Whittington Health NHS

ITEM:10

Trust Board Meeting

Date: 27 June 2012

Title: **Performance Dashboard**

Sponsor: **Maria da Silva – Chief Operating Officer**	**Report From:** Directors of Operations

Purpose of Report:	**This report aims to inform the Board on Trust Performance for Month 1 - April 2012 – National, SLA and Local Access Targets**

Executive Summary:

- **ED 4 Hour Performance –** The recent visit from the National Support team has demonstrated that this indicator needs to be part of a whole system change to the acute pathway. There has been a link to bed capacity issues in the deterioration in performance in April, causing a backflow in ED, but in the same instance this has not always been the reason for poor performance. The actions put in place to improve performance are to look at test methods of rapid assessment and treatment, a review of internal professional standards, better communication between the ED and admission teams and changes to the internal escalation policy which will ensure that Consultants are alerted when trigger points are reached. **Lead: Carol Gillen**
- **Referral to Treatment –** The main challenge for the admitted pathway target has been in the orthopaedic services on a national level. A trajectory target at specialty level was submitted by all trusts to the NCL of 90% by September 2012. The Division is reviewing and the redistribution of current waiting lists to maximised capacity. **Lead: Matthew Boazman**
- **Cancer Two Week Wait –** The Trust is above the 93% target. Breaches in this area are solely due to patient choice. It also should be noted that only one patient choosing an appointment outside the parameter for this target could skew performance, resulting in Amber or Red ratings.
- **Cancelled Operations –** April has demonstrated has being an exceptional month for this target, which has been missed as a result of the urology middle grade's unavailability on the morning of a planned urology cystoscopy list, resulting in cancellation of the list and patients being given new dates for their procedures. Urology cancellations counted for 11 out of 13 in total. The performance rates are now back to below threshold and back on track May and June.
- **Follow-Up Ratio –** The target is to reach upper quartile by March 2013 and the

Divisions have clear trajectory to be able to reach the upper quartile performance. In the following months, this target will be measured as a trajectory. A review is being undertaken of the coding of clinical notes by consultants in each of the services with the view of discharging patients with non-essential follow-up ratios.

- **Emergency Readmissions from original elective admissions –** The target of zero elective readmissions continues to be a challenge and will result as unachievable due to the complex elective surgery case mix at the Trust.
- **Emergency Readmissions from original emergency admissions –** Target to achieve a 25% reduction on 2010/11 levels. As part of the ICAM division's plans to work towards achieving this target, there will be the implementation and on going expansion of the Ambulatory Emergency Care Service as well as the development of virtual wards to offer additional community support to those deemed at risk of readmission. There has been an improvement for the WFC division in readmission rates for April, although they still need to undertake validation at patient level data to determine admission reasons.
- **Consultant 7 day ward rounds –** For general surgery the new consultant rota for 7 days ward round will commence on 29 June . ICAM division - the implementation of the new rota for 7 day ward rounds, dependent on successful recruitment, will take place by August. There will also be the introduction of 5 day board rounds starting at the end of June in Medicine.
- **Discharges before 11am –** ENIST recommendation that this target be reduced to 40%, especially as it is no longer a CQUIN target. This would enable sufficient beds to be identified each morning allowing patient flow to be maintained and the target to be more achievable and be in line with other high achieving trusts. Divisions continue to monitor this target on a weekly basis and addressing key elements for improvement.

Proposed Actions:	For discussion

Appendices:	Performance Dashboard

Declaration

In completing this report, I confirm that the implications associated with the proposed action shown above have been considered – any exceptions are reported in the Supporting Information:
Implications for the NHS Constitution, CQC registration
Financial, regulatory and legal implications of proposed action
Risk management, Annual Plan/IBP
Moving Ahead – how does this report support any of the Trust's 5 Strategic Goals

PERFORMANCE DASHBOARD

APRIL 2012

Whittington Health NHS

Domain (target)	Trust Summary		IC & Acute Medicine		Surgery & Diagnostics		Women, Children & Families	
National Targets	Apr-12	YTD	Apr-12	YTD	Apr-12	YTD	Apr-12	YTD
Emergency Department 4 Hour Performance (95%)	94.9%	94.9%	94.9%	94.9%				
Referral to Treatment: Completed Admitted Pathways (90%)	93.1%	93.1%	92.3%	92.3%	92.4%	92.4%	95.9%	95.9%
Referral to Treatment: Completed Non-Admitted Pathways (95%)	98.8%	98.8%	98.6%	98.6%	98.1%	98.1%	99.9%	99.9%
Referral to Treatment: Incomplete Pathways (92%)	92.2%	92.2%	86.4%	86.4%	97.2%	97.2%	99.0%	99.0%
Diagnostic Waiting Times (99%)	100%	100%	100%	100%	100%	100%	100%	100%
Cancer: 14 days from urgent GP/breast referral (93%) (Mar)	94.2%	95.4%	91.0%	92.0%	95.2%	96.1%	91.2%	94.8%
Cancer: 31 days from decision to treat to treatment (96%) (Mar)	100%	99.5%	100%	100%	100%	99.3%	100%	100%
Cancer: 62 days from referral/upgrade to treatment (86%) (Mar)	93.9%	88.3%	100.0%	95.5%	90.9%	88.6%	100.0%	64.5%
Cancelled Operations (<0.8% of elective admissions)	1.2% ↓	1.2%	0.0%	0.0%	2.1%	2.1%	2.9%	2.9%
Single-Sex Accommodation (0 mixed sex breaches)	0	0	0	0	0	0	0	0
Delayed Transfers of Care (<3.5% of beddays)	2.9%	2.9%						
Diagnostics: Cervical Cytology Turnaround Times (98% within 14 days)	100%	100%			100%	100%		
Maternity Bookings within 12 weeks 6 days (90%)	88.1%	88.1%					88.1%	88.1%
Maternity: 1:1 care in established labour (100%) (Jan 2012)	100%	100%					100%	100%
Maternity: Smoking in pregnancy at delivery (<17%)	6.0%	6.0%					6.0%	6.0%
Maternity: Breastfeeding at birth (90%)	90.2%	90.2%					90.2%	90.2%
Health Visits: Prevalance of breastfeeding at 6-8wks (74%) (Q4)	78%	75%					78%	75%
Health Visits: New Birth Visits (Islington, 95% within 14 days)	51.3%	51.3%					51.3%	51.3%
Health Visits: New Birth Visits (Haringey, 95% within 28 days) - March data	92.5%						92.5%	
Child Health: Immunisations - Islington (80%) (Q4)	88.0%	88.0%					88.0%	88.0%
Child Health: Immunisations (Haringey) (80%) (Q4)								
GUM: Patients offered appointment within 2 days (100%)	100%	100%					100%	100%
IAPT: Number entering psychological therapies (Q4)	921	3032	921	3032				
IAPT: Number moving off sick pay & benefits (Q4)	25	150	25	150				
Monitor Community Services Governance Indicators: Referrals	8996	8996	6668	6668			2328	2328
Monitor Community Services Governance Indicators: Contacts	50036	50036	35848	35848			14188	14188

SLA Indicators

Domain (target)	Trust Summary Apr-12	Trust Summary YTD	IC & Acute Medicine Apr-12	IC & Acute Medicine YTD	Surgery & Diagnostics Apr-12	Surgery & Diagnostics YTD	Women, Children & Families Apr-12	Women, Children & Families YTD
Outpatient Follow-Up Ratio (Upper Quartile) - % excess follow-ups (<1%)	32.0%		50.0%		20.7%		29.6%	
Consultant to Consultant Activity (Upper Quartile) - % excess firsts (<1%)	2.9%		2.6%		2.3%		4.6%	
Emergency Readmissions - from original elective admission (reduction TBC)	11	11	2	2	8	8	1	1
Emergency Readmissions - from original emergency admission (reduction TBC)	94	94	72	72	16	16	6	6
Excess Beddays (against SLA plan)								

Above standard — near miss/at risk — below standard — not applicable

Arrows indicate an improvement/deterioration in performance determined by a change in RAG rating compared with the previous month (Trust level)

PERFORMANCE DASHBOARD

APRIL 2012

Whittington Health NHS

Domain (target)	Trust Summary		IC & Acute Medicine		Surgery & Diagnostics		Women, Children & Families	
Local Targets	Apr-12	YTD	Apr-12	YTD	Apr-12	YTD	Apr-12	YTD
Urgent Care: Total Time in ED (95th % Wait < 240 mins)	262 ↓	262	262	262				
Urgent Care: Total Time in ED - Admitted (95th % Wait < 240 mins)	452	452	452	452				
Urgent Care: Total Time in ED - Non-Admitted (95th % Wait < 240 mins)	238	238	238	238				
Urgent Care: Wait for Assessment (95th % Wait < 15 mins)	7	7	7	7				
Urgent Care: Wait for Treatment (Median < 60 mins)	89	89	89	89				
Urgent Care: Left Without Being Seen Rate (<5%)	4.5%	4.5%	4.5%	4.5%				
Urgent Care: Re-attendance Rate (>1% and <5%)	3.7%	3.7%	3.7%	3.7%				
Formal Complaints Response Times - % responded on time (85%) (Mar data)	82% ↑		83%		73%		100%	
Consultant 7 Day Ward Rounds	N	N	N	N	N	N	N	N
Acute Medicine: Consultant presence 8am-8pm every day	N	N	N	N				
Surgery: Consultants with no elective work on call 7 days	N	N			N	N		
Discharge Before 11am (50%)	25.7%	25.7%	22.9%	22.9%	30.9%	30.9%	26.4%	26.4%
Average Length of Stay (1 day reduction by March 2013)	6.6	6.3	8.9	7.8	3.5	4.2		
Theatre Session Utilisation (95%)	78.0%	78.0%			78.0%	78.0%		
Outpatient DNA Rate - Acute (8%)	13.3%	13.3%	14.6%	14.6%	14.5%	14.5%	11.4%	11.4%
Outpatient DNA Rate - Community Adult Services (8%)	10.8%	10.8%	10.8%	10.8%				
Outpatient DNA Rate - Community Children's Services (8%)	13.0%	13.0%					13.0%	13.0%
Outpatient Clinics: % waiting less than 15 minutes (98%)	67.5%	67.5%	59.2%	59.2%	59.3%	59.3%	78.7%	78.7%
Community Average Waiting Times: Children (18 weeks)	14.9	14.9					14.9	14.9
Community Average Waiting Times: Adults (6 weeks)	5.1	5.1	5.1	5.1				
Data Quality: NHS Number Completeness - Acute (2011/12 total)		97.2%						
Data Quality: NHS Number Completeness - Community	99.9%	99.9%						
Data Quality: Outcomes Not Recorded - Acute (<0.5%)	0.2%		0.1%		0.1%		0.4%	
Data Quality: Outcomes Not Recorded - Community (<0.5%)	2.7%		1.5%				5.4%	

Above standard — near miss/at risk — below standard — not applicable

Arrows indicate an improvement/deterioration in performance determined by a change in RAG rating compared with the previous month (Trust level)

PERFORMANCE DASHBOARD
April 2012

Women, Children & Families Feedback

Indicator: Cancer Two Week Wait	**This Month**	(red)
	Last Month	(green)

Target: 93%

WCF 2 week wait breaches (March 2012)

Patient choice (cancelled day 13 - patient lives in home)

Patient DNA day 9 then cancelled day 14 (after clock re-set)

Choose & book rejection (originally referred as routine) but then booked after 15 days as target

Commentary & Action plan

Trust target is 93% and the reason for breaches is patient choice. Trust is achieving overall 93% and as there is few cancer pathways in W,C & F than other areas then the denominator is small therefore only 1 or two patients choosing appointments outside the target can skew the figures for our division.

