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The Whittington Hospital NHS Trust
Magdala Avenue
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# Whittington Health Trust Board meeting
# 24 October 2012

| | | | |
|---|---|---|---|
| **Title:** | Month 6 Performance Dashboard with exception report (Appendix 1) and the paper: "Proposed improvements to performance management information" (Appendix 2). | | |
| **Agenda item:** | **8** | **Paper** | **D** |
| **Action requested:** | **For Discussion:** Dashboard and Exception Report<br><br>**For agreement:** Proposals to deliver improvements to the Trust Board's Performance Dashboard and wider performance management information. | | |
| **Executive Summary:** | This report informs the Trust Board about performance for Month 6 - September 2012 (or the latest month available). Exceptions ('red' RAG rated 'in month' and/or 'Year to Date') and targets in development are in the attached Exception Report.<br><br>**Emergency Department performance** against the 4 hour target is causing concern. In September, 93.8% of patients waited less than four hours against a target of 95%. The year to date performance is 94.9%. To recover, average performance in Q3 must be at least 94.97%. The recovery plan involves increased board rounds to ensure timely discharge and the development of a standard operating procedure for the allocation of medical staff and queue management within ED in the evenings.<br><br>**New Birth Visits (NBVs)** are now being made much more promptly. The proportion of NBVs completed within 14 days increased from 67.5% to 78.9% from July to August in Islington, and 41.0% to 70.5% in Haringey. The target is 95%. We are on track to continue improving with increased staffing and improved processes. | | |
| **Summary of recommendations:** | Agree to the actions proposed in the document: "Proposed improvements to performance management information". | | |
| **Fit with WH strategy:** | The performance dashboard is a key part of achieving our strategic goals, especially goal 3, "efficient and effective care". | | |
| **Reference to related / other documents:** | 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:<br>Implications for the NHS Constitution, CQC registration<br>Financial, regulatory and legal implications of proposed action<br>Risk management, Annual Plan/IBP<br>Moving Ahead – how does this report support any of the Trust's 5 Strategic Goals | | |
| **Date paper completed:** | 12 October 2012 | | |

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|---|---|---|---|---|---|---|---|
| **Author name and title:** | | **Naser Turabi<br>Head of Performance** | | **Director name and title:** | | **Maria Da Silva<br>COO** | |
| **Date paper seen by EC** | **NA** | **Equality Impact Assessment complete?** | **NA** | **Risk assessment undertaken?** | **NA** | **Legal advice received?** | **NA** |

# Month 6 – September 2012 Whittington Health Performance Dashboard Exception Report

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

| Indicator | Sep'12 | YTD | Target | Comment/ Description of issue | Actions planned/taken to achieve target | Target date / trajectory | Accntbl./Rspnsbl. Officer for Action |
|---|---|---|---|---|---|---|---|
| **WORKFORCE** | | | | | | | |
| **Vacancy Rates** | 11.1% | 12.3% | <12% | See Below | See Below | | |
| | | | | Target based on average figure for Trusts across NHS London region.<br>Further improvements are ***not*** expected in the short/medium term due to the TPE project, CIP freeze on posts/ better control through vacancy panel. TPE project consultation only recently commenced and admin turnover relatively low at c. 7%.<br>Current figure has been falling in recent months. Latest decrease due to increased staff in post (up by 48 wte) and slight reduction in the overall establishment. | 1. Recruitment of substantive staff in particular nurses is planned over the next few months<br>2. The target date and trajectory will require adjustment following the implementation of the Patient Experience project | March 2013 | Paul Campbell |
| **Turnover** | 10.8% | 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. Dir. Ops. to ensure exit interviews are carried out for analysis by human resources team – on track<br>2. Analysis of turnover and exit interview data for areas of concern to determine specific issues to address – on track | Nov 2012<br>Nov 2012 | 1. Div. Dirs. Operations<br>2. Paul Campbell |
| **Appraisal** | 20% | 20% | 90% | See Below | See Below | | |
| | | | | Target is based on appraisals recorded on ESR.<br>Target not being met due to under reporting/recording issue – significantly more appraisals are being carried out than are being recorded. | 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<br>Learning and Development team are inputting any available backlog data on behalf of managers during October | Oct 2012 for Nov D/Board | Div. Dirs. Operations |

# Month 6 – September 2012 Whittington Health Performance Dashboard Exception Report

| Indicator | Sep'12 | YTD | Target | Comment/ Description of issue | Actions planned/taken to achieve target | Target date / trajectory | Accntbl./Rspnsbl. Officer for Action |
|---|---|---|---|---|---|---|---|
| **Mandatory Training** | 70% | 70% | 90% (Dec'12) | See below | See below | | |
| | | | | Staff turnover is accounted for by the 90% target.<br><br>Overall performance is slowly improving although still significantly short of target. Both elements of the action plan have been completed. | 1. Clear user guide (with appropriate module nos.) to be produced ASAP for Dir. Ops.<br>2. Dir. Ops to plan group and face-to-face sessions, working with HR, in order to ensure on track for December delivery<br>Both elements completed. | Sept 2012<br><br>Sept 2012 | 1. Paul Campbell<br><br>2. Div. Dirs. Operations |
| **NATIONAL TARGETS** | | | | | | | |
| **Patients in ED for < 4 hours** | 93. 8% | 94.9% | 95% | See Below | See Below | | |
| | | | | Performance deteriorated in September following a period of sustained improvement. However, the Trust met the standard for Q2.<br>The last week in September was a particular challenge. The main causes being reduced bed capacity that impacts on flow through the ED. Additionally the department experienced a period of high acuity / high volume attendances | The implementation of board rounds across all wards will assist in identifying delays<br>The daily bed management meeting has been reviewed and takes places after the board rounds. Membership now includes full MDT who can focus on issues identified from board round.<br>Internally to the ED a review of flow management and escalation in the evening is taking place. | In place<br><br>Completed<br><br>By mid Oct 2012 | Carol Gillen (Dir Ops – ICAM) |
| **Cancer – 14 day 1st OP (August)** | 93.2% | 92.9% | 93% | See Below | See Below | | |
| | | | | Performance on track in month following additional capacity provided for two week target referrals.<br>Additional escalation mechanism and early alert of 2 week capacity | Actions already in place (see comment to left) | | Matthew Boazman (Dir Ops – SCD) |

