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Whittington Health NHS

The Whittington Hospital NHS Trust
Magdala Avenue
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Whittington Health Trust Board meeting

28th November 2012

Title:	**Month 7 Performance Dashboard with exception report, List of definitions (Appendix 1), BAF Mapping Matrix (Appendix 2), Summary of changes to Trust Board Performance Report (Appendix 3).**		
Agenda item:	**8a**	**Paper**	**C**
Action requested:	**For Discussion:** Dashboard and Exception Report. Please note "Summary of changes to Trust Board Performance report".		
Executive Summary:	This report informs the Trust Board about performance for Month 7 – October 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. **Emergency Department performance** against the 4 hour target remains a cause for concern. Performance has recovered since last month – we met target in October and YTD – however the situation is fragile going into winter period. After a period of volatile performance we have committed to 95% YTD performance by end of November to NHS London requested an action plan. We have begun implementation of enhanced recovery in ICAM to free up bed capacity and implemented floor leadership interventions in ED. **New Birth Visits (NBVs)** timeliness continues to improve. The Board is asked to note that our commissioners have agreed to stop monitoring the 28 Day Haringey NBV target in the light of progress made.		
Summary of recommendations:	No specific recommendations (please note separate paper: "Plan to develop Performance Management Framework and Management Information at WH")		
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: 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		
Date paper	19th November 2012		

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

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

Whittington Health NHS

Please note that all data is dated October 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	23,336	23,336	0	161,016	159,600	1,416	275,067
Total Expenditure	21,679	21,693	13	151,633	150,145	(1,488)	257,536
EBITDA	1,657	1,643	14	9,383	9,455	(72)	17,531
Net Surplus/Deficit	497	478	19	1,231	1,269	(38)	3,120
Net Surplus/Deficit excluding PFI IFRS	544	525	19	1,440	1,477	(38)	3,562

SERVICE LINE REPORTING

	Women, Children & Families	IC & Acute Medicine	Surgery, Cancer & Diagnostics
Total Direct & Indirect Cost	31,208,588	37,187,106	21,404,797
Service Line Contribution Margin %	17.1%	17.4%	28.3%

CIP MONITORING

	2012/13 Target £'000	Forecast Variance £'000	Best Case Forecast Variance £'000	Worst Case Forecast Variance £'000		June	July	August	September	October
Total	**13,100**	**0**	**0**	**(3,182)**	**cumulative % achieved against target**	69%	74%	80%	86%	86%

Whittington Health Integrated Dashboard - November 2012 (October 2012 Data)

Whittington Health NHS

KEY	
In month	**Colours**
Below target	→
At risk	→
On Target	→
No Target	→
	Direction
Inproving	↑
No change	→
Worsening	↓

Trust Board Performance Report includes data for October 2012, unless stated otherwise

"Q" denotes information only available quarterly

WORKFORCE AND MANDATORY TRAINING

Domain	Indicator	Target	Apr	May	June	Jul	Aug	Sept	Oct	YTD	Trend
Workforce	Vacancy Rates	<12%	14.2%	11.7%	12.6%	11.7%	12.6%	11.1%	11.1%	11.7%	→
	Sickness Absence	<3%	2.8%	3.2%	3.1%	3.1%	2.8%	3.1%	2.8%	3.1%	↑
	Long Term Sick Leave	<1%	1.1%	1.3%	1.4%	1.3%	1.2%	1.2%	1.1%	1.2%	↓
	Turnover	<10%	10.1%	8.9%	11.2%	11.1%	11.0%	10.8%	10.9%	10.6%	↓
	Staff in post	-	3661.8	3644.3	3,606.3	3,569.2	3,606.8	3,654.7	3,651.3	3,638.2	
	Stability Level	>80%	80.3%	83.8%	82.9%	83.4%	83.7%	83.6%	83.2%	83.0%	↓
	Appraisals recorded on ESR	90%	-	-	20%	20%	19%	20%	26%	20%	↑
	Number of case of bullying & harassment (cumulative)	0	1	1	1	1	1	3	3	3	→
	% of qualified to unqualified staff (nurses)	70:30	77/23	76/24	76/24	77/23	79/21	79/21	80/20	78/22	↓
	Mandatory Training Compliance	90% by Dec	69%	69%	67%	68%	69%	70%	74%	74%	↑
	No. of staff activated on ESR	95%	6.2	638	652	665	680	687	698	698	

[1] Bank & Agency spend has been removed - see Section 6 on Expenditure Performance of the Trust Board Finance report for figures and appropriate context of overall spend against budget

Whittington Health Integrated Dashboard - November 2012 (October 2012 Data)

NATIONAL INDICATORS - ACUTE SERVICES

Domain	Indicator	Target	Apr	May	June	Jul	Aug	Sept	Oct	YTD	Trend
ED Targets	Patients in A&E under 4 hours	**95%**	94.7%	93.8%	95.4%	95.2%	97.1%	94.0%	95.6%	95.1%	↑
18 Weeks RTT	Referral to Treatment - Admitted	**90%**	93.1%	92.8%	91.7%	92.5%	90.0%	90.3%	89.4%	91.5%	↓
	Referral to Treatment - Non Admitted	**95%**	98.8%	98.8%	98.9%	99.0%	99.1%	98.4%	98.4%	98.8%	→
	Referral to Treatment - Incomplete	**92%**	91.7%	96.2%	92.2%	95.4%	95.2%	92.8%	92.7%	94.4%	↓
	Diagnostic Waiting Times	**99%**	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	→
Cancer Access	14 days GP referrals - 1st Outpatients - **[1]**	**93%**	91.7%	93.6%	92.9%	92.6%	93.3%	92.2%	-	92.8%	↓
	14 days GP referrals - Breast symptoms **- [1]**	**93%**	95.6%	97.7%	90.7%	86.2%	94.3%	87.8%	-	91.8%	↓
	31 days to First Treatment **- [1]**	**96%**	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	-	100.0%	→
	31 days to Second or Subsequent Treatment (Surgery)	**94%**	**[2]**					**[2]**	-	-	→
	31 days to Second or Subsequent Treatment (drugs)	**98%**						100.0%	-	100.0%	→
	62 days Referral to Treatment - **[1]**	**85%**	90.9%	78.4%	70.0%	85.3%	100.0%	90.0%	-	84.95%	↓
	62 days Wait First Treatment from Cancer Screening - **[1]**	**90%**	-	-	100.0%	100.0%	100.0%	100.0%	-	100.0%	→
Fractured Neck of Femur	Fractured Neck of Femur operated within <36 hours	**85%**	93.8%	100.0%	87.5%	100.0%	100.0%	85.7%	100.0%	94.4%	↑
	Fractured Neck of Femur operated within <48 hours	**85%**	100.0%	100.0%	100%	100.0%	100.0%	100.0%	100.0%	100.0%	→
Cancelled Operations	Cancelled Operations as percentage of elective admissions	**<0.8%**	1.2%	0.2%	0.2%	0.2%	0.3%	0.7%	0.7%	0.5%	→
	Cancelled Operations not rescheduled within 28 days	**0**	0	0	0	0	0	0	0	0	→
Single Sex Accomm.	Single Sex Accommodation Breaches	**0**	0	0	0	0	0	0	0	0	→
Transfer of Care	% of Inpatients with Delayed Transfer of Care	**<3.5%**	2.9%	1.3%	1.2%	2.1%	2.0%	3.6%	1.7%	2.1%	↑
Diagnostics	Cervical Cytology turnaround times within 14 days	**98%**	100%	100%	100%	100%	100%	100%	**[3]**	100%	→
Maternity	% of women seen by HCP or midwife within 12 weeks and 6 days	**90%**	88.3%	88.9%	87.9%	90.5%	89.7%	96.6%	88.2%	87.4%	↓
	1:1 care in established labour	**100%**	100%	100%	100%	100%	100%	100%	100%	100%	→
	Breast Feeding at Birth	**90%**	90%	92%	92%	90%	91%	92%	93%	92%	↑
	Smoking during pregnancy at time of delivery	**<17%**	6%	8%	5%	6%	8%	8%	7%	7%	↓

[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.

[2] Data available from Sept only. No cases for S*econd/subsequent treatment (Surgery)* in month.

[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 - November 2012 (October 2012 Data)

QUALITY INDICATORS - INTEGRATED CARE ORGANISATION

Domain	Indicator	Target	Apr	May	June	Jul	Aug	Sept	Oct	YTD	Trend
Incident Reporting	Number of Serious Incidents	**n/a**	17	11	16	16	8	12	17	97	→
	Timeliness of external SI Report submission	**Green**			**[1]**						→
	Incident Reporting Rates per 1000 beddays / contacts - **[2]**	**[2]**	3.2	3.2	3.5	3.6	3.0	3.5	3.3	3.3	→
	Number of Falls - **[2]**	**[2]**	25	50	35	26	21	27	26	135	→
	Number of Falls Causing Severe Harm - **[2]**	**[2]**	0	0	0	1	0	0	0	1	→
	Never Events	**0**	0	2	0	0	0	0	1	3	→
Clinical Effectiveness	Safety Alerts Compliance	**100%**	100%	100%	100%	100%	100%	100%	100%	100%	→
Patient Experience	Complaints Received	**n/a**	49	62	37	59	49	41	48	234	→
	Complaints Responded to within specified timeframe	**80%**	76%	66%	86%	63%	65%	64%	**[3]**	70%	↓

