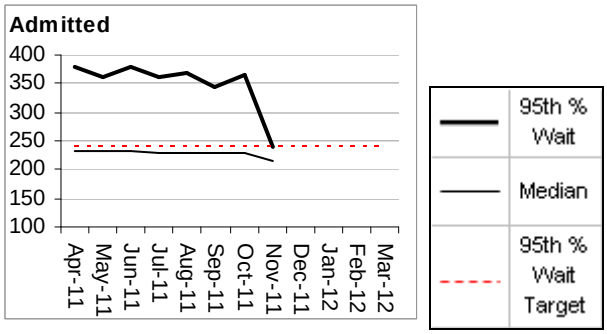
PERFORMANCE & QIPP DASHBOARD COMMENTARY November 2011

1. National Targets- Red/Amber Ratings & Action Plans

Indicator: Total Time in ED for admitted patients- ICAM

Target: 95th percentile to be less than 240 minutes



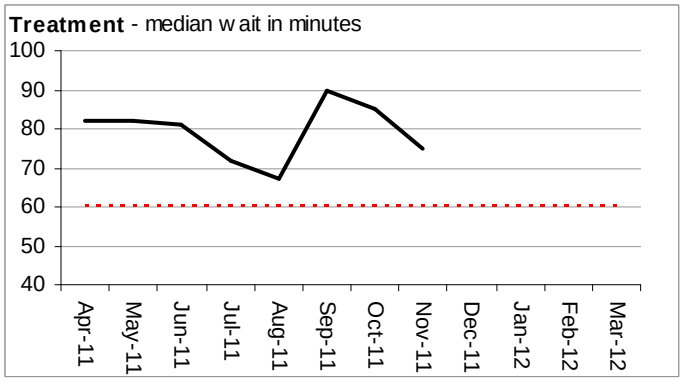
Commentary & Action plan

The main causes for the outstanding breach problem in current waiting time relate to delays predominantly associated with mental health patients and particularly repatriation to borough of residence.

The ICAM team met with C&I MHFT in December 2011 to agree performance management arrangements as part of the contract for mental health services. The SLA for 2012/13 is currently being negotiated with the provider and this will include explicit performance targets and penalty arrangements for the service provider access and quality targets.

Indicator: Urgent Care – Wait for Treatment ICAM

Target: Median wait to be less than 60 minutes



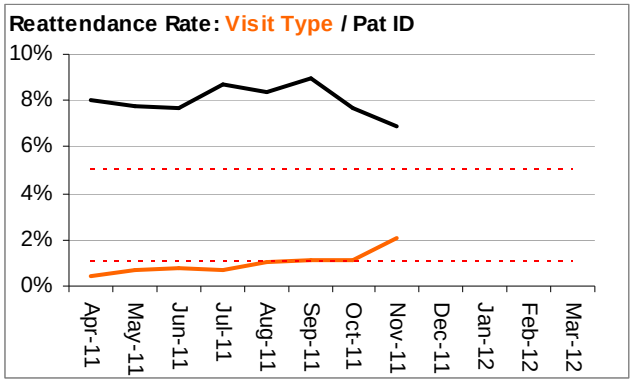
Commentary & Action plan

The following actions have been put in place to support the reduction in median waiting times.

- Development of “pit stop” assessment of major patients to speed up diagnosis and clinical decision – commenced November 11
- Establishment of a dedicated team who would be solely responsible for the initial assessment and treatment of LAS patients when they arrive in ED (bid submitted to NCL as part of NHS London ED Performance bids and approved).
- Escalation plan has been developed, ratified by the Executive Committee and is now in operation.
- The clinical team are currently developing the inter-professional standards and performance measures for supporting ED referrals to specialty teams.

Indicator: Urgent Care – Reattendance Rate ICAM

Target: To be between 1% and 5%



Pat ID method is currently being used to capture this information as more accurate. Department is switching to “visit type” methodology during December 2011.

Commentary & Action plan

- Patients who re-attend ED within a week – information lists and reports have now been developed to support monitoring by condition type
- If patients re-attend within 1 week this is now being logged on EDIS as a re-attendance to support improved data accuracy and escalation
- ED team is linked in with community re-attendance project focused on tackling multiple ED attendances.
- Review of patient information leaflets has been currently undertaken to ensure patients are provided with clear information at discharge to support them and to identify alternatives to re-attendance if the condition deteriorates
- Case review of patients being brought back routinely by doctors and ENP’s currently being undertaken in order to identify strategies to support patient management and avoid re-attendances

Indicator: 18 Weeks: Admitted Clock Stops- ICAM

Target: 95th percentile wait to be less than 23 weeks. Relates to red RAG rated November performance within ICAM. Trust performance overall is 20 weeks for the 95th percentile and green rated year to date.

November 2011 Performance by Specialty across ICAM.

Specialty	<18wks	>18wks	% within 18wks	95th percentile
Haematology	9	0	100%	13.6
Cardiology	3	0	100%	9.9
Pain Relief	12	5	71%	26.2
Rheumatology	0	1	0%	27.0
ICAM Total	**24**	**6**	**75%**	**26.1**

Commentary & Action plan

Performance issues specifically relate to the Chronic Pain service. This is a combination of incorrect data capture of first clock stops and some temporarily reduced capacity (Consultant sickness). Training has taken place for ICAM clinic staff within the chronic pain service to ensure that clock stops are appropriately being captured at the first definitive treatment.

Temporary locum consultant capacity has been approved by the Executive Committee to cover the lost capacity due to Consultant sickness (led to 50% reduction in substantive consultant capacity)

Indicator: Diagnostic 6 Week Wait (ICAM)

Target: 99% seen within 6 weeks (NB target is for 2012/13; no official target for 2011/12) The November performance issues related to diagnostic breaches within ICAM- specifically there were 11 breaches reported in Neurophysiology as at the end of November 2011.

Commentary & Action plan

The capacity for Neurophysiology has been reviewed and amended to increase the availability of Consultant sessions for neurophysiology. This should provide sufficient capacity to manage the demand for 6 week neurophysiology tests and support the achievement of the target from January 2012.

Indicator: 62 Day Cancer Referral/Upgrade to Treatment- WCF

The Trust is fully meeting cancer performance targets for 62 days both in month and year to date as a whole.

However, WC&F did not achieve the 62 day target within the division- November dashboard relates to October data taken from CWT database.

Target: 86%

October 2011: 1.5 treated / 0.5 breaches
2011/12 YTD: 7.5 treated / 2.5 breaches

(Patients referred to Whittington Health but who are treated elsewhere count as 0.5 treated patients. If that patient breaches, both referring and treating Trust is attributed 0.5 breaches).

