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Whittington HealthTrust Board
23 January 2013

Title:	Month 9 Performance Dashboard, exception report, and Performance Management Framework		
Agenda item:	**13/008**	**Paper**	**3**
Action requested:	• For Trust Board to note performance • To agree change requests • To approve Trust Performance Management Framework		
Executive Summary:	The Performance Dashboard attached informs the Trust Board about performance at month 9 – December 2012 (or the latest month available). **1) Areas of improvement** a) **Theatre Utilisation** – significant improvements have been made (90.5%)and we are on track to achieve 95% target by year end. b) **Pressure ulcers in acute settings** – zero pressure ulcers were recorded for two months running (Nov-Dec) c) **Consultant presence 8am-8pm** – new rotas are in place to sustainably meet this requirement. **2) Areas of concern:** a) **Emergency Department** – the 4 hour target performance against 95% target deteriorated in the latter half of December due to some key pressure periods on bed capacity, high numbers of attendances and specific periods of high acuity attendances. Performance was 94.73% in December, 95.2% in Q3, and 94.9% YTD (at 15/1/13). Winter pressures funding bids were successful and this should relieve pressure. We forecast meeting 95% target by year end. b) **Cancer access October**– two week wait and two week wait for Breast symptoms were missed in November. The key reason for breast symptoms is patient choice. For main 2 week waits patient choice is an issue but there are also some capacity and prioritisation issues. A detailed action plan is in place. We forecast meeting the main 14 days target by year end. However the Breast symptoms target is at risk due to the patient choice issue. c) **Complaints response times** – performance has improved after the considerable drop in performance in October, but is still significantly short of target. There is a comprehensive action plan in place to improve performance and we forecast achieving 65% by year end and achieving the 80% target by end of Q1 13/14. d) **Mandatory Training** – the 90% by end 2012 target was not met (84%). Efforts are continuing to ensure we meet the target as soon as possible. e) **Appraisals** – The recorded appraisal rates increased but still well short of target. The 90% target by end of financial year is at risk. An action plan is place. **3) Change requests** a) **Staff Turnover** - The Trust Board is asked to agree a change in the target for staff turnover to <13% from <10%. After benchmarking against		

	similar London Trusts it was assessed that <13% is more realistic. b) **Bed utilisation** – remove bed days figure and replace with bed utilisation to give a better focus on capacity issues. c) **Emergency readmissions** – to remove indicators until targets are agreed with commissioners. 4) **Performance Management Framework** This document describes and standardises the processes Whittington Health (WH) has put in place to ensure appropriate management of our performance against operational and strategic goals. These processes constitute the Trust's performance management framework which includes: • Accountabilities and responsibilities for performance. (Section 2) • How performance measures have been defined and how targets have been identified; (Section 3.1) • How performance is monitored; (Section 3.2) • How adverse performance is addressed; (Section 4) • Tactics that Whittington Health uses to promote excellent performance. (Section 5) Trust Operating Board is the key forum for performance management of the divisions, with the COO having overall accountability to Trust Board for performance. Divisional Directors and Directors of Operations report to the COO and are held to account for performance in their respective divisions. This document is designed to meet the needs of relevant external bodies.
Summary of recommendations:	• For Trust Board to note performance • To agree change requests • To approve Trust Performance Management Framework
Fit with WH strategy:	The Performance dashboard is a key monitoring tool for achieving Whittington Health 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 completed:	14 January 2013

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

Whittington Health Integrated Dashboard - January 2013 (December 2012 Data)

Whittington Health NHS

KEY	
In month	**Colours**
Below target	
At risk	
On Target	
No Target	
	Direction
Improving	
No change	
Worsening	

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

"Q" denotes information only available quarterly

WORKFORCE AND MANDATORY TRAINING

Domain	Indicator	Target	Apr	May	June	Jul	Aug	Sept	Oct	Nov	Dec	YTD	Trend
Workforce	Vacancy Rates	<12%	14.2%	11.7%	12.6%	11.7%	12.6%	11.1%	11.1%	11.3%	11.7%	12.0%	
	Sickness Absence	<3%	2.8%	3.2%	3.1%	3.1%	2.8%	3.1%	3.5%	3.3%	2.8%	3.1%	
	Long Term Sick Leave	<1%	1.1%	1.3%	1.4%	1.3%	1.2%	1.2%	1.5%	1.3%	1.2%	1.3%	
	Turnover	<10% **[2]**	10.1%	8.9%	11.2%	11.1%	11.0%	10.8%	10.9%	11.0%	10.8%	10.6%	
	Staff in post	-	3661.8	3644.3	3,606.3	3,569.2	3,606.8	3,654.7	3,651.3	3,636.9	3,639.7	3,638.2	
	Stability Level	>80%	80.3%	83.8%	82.9%	83.4%	83.7%	83.6%	83.2%	86.9%	83.1%	83.4%	
	Appraisals recorded on ESR	90%	-	-	20%	20%	19%	20%	26%	29%	34%	34%	
	Number of case of bullying & harassment (cumulative)	0	1	1	1	1	1	3	3	4	4	4	
	% of qualified to unqualified staff (nurses)	70:30	77/23	76/24	76/24	77/23	79/21	79/21	80/20	80/20	80/20	78/22	
	Mandatory Training Compliance	90% by Dec	69%	69%	67%	68%	69%	70%	74%	79%	84%	84%	
	No. of staff activated on ESR	95%	6.2	638	652	665	680	687	698	711	724	724	

