **Gade and Heronsgate- 4 safety and 2 process measures. S**afety measures: 2 pressure ulcer grade 2, 10 falls (2 with low harm), 1 Hospital acquired MRSA isolate Process measures low FFT response rate, 14 red flags .
- **AAUBY3-3 safety and 4 process measures.** Safety measures: 8 pressure ulcer all 2 grade 2, 13 falls ,2 with low harm and 1 severe harm. Process measures: low Matron Quality Patient checks, FFT response rate, 27 red flag shifts less than 8 hours RN planned and 45% of supervisory hours.
- **Flaunden - 3 safety and 4 process measures.** Safety measures: 5 falls ,1 with with low harm, low Friends and Family extremely likely response rate for FFT. Process alerts: FFT response rate and 16 Red Flag shifts less than 8 hours RN planned, 38% of supervisory hours. and overall fill rate .
- **Bluebell - 3 safety and 4 process measures.** Safety measures: 12 falls , 1with low harm,1 with medium harm . low Friends and Family extremely likely response rate for FFT. Process alerts: low Matron Checks – patients , FFT response rate, 58 Red Flag shifts less than 8 hours RN planned 60% percentage of supervisory hours.
- **Simpson - 3 safety and 4 process measures.** Safety measures: 6 falls , 2 with low harm, low Friends and Family extremely likely response rate for FFT. Process alerts: low Test Your Care TVN section , FFT response rate, 11 Red Flag shifts less than 8 hours RN planned 83% percentage of supervisory hours
- **Croxley Ward -3 safety and 3 process measures.** Safety measures: 1 pressure ulcer grade 2, 2 falls all with low harm , low Friends and Family extremely likely response rate for FFT. Process measures:, low FFT response rate ,2 Red Flag shifts less than 8 hours RN planned and 80% of supervisory hours
- **Stroke -3 safety and 3 process measures.** Safety measures: 2 pressure ulcer grade 2, 5 falls all no harm , 1 Hospital acquired C Diff . Process measures:, low hand hygiene audit. low FFT response rate ,8 Red Flag shifts less than 8 hours RN planned.
- **Sarratt- 2 safety & 4 process measures**. Safety measures: 1 pressure ulcers grade 2, 4 falls 1 with low harm. Process alerts : low Test Your Care TVN section, low commode audit ,low FFT response rate, 4 Red Flag shifts less than 8 hours RN planned.
- **Ridge- 2 safety and 4 process measures.** Safety measures: 1 Pressure ulcer grade 2, 1 fall with low harm. Process alerts: low section FFT response rate and 17Red Flag shifts less than 8 hours RN planned, 25% of supervisory hours. and overall fill rate .
- **Red Suite-2 safety and 3 process measures.** Safety measures: 3 fall s, 1 with low harm, low Friends and Family extremely likely response rate for FFT. Process alerts: Low Matrons quality checks patients, 3 Red Flag shifts less than 8 hours RN planned, 60% of supervisory hours..
- **Aldenham - 2 safety and 3 process measures.** Safety measures: 1 pressure ulcer grade 2 ,1 fall with low harm. Process measures: low FFT response rate, 21 red flags and 65% supervisory hours
- **Cassio –2 safety and 2 process measures**. Safety measures: 5 falls all with no harm, low Friends and Family extremely likely response rate for FFT. Process measures : 14 Red Flag shifts less than 8 hours RN planned and 60% supervisory hours
- **DLM- 1 safety and 6 process measures.** Safety measures: 1 Pressure ulcer grade 2. Process alerts: low matron quality checks for staff, low Test Your care TVN section FFT response rate and 46 Red Flag shifts less than 8 hours RN planned, 50% of supervisory hours. and overall fill rate .
- **AAUG1 -1 safety and 7 process measures. Safety measures: 1 Fall with low harm .** Process measures: low Matron Quality Patient and staff checks, TYC TVN section, LOW Hand Hygiene audit, FFT response rate, 3 red flag shifts less than 8 hours RN planned and 75% of supervisory hours.
- **The majority of Process measures are related to staffing** – shifts less than 8 hours planned but this is mitigated on a daily basis to ensure wards are safe. There is not a strong correlation between number of red flag shifts and safety measures.
- **Improved from March 2017 data** – Winyard , Cleves, AAUP1