Commentary & Action plan

One patient breached in October and was a shared breach with UCLH. The patient required multiple complex investigations and work up and was deemed to have been an unavoidable breach when the case review was undertaken. This significantly affected WCF performance due to the low number of cases.

Year to date however there have been issues with diagnostic capacity within WCF and specifically access to hysteroscopy appointments and excessive waiting times. An additional 5 cancer target hysteroscopy slots were implemented in December 2011 within gynaecology to support rapid diagnostics and avoid hysteroscopy associated delays.

Indicator: Cancelled Operations for Non-Clinical Reasons- W,C&F

Target: <0.8% of elective admissions. Trust performance is 0.39% overall and achieving the target.

However, WCF did not achieve the target in November (2.28%).

November 2011 Gynaecology Cancellations Summary:

No notes = 1 cancellation
No op time/list overran = 6 cancellations

Commentary & Action plan

6 of the cancellations in month related to insufficient list time and overrunning lists. This is a particular problem with one the of the consultant Gynaecology surgeons. The WCF team have reviewed the consultant waiting list and cases (not requesting a named surgeon) have now been pooled onto a generic waiting list so that they can be distributed to other members of the gynaecology team since January 2012.

The team are also reviewing the individual consultant theatre time and list allocation with the view of providing additional theatre sessions given the current demand for their lists.

Indicator: Maternity bookings within 12 weeks 6 days- W,C&F

Target: 90%

Month	% of bookings received within 12+6

	and booked within 12+6
Apr	90.2%
May	88.0%
Jun	90.1%
Jul	91.0%
Aug	88.7%
Sep	89.2%
Oct	90.1%
Nov	91.5%
Total YTD	89.9%

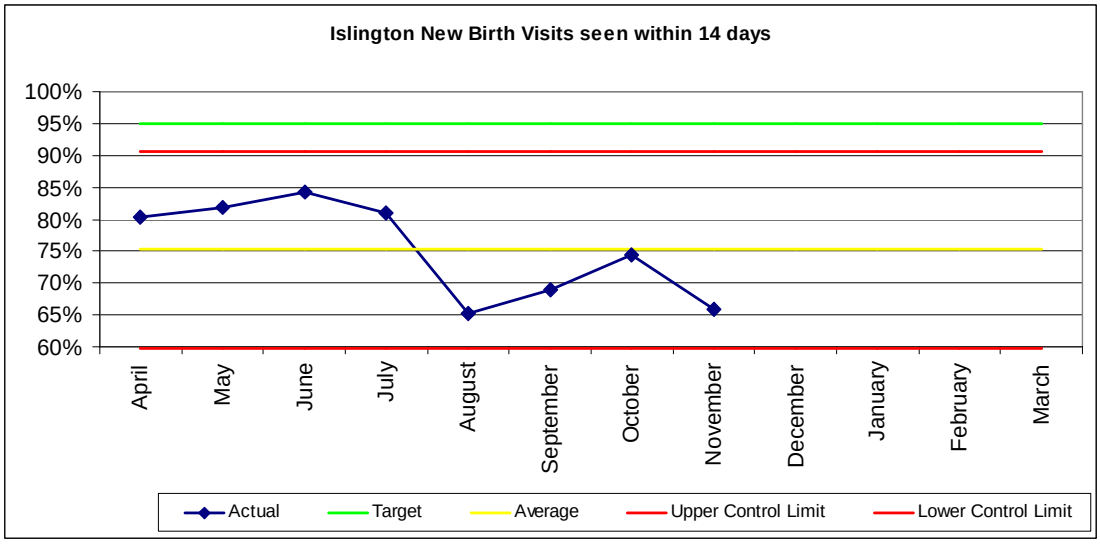
Commentary & Action plan

Target has now been achieved for October and November and is on trajectory to meet 90% YTD by December 2011.

Indicator: New Birth Visits W,C&F

Target: 95% within 14 days (Islington); 95% within 28 days (Haringey)

Islington:



Haringey:

	Target	September	October	November
Seen in 14 days	95%	21.78%	17.53%	14.95%
Seen in 28 days	95%	73.64%	79.18%	76.64%

Commentary & Action plan

The performance data is currently affected as a result of some data capture problems

associated with RiO. The Child and Maternity Information Systems Manager is working with IM&T and the Data Quality Team to resolve this. In addition high levels of Health visitor vacancies across both Haringey and Islington, action plan in place to aid recruitment

2. SLA Indicators- Red/Amber Ratings & Action Plans

Indicator: Follow-Up Ratio (Median & Upper Quartile)- ICAM

Target: to achieve median benchmark by March 2012 and upper quartile by March 2013

Exclusions: Respiratory Medicine and Gastroenterology

	Follow-Up Ratio			
Specialty	**Median**	**Upper Quartile**	**Nov 11**	**Q3**
Cardiology	1.43	0.92	2.60	2.88
Diabetics	5.96	3.48	12.12	11.89
Elderly Care	2.16	1.37	2.65	2.85
Endocrinology	2.96	2.46	3.67	3.21
General Medicine	2.66	1.52	6.35	7.12
Haematology (Clinical)	6.46	4.84	4.05	3.88
Nephrology	5.82	3.92	4.09	3.58
Neurology	1.20	0.89	0.95	0.91
Pain Relief/Anaesthetic	1.82	1.42	1.52	1.63
Rheumatology	3.75	3.18	3.25	3.13

Commentary & Action plan

Cardiology

Cardiac Rehabilitation and Nurse Led Clinics are being moved into the community and will support an improvement in follow up rates from December 2011.

Diabetes

The service is undergoing a “table top Exercise” in January 2012 with clinical leads and specialist nursing colleagues. This will include case note reviews and modelling required pathway changes to support and achieve the f/up metrics for the service.

Elderly Care

Predominant work stream for elderly care relates to data cleansing exercise Incorrect procedure codes- tissue viability sessions within the Dorothy Warren Day Hospital currently included. Data is being validated and will support improved performance from January 2012.

Acute Medicine

Agreed that this data is incorrect as relates to diagnostic clinic not outpatient service and agreed at performance board that this should be excluded.