QUALITY INDICATORS - ACUTE SERVICES

Domain	Indicator	Target	Apr	May	June	Jul	Aug	Sept	Oct	YTD	Trend
Infection Prevention	MRSA Bacteraemia Cases	**1 (year)**	1	0	0	0	0	0	0	1	→
& Control	C.DIFF Cases	**21 (year)**	1	1	0	1	2	1	1	6	→
	E Coli Cases - **[2]**	**[2]**	1	1	1	1	1	1	2	8	→
	MSSA Bacteraemia Cases - **[2]**	**[2]**	0	0	1	0	0	0	0	1	→
	MRSA Screening - Non-Elective Patients	**95%**	92.4%	90.6%	89.8%	90.5%	91.3%	94.1%		91.5%	↑
	MRSA Screening - Elective Patients **[9]**	**95%**	98.5%	96.7%	95.8%	96.4%	95.4%	96.8%		96.6%	↑
	Hand Hygiene Audit	**95%**	99.5%	93.3%	99.4%	97.9%	95.8%	100.0%	98.8%	97.9%	↓
Incident Reporting	Pressure Ulcers - grade 3/4 (80% reduction from 2010/11 baseline)	**3/yr**	1	2	0	1	1	1	2	8	↓
	VTE Assessment	**95%**	95.4%	95.1%	96.7%	95.3%	95.6%	95.8%	**[4]**	95.6%	→
	VTE ~~Rate~~ Incidence - Hospital Acquired	**[5]**	4	1	4	4	1			14	→
	Appropriate Prophylaxis for VTE	**90%**	82.7%	65.8%	95.2%	95.1%	99.2%	98.4%		86.5%	→
	Post Operative Sepsis	**AE**	0	0	1	0	0			1	→
	Post Operative Sepsis - Hips	**AE**	0	0	0	0	0			0	→
	Post Operative Sepsis - Knees	**AE**	0	0	1	0	0			1	→
	Deaths After Surgery	**AE**	1	1	2	0	0	**[6]**		4	→
	Deaths in Low Risk Conditions	**AE**	0	0	2	1	0			3	→
	Deaths After Bariatric Surgery	**AE**	0	0	0	0	0			0	→
	Hospital Level Mortality Indicator - Summary	**<100**	78.3	80.8	91.0	80.4	71.2			78.3	↑
Clinical Effectiveness [7]	Emergency Admission Rate for LTC	**[7]**	152	149	127	157	141	172		898	→
	Emergency Admission Rate Paediatric (asthma, epilepsy, diabetes)	**[7]**	10	15	7	27	10	17	**[7]**	86	→
	Emergency Admission for VTE	**[7]**	2	6	8	8	9	19		52	→
Patient Experience [8]	Friends & Family Test (Net Promoter Score)	**[8]**	26%	28%	22%	27%	33%	29%	31%	28%	→
PTO FOR NOTES	Cleanliness Audit	**>95%**	96.1%	97.1%	97.1%		98.1%		97.3%	97.5%	↓

Whittington Health Integrated Dashboard - November 2012 (October 2012 Data)

QUALITY INDICATORS - COMMUNITY SERVICES

Domain	Indicator	Target	Apr	May	June	Jul	Aug	Sept	Oct	YTD	Trend
Infection Prevention & Control	Dentistry Compliance with Infection Control Standard	**90%**		95%			96%		Q	96%	→
Incident Reporting	Pressure Ulcers - grade 3/4 (30% reduction from 2011/12 baseline)	**21/yr**	5	4	7	8	4	3	6	37	↓
Patient Experience	Friends & Family Test (Net Promoter Score) **[8]**	**[8]**	45%	40%	28%	28%	17%	36%	41%	34%	→
	Dentistry - Patient Involvement	**90%**	90%	95%	92%	90%	98%	95%	88%	93%	↓
	Dentistry - Patient Experience	**90%**	97%	90%	100%	98%	92%	100%	100%	97%	→
Clinical Effectiveness	Respiratory - number of admissions avoided	**25 / Qtr**	9	3	3	18	13	8	8	62	→
	Diabetes - % of patients with at least a 1% reduction in HbA1c after 6 months	**60%**	57%	83%	42%	80%	80%	69%	61%	67%	↓
	Diabetes - % of patients reporting confidence in managing their condition	**85%**	100%	60%	100%	100%	71%	73%	100%	86%	↑
	Heart Failure / Cardiology - % of patients on optimum Ace Therapy	**80%**	90%	90%	88%	90%	86%	85%	89%	88%	↑
	Heart Failure / Cardiology - % of patients on optimum Beta Blocker Therapy	**80%**	85%	83%	84%	87%	86%	85%	85%	85%	→
	Rehab Intermediate Care - % of patients with self-directed goals set	**70%**	60%	75%	60%	71%	78%	73%	77%	71%	↑
	Rehab Intermediate Care - % of patients with improved or maintained function	**70%**	75%	71%	67%	76%	80%	77%	90%	77%	↑
	MSK - % of patients who have completed the Patient Specific Functional Scale	**40%**	1%	13%	14%	22%	46%	62%	44%	35%	↓
	MSK - % of patients completing their treatment on discharge	**40%**	43%	44%	35%	36%	36%	36%	36%	37%	→
	CAMHS - % of Cases where mental health problems resolved or improved	**60%**		73%			71%		Q	72%	↓
	CAMHS - % of Cases where severity of mental health at end of treatment is normal	**80%**		89%			87%		Q	88%	↓
	% of new patients with an HIV test within preceding 90 days	**60%**	85%	84%	83%	85%	83%	83%	83%	84%	→
	% of women 18 to 25 years old attending for contraception given LARC	**20%**	28%	29%	26%	30%	32%	29%	28%	29%	↓
	% of new male patients who had an STI screen who were under 25 years	**20%**	30%	30%	34%	31%	30%	30%	35%	31%	↑
	% of new female patients who had an STI screen who were under 25 years	**20%**	46%	46%	47%	47%	43%	48%	46%	46%	↓

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

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

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

[6] 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 **available 1 month in arrears**: data derived from coding of clinical records, completed 10th day following month end.

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

[9] MRSA Screening (elective) parameters have been changed to reflect clinical relevance and match practice by other trusts in sector. Daycases have been excluded as patients are not in hospital long enough to begin suppression therapy which is the purpose of MRSA Screening.

Whittington Health Integrated Dashboard - November 2012 (October 2012 Data)

NATIONAL INDICATORS - COMMUNITY

Domain	Indicator	Target	Apr	May	June	Jul	Aug	Sept	Oct	YTD	Trend
Health Visiting	Prevalance of breast feeding at 6-8 weeks	**74%**	76%			73%			**Q**	74%	↓
	New Birth Visits - Islington	**95% <=14 days**	51.4%	55.8%	57.9%	67.5%	78.9%	78.6%	**[1]**	66.4%	↓
	New Birth Visits - Haringey	**95% <=14 days**	18.8%	22.8%	21.6%	41.0%	70.5%	83.5%	**[1]**	43.6%	↑
	New Birth Visits - Haringey	**95% <=28 days**	90.8%	86.5%	85.1%	92.7%	93.4%	93.4%	**[1]**	91.0%	→
Child Heath	% of Immunisation - Islington	**80%**	88.5%						**Q**	88.5%	→
	% of Immunisation - Haringey	**80%**	88.5%						**Q**	88.5%	→
Community Sexual Health	GUM: Patients offered appointment within 2 days	**100%**	100%	100%	100%	100%	100%	100%	100%	100%	→
	% positivity for all Chlamydia Screening	**5%**	13.5%	10.6%	7.6%	14.8%	8.9%	7.3%	7.1%	10.4%	↓
	% of chlamydia screens that are males <25 years old	**[4]**	12.5%	7.1%	11.1%	12.1%	11.3%	11.1%	12.6%	10.9%	→
	% of chlamydia screens that are females <25 years old	**[4]**	46.0%	47.9%	46.5%	28.4%	26.9%	30.0%	29.6%	37.6%	→
Primary Care Psychology	IAPT - Number entering psychological therapies	**[5]**	466			251	348	325	354	1744	→
	IAPT - Number moving off sick pay and benefits	**90 per year**	23			13	9	19	9	73	→
Stop Smoking	Actual 4 Week Quitters	**506 - Qtr 1 446 - Qtr 2**	568			DoH Reporting deadline 10-12			**Q**	568	→
Dental	Units of Dental Activity	**90% of contract**	99%	127%	99%	129%	111%	103%	108%	111%	→
	Contacts	**90% of contract**	92%	122%	96%	146%	116%	95%	123%	113%	→
Drugs & Alcohol	% of Treatment Starts	**80%**	-	-	100%	100%	100%	90%	82%	94%	→
	% of treatment Reviews	**80%**	-	-	100%	96%	100%	92%	83%	94%	→

[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 - November 2012 (October 2012 Data)

LOCAL INDICATORS - ACUTE

Domain	Indicator	Target	Apr	May	June	Jul	Aug	Sept	Oct	YTD	Trend
Inpatient	Consultant 7 Day Ward Rounds	**Y**	N	N	N	N	N	N	N	N	→
	Consultant presence every day 8am - 8pm (Acute Medicine)	**Y**	N	N	N	N	N	N	N	N	→
	Discharge Before 11am - Surgery / Medicine	**40% by Mar '13**	27.1%	31.7%	20.2%	25.4%	26.0%	28.7%	25.6%	26.2%	↓
	Average Length of Stay - Medicine - **[1]**	**[1]**	7.9	8.2	7.1	8.3	7.3	7.3	7.0	7.6	→
	Bed Days - Medicine - **[1]**	**[1]**	4754	4953	4031	4979	4456	4527	4880	32550	→
	Average Length of Stay - Surgery - **[1]**	**[1]**	4.8	4.8	4.0	4.0	3.2	3.1	3.7	3.9	→
	Bed Days - Surgery - **[1]**	**[1]**	1954	2155	1732	1902	1405	1395	1725	12327	→
	Theatre Session Utilisation	**95%**	77.0%	77.2%	79.5%	77.9%	77.3%	82.7%	82.8%	81.7%	↑
Outpatients	Number of First Appointments - **[2]**	**[2]**	4906	5922	4826	5528	5077	4763	6092	37114	→
	Number of Follow-Up Appointments - **[2]**	**[2]**	12736	15046	11406	13299	13047	11686	13974	91194	→
	DNA Rates - First Appointments	**8%**	11.6%	12.2%	12.8%	12.5%	14.6%	12.9%	11.9%	12.6%	↑
	DNA Rates - Follow-Up Appointments	**8%**	13.4%	13.3%	13.8%	13.5%	13.9%	14.1%	13.8%	13.7%	↑
	Hospital Cancellation Rate - First Appointments	**2%**	3.2%	3.4%	3.8%	3.3%	3.2%	6.1%	3.8%	4.4%	↑
	Hospital Cancellation Rate - Follow-up Appointments	**2%**	7.0%	5.6%	7.9%	8.4%	5.7%	8.3%	5.5%	8.0%	↑
	% Waiting less than 30 minutes in clinic	**90%**	85%	84%	84.0%	85.9%	87.7%	85.8%	87.2%	85.5%	↑
Data Quality - Acute	NHS Number Completeness - Acute	**99%**	97%	97%	96%	94%	95%	96%	96%	97%	→
	Outcomes not recorded - Acute	**<0.5%**	0.2%	-	0.9%	0.4%	0.4%	0.4%	0.4%	0.4%	→

[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**

[3] Consultant with no elective work on call 7 days (General Surgery) removed as now part of the rota.