# Month 6 – September 2012 Whittington Health Performance Dashboard Exception Report

| Indicator | Sep'12 | YTD | Target | Comment/ Description of issue | Actions planned/taken to achieve target | Target date / trajectory | Accntbl./Rspnsbl. Officer for Action |
|---|---|---|---|---|---|---|---|
| | | | | issues implemented during August<br>Additional clinic capacity provided for 2 week clinics during August to address any loss of capacity due to annual leave. | | | |
| **Cancer – 14 day breast (August)** | 94.3% | 92.7% | 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.<br>Performance also affected 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 (August)** | 100% | 83.4% | 85% | See below | See below | | |
| | | | | Performance in month is above target- YTD target relates to breaches from earlier in the year described in previous Trust Board report.<br>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.<br>4 of the 5 patients who breached in June 2012 were complex clinical | 1. Clinician not following appropriate clinical pathway addressed<br>2. Actions in place to ensure non-clinical delays are minimised<br>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<br>Sept. 2012<br>Oct 2012 | 1. Matthew Boazman<br>2. Mark Rose<br>3. Mark Rose |

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|---|---|---|---|---|---|---|---|
| | | | | cases that required substantial clinical work up and diagnostic investigation. This month continues to effect the YTD rating<br>One breach was avoidable and related to a clinician referring for a diagnostic test incorrectly – not requested as urgent | | | |
| **Delayed Transfer of Care** | 3.6% | 2.2% | <3.5% | | | | |
| | | | | % of Inpatients with Delayed Transfer of Care<br>Some very long delays are patients waiting for specialist neurological rehabilitation beds.<br>Others due to difficulties with placing people in Islington care homes delays where the patient or family are unwilling to accept the placement offered can occur. | 1. Active monitoring of potential delays and escalation to unblock these where possible.<br>2. Clear communication to patients that they will have to go to an interim placement is being rolled out across ward teams.<br>3. Board rounds and daily revamped bed meeting also supporting reduction in delays. | | Delia Thomas |
| **QUALITY** | | | | | | | |
| **Complaints response < 28days** | **Aug'12** 65% | 71% | 80% | See Below | See Below | | |
| **N.B AUGUST'12 DATA** | | | | Increasing number of complaints.<br>Lack of capacity within divisions to respond within agreed timescale<br>Members of staff not usually involved in formal responses asked to lead on whole process.<br>Holiday season has had impact on response timescales. | 1. Complaints investigation training arranged Oct /Nov'12; bespoke training offered for key managers in interim;<br>2. New PALS and Complaints manager now in post as of October 1st 2012<br>3. Head of Patient Experience managing all complex complaints to free up more capacity<br>4. Operations allocating capacity to ensure back on track Sept for Oct D/Board – challenges are in SCD and ICAM and they have | Nov 2012<br>Sept for Oct 2012 D/Board | 1/2/3 Cassie Williams / Jennie Williams<br>4. Div. Dirs. Ops. |

# Month 6 – September 2012 Whittington Health Performance Dashboard Exception Report

| Indicator | Sep'12 | YTD | Target | Comment/ Description of issue | Actions planned/taken to achieve target | Target date / trajectory | Accntbl./Rspnsbl. Officer for Action |
|---|---|---|---|---|---|---|---|
| | | | | | recruited and will be in post in November | | |
| **MRSA Screening - Elective** | 78.8% | 79.3% | 95% | See below | See below | | |
| **MRSA Screening - Non-Elective** | 86.0% | 84.6% | 95% | See below | See below | | |
| | | | | All hospital patients should be screened for MRSA. Reporte4d screening rates dropped between March and April 2012, likely due to a change in data methodology. | 1. Increased feedback to ED and clinics including education sessions<br>2. Changes to requesting process for MRSA screening we have made the way to request MRSA screening even easier.<br>3. Further analysis of data methodology to ensure full data capture | October 2012<br>October 2012 (complete)<br>October | Julie Andrews<br>Julie Andrews<br>Anita Garrick |
| **Pressure Ulcers – Acute** | 1 | 6 | 3/yr | See Below | See Below | | |
| **GRADE3-4** | | | | Target based on 80% reduction from 2010/11 baseline<br>Target has been exceeded as increased awareness and reporting within community teams<br>From Q1 2012 all completed RCAs have been reported to the Serious Incident Executive Approval Group for agreement before submission to NHS London.<br>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. The panel also considers initiatives | A performance managed programme of work is underway that will to embed change in practice | April 2013 | Bronagh Scott |