Indicator: Follow-Up Ratio (Median & Upper Quartile)- W,C&F

Target: to achieve median benchmark by March 2012 and upper quartile by March 2013

Exclusions: Obstetrics

Follow-Up Ratio

Specialty	Median	Upper Quartile	Nov 11	Q3
Gynaecology	1.17	0.95	1.92	1.67
Paediatrics	1.34	0.93	1.52	1.60

Commentary & Action plan

The WCF is currently exploring the coding of colposcopy and fertility figures- currently included within the figures for WCF but are treated as a separate specialty by a number of comparator trusts. Colposcopy clinic planned follow up appointments have also now been changed from a 6 monthly to annual planned follow up to support reduction in follow up rates.

The data associated with telephone follow-up clinic has also been amended to ensure that it is included correctly in the data reports and will be included in December 2011 figures. In addition a further telephone clinic has been set up to support the Women's Diagnostic Unit to prevent women returning for a face to face appointment if their results are normal or can be managed outside of the hospital setting.

Outpatient hysteroscopy has now started at Hornsey Central. This clinic runs as a one-stop clinic and reduces patient attendances by approximately two appointments. This clinic is running as a pilot until April 2012. There are plans to convert the hospital based outpatient hysteroscopy service to the same model.

An audit of new to follow up ratio appointments is due to be presented for Gynaecology at the WCF Performance Meeting in January 2012. This will highlight additional areas where it may be possible to reduce the ratio. An audit of general paediatric clinic appointments has been undertaken to show appointments/conditions that could have been managed in a different setting eg. community clinic or GP surgery and this is due for presentation in January 2012.

Indicator: Follow-Up Ratio (Median & Upper Quartile) S,C&D

Target: to achieve median benchmark by March 2012 and upper quartile by March 2013

Exclusions: Oncology

	Follow-Up Ratio			
Specialty	**Median**	**Upper Quartile**	**Nov 11**	**Q3**
Dermatology	1.89	1.41	2.10	1.80
Ear, Nose & Throat	1.23	1.08	1.08	1.07
General Surgery	1.63	1.12	1.68	1.66
Ophthalmology	2.61	1.96	2.48	2.86
Plastic Surgery	1.36	1.05	0.38	0.43
Trauma &Orthopaedic	1.68	1.55	2.06	1.95
Urology	2.09	1.74	1.78	1.64

Commentary & Action plan

Ophthalmology and Trauma and Orthopaedics are particular target areas for surgical division. General surgery is achieving the target year to date.

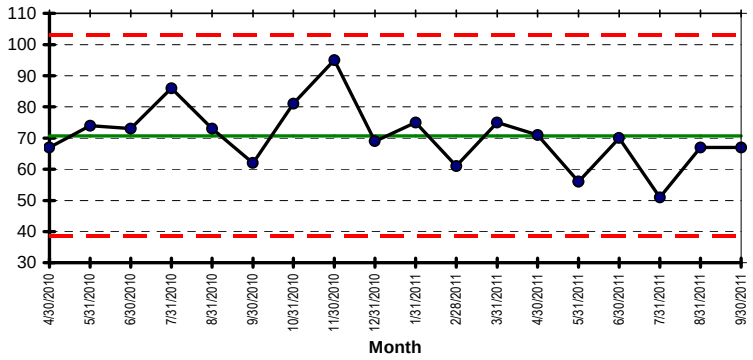
Both ophthalmology and orthopaedic coding is being reviewed in conjunction with Performance and Planning team as both include support staff clinics (orthotics, optometrist) that are currently coded as consultant activity.

In addition to the data review the General Manager for Surgery is leading a clinical notes review with each service consultant with aim of discharging patients with non-essential follow-up to support the target. This will be completed by February 2012. The templates are also being reviewed to ensure that the ratio of follow up slots: new slots on the template matches the performance KPI target as the metric is devised by divided total follow up slots by total new slots- and is tracked on patient by patient basis.

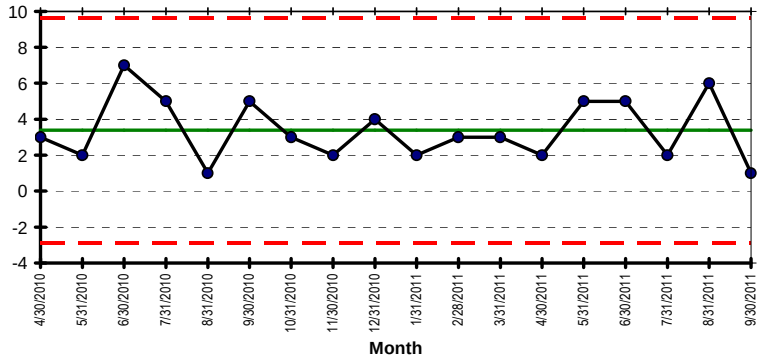
Indicator: Emergency Readmissions- ICAM

Target: to achieve a 25% reduction on 2010/11 levels

following Emergency Medical Discharge



following Medical DC discharge



Commentary & Action plan

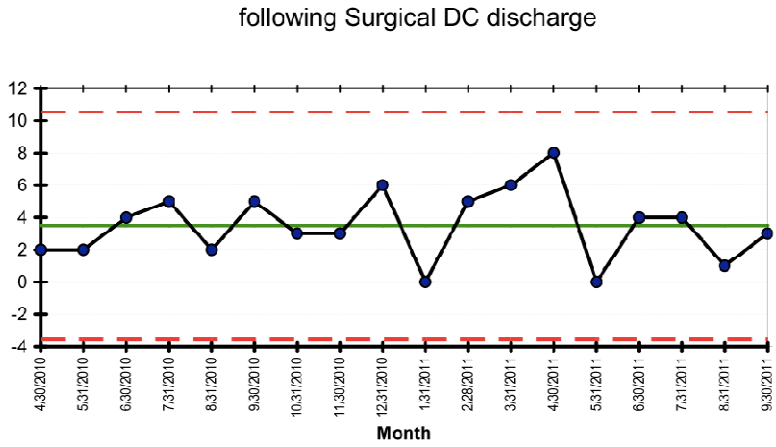
The flagging system for patients arriving in ED have been amended and potential readmission patients are now being flagged on arrival, which links to the ambulatory care programme in place to support alternatives to admission.

ED consultants on shop floor will be referred flagged potential readmissions to enable senior consultant involvement and decision making is in place to prevent avoidable readmissions for patients who present.