Indicator: Cancelled Operations	**This Month**	(red)
	Last Month	(green)

Target: <0.8% of total elective admissions

April 2012 cancellations:

2 cases where the list overran
4 cases where there was no surgeon

Commentary & Action plan
Reviewing number of patients on lists to prevent over runs
Surgeon called in sick on day and no other consultant available, unusual and anticipate being Green next month

Indicator: Maternity bookings within 12wks 6 days	This Month	
	Last Month	

Target: 90%

Actual: April 2012 88.1%

Commentary & Action plan
Weekly monitoring in place additional clinics to meet spikes in demand when staffing permits

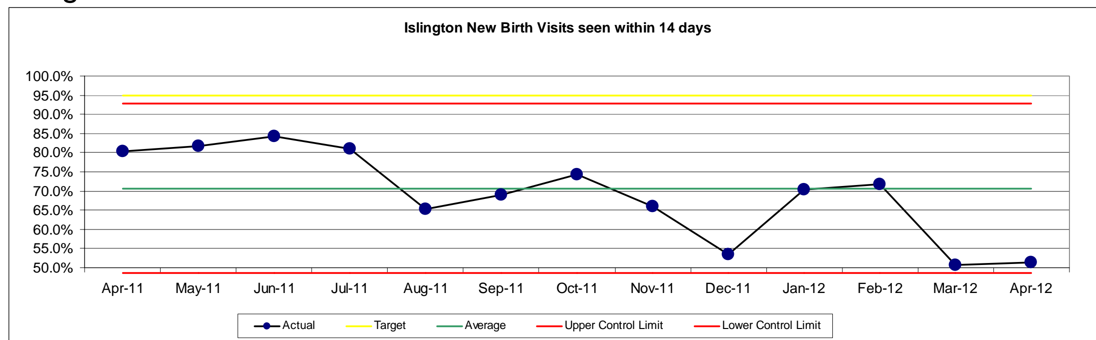
Update on Progress

Review of patient level data has indicated that target was missed by 1 patient. Increased pressure on service as high number of referrals still coming in to the department. Matron is monitoring on a weekly basis and putting additional slots in place where possible. Patient choice can mean we miss this target if patients DNA, Islington and Haringey are doing a piece of targeted work to increase awareness of reasons for early booking. So anticipate in a few months time to see an improvement

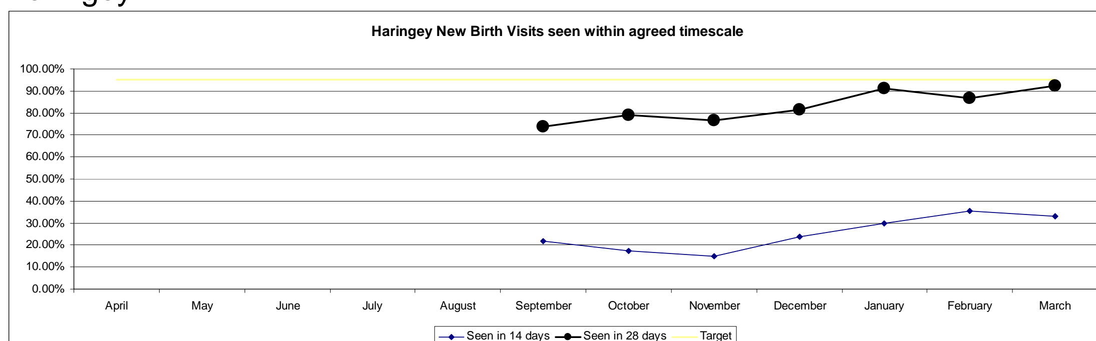
Indicator: New Birth Visits	This Month	
	Last Month	

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

Islington:



Haringey:



Commentary & Action plan
High levels of Health visitor vacancies across both Haringey and Islington, action plan in place to aid recruitment
Update on Progress
Staffing problems continue as outlined below. Current vacancies: Haringey: 4.86 (4 just recruited) against 11/12 budget Islington: 7.55 against 11/12 budget Current sickness: 3 wte in Haringey 1 wte in Islington plus 1 phased return Expansion in 12/13: Haringey: 5 wte with promise of increase Islington: 8 wte Students qualifying in September: Haringey 3 Islington 4

Indicator: Follow-Up Ratio (Upper Quartile)	**This Month**	
	Last Month	

Target: to achieve upper quartile by March 2013

Exclusions: Obstetrics

Specialty	Upper Quartile	Apr 12	Q1
Gynaecology	95 %	1.36	1.36
Paediatrics	93 %	1.35	1.35

Commentary & Action plan

Significant improvement from March Gynaecology was 1.55 and Paediatrics 1.48 showing the success of the actions below, anticipate this trend continuing.

Colposcopy regular follow up appointments have also been altered to annually instead of 6 monthly to reduce follow ups and increase clinic capacity.

An additional 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 started at Hornsey Central. This clinic runs as a one-stop clinic and therefore reduces patient attendances by up to two appointments. . There are plans to convert the hospital based outpatient hysteroscopy service to the same model.

Some previously hospital based community paediatrician clinics have been moved to the Northern Health Centre to reduce hospital recorded follow up.

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 feeding this back to the GP's should assist with managing inappropriate referrals.

Indicator: Cons to Cons Referrals (Upper Quartile)	**This Month**	
	Last Month	

Target: to achieve upper quartile by March 2013

Exclusions: Obstetrics

Specialty	Upper Quartile	Apr 12	Q1
Gynaecology	19 %	12 %	12 %
Paediatrics	20 %	23 %	23 %

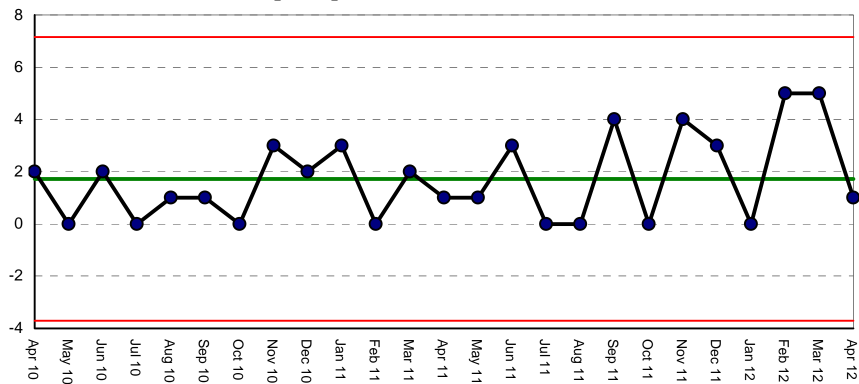
Commentary & Action plan

Achieved in Gynaecology, **need to review Paediatric data as previously achieving this target querying the target as previous data report has target as 29% so would be Green waiting response from Information dept**

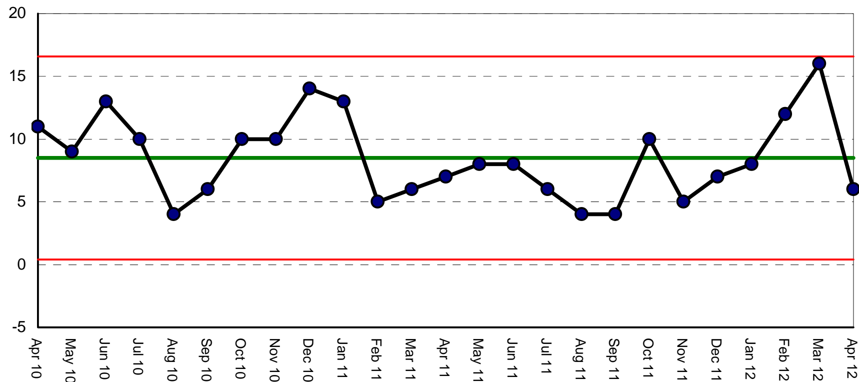
Update on Progress see above

Indicator: Readmissions	This Month	
	Last Month	

Readmission following original elective admission:



Readmission following original emergency admission:



Commentary & Action plan

Improvement this month but still need to undertake validation at patient level. Currently no capacity to do this as paediatric staff working in split site location while refurbishment is undertaken.

Some readmissions appear to be close to 30 days after the original admission date. Paediatrics is particularly difficult to measure here as differentiation between admission reason cannot be instantly determined from PAS ie. all Paediatric admissions are coded as ‘Paediatrics’ but admission could be for a different diagnosis.

Indicator: Consultant 7 day ward rounds	

Commentary & Action plan

Should be amber as consultant ward round rotas are in place for all specialties. Paediatrics, neonatology and labour ward rounds occur every day. Gynaecology and maternity ward rounds currently occur 50-60% of the time. Job plans are being reviewed in line with a change in Labour Ward cover at which point this figure should return to green. Anticipating this by December

Indicator: Discharges before 11am	This Month	
	Last Month	

Target: 50%

Betty Mansell: 26.4% in April 2012

Commentary & Action plan

Ward has had 3 additional beds and therefore increased temporary staffing which is impacting on achieving this target

Missing EDD data significantly reduced. Raised profile of this target with Matron and ward manager.

