Whittington Health NHS

Trust Board Meeting

ITEM: 09
PAPER: E

Date:	**26th September 2012**

Title:	**Performance Dashboard**

Sponsor:	**Maria da Silva** **Chief Operating Officer**	**Report From:**	Adam Smith Assist. Director of Information Governance

Purpose of Report:	**This report informs the Trust Board about National, SLA Quality and Local standards and target performance for Month 5 August 2012**

Executive Summary:	The Dashboard reports performance data for August 2012. Exceptions, either 'red' RAG rated for August and/or 'Year to Date'; together with targets that are in development are detailed on the attached Exception Report. This includes data that is currently only available 2 months in arrears. This is commonly due to a misalignment of the date the dashboard is required to be completed in order to meet the deadline for board papers, and the date by which reliable and valid indicator data is available. This exception report includes a new section that details the management systems in place to manage the risk of reporting two months in arrears in order to give assurance to the board that this data is monitored closely by the operations team.

Proposed Actions:	**For Discussion:** Dashboard and Exception Report **For Agreement:** 1. **Revise 'waiting in clinic <15 mins. from 98% to 90% <30 mins.** The Trust Board is asked to revise the target for waits in clinic to 90%< 30 mins. in line with national recommendations. This reflects an achievable stretch-target that accounts for variation in the time spent in individual patient care. This can vary appropriately for each patient and can cause a variation in waiting times in each clinic (e.g. clinic slots are for 10 mins and notification and counselling concerning newly diagnosed cancer may take up to an hour)

Appendices:	1. Performance Dashboard Exception Report 2. 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

AUGUST 2012 PERFORMANCE DASHBOARD EXCEPTION REPORT AND MITIGATING ACTIONS

Rationale: RED YTD and/or RED in-month AND Data quality/development items are selected/referenced as an exception to Dashboard completeness below

Indicator	Aug'12	YTD	Target	Comment/ Description of issue	Actions planned/taken to achieve target	Target date / trajectory	Accntbl./Rspnsbl. Officer for Action
WORKFORCE							
Vacancy Rates	12.6%	13.9%	<12%	See Below	See Below		
				Target based on average figure for Trusts across NHS London region. Current figure has been falling in recent months. Improvement to meet target is ***not*** expected in the short/medium term due to the TPE project , CIP freeze on posts/ better control of through vacancy panel.	1. Recruitment of substantive staff in particular nurses is planned over the next few months 2. The target date and trajectory will require adjustment following the implementation of the Patient Experience project	March 2013	Paul Campbell
Turnover	11.0%	10.5%	<10%	See Below	See Below		
				Target based on average figure for Trusts across NHS London region and is based on staff leaving voluntarily	1. All Dir. Ops. to ensure that exit interviews are carried out for staff for analysis by human resources team 2. Analysis of the turnover and exit interview data planned for areas of concern in order to determine specific issues to address	Nov 2012 Nov 2012	1. Div. Dirs. Operations 2. Paul Campbell
Appraisal	19%	19%	90%	See Below	See Below		
				Target is based on appraisals recorded on ESR. Target not being met due to a recording issue – appraisals are being carried out	Dirs. Ops. will ensure that all data is up to date on ESR, allocating resource to this issue, by the end of October for the November Dashboard	Oct 2012 for Nov D/Board	Div. Dirs. Operations
Mandatory Training	69%	69%	90% (Dec'12)	See below	See below		
				Staff turnover is accounted for by the 90% target.	1. Clear user guide (with appropriate module nos.) to be produced ASAP for Dir. Ops. 2. Dir. Ops to plan group and face-to-face sessions, working with HR, in order to ensure on track for December delivery	Sept 2012 Sept 2012	1. Paul Campbell 2. Div. Dirs. Operations

AUGUST 2012 PERFORMANCE DASHBOARD EXCEPTION REPORT AND MITIGATING ACTIONS

Indicator	Aug'12	YTD	Target	Comment/ Description of issue	Actions planned/taken to achieve target	Target date / trajectory	Accntbl./Rspnsbl. Officer for Action
NATIONAL TARGETS							
Cancer – 14 day breast (July)	86.3%	92.4%	93%	See Below	See Below		
				During July 2012 there was a decrease in performance due to Shortfall in clinical capacity in-month: shortfall due to the timing of the start date of new breast surgeon; interim locum cover; and, availability of substantive breast surgeon. Performance also effected by a significant increase in referral rate in July (132 compared to an av. of 107 pcm), and an increase in patients choosing to be seen beyond their 2 week target date end of July.	Additional breast capacity now in place: due to be back on track in September for November Dashboard (dependent on YTD position > 93% target for Aug/Sept given low average demand)	Sept for Nov 2012 Dashboard	Matthew Boazman
Cancer – 62 day (July)	85.3%	80.3%	85%	See below	See below		
				Small numbers of patients have a significant effect on the monthly percentage. June performance was particularly poor due to a combination of complex clinical cases and one avoidable breach-clinician error. 4 of the 5 patients who breached in June2012 were complex clinical cases that required substantial clinical work up and diagnostic investigation . This month continues to effect the YTD rating One breach was avoidable and related to a clinician referring for a diagnostic test incorrectly – not requested as urgent	1. Clinician not following appropriate clinical pathway addressed 2. Actions in place to ensure non-clinical delays are minimised 3. Detailed breach analysis/ trend review by all tumour sites agreed at Sept Cancer Board to identify specific tumour pathway actions led by the individual tumour site clinical leads	Complete Sept. 2012 Oct 2012	1. Matthew Boazman 2. Mark Rose 3. Mark Rose