[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

[2] It is proposed to change the target to <13% to bring in line with London benchmark

Whittington Health Integrated Dashboard - January 2013 (December 2012 Data)

NATIONAL INDICATORS - ACUTE SERVICES

Domain	Indicator	Target	Apr	May	June	Jul	Aug	Sept	Oct	Nov	Dec	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%	95.3%	94.7%	95.1%	↓
18 Weeks RTT	Referral to Treatment - Admitted	**90%**	93.1%	92.8%	91.7%	92.5%	90.0%	90.3%	90.2%	90.3%	91.4%	91.4%	↑
	Referral to Treatment - Non Admitted	**95%**	98.8%	98.8%	98.9%	99.0%	99.1%	98.4%	98.4%	98.7%	97.8%	98.7%	↓
	Referral to Treatment - Incomplete	**92%**	91.7%	96.2%	92.2%	95.4%	95.2%	92.8%	92.7%	93.5%	92.1%	94.0%	↓
	Diagnostic Waiting Times	**99%**	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	99.5%	99.8%	99.1%	↑
Cancer Access	14 days GP referrals - 1st Outpatients - **[1]**	**93%**	91.7%	93.6%	92.9%	92.6%	93.3%	92.2%	92.5%	92.8%	-	92.7%	↑
	14 days GP referrals - Breast symptoms **- [1]**	**93%**	95.6%	97.7%	90.7%	86.2%	94.3%	87.8%	87.2%	85.8%	-	90.1%	↓
	31 days to First Treatment **- [1]**	**96%**	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	-	100.0%	→
	31 days to Second or Subsequent Treatment (surgery) **- [1]**	**94%**	**[2]**					**[2]**	100.0%	100.0%	-	100.0%	→
	31 days to Second or Subsequent Treatment (drugs) **- [1]**	**98%**						100.0%	100.0%	100.0%	-	100.0%	→
	62 days Referral to Treatment - **[1]**	**85%**	90.9%	78.4%	70.0%	85.3%	100.0%	90.0%	78.6%	85.3%	-	85.3%	↑
	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%	90.9%	76.5%	91.0%	↓
	Fractured Neck of Femur operated within <48 hours	**85%**	100.0%	100.0%	100%	100.0%	100.0%	100.0%	100.0%	90.9%	88.2%	97.0%	↓
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%	1.0%	0.2%	0.5%	↑
	Cancelled Operations not rescheduled within 28 days	**0**	0	0	0	0	0	0	1	0	0	1	→
Single Sex Accomm.	Single Sex Accommodation Breaches	**0**	0	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%	2.3%	2.4%	2.2%	↓
Diagnostics	Cervical Cytology turnaround times within 14 days	**98%**	100%	100%	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%	90.1%	90.6%	89.8%	↑
	1:1 care in established labour	**100%**	100%	100%	100%	100%	100%	100%	100%	98.9%	100%	100%	↑
	Breast Feeding at Birth	**90%**	90%	92%	92%	90%	91%	92%	93%	92%	93%	92%	↓
	Smoking during pregnancy at time of delivery	**<17%**	6%	8%	5%	6%	8%	8%	7%	6%	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 *Second/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 - January 2013 (December 2012 Data)

QUALITY INDICATORS - INTEGRATED CARE ORGANISATION

Domain	Indicator	Target	Apr	May	June	Jul	Aug	Sept	Oct	Nov	Dec	YTD	Trend
Incident Reporting	Number of Serious Incidents	**n/a**	17	11	16	16	8	12	17	5	8	110	→
	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	4.2	4.7	3.6	→
	Number of Falls - **[2]**	**[2]**	35	20	25	26	23	27	26	33	30	245	→
	Number of Falls Causing Severe Harm - **[2]**	**[2]**	0	0	0	1	0	0	0	0	1	2	→
	Never Events	**0**	0	2	0	0	0	0	1	0	0	3	→
Clinical Effectiveness	Safety Alerts Compliance	**100%**	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	→
Patient Experience	Complaints Received	**n/a**	49	62	37	59	49	41	48	38	23	406	→
	Complaints Responded to within specified timeframe	**80%**	76%	66%	86%	63%	65%	64%	26%	40%	**[3]**	62%	↑