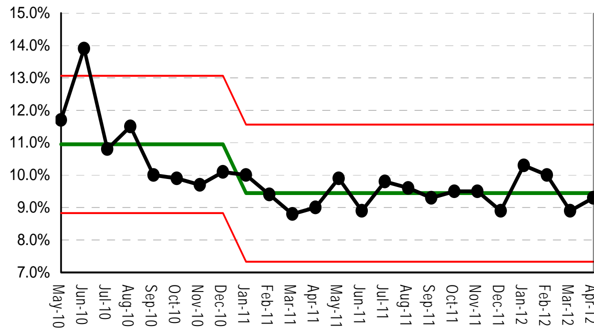
Exclusions not exempt from this report despite valid clinical reason not to be counted, e.g TWOC patients.

Majority of patients on Betty Mansell ward remain Medical not Gynae which increases the difficulty of achieving this target, improvement since last month, however the target does not report patients who where discharge the day before EDD but after 11am.

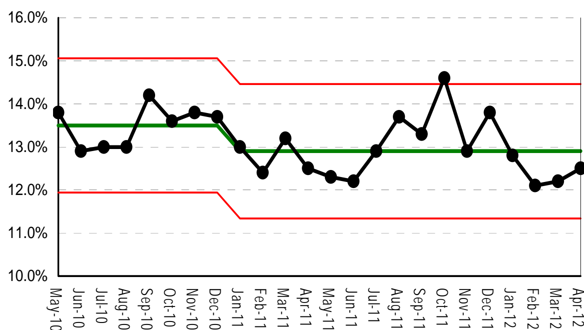
Indicator: DNA Rate – Acute	This Month	
	Last Month	

Target: <8%

First Attendances



Follow-Up Attendances



Commentary & Action plan

Much work has been undertaken within Colposcopy to reduce DNA rates including patients being texted, telephoned and sent reminder letters and this has remained fairly low as a result.

The Trust DNA policy has been adhered to strongly in Gynaecology and this is reflected in their low DNA rate. Maternity and Paediatric have a local policy due to safe guarding issues and therefore those who DNA are offered alternative appointments.

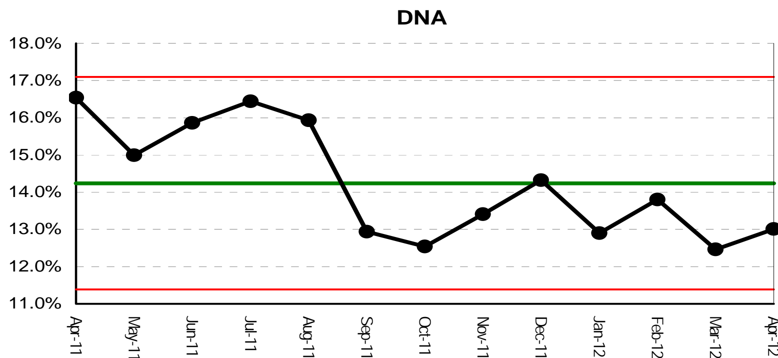
Both Maternity and Paediatric DNAs are reviewed by the relevant clinician and attempts are made to discover why the patient did not turn up and to re-book an appropriate appointment. This information is recorded in the notes.

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

Update on Progress

Nothing to report; work ongoing

Indicator: DNA Rates – Community	This Month	
	Last Month	



Commentary & Action plan
DNA rates have significantly reduced in child development services, due to new texting system. In physiotherapy MSK services this still remains high and we are carrying out a telephone survey to look at reasons for this. SLT introducing texting in Nov so hope to see an improvement following this.

Update on Progress

Work continuing but children's services and in particular paediatric services are hard to engage, reviewing systems in audiology and spreading best practice.

Indicator: Waiting times in outpatient clinics	This Month	
	Last Month	

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

Colposcopy	78.3%
Gynaecology	85.1%
Maternity Ante-Natal OP	95.1%
Paediatrics	16.7%

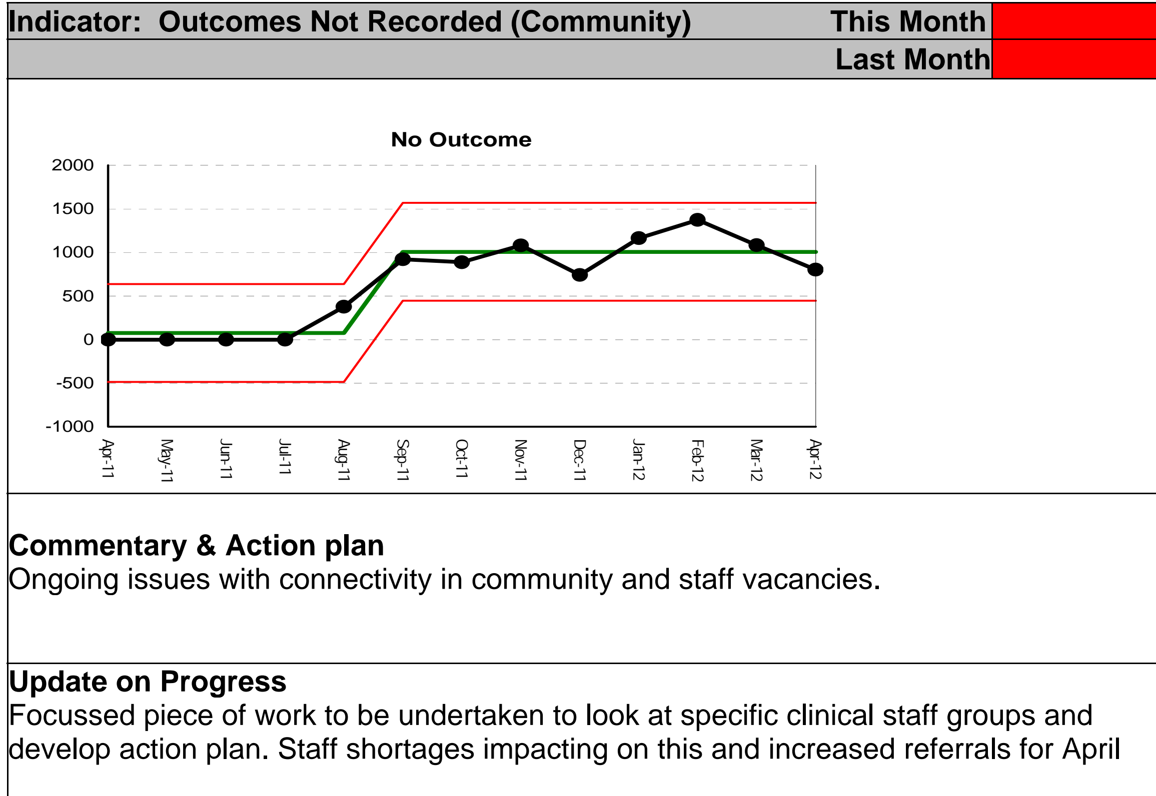
Commentary & Action plan

This target will be monitored at the monthly WCF Performance Meetings

Update on Progress
Continued Medical staff sickness in Obstetrics and Gynae impacting on waiting times
High sickness in junior Paediatric staff

Staff across the division will be reminded to input missing data.

Indicator: Outcomes Not Recorded (Community)	This Month	
	Last Month	



Commentary & Action plan
Ongoing issues with connectivity in community and staff vacancies.

Update on Progress
Focussed piece of work to be undertaken to look at specific clinical staff groups and develop action plan. Staff shortages impacting on this and increased referrals for April

PERFORMANCE DASHBOARD
April 2012

ICAM Feedback

Indicator: Emergency Department 4 Hour Performance	This Month	
	Last Month	

Target: 95%

April 2012 performance: 94.9%

Commentary & Action plan
Following the interim visit from the National support team this indicator needs to be viewed as part of the whole system change to the acute pathway.

Performance has deteriorated since last month and there is direct linkage to bed capacity issues causing backflow in ED. However, there remain days where bed capacity has not been an issue and performance had been poor.

Planned actions:
- Further test methods of rapid assessment and treatment
- Review internal professional standards document to make expectation of visiting teams more explicit
- Changes to the internal escalation policy to ensure Consultant staff are contacted when trigger points are reached
- To develop closer working between ED and admission unit

Expect to be green by June 2012

Indicator: RTT Completed Non-Admitted Pathways	This Month	
	Last Month	

Target: 95% within 18 weeks in all specialties

April 2012 performance: 98.6% overall; standard not achieved in Pain Relief

Commentary & Action plan

Indicator: RTT Incomplete Pathways	This Month	
	Last Month	

Target: 92% waiting within 18 weeks in all specialties

April 2012 performance: 86.4% overall

Commentary & Action plan

Indicator: Cancer Two Week Wait	This Month	
	Last Month	

Target: 93%

ICAM 2 week wait breaches (March 2012)

Suspected haematological malignancies	Patient choice (cancelled day 9 as still abroad at time of appointment)
Suspected lung cancer	Patient choice (cancelled day 12 due to holiday)
Suspected upper gastrointestinal cancer	Patient choice (cancelled day 13 - straight to test appointment)
Suspected upper gastrointestinal cancer	Patient choice (cancelled day 13 via support worker due to receiving letter late)
Suspected upper gastrointestinal cancer	Patient choice (straight to test)
Suspected upper gastrointestinal cancer	Straight to test - cancelled on day of procedure as patient had not followed starving instructions
Suspected upper gastrointestinal cancer	Not booked within 14 days

Commentary & Action plan

Trust target is 93% and the reason for breaches is down to patient choice booking outside the 14 day target. Trust is achieving overall 93% and as there is few cancer pathways in ICAM that other areas then the denominator is small therefore only 1 or two patients choosing appointments outside the target can skew the figures for out division.

Indicator: Follow-Up Ratio (Upper Quartile)	This Month	
	Last Month	

Target: to achieve upper quartile by March 2013

Exclusions: Respiratory Medicine and Gastroenterology

Specialty	Upper Quartile	Apr 12	Q1
Cardiology	0.92	2.30	2.30
Diabetic Medicine	3.48	15.68	15.68
Endocrinology	2.46	3.34	3.34
General Medicine	1.52	9.03	9.03
Geriatric Medicine	1.37	3.91	3.91
Haematology (Clinical)	4.84	7.87	7.87
Nephrology	3.92	3.95	3.95
Neurology	0.89	0.81	0.81
Pain Relief	1.42	1.95	1.95
Rheumatology	3.18	3.85	3.85

Commentary & Action plan

Cardiology
Cardiac Rehabilitation and Nurse Led Clinics are being moved and therefore should see an improvement in December report

Diabetes
A date is being set for a table top exercise. To include clinical lead, specialist nurse, within January.