AUGUST 2012 PERFORMANCE DASHBOARD EXCEPTION REPORT AND MITIGATING ACTIONS

Indicator	Aug'12	YTD	Target	Comment/ Description of issue	Actions planned/taken to achieve target	Target date / trajectory	Accntbl./Rspnsbl. Officer for Action
Maternity Access – 12+6	89.7%	89.1%	90%	See Below	See Below		
				17 breached in August 1 of which was under the control of the team, the rest were patient choice.	Maternity monitor the position on a weekly basis	April 2013	Jenny Cleary
				QUALITY			
Complaints rspnse < 28days	**July'12** 63%	71%	85%	See Below	See Below		
N.B JULY'12 DATA				Increasing number of complaints. Lack of capacity within divisions to respond within agreed timescale Members of staff not usually involved in formal responses asked to lead on whole process. Vacant Complaints manager post since July 2012. Holiday season has had impact on response timescales.	1. Complaints investigation training arranged Oct /Nov'12; bespoke training offered for key managers in interim; New PALS and Complaints manager in post on October 1st 2012 2. Operations allocating capacity to ensure back on track Sept for Oct D/Board	Nov 2012 Sept for Oct 2012 D/Board	1. Cassie /Jennie Williams 2. Div. Dirs. Ops.
Pressure Ulcers – Acute	1	5	3/yr	See Below	See Below		
GRADE3-4				Target based on 80% reduction from 2010/11 baseline Target has been exceeded as increased awareness and reporting within community teams From Q1 2012 all completed RCAs have been reported to the Serious Incident Executive Approval Group for agreement before submission to NHS London. The Pressure Ulcer Serious Incident Panel (PUSIP), chaired by the Deputy Director of Nursing and Patient Experience reviews trends and also oversees the action plans for all completed RCAs in order to gain assurance that issues are addressed and actions completed.	A performance managed programme of work is underway that will to embed change in practice	April 2013	Sarah Hayes

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Indicator	Aug'12	YTD	Target	Comment/ Description of issue	Actions planned/taken to achieve target	Target date / trajectory	Accntbl./Rspnsbl. Officer for Action
				The panel also considers initiatives for awareness raising and training about the prevention of pressure ulcers within the Trust.			
Pressure Ulcers – Community	4	28	21/yr	See Below	See Below		
GRADE 3-4				Target based on a 30% reduction from 2011/12 baseline As Acute above	As Acute above	April 2013	Sarah Hayes
MSK funct. scale	46%	19%	40%	See Below	See Below		
% of pats. completing Patient Specific Functional Scale				Data quality issues account for some of this target being missed We are confident that by October we should have addressed the data quality issues with extracting data from RIO. Improvement already seen from last month	Recording issues with RiO on target to be completely remedied in Oct 2012	Oct 2012	Fiona Yung
Diabetes	71%	86%	85%	See Below	See Below		
Confidence to manage condition				Process for recoding data changed in August 2012 to enable data to be collected in a more reliable format. The changeover of process has led to slippage for this month but should be on track to October.	New system in place for September 2012 whereby. The diabetes administrator now rings patients following their appointment to capture this data.	Sept 2012	Fiona Yung
NATIONAL - COMMUNITY							
New Birth Visits Islington 14 Day	JulIsl: 67.5%;	Isl: 57.0%;	95%	See Below	See Below		
Haringey 14 Day	JulHar: 41.0%	Har: 21.4%	95%	See Below	See Below		
				Data has been shown to be improving in this area over 2 last months 14 Day visits are dependent upon both staff resource and efficient	HV have just finished a LEAN review. An Action plan is in development. Recruiting to 13/Islington 5/ Haringey	Oct 2012	Sam Page

AUGUST 2012 PERFORMANCE DASHBOARD EXCEPTION REPORT AND MITIGATING ACTIONS

Indicator	Aug'12	YTD	Target	Comment/ Description of issue	Actions planned/taken to achieve target	Target date / trajectory	Accntbl./Rspnsbl. Officer for Action
				systems. There is a national shortage of health visitors being addressed in partnership with the Deanery	vacant posts (not covered). 12 students for training as HVs in O 2012		
Haringey 28 days	Jul Har: 92.70%	Har: 87.7%	95%	See Below	See Below		
				Service commissioned as a 28 day service following Baby P. level of staff reflects this target. However still susceptible to resource and system efficiencies improvements. n.b. There is careful and consistent risk management where visits have not occurred	As Above	Oct 2012	Sam Page
LOCAL TARGETS							
Theatre Utilisation	77.3 %	76.5 %	95%	See Below	See Below		
				Theatre utilisation captured as a measure of all available theatre sessions timetabled throughout the week / % minutes utilised. Key issues affecting utilisation August: - closed lists due to consultant annual leave - patients on the waiting list declining offer of August dates due to leave - two specialties had no patients waiting for day case surgery- list closed - partial filled lists provided to avoid 18 week breaches (e.g. ENT) leading to under-utilisation - reduction in day case cystoscopy due to equipment failure in month	1. New theatre timetable, dedicated anaesthetic and general surgeon rotas introduced. 2. Data quality review in Sept 2012 e.g. inclusion of data for planned closures adversely effecting utilisation data. 3. Target will separate Emergency from Elective to represent new streamlining of services Sept 2012	Aug 2012 Sept 2012 Sept 2012	1. Graham Booth 2. Graham Booth 3. Anita Garrick

AUGUST 2012 PERFORMANCE DASHBOARD EXCEPTION REPORT AND MITIGATING ACTIONS

Indicator	Aug'12	YTD	Target	Comment/ Description of issue	Actions planned/taken to achieve target	Target date / trajectory	Accntbl./Rspnsbl. Officer for Action
Acute DNA Rates - First	14.6%	12.7%	<8%	See Below	See Below		
- Follow Up	13.9%	13.6%	<8%	See Below	See Below		
				Maternity and Paediatric have a local policy due to safeguarding issues and therefore those who DNA are offered alternative appointments.	1. The trust Wide DNA and cancellation policy updated and launched to reflect guidance on discharging DNA patients, managing partial bookings and clinic cancellation. 2. All Divisions due to review underlying reasons for DNAs and have action plans in place by Dec 2012 (e.g. demand and capacity/ template reviews) 3. Transforming Patient Experience key roles being proposed is the Patient Pathway Coordinator (PPC) aimed at improving patient communication, reducing patient handoffs between functions.	1. Complete 2. Dec 2012 3. Dec 2012	1. Laura Bell 2. Div. Dirs. Ops. 3. Matthew Boazman
Hospital Cancellations	5.7%	7.2%	<2%	See Below	See Below		
FOLLOW-UP Cancellations				Cancellation rates have reduced in August SCD division: a small increase in cancellation rates July/Aug 2012 related to scheduled clinic appointments having to be moved due to the introduction of new emergency general surgical rota.. The majority of patients were either brought forward to an earlier date or had their appointment on the same day with a different member of the surgical team (new apps). In both cases these are counted as hospital cancellations on PAS.	1. The trust Wide DNA and cancellation policy updated and launched to reflect guidance on discharging DNA patients, managing partial bookings and clinic cancellation. 2. Transforming Patient Experience key roles being proposed is the Patient Pathway Coordinator (PPC) aimed at improving patient communication, coordination/reducing patient handoffs between functions 3. Partial Booking to be introduced for follow-Ups in all divisions	1. Complete 2. Dec 2012 3. Dec 2012	1. Laura Bell 2. Matthew Boazman 3. Div. Dirs. Ops.