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| Indicator | Sep'12 | YTD | Target | Comment/ Description of issue | Actions planned/taken to achieve target | Target date / trajectory | Accntbl./Rspnsbl. Officer for Action |
|---|---|---|---|---|---|---|---|
| | | | | for awareness raising and training about the prevention of pressure ulcers within the Trust. | | | |
| **Pressure Ulcers – Community** | 3 | 31 | 21/yr | See Below | See Below | | |
| **GRADE 3-4** | | | | Target based on a 30% reduction from 2011/12 baseline<br>As Acute above | As Acute above | April 2013 | Bronagh Scott |
| **MSK funct. scale** | 62% | 33% | 40% | See Below | See Below | | |
| **% of pats. completing Patient Specific Functional Scale** | | | | October target has been met. We aim to meet the YTD by the last quarter | On track to meet YTD target | Jan 2012 | Fiona Yung |
| **Diabetes** | 73% | 80% | 85% | See Below | See Below | | |
| **Confidence to manage condition** | | | | This target is based on small numbers therefore small variation can affect the target. 2 patients contacted had not used the service within the 6 months time limit and therefore were not able to answer this question meaningfully. | Ensure that only patients that have been in the service for at least 6 months are asked this question to determine impact of service which we are currently not doing | Sept 2012 | Fiona Yung |
| **NATIONAL - COMMUNITY** | | | | | | | |
| **New Birth Visits Islington 14 Day** | August Isl: 78.9%; | Isl: 64.1%; | 95% | See Below | See Below | | |
| **Haringey 14 Day** | August Har: 70.5% | Har: 35.4% | 95% | See Below | See Below | | |
| | | | | Performance is improving across Haringey and Islington in response to increasing staffing levels, improving information flow and information sharing processes and | 1. A LEAN review of the NBV process has identified significant areas for improved efficiency including the flow of information from midwifery to health visiting | Oct 2012 | Sam Page |

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| Indicator | Sep'12 | YTD | Target | Comment/ Description of issue | Actions planned/taken to achieve target | Target date / trajectory | Accntbl./Rspnsbl. Officer for Action |
|---|---|---|---|---|---|---|---|
| | | | | a refocusing of attention on preventative work with families. | services. An Action plan is in development.<br>2. Audit is being completed to identify reasons for late NBVs.<br>3. Recruitment to 13 Islington and 5 Haringey vacant posts (includes expansion posts in line with government commitment).<br>4. 12 students are being trained from September 2012 with a further 2 expected from January 2012. | | |
| **Haringey 28 days** | August Har: 93.4% | Har: 90.3% | 95% | See Below | See Below | | |
| | | | | The 28 day target is being used to identify outliers. Expectation that this target will be reached as performance on 14 day target improves. | As Above | Oct 2012 | Sam Pag |
| **LOCAL TARGETS** | | | | | | | |
| **Theatre Utilisation** | 82.7 % | 81.5 % | 95% | See Below | See Below | | |
| | | | | Theatre utilisation captured as a measure of all available theatre sessions timetabled throughout the week / % minutes utilised.<br>Key issues affecting utilisation August:<br>- closed lists due to consultant annual leave<br>- partial filled lists provided to avoid 18 week breaches (e.g. ENT) leading to under-utilisation<br>- reduction in day case cystoscopy due to equipment failure in month<br>- underutilised urology lists | 1. New theatre timetable, dedicated anaesthetic and general surgeon rotas introduced. - complete<br>2. Data quality review in Sept 2012 e.g. inclusion of data for planned closures adversely effecting utilisation data – extended to October<br>3. Target will separate Emergency from Elective to represent new streamlining of services Sept 2012 - complete<br>4. Replacement cystocopy equipment in place - complete<br>5. Review on new G Surgery rota | Aug 2012<br>Sept 2012 (now October 2012)<br>Sept 2012<br>September 2012 | 1. Graham Booth<br>2. Graham Booth<br>3. Anita Garrick<br>4. Completed<br>5. Hasan Mukhtar |

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| Indicator | Sep'12 | YTD | Target | Comment/ Description of issue | Actions planned/taken to achieve target | Target date / trajectory | Accntbl./Rspnsbl. Officer for Action |
|---|---|---|---|---|---|---|---|
| | | | | | being undertaken by Clinical Director for surgery to review theatre session provision<br>6. Urology job planning for 2012/13 to be revisited in order to review theatre allocation and usage<br>7. Orthopaedic day case lists to be reallocated and increased hip inpatient list to be provided following job planning review within orthopaedics. | October 2012<br><br>November 2012<br><br>November 2012 for new listed patients | <br><br>6. Matthew Boazman and Nick Harper<br><br>7. Graham Booth (agreed with David Sweetnam) |
| **Acute DNA Rates - First** | 12.9% | 12.8% | <8% | See Below | See Below | | |
| **- Follow Up** | 14.1% | 13.7% | <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. 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 )<br>2. Transforming Patient Experience key roles being proposed is the Patient Pathway Coordinator (PPC) aimed at improving patient communication, reducing patient handoffs between functions. | 1. Dec 2012<br><br>2. Dec 2012 | 1. Div. Dirs. Ops.<br><br>2. Matthew Boazman |
| **Hospital Cancellations (1st OP Appt)** | 6.1% | 3.8% | <2% | See Below | See Below | | |
| **Hospital Cancellations (Follow ups)** | 8.3% | 7.1% | <2% | See Below | See Below | | |
| | | | | General Surgery had high level of cancelled and rebooked appointments between July-September as a result of the new consultant on-call rota being implemented in line with the emergency care standards. As a | 1. The trust Wide DNA and cancellation policy updated and launched to reflect guidance on discharging DNA patients, managing partial bookings and clinic cancellation.<br>2. Transforming Patient Experience | 1. Complete<br><br>2. Dec | 1. Laura Bell<br><br>2. Matthew |