Elderly Care
Incorrect procedure codes- including tissue viability sessions at Dorothy Warren Day Hospital. Action : data clean

Acute Medicine
JLM activity to be removed as agreed at ICAM board.

Update on Progress:
Discussions are underway with CCGs to discuss how patients from diabetes will be repatriated back to GPs. The organisational change implementation date for nursing workforce is the 1st July when we will be able to plan transfer of all the appropriate nurse led intermediate care activity to community clinics.

Cardiac rehab and nurse led activity continue to included in activity – this should be included.

General Medicine continues to be an major issue for the division as it includes James Malone Lee's activity and the performance of this speciality falls within the surgical division. This speciality needs to be divided in two for performance purposes.

Elderly Care are still seeing problems with data which has eventually been resolved and relates to outcomes for procedure codes but also the booking of ward discharges

as follow ups rather than new patients into the services. This has now been addressed but will only start being reflected in April activity but will see complete. Ward discharges were also being booked as follow up when in fact they should have been booked as new – this has now been rectified.

Rheumatology consultants are undertaking a further review of clinics and templates to reflect what the activity should be to achieve upper quartile. This should be completed by July.

Pain has done considerable work toward achieving median range and is very near achieving upper quartile. It should be noted that the difference between achieving 1.42 ratio is the difference of 3 patients.

Haematology has been showing as an outlier however activity charts and analysis from the data shows the clinical haematology is in fact achieving its target.

Endocrinology is continue to be an outlier due to maternity clinics being included in data. This should be coded to maternity clinics but financial flows need to be agreed between divisions.

Consultant	First Atts	Follow-Up Atts	Follow-Up Ratio	Excess Follow Ups (Median)	Excess Follow Ups (Median) £	Excess Follow-Ups (Upper Quartile)	Excess Follow Ups (Upper Quartile) £
Dr. B. Davis	12	51	4.25	0	£0	0	£0
Dr. F. Shah	12	73	6.08	0	£0	15	£2,163
Dr. N. Parker	22	45	2.05	0	£0	0	£0
Haematology (Clinical) Total	**46**	**169**	**3.67**	**0**	**£0**	**0**	**£0**

Nephrology is an outlier by just 1 patient

Indicator: Cons to Cons Referrals (Upper Quartile)	This Month	
	Last Month	

Target: to achieve upper quartile by March 2013

Exclusions: Respiratory Medicine and Gastroenterology

Specialty	Upper Quartile	Apr 12	Q1
Cardiology	24 %	21 %	21 %
Diabetic Medicine	18 %	25 %	25 %
Endocrinology	16 %	16 %	16 %
General Medicine	27 %	21 %	21 %
Geriatric Medicine	35 %	52 %	52 %
Haematology (Clinical)	27 %	24 %	24 %
Nephrology	21 %	32 %	32 %
Neurology	17 %	13 %	13 %
Pain Relief	30 %	29 %	29 %
Rheumatology	14 %	16 %	16 %

Commentary & Action plan

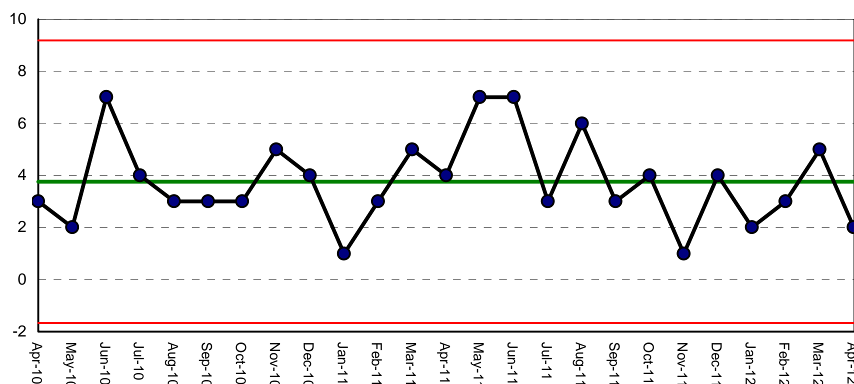
Significant work has been done by all departments to reduce consultant to consultant referrals to their departments. Further work is being undertaken with each speciality to take achieve the upper quartile but it should be noted that the numbers of patients that are relevant to achieving this upper quartile are very small and therefore harder to monitor from month to month
Cardiology - 2 patients
Diabetes - 2 patients
Geriatric Medicine – 7 patients
Nephrology – 3 patients
Rheumatology – 2 patients

Indicator: Emergency Readmissions	This Month	
	Last Month	

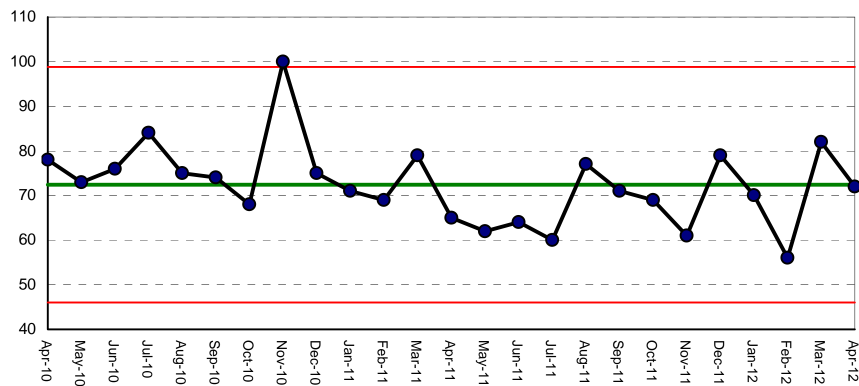
Target:
Following emergency admission: to achieve a 25% reduction on 2010/11 levels
Following elective admission: 0

Readmissions have been adjusted as per PbR guidance. Only readmissions relating to the same HRG chapter as the original admission are shown.

Following original elective admission:



Following original emergency admission:



Commentary & Action plan

What has already been done

AECS project group set up with wider remit on readmissions following confirmation of 30 day readmission monies

Proposed actions

1. Implementation and on going expansion of the Ambulatory Emergency Care Service.
2. 10 PAs per week of Consultant leadership
3. Large scale MDT audit of 100 readmissions to improve our understanding of issues
4 Development of patient information leaflets to improve discharge planning and options available to patients who encounter post discharge concerns
5. Development of a virtual ward to offer additional community support to those deemed at risk of readmission
6. MDT meetings to discuss frequent attendees to ED / readmissions

PROJECT GROUP ASSESSING IMPACT OF BED PRESSURES EARLY DISCHARGES ON READMISISON RATES

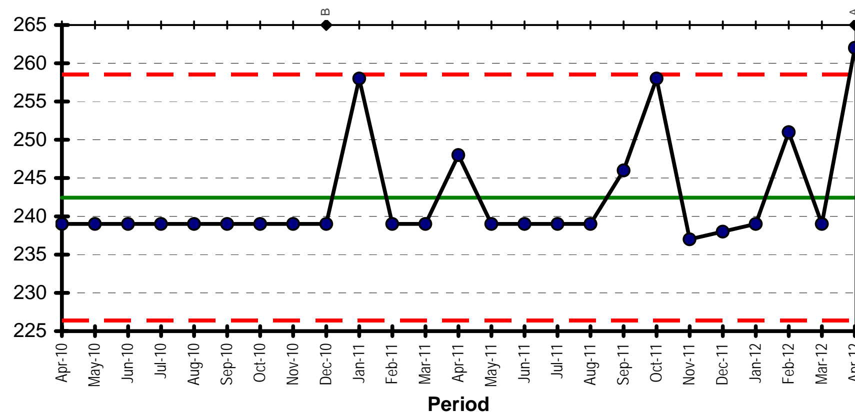
Responsibilities & timetable

Clinical leads, Clarissa Murdoch , Natalie Richard. Operational Lead Paula Mattin
We aim to:
During Q1: demonstrate three consecutive months with less that 70 readmissions
During Q2: demonstrate three consecutive months with less that 60 readmissions
During Q3: Hit target

Update on Progress:

Indicator: Total Time in ED	This Month	
	Last Month	

Target: 95th percentile to be less than 240 minutes



Commentary & Action plan

Following the interim visit from the National support team this indicator needs to be viewed as part of the whole system change to the acute pathway.
Performance has deteriorated since last month and there is direct linkage to bed capacity issues causing backflow in ED. However, there remain days where bed capacity has not been an issue and performance had been poor.

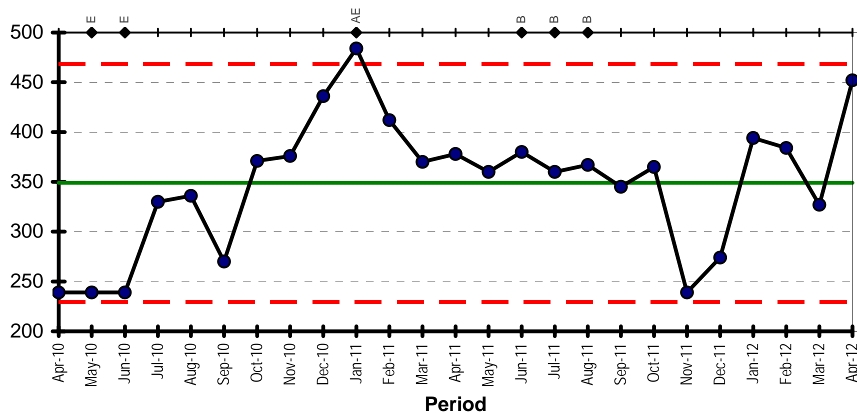
Planned actions:

- Further test methods of rapid assessment and treatment
- Review internal professional standards document to make expectation of visiting teams more explicit
- Changes to the internal escalation policy to ensure Consultant staff are contacted when trigger points are reached
- To develop closer working between ED and admission unit

Expect to be green by June 2012

Indicator: Total Time in ED for admitted patients	This Month	
	Last Month	

Target: 95th percentile to be less than 240 minutes



Commentary & Action plan

Bed capacity pressures impact on this target
Mental health admissions cause some of the longest waits
Meeting held in Dec 11 with C&I MHFT who will now provide a response on breaches as part of the breach analysis.
Discussions taking place with Planning and Performance Team to renegotiate the Camden and Islington Foundation Trust SLA. The 12/13 SLA will include explicit targets that reflect Quality indicators.
Developed a shared mental health escalation plan which has been operationally agreed but requires ratification by ICAM Board
Bed modelling review being undertaken
Developing a SAU
Planning to review recommendations from National Support Team in relation to how we use MAU
Expansion of Ambulatory Emergency care to offer alternative to admisison
Also see action for pre 11am discharge and reduction in length of stay.