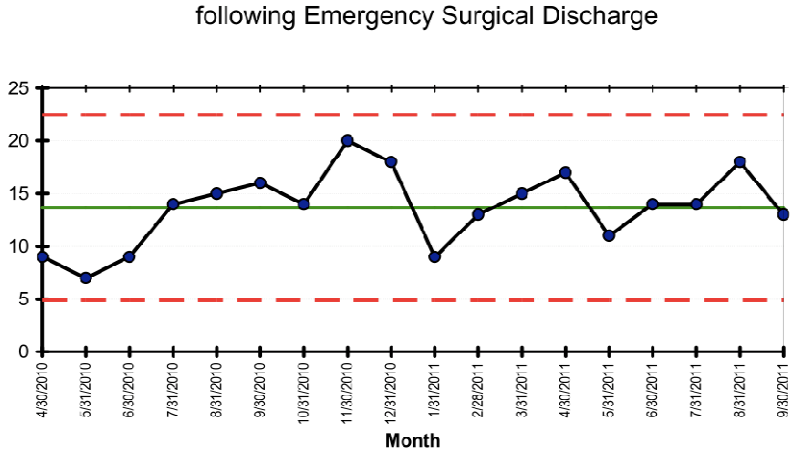
Clarissa Murdoch is leading a linked programme of work focused on enabling flagged attendees to be reviewed rapidly by specialty teams to avoid admission.

Indicator: Emergency Readmissions S,C&D

Target: 0 readmissions following elective discharge



Target: to achieve a 25% reduction on 2010/11 levels for readmissions following an emergency admission



Commentary & Action plan

There has been no reduction in the rate of readmissions following an elective discharge or those following an emergency discharge. It is however worth noting that the overall readmission rate for surgical patients as a proportion of total activity is relatively low, does not always relate directly to the procedure and the dataset includes readmission rates for bariatric surgery patients, which have a slightly higher complication and therefore readmission rate (within 30 days). Most units do not provide bariatric surgery so this will slightly impact upon the KPI metrics when comparing trusts.

General Surgery

Within General Surgery the department is currently submitting to the Executive Committee (20th December) proposals for expanding consultant general surgeon cover in line with emergency care standards in order to provide 12/7 consultant presence for Whittington Health. The Trust already has daily consultant input for the specialty but this will increase the coverage throughout the working week. This will enable 12/7 coverage to be provided when the 2 further posts are filled and will completely separate out elective and on-call commitment ensuring there is increased consultant presence throughout the week to manage emergency cases (highest readmitting group) and also to ensure that consultant that are on-call do not have clashes with elective commitments.

In terms of supporting readmissions this will ensure that there is increased consultant presence throughout the week and increased proportion of consultant led procedures (as opposed to consultant supervised) will be increased. It will also enable more rapid access to theatre for complex cases admitted non-electively that require consultant input. The increased presence will also enable a more complete ward round of patients to be taken throughout the week and enable emergency admissions to be reviewed by a consultant throughout the working day over a 12 hour period. It is envisaged that this increased level of consultant input will facilitate improved decision making, support discharge and help to potentially reduce complications.

Enhanced Recovery

The roll out of enhance recovery for elective procedure is being used to support improved efficiency (length of stay), patient experience and the quality of the pre-assessment, procedure and discharge process. This has already been introduced over the last year across elective knee surgery and some hip surgery and is well established for colorectal patients. The advantage of the pathway is that is standardises care and reduces variation in terms of both potential length of stay and outcome/readmission risks. As part of this years divisional QIPP programme the full roll out of enhanced recovery for all hip surgery and gynaecology surgery is currently being implemented, with the aim of all elective patients going through an ER pathway by the end of quarter 4.

Orthopaedics

In addition to the enhanced recovery work described above the other area of potential readmission relates to emergency trauma patients who arrive with fractured neck of femur. Readmissions can be due to a range of potential issues including post surgical complications through to inadequate discharge planning and support

The main divisional QIPP programmes this year covers the fractured neck of femur pathway. The aim of this particular programme of work is to improve the outcome, experience and quality of patients presenting with fractured neck of femur at Whittington Health and this should help to also support readmission work. The project is being led by Mary Jamal, Deputy Director of Operations and aims to deliver the following objectives.

- The pathway is co-ordinated and designed to reduce actual length of stay and to limit variation, reduce mortality and re-admissions
- Appropriate, medically fit patients receive surgery within 24 hours
- Patients are mobilised within 12-18 hours post op and receive therapy input over weekends Patients are discharged back to their usual address using a criteria based discharge process Health and social care multi agency teams are co-ordinated and integrated across the patient pathway
- LOS is reduced from average of 21days (current) to 6 days (national best practice)

3. Local Targets- Red/Amber Ratings & Action Plans

Indicator: % Complaints responded to on time – All division	
Target: 85% ICAM 71% WCF 68% Actual: 38% Dashboard performance is based on October data.	
Commentary & Action plan There has been a continued focus on ensuring all complaints are responded to in time and this has been communicated to all relevant managers and senior staff. The majority of relevant staff have now attended the complaints training session and support is being provided from senior management to ensure responses are turned around quickly. Delays are escalated weekly to Director of Operations and Divisional Management Teams. Within S,C&D a number of the overdue complaints within the division were not completed in time due to delays in receiving clinical statements for clinically complex cases during the month - multiple clinicians. Two of the delayed complaints included in the dashboard relate to cases that are being dealt with as claims. All complaints involving clinicians are now escalated immediately to both clinical director and divisional director and a single nominated clinician is now identified for multiple department complaints. Delayed responses are escalated on a daily basis tracked against the expected response date by the Director of Operations. 89% of November complaints were completed within the timescale for S,C&D showing significant improvement from the poor performance in October. (Cassie Williams data source)	

Indicator: Consultant 7 day ward rounds, 8-8 Consultant Presence and Consultants with no Elective work whilst on-call- ICAM & S,C&D	

Commentary & Action plan- ICAM

Business case on ICAM consultant requirements to meet NHSL commissioning intents for acute emergency care to be presented to EC in January 2012.

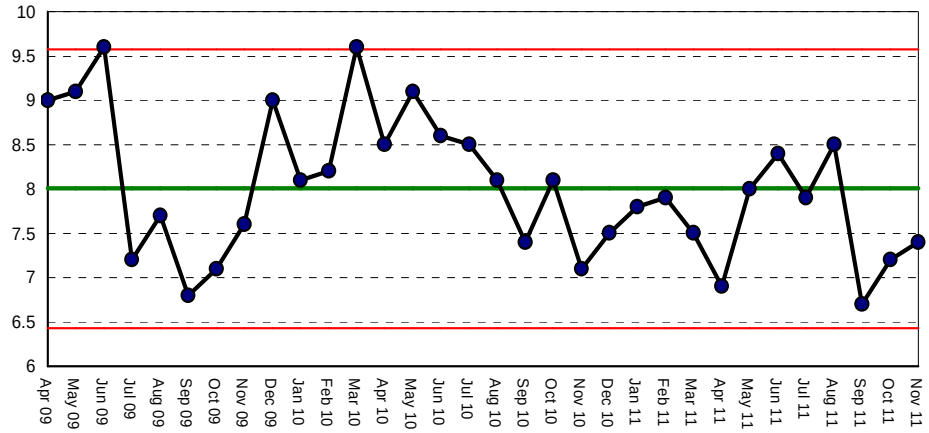
Commentary & Action plan- S,C&D

Business case taken to EC in December 2011. Approval gained for two additional general surgeons to support the split of emergency and elective work in general surgery.