Whittington Health Integrated Dashboard - November 2012 (October 2012 Data)

LOCAL INDICATORS - COMMUNITY

Domain	Indicator	Target	Apr	May	June	Jul	Aug	Sept	Oct	YTD	Trend
Access	DNA Rates - Community Adult Service	10%	8.6%	8.3%	9.8%	11.0%	10.3%	10.4%	10.2%	9.8%	↓
	DNA Rates - Community Children Services	10%	12.7%	11.6%	11.7%	12.0%	11.7%	9.0%	6.9%	10.8%	↑
	Community Average Waiting Times - Adults	6wks	4.1	4.0	4.1	3.8	3.3	3.7	3.4	3.8	↑
	Community Average Waiting Times - Children	18 wks	14.0	15.0	14.0	13.0	11.0	14.0	14.0	14.0	→
Data Quality	NHS Number Completeness - Community	99%	99.8%	99.9%	99.9%	99.8%	99.9%	99.9%	99.7%	99.8%	↓
	Outcomes not recorded - Community	<0.5%	0.9%	2.0%	4.8%	5.7%	3.9%	4.0%	2.2%	3.5%	↑

SLA INDICATORS

Domain	Indicator	Target	Apr	May	June	Jul	Aug	Sept	Oct	YTD	Trend
	Outpatient Follow-up Ratio - % excess follow-ups	<1%	30%	25%	25%	26%	32%	33%	24%	27%	↑
	Consultant to Consultant Activity (Upper Quartile) - % excess firsts	<1%	3.1%	2.1%	2.4%	1.4%	1.6%	2.1%	2.4%	2.3%	↓
	Emergency Readmissions - from original elective admissions	[1]	32	38	31	31	49	23	[2]	204	→
	Emergency Readmissions - from original emergency admissions	[1]	177	187	201	195	179	193		1132	→
	Excess Beddays [3]	SLA Plan = 100%	89.2%	107.0%	82.0%	95.0%	97.8%	143% [4]		101%	→

CQUIN 2012/13

Domain	Indicator	Target	Apr	May	June	Jul	Aug	Sept	Oct	YTD	Trend
CQUINS [5]	VTE 24 Hr Risk Assessment	25%	15.8%	17.9%	17.4%	19.4%	25.0%	26.5%	[8]	20.2%	↑
	NHS Safety Thermometer for Acute	100%	-	-	-	100.0%	100.0%	99.7%	100.0%	[6]	↑
	NHS Safety Thermometer for Community	100%	-	-	-	95.1%	87.8%	86.7%	98.3%	[6]	↑
	COPD Care Bundle	85%	94.4%	100.0%	93.8%	94.4%	94.4%	100.0%	[8]	96.2%	↑

[1] Target to be set at end of year based on actual performance in preparation for post block contract.

[2] 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.

[3] Excess Bed days is now reported as percentage of SLA Plan target - where as close to 100% is most desirable.

[4] Please note that excess bed days in Sept was high as two children with very long lengths of stay were discharged in month. Underlying performance has not changed markedly.

[5] Some CQUINS agreed by WH are not included in this month's Trust Board report as they are either too early in the implementation phase to report meaningfully or are being reviewed. An update will be provided at the December Board.

[6] YTD not applicable. The target is for an individual month's completeness so a YTD figure would be misleading.

[7] Please note that VTE Risk Assessment and Appropriate Prophylaxis for VTE are also CQUINS but are reported in the Quality Indicators (acute) section above.

[8] Data available only 1 month in arrears of the current reporting schedule

WORKFORCE AND MANDATORY TRAINING

Appendix 1: Definitions and October values for Numerator and Denominator where relevant

Indicator	Numerator	Denominator	Definition
Vacancy Rates			Vacant posts as % of all posts on staff establishment
Sickness Absence			Working hours lost due to sickness absence as a % of contracted hours. (YTD = average of monthly figures)
Long Term Sick Leave			sickness hours from long term sickness as % of all possible hours worked
Turnover			Rolling 12 month position of voluntary leavers as a % of total staff excludes e.g. fixed term contracts, dismissals etc
Staff in post			Number whole time equivalent staff in post at end of month
Stability Level			Staff with more than one year's service as % of total number of staff
Appraisals recorded on ESR	898	3493	Staff with appraisals in last 12 months recorded on ESR as % of staff who have been in post for >= 12months
Number of case of bullying & harassment (cumulative)			Number of ongoing bullying and harassment cases that are at a formal stage in the process.
% of qualified to unqualified staff (nurses)			Ratio of total nursing staff split by qualified (band 5 and above) and unqualified (bands 2 to 4).
Mandatory Training Compliance	29607	40240	Completed courses as % of all required training courses

NATIONAL INDICATORS - ACUTE SERVICES

Appendix 1: Definitions and October values for Numerator and Denominator where relevant

Indicator	Numerator	Denominator	Definition
Patients in A&E under 4 hours	7550	7896	% of attendees wating <= 240 minutes in emergency department before discharge or admission.
Referral to Treatment - Admitted	641	717	% of daycase or inpatients whose treatment started in month and waited <18 weeks (who qualify for 18 week pathway)
Referral to Treatment - Non Admitted	5088	5170	% of outpatients whose treatment started in month and waited <18 weeks (who qualify for 18 week pathway)
Referral to Treatment - Incomplete	12818	13831	% of all patients whose treatment has not yet started and have been waiting <18 weeks (who qualify for 18 week pathway)
Diagnostic Waiting Times	3401	3401	% of patients waiting less than 6 weeks for diagnostic procedures
14 days GP referrals - 1st Outpatients - [1]	306	332	% of patients waiting <=14 days for first OP appt from receipt of GP urgent suspected cancer referral
14 days GP referrals - Breast symptoms - [1]	101	115	% of patients waiting <=14 days for first OP appt from receipt of GP urgent suspected breast cancer referral
31 days to First Treatment - [1]	39	39	% of pts diagnosed with cancer treated within 31 days between decision to treat and first treatment
31 days to Second or Subsequent Treatment (Surgery)	0	0	% of pts waiting <=31 days between decision to treat and second of subsequent treatment (surgery)
31 days to Second or Subsequent Treatment (drugs)	1	1	% of pts waiting <=31 days between decision to treat and second of subsequent treatment (anti cancer drugs)
62 days Referral to Treatment - [1]	18	20	% of pts diagnosed with cancer treated <=62 days of receipt of GP urgent suspected cancer referral
62 days Wait First Treatment from Cancer Screening - [1]	0.5	0.5	% of pts diagnosed with cancer treated <=62 days of receipt of suspected cancer screening result
Fractured Neck of Femur operated within <36 hours	9	9	Fractured Neck of Femur operated within <36 hours of arrival as % of all emergency FNOF admissions
Fractured Neck of Femur operated within <48 hours	9	9	Fractured Neck of Femur operated within <48 hours of arrival as % of all emergency FNOF admissions
Cancelled Operations as percentage of elective admissions	13	1817	Hospital initiated cancellations on day of operation as % of elective admissions
Cancelled Operations not rescheduled within 28 days			Hospital initiated cancellations on day of operation not rescheduled within 28 days
Single Sex Accommodation Breaches			Pts in beds in mixed sex accomodation, excluding critical care as per national guidelines
% of Inpatients with Delayed Transfer of Care			Pts with delayed transfer of care as defined by discharge planning team as % of all inpatients at midnight snapshot
Cervical Cytology turnaround times within 14 days			% of cervical smears where women have received their results within 14 days
% of women seen by HCP or midwife within 12 weeks and 6 days	286	391	Women seen by HCP or midwife as % of all referred pregnant women (including those referred just before deadline)
1:1 care in established labour			Those deliveries with 1:1 care as measured in monthly audits as % of all those deliveries audited
Breast Feeding at Birth	313	337	All those breastfeeding at birth or attempting to do so as % of all new mothers who deliver at WH
Smoking during pregnancy at time of delivery	23	322	as % of those who deliver at WH.

QUALITY INDICATORS - INTEGRATED CARE ORGANISATION ***Appendix 1: Definitions and October values for Numerator and Denominator where relevant***

Indicator	Numerator	Denominator	Definition
Number of Serious Incidents			Number of Serious Incidents using national framework for reporting SIs - declaration agreed by executive directors.
Timeliness of external SI Report submission			NHS London assess quarterly against RAG rating
Incident Reporting Rates per 1000 beddays / contacts - [2]			All pt safety incidents reported on DATIX as % of (all beddays + all community contacts + all OP and ED attendances)
Number of Falls - [2]			No of falls recorded on datix (falls while in care of WH)
Number of Falls Causing Severe Harm - [2]			No of falls recorded on datix reported as causing seriouos harm (falls while in care of WH)
Never Events			Number of serious, largely preventable patient safety incidents, from list of 25 defined byDH
Safety Alerts Compliance			Completion of required actions set out in safety alerts from NPSA
Complaints Received			Number of complaints classed as formal ie those which complainant has asked for formal response
Complaints Responded to within specified timeframe			Formal complaints responded to within 25 working days