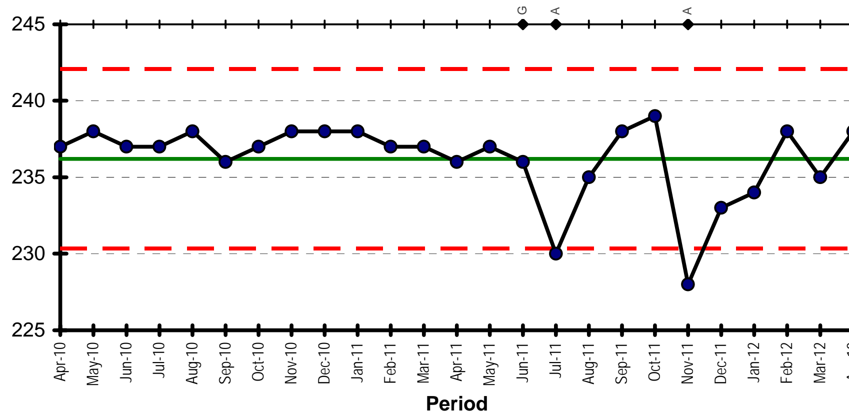
Update on Progress:

During April the Trust continued to experience several episodes of intense bed pressures which have impacted upon total time for admitted patients again this month.
Bed modelling workshop planned for May 2012.
The planned changes to the bed base (Cavell Ward and development of a dedicated T&O unit) will take time to settle.

It is not anticipated that this target will not be green rated within the next 3 months.

Indicator: Urgent Care – Wait for Treatment	This Month	
	Last Month	

Target: Median wait to be less than 60 minutes **WRONG GRAPH**



Commentary & Action plan

- Development of "pit stop" assessment of major patients to speed up diagnosis and clinical decision – commenced Nov 11
- Establish a dedicated team who would in busy periods 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
- Escalation plan in place and ratified at EC
- In process of developing inter-professional standards for the ED clarifying expectations for joint working between ED and speciality teams

Update on Progress

- Changes now made to the IT system to capture nurse initiated treatment staff being instructed on this change and we expect to see impact over next few months - PM leading on this
- Agreement on sixth ED Consultant post will increase availability of senior decision makers
- Need to amend and test new models for see and treat.
- By May expect to hit 70 mins
- Expect to be green end of Q2

Indicator: Complaints Response Times	This Month	
	Last Month	

Target: 85%

29 out of 35 responded to in time (March 2012)

Commentary & Action plan

Indicator: Consultant 7 day ward rounds	This Month	
	Last Month	

Commentary & Action plan
Action plan completed and expected delivery of model to be implemented by August 2012. See action plan attached. Recruitment for locum posts has begun for all divisions to fill gaps in the interim whilst substantive recruitment is undertaken.

Indicator: Consultant presence 8-8 every day	This Month	
	Last Month	

Commentary & Action plan
As above.

Update on Progress:

Business case was presented to EC on 14 March and approved. We are now currently drafting proposed timetables and job plans for the new appointments and intend to recruit to two of the posts as locums as quickly as possible for six months to ensure that we have cover arrangements in place whilst the substantive recruitment, which takes longer, are put in place. ED consultant will be recruited to substantively within the next few weeks.

Indicator: Discharge before 11am	This Month	
	Last Month	

CAVELL WARD	13.3%
CLOUDESLEY WARD	40.5%
MARY SEACOLE SOUTH	26.7%
MARY SEACOLE WARD	17.6%
MERCERS	19.6%
MEYRICK WARD	30.2%
MONTUSCHI WARD	12.2%
NIGHTINGALE	17.0%

Commentary & Action plan

At the end of the week to 1.4.2012 two wards had exceeded the target, Mercers (54.5%) and Meyrick (69.2%). Meyrick has very actively engaged in the daily discharge board rounds, and weekly point prevalence.

Nightingale had 0% discharges before 11am (w/e 1.4.12), but achieved 85% discharged before the EDD.

Advice from ENIST is to make the target achievable and it is recommended that, as this is no longer a CQUIN, the target is set at 40% which would allow for enough beds to be identified in the morning for patient flow to be maintained but would be more achievable.

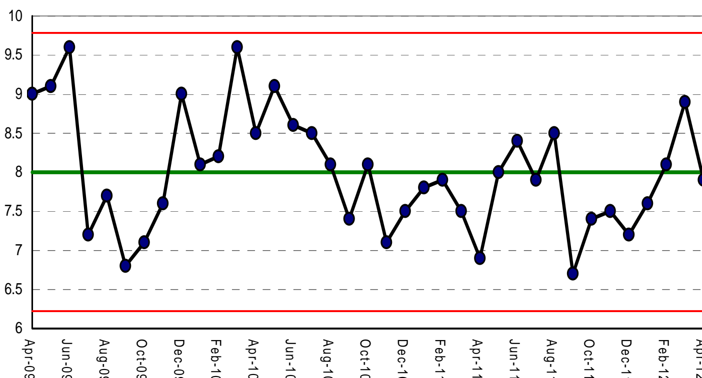
It is also recommended that the two Mary Seacole medical assessment wards be removed from the target report, as the pattern of work is different, and it might be entirely appropriate for people to be discharged later in the day once their assessment and treatment is completed.

Making the amendments to the target (which is no longer a CQUIN, but which is important for maintaining available beds and reducing waits for admission) would make it more possible to achieve. 40% matches what other high performing trusts are achieving.

DT leading on this target.

Indicator: Average Length of Stay reduction	This Month	
	Last Month	

Target: 1 day by March 2013

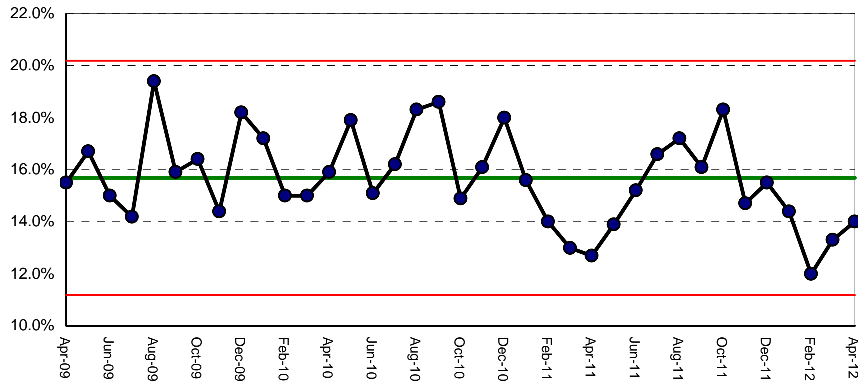


Commentary & Action plan Reducing LOS multifactorial and will involve actions as reported last month: - Setting EDD at point of admission and one that is clinically owned. Continuing to push for and report discharges before 11am Targeted work on lengths of stay over 14 days Proactive targeting of readmissions with rapid progressed discharge. Daily ward/board rounds and active use of whiteboards Impact of successful ambulatory care (ICRAS) might be to increase average LOS if avoid very short stay admissions. Suggest monthly ward based discharge performance reports produced – to include LOS, over 14 day stays, weekend discharges, pre 11 am discharges, EDD set, and reattendance/readmissions of discharges from that ward. From overall report not clear why LOS has gone up - ? increased number of outliers.
Update on Progress: Setting criteria led EDD at point of admission – Dr. Murdoch leading on review of post-take forms to improve this. Continued focus on pre 11am discharges – as above Joined up discharge planning with hospital SW to create one complex discharge team (achieved April 2012) Targeted work on lengths of stay over 14 days – number has reduced (85 to 76 in last two months). Discharge team to check reports monthly to ensure accurate. Proactive targeting of readmissions with rapid progressed discharge. Daily ward/board rounds and active use of white boards as part of Discharge Project (DT lead) – pilot of redesigned whiteboard layout and handover sheets on Meyrick and Cloudsley to be reviewed prior to NIST visit 30.5.12.

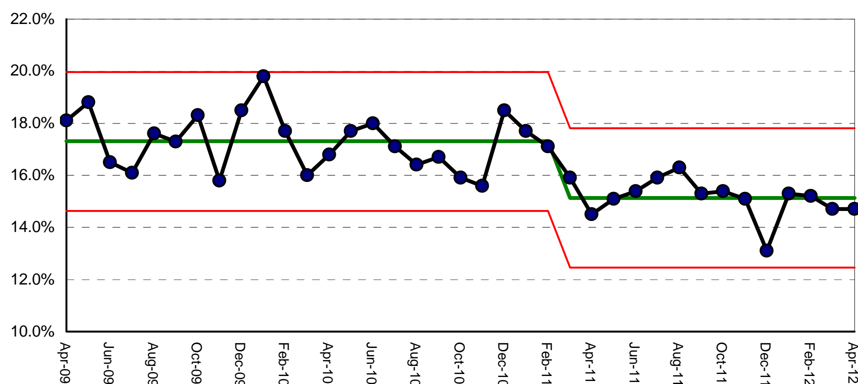
Indicator: DNA Rates – Acute	This Month	
	Last Month	

Target: <8%

First Appointments:



Follow-Up Appointments:



Commentary & Action plan

Pan divisional approach

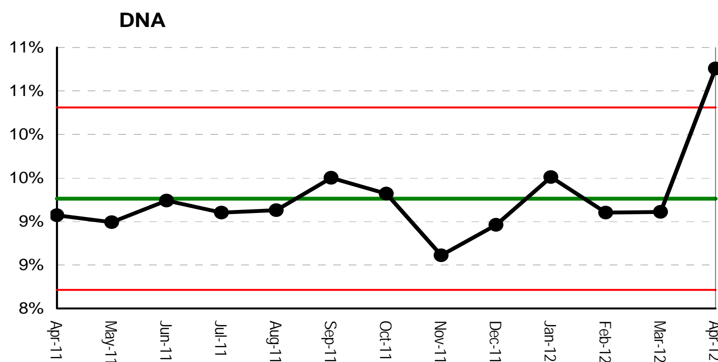
Further discussion on how this can be managed collaboratively - as with other outpatient kpis

Update on Progress:

It is clear that the trajectory is heading in the right direction as current rag rating has improved. This has been as a result of more proactive approach to discharging patients after 1st DNA where appropriate and better slot utilisation within the clinics. However, there is still further work to be done is some of the specialities. The organisation how now set up an operational group across divisions to work collaboratively in order to address the pan-division issues that will address further improvement in this target, such as partial booking for follow ups, full booking for new appointments.