QUALITY INDICATORS - ACUTE SERVICES

Domain	Indicator	Target	Apr	May	June	Jul	Aug	Sept	Oct	Nov	Dec	YTD	Trend
Infection Prevention	MRSA Bacteraemia Cases	**1 (year)**	1	0	0	0	0	0	0	0	0	1	→
& Control	C.DIFF Cases	**21 (year)**	1	1	0	1	2	1	1	2	2	11	→
	E Coli Cases - **[2]**	**[2]**	1	1	1	1	1	1	2	1	2	11	→
	MSSA Bacteraemia Cases - **[2]**	**[2]**	0	0	1	0	0	0	0	0	0	1	→
	MRSA Screening - Elective Inpatients	**95%**	98.6%	96.3%	94.2%	96.4%	95.5%	96.9%	93.0%	96.6%	**[4]**	95.9%	↑
	Hand Hygiene Audit	**95%**	99.5%	93.3%	99.4%	97.9%	95.8%	100.0%	98.8%	99.1%	100.0%	98.4%	↑
Incident Reporting	Pressure Ulcers - grade 3/4 (80% reduction from 2010/11 baseline)	**3/yr**	1	2	0	1	1	1	2	0	0	8	↑
	VTE Assessment	**95%**	95.4%	95.1%	96.7%	95.3%	95.6%	95.8%	95.1%	97.1%		95.8%	↑
	VTE Incidence - Hospital Acquired	**[2]**	4	1	4	4	1	3	**[4]**		**[4]**	17	→
	Appropriate Prophylaxis for VTE	**90%**	82.7%	65.8%	95.2%	95.1%	99.2%	98.4%	94.4%	93.4%		90.5%	↓
	Post Operative Sepsis	**AE**	0	0	1	0	0	0	0			1	→
	Post Operative Sepsis - Hips	**AE**	0	0	0	0	0	0	0			0	→
	Post Operative Sepsis - Knees	**AE**	0	0	1	0	0	0	0			1	→
	Deaths After Surgery	**AE**	1	1	2	0	0	3	1	**[5]**		8	↑
	Deaths in Low Risk Conditions	**AE**	0	0	2	1	0	3	1			7	↑
	Deaths After Bariatric Surgery	**AE**	0	0	0	0	0	0	0			0	→
	Hospital Level Mortality Indicator - Summary	**<100**	81	80.8	91.0	80.5	74	62.6	58.5			74.7	↑
Clinical Effectiveness [6]	Emergency Admission Rate for LTC	**[6]**	152	149	127	157	141	172	187	166		1252	→
	Emergency Admission Rate Paediatric (asthma, epilepsy, diabetes)	**[6]**	10	15	7	27	10	17	14	12	**[6]**	112	→
	Emergency Admission for VTE	**[6]**	2	6	8	8	9	19	9	7		68	→
Patient Experience [7]	Friends & Family Test - Inpatient Coverage	**15%**	**New measure from November 2012**							12.6%	10.3%	11.5%	↓
	Friends & Family Test - Inpatient Response (% likely to recommend)	**[7]**	**New measure from November 2012**							90.0%	83%	86.6%	→
	Friends & Family Test - Emergency Department Coverage	**15%**	**New measure from November 2012**							1.4%	0.1%	0.8%	↓
	Friends & Family Test - Emergency Department Response (% likely to recommend)	**[7]**	**New measure from November 2012**							54.0%	33.0%	52.0%	→
PTO FOR NOTES	Cleanliness Audit	**>95%**	96.1%	97.1%	97.1%		98.1%		97.3%	96.7%		97.1%	↓

Whittington Health Integrated Dashboard - January 2013 (December 2012 Data)

QUALITY INDICATORS - COMMUNITY SERVICES

Domain	Indicator	Target	Apr	May	June	Jul	Aug	Sept	Oct	Nov	Dec	YTD	Trend
Infection Prevention & Control	Dentistry Compliance with Infection Control Standard	**90%**		95%			96%			95%		95%	→
Incident Reporting	Pressure Ulcers - grade 3/4 (30% reduction from 2011/12 baseline)	**21/yr**	5	4	7	8	4	3	6	4	2	43	↑
Patient Experience	Friends & Family Test - Community Services Response (% likely to recommend)	**[7]**	**New measure in development**										→
	Dentistry - Patient Involvement	**90%**	90%	95%	92%	90%	98%	95%	97%	87%	99%	94%	↓
	Dentistry - Patient Experience	**90%**	97%	90%	100%	98%	92%	100%	100%	95%	98%	97%	→
Clinical Effectiveness	Respiratory - number of admissions avoided	**25 / Qtr**	9	3	3	18	13	8	8	9	12	83	→
	Diabetes - % of patients with at least a 1% reduction in HbA1c after 6 months	**60%**	57%	83%	42%	80%	80%	69%	61%	65%	64%	66%	→
	Diabetes - % of patients reporting confidence in managing their condition	**85%**	100%	60%	100%	100%	71%	73%	100%	90%	81%	86%	↑
	Heart Failure / Cardiology - % of patients on optimum Ace Therapy	**80%**	90%	90%	88%	90%	86%	85%	89%	83%	83%	87%	↓
	Heart Failure / Cardiology - % of patients on optimum Beta Blocker Therapy	**80%**	85%	83%	84%	87%	86%	85%	85%	80%	83%	84%	↓
	Rehab Intermediate Care - % of patients with self-directed goals set	**70%**	60%	75%	60%	71%	78%	73%	77%	74%	70%	71%	↓
	Rehab Intermediate Care - % of patients with improved or maintained function	**70%**	75%	71%	67%	76%	80%	77%	90%	81%	91%	79%	↑
	MSK - % of patients who have completed the Patient Specific Functional Scale	**40% (60% from Dec)**	2%	13%	14%	27%	47%	63%	45%	57%	63%	42%	↑
	MSK - % of patients completing their treatment on discharge	**40% [9]**	48%	48%	38%	37%	38%	39%	40%	35%	35%	39%	→
	CAMHS - % of Cases where mental health problems resolved or improved	**60%**		73%			71%			67%		71%	↓
	CAMHS - % of Cases where severity of mental health at end of treatment is normal	**80%**		89%			87%			87%		88%	→
	% of new patients with an HIV test within preceding 90 days	**60%**	85%	84%	83%	85%	83%	83%	83%	85%	87%	84%	↑
	% of women 18 to 25 years old attending for contraception given LARC	**20%**	28%	29%	26%	30%	32%	29%	28%	31%	29%	29%	↓
	% of new male patients who had an STI screen who were under 25 years	**20%**	30%	30%	34%	31%	30%	30%	35%	29%	27%	31%	↓
	% of new female patients who had an STI screen who were under 25 years	**20%**	46%	46%	47%	47%	43%	48%	46%	45%	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 data is **available 1 month in arrears of the current 7th working day reporting schedule**: Data available 25th working day following month end.