QUALITY INDICATORS - ACUTE SERVICES

Indicator	Numerator	Denominator	Definition
MRSA Bacteraemia Cases			Number of MRSA Bacteraemia cases
C.DIFF Cases			Number of C Diff cases
E Coli Cases - [2]			Number of Ecoli cases
MSSA Bacteraemia Cases - [2]			Number of MSSA Bacteraemia cases
MRSA Screening - Elective Patients [9]	152	157	Number of elective patients screened for MRSA as % of all inpatients excluding daycases (as not clinically relevant)
Hand Hygiene Audit	247	250	Result of observed audit of hand hygiene practice
Pressure Ulcers - grade 3/4 (80% reduction from 2010/11 baseline)			Pressure ulcers reported on DATIX validated by nursing specialists
VTE Assessment	3522	3675	Pts who have had VTE assessment (or do not require assessment) as % of all admitted patients
VTE Rate Incidence - Hospital Acquired			Based on census of patients using diagnostics data to identify patients with VTE (validated by VTE team)
Appropriate Prophylaxis for VTE	131	133	Based on audit of those patients assessed as having VTE risk
Post Operative Sepsis			No. of observed sepsis cases (of elective surgery discharges and length of stay >= 4 days)
Post Operative Sepsis - Hips			Subset of above relating to hip procedures
Post Operative Sepsis - Knees			Subset of above relating to knee procedures
Deaths After Surgery			Surgical patients who have died from a possible complication
Deaths in Low Risk Conditions			Deaths from conditions where patients would normally survive
Deaths After Bariatric Surgery			Bariatric surgical patients who have died from a possible complication
Hospital Level Mortality Indicator - Summary			Any deaths occurring in the 30 days following discharge from hospital treatment
Emergency Admission Rate for LTC			Discharges in month after emergency Admission with relevant ICD 10 codes
Emergency Admission Rate Paediatric (asthma, epilepsy, diabetes)			Discharges in month after emergency Admission with relevant ICD 10 codes
Emergency Admission for VTE			Discharges in month after emergency Admission with relevant ICD 10 codes
Friends & Family Test (Net Promoter Score)	108	354	Pts rating likelihood to recommend 9-10 minus those rating 0-6 - NB Scale is from -100 to +100
Cleanliness Audit	8178	8408	% of areas meeting required standard in regular cleanliness audits

QUALITY INDICATORS - COMMUNITY SERVICES

Appendix 1: Definitions and October values for Numerator and Denominator where relevant

Indicator	Numerator	Denominator	Definition
Dentistry Compliance with Infection Control Standard			Quarterly audit to assess compliance of the HTM 01-05 decontamination standards using the DH Toolkit.
Pressure Ulcers - grade 3/4 (30% reduction from 2011/12 baseline)			Community acquired pressure ulcer
Friends & Family Test (Net Promoter Score) [8]	91	221	Pts rating likelihood to recommend 9-10 minus those rating 0-6 - NB Scale is from -100 to +100
Dentistry - Patient Involvement			% responding "Yes definitely" to "...involved as much as you wanted to be in decisions about your care and treatment?"
Dentistry - Patient Experience			% responding "Excellent" to How satisfied were you with the service overall today?"
Respiratory - number of admissions avoided			Respiratory - number of admissions avoided
Diabetes - % of patients with at least a 1% reduction in HbA1c after 6 months	11	18	Diabetes - % of patients with at least a 1% reduction in HbA1c after 6 months
Diabetes - % of patients reporting confidence in managing their condition	9	10	Diabetes - % of patients reporting confidence in managing their condition
Heart Failure / Cardiology - % of patients on optimum Ace Therapy	174	196	Heart Failure / Cardiology - % of patients on optimum Ace Therapy
Heart Failure / Cardiology - % of patients on optimum Beta Blocker Therapy	167	196	Heart Failure / Cardiology - % of patients on optimum Beta Blocker Therapy
Rehab Intermediate Care - % of patients with self-directed goals set	38	49	Rehab Intermediate Care - % of patients with self-directed goals set
Rehab Intermediate Care - % of patients with improved or maintained function	70	78	Rehab Intermediate Care - % of patients with improved or maintained function
MSK - % of patients who have completed the Patient Specific Functional Scale	295	674	MSK - % of patients who have completed the Patient Specific Functional Scale
MSK - % of patients completing their treatment on discharge	665	1863	MSK - % of patients completing their treatment on discharge
CAMHS - % of Cases where mental health problems resolved or improved			CAMHS - % of Cases where mental health problems resolved or improved
CAMHS - % of Cases where severity of mental health at end of treatment is normal			CAMHS - % of Cases where severity of mental health at end of treatment is normal
% of new patients with an HIV test within preceding 90 days	2437	2947	% of new patients with an HIV test within preceding 90 days
% of women 18 to 25 years old attending for contraception given LARC	131	467	% of women 18 to 25 years old attending for contraception given LARC
% of new male patients who had an STI screen who were under 25 years	149	431	% of new male patients who had an STI screen who were under 25 years
% of new female patients who had an STI screen who were under 25 years	347	750	% of new female patients who had an STI screen who were under 25 years

NATIONAL INDICATORS - COMMUNITY

Appendix 1: Definitions and October values for Numerator and Denominator where relevant

Indicator	Numerator	Denominator	Definition
Prevalance of breast feeding at 6-8 weeks	464	637	Those assessed by HV as % of infants due 6-8 week check (excludes children who moved in >56 days after birth)
New Birth Visits - Islington	198	252	Babies visited <=14 days after birth as % of number of babies born in month with GP/postode in area, exc late referrals
New Birth Visits - Haringey	279	334	Babies visited <=14 days after birth as % of number of babies born in month with GP/postode in area, exc late referrals
New Birth Visits - Haringey	312	334	Babies visited <=28 days after birth as % of number of babies born in month with GP/postode in area, exc late referrals
% of Immunisation - Islington			Immunisations given as % of all immunisations required
% of Immunisation - Haringey			Immunisations given as % of all immunisations required
GUM: Patients offered appointment within 2 days			1st attendances at GUM services were offered an appt within 48 hours as % of all first attendances (Haringey only)
% positivity for all Chlamydia Screening	87	1221	% of tests for chlamydia that are positive (higher number is considered better as it supports identification) (Haringey only)
% of chlamydia screens that are males <25 years old	154	1221	Number of males < 25yrs that have Chlamydia screening as % of total males attending community sexual health (Haringey only)
% of chlamydia screens that are females <25 years old	361	1221	Number of females < 25yrs that have Chlamydia screening as % of total males attending community sexual health (Haringey only)
IAPT - Number entering psychological therapies			The number of people who have entered pschologcial therapies (i.e. had first therapeutic session) (Haringey only)
IAPT - Number moving off sick pay and benefits			The number of people reciving psychological therapies moving off sick pay and benefits during the month (Haringey only)
Actual 4 Week Quitters			The number of people reciving psychological therapies moving off sick pay and benefits during the month (Haringey only)
Units of Dental Activity			UDA = a nationally defined measure of specific clinical acitivity
Contacts			Number of community dental contacts
% of Treatment Starts	28	34	Tier 3 treatment starts
% of treatment Reviews	102	124	Treatment outcome profiles and tier 3 case reviews as % of all due

LOCAL INDICATORS - ACUTE

Appendix 1: Definitions and October values for Numerator and Denominator where relevant

Indicator	Numerator	Denominator	Definition
Consultant 7 Day Ward Rounds			Based on response from Divisional Directors
Consultant presence every day 8am - 8pm (Acute Medicine)			Based on response from Divisional Directors
Discharge Before 11am - Surgery / Medicine	195	761	Discharges before 11am as % of all discharges (exc Mary Seacole, ISIS and MAU)
Average Length of Stay - Medicine - [1]			Pts discharged from medical specialties apart from those under care of ed consultant
Bed Days - Medicine - [1]			Sum of LOS of Pts discharged from medical specialties apart from those under care of ed consultant
Average Length of Stay - Surgery - [1]			Pts discharged from surgical specialties
Bed Days - Surgery - [1]			Sum of LOS Pts discharged from surgical specialties
Theatre Session Utilisation	59508	71880	Time utilised divided by total session time allocated
Number of First Appointments - [2]			All first hospital outpatient appointments
Number of Follow-Up Appointments - [2]			All follow up hospital outpatient appointments
DNA Rates - First Appointments	824	6916	DNAs as % of all first hospital outpatient appointments
DNA Rates - Follow-Up Appointments	2232	16206	DNAs as % of all follow up hospital outpatient appointments
Hospital Cancellation Rate - First Appointments	311	8231	Hospital cancelled first OP appts that resulted in delays as % of all OP appointments
Hospital Cancellation Rate - Follow-up Appointments	1075	19459	Hospital cancelled follow up OP appts that resulted in delays as % of all OP appointments
% Waiting less than 30 minutes in clinic	12037	13799	As % of all op attendances where valid time is recorded
NHS Number Completeness - Acute	40288	41991	Number of those with NHS Number as % of all ed attendances, admissions and OP attendances
Outcomes not recorded - Acute	122	29604	Number of appts with no outcome recorded as % of all OP appts

LOCAL INDICATORS - COMMUNITY

Appendix 1: Definitions and October values for Numerator and Denominator where relevant

Indicator	Numerator	Denominator	Definition
DNA Rates - Community Adult Service	4534	44632	DNAs as % of all community adult services appointments
DNA Rates - Community Children Services	1616	23321	DNAs as % of all first community children's services appointments
Community Average Waiting Times - Adults			Mean waiting time for all community appointments combined
Community Average Waiting Times - Children			Mean waiting time for all community appointments combined
NHS Number Completeness - Community	9495	9520	Number of pts who had initial contact in month with verified NHS number as % of all initial contacts (exc sexual health)
Outcomes not recorded - Community	1310	60700	The number of appointments with outcomes not recorded on RiO as % of all appts in month

SLA INDICATORS

Indicator	Numerator	Denominator	Definition
Outpatient Follow-up Ratio - % excess follow-ups	1635	6820	Follow up appts above new:follow up ratios for each specialty as set out by commissioners
Consultant to Consultant Activity (Upper Quartile) - % excess firsts	95	3911	Number of consultant to consultant referrals above that allowed for that specialty as % of all 1st attendances
Emergency Readmissions - from original elective admissions			within 30 days excluding <4yrs old; cancer patients; RTA and maternity
Emergency Readmissions - from original emergency admissions			within 30 days excluding <4yrs old; cancer patients; RTA and maternity
Excess Beddays [3]			excess bedday by HRG (negative is better); calculated based on total bed days for all discharges in month

CQUIN 2012/13

Indicator	Numerator	Denominator	Definition
VTE 24 Hr Risk Assessment			Repeat VTE risk assessment within 24 hours of admission
NHS Safety Thermometer for Acute			Assessment according to standardised safety analysis tool: focus on pressure ulcers, falls, urinary tract infection in those with a catheter, and VTE
NHS Safety Thermometer for Community			Assessment according to standardised safety analysis tool
COPD Care Bundle			COPD discharge bundle: All patients admitted with a COPD exacerbation should be discharged with a completed COPD care bundle.