Indicator: DNA Rates – Community	This Month	
	Last Month	

Target: <8%



Commentary & Action
DNA rate has shown an increase in April from the following areas
MSK
Nutrition and Dietetics
Respiratory service
Cardiology service
Podiatry

In general the median for DNA's in community services averages at around 9.5%. All community service have been asked to benchmark their DNA's rates against national figures to provide a more reflective picture on performance within like for like services. We feel that the local target may need to be reviewed in terms of realistic achievability.

In order to improve productivity cardiology and respiratory services are increasing their clinic capacity and reducing their case management. This has meant encouraging more patient to attend clinics where possible. We will be putting in an action plan to improve the DNA rate in these areas.

Nutrition and dietetics saw an increase from previous improvement in Q4. However lower than average activity this month has reflected in a higher DNA rate. This is currently being investigated.

MSK services are currently undertaking a RIO migration onto one server. In order to effectively manages appointments patients are being sent "opt in " letters in which they have to contact the service to activate an appointment. We anticipate that this new way of appointing will help to manage the DNA rate more effectively. Timing of "opt in" letters is crucial to ensure patients can respond within an adequate time period. We are currently experiencing postal problems which we are in the process of sorting out.

Podiatry service is experiencing higher DNA rate which have resulted from follow-up patients. Actions are in place to address this such as text messaging reminders however national DNA rates for podiatry run between 18-25%.

Update on Progress: **As above**

Indicator: Waiting times in outpatient clinics	This Month	
	Last Month	

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

	Apr
Cardiology	73.2%
Diabetics	73.9%
Elderly Care	33.3%
Endocrinology	83.8%
Gastroenterology	35.8%
General Medicine	71.4%
Haematology (Clinical)	57.9%
Nephrology	46.4%
Neurology	61.7%
Pain Relief/Anaesthetic	66.0%
Rheumatology	41.5%
Thoracic Medicine	68.9%

Commentary & Action plan

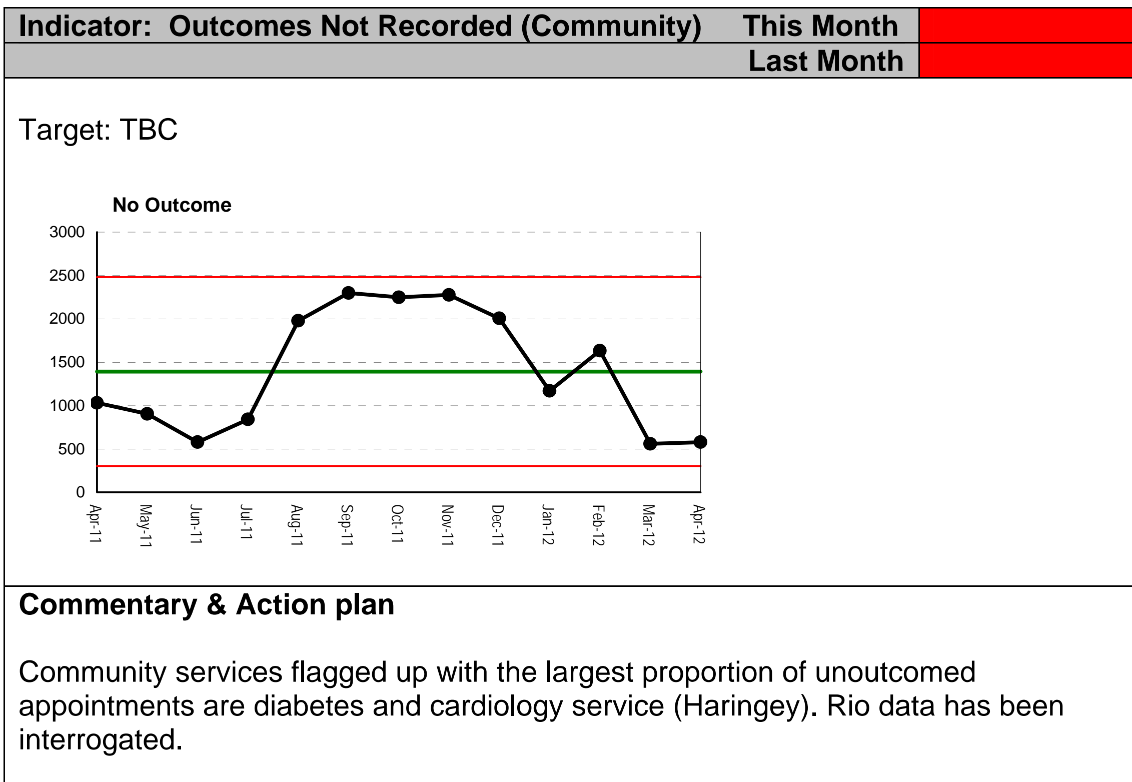
An action plan will be put into place on how this can be managed corporately.

Update on Progress:

An action plan will be put into place on how this can be managed corporately

Indicator: Outcomes Not Recorded (Community)	This Month	
	Last Month	

Target: TBC



Commentary & Action plan

Community services flagged up with the largest proportion of unoutcomed appointments are diabetes and cardiology service (Haringey). Rio data has been interrogated.

Update on Progress:
It is clear that timely reporting is essential for accurate reflection of performance. Cardiology and diabetes service did not report their outcomes by the 5th of the month and therefore reflect a high unoutcomed percentage. Action plan is in place for both services to ensure that data is sent by the 5th of the month and a reminder to outcome any remaining unoutcomed appoitment by the 1st of each month. We should start to see improvement for May/June.

PERFORMANCE DASHBOARD
April 2012

Surgery, Cancer, & Diagnostics Feedback

Indicator: RTT Completed Admitted Pathways	This Month	
	Last Month	

Target: 90% within 18 weeks in all specialties

April 2012 performance: 92.4% overall; standard not achieved in Orthopaedics

Commentary & Action plan

This is an amended target for 2012/13 – previously measured Trust wide but from 2012/13 performance also measured at specialty level.

Main challenged specialty relates to orthopaedic services, which is nationally one of the most challenged areas for achieving 18 week specialty level performance. Trajectory was submitted to NCL along with all other Trusts in the sector outlining plans for achieving this at a specialty level 90% by September 2012.

Current waiting lists are being reviewed and being redistributed (excluding sub specialty and named consultant work) to ensure that available capacity is maximised. Additional clinical capacity has been identified and agreed as part of the job planning process during, which will increase overall capacity. There will however continue to be specific challenges associated with certain sub-specialty areas and admitted waiting time- spinal, hip and certain knee procedures (named surgeon). A new spinal pathway

For these areas confirmation is required for the contract position regarding 18 week penalities and also payment for over performance if activity is required to be significantly above current levels to maintain 92% performance.

Indicator: RTT Incomplete Pathways	This Month	
	Last Month	

Target: 92% waiting within 18 weeks in all specialties

April 2012 performance: 97.2% overall; standard not achieved in Oncology

Commentary & Action plan

All specialties achieved the target with the exception of oncology- which is a low volume specialty which had some patients over the incomplete target.

The General Manager for Surgery has reviewed the current pathway for oncology incomplete pathways with the cancer services manager and reviewed the patient tracking associated with the MDT coordinators. As a result the validation process and tracking of oncology has been strengthened to ensure all incomplete pathway data is accurately captured and reflected on the performance data to ensure compliancy with the incomplete pathway target

Indicator: Cancelled Operations	This Month	
	Last Month	

Target: <0.8% of total elective admissions

April 2012 cancellations:

Total of 13 cancellations in month

1 General Surgery
1 General Surgery
11 Urology

Commentary & Action plan

Cancellations are monitored extremely closely by the theatre team and escalated on a daily basis to ensure cancellations are minimised. The target has been fully achieved continuously for the last 12 months. Unfortunately, this was an exceptional month and the target was missed primarily as a result of the urology middle grade being unavailable on the morning of a planned urology cystoscopy list. The list could not be covered on the morning as all remaining clinicians had clinical lists (theatres IP and DTC or clinic) - as a result the cystoscopy list had to be cancelled and patients given new dates for the procedure which resulted in 11 out of 13 cancellations. All patients have been theatres or planned and this was exceptional month. Rates now returned to lower than threshold and year to date target achieved.

It is expected to return to Green during May 2012.

Indicator: Follow-Up Ratio (Upper Quartile)	This Month	
	Last Month	

Target: to achieve upper quartile by March 2013
Exclusions: Oncology

Specialty	Upper Quartile	Apr 12	Q1
Dermatology	1.41	2.15	2.15
Ent	1.08	0.86	0.86
General Surgery	1.12	1.58	1.58
Ophthalmology	1.96	2.55	2.55
Plastic Surgery	1.05	0.91	0.91
Trauma & Orthopaedics	1.55	1.91	1.91
Urology	1.74	1.76	1.76

Commentary & Action plan

Ophthalmology and Trauma and Orthopaedics continue to be the main areas of focus for the division with regards to this metric. Ophthalmology and orthopaedic clinics to be reviewed in conjunction with Performance and Planning as both include support staff run clinics (orthotics, optometrist).

In addition to reviewing the information and coding a clinical notes review will be undertaken by consultants in each of the service with aim of discharging patients with non-essential follow-up ratios.

Update on Progress

Work still ongoing with ophthalmology and orthopaedic teams as part of the notes review and service configuration- this is being led by the General Manager for Surgery in conjunction with the Service Manager and the Clinical Lead for orthopaedics- to be completed May 2012. Decreases continue to be seen in month with a reduction in these specialty follow-up ratios in March compared to Q4.

Following on from the notes audit the clinical team are working on the development of specific clinical profiles linked to the target follow-up ratio in order to standardise pathway follow-up and imaging.

Additional work in orthopaedics is also taking place to centralise the Image Exchange Portal (IEP) pulling and clinic preparation and to alongside this enable linked appointments for all modalities of imaging (including MRI) to try and optimise one stop initial appointments and reduce unnecessary follow review - completion May 2012.

The Divisional Team are awaiting the current list of included /excluded clinics linked to the agreed contract measures from the finance team in order to review and ensure correct exclusions/inclusions within the data - this is particularly relevant as some acute (low follow up ratio activity) is now being delivered in the community but excluded from the above measures- which is adversely impacting on acute delivered activity, despite it being the same specialty.

Division is marked red on basis it is not yet at upper quartile performance- however, this is a target not due to be complete until March 2013. The division has a clear trajectory for achieving upper quartile performance by March 2013 with two of the specialties already achieving upper quartile performance.