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| Indicator | Sep'12 | YTD | Target | Comment/ Description of issue | Actions planned/taken to achieve target | Target date / trajectory | Accntbl./Rspnsbl. Officer for Action |
|---|---|---|---|---|---|---|---|
| | | | | result all of the consultant clinic and theatre templates changed in order to provide 12/7 on call which meant a number of appointments had to be rescheduled. | key roles being proposed is the Patient Pathway Coordinator (PPC) aimed at improving patient communication, coordination/reducing patient handoffs between functions<br>3. Partial Booking to be introduced for follow-Ups in all divisions | 2012<br>3. Dec 2012 | Boazman<br>3. Div. Dirs. Ops. |
| **DNA Rates** | 9.0% | 11.5% | 10% | See below | See below | | |
| **Community Children Services** | | | | 2.7% point decrease between August and September – now achieving target in month. | If current performance is maintained on track to achieve YTD target by Q3<br><br>Various methods including: texting service, interpreting, checks with patient on site re details, phoning parents day before, partial booking system, '1 strike and out policy' (e.g. in SLT saw significant reduction in DNA rate;CAMHS have set up process to review serial non-attenders | | Dee Hackett |
| **Outcomes Not Recorded** | 4.0% | 3.5% | <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** | 33% excess | 29% 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.<br>Diabetes: Audit show 46% eligible for discharge. Of those 50% primary | 1. Diabetes and Cardiology expect to meet KPI for first to follow up by end of March 2013<br>2. Cardiac rehabilitation patients to be excluded from this figure in following months<br>3. Discussions at contract monitoring with NCL regarding | 1. Mar 2013<br>2. Sept 2012<br>3. Oct | 1. Dr David Brull<br>2. Anita Garrick<br>3. Fiona Smith |

# Month 6 – September 2012 Whittington Health Performance Dashboard Exception Report

| Indicator | Sep'12 | YTD | Target | Comment/ Description of issue | Actions planned/taken to achieve target | Target date / trajectory | Accntbl./Rspnsbl. Officer for Action |
|---|---|---|---|---|---|---|---|
| | | | | care /50 % intermediate services; audit also to be carried out on nurse led clinics<br>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.<br>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. | the exclusion of some specialist clinics from KPI targets.<br>4. 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.<br>5. Specialty action plans and named clinical leads for implementation were approved at the July Surgical Board for Oct 2012 trajectory<br>6. Orthopaedic template review is continuing and the clinical lead is support specialty actions for local management of follow ups and diagnostic requests | 2012<br>4. Oct 2012<br>5. Oct 2012<br>6. Nov 2012 | Fiona Smith<br>5. Nick Harper<br>4. 6. Mr David Sweetnam |

| DATA EXCEPTIONS / TARGETS IN DEVELOPMENT | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Indicator** | **Sep'12** | **YTD** | **Target** | **Comment/ Description of issue** | **Actions planned/taken to achieve target** | **Target date / trajectory** | **Accntbl./Rspnsbl. Officer for Action** |
| **FINANCE** | | | | | | | |
| **Bank Spend** | **1,332** | **6,489** | No target | Bank spend will increase as agency spend decreases – it is planned to monitor bank spend but not set a | | | |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | | | | target. | | | |
| **Agency Spend** | **1,027** | **4,789** | TBC | Targets are being developed to reduce levels of agency spend by 50% by April 2013 | | | |
| | | | | Meeting this target is dependent on increasing recruitment to the Nurse bank, reducing the dependency on extra beds, increased scrutiny and challenge | Bank pay rates increased in line with AFC<br>Tax payment method under review<br>Nurse Manager appointed<br>Extended hours of Bank office | **April 2013** | Bronagh Scott |
| **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.<br>The Cancer Team were unable to collect data due to IT technical issues that have now been addressed – Data collection for October has started and full month will be available at the end of October | 1. Data base has been updated to allow data collection<br>2. Processes have been changed within the cancer team to enable data collection | 1. Sept 2012<br>2. Oct for Nov 2012 D/Board | 1. Anita Garrick<br>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<br>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 | | |

# Month 6 – September 2012 Whittington Health Performance Dashboard Exception Report

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|---|---|---|---|---|---|---|---|
| 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 – further discussions on most appropriate target for sexual health will form part of dashboard review. | Sept 2012 | Claire O'Conner |
| **Patient Experience** | | | | | | | |
| **Cleanliness Audit** See Note **[7]** page 3-4 | | | | Audit data for this indicator incomplete in August | Due to report for September 2012 – now complete. Reported and meeting target. | 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 | **4763** | **31022** | No target | Target requires revision to reflect SLA in financial terms | Target to be revised as an aggregated Financial Target for October Dashboard | Oct 2012 | Fiona Smith |
| Number of Follow-Up Appointments | **11686** | **77220** | No target | See Above | See Above | Oct 2012 | Fiona Smith |

# Proposed improvements to performance management information

This paper proposes two sets of actions that the Board is asked to agree:

1) Further incremental improvements are made to the Trust Performance Dashboard
2) Development of a plan to renew the performance management framework and associated management information.

These actions are in line with Trust strategy, especially with regard to ensuring efficient and effective care. They directly support our foundation trust application.

## 1. Incremental Improvements for the M7 Dashboard

For next month's Trust Board meeting (M7 Dashboard) it is proposed that further incremental improvements are made:

1. Partial reorganising to align metrics with the strategic risks in the Board Assurance Framework to facilitate board oversight
2. Highlighting of key indicators relating to transformation programmes and major CIPs
3. Easy access to definitions of indicators, and explicit display of numerator and denominator where appropriate
4. Areas where no targets/thresholds have been defined to be progressed
5. Greater use of trend analysis especially in relation to indicators that are causing concern
6. Inclusion of more activity data (i.e. numbers of admissions, contacts, OP appointments etc) including trends to enable monitoring of performance against plan
7. Removal of metrics that do not require board oversight and inclusion of any that are required but not currently included.