[4] MRSA and 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. Hospital acquired VTE incidence requires detailed audit.

[5] 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.

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

[7] In line with national guidance, the Friends and Family test has replaced the Net Promoter Score from November 2012. The target for this test is due to be released by the DoH from April 2013. Due to technical issues, community data was not available for November 2012.

[8] Cleaning audit scores for November and December combined will be presented on the January Performance Report

[9] See end of exception report for proposed action re this target

Whittington Health Integrated Dashboard - January 2013 (December 2012 Data)

NATIONAL INDICATORS - COMMUNITY

Domain	Indicator	Target	Apr	May	June	Jul	Aug	Sept	Oct	Nov	Dec	YTD	Trend
Health Visiting	Prevalence of breast feeding at 6-8 weeks	**74%**	76%			73%				[2]		74%	↓
	New Birth Visits - Islington	**95% <=14 days**	51.4%	55.8%	57.9%	67.5%	78.9%	78.6%	80.0%	87.3%	[1]	71.0%	↑
	New Birth Visits - Haringey	**95% <=14 days**	18.8%	22.8%	21.6%	41.0%	70.5%	83.5%	73.6%	78.6%	[1]	51.7%	↑
Child Heath	% of Immunisation - Islington	**80%**	88.5%			89.3%				[2]		88.9%	→
	% of Immunisation - Haringey	**80%**	88.5%			87.3%				[2]		87.9%	→
Community Sexual Health	GUM: Patients offered appointment within 2 days	**100%**	100%	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%	9.0%	10.5%	9.9%	↑
	% of chlamydia screens that are males <25 years old	**[3]**	12.5%	7.1%	11.1%	12.1%	11.3%	11.1%	12.6%	10.8%	10.4%	11.1%	→
	% of chlamydia screens that are females <25 years old	**[3]**	46.0%	47.9%	46.5%	28.4%	26.9%	30.0%	29.6%	28.5%	28.6%	35.5%	→
Primary Care Psychology	IAPT - Number entering psychological therapies	**[4]**	466			251	348	325	354	404	257	2405	→
	IAPT - Number moving off sick pay and benefits	**90 per year**	23			13	9	19	9	15	11	99	→
Stop Smoking	Actual 4 Week Quitters	**952 for Qtr 1 & 2**	594			432				[2]		1026	→
Dental	Units of Dental Activity	**90% of contract**	99%	127%	99%	129%	111%	103%	109%	103%	82%	107%	→
	Contacts	**90% of contract**	92%	122%	96%	146%	116%	95%	123%	116%	84%	110%	→
Drugs & Alcohol	% of Treatment Starts	**80%**	-	-	100%	100%	100%	90%	82%	83%	100%	93%	↑
	% of treatment Reviews	**80%**	-	-	100%	96%	100%	92%	83%	80%	81%	92%	↑

[1] New Birth Visits are reported **1 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] There is currently no national target set for this indicator - **see exception report for update**

[4] Target was due to be released in October 2012

Whittington Health Integrated Dashboard - January 2013 (December 2012 Data)