Currently G Surgery data includes bariatrics and the division is increasing bariatric work in 2012/13 in line with agreed SLA> However, bariatrics is not excluded from KPI metrics despite having higher follow up rates than G Surgery clinics and the fact that there are only a few providers of bariatric surgery across London.

Similarly dermatology community clinics in Islington are now being excluded from the follow up ratio. The community model sees less complex dermatology patients (lower follow up ratio) with the aim of the complex patients remaining in the acute setting. As a result acute follow-up ratio will be higher than community ratio but currently community rates excluded, which is creating artificially increased acute follow up rate.

Indicator: Cons to Cons Referrals (Upper Quartile)	This Month	
	Last Month	

Target: to achieve upper quartile by March 2013

Exclusions: Oncology

Specialty	Upper Quartile	Apr 12	Q1
Dermatology	4 %	8 %	8 %
Ent	12 %	9 %	9 %
General Surgery	14 %	24 %	24 %
Ophthalmology	16 %	21 %	21 %
Plastic Surgery	27 %	45 %	45 %
Trauma & Orthopaedics	42 %	12 %	12 %
Urology	20 %	19 %	19 %

Commentary & Action plan

Plastic surgery is a consultant to consultant service and should not be included in the figures as is mainly a consultant to consultant based service, supported by visiting plastics input.

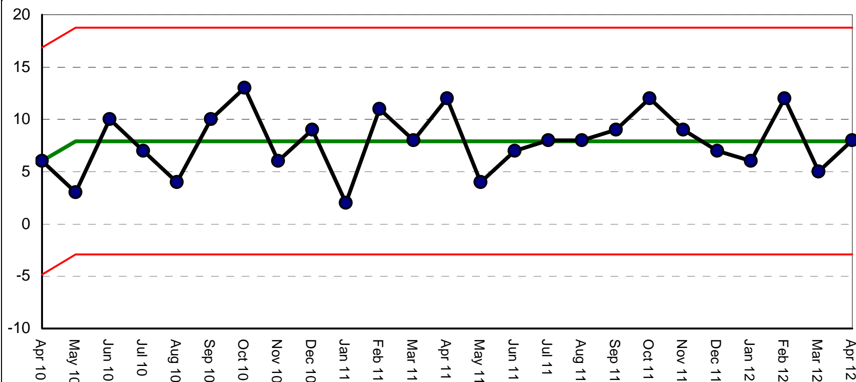
Target is set to reach UQ by March 2013- three of remaining specialties are already achieving UQ performance and action plans are in place to meet the March 2013 trajectory

Indicator: Emergency Readmissions	This Month	
	Last Month	

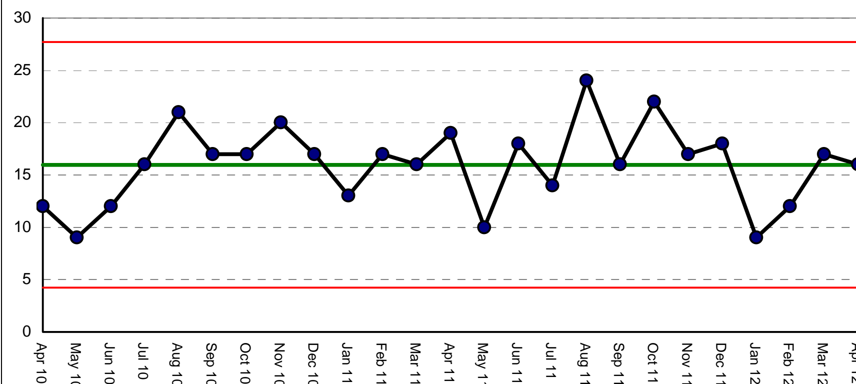
Target: 0 readmissions following elective discharge

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

Following original elective admission:



Following original emergency admission:



Only readmissions related to the original admission have been included (same HRG chapter). Exclusions as per PbR guidance.

Key updates since the last performance report:

New general surgery consultant rota starts 29 June 2012, which will ensure 12/7 consultant presence and input enabling more senior decision making both in the discharge and admission process.

Protocols have now been developed and are in place for urology conditions to reduce admissions and support ambulatory care model. In addition, a pilot has now commenced on May 15th which involves a nominated Urology CNS being available in-hours to triage any queries from Urology outpatients. This action was identified following an avoidable admission post op and subsequent complaint. This is supported by a named consultant Urologist. If it is proven to be successful, this will be rolled out to cover out-of hours.

Coyle and Thorogood ward are now ring fenced from May 2012 onwards, linked to the fractured neck of femur project, this will support earlier intervention and compliancy with the fractured neck of femur pathway and will support earlier discharge. Significant progress has already been seen on the project work to date with average length of stay reducing from 21 days to an average 14 days in the first three months of the project. to be ring fenced for orthopaedic patients only from May 2012 to support fractured neck of femur work.

As stated previously the target for zero elective readmissions continues to be extremely challenging and potentially unachievable given the complex elective case mix at the Trust - including major colorectal and bariatric surgery, which has an associated complication factor and potential readmission risk.

Indicator: Complaints Response Times	**This Month**	(red)
	Last Month	(amber)

Target: 85%

8 out of 11 responded to in time (March 2012)

Commentary & Action plan

3 complaints were responded to out of time during the reporting period. The overall complaints response performance was compounded by 3 delayed responses during a reporting period with a relatively low overall volume of reported complaints. 2 of the delays were specifically associated with delays in obtaining consultant statements/information in time to enable the responses to be completed. One delay was associated with sickness in the PALS/complaints office. The key actions are detailed below and the Division is expected to return to green RAG rating for April 2012 data.

- Complaints performance is now monitored on a weekly basis at the Divisional Management Team meeting chaired by the Director of Operations and Divisional Director.
- Delayed responses are escalated on a weekly basis at the DMT meetings to the Director of Operations and Clinical Director leads if delay is related to late

clinician response.

- The Complaints office are escalating delayed responses to the Director of Operations at an earlier stage in the process

This KPI should return to green RAG rating in the next dashboard report.

Indicator: Consultant 7 day ward rounds

Commentary & Action plan

New general surgery consultant rota starts 29 June 2012, which will ensure 12/7 consultant presence and input enabling more senior decision making both in the discharge and admission process. Will be red rated until then.

Indicator: Consultants on call with no elective commitment

Commentary & Action plan

See above commentary as links to appointments – additional two general surgery consultant posts are currently out to advert. On-call and elective commitment rota being drafted to be implemented from April to enable twice daily consultant-led 7 day ward rounds.

Update on Progress

New general surgery consultant rota starts 29 June 2012, which will ensure 12/7 consultant presence and input enabling more senior decision making both in the discharge and admission process. Will be red rated until then.

Indicator: Discharges before 11am	This Month	
	Last Month	

Target: 50%

COYLE WARD	23%
VICTORIA WARD	36%

Commentary & Action plan

Weekly monitoring of target.

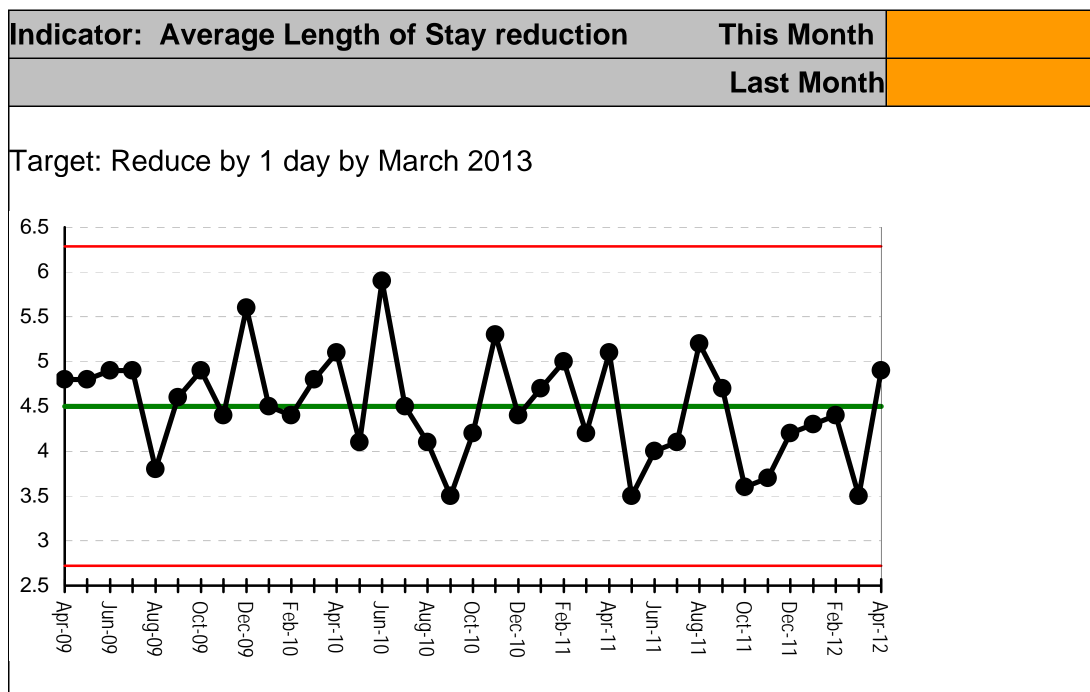
Ward managers and Matrons continue to work on addressing the following key elements:

- 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 need to void satisfactorily on a number of occasions and have a bladder scan. These are usually post op patients.
- 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.

There continue to be challenges associated with some of the patient data as indicated by local sample audits. During further local audits approximately 20-25% of surgical discharges classed as after 11 am were either patients discharge before their Estimate Date of Discharge (the night before) and so had a reduced length of stay, where transferred to another ward or should have been excluded (TWOC patients). In all sample cases they continue to be included in the post- 11 discharge on the reports as the data is based on an automated PAS report of time of discharge and cannot capture such issues without manual validation. Further work is ongoing with the information team in order to identify a mechanism for correcting these issues without the need for manual updating.