AUGUST 2012 PERFORMANCE DASHBOARD EXCEPTION REPORT AND MITIGATING ACTIONS

Indicator	Aug'12	YTD	Target	Comment/ Description of issue	Actions planned/taken to achieve target	Target date / trajectory	Accntbl./Rspnsbl. Officer for Action
Acute Wait % < 15mins in clinic	71.6%	68.6%	98%	See Below	See Below		
				Relates to specialties reviewing overbooking clinic templates and capacity issues impacting on waiting times in clinic. Also related to work being carried out on reasons for DNAs. A small increase SCD division cancellation rates during July/Aug 2012 related to the introduction of the new emergency general surgery rota	Divisions to review underlying reasons for waits and have action plans in place by Dec 2012 Additional clinics have been established for the breast service in place from August onwards across the working week to reduce overbooking and thereby waits. The Trust Board is asked to revise the target for waits in clinic to 90%< 30 mins. in line with national recommendations This reflects an achievable stretch-target that accounts for variation in the time spent in individual patient care This can vary appropriately for each patient and can cause a variation in waiting times in each clinic (e.g. clinic slots are for 10 mins and notification and counselling concerning newly diagnosed cancer may take up to an hour)	1. Dec 2012 2. Complete 3. Sept 2012	1. Div. Dirs. Ops. 2. Matthew Boazman 3. Maria Da Silva
Outcomes Not Recorded	3.9%	4.1%	<0.5%	See Below	See Below		
COMMUNITY				All data requires input by the third working day after month end. Managers are working with staff to achieve this.	Managers monitor staff performance on a weekly basis: disciplinary action taken against staff who do not input in a timely way.	Sept 2012	Div. Dirs. Ops.
				SLA			
Acute Outpatients	32% excess	30% excess	<1%	See Below	See Below		
FOLLOW-UP RATIO				Clinical Directors and Divisional Directors working with individual clinical leads to continue to work reviewing pathway protocols to reduce towards upper quartile targets.	1. Diabetes and Cardiology expect to meet KPI for first to follow up by end of March 2013 2. Cardiac rehabilitation patients to be excluded from this figure in following months	1. Mar 2013 2. Sept 2012	1. Dr David Brull 2. Anita Garrick

AUGUST 2012 PERFORMANCE DASHBOARD EXCEPTION REPORT AND MITIGATING ACTIONS

Indicator	Aug'12	YTD	Target	Comment/ Description of issue	Actions planned/taken to achieve target	Target date / trajectory	Acctbl./Rspnsbl. Officer for Action
				Diabetes: Audit show 46% eligible for discharge. Of those 50% primary care /50 % intermediate services; audit also to be carried out on nurse led clinics Cardiology: Business case to be developed for change in model of Nurse led clinics developed as intermediate care; Aim to reduce medical outpatient follow up activity by 1 consultant PA per week. This activity could be shifted to the community HF nurses and included in the business case for intermediate care. SCD focus is on orthopaedics and Ophthalmology –- trajectory has improved from 1.91-1.67 April-June 2012 - remaining specialties achieving or on trajectory to achieve upper quartile.	3. Discussion on-going at contract monitoring committee NCL regarding WH's repatriation intentions: In conjunction the top 10 practices have been identified for both Haringey and Islington and the diabetes nursing leads are working with the practices to agree patients that can be directly returned to the GP practice. 4. Specialty action plans and named clinical leads for implementation were approved at the July Surgical Board for Oct 2012 trajectory 5. Orthopaedic template review is continuing and the clinical lead is support specialty actions for local management of follow ups and diagnostic requests	3. Oct 2012 4. Oct 2012 5. Nov 2012	3. Fiona Smith 4. Nick Harper 5. Mr David Sweetnam
DATA EXCEPTIONS / TARGETS IN DEVELOPMENT							
FINANCE							
Bank Spend	**1,332**	**6,489**	No target	See Below	See Below		
Agency Spend	**1,027**	**4,789**	No target	See Below	See Below		
				Target development is dependent upon bed reconfiguration projects/ re-establiblishment currently beign established as a programme of work	Targets to be finalised this financial year	April 2013	Bronagh Scott

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Indicator	Aug'12	YTD	Target	Comment/ Description of issue	Actions planned/taken to achieve target	Target date / trajectory	Accntbl./Rspnsbl. Officer for Action
NATIONAL TARGETS							
Cancer Access: See p.2 Note [2]	**No data**	**No data**	94% & 98%	See Below	See Below		
31 days to Second or Subsequent Treatment: (Surgery = 94% Drugs = 98%)				Data relating to subsequent cancer treatment is not yet available. The Cancer Team were unable to collect data due to IT technical issues that have now begun to be addressed	1. Data base has been updated to allow data collection 2. Processes to be changed with the cancer team to enable data collection	1. Sept 2012 2. Oct for Nov 2012 D/Board	1. Anita Garrick 2. Mark Rose
QUALITY TARGETS							
Incident Reporting	See Below	See Below	See Below	See Below	See Below		
Reporting Rate/1000 beddays/contacts	**3.0**	**3.3**	No target	Performance for these areas currently being benchmarked See p.3 Note **[2]**	Targets to be set at end of this financial year for 2013/14	April 2013	David williams
Number of Falls	**21**	**157**	No target	See Above	See Above	April 2013	David williams
No. Falls Causing Severe Harm	**0**	**1**	No target	See Above	See Above	April 2013	David williams
VTE Appropriate Prophylaxis	**June 95.2%**	**83.3%**	90%	See Below	See Below		
Hospital Acquired VTE	**No Data**	**No Data**	No target	See Below	See Below		
See pages 3 & 4 Note **[4]**				Both of these targets do not require external reporting until the end of Q4 – April 2013. There is confidence that these targets will be met.	Audit and root cause analysis is underway and a system is being put in place to finalise data recording for these indicators. Due to finalise by the end of Q3	Dec 2012	Kathriona McCann
% of Chlamydia screens that are males/females <25 years old	**No Data**	**No Data**	No target	See Below	See Below		
See page 5Note **[4]**				There is currently no national target set for this indicator	Claire O Connor to discuss at TOB and within WCF more appropriate targets indicators of performance in Sexual Health services	Sept 2012	Claire O'Conner