These changes will be tracked to ensure that the Board can transparently monitor the improvements and every effort will be made to ensure readability and ease of use.

## 2. Presenting plan to renew the performance management framework

In addition to the incremental improvements described above, a plan to renew the performance management framework and associated management information will be presented in overview at November Board.

This plan will seek to ensure that Whittington Health's performance management framework supports:

1. Strong management control of operational performance reflecting the diversity of Whittington Health;
2. Board to frontline consistency in performance management information
3. The development of a service line management culture; and,
4. Our strategic goals .

The plan will be informed by consultation with key managers, published guidance from Monitor, and recommendations made by external reviewers as part of the FT application process so far.

The actions proposed above will be implemented by the Head of Performance with oversight from the COO and input from relevant senior managers.

Whittington Health NHS

**Please note that all data is dated September 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 | 22,048 | 22,364 | (316) | 137,680 | 136,264 | 1,416 | 274,658 |
| Total Expenditure | 21,457 | 22,053 | 596 | 129,954 | 128,453 | (1,501) | 257,127 |
| EBITDA | 591 | 311 | 280 | 7,726 | 7,812 | (85) | 17,531 |
| Net Surplus/Deficit | (555) | (850) | 295 | 734 | 791 | (57) | 3,120 |
| Net Surplus/Deficit excluding PFI IFRS | (633) | (928) | 295 | 841 | 899 | (57) | 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 | September |
|---|---|---|---|---|---|---|---|---|---|
| **Total** | **13,100** | **0** | **0** | **2,670** | **cumulative % achieved against target** | 69% | 74% | 80% | 86% |

## WORKFORCE AND MANDATORY TRAINING

| Domain | Indicator | Target | June | July | August | September | YTD | FOT for QTR2 |
|---|---|---|---|---|---|---|---|---|
| **Workforce** | Vacancy Rates | <12% | 12.6% | 11.7% | 12.6% | 11.1% | 12.3% | → |
| | Sickness Absence | <3% | 3.1% | 3.1% | 2.8% | 2.5% | 2.8% | → |
| | Long Term Sick Leave | <1% | 1.4% | 1.3% | 1.2% | 1.2% | 1.3% | → |
| | Turnover | <10% | 11.2% | 11.1% | 11.0% | 10.8% | 10.5% | → |
| | Bank Spend (£000) | Note **[1]** | 1,144 | 1,409 | 1,332 | 1,297 | 7,786 | 4,038 |
| | Agency Spend (£000) | Note **[1]** | 816 | 933 | 1,027 | 711 | 5,500 | 2,672 |
| | Staff in post | TBC | 3,606.3 | 3,569.2 | 3,606.8 | 3,654.7 | 3,636.0 | |
| | Stability Level | >80% | 82.9% | 83.4% | 83.7% | 83.6% | 82.9% | → |
| | Appraisal | 90% | 20% | 20% | 19% | 20% | 20% | → |
| | Number of case of bullying & harassment (cumulative) | 0 | 1 | 1 | 1 | 3 | 3 | → |
| | % of qualified to unqualified staff (nurses) | 70% qualified 30% unqualified | 76/24 | 77/23 | 79/21 | 79/21 | 77/23 | → |
| **Training Compliance** | Mandatory Training Compliance | 90% by Dec | 67% | 68% | 69% | 70% | 70% | → |
| **ESR** | No. of staff activated on ESR | 95% | 652 | 665 | 680 | 687 | 687 | → |

| KEY | |
|---|---|
| **RAG rated Arrow colours** | |
| → | Significantly below target |
| → | Below target Note **[2]** |
| → | On Target |
| → | No Target |
| **Arrow Direction** | |
| ↑ | Improvement |
| → | No change |
| ↓ | Worsening Position |

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

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

Whittington Health NHS

## NATIONAL INDICATORS - ACUTE SERVICES

**Please note that all data is dated September 2012 unless otherwise stated**

| Domain | Indicator | Target | July | August | Sept | YTD | QTR 2 | Trend | FOT for QTR 2 |
|---|---|---|---|---|---|---|---|---|---|
| **ED Targets** | Patients in A&E under 4 hours | **95%** | 95.1% | 97.0% | 93.8% | 94.9% | 95.3% | ↓ | → |
| **18 Weeks RTT** | Referral to Treatment - Admitted | **90%** | 92.5% | 90.0% | 90.3% | 91.9% | 91.0% | → | → |
| | Referral to Treatment - Non Admitted | **95%** | 99.0% | 99.1% | 98.4% | 98.9% | 98.8% | → | → |
| | Referral to Treatment - Incomplete | **92%** | 95.4% | 95.2% | 92.8% | 94.6% | 94.5% | → | → |
| | 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 - **Note [1]** | **93%** | 92.6% | 93.2% | 91.9% | 92.9% | 92.9% | ↑ | ↑ |
| | 14 days GP referrals - Breast symptoms - **Note [1]** | **93%** | 86.2% | 94.3% | 87.2% | 92.7% | 89.4% | ↑ | ↑ |
| | 31 days to First Treatment - **Note [1]** | **96%** | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | → | → |
| | 31 days to Second or Subsequent Treatment (Surgery) | **94%** | See Note **[2]** | | | | | → | → |
| | 31 days to Second or Subsequent Treatment (drugs) | **98%** | | | | | | → | → |
| | 62 days Referral to Treatment - **Note [1]** | **85%** | 85.3% | 100.0% | 81.8% | 83.4% | 91.7% | → | → |
| | 62 days Wait First Treatment from Cancer Screening - **Note [1]** | **90%** | 100.0% | 100.0% | - | 100.0% | 100.0% | → | → |
| **Fractured Neck of Femur** | Fractured Neck of Femur operated within <36 hours | **85%** | 100.0% | 100.0% | 85.7% | 93.4% | 95.5% | → | → |
| | Fractured Neck of Femur operated within <48 hours | **85%** | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | → | → |
| **Cancelled Operations** | Cancelled Operations as percentage of elective admissions | **<0.8%** | 0.2% | 0.3% | 0.7% | 0.5% | 0.4% | → | → |
| | 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%** | 2.1% | 2.0% | 3.6% | 2.2% | 2.7% | ↓ | → |
| **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%** | 90.5% | 89.7% | 96.6% | 90.2% | 92.1% | ↑ | ↑ |
| | 1:1 care in established labour | **100%** | 100% | 100% | 100% | 100% | 100% | → | → |
| | Breast Feeding at Birth | **90%** | 90% | 91% | 92% | 91% | 91% | → | → |
| | Smoking during pregnancy at time of delivery | **<17%** | 6% | 8% | 8% | 7% | 7% | → | → |