Appendix 2: Mapping of Trust Dashboard to BAF Key risks

Denotes direct relevance
Denotes indirect relevance

Ref	BAF Key risk	WORKFORCE AND MANDATORY TRAINING	NATIONAL INDICATORS - ACUTE SERVICES	QUALITY INDICATORS - INTEGRATED CARE ORGANISATION	QUALITY INDICATORS - ACUTE SERVICES	QUALITY INDICATORS - COMMUNITY SERVICES	NATIONAL INDICATORS - COMMUNITY	LOCAL INDICATORS - ACUTE	LOCAL INDICATORS - COMMUNITY	SLA INDICATORS	CQUIN 2012/13
1.2	If we do not improve the quality, completeness and timeliness of performance reports, then we may lose the support of commissioners who value more detailed data, we may be unable to correct performance issues in a timely manner and our FT application may fail.										
1.3	If commissioners are unable to realise the benefits of having an ICO in the sector to control demand, our CCGs could become insolvent, then they will not be able to afford our services and the Trust will not be viable as an FT		■	■	■	■	■	■	■	■	■
2.1	If we lose focus on safety and patient experience at the time of cutting costs, then our main business of caring, patient safety and quality of care could be put at risk.			■	■	■					
2.2	If there are persistent or serious lapses in information governance, then we will be failing in our statutory obligations			■							
4.1	If we fail to meet quality and safety standards and maintain or improve our performance in patient safety and patient experience, then our patients may be experiencing poor care, our reputation will suffer, and our CQC licence and FT application are both at risk.		■	■	■	■	■				
4.2	If we fail to meet CQC essential targets (KPIs) including ED and cancer waiting times, then our patients will be experiencing poor care and our CQC licence and FT application are both at risk.		■				■				
4.4	If GPs and patients do not believe that all our services are available and accesible (i.e. have short waiting times), of high quality and good value, then we may lose market share through Patient Choice		■	■	■	■	■	■	■	■	■
5.2	If we are unable to fully implement our workforce strategies (e.g. for efficiency, engagement, skill mix), then we will not be able to deliver cost savings or service transformation and will not be viable as an FT. Management capacity is stretched and unsustainable for longer than the short term.	■									
5.4	If we do not continue to improve the uptake of mandatory training, then we are in breach of our corporate responsibility as an employer, we are at risk of litigation should accidents happen, our patient care may suffer and our FT application may fail	■									

Month 7 – October 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	Oct'12	YTD	Target	Comment/ Description of issue	Actions planned/taken to achieve target	Target date / trajectory	Accntbl./Rspnsbl. Officer for Action
WORKFORCE							
Sickness	**2.8%**	**3.1%**	**<3%**	See Below	See Below		
				Please note that the data continues to be updated post insertion in Trust Board report. There is often a time lag between sickness having occurred and the data being input into ESR. This results in previous months reported data being updated after it has been reported to the Trust Board. This issue will be reviewed.	All staff on long term sickness have actions to plans to enable them to return to work soon, or to look at alternative ways forward. Within surgery all of the high Bradford scoring staff members have an agreed action plan in place with their operational manager and HR lead to address sickness rates. Sickness reports are being monitored for staff affected by current organisational changes – TPE- to assess if this is impacting on current performance rates. Review of timeliness of ESR data	**On-going** Dec 2012	1. Paul Campbell 2. Matthew Boazman Naser Turabi
Turnover	**10.9%**	**10.6%**	<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 2. Analysis of turnover and exit interview data for areas of concern to determine specific issues to address – on track 3. Turnover trends will be reviewed to identify if there are themes/particular issues identified so that actions can be put in place to address.	Nov 2012 - complete Nov 2012 - complete Dec 2012	1. Div. Dirs. Operations 2. Paul Campbell
Appraisal	**26%**	**26%**	90%	See Below	See Below		
				Target is based on appraisals recorded on ESR.	Dirs. Ops. will ensure that all data is up to date on ESR, allocating	Oct 2012 for Nov D/Board	Div. Dirs. Operations

Month 7 – October 2012 Whittington Health Performance Dashboard Exception Report

Indicator	Oct'12	YTD	Target	Comment/ Description of issue	Actions planned/taken to achieve target	Target date / trajectory	Accntbl./Rspnsbl. Officer for Action
				Target not being met due to under reporting/recording issue – significantly more appraisals are being carried out than are being recorded.	resource to this issue, by the end of October for the November Dashboard Learning and Development team are inputting any available backlog data on behalf of managers This process is now being closely performance managed with lists of ESR appraisal recording by line manager circulated to divisions.	- not complete	
Mandatory Training	**74%**	**74%**	90% (Dec'12)	See below	See below		
				Staff turnover is accounted for by the 90% target. Overall performance is slowly improving although still significantly short of 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 3. An e-learning suite of PCs has been opened fr any member of staff to use at Crouch End and 4. Further suite of PCs is due to become available at Whittington Hospital site by the end of November 2012. 5. Weekly information is made available to all staff and managers as to their own, and everyone else's compliance position. 6. All managers have been asked to ensure they are rostering time for staff to complete their e learning mandatory training. 7. Face to face training sessions have been held/are arranged to supplement the e learning available. Information is	Sept 2012 - complete Sept 2012 – complete All ongoing	Paul Campbell Div. Dirs. Operations

Month 7 – October 2012 Whittington Health Performance Dashboard Exception Report

Indicator	Oct'12	YTD	Target	Comment/ Description of issue	Actions planned/taken to achieve target	Target date / trajectory	Accntbl./Rspnsbl. Officer for Action
					publicised through CEO briefing; Whittington Bulletin; screen savers; Learning and Development bulletin. 7 directorates are now over 90% compliant.		
NATIONAL TARGETS							
Patients in ED for < 4 hours	**95.6%**	**95.1%**	95%	See Below	See Below		
				Although ED Performance is green in Oct and YTD, it is included in this exception report as the situation is fragile going into the winter period, when we would expect higher numbers of ED attendances. Performance deteriorated in September following a period of sustained improvement. However, the Trust has met the standard for Q2. After some weeks of poor performance the trust submitted a full action plan to NHS London which committed us to achieving 95% YTD by the end of November which it is on track to deliver. The following issues were identified as key drivers of poor performance: • Consistency of leadership • Raising awareness of performance • Improving time to treatment • Flow management in the evenings • Speciality response times	These are a selection of the key actions completed already: 1. Secondment of senior manager to be dedicated solely to ED (Head of Acute Services) 2. Changes to consultant rota to ensure no gaps 3. Interim Clinical lead in place; interviews for permanent lead on 26/11 4. ED Manager job advertised (Interviews on 7th Dec) 5. Competency assessments for nurse shift leaders – letters sent to all shift leaders and assessments scheduled to finish by 7/12 6. Daily conference calls instituted if performance is <96.5% to problem solve for next day/s 7. Weekly meetings, Dir Ops and Div Director with COO and Head of Performance to hold division to account. 8. Acute Physician dedicated 12 hours per day to ED and Acute Admission unit commencing on	Complete Complete Complete Complete Complete Complete Complete Complete	Carol Gillen (Dir Ops – ICAM

Month 7 – October 2012 Whittington Health Performance Dashboard Exception Report

Indicator	Oct'12	YTD	Target	Comment/ Description of issue	Actions planned/taken to achieve target	Target date / trajectory	Accntbl./Rspnsbl. Officer for Action
					5/11/12		
				These issues are all being addressed by the action plan. The actions in the next column are a high level selection of those actions.	9. 120 minute breach prevention protocol. On majors every patient in the department for 120 minutes who does not have a clear indication of treatment plan/admission/ discharge plan will be flagged to Consultant in charge between 08:00-20:00 and Nurse in charge overnight	Complete	
					10. Reduction in threshold of escalation to silver on call	Complete	
					11. Attendance by consultant physician and consultant surgeon at daily 3pm board round to problem solve patient flow issues with relation to admitting wards.	Complete	
					12. Daily consultant led multi-disciplinary board rounds including social care	Complete	
					Ongoing work focuses on three areas:		
					13. Reduce time to treatment (Current mean 80-90 mins, need 60 minutes) by introducing a "Rapid Assessment and Treatment Model" by which every patient arriving at the major's area is seen by a senior medical officer on arrival.	November 2012	
					14. Introduce 'hot floor' concept and optimize the impact of new rota. This improves joint working / flow between ED and Acute Medicine. This helps admission	November 2012	

Month 7 – October 2012 Whittington Health Performance Dashboard Exception Report

Indicator	Oct'12	YTD	Target	Comment/ Description of issue	Actions planned/taken to achieve target	Target date / trajectory	Accntbl./Rspnsbl. Officer for Action
					avoidance by ensuring fast track consultant decisions 15. Focus on floor leadership competences and queue management. This includes building on the introduction of internal professional standards which happened last month.	November 2012	
Referral to Treatment – Admitted	**89.4%**	**91.5%**	90%				
				There were patients waiting over 18 weeks across two main surgical specialties- orthopaedics and General Surgery. Within orthopaedics this is predominantly being caused by the current waiting times for spinal surgery and treatment and specialist hip surgery- both have long waiting lists and are single consultant led services due to their sub-specialty nature.	- Within the spinal service a review of referrals has been completed and identified patients that can be suitably managed by MSK model. This triage has been introduced and also communicated with GPs via the GP newsletter. This will reduce current spinal demand. - MSK services are being reviewed as part of the NHS London service improvement programme. - An additional hip inpatient surgical list has been added to the hip surgeon with the shoulder list swapping ad now being a day case led service. This has increased inpatient capacity.	November 2012 November 2012 ongoing October 2012	Matthew Boazman (Dir Ops – SCD)
Cancer – 14 day 1st OP (Sept)	**92.2%**	**92.8%**	93%	See Below	See Below		
				Performance on track in month following additional capacity provided for two week target referrals.	Actions already in place (see comment to left)		Matthew Boazman (Dir Ops – SCD)