Action
- Reinforcing Safety huddles to cover harms, deteriorating patients and issues with medicines.
- Developing a record book for Safety Huddles
- Ward Accreditation Tool being launched in 2017.
- Competencies being aligned with Ward Accreditation and gaps identified in learning
- Reinforcing Safety Huddles to be undertaken immediately post Grade 3 Pressure damage notification to establish root causes
- Reviewing availability of e-learning nutritional tools
- Focus on Harm Free care by the specialist nurses using Mr B Harmfree
- New slipper socks for falls prevention
- Once a month 'Harm Free Friday' – specialist nurses visiting clinical areas.
- Ward Scorecard being developed further to match process and outcome measures.
- Developing more Champion roles – such as Falls, Safeguarding, Patient Experience. Study dates planned.
- Trust Improvement plan submitted as part of the national Pressure Ulcer programme being launched by NHSI.
- Trust action plan around the Deteriorating Patient Alert .
- Electronic Observations being scoped
- Easter Harm Free Care Quiz on medicine management undertaken.
- NEWs Training and e learning tool being driven – recorded on E roster.
- Quality data being taken to 12:30 bed meeting to review post 24 hours such as Pressure ulcers, falls, - trial – 23rd May 2017. This is a lead up to safe Care module.

Safer staffing

Indicator	Performance (April)	Threshold	Trend	Forecast next month
% Nursing hours versus planned	97.6%	>95%	Up	>99%
Care hours per patient day	7.8	n/a	Down	7.2



Indicator by shift and skill mix	Shift	RN	Care staff
% Nursing hours versus planned	Day	88.0%	109.6%
	Night	93.8%	112.4%
Care hours per patient day	All	4.8	3.0

What actions have been taken to improve performance

- Enhanced care needs team commenced in May 2017
- Local and international recruitment initiatives continue.
- Use of Bank/Agency to cover surge areas
- Shared bank approach across four Trusts to commence 1st July.