Recruitment undergoing with aim to have consultants in place by April/May 2012. This recruitment will enable the general surgery consultant on-call to be free of elective commitments and undertake twice daily ward rounds.

Indicator: Average Length of Stay reduction- ICAM

Target: 1 day by March 2011



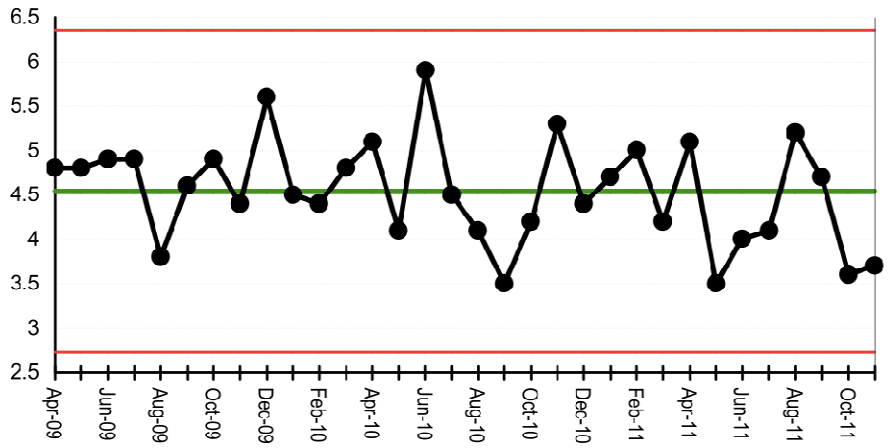
Commentary & Action plan

The key actions being implemented to support this target LoS reduction in ICAM in addition to earlier comments on readmission programme are:

- Setting EDD at point of admission.
- Achieving 50% target on discharge by 11am
- Introduction of increased consultant presence and daily 7 day ward rounds as illustrated above
- Specific pathway work has been undertaken to focus on joined up discharge pathway with a focus on over 14 day LoS (implemented February 2012)

Indicator: Average Length of Stay reduction – S,C&D

Target: 1 day by March 2013



Commentary & Action plan

A number of initiatives are underway to support the achievement of the reduction in length of stay by 1 day by March 2013. The recruitment of two additional general surgery consultants will play an integral part in ensuring consultant-led emergency service provision within the surgical directorate. Ensuring that there is always a general surgery consultant who is free of elective commitments will result in a senior decision maker being more involved in care of all general surgery inpatients. This will be in place from April 2012.

The roll out of enhanced recovery for all surgical patients is underway. A reduction in length of stay has already been demonstrated in colorectal and joint replacement patients using the principles of enhanced recovery and this has delivered significant length of stay reductions already for colorectal surgery (21- 10 days) and orthopaedic knee replacement (1 day reduction and almost zero pre-op LoS)- now being rolled out for remainder of elective surgery.

There is also a project specifically focused on fractured neck of femur patients referenced earlier in this report.

Indicator: Discharges before 11am- All Divisions

Target: 50% by December 2011

Commentary & Action plan

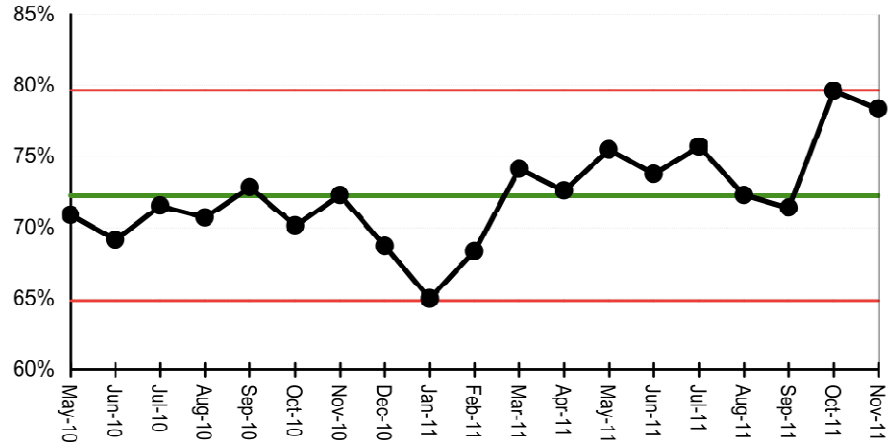
Weekly monitoring of target. Ward mangers and Matrons have identified a list of issues that inhibit the discharge of patients by 11am and include:

- Delay in TTA prescribing by FY1.
- Delays from pharmacy supplying TTA
- Patients who require results from investigations before being discharged
- Patients admitted to the ward post op from recovery who make a quicker than expected recovery and are discharged late in the evening. This is also applicable for the elective joint patients
- Patients requiring trial without catheter –i.e. cannot be discharged until they have passed urine post removal of catheter.
- Patients with high care needs at home requiring discharge after care package is activated. In many cases this can be after 4pm.
- Residential of nursing home request.

Kara Blackwell has developed and implemented a "discharge breach" report that WMs are completing to identify target areas and reasons for breaches. This will include escalation of breaches against the agreed Estimate Discharge Date and 11am target to Divisional Heads of Nursing and Divisional teams.

Indicator: Theatre Utilisation

Target: 85%



Commentary & Action plan

The target for the first phase of the theatre utilisation project is 85% - this includes elective, obstetric and emergency theatre utilisation and is based on total available session time- not funded sessions. It is proposed that this should be broken down into elective and emergency utilisation rates for the dashboard report- information already provided to theatre QIPP team

The Theatre QIPP programme is in place chaired by the Clinical Lead for Theatres and Anaesthetics (Dr Nick Harper) and supported by the transformation team. The project group have agreed the redesigned theatre programme from January 2012 which will support the closure of inpatient theatre capacity and increased theatre utilisation.

Since January the same volume of theatre activity has been provided through one closed theatre within the inpatient complex- converted to support Obstetric theatre refurbishment.