LOCAL INDICATORS - ACUTE

Domain	Indicator	Target	Apr	May	June	Jul	Aug	Sept	Oct	Nov	Dec	YTD	Trend
Inpatient	Consultant 7 Day Ward Rounds	**Y**	N	N	N	N	N	N	N	N	N	N	→
	Consultant presence every day 8am - 8pm (Acute Medicine)	**Y**	N	N	N	N	N	N	N	Y	Y	N	→
	Discharge Before 11am - Surgery / Medicine	**40% by Mar '13**	27.1%	31.7%	20.2%	25.4%	26.0%	28.7%	25.6%	23.4%	19.4%	25.3%	↓
	Average Length of Stay - Medicine - **[1]**	**[1]**	7.9	8.2	7.1	8.3	7.3	7.3	7.0	6.9	7.1	7.4	→
	Bed Days - Medicine - **[1]**	**[1]**	4754	4953	4031	4979	4456	4527	4880	4918	4648	41978	→
	Average Length of Stay - Surgery - **[1]**	**[1]**	4.8	4.8	4.0	4.0	3.2	3.1	3.7	3.8	4.9	4.0	→
	Bed Days - Surgery - **[1]**	**[1]**	1954	2155	1732	1902	1405	1395	1725	1766	1845	15979	→
	Theatre Session Utilisation	**95%**	77.0%	77.2%	79.5%	77.9%	77.3%	82.7%	82.8%	82.0%	90.5%	82.8%	↑
Outpatients	Number of First Appointments - **[2]**	**[2]**	4906	5922	4826	5528	5077	4763	6092	5677	4382	47173	→
	Number of Follow-Up Appointments - **[2]**	**[2]**	12736	15046	11406	13299	13047	11686	13974	12953	9611	113758	→
	DNA Rates - First Appointments	**8%**	11.6%	12.2%	12.8%	12.5%	14.6%	12.9%	11.9%	12.3%	13.9%	12.7%	↓
	DNA Rates - Follow-Up Appointments	**8%**	13.4%	13.3%	13.8%	13.5%	13.9%	14.1%	13.8%	13.2%	14.3%	13.7%	↓
	Hospital Cancellation Rate - First Appointments	**2%**	3.2%	3.4%	3.8%	3.3%	3.2%	6.1%	3.8%	3.2%	4.2%	3.7%	↓
	Hospital Cancellation Rate - Follow-up Appointments	**2%**	7.0%	5.6%	7.9%	8.4%	5.7%	8.3%	5.5%	6.1%	6.2%	6.7%	↓
	% Waiting less than 30 minutes in clinic	**90%**	85%	84%	84.0%	85.9%	87.7%	85.8%	87.2%	85.7%	88.0%	85.8%	↑
Data Quality - Acute	NHS Number Completeness - Acute	**99%**	97%	97%	96%	94%	95%	96%	96%	95%	94%	97%	↓
	Outcomes not recorded - Acute	**<0.5%**	0.0%	0.0%	0.0%	0.0%	0.0%	0.1%	0.1%	0.2%		0.0%	→

[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 - January 2013 (December 2012 Data)

LOCAL INDICATORS - COMMUNITY

Domain	Indicator	Target	Apr	May	June	Jul	Aug	Sept	Oct	Nov	Dec	YTD	Trend
Access	DNA Rates - Community Adult Service	**10%**	8.6%	8.3%	9.8%	11.0%	10.3%	10.4%	10.2%	10.5%	10.1%	9.9%	↑
	DNA Rates - Community Children Services	**10%**	12.7%	11.6%	11.7%	12.0%	11.7%	9.0%	6.9%	10.1%	12.9%	11.0%	↓
	Community Average Waiting Times - Adults	**6wks**	4.1	4.0	4.1	3.8	3.3	3.7	3.4	4.0	3.2	3.7	↑
	Community Average Waiting Times - Children	**18 wks**	14.0	15.0	14.0	13.0	11.0	14.0	14.0	14.3	12.7	13.6	↑
Data Quality	NHS Number Completeness - Community	**99%**	99.8%	99.9%	99.9%	99.8%	99.9%	99.9%	99.8%	99.8%	99.8%	99.8%	→
	Outcomes not recorded - Community	**<0.5%**	0.6%	0.6%	1.2%	1.0%	0.8%	1.2%	0.9%	1.2%		0.9%	→

SLA INDICATORS

Domain	Indicator	Target	Apr	May	June	Jul	Aug	Sept	Oct	Nov	Dec	YTD	Trend
	Outpatient Follow-up Ratio - % excess follow-ups	**<1%**	30%	25%	25%	26%	32%	33%	24%	30%	29%	29%	↑
	Consultant to Consultant Activity (Upper Quartile) - % excess firsts	**<1%**	3.1%	2.1%	2.4%	1.4%	1.6%	2.1%	2.4%	2.4%	2.4%	2.2%	→
	Emergency Readmissions - from original elective admissions	**[1]**	33	39	31	31	49	23	40	34		280	↑
	Emergency Readmissions - from original emergency admissions	**[1]**	178	190	202	195	178	186	205	176	**[2]**	1510	↑
	Excess Beddays **[3]**	**SLA Plan = 100%**	89.2%	107.0%	82.0%	95.0%	97.8%	143% **[4]**	69.7%	86.3%		94%	→

CQUIN 2012/13

Domain	Indicator	Target	Apr	May	June	Jul	Aug	Sept	Oct	Nov	Dec	YTD	Trend
CQUINS [5]	VTE 24 Hr Risk Assessment	**70% in Q4**	15.8%	17.9%	17.4%	19.4%	25.0%	26.5%	20.8%	45.1%	**[8]**	NA	↑
	NHS Safety Thermometer for Acute	**100%**	-	-	-	100.0%	100.0%	99.7%	100.0%	100.0%	100.0%	**[6]**	→
	NHS Safety Thermometer for Community	**100%**	-	-	-	95.1%	87.8%	86.7%	98.3%	100.0%	99.8%	**[6]**	↑
	Smoking advice	**70% in Q4**				38.0%	46.0%	53.0%	54.0%	55.0%	64.0%	51.0%	↑
	COPD Care Bundle	**85%**	94.4%	100.0%	93.8%	94.4%	94.4%	100.0%	100.0%	93.8%	**[8]**	96.0%	↓

[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] Four CQUINS have not been included in this report as they are too early in implementation phase to report.