Month 7 – October 2012 Whittington Health Performance Dashboard Exception Report

Indicator	Oct'12	YTD	Target	Comment/ Description of issue	Actions planned/taken to achieve target	Target date / trajectory	Accntbl./Rspnsbl. Officer for Action
				Additional escalation mechanism and early alert of 2 week capacity issues implemented during August Additional clinic capacity provided for 2 week clinics during August to address any loss of capacity due to annual leave.			
Cancer – 14 day breast (Sept)	**87.8%**	**91.8%**	93%	See Below	See Below		
				There has been a delay in increasing further breast clinics linked to the availability of radiology support and the need to re-provide vascular support in order to free up imaging support for breast clinics. This has meant that despite additional clinics already provided total available capacity was not at maximum level in month. There has been an increase in patients choosing to wait over 14 days. The audit data for Q2 established that there were 37 patients who breached the 14 day target- 32 of these were due to patient choice. Of those patients who breached due to choice 28% chose initially to wait over 14 days despite being given an appt date within 14 days 72% patients that breached initially had a date in <14 days but subsequently cancelled their appointment and chose a date after 14 days. Performance also affected by a continued high increase in referral rate in July (132 compared to an av.	One further weekly breast clinic is being introduced in November in line with the increased referral rate and demand. CNS leads will contact all patients by phone who are choosing to book beyond 14 days in order to encourage them to retain their initial date/ be seen in available slots <14 days.	November 2012 November 2012	Matthew Boazman Marie Kernec Mark Rose

Month 7 – October 2012 Whittington Health Performance Dashboard Exception Report

Indicator	Oct'12	YTD	Target	Comment/ Description of issue	Actions planned/taken to achieve target	Target date / trajectory	Accntbl./Rspnsbl. Officer for Action
				of 107 pcm) date end of July.			
Cancer – 62 day (Sept)	**90.0%**	**85.0%**	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. Based on current (unvalidated performance) as of 12th November 2012 is 87.9%- achieving the target	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 Complete Complete	1. Matthew Boazman 2. Mark Rose 3. Mark Rose
Pregnant women seen within 12 weeks and 6 days	**88.2%**	**87.4%**	90%				
				Lower performance driven by DNAs patient choice. Only 2 cases of late booking appointments were not due to these factors.	1. Deep dive into data to investigate reasons for DNA.	December 2012	Dee Hackett / Claire O'Connor
QUALITY							
Complaints response < 25 working days	**64%**	**70%**	80%	See Below	See Below		
N.B SEPT'12 DATA				Ongoing capacity issues in a slight decrease in response times in year to date. Reasons for this are unchanged and have a cumulative effect. 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.	1. Complaints investigation training delivered - further training arranged for January 2013. 2. New PALS and Complaints manager now in post as of October 1st 2012 3. Detailed action plan to reduce number of complaints has been developed and will be monitored by PEC. 4. 3/12 additional capacity provided	Nov 2012 Sept for Oct 2012 D/Board – carried over to December	1/2/3 Cassie Williams / Jennie Williams 4/5 Div. Dirs. Ops.

Month 7 – October 2012 Whittington Health Performance Dashboard Exception Report

Indicator	Oct'12	YTD	Target	Comment/ Description of issue	Actions planned/taken to achieve target	Target date / trajectory	Accntbl./Rspnsbl. Officer for Action
					to PALS and Complaints team to provide additional support to Divisions to manage backlog. 5. Operations allocating capacity to ensure back on track Sept for Oct D/Board – challenges are in SCD and ICAM and they have recruited and will be in post in November - carried over	Board	
MRSA Screening - Non-Elective Patients	**94.1% (Sept)**	**91.5%**	95%	See Below	See Below		
				August to September performance improved. It is expected that changes will have impact for October (reported in next month's performance report due to time constraints related to coding requirements)	1. Increased feedback to ED and clinics including education sessions 2. Changes to requesting process for MRSA screening we have made the way to request MRSA screening even easier. 3. Further analysis of data methodology to ensure full data capture	October 2012 (complete) October 2012 (complete) October (complete)	Julie Andrews Julie Andrews Anita Garrick
Pressure Ulcers – Acute	**2**	**8**	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	A performance managed programme of work is underway that will to embed change in practice	April 2013	Bronagh Scott

Month 7 – October 2012 Whittington Health Performance Dashboard Exception Report

Indicator	Oct'12	YTD	Target	Comment/ Description of issue	Actions planned/taken to achieve target	Target date / trajectory	Accntbl./Rspnsbl. Officer for Action
				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 for awareness raising and training about the prevention of pressure ulcers within the Trust.			
Pressure Ulcers – Community	**6**	**37**	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	Bronagh Scott
Appropriate Prophylaxis for VTE	**98.4% Sept**	**86.5%**		See Below	See Below		
				Poor performance in May is driving YTD performance. These issues have been resolved.	Actions to maintain high performance in place. On target to recover YTD performance by December	December 2012	
MSK funct. scale	**44%**	**35%**	40%	See Below	See Below		
% of pats. completing Patient Specific Functional Scale				October has seen an improvement in the recording of PSFS. If we continue to report over 40% in subsequent months we should meet the revised trajectory.	On track to meet YTD target	Jan 2012	Fiona Yung
NATIONAL - COMMUNITY							
New Birth Visits Islington 14 Day	**Sept Isl: 78.6%;**	**Isl: 66.4%;**	95%	See Below	See Below		
Haringey 14 Day	**Sept Har: 83.5%**	**Har: 43.6%**	95%	See Below	See Below		
				The NBV rate continues to improve across Haringey and Islington as	1. The LEAN review has improved processes and we are working with	Dec 2012	Sam Page

Month 7 – October 2012 Whittington Health Performance Dashboard Exception Report

Indicator	Oct'12	YTD	Target	Comment/ Description of issue	Actions planned/taken to achieve target	Target date / trajectory	Accntbl./Rspnsbl. Officer for Action
				teams refocus work on preventative work with families.	individual teams to address individual issues. 2. The late NBV audit shows that significant numbers of late NBVs are due to inaccurate information from maternity services. Data to be shared with Heads of Midwifery to develop clear and accurate information flows. 3. Successful recruitment in Haringey means that we are now recruiting to expansion posts. Recruitment in Islington remains challenging. 4. Student training programme is underway.		
Haringey 28 days	**Sept Har: 93.4%**	**Har: 91.0%**	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. Performance stayed constant between August and September improving YTD performance.	As Above	Oct 2012	Sam Page
LOCAL TARGETS							
Theatre Utilisation	**82.8 %**	**81.7 %**	95%	See Below	See Below		
				Theatre utilisation captured as a measure of all available theatre sessions timetabled throughout the week / % minutes utilised. Information analysts copied into changes within weekly theatre	1. New theatre timetable, dedicated anaesthetic and general surgeon rotas introduced. - complete 2. Data quality review in Sept 2012 e.g. inclusion of data for planned closures adversely effecting utilisation data – extended to	Aug 2012 Sept 2012 (now October 2012)	1. Graham Booth 2. Graham Booth

Month 7 – October 2012 Whittington Health Performance Dashboard Exception Report

Indicator	Oct'12	YTD	Target	Comment/ Description of issue	Actions planned/taken to achieve target	Target date / trajectory	Accntbl./Rspnsbl. Officer for Action
				programme. Anaesthetic administrator / theatre receptionist will keep analyst up to date with changes in the theatre programme. Key issues affecting utilisation August: - closed lists due to consultant annual leave - partial filled lists provided to avoid 18 week breaches (e.g. ENT) leading to under-utilisation New surgical on call rota to be implemented from mid December will change current theatre and endoscopy programme - reduction in day case cystoscopy due to equipment failure in month - underutilised urology lists - underutilised lists for new consultants (colorectal / bariatric / breasts) due to insufficient new patients currently. Need to pool patients for colorectal / bariatric. Patients also will not take up offer of dates with surgeons different to the one they saw in OPD.	October 3. Target will separate Emergency from Elective to represent new streamlining of services Sept 2012 - complete 4. Replacement cystocopy equipment in place - complete 5. Review on new G Surgery rota being undertaken by Clinical Director for surgery to review theatre session provision 6. Urology job planning for 2012/13 to be revisited in order to review theatre allocation and usage 7. Orthopaedic day case lists to be reallocated and increased hip inpatient list to be provided following job planning review within orthopaedics.	Sept 2012 September 2012 October 2012 November 2012 November 2012 for new listed patients	3. Anita Garrick 4. Completed 5. Hasan Mukhtar 6. Matthew Boazman and Nick Harper 7. Graham Booth (agreed with David Sweetnam)
Acute DNA Rates - First	**11.9%**	**12.6%**	<8%	See Below	See Below		
- Follow Up	**13.8%**	**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)	1. Dec 2012	1. Div. Dirs. Ops.

Month 7 – October 2012 Whittington Health Performance Dashboard Exception Report

Indicator	Oct'12	YTD	Target	Comment/ Description of issue	Actions planned/taken to achieve target	Target date / trajectory	Accntbl./Rspnsbl. Officer for Action
					2. Transforming Patient Experience key roles being proposed is the Patient Pathway Coordinator (PPC) aimed at improving patient communication, reducing patient handoffs between functions. Consultation for PPC gone out this week. 3. In WCF letters are sent and phone calls are made to alert parents to appointments.	2. Dec 2012 3. Ongoing	2. Matthew Boazman 3. Dee Hackett
Hospital Cancellations (Follow ups)	**5.5%**	**8.0%**	<2%	See Below	See Below		
				Significant improvement Sept to October. Within G Surgery the new rota has been implemented and this caused an increase in cancellations the previous month due to the number of clinics that had to be rebooked and moved. This has now stabilised and the number of appointments needing to be moved reduced.	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.
Outcomes Not Recorded	**2.2%**	**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. There is an issue re intermittent access to RIO in community in some locations.	Managers monitor staff performance on a weekly basis: disciplinary action taken against staff who do not input in a timely way. IT in process of works to resolve RIO connectivity	Ongoing Ongoing	Div. Dirs. Ops.