Fractured NOF protocol has been agreed as part of the NOF programme and in place January 2012- included agreed process for fast tracking to emergency theatres.

Indicator: Outpatient Slot Utilisation- All Divisions	

Target: TBC

ICAM and WCF currently red rated. S,C&D amber.

Commentary & Action plan

All divisions are currently undertaking a review of clinic templates across specialties to ensure that slot utilisation is being measured correctly and that only live clinic slots are included in the data reports. Will be completed by February 2012.

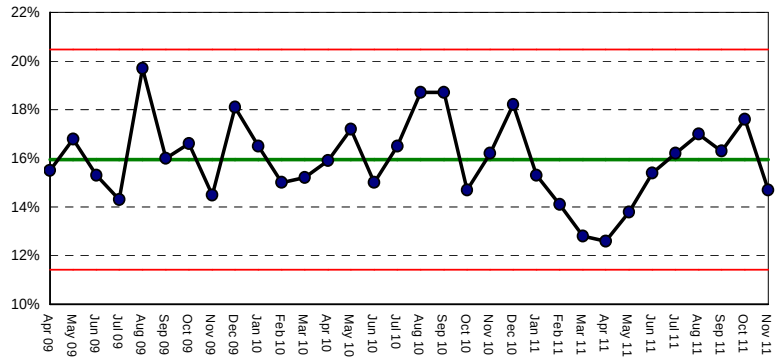
Clinic team leaders are getting reports on slot utilisation and patients that have cancelled their appointments on a daily basis to enable them to rebook patients from the waiting lists into the available slots and improve utilisation. This is now in place.

The Standard Operating Policy for appointments including escalation of unused choose and book slots and conversion to be used by non- C&B patients to ensure that C&B slots are utilised and not-wasted.

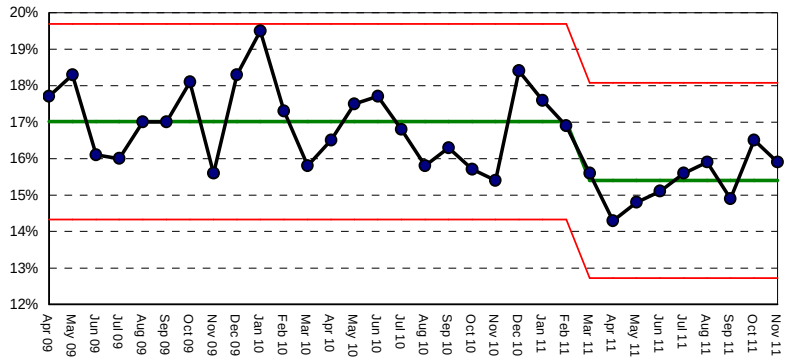
Indicator: DNA Rates – Acute (All Divisions)