[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

Month 9 – December 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	Dec'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		
				Work is ongoing to ensure that the time lag issue identified in the last exception report is resolved.	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.	**On-going**	1. Paul Campbell 2. Mary Jamal
Turnover	**10.8%**	**10.6%**	<10%	See Below	See Below		
				This target has been reviewed and the London benchmark for similar trusts is 13%. Going forward a key part of implementing the workforce plan is to allow for redeployment, whilst transformation of services advances. In the light of this there is a strong case for revising the turnover target to 13% to bring us in line with other similar trusts in London and to take account of the workforce planning position.	1. Turnover trends will be reviewed to identify if there are themes/particular issues identified so that actions can be put in place to address.	Dec 2012 - complete	1. Paul Campbell
Appraisal	**34%**	**NA**	90%	See Below	See Below		
				Target is based on appraisals recorded on ESR. The poor performance is due to a combination of reasons – in many cases appraisals are being carried	Dirs. Ops. will ensure that all data is up to date. ESR super users to be designated and trained in each division to support recording on ESR Learning and Development team are	End of Jan Ongoing	Div. Dirs. Operations Charlotte Johnson

Month 9 – December 2012 Whittington Health Performance Dashboard Exception Report

Indicator	Dec'12	YTD	Target	Comment/ Description of issue	Actions planned/taken to achieve target	Target date / trajectory	Accntbl./Rspnsbl. Officer for Action
				our but not recorded. This process is now being closely performance managed with lists of ESR appraisal recording by line manager circulated to divisions. Target to achieve 90% by end of March	inputting any available backlog data on behalf of managers Multiple messages to all staff have gone out reminding them of the requirement to complete their appraisal and ensure that it is recorded Similar approach to mandatory training in terms of emails sent to all staff showing appraisal status. Support for managers with very large numbers of staff (>15) to complete their appraisals Standing item at TOB for department level performance management	Ongoing Mid Jan Ongoing 21/1/13	Comms/Margaret Boltwood Anita Garrick Div. Dirs. Operations Maria Da Silva
Mandatory Training	**84%**	**NA**	90% (Dec'12)	See below	See below		
				Staff turnover is accounted for by the 90% target. Target for December 12 not met. Key gaps remain in Facilities directorate. A barrier is the fact that many staff do not do any day shifts so special training is being organised at night.	1. An e-learning suite of PCs has been opened fr any member of staff to use at Crouch End and 2. Further suite of PCs is due to become available at Whittington Hospital site by the end of November 2012. 3. Weekly information is made available to all staff and managers as to their own, and everyone else's compliance position. 4. All managers have been asked to ensure they are rostering time for staff to complete their e learning mandatory training. 5. Face to face training sessions have been held/are arranged to supplement the e learning available. Information is publicised through CEO briefing; Whittington Bulletin; screen savers; Learning and	All ongoing	Paul Campbell

Month 9 – December 2012 Whittington Health Performance Dashboard Exception Report

Indicator	Dec'12	YTD	Target	Comment/ Description of issue	Actions planned/taken to achieve target	Target date / trajectory	Accntbl./Rspnsbl. Officer for Action
					Development bulletin. 7 directorates are now over 90%. 6. Special evening and night time training for facilities staff.		Phil Ient
NATIONAL TARGETS							
Patients in ED for < 4 hours	**94.7%**	**95.1%**	95%	See Below	See Below		
				Performance deteriorated again in December. High acuity and specific periods (lasting hours) of high volumes. We did not meet the target for December but q3 performance was > 95%. The full action plan presented to NHS London in October remains relevant and the requirement is to continue to implement and embed those actions. 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 issues are all being addressed by the action plan. The actions in the next column are a high level selection of those actions.	In summary, ongoing work focuses on three areas: 1. 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. 2. Introduce 'hot floor' concept and optimize the impact of new rota. This improves joint working / flow between ED and Acute Medicine. This helps admission avoidance by ensuring fast track consultant decisions 3. Focus on floor leadership competences and queue management. This includes building on the introduction of internal professional standards which happened last month. In addition winter pressures funding was received from NHS London (£108,000) which is being used to fund extra consultant and middle grade doctor support for rapid assessment.	Ongoing Ongoing Ongoing Complete	Carol Gillen (Dir Ops – ICAM
Cancer – 14	**92.8%**	**92.7%**					

Month 9 – December 2012 Whittington Health Performance Dashboard Exception Report