**Notes:**

**[1]** Finalised 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. Unvalidated data for the most recent month is shown in grey. These figures are not included in the year to date or quarter totals. **Unvalidated data is displayed in grey for this month only. The validation process results in improvements in recorded performance as data is cleansed.**

**[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 - October 2012 (September 2012 Data)

Whittington Health NHS

## QUALITY INDICATORS - INTEGRATED CARE ORGANISATION

**Please note that all data is dated September 2012 unless otherwise stated**

| Domain | Indicator | Target | July | August | Sept | YTD | QTR 2 | Trend | FOT for QTR 2 |
|---|---|---|---|---|---|---|---|---|---|
| **Incident Reporting** See Note **[1]** below | Number of Serious Incidents | **n/a** | 16 | 8 | 12 | 69 | 36 | → | → |
| | Timeliness of external SI Report submission | **Green** | See Note **[1]** | | | | | → | → |
| | Incident Reporting Rates per 1000 beddays / contacts - see Note **[2]** | Note **[2]** | 3.6 | 3.0 | 3.5 | 3.3 | 3.4 | → | → |
| | Number of Falls - see Note **[2]** | Note **[2]** | 26 | 21 | 27 | 184 | 74 | → | → |
| | Number of Falls Causing Severe Harm - see Note **[2]** | Note **[2]** | 1 | 0 | 0 | 1 | 1 | → | → |
| | Never Events | **0** | 0 | 0 | 0 | 2 | 0 | → | → |
| **Clinical Effectiveness** | Safety Alerts Compliance | **100%** | 100% | 100% | 100% | 100% | 100% | → | → |
| **Patient Experience** See Note **[3]** below | Complaints Received | **n/a** | 59 | 49 | 41 | 303 | 148 | → | → |
| | Complaints Responded to within specified timeframe | **80%** | 63% | 65% | Note **[3]** | 71% | 64% | → | → |

## QUALITY INDICATORS - ACUTE SERVICES

| Domain | Indicator | Target | July | August | Sept | YTD | QTR 2 | Trend | FOT for QTR 2 |
|---|---|---|---|---|---|---|---|---|---|
| **Infection Prevention & Control** | MRSA Bacteraemia Cases | **1 (year)** | 0 | 0 | 0 | 1 | 0 | → | → |
| | C.DIFF Cases | **21 (year)** | 1 | 2 | 1 | 6 | 4 | → | → |
| | E Coli Cases - see Note **[2]** | Note **[2]** | 1 | 1 | 1 | 6 | 3 | → | → |
| | MSSA Bacteraemia Cases - see Note **[2]** | Note **[2]** | 0 | 0 | 0 | 1 | 0 | → | → |
| | MRSA Screening - Elective Patients | **95%** | 80.2% | 76.7% | 78.8% | 79.3% | 78.6% | → | → |
| | MRSA Screening - Non-Elective Patients | **95%** | 79.6% | 84.8% | 86.0% | 84.6% | 83.5% | → | → |
| | Hand Hygiene Audit | **95%** | 97.9% | 95.8% | 100.0% | 97.7% | 97.7% | → | → |
| **Incident Reporting** **See** Notes **[4]** **[5]** **[6]** below | Pressure Ulcers - grade 3/4 (80% reduction from 2010/11 baseline) | **3/yr** | 1 | 1 | 1 | 6 | 3 | → | → |
| | VTE Assessment | **95%** | 95.3% | 95.6% | | 95.6% | 95.4% | → | → |
| | VTE Rate - Hospital Acquired | **0** | 4 | 1 | Note **[4]** | 12 | 5 | → | → |
| | Appropriate Prophylaxis for VTE | **90%** | 95.1% | 99.2% | | 84.6% | 97.0% | → | → |
| | Post Operative Sepsis | **AE** | 0 | See Note **[6]** | | 1 | 0 | → | → |
| | Post Operative Sepsis - Hips | **AE** | 0 | | | 0 | 0 | → | → |
| | Post Operative Sepsis - Knees | **AE** | 0 | | | 1 | 0 | → | → |
| | Deaths After Surgery | **AE** | 0 | | | 4 | 0 | → | → |
| | Deaths in Low Risk Conditions | **AE** | 1 | | | 3 | 1 | → | → |
| | Deaths After Bariatric Surgery | **AE** | 0 | | | 0 | 0 | → | → |
| | Hospital Level Mortality Indicator - Summary | **<100** | 80.1 | | | 82.3 | 80.1 | → | → |
| **Clinical Effectiveness** See Note **[7]** below | Emergency Admission Rate for LTC | Note **[7]** | 157 | 140 | | 724 | 297 | → | → |
| | Emergency Admission Rate for Paediatric Conditions (asthma, epilepsy, diabetes) | Note **[7]** | 27 | 10 | Note **[7]** | 69 | 37 | → | → |
| | Emergency Admission for VTE | Note **[7]** | 8 | 9 | | 33 | 17 | → | → |
| **Patient Experience** See Notes **[8]** **[9]** below | Friends & Family Test (Net Promoter Score) See Note **[9]** below | Note **[9]** | 27% | 33% | 29% | 27% | 29% | → | → |
| | Cleanliness Audit | **>95%** | 97.1% | 98.1% | | 97.3% | 97.6% | ↑ | |