Month 7 – October 2012 Whittington Health Performance Dashboard Exception Report

Indicator	Oct'12	YTD	Target	Comment/ Description of issue	Actions planned/taken to achieve target	Target date / trajectory	Accntbl./Rspnsbl. Officer for Action
				Significant improvement from Sept to Oct			
SLA							
Acute Outpatients	**24% excess**	**27% 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. 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 Following on from the diabetes audit a n option appraisal will go to TOB 19th November for agreement to repatriate. Discussions are also ongoing with CCGs regarding repatriation, no agreement has been made with regard to numbers that can return to primary care. Plans for repatriating our cardiology HF patients have had to be put on hold due to the resignation of a community HF nurse in Haringey. Interim cover arrangement in place but the service is under-resourced. Discussion with the CCGs on how to manage current risk. Cardiology: Business case to be	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 3. Discussions at contract monitoring with NCL regarding the exclusion of some specialist clinics from KPI targets are ongoing. 4. Discussion on-going at contract monitoring committee NCL regarding WH's repatriation intentions: Work continues with 10 practices across Haringey and Islington to repatriate patient. However the pace of repatriation is not enough to effect a significant change to our KPI's 5. Specialty action plans and named clinical leads for implementation were approved at the July Surgical Board for Oct 2012 trajectory 6. Orthopaedic template review is continuing and the clinical lead is support specialty actions for local management of follow ups and diagnostic requests	1. Mar 2013 2. Sept 2012 3. Dec 2012 4. Oct 2012 5. Oct 2012 6. Nov 2012	1. Dr David Brull 2. Anita Garrick 3. Fiona Smith Fiona Yung 5. Nick Harper 6. Mr David Sweetnam

Month 7 – October 2012 Whittington Health Performance Dashboard Exception Report

Indicator	Oct'12	YTD	Target	Comment/ Description of issue	Actions planned/taken to achieve target	Target date / trajectory	Accntbl./Rspnsbl. Officer for Action
				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.			

Month 7 – October 2012 Whittington Health Performance Dashboard Exception Report

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**
QUALITY TARGETS							
Incident Reporting	See Below	See Below	See Below	See Below	See Below		
Reporting Rate/1000 beddays/ contacts	**3.3**	**3.3**	No target	Performance for these areas currently being benchmarked	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 Note that YTD figure decreased between September and October as invalid data was removed from previous dataset.	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	**Sept 98.4%**	**86.5%**	90%	See Below	See Below		
Hospital Acquired VTE	**Aug 1**	**14**	No target	See Below	See Below		
				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
LOCAL INDICATORS							
ACUTE: LOS and Av Bed Days	**No Data**	**No Data**	No target	See Below	See Below		
				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 – deferred to be	Dec 2012	Ian Tritschler

Month 7 – October 2012 Whittington Health Performance Dashboard Exception Report

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**
					addressed as part of the Enhanced recovery Programme		
Outpatients				See Below	See Below		
Number of First Appointments	6092	37114	No target	Target requires revision to reflect SLA in financial terms	Target to be revised as an aggregated Financial Target for Dec Dashboard	Dec 2012	Fiona Smith
Number of Follow-Up Appointments	13974	91194	No target	See Above	See Above	Dec 2012	Fiona Smith

Appendix 2: Summary of Changes to Trust Board Performance Report

Last month, a paper was submitted to board that outlined some changes that would be made to the Trust Dashboard for this month. This paper lists those changes:

1. **Various indicator specific changes** – where possible and relevant indicators have: been removed, updated to reflect better data collation methods, or changed from absolute numbers to rates. These changes have all been referenced in footnotes in the performance report itself.

2. **Longer period of historical data for all indicators** – Instead of displaying data for last three months, data from every month of this financial year are shown.

3. **Definitions of indicators**: these have been provided as a separate part of Trust Dashboard report. In the future this will not be printed but will be available as a separate worksheet in the electronic file. (See appendix 1)

4. **Numerator and Denominator:** The value of the numerator and denominator, where relevant, has been provided in the same report as the definitions. This serves to provide context to some indicators where small fluctuations in the denominator can lead to large fluctuations in the displayed performance. (See appendix 1)

5. **BAF mapping:** Sections of the Trust board report have been mapped to key risks in the Trusts board assurance framework (see Appendix 3)

6. **Further clarifications of Red/Amber/Green Ratings** – common sense changes have been made where possible. In addition further changes will be made as part of a properly governed process that will be described as part of the Board Escalation Policy (due with the Board in December).

Whittington Health NHS

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Whittington Health Trust Board

28/11/12

Title:	**Plan to develop Performance Management Framework and Management Information at WH**		
Agenda item:	**8b**	**Paper**	**C**
Action requested:	For agreement of key deliverables and timescales		
Executive Summary:	Recent independent external reviews (Historical due diligence, Board Governance Assurance Framework, Monitor Quality Governance Framework) recommended that the trust reviews its performance management arrangements to ensure that Board reports present fully integrated and timely information so that the Board can be properly assured in relation to performance management. This paper sets out the plan in response. This programme of work will deliver the following: a) **Trust Performance Management Framework document** (which will form part of the evidence submission to Monitor)- submitted to board for approval in December 2012 b) **Board Escalation Policy – performance section** – submitted to board for approval in December 2012 c) **Trust Board Integrated Report (incremental improvements – already agreed by Trust Board)** – begun for November Board meeting, to be completed by January) d) **Improved Divisional Dashboards** (to mirror Trust Board Integrated Report) – January 2013 e) **Service line balanced scorecards (aligned to service line leaders in each division** – c. 15 for Trust) – all in place by end of July 2013 f) **Domain specific reports ie those related to particular dataset** e.g. SLR, activity, waiting lists – feasibility and scoping by early Dec 2012		
Summary of recommendations:	The Board is asked review this plan and give its approval and support		
Fit with WH strategy:	Related to Efficient and Effective Services goal; Performance management Framework required for FT application		
Reference to related / other documents:	Related to Board Escalation Policy		
Date paper completed:	9/11/12		

Author name and title:		**Naser Turabi, Head of Performance**		**Director name and title:**		**Maria Da Silva, COO**	
Date paper seen by EC	**13/11/12**	**Equality Impact Assessment complete?**	**N/A**	**Risk assessment undertaken?**	**N/A**	**Legal advice received?**	**N/A**

Developing Performance Management at Whittington Health

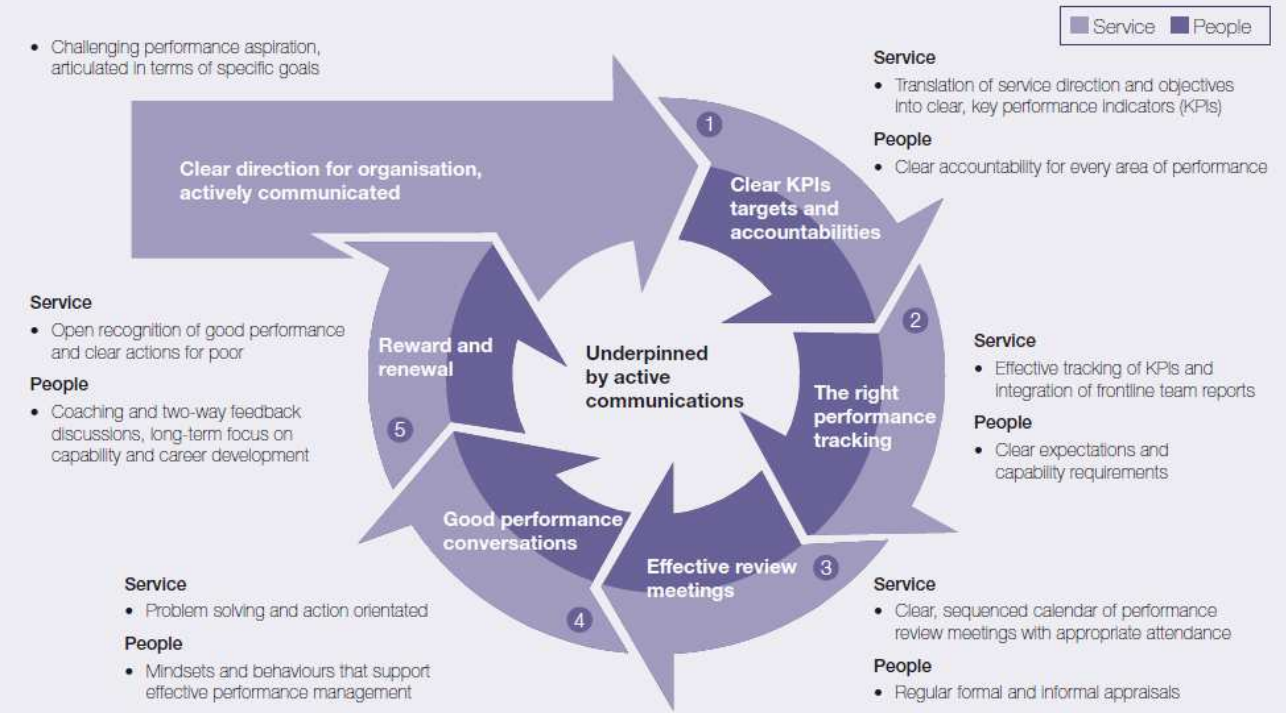
1. Introduction

This document describes a programme of work to renew the performance management framework for Whittington Health.

The purpose of the performance management framework is to facilitate robust management control of operational performance in the pursuit of our strategic goals. It achieves this by:

1. Clarifying lines and levels of **accountability**
2. **Documenting processes** for performance management including escalation of performance issues
3. Promoting high standards for performance management **behaviours and conversations**
4. Ensuring that the right management **information** is in place to support assurance, performance monitoring, and operational performance management

The diagram below is Monitor's representation of a best practice performance management framework that translates Trust strategy into a system of accountability underpinned by good information and behaviours.[1]



A best practice performance management framework is driven by the following principles:

- Promotes accountability among key managers by giving them the information they need and clarifying their roles
- Vertical coherence – achievement of goals at service and team level will lead to the achievement of trust goals
- Horizontal coherence – comparability between services streamlines the process of performance management and assurance.

In addition it should be informed by external requirements including externally monitored targets (DH, commissioners) and requirements for external inspection (Monitor, CQC).