Indicator	Dec'12	YTD	Target	Comment/ Description of issue	Actions planned/taken to achieve target	Target date / trajectory	Accntbl./Rspnsbl. Officer for Action
day 1st OP (Nov)							
				Cancer waiting times have not been met due to a combination of patient choice to be seen beyond two weeks and capacity issues. Issues are specific to specialties: Colorectal - Need to ensure CNS cover so that patients can be encouraged to come in within 2 weeks. - Limited capacity in endoscopy Skin - Key issue seems to routine referrals being referred through cancer pathway - Capacity has been reviewed and there is ample capacity - Large numbers of patients choosing to be seen beyond 2 weeks. Upper GI - Delays in consultant grading referrals now resolved - Limited capacity in endoscopy Urology - A specialist clinic was set up that although it made the overall pathway shorter and improved clinical effectiveness, it often led to two week wait breaches. This has now been rectified.	- Review arrangements for CNS cover to ensure capacity contact all patients - Review prioritisation of suspected cancer endoscopies to ensure they are seen before routine endoscopies. - Audit skin referrals to decide whether to implement full grading of cancer referral letters. - Revise script for telephone calls to further encourage patients to come in within 2 weeks - Rota now in place for consultant grading in Upper GI. - Update Trust Access Policy to provide more stringent standard for consultant grading - Pathway for Urology updated to ensure all pts seen within 2 weeks.	End of Jan 18/1/13 End of Jan 18/1/13 Complete End of Jan Complete	Mary Jamal Naser Turabi Marie Kernec Mark Rose Mary Jamal
Cancer – 14 day breast (Nov)	**85.8%**	**90.1%**	93%	See Below	See Below		

Month 9 – December 2012 Whittington Health Performance Dashboard Exception Report

Indicator	Dec'12	YTD	Target	Comment/ Description of issue	Actions planned/taken to achieve target	Target date / trajectory	Accntbl./Rspnsbl. Officer for Action
				- Capacity – the clinics were not set up optimally to ensure the most reasonable choice of days for appointments - Large numbers of patients are choosing to wait beyond 2 weeks compared to other tumour types; Analysis of reasons behind patient choice shows that 61% of patients cancelled a scheduled 2WW appointment and re-booked it outside of two weeks.	- New clinic templates offer patients more days and more times for new clinic appointments. - Script trialled in appointments for scheduling of breast symptomatic patients over a three week period. - Breast CNS' calling patients who choose to wait longer than 14 days to encourage them to attend. - Ensure appointments use script permanently going forward. - Adapt script and cancer 2WW leaflet to devise leaflet to send to breast symptomatic patients when booked. - To liaise with local GP practices to ensure GPs are referring breast symptomatic patients with appropriate information.	Complete Complete Complete 18/1/13 End of Jan TBC	Mark Rose TBC
Fractured Neck of Femur operated <36 hours	**76.5%**	**91.0%**					
				Four specific patients' cases were not clinically suitable for operation within 36 hours which accounts for all of 'under performance'			
Pregnant women seen within 12 wks and 6 days	**90.6%**	**89.8%**	90%				
				Further investigation has suggested that the Trust books all women who choose to be booked in time, but that some women are not declaring themselves as pregnant to a health	1. Explore ways to promote the need to declare pregnancy to a health professional	January 2012	Dee Hackett / Claire O'Connor

Month 9 – December 2012 Whittington Health Performance Dashboard Exception Report

Indicator	Dec'12	YTD	Target	Comment/ Description of issue	Actions planned/taken to achieve target	Target date / trajectory	Accntbl./Rspnsbl. Officer for Action
				professional early enough.			
QUALITY							
Complaints response < 25 working days	**40%**	**62%**	80%	See Below	See Below		
N.B Nov'12 DATA				Performance has recovered slightly from October to November but still well below target. 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. Detailed action plan to reduce number of complaints has been developed and will be monitored by PEC. 3. 3/12 additional capacity provided to PALS and Complaints team to provide additional support to Divisions to manage backlog. 4. 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	Complete	Cassie Williams / Jennie Williams Div. Dirs. Ops.
Pressure Ulcers – Acute	**0**	**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	1. A performance managed programme of work is underway that will to embed change in practice 2. A pressure ulcer reduction strategy for the organisation is being implemented 3. There is a downward trajectory of grade 2, 3 and 4 pressure ulcers across the organisation	April 2013	Bronagh Scott

Month 9 – December 2012 Whittington Health Performance Dashboard Exception Report

Indicator	Dec'12	YTD	Target	Comment/ Description of issue	Actions planned/taken to achieve target	Target date / trajectory	Accntbl./Rspnsbl. Officer for Action
				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 for awareness raising and training about the prevention of pressure ulcers within the Trust.			
Friends & Family Test -	**0.1%**	**0.8%**	15%	See Below	See Below		
Emergency Department Coverage				The booth and handheld device have not been working but have now been repaired.	Devices now repaired Postcard designed for patients not wishing to use electronic devices	Complete End of Jan	Carol Gillen / Paula Mattin
Pressure Ulcers – Community	**2**	**43**	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
NATIONAL - COMMUNITY							
New Birth Visits Islington 14 Day	**Nov Isl: 87.3%;**	**Isl: 71.0%;**	95%	See Below	See Below		
Haringey 14 Day	**Nov Har: 78.6%**	**Har: 51.7%**	95%	See Below	See Below		
				The teams are containing to focus on and prioritise NBVs across Haringey and Islington. Performance is poorer where teams have higher vacancy rates and managers continue to support the training and recruitment of HVs. Work to improve communication with maternity services continues	1. The LEAN review has improved processes and we are working with 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	Complete	Sam Page