AUGUST 2012 PERFORMANCE DASHBOARD EXCEPTION REPORT AND MITIGATING ACTIONS

Indicator	Aug'12	YTD	Target	Comment/ Description of issue	Actions planned/taken to achieve target	Target date / trajectory	Accntbl./Rspnsbl. Officer for Action
Patient Experience	**No Data**	**No Data**	No target	See Below	See Below		
Cleanliness Audit See Note **[7]** page 3-4				Audit data for this indicator incomplete in August	Due to report for September 2012	Sept 2012	Phil Ient
LOCAL INDICATORS							
ACUTE: LOS and Av Bed Days	**No Data**	**No Data**	No target	See Below	See Below		
See page 6 Note **[1]**				Average Length of Stay and Bed Days targets in Medicine and Surgery are dependent upon modelling work	New programme manager appointed September 2012 will devised plan for modelling bed day reduction based on bed projects PID	Oct 2012	Mark Ellis
Outpatients page 6 Note **[2]**				See Below	See Below		
Number of First Appointments	**5077**	**26259**	No target	Target requires revision to reflect SLA in financial terms	Target to be reviseed as an aggregated Finaincail Target for October Dashboard	Oct 2012	Fiona Smith
Number of Follow-Up Appointments	**13047**	**65534**	No target	See Above	See Above	Oct 2012	Fiona Smith

DATA PRESENTED MORE THAN ONE MONTH IN ARREARS ON AUGUST 2012 PERFORMANCE DASHBOARD

The indicators listed below and referenced in the dashboard report are not available to meet the production deadline for the dashboard (the 7th working day) required to meet the Trust Board papers deadline.

This data will always be presented two months in arrears to the Trust Board, unless there are changes to the targets, resources allocated for collection or the Trust board dates change.

This table shows the escalation and risk management that is applied in each case to give assurance to the board in lieu of more timely reporting.

Indicator	July'12	YTD	Target	Comment/ Description of issue	Risk Management / Escalations in place	Accntbl./Rspnsbl. Officer for Action
NATIONAL TARGETS						
Cancer access (Note **[1]** page 2)	Accurate data cannot be report before 25th working day of the month, the national deadline for cancer submissions. WH relies on other trusts to upload data to the national Cancer Waiting Times database for those patients we have referred to their services. A complete data set for the previous month is therefore not available by the production schedule deadline (7th working day of the month) required in order to meet the Trust Board papers deadline.					
14 days GP referrals - 1st Outpatients	92.6%	92.8%	93%	See Below	See Below	
				Data available on the **25th working day** following month end.	Daily reports monitored for exceptions by MDT coordinators and cancer service team Weekly validation Sign off report provided	Matthew Boazman
14 days GP referrals - Breast symptoms	86.3%	92.4%	93%	As above	As above	Matthew Boazman
31 days to First Treatment	100.0%	100.0%	96%	As above	As above	Matthew Boazman
62 days Referral to Treatment	85.3%	80.3%	85%	As above	As above	Matthew Boazman
62 days Wait First Treatment from Cancer Screening	100.0%	100.0%	90%	As above	As above	Matthew Boazman
Diagnostics: Cytology turnaround <14 days	A complete data set for the previous month is not available by the production schedule deadline (7th working day of the month). Cytology turnaround is expected 100% within 14 days. There will therefore be samples from the end of the reporting month yet to be reported but still 'in time' on the 7th working day. Reporting the performance on the 7th working day does give an accurate reflection of the month's performance.					
(Note **[3]** page 2)	100.0%	100.0%	100%	Data available on the **14th working day** following month end.	Weekly exception reports escalated	Matthew Boazman

DATA PRESENTED MORE THAN ONE MONTH IN ARREARS ON AUGUST 2012 PERFORMANCE DASHBOARD

Indicator	July'12	YTD	Target	Comment/ Description of issue	Risk Management / Escalations in place	Accntbl./Rspnsbl. Officer for Action
				QUALITY INDICATORS - COMMUNITY SERVICES		
Complaints response < 28days	A complete data set for the previous month is not available by the production schedule deadline (7th working day of the month) as there will still be complaints from the reporting month to be responded to which are 'in time' for the 85% < 25 days target. Reporting the performance as at the 7th working day will not be a full reflection of the month's performance.					
Note**[2]** Page 3	**63%**	**71%**	85%	Data available on the **25th working day** following month end.	Weekly complaints report	All Div. Dirs. Ops
VTE screening prevalence	Data Relating and reliant upon to Clinical Coding: An average of 4800 episodes per month require clinical coding. This is function is performed by the Coding Team (Clinical Data Manager, 5 coders and 1 trainee). The Trust target is to complete coding for the previous month is the 10th working day of the following month. Data for the previous month is therefore not available by the production schedule deadline (7th working day of the month) required in order to meet the Trust Board papers deadline.					
Note **[3]** Page 3	**95.3%**	**95.6%**	95.7%	Data is derived from the coding of clinical records, completed on the **10th working day** following month end.	Weekly Performance Data reports produced against trajectory	All Div. Dirs. Ops
Clinical Effectiveness Page 3 Note **[6]**	Data Relating and reliant upon to Clinical Coding: An average of 4800 episodes per month require clinical coding. This is function is performed by the Coding Team (Clinical Data Manager, 5 coders and 1 trainee). The Trust target is to complete coding for the previous month is the 10th working day of the following month. Data for the previous month is therefore not available by the production schedule deadline (7th working day of the month) required in order to meet the Trust Board papers deadline.					
Emergency Admission Rate for LTC	157	584	No target	data is derived from the coding of clinical records, completed on the **10th working day** following month end.	performance indicator and targets to be discussed with stakeholders Nov 2012	New Performance Manager
VTE Emergency Admission	9	25	No target	As above	As above	As above
Emergency Admission Rate for Paediatric Conditions (asthma, epilepsy, diabetes)	27	59	No target	As above	As above	As above
				NATIONAL INDICATORS - COMMUNITY		
New Birth Visits - within 14 and 28 days Note [1] Page x)	The target stipulates that the new birth visit needs to occur 14 and 28 days (for Haringey only) after the end of the previous month. Reporting the performance as at the 7th working day will not be a full reflection of the previous month's performance.					
New Birth Visits – Islington - 14 Days	**67.5%**	**57.0%**	95%	Data is available on the **14th working day** after the end of the month	Monitored at weekly allocation meetings	Sam Page
New Birth Visits – Haringey - 14 Days	**41.0%**	**21.4%**	95%	As above	As above	Sam Page
New Birth Visits – Haringey - 28Days	**92.7%**	**87.7%**	95%	As above	As above	Sam Page