## QUALITY INDICATORS - COMMUNITY SERVICES

Whittington Health NHS

**Please note that all data is dated September 2012 unless otherwise stated**

| Domain | Indicator | Target | July | August | Sept | YTD | QTR 2 | Trend | FOT for QTR 2 |
|---|---|---|---|---|---|---|---|---|---|
| **Infection Prevention & Control** See Note **[10]** below | Dentistry Compliance with Infection Control Standard | **90%** | 96% (See Note **[10]**) | | | 96% | 96% | → | → |
| **Incident Reporting** | Pressure Ulcers - grade 3/4 (30% reduction from 2011/12 baseline) | **21/yr** | 8 | 4 | 3 | 31 | 15 | → | → |
| **Patient Experience** See Note **[9]** below | Friends & Family Test (Net Promoter Score) See Note **[9]** below | Note **[9]** | 28% | 17% | 36% | 32% | 27% | → | → |
| | Dentistry - Patient Involvement | **90%** | 90% | 98% | 95% | 93% | 94% | ↑ | ↑ |
| | Dentistry - Patient Experience | **90%** | 98% | 92% | 100% | 98% | 97% | → | → |
| **Clinical Effectiveness** | Respiratory - number of admissions avoided | **25 / Qtr** | 18 | 13 | 8 | 54 | 39 | ↑ | ↑ |
| | Diabetes - % of patients with at least a 1% reduction in HbA1c after 6 months | **60%** | 80% | 80% | 69% | 74% | 76% | → | → |
| | Diabetes - % of patients reporting confidence in managing their condition | **85%** | 100% | 71% | 73% | 80% | 81% | ↓ | → |
| | Heart Failure / Cardiology - % of patients on optimum Ace Therapy | **80%** | 90% | 86% | 85% | 88% | 87% | → | → |
| | Heart Failure / Cardiology - % of patients on optimum Beta Blocker Therapy | **80%** | 87% | 86% | 85% | 85% | 86% | → | → |
| | Rehab Intermediate Care - % of patients with self-directed goals set | **70%** | 71% | 78% | 73% | 70% | 74% | → | → |
| | Rehab Intermediate Care - % of patients with improved or maintained function (from pre- and post- treatment goals) | **70%** | 76% | 80% | 77% | 74% | 78% | → | → |
| | MSK - % of patients who have completed the Patient Specific Functional Scale | **40%** | 22% | 46% | 62% | 33% | 45% | ↑ | → |
| | MSK - % of patients completing their treatment on discharge | **40%** | 36% | 36% | 36% | 37% | 36% | → | ↑ |
| | CAMHS - % of Cases where mental health problems has been resolved or improved | **60%** | See Note **[10]** | | | 73% | 71% | → | → |
| | CAMHS - % of Cases where severity of mental health at end of treatment is normal | **80%** | See Note **[10]** | | | 89% | 87% | → | → |
| | % of new patients with an HIV test within preceding 90 days | **60%** | 85% | 83% | 83% | 84% | 84% | → | → |
| | % of women 18 to 25 years old attending for contraception given LARC | **20%** | 30% | 32% | 29% | 29% | 30% | → | → |
| | % of new male patients who had an STI screen who were under 25 years | **20%** | 31% | 30% | 30% | 31% | 30% | → | → |
| | % of new female patients who had an STI screen who were under 25 years | **20%** | 47% | 43% | 48% | 46% | 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 NHS

## NATIONAL INDICATORS - COMMUNITY

**Please note that all data is dated September 2012 unless otherwise stated**

| Domain | Indicator | Target | July | August | Sept | YTD | QTR 2 | 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% | | → | → |
| | New Birth Visits - Islington | **95% within 14 days** | 67.5% | 78.9% | Note **[1]** | 64.1% | 73.3% | ↑ | → |
| | New Birth Visits - Haringey | **95% within 14 days** | 41.0% | 70.5% | | 35.4% | 54.7% | ↑ | → |
| | New Birth Visits - Haringey | **95% within 28 days** | 92.7% | 93.4% | | 90.3% | 93.0% | ↑ | → |
| **Child Heath** | % of Immunisation - Islington | **80%** | See Note **[2]** | | | 88.5% | | → | → |
| | % of Immunisation - Haringey | **80%** | See Note **[2]** | | | 88.5% | | → | → |
| **Community Sexual Health** | GUM: Patients offered appointment within 2 days | **100%** | 100% | 100% | 100% | 100% | 100% | → | → |
| | % positivity for all Chlamydia Screening | **5%** | 14.8% | 8.9% | 7.3% | 10.4% | 10.3% | ↓ | → |
| | % of chlamydia screens that are males <25 years old | See Note **[4]** | 12.1% | 11.3% | 11.1% | 10.9% | 11.5% | → | → |
| | % of chlamydia screens that are females <25 years old | See Note **[4]** | 28.4% | 26.9% | 30.0% | 37.6% | 28.4% | → | ↓ |
| **Primary Care Psychology** | IAPT - Number entering psychological therapies | See Note **[5]** | 251 | 348 | 325 | 1380 | 924 | → | → |
| | IAPT - Number moving off sick pay and benefits | **90 per year** | 13 | 9 | 19 | 64 | 41 | → | → |
| **Stop Smoking** | Actual 4 Week Quitters | **506 for Qtr 1** | See Note **[2] & [3]** | | | 568 | | → | → |
| **Dental** | Units of Dental Activity | **90% of contract** | 146% | 116% | 103% | 111% | 114% | → | → |
| | Contacts | **90% of contract** | 129% | 111% | 95% | 111% | 119% | → | → |
| **Drugs & Alcohol** | % of Treatment Starts | **80%** | 100% | 100% | 90% | 98% | 97% | → | → |
| | % of treatment Reviews | **80%** | 96% | 100% | 92% | 97% | 96% | → | → |