Target: <8%

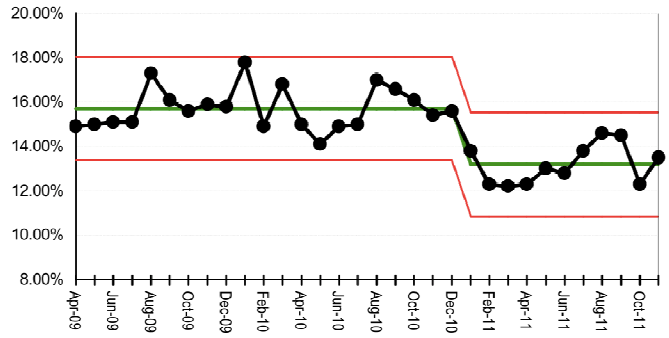
First Appointments ICAM



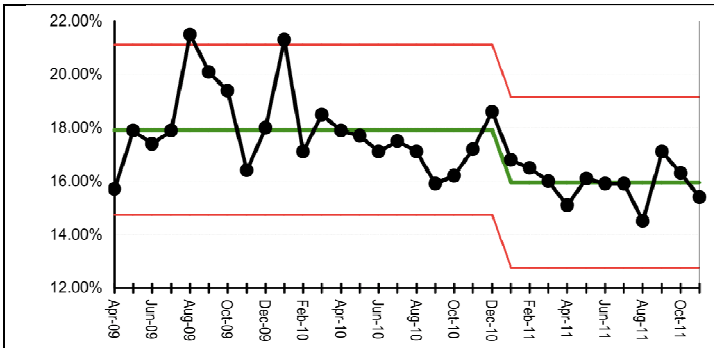
Follow-Up Appointments ICAM



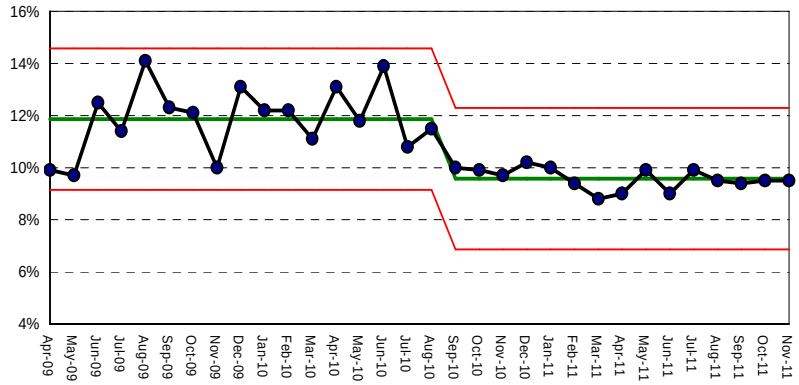
First Appointments S,C&D



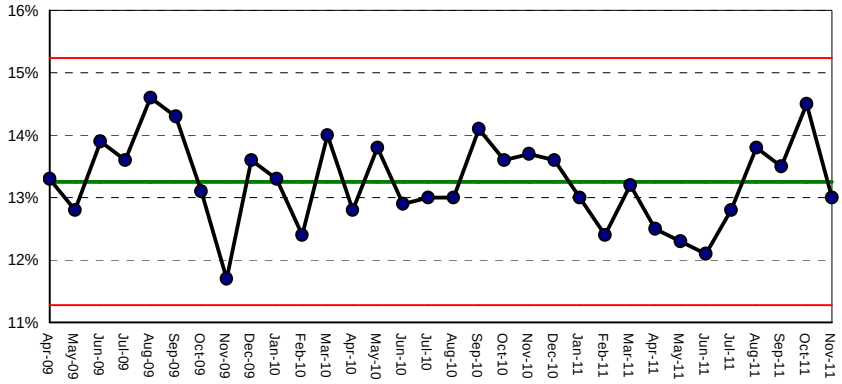
Follow Up Appointments S,C&D



First Attendances WCF



Follow-Up Attendances



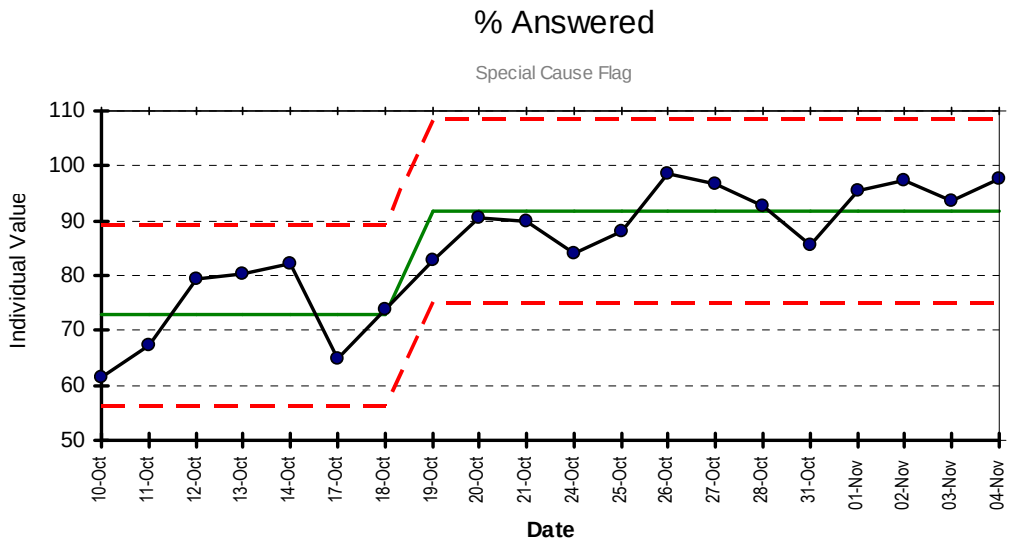
Commentary & Action plan

Roll out of partial bookings is being rolled out across the high DNA specialties within Divisions. Already in place within the high DNA specialties in S,C&D (Ophthalmology & Urology).This will be completed by March 2012.

Service leads are currently reviewing compliancy by clinical teams with the DNA policy to ensure strict adherence to the Trust DNA policy.

Some significant improvements in contacting the appointments and admissions have been put in place. The team have introduced a new call handling system to monitor call response times and performance manage the department. As illustrated below only 72% of patients were having their calls answered by the appointments centre before the new system was introduced (up to 28% of patients hung up or went to

voicemail). Since introducing the system within two weeks average response rate was 92%. This has been improved to 95% during December and January.



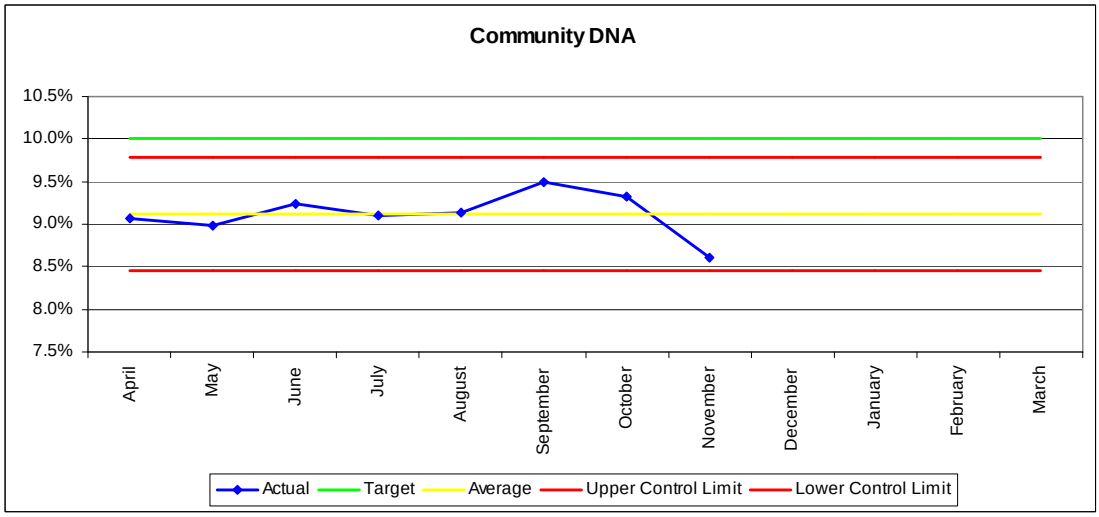
The admissions and appointments team are currently reviewing the Remind+ text messaging system to review its effectiveness and identify how it can be reconfigured to further support patient appointment DNA rates. Linked to this the current PAS system is being converted to enable email letter and appointments to be provided for patient administration and clinic invites- target date for both of these projects is implementation by April 2012.

Open appointments and annual follow ups have now been reduced for all specialties within WCF, preventing appointments being missed due to patients no longer feeling unwell or forgetting the appointment had been booked.

Indicator: DNA Rates – Community (ICAM & WCF)

Target: <8%

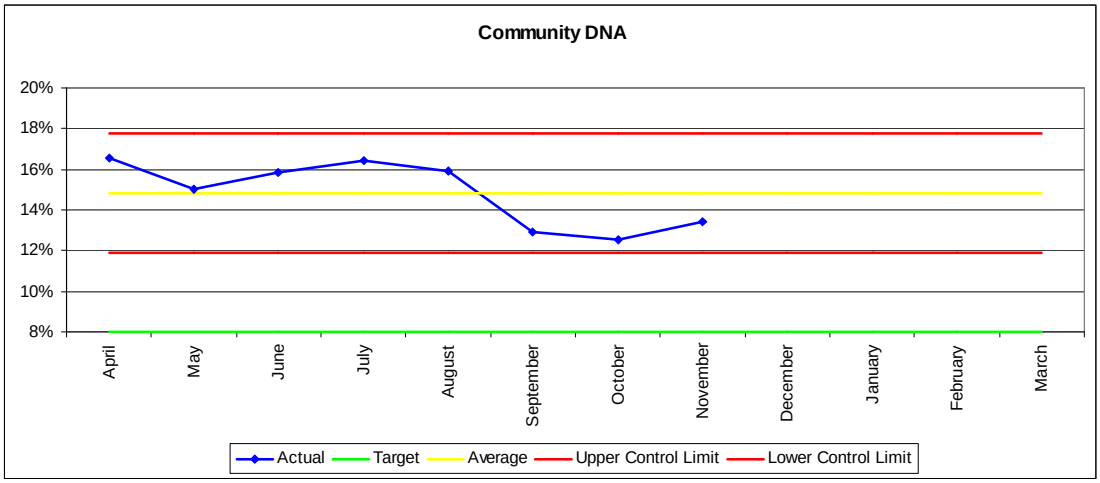
ICAM Data



November 2011:

	Haringey	Islington
Bladder And Bowel Management	13%	17%
Cardiology Service	13%	4%
Community Beds		
Community Matron	4%	6%
Community Rehabilitation	9%	20%
Community Total		
Diabetes Service	3%	15%
District Nursing	4%	4%
Intermediate Care		4%
Lymphodema Care		5%
Musculoskeletal Service	17%	17%
Nutrition and Dietetics	32%	18%
Palliative Care Service	1%	
Podiatry (Foot Health)	18%	12%
Respiratory Service	21%	21%
Tissue Viability Service	11%	16%
Wheelchair Service	10%	

WCF Data



November 2011:

Service	Haringey	Islington
Audiology	13%	41%
Child Development Services		9%
Community Children's Nursing		4%
Community Paediatrics Services	20%	24%
Haematology Service		16%
Health Visiting	16%	8%
Looked After Children	6%	28%
Nutrition and Dietetics	32%	
Occupational Therapy	11%	8%
Physiotherapy	26%	17%
Psychology Services		24%
School Nursing	10%	14%
Speech and Language Therapy	15%	12%

Commentary & Action

ICAM

N&D Haringey -highest DNA were in GP surgeries. Now centralised into health centres and bookings managed centrally (as opposed to booking made by surgery staff previously)

WCF

DNA rates have significantly reduced in child development services, due to new texting system. In physiotherapy MSK services this still remains high and a telephone survey to look at reasons for this is currently underway. SLT introduced text message reminders in November 2011

Indicator: Waiting times in outpatient clinics- All Divisions

Target: 90% of patients seen within 15 mins (TBC)

Specialty	Atts	% with valid times entered	% seen within 15 mins (apts with valid times)
Haematology (Clinical)	197	54.8 %	88.0 %
Elderly Care	168	17.9 %	80.0 %
Diabetics	552	61.8 %	74.2 %
Thoracic Medicine	650	92.3 %	71.5 %
Nephrology	173	23.7 %	70.7 %
Neurology	199	42.2 %	67.9 %
Cardiology	551	87.7 %	67.1 %
Pain Relief/Anaesthetic	142	93.0 %	63.6 %
Rheumatology	658	54.9 %	40.2 %
General Medicine	305	3.3 %	40.0 %
Gastroenterology	729	97.1 %	27.7 %
	4,324	**67.0 %**	**56.6 %**

Specialty	Atts	% with valid times entered	% seen within 15 mins (apts with valid times)
Dermatology	925	57.4 %	84.9 %
Trauma & Orthopaedic	2,296	100.0 %	68.6 %
Plastic Surgery	18	100.0 %	66.7 %
Ophthalmology	1,039	99.5 %	59.9 %
Urology	860	93.3 %	41.0 %
General Surgery	1,450	89.8 %	36.8 %
Ear, Nose & Throat	397	94.7 %	29.5 %

Specialty	Atts	% with valid times entered	% seen within 15 mins (apts with valid times)
Colposcopy	374	99.7 %	82.0 %
Paediatrics	1,123	15.3 %	78.5 %
Maternity Ante-Natal Op	4,063	97.6 %	78.2 %
Gynaecology	1,552	92.7 %	58.9 %

Commentary & Action plan

This is the first month that detailed waiting time data by specialty has been provided in this format for operational teams. The focus is on data capture and reducing delays in clinic.

Outpatient teams are now working towards ensuring that 100% of patients have valid times seen entered and the methodology for data capture is being confirmed with the PAS team. This will include agreeing methodologies for entering and capturing data

in a standardised manner across divisions within the currently devolved outpatient structures.

Review of data has identified the specific clinics to be targeted with long waiting times and service managers have been asked to produce specific action plans for these clinics, which will also link into the corporate wide patient experience work being coordinated by Jennie Williams- January 2012 completion.

As part of this exercise a review of clinic templates has started for all specialities in conjunction with clinical lead to ensure that current capacity is being maximised and that template are appropriate in terms of allocated appointment time. Capacity problems will be flagged as part of this exercise and capacity shortfall being reviewed by speciality.

Within surgery one of the challenging areas has been breast clinic waits (included in General Surgery figures). Business case has been approved for additional breast capacity at the Executive Committee, which will increase total available clinic capacity and provide extra clinics throughout the working week. The new appointments will be in place from April 2012.

Indicator: Consultant to consultant activity

Target: Upper quartile by March 2013

ICAM Data

Specialty	Upper Quartile	Nov 11
Cardiology	24 %	14 %
Diabetics	18 %	29 %
Elderly Care	35 %	26 %
Endocrinology	16 %	10 %
Gastroenterology	17 %	17 %
General Medicine	27 %	30 %
Haematology (Clinical)	27 %	13 %
Nephrology	21 %	12 %
Neurology	17 %	11 %
Pain Relief/Anaesthetic	30 %	39 %
Rheumatology	14 %	29 %

S,C&D Data
Exclusions Plastics

Specialty	Upper Quartile	Nov 11
Dermatology	4 %	4 %
Ent	12 %	9 %
General Surgery	14 %	13 %
Medical Oncology	60 %	52 %
Ophthalmology	16 %	20 %
Plastic Surgery	27 %	54 %
Trauma & Orthopaedics	42 %	17 %
Urology	20 %	25 %

Commentary & Action plan

S,C&D

Surgical division have worked with IT department to mandate entry of referrer on PAS system to enable targeting of source of consultant to consultant referrals- this is now in place as the demand relates to referring source not receiving source.

A review of PAS coding for both specialties is currently being conducted by the General Management and service team to ensure appropriate data capture and recording. This is particularly focused on Ophthalmology where patients get seen between The Royal Free and Whittington Health. This will be completed by March 2012.

Within ophthalmology and urology consultant level review of all referrals is now in place across both specialties to ensure senior decision making and also rejection of inappropriate referrals.

Indicator: Outcomes Not Recorded (Community) ICAM

Target: TBC

Commentary & Action plan

The ICAM team have put significant effort on reducing the volume of outcomes not recorded within the services through redesigning the data capture process and increasing support for data capture. This has now reduced significantly to 1000 episodes of data, is expected to be at 400 by end of January and achieving trajectory by February 2012.