DATA PRESENTED MORE THAN ONE MONTH IN ARREARS ON AUGUST 2012 PERFORMANCE DASHBOARD

Indicator	July'12	YTD	Target	Comment/ Description of issue	Risk Management / Escalations in place	Accntbl./Rspnsbl. Officer for Action
Smoking Cessation 4 week quitter target	This target is reported quarterly and at a later date in the month than the production date for the dashboard The smoking cessation 4 week quitter targets has been achieved for Q1					
See Note [3]page 5	**n/a**	**568 / Q1**	506 / Qtr	met for first quarter	See Below	See Below
				The DH reporting deadlines are: 10.09.12; 10.12.12; 14.06.13; 17.06 Next reporting date is 10.12.12	Target monitored by service manager	Vicky Smith
SLA INDICATORS						
Emergency readmissions and excess bed day data Note **[1]** Page 7	Data Relating and reliant upon to Clinical Coding: An average of 4800 episodes per month require clinical coding. This is function is performed by the Coding Team (Clinical Data Manager, 5 coders and 1 trainee). The Trust target is to complete coding for the previous month is the 10th working day of the following month. Data for the previous month is therefore not available by the production schedule deadline (7th working day of the month) required in order to meet the Trust Board papers deadline.					
Emergency Readmissions - from original elective admissions	**31**	**133**	20% < 2010/11	20% reduction from 10/11 baseline Data derived from the coding of clinical records, completed on the **10th working day** following month end.	Draft data reviewed on a monthly basis at Divisional boards, trends examined and escalated	All Div. Dirs. Ops
Emergency Readmissions - from original emergency admissions	**194**	**759**	20% < 2010/11	As above	As Above	All Div. Dirs. Ops
Excess Bed days	**-40**	**-238**	SLA Plan	Data derived from the coding of clinical records, completed on the **10th working day** following month end.	As Above	All Div. Dirs. Ops

Whittington Health Integrated Dashboard - September 2012 (August 2012 Data)

Whittington Health NHS

Please note that all Data is dated August 2012 unless otherwise Stated

FINANCE - INCOME & EXPENDITURE SUMMARY

	Current Month			Year To Date			Annual Budget £'000
	Actual £'000	Budget £'000	Variance £'000	Actual £'000	Budget £'000	Variance £'000	
Total Income	23,378	22,633	745	115,632	113,900	1,732	274,724
Total Expenditure	22,074	21,363	(712)	108,497	106,400	(2,097)	257,182
EBITDA	1,304	1,270	33	7,135	7,500	(365)	17,542
Net Surplus/Deficit	145	102	43	1,289	1,641	(352)	3,120
Net Surplus/Deficit excluding PFI IFRS	67	24	43	1,371	1,723	(352)	3,504

SERVICE LINE REPORTING

	Women, Children & Families	IC & Acute Medicine	Surgery, Cancer & Diagnostics
Total Direct & Indirect Cost	25,040	29,874	17,055
Service Line Contribution Margin %	16.3%	17.4%	28.5%

CIP MONITORING

	2012/13 Target £'000	Forecast Variance £'000	Best Case Forecast Variance £'000	Worst Case Forecast Variance £'000		June	July	August
Total	**13,100**	**0**	**0**	**2,500**	cumulative % achieved against target	69%	74%	80%

WORKFORCE AND MANDATORY TRAINING

Domain	Indicator	Target	May	June	July	August	YTD	FOT for QTR2
Workforce	Vacancy Rates	<12%	11.7%	12.6%	11.7%	12.6%	13.9%	→
	Sickness Absence	<3%	3.2%	3.1%	3.1%	2.3%	2.9%	→
	Long Term Sick Leave	<1%	1.3%	1.4%	1.3%	1.1%	1.3%	→
	Turnover	<10%	8.9%	11.2%	11.1%	11.0%	10.5%	→
	Bank Spend (£000)	Note **[1]**	1,457	1,144	1,409	1,332	6,489	3,094
	Agency Spend (£000)	Note **[1]**	1,130	816	933	1,027	4,789	2,257
	Staff in post	TBC	3,644.3	3,606.3	3,569.2	3,606.8	3,632.3	
	Stability Level	>80%	83.8%	82.9%	83.4%	83.7%	82.8%	→
	Appraisal	90%	-	20%	20%	19%	19%	→
	Number of case of bullying & harassment (cumulative)	0	1	1	1	1	1	→
	% of qualified to unqualified staff (nurses)	70% qualified 30% unqualified	76/24	76/24	77/23	79/21	77/23	→
Training Compliance	Mandatory Training Compliance	90% by Dec	69%	67%	68%	69%	68%	→
ESR	No. of staff activated on ESR	95%	638	652	665	680	680	

[1] Targets to be devised **- see exception report**

KEY

RAG rated Arrow colours

→ (red)	Significantly below target
→ (amber)	Below target Note **[2]**
→ (green)	On Target
→ (grey)	No Target

Arrow Direction

↑	Improvement
→	No change
↓	Worsening Position

Note: **[2]** RAG rating and thresholds to be clarified in Data Dictionary.