**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]** Quarter 1 data will be available in October 2012

**[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 - October 2012 (September 2012 Data)

Whittington Health NHS

## LOCAL INDICATORS - ACUTE

**Please note that all data is dated September 2012 unless otherwise stated**

| Indicator | Target | July | August | Sept | YTD | QTR 2 | 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** | Y | Y | Y | Y | Y | → | → |
| Discharge Before 11am - Surgery / Medicine | **40% by Mar '13** | 25.4% | 26.0% | 28.7% | 26.3% | 26.3% | → | → |
| Average Length of Stay - Medicine - See Note **[1]** below | Note **[1]** | 8.3 | 7.3 | 7.3 | 7.7 | 7.6 | → | → |
| Bed Days - Medicine - See Note **[1]** below | Note **[1]** | 4979 | 4456 | 4527 | 27637 | 13904 | → | → |
| Average Length of Stay - Surgery - See Note **[1]** below | Note **[1]** | 4.0 | 3.2 | 3.1 | 4.0 | 3.5 | → | → |
| Bed Days - Surgery - See Note **[1]** below | Note **[1]** | 1902 | 1405 | 1395 | 10602 | 4765 | → | → |
| Theatre Session Utilisation | **95%** | 77.9% | 77.3% | 82.7% | 81.5% | 83.2% | → | → |
| **Outpatients** | | | | | | | | |
| Number of First Appointments - See Note **[2]** below | Note **[2]** | 5528 | 5077 | 4763 | 31022 | 15368 | → | → |
| Number of Follow-Up Appointments - See Note **[2]** below | Note **[2]** | 13299 | 13047 | 11686 | 77220 | 38032 | → | → |
| DNA Rates - First Appointments | **8%** | 12.5% | 14.6% | 12.9% | 12.8% | 13.3% | → | → |
| DNA Rates - Follow-Up Appointments | **8%** | 13.5% | 13.9% | 14.1% | 13.7% | 13.8% | → | → |
| Hospital Cancellation Rate - First Appointments | **2%** | 3.3% | 3.2% | 6.1% | 3.8% | 4.1% | ↓ | → |
| Hospital Cancellation Rate - Follow-up Appointments | **2%** | 8.4% | 5.7% | 8.3% | 7.1% | 7.4% | → | → |
| % Waiting less than 30 minutes in clinic | **90%** | 85.9% | 87.7% | 85.8% | 85.2% | 86.5% | → | → |
| **Data Quality** | | | | | | | | |
| NHS Number Completeness - Acute | **99%** | 94% | 95% | 96% | 97% | 96% | → | → |
| Outcomes not recorded - Acute | **<0.5%** | 0.4% | 0.4% | 0.4% | 0.4% | 0.4% | → | → |

## LOCAL INDICATORS - COMMUNITY

| Indicator | Target | July | August | Sept | YTD | QTR 2 | Trend | FOT for QTR 2 |
|---|---|---|---|---|---|---|---|---|
| DNA Rates - Community Adult Service | **10%** | 11.0% | 10.3% | 10.4% | 9.7% | 10.6% | → | → |
| DNA Rates - Community Children Services | **10%** | 12.0% | 11.7% | 9.0% | 11.5% | 10.9% | → | → |
| Community Average Waiting Times - Adults | **6wks** | 4.2 | 5.4 | 4.0 | 4.9 | 4.5 | → | → |
| Community Average Waiting Times - Children | **18 wks** | 13.0 | 11.0 | 14.0 | 14.0 | 13.0 | → | → |
| **Data Quality** | | | | | | | | |
| NHS Number Completeness - Community | **99%** | 99.8% | 99.9% | 99.9% | 99.9% | 99.8% | → | → |
| Outcomes not recorded - Community | **<0.5%** | 5.7% | 3.9% | 4.0% | 3.5% | 4.6% | → | → |

**[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 - October 2012 (September 2012 Data)

Whittington Health NHS

**Please note that all data is dated September 2012 unless otherwise stated**

**SLA INDICATORS**

| Indicator | Target for Qtr1 | July | August | Sept | YTD | QTR2 | Trend | FOT for QTR 2 |
|---|---|---|---|---|---|---|---|---|
| Outpatient Follow-up Ratio (Upper Quartile) - % excess follow-ups - <1% by Qtr 4 | **<1%** | 26% | 32% | 33% | 29% | 30% | → | → |
| Consultant to Consultant Activity (Upper Quartile) - % excess firsts | **<1%** | 1.4% | 1.6% | 2.1% | 2.2% | 1.9% | → | → |
| Emergency Readmissions - from original elective admissions - see Note **[1]** below | **20% reduction from 10/11 baseline** | 31 | 49 | See Note **[1]** | 181 | 80 | → | → |
| Emergency Readmissions - from original emergency admissions see Note **[1]** below | | 195 | 179 | | 939 | 374 | → | → |
| Excess Beddays - see Note **[1]** below | **SLA Plan** | -40 | -18 | | -256 | -58 | → | → |

**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.