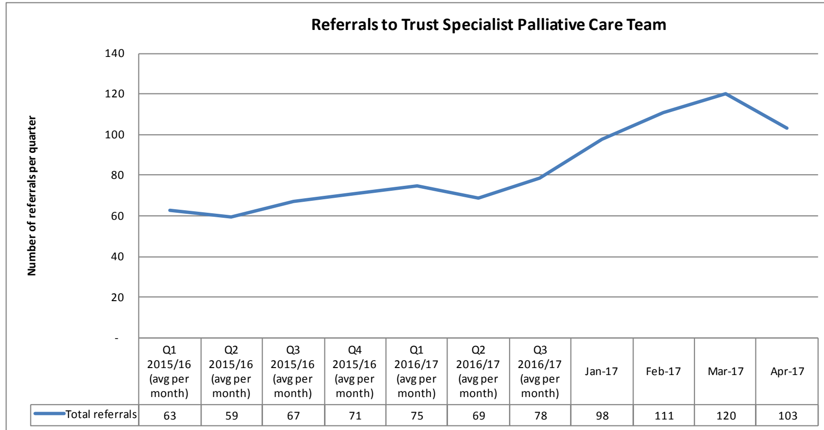
What is causing the variance

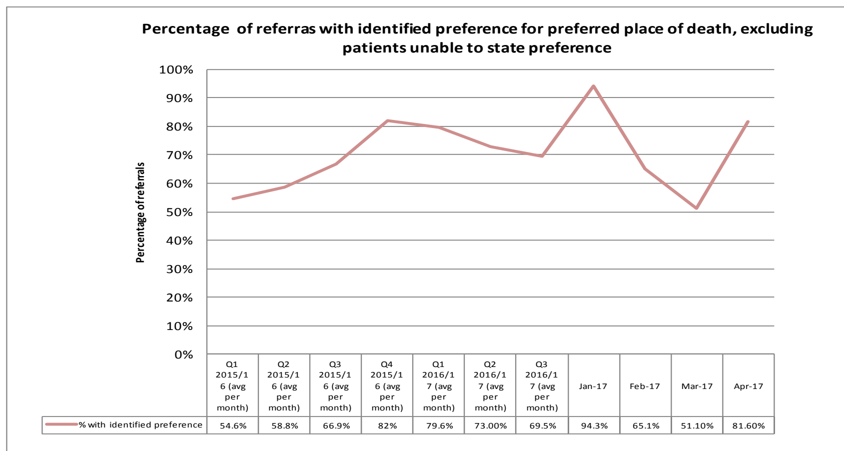
Overall the Trust % fill rate for April was 97.9% which showed a 0.7 % increase from last month but continues to remain above the threshold of 95%. Designated surge areas continue to be open due to demand. RN day fill rates during the day show a further decrease from last month now showing at 88 %, 0.3% less than last month; and 5% less than December 2016. RN night fill rates showed a decrease of 1.5% from last month. There is a low RN fill rates in some areas such as De La Mare, Blue Bell and AAU level 1 Blue and Yellow. Fill rates for HCAs shows an increase of 3.1% by day and 4.2% at night compared to last month. The continued usage of above percentage fill rates for HCAs is due to patients with enhanced care needs and escorts. In addition to cover patient care on Simpson ward following increase of beds from 18 to 21. When the fill rate is lower than planned, support staff, supervisory sisters and senior staff continue to be deployed to maintain safe staffing levels. In addition this has been supported by corporate nursing weekly visits on Mondays to surge areas to support matrons and HONs in reviewing patient safety and quality. Maternity fill rates remain low but no red shifts reported. The monthly workforce meetings with ward managers, matrons and HONs to review KPI's and rostering continues. The overall Trust supervisory hours lost in April was 23.5% equates to an increase of1.6 % compared to last month – Breakdown per area, Unscheduled care – 22.6% (decrease 4.4%), Surgery 25.4% (increase 11.7%) , Women and Children's 20% (increase 6.8%). The number of RAG Rated Green 86.2% increase 0.1% from last month, Amber 13.8% remains the same and Red 0 %. There were no red flags for the month. CHPPD are reviewed monthly and adjustments have been made to Tudor /Castle to incorporate all patients in the ward area and De La Mare/Beckett recognising this is an inpatient/day surgery ward following a review of national guidance. Bluebell as a dual frailty unit remains at 11.8 above the normal range. CHPPD as a staffing indicator is being used in the adult inpatient establishment reviews.

West Hertfordshire Hospitals NHS Trust

End of Life Care

Number of patients who are referred to the palliative care team and who have an identified preferred place of death





What actions have been taken to improve performance

• In 2008, the End of Life Care Strategy (Department of Health) was published and one of the insights from this was that people weren't supported to die in their place of choice; and although progress has been made this has been evidenced in many other reports. In July 2014 just over 50% of respondents to the National Survey of Bereaved People (VOICES-SF) felt that their relative had died in a place of their choice (Office of National Statistics, 2014).There is now a national focus on reducing the numbers of patients dying in hospital and offering everyone who is approaching the end of their life the opportunity to express and share their preference for where they want to die as well as any goals that are important to them (National Palliative and End of Life Care Partnership, 2015).

In April , the number of referrals to the Trust Specialist Palliative Care Team was 103 and the number of patients seen by The Specialist Palliative Care Team with an identified preferred place of death (PPD) was 44 out of the 49 patients who had capacity and were appropriate to have this discussion, equating to 81.6%.