Whittington Health Integrated Dashboard - September 2012 (August 2012 Data)

Whittington Health NHS

NATIONAL INDICATORS - ACUTE SERVICES

Please note that all Data is dated August 2012 unless otherwise Stated

Domain	Indicator	Target	June	July	August	YTD	QTR 1	Trend	FOT for QTR 2
ED Targets	Patients in A&E under 4 hours	**95%**	95.3%	95.1%	97.0%	95.1%	94.5%	↑	↑
18 Weeks RTT	Referral to Treatment - Admitted	**90%**	91.7%	92.5%	90.0%	92.2%	92.5%	→	→
	Referral to Treatment - Non Admitted	**95%**	98.9%	99.0%	99.1%	99.0%	98.9%	→	→
	Referral to Treatment - Incomplete	**92%**	92.2%	95.4%	95.2%	95.0%	93.4%	→	→
	Diagnostic Waiting Times	**99%**	100.0%	100.0%	100.0%	100.0%	100.0%	→	→
Cancer Access See Notes **[1]** and **[2]** below	14 days GP referrals - 1st Outpatients	**93%**	92.9%	92.6%	See Note **[1]**	92.8%	92.8%	→	→
	14 days GP referrals - Breast symptoms	**93%**	90.7%	86.3%		92.4%	94.8%	↓	→
	31 days to First Treatment	**96%**	100.0%	100.0%		100.0%	100.0%	→	→
	31 days to Second or Subsequent Treatment (Surgery)	**94%**	See Note **[2]**			See Note **[2]**		→	→
	31 days to Second or Subsequent Treatment (drugs)	**98%**						→	→
	62 days Referral to Treatment	**85%**	70.0%	85.3%		80.3%	78.6%	↑	↑
	62 days Wait First Treatment from Cancer Screening	**90%**	100.0%	100.0%		100.0%	100.0%	→	→
Fractured Neck of Femur	Fractured Neck of Femur operated within <36 hours	**85%**	87.5%	100%	100%	94.4%	92.1%	→	→
	Fractured Neck of Femur operated within <48 hours	**85%**	100%	100%	100%	100%	100%	→	→
Cancelled Operations	Cancelled Operations as percentage of elective admissions	**<0.8%**	0.2%	0.2%	0.3%	0.4%	0.5%	→	→
	Cancelled Operations not rescheduled within 28 days	**0**	0	0	0	0	0	→	→
Single Sex Accommodation	Single Sex Accommodation Breaches	**0**	0	0	0	0	0	→	→
Transfer of Care	% of Inpatients with Delayed Transfer of Care	**<3.5%**	1.2%	2.1%	2.0%	1.9%	1.8%	→	→
Diagnostics See **[3]** below	Cervical Cytology turnaround times within 14 days	**98%**	100%	100%	See **[3]**	100%	100%	→	→
Maternity	% of women seen by HCP or midwife within 12 weeks and 6 days	**90%**	87.9%	90.5%	89.7%	89.1%	88.3%	↓	→
	1:1 care in established labour	**100%**	100%	100%	100%	100%	100%	→	→
	Breast Feeding at Birth	**90%**	92%	90%	91%	91%	91%	↓	→
	Smoking during pregnancy at time of delivery	**<17%**	5%	6%	8%	6%	7%	→	→

Notes:

[1] Cancer access data is **available 1 month in arrears of the current 7th working day reporting schedule**: Data available on the 25th working day following month end.

[2] Data relating to subsequent cancer treatment is not yet available. **See exception report for update.**

[3] Cytology turnaround <14 days data is **available 1 month in arrears of the current 7th working day reporting schedule**: Data available on the 14th working day following month end.

[4] No Amber RAG rating for National Targets

Whittington Health Integrated Dashboard - September 2012 (August 2012 Data)

Whittington Health NHS

QUALITY INDICATORS - INTEGRATED CARE ORGANISATION

Please note that all Data is dated August 2012 unless otherwise Stated

Domain	Indicator	Target	June	July	August	YTD	QTR1	Trend	FOT for QTR 2
Incident Reporting See Note **[1]** below	Number of Serious Incidents	**n/a**	16	16	8	57	33	→	→
	Timeliness of external SI Report submission	**Green**	See Note **[1]**					→	→
	Incident Reporting Rates per 1000 beddays / contacts - see Note **[2]**	Note **[2]**	3.5	3.6	3.0	3.3	3.3	→	→
	Number of Falls - see Note **[2]**	Note **[2]**	35	26	21	157	110	→	→
	Number of Falls Causing Severe Harm - see Note **[2]**	Note **[2]**	0	1	0	1	0	→	→
	Never Events	**0**	0	0	0	2	2	→	→
Clinical Effectiveness	Safety Alerts Compliance	**100%**	100%	100%	100%	100%	100%	→	→
Patient Experience See Note **[3]** below	Complaints Received	**n/a**	37	59	48	262	155	→	→
	Complaints Responded to within specified timeframe	**85%**	86%	63%	Note **[3]**	71%	76%	↓	→

QUALITY INDICATORS - ACUTE SERVICES

Domain	Indicator	Target	June	July	August	YTD	QTR1	Trend	FOT for QTR 2
Infection Prevention & Control	MRSA Bacteraemia Cases	**1 (year)**	0	0	0	1	1	→	→
	C.DIFF Cases	**21 (year)**	0	1	2	5	2	→	→
	Hand Hygiene Audit	**95%**	99.4%	97.9%	95.8%	97.4%	97.7%	→	→
Incident Reporting **See** Notes **[4] [5] [6]** below	Pressure Ulcers - grade 3/4 (80% reduction from 2010/11 baseline)	**3/yr**	0	1	1	5	3	→	→
	VTE Screening	**95%**	96.7%	95.3%	Note **[4]**	95.6%	95.7%	→	→
	VTE Rate - Hospital Acquired	**0**	See Note **[5]**					→	→
	Appropriate Prophylaxis for VTE	**90%**	95.2%	Note **[5]**		83.3%	83.3%	↑	↑
	Post Operative Sepsis	**AE**	1	See Note **[6]**		1	1	→	→
	Post Operative Sepsis - Hips	**AE**	0			0	0	→	→
	Post Operative Sepsis - Knees	**AE**	1			1	1	→	→
	Deaths After Surgery	**AE**	2			4	4	→	→
	Deaths in Low Risk Conditions	**AE**	2			2	2	→	→
	Deaths After Bariatric Surgery	**AE**	0			0	0	→	→
	Hospital Level Mortality Indicator - Summary	**<100**	83			83	83	→	→
Clinical Effectiveness See Note **[7]** below	Emergency Admission Rate for LTC	Note **[7]**	126	157	Note **[7]**	584	427	→	→
	Emergency Admission Rate for Paediatric Conditions (asthma, epilepsy, diabetes)	Note **[7]**	7	27		59	32	→	→
	Emergency Admission for VTE	Note **[7]**	8	9		25	16	→	→
Patient Experience See Notes **[8] [9]** below	Friends & Family Test (Net Promoter Score) See Note **[9]** below	Note **[9]**	22%	27%	36%	26%	25%	→	→
	Cleanliness Audit	**>95%**	97%		Note **[8]**	97%	97%	↑	→