Month 9 – December 2012 Whittington Health Performance Dashboard Exception Report

Indicator	Dec'12	YTD	Target	Comment/ Description of issue	Actions planned/taken to achieve target	Target date / trajectory	Accntbl./Rspnsbl. Officer for Action
				alongside the development of better information flow.	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.		
LOCAL TARGETS							
Theatre Utilisation	**90.5 %**	**82.8%**	95%	See Below	See Below		
				Significant improvements made since last month and on track to meet target.	1. Review on new G Surgery rota being undertaken by Clinical Director for surgery to review theatre session provision 2. Urology job planning for 2012/13 to be revisited in order to review theatre allocation and usage 3. Orthopaedic day case lists to be reallocated and increased hip inpatient list to be provided following job planning review within orthopaedics.	Complete Complete Complete	5. Hasan Mukhtar 5. Matthew Boazman and Nick Harper 7. Graham Booth (agreed with David Sweetnam)
Acute DNA Rates - First	**13.9%**	**12.7%**	<8%	See Below	See Below		
- Follow Up	**14.3%**	**13.7%**	<8%	See Below	See Below		
				Maternity and Paediatric have a local policy due to safeguarding	1. Transforming Patient Experience key roles being proposed is the	March 2013	1. TPE project

Month 9 – December 2012 Whittington Health Performance Dashboard Exception Report

Indicator	Dec'12	YTD	Target	Comment/ Description of issue	Actions planned/taken to achieve target	Target date / trajectory	Accntbl./Rspnsbl. Officer for Action
				issues and therefore those who DNA are offered alternative appointments.	Patient Pathway Coordinator (PPC) aimed at improving patient communication, reducing patient handoffs between functions. Consultation for PPC gone out this week. – implementation in progress		
Hospital Cancellations (Follow ups)	**6.2%**	**6.7%**	<2%	See Below	See Below		
				A key issue is the management of clinics and it is expected that this will be improved through the new patient pathway coordinator role.	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 - complete	1. Complete 2. March 2013 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	.
SLA							
Acute Outpatients	**29% excess**	**29% exces**	<1%	See Below	See Below		

Month 9 – December 2012 Whittington Health Performance Dashboard Exception Report

Indicator	Dec'12	YTD	Target	Comment/ Description of issue	Actions planned/taken to achieve target	Target date / trajectory	Accntbl./Rspnsbl. Officer for Action
		S					
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. Discussions are also ongoing with CCGs regarding repatriation of certain diabetes patients, 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.	1. 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	1. Mar 2013	1. Fiona Smith

Month 9 – December 2012 Whittington Health Performance Dashboard Exception Report

DATA EXCEPTIONS / TARGETS IN DEVELOPMENT							
Indicator	**Dec 12**	**YTD**	**Target**	**Comment/ Description of issue**	**Actions planned/taken to achieve target**	**Target date / trajectory**	**Accntbl./Rspnsbl. Officer for Action**
MSK - % of patients completing their treatment on discharge	35%	39%	40%	After review of this target it was discovered that current data extraction process may be capturing incomplete data. Some clinicians may be stating completion within patient notes which cannot be analysed easily.	Suspend reporting of this target while an audit is carried out of a random sample of cases.	End of March 2013.	Fiona Yung

Whittington Health NHS

Performance Management Framework

Author/s:	Naser Turabi (Head of Performance)
Date written:	January 2012
Approved by:	Trust Operating Board
Date Approved:	7/1/13
Ratified by:	
Date Ratified:	
Date Policy becomes Live :	
Next due for revision:	January 2013
Target Audience:	All senior clinicians, managers and directors
Related Policies:	Board Escalation Framework Performance Development Framework

Document Version Numbering

Version No.	Updated by	Updated on	Description of changes
0.4	NT	Jan 2013	Updates following comments from AD Governance
0.5	NT	Jan 2013	Updated following discussion at TOB 7/1/13

Contents

1 Introduction

The purpose of this document is to describe and standardise the processes Whittington Health (WH) has put in place to ensure appropriate management of our performance against operational and strategic goals. These processes constitute the Trust's performance management framework which includes:

- Accountabilities and responsibilities for performance. (Section 2)
- How performance measures have been defined and how targets have been identified; (Section 3.1)
- How performance is monitored; (Section 3.2)
- How adverse performance is addressed; (Section 4)

In addition Section 5 describes key tactics that Whittington Health uses to promote excellent performance.

2 Roles, Reporting lines and Accountability

2.1 Roles of key committees and individuals

	Name	Role regarding Performance
Committees	Trust Board	(Monthly) Chaired by Trust Chair; overall responsibility for setting Trust Strategy and assures risks to delivery of strategy are mitigated.
	Quality Committee (Board