[1] *Toolkit 1: Working towards service-line management: a how-to guide*, Monitor, 2009

2. Overview of key deliverables

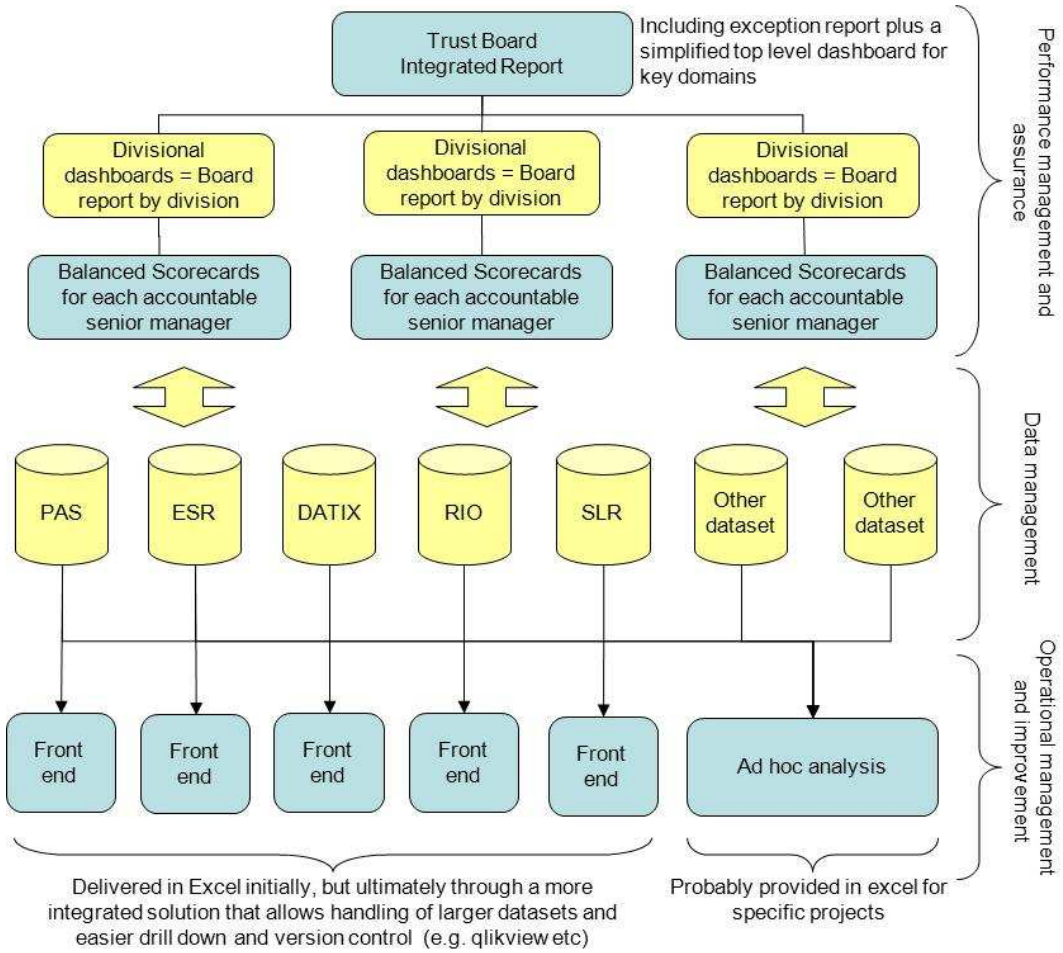
This programme of work will focus on producing the following deliverables:

	Deliverable	Description	Responsibility	Timescale
Governance	a) Trust Performance Management Framework document	• Short document setting out how performance is managed at key levels of the organisation including key aspects of governance such as how decisions are made about target setting • Requires board approval; must assure board and external stakeholders that WH has systems to robustly manage operational performance.	Head of Perf.	December Trust Board
	b) Board Escalation Policy – performance section	• Defines circumstances when performance issues are escalated to the board • Requires board approval; needs to ensure that performance issues are escalated in timely and appropriate way.	Head of Perf. With AD Governance	December Trust Board
Information	c) Trust Board Integrated Report	• Incremental improvements to the existing Trust performance report • Needs to support board assurance of performance	Head of Perf.	November Trust Board
	d) Improved Divisional Dashboards	• Divisional dashboards will match the Trust board Integrated report but broken down by division and department. • Existing divisional dashboards will be run until service line BSCs are in place.	Information working group	January Trust Board
	e) Service line[2] balanced scorecards	• For each service line leader in the divisions, a balanced scorecard will be developed that can be provided on a monthly basis. It is expected that there will be c.15-25 service line balanced scorecards. • Service line identity and key performance domains agreed by TOB; • Indicators and metrics chosen to include Board level performance; • Sign off from service line leader and HoP	Information working group	All by end of July – rolling programme from Dec/Jan
	f) Domain specific reports	• Domain specific reports such as activity/against plan; waiting times (18 weeks, cancer, community etc) that facilitate access to essential business intelligence. • Against agreed workplan with information and finance as resources allow. • Head of Performance signs off reports as fit for purpose in consultation with Divisional leads	Information and finance working groups	Feasibility study by mid December

This programme of work recognises the challenges of developing a performance management framework for an ICO such as Whittington Health. We have an unusually large number of services and underlying systems are still in the process of being integrated across the predecessor organisations. Much work has already been completed and this programme will identify areas of good practice and endeavour to spread that practice.

[2] Service lines will be defined to be contiguous with finance SLR but will be centred around senior manager responsibility so some Service Line Balanced Scorecards will include multiple service lines as defined by finance.

3. Vision for Management Information.



The information deliverables described in section 2 above form part of a vision for management information that supports performance management framework.

The diagram to the left shows a provisional vision for management information. This will be presented to TOB for approval.

It focuses on supporting accountability and performance assurance upwards, while also supporting performance management within divisions and service lines, and operational management and improvement through domain specific reports in areas such as service line finance reporting, waiting times, and activity.

Service Line Balanced Scorecards will serve to focus accountability on service line leaders while giving them a tool to monitor the performance of their services. The number (likely to be between 3 and 7 per division) reflects the complexity of our divisions.

Domain specific reports: In addition to service oriented scorecards, managers and clinicians need access to domain specific reports focusing on particular datasets e.g. waiting times, income/activity. A key gap highlighted in discussions with senior managers is the **lack of regular reporting of activity levels**, including in relation to actual and planned income.

4. Delivery and oversight

Oversight

- The programme of work will be overseen by Trust Operational Board (TOB). It is proposed that every four weeks a portion of the agenda will be used as a steering group with the purpose of ensuring the delivery of a performance management framework as described above.
- As well as the usual membership of TOB, when agenda items require, the Director for Planning and Programmes and a senior representative from Finance will be invited.
- If an unplanned decision is required between meetings the Programme Manager will involve relevant stakeholders and the Chair of TOB (COO).

Delivery

Delivery will be split into three workstreams: Information, Finance, and Governance each with its own working group.

Workstream	Deliverable
Governance	a) Trust wide Performance Management Framework document
Governance	b) Board Escalation Policy – performance section
Information	c) Improved Trust Board Integrated Report
Information	d) Improved Divisional Dashboards
Information and Finance	e) Service line balanced scorecards
Information and Finance	f) Domain specific reports

Workstream 1: Information

This workstream will focus on developing and agreeing specifications for outputs that will then be provided by the Information team.

Key deliverables	Outputs	Deadline
Improved Trust Board Integrated Report and Improved Divisional Dashboards	Add trend data to Trust Board exception report	November Board
	Provide definitions of all indicators and provide a brief summary of the numerator and denominator	
	Ensure alignment to Trust Board Assurance Framework	
	Add Activity data to trust Board report	November to December Board
	Add breakdown by division for each metric where possible/ appropriate (for circulation to divisions only)	January Board
Development of service line balanced scorecards	Decision over number and identity of service lines (in consultation with finance, information, directors of Ops and COO)	14/11/12
	Prioritised workplan for service line balanced scorecards	3/12/12

Key deliverables	Outputs	Deadline
	Development of output specifications for service line balanced scorecards	Rolling programme
	Delivery of service line balanced scorecards	Work to be completed by end of March 2013
Domain specific reports	Prioritised workplan for fit for purpose reports for key performance areas	3/12/12
	Report: 18 weeks RTT report	TBC
	Report: Overall waiting list reports	TBC
	Report: Cancer waiting times	TBC
	Report: Activity trends against plan	TBC

Delivery Risk	Mitigation
Too much complexity in reports slows down production	It is recognised that WH is a complex organisation and has to measure a wide range of indicators. However complexity can limit the usefulness of performance information. Therefore the Head of Performance will ensure that performance domains (quality, finance, workforce etc.) will be consistent across service lines; in addition the focus will be on iterative products.
Inability of information to meet demand for renewed information	An external provider has been commissioned by the information department to support this work and specifically build capacity in producing more automated reports. However this remains a risk as the permanent team are still required to have the main input.

Working group:

- Head of Performance
- Information representation;
- Representatives from each division;
- Information stakeholders as required (e.g. HR, clinical governance, IT etc)

Workstream 2: Finance

The initial goal of this workstream will be to review the current provision of financial management information, identify gaps and assess resources required to fill those gaps.

The output of this review will be a paper to TOB that sets out a plan with a realistic assessment of the resources required to deliver.

Key deliverables	Outputs	Deadline
Improved Trust Board Integrated Report and Improved Divisional Dashboards	Paper to TOB that summarises: • Current provision of financial management information to operations directorate; • Gaps in provision, with particular regard to standards required by Monitor for FT application • Realistic assessment of resources required to fill any gaps identified	**10/12/12**
Development of service line balanced scorecards		
Domain specific reports		

Risks – It is envisaged that the resources required to deliver further financial information will be a limiting factor and the paper to TOB will identify the relevant delivery risks.

Working group:

- Head of Performance
- Senior finance representation
- Representatives from each division

Workstream 3: Governance

Key deliverables	Outputs	Deadline
Board Escalation Policy – performance section	Updated Escalation Framework	To TOB by 3/12/12 in advance of December Trust Board
Trust Performance Management Framework	Board Approved Performance Management Framework document	To TOB by 3/12/12 in advance of December Trust Board

Delivery Risk	Mitigation
Board escalation policy and Performance Management Framework do not reflect changes that are happening in parallel	• The performance section of the board escalation policy will be drafted to focus on clear principles and governance arrangements for judging whether performance issues need escalation to Board, rather than setting specific thresholds. • The initial version of the Performance Management Framework will be based on existing governance and structures.

Working group:

- Head of Performance
- AD Governance
- co-opting others as required.