PTO for Notes for this page

Whittington Health Integrated Dashboard - September 2012 (August 2012 Data)

QUALITY INDICATORS - COMMUNITY SERVICES

Whittington Health NHS

Please note that all Data is dated August 2012 unless otherwise Stated

Domain	Indicator	Target	June	July	August	YTD	QTR1	Trend	FOT for QTR 2
Infection Prevention & Control See Note **[10]** below	Dentistry Compliance with Infection Control Standard	**90%**	See Note **[10]**			95%	95%	→	→
Incident Reporting	Pressure Ulcers - grade 3/4 (30% reduction from 2011/12 baseline)	**21/yr**	7	8	4	28	16	→	→
Patient Experience See Note **[9]** below	Friends & Family Test (Net Promoter Score) See Note **[9]** below	Note **[9]**	28%	28%	17%	28%	34%	→	→
	Dentistry - Patient Involvement	**90%**	92%	90%	98%	93%	92%	↑	↑
	Dentistry - Patient Experience	**90%**	100%	98%	92%	95%	96%	→	→
Clinical Effectiveness	Respiratory - number of admissions avoided	**25 / Qtr**	3	18	13	46	15	↑	↑
	Diabetes - % of patients with at least a 1% reduction in HbA1c after 6 months	**60%**	42%	67%	80%	66%	61%	→	→
	Diabetes - % of patients reporting confidence in managing their condition	**85%**	100%	100%	71%	86%	87%	↓	→
	Heart Failure / Cardiology - % of patients on optimum Ace Therapy	**80%**	88%	90%	89%	89%	89%	→	→
	Heart Failure / Cardiology - % of patients on optimum Beta Blocker Therapy	**80%**	84%	84%	82%	84%	84%	→	→
	Rehab Intermediate Care - % of patients with self-directed goals set	**70%**	60%	71%	78%	70%	65%	→	→
	Rehab Intermediate Care - GAS scores pre and post treatment	**70%**	67%	76%	80%	74%	71%	→	→
	MSK - % of patients who have completed the Patient Specific Functional Scale	**40%**	14%	22%	46%	19%	8%	↑	→
	MSK - % of patients completing their treatment on discharge	**40%**	35%	36%	36%	39%	41%	→	↑
	CAMHS - % of Cases where mental health problems has been resolved or improved	**60%**	See Note **[10]**			75%	75%	→	→
	CAMHS - % of Cases where severity of mental health at end of treatment is normal	**80%**	See Note **[10]**			90%	90%	→	→
	% of new patients with an HIV test within preceding 90 days	**60%**	83%	85%	83%	84%	84%	→	→
	% of women 18 to 25 years old attending for contraception given LARC	**20%**	26%	30%	32%	31%	28%	→	→
	% of new male patients who had an STI screen who were under 25 years	**20%**	34%	31%	30%	31%	31%	→	→
	% of new female patients who had an STI screen who were under 25 years	**20%**	47%	47%	43%	45%	46%	→	→

Notes:

[1] Data is **produced quarterly as a RAG rating the** from NHS London Organisational Health Intelligence report.

[2] Targets are not yet established - see exception report for detail

[3] Data concerning complaints response times is **available 1 month in arrears of the current reporting 7th working day reporting schedule**: Data available on the 25th working day following month end.

[4] VTE screening data is **available 1 month in arrears of the current 7th working day reporting schedule**: the data is derived from the coding of clinical records, completed on the 10th day following month end.

[5] This data is not currently available - please see **exception report** for update.

[6] These data items are derived from the **most recent available Dr Foster Intelligence**. N.B The target for these indicators is a relative risk target: i.e. 'As Expected' (AE) or better.

[7] Clinical effectiveness data is **available 1 month in arrears of the current 7th working day reporting schedule**: the data is derived from the coding of clinical records, completed on the 10th day following month end.

Targets are not yet established - **see exception report for detai**l

[8] This data is not currently available - please see **exception report** for update.

[9] The target for the patient experience 'Friends and Family / Net Promoter Score' test is due to be released by the DoH from April 2013

[10] This data is **available quarterly**

Whittington Health Integrated Dashboard - September 2012 (August 2012 Data)

Whittington Health NHS

NATIONAL INDICATORS - COMMUNITY

Please note that all Data is dated August 2012 unless otherwise Stated

Domain	Indicator	Target	June	July	August	YTD	QTR1	Trend	FOT for QTR 2
Health Visiting See Notes **[1] [2]** below	Prevalance of breast feeding at 6-8 weeks	**74%**	See Note **[2]**			76%	76%	→	→
	New Birth Visits - Islington	**95% within 14 days**	57.9%	67.5%	Note **[1]**	57.0%	57.0%	↑	→
	New Birth Visits - Haringey	**95% within 14 days**	21.6%	41.0%		21.4%	21.4%	↑	→
	New Birth Visits - Haringey	**95% within 28 days**	85.1%	92.7%		87.7%	87.7%	↑	→
Child Heath	% of Immunisation - Islington	**80%**	See Note **[2]**			88.5%	88.5%	→	→
	% of Immunisation - Haringey	**80%**	See Note **[2]**			88.5%	88.5%	→	→
Community Sexual Health	GUM: Patients offered appointment within 2 days	**100%**	100%	100%	100%	100%	100%	→	→
	% positivity for all Chlamydia Screening	**5%**	7.6%	14.8%	8.9%	11.9%	10.6%	↓	→
	% of chlamydia screens that are males <25 years old	See Note **[4]**	11.1%	12.1%	11.3%	11.7%	10.2%	→	→
	% of chlamydia screens that are females <25 years old	See Note **[4]**	46.5%	28.4%	26.9%	27.7%	46.8%	→	↓
Primary Care Psychology	IAPT - Number entering psychological therapies	See Note **[5]**	196		78	274	196	→	→
	IAPT - Number moving off sick pay and benefits	**90 per year**	35	18	16	69	35	→	→
Stop Smoking See Note **[3]** below	Actual 4 Week Quitters	**506/Qtr**	See Note **[3]**					→	→
	Projected 4 Week Quitters	See Note **[3]**	See Note **[3]**					→	→
Dental	Units of Dental Activity	**90% of contract**	96%	146%	116%	114%	103%	→	→
	Contacts	**90% of contract**	99%	129%	111%	112%	109%	→	→
Drugs & Alcohol	% of Treatment Starts	**80%**	100%	100%	100%	100%	100%	→	→
	% of treatment Reviews	**80%**	100%	96%	100%	99%	100%	→	→