Indicator: Average Length of Stay reduction	This Month	
	Last Month	

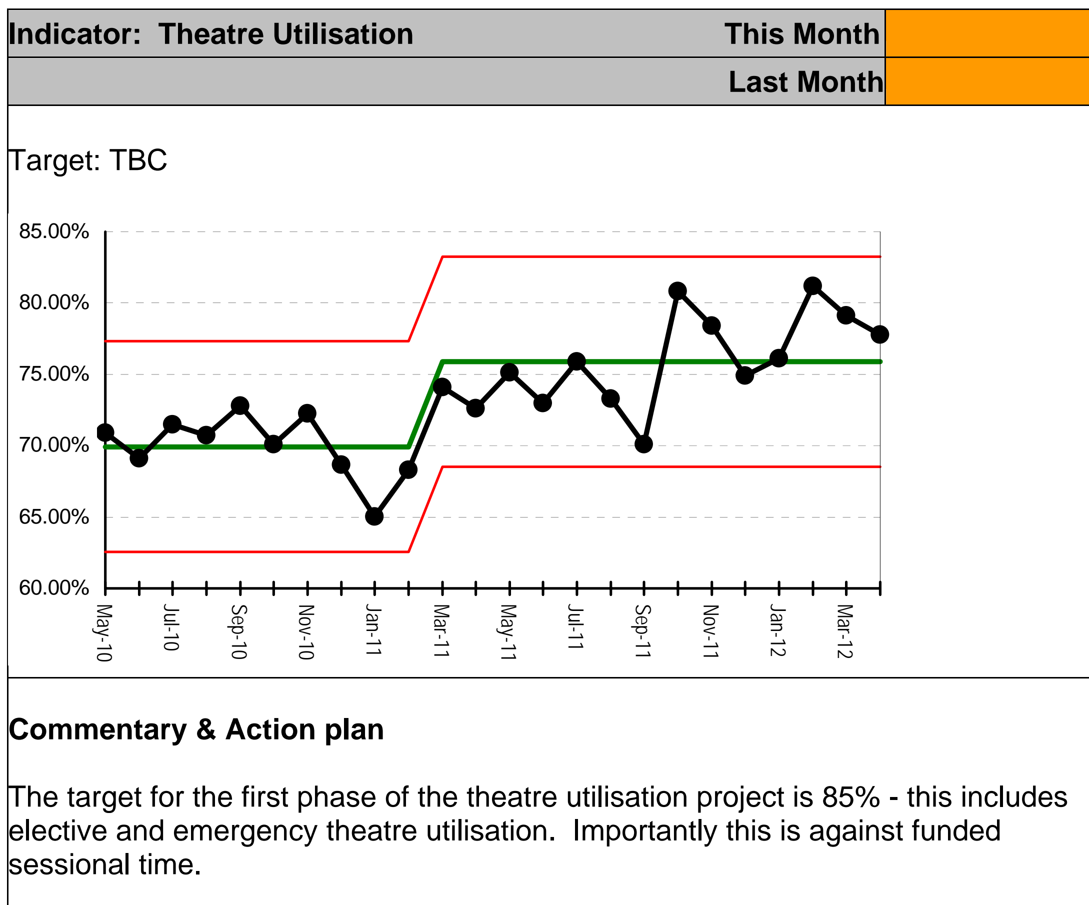
Target: Reduce by 1 day by March 2013



Update on Progress:
Surgical length of stay has already reduced by 0.7 days overall (4.2- 3.5 days) and on target to hit March 2013 target. New consultant rota splitting elective and emergency work to start 29 June. This must coincide with ringfencing of beds on Victoria to provide Surgical Assessment Unit to ensure surgical admissions receive appropriate, timely care with aim of discharging as promptly as possible. Ringfencing of orthopaedic wards (Thorogood and Coyle) has now been achieved following re-opening of additional beds on Coyle. This will enable targeted care of orthopaedic patients by medical and nursing staff. Issues with medical outliers inappropriately on Victoria remain which is likely to contribute to increased length of stay of all patients on Victoria.

Indicator: Theatre Utilisation	**This Month**	
	Last Month	

Target: TBC



Commentary & Action plan

The target for the first phase of the theatre utilisation project is 85% - this includes elective and emergency theatre utilisation. Importantly this is against funded sessional time.

Update on Progress

A new theatre timetable has been agreed with the surgical specialties and will be implemented in July 2012- anaesthetic timetable and job plans completed. This will enable dedicated separate trauma and emergency theatres lists to be provided through reconfiguring the orthopaedic day case list, which will support both quicker times to theatre and improve efficiency of theatre lists in terms of utilised session time. As part of this the anaesthetic rotas are being reconfigured to move named anaesthetic cover from half to full day cover for a number of specialties which will also support additional support theatre productivity. Will be going live 2nd July 2012.

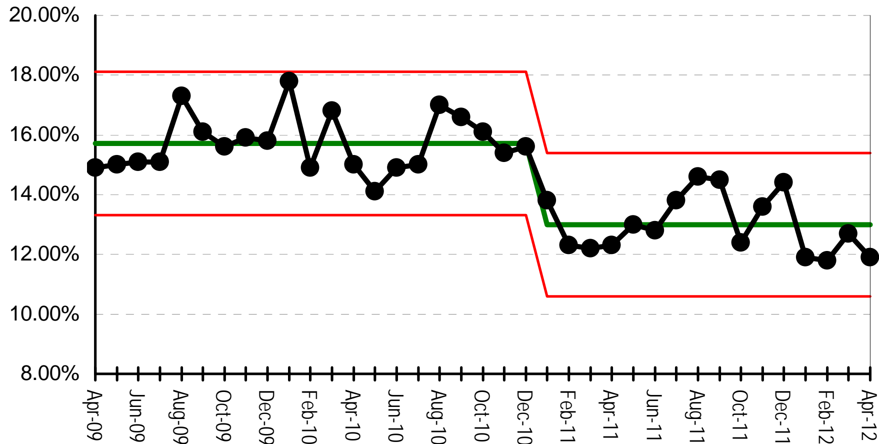
New consultant rota splitting elective and emergency work to start 29 June 2012, which will enable better utilisation of CEPOD theatre list and will support improved theatre utilisation across trauma/emergency due to currently competing demands insufficient trauma operating time- links to revised theatre timetable.

The urology team are undertaking a pilot in May 2012 to consent a cohort of their patients in clinic to support reduced patient choice cancellations on the day through improved consenting and reduce time taken before a patient is ready for theatre on the day of surgery, which will increase the urology theatre utilisation rates. Further work with the Theatre group has also identified that there needs to be a change to the way the Urology service utilise their theatre sessions and the data is being captured. The clinicians attend clinical MDT sessions during the lunchtime period and the theatre day has been amended to a 2 ½ day sessions to reflect this. ORMIS currently monitors their attendance at a meeting as a delay / inactivity as it is rostering it based on 2 session day.

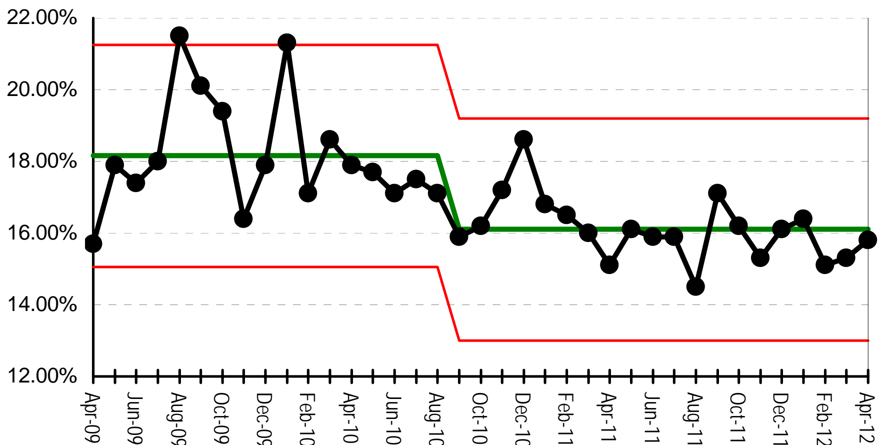
Indicator: DNA Rates – Acute	This Month	
	Last Month	

Target: <8%

First Appointments:



Follow-Up Appointments:



Commentary & Action plan

Roll out of partial bookings is commencing within surgery.

Improvement in the call handling of our hospital booking system also means that patients calling to cancel or change appointments are answered or now able to leave a message.

Update on Progress

Outpatient management team and team leaders are continuing to work directly with clinic staff to ensure that all staff are fully compliant with the current DNA policy. All previous DNA patients that needed rebooking (clinically requested and not suitable for discharge at appt no 1) are being telephone a week in advance to provide to a direct phone reminder of their forthcoming appointments and also informing them of the policy should they DNA for a second time. This is in addition to the Remind + text message system. This is supported by weekly meetings with clinic staff to review DNA patients and monitor compliancy with applying the DNA policy.

Partial booking is now in place in ophthalmology and orthopaedics, with ENT and urology being implemented in May. Patients with a follow-up more than 3 months are now being asked to contact the hospital one month before their appointment to ensure suitable time and date can be arranged. This aims to reduce the number of hospital cancelled appointments due to leave and also reduce the patient DNA rate.

The roll out of the e-communications project, being led by the Director of Operations for WCF, is supporting the patient administration of clinics and will be implementing e-comms for clinic letters when the PAS system upgrade is completed in 2012.

Indicator: Waiting times in outpatient clinics	**This Month**	
	Last Month	

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

April 2012:

	Apr
Dermatology	75.8%
Ear, Nose & Throat	22.0%
General Surgery	32.8%
Ophthalmology	94.0%
Plastic Surgery	100.0%
Trauma & Orthopaedic	66.0%
Urology	45.7%

Commentary & Action plan

Outpatient teams are now working towards ensuring that 100% of patients have valid times seen entered. This will include agreeing methodologies for entering and capturing data across divisions - for example outpatient support is run by the IC&M division for dermatology.

Update on Progress

- The Director of Operations has now established an Outpatient Steering Group across operations and a detailed series of actions and work programme for the group has been developed and approved through The Trust Operating Board. It will also be reporting through to the TOB on progress. This includes specific actions aimed at support clinic waiting time:
    - Capacity review to be undertaken for all OP clinics
    - Demand modelling to be completed and review of current templates
    - Publishing waiting times standard in clinic for staff and patients and current performance
    - Increasing visible leadership and visibility in clinic- OP clinic and Outpatient staff, both administrative and clinical, have now been issued with badges displayed their names in line with the action plan.
    - Posters displaying manager to contact for each clinic now in place with details of other staff to follow.

- Divisional Director has held meetings with clinical lead for ENT to discuss particular concerns regarding ENT waiting times. Clinic session times reviewed as a result of this meeting.

- A review of the patient administrative pathway is being led by the Trust in partnership with Unipart Expert Practices. The pathway mapping and cycle timing is virtually complete and the pathway redesign work will commence in the next few weeks with the aim of re-launching the proposed administrative pathway that will be developed over the summer.