Trust data quality, by exception

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

Domain	Indicator	Data Quality RAG	Description of issues	Improvement action plan	Target date for 'Green' rating
Safe, Effective, Caring	Discharges between 8am and 12pm* (main adult wards excl AAU)	A			
Safe, Effective, Caring	% Complaints responded to within one month or agreed timescales with complainant	R	Operational and clinical pressures has meant it has been challenging to find the time for clinical and operational staff to respond to concerns on time.	The Unscheduled Care Division are recruiting a 0.5 WTE position to assist clearing the backlog. The team are recruiting a new complaints manager and have approach NHSP and agencies to fill the vacancy. The Surgery Division has held a complaints workshop to address backlog. The same will be done in Unscheduled Care. The Women and Children's Division are recruiting a post to deal with complaints. The Environment and Medicines Division have improved their response times considerably.	Recruitment expected to be completed by end of Summer. Improvements are hoped to be seen by end of 2017.
Safe, Effective, Caring	Complaints - rate per 10,000 bed days	R	Capturing complaints across the Trust.	All complaints are captured and triaged daily. All complaints are logged daily and there are systems in place to capture all complaints received through the CEO, executive assistants, through NHS net and on social media. Reminders are sent to all staff about forwarding complaints received in clinical areas. There is a system for auditing all new complaints taken through triage on the following day.	This risk is being minimised as much as possible.
Safe, Effective, Caring	Reactivated complaints	R	Increase in reactivated complaints	We telephone every reactivated complaint to talk through concerns. We consider if someone independent needs to investigate. We send reactivated complaints to external investigators in complex cases. We invite complainants to meetings to discuss their concerns. We now record the reason for reactivated complaints and will audit this. We have asked Healthwath Hertfordshire to review a pool of complaints and provide feedback. We will ask that they include a small pool of reactivated complaints also.	This risk is being minimised as much as possible.
Safe, Effective, Caring	Serious incidents - number*	A			
Safe, Effective, Caring	Serious incidents - % that are harmful*	A			
Safe, Effective, Caring	% of patients safety incidents which are harmful*	A			
Safe, Effective, Caring	Medication errors causing serious harm *	A			
Safe, Effective, Caring	CAS Alerts: Number issued each month	A			
Safe, Effective, Caring	CAS alerts not acknowledged within 48 hours	A			
Safe, Effective, Caring	Hospital Acquired Pressure Ulcers - Grade 3	A			
Safe, Effective, Caring	Number of Falls*	A			
Safe, Effective, Caring	VTE risk assessment*	A	Paper based VTE forms used for assessing compliance by clinical coding team. Evidence elsewhere within notes demonstrating compliance not on form not previously identified.	Clinical Advisory Group has approved new process for coding team to assess VTE compliance. Electronic system required to improve compliance to green.	July 2017 (Amber). Electronic system date of implementation TBC (for Green)
Safe, Effective, Caring	Caesarean Section rate - Combined*	A	Perception that there is a difference between caesarean section rate on CMiS compared to what has been clinically coded	Review of clinically coded notes and comparison to CMiS to review discrepancies	July 2017
Safe, Effective, Caring	Caesarean Section rate - Emergency*	A	As above	As above	As above
Safe, Effective, Caring	Caesarean Section rate - Elective*	A	As above	As above	As above
Safe, Effective, Caring	Stroke patients spending 90% of their time on stroke unit *	A			
Responsive	Ambulance turnaround time between 30 and 60 mins	R	Identified inaccuracies in timing of Ambulance Service data	Ongoing work with ambulance service	TBA
Responsive	Ambulance turnaround time > 60 mins	R	As above	Ongoing work with ambulance service	TBA
Well Led	Sickness rate	A	1. Potential for under reporting 2. There can be issues with data recorded on ESR but this will be fixed with the implementation of the new ESR 2 system.	1. HR undertook a number of audits to look into areas who were reporting 0% sickness throughout 2016 and have implemented learning from those audits, including a new process for capturing absences if medical staff. 2. implementation of the new ESR 2 system.	September 2017 (linked to the ESR implementation). There will also be ongoing audits to ensure that absence data is still being accurately recorded