Notes:

[1] New Birth Visits are reported **I months in arrears of the current 7th working day reporting schedule**: Data is available on the 14th working day after the end of the month

[2] This data is available quarterly

[3] This data will be available in October 2012. Please see the **exception report** for an update

[4] There is currently no national target set for this indicator - **see exception report for update**

[5] Target due to be released in October 2012

Whittington Health Integrated Dashboard - September 2012 (August 2012 Data)

Whittington Health NHS

LOCAL INDICATORS - ACUTE

Please note that all Data is dated August 2012 unless otherwise Stated

Indicator	Target	June	July	August	YTD	QTR1	Trend	FOT for QTR 2
Consultant 7 Day Ward Rounds	**Y**	N	N	N	N	N	→	→
Consultant presence every day 8am - 8pm (Acute Medicine)	**Y**	N	N	N	N	N	→	→
Consultant with no elective work on call 7 days (General Surgery)	**Y**	N	Y	Y	Y	N	→	→
Discharge Before 11am - Surgery / Medicine	**40% by Mar '13**	20.2%	25.4%	26.0%	25.9%	26.9%	→	→
Average Length of Stay - Medicine - See Note **[1]** below	Note **[1]**	7.1	8.3	7.3	7.8	7.7	→	→
Bed Days - Medicine - See Note **[1]** below	Note **[1]**	4031	4979	4456	23155	13738	→	→
Average Length of Stay - Surgery - See Note **[1]** below	Note **[1]**	4.0	4.0	3.2	4.1	4.5	→	→
Bed Days - Surgery - See Note **[1]** below	Note **[1]**	1732	1902	1405	9159	5841	→	→
Theatre Session Utilisation	**95%**	79.5%	77.9%	77.3%	76.5%	75.7%	→	→
Outpatients								
Number of First Appointments - See Note **[2]** below	Note **[2]**	4826	5528	5077	26259	15654	→	→
Number of Follow-Up Appointments - See Note **[2]** below	Note **[2]**	11406	13299	13047	65534	39188	→	→
DNA Rates - First Appointments	**8%**	12.8%	12.5%	14.6%	12.7%	12.2%	↓	→
DNA Rates - Follow-Up Appointments	**8%**	13.8%	13.5%	13.9%	13.6%	13.5%	→	→
Hospital Cancellation Rate - First Appointments	**2%**	3.8%	3.3%	3.2%	3.4%	3.5%	→	→
Hospital Cancellation Rate - Follow-up Appointments	**2%**	7.9%	8.4%	5.7%	7.2%	6.8%	→	→
% Waiting less than 15 minutes	**98%**	67.9%	70.1%	71.6%	68.6%	67.1%	→	→
Data Quality								
NHS Number Completeness - Acute	**99%**	96%	94%	95%	96%	97%	→	→
Outcomes not recorded - Acute	**<0.5%**	0.9%	0.4%	0.4%	0.4%	0.6%	→	→

LOCAL INDICATORS - COMMUNITY

Indicator	Target	June	July	August	YTD	QTR1	Trend	FOT for QTR 2
DNA Rates - Community Adult Service	**10%**	9.8%	11.0%	10.3%	9.6%	8.8%	→	→
DNA Rates - Community Children Services	**10%**	11.7%	12.0%	11.7%	11.9%	11.9%	→	→
Community Average Waiting Times - Adults	**6wks**	5.6	4.2	5.4	5.1	5.3	→	→
Community Average Waiting Times - Children	**18 wks**	14.0	13.0	11.0	13.0	14.0	→	→
Data Quality								
NHS Number Completeness - Community	**99%**	99.9%	99.8%	99.9%	99.8%	99.9%	→	→
Outcomes not recorded - Community	**<0.5%**	4.8%	5.7%	3.9%	4.1%	3.8%	→	→

[1] LOS and Bed day targets are dependent upon modelling work - **see exception report** for an update

[2] Targets are not yet established - **see exception report for detail**

Whittington Health Integrated Dashboard - September 2012 (August 2012 Data)

Please note that all Data is dated August 2012 unless otherwise Stated

Whittington Health NHS

SLA INDICATORS

Indicator	Target for Qtr1	June	July	August	YTD	QTR1	Trend	FOT for QTR 2
Outpatient Follow-up Ratio (Upper Quartile) - % excess follow-ups - <1% by Qtr 4	**29%**	25%	26%	32%	30%	29%	↓	→
Consultant to Consultant Activity (Upper Quartile) - % excess firsts	**<1%**	2.4%	1.4%	1.6%	2.0%	2.3%	→	→
Emergency Readmissions - from original elective admissions - see Note **[1]** below	**20% reduction from 10/11 baseline**	31	31	See Note [1]	133	102	→	→
Emergency Readmissions - from original emergency admissions see Note **[1]** below		201	194		759	565	→	→
Excess Beddays - see Note **[1]** below	**SLA Plan**	-152	-40		-238	-198	→	→

CQUIN 2012/13 - Reported from October 2012

Notes:

[1] Emergency readmissions and excess bed day data is available **1 month in arrears of the current reporting schedule of the 7th working day:** the data is derived from the coding of clinical records, completed on the 10th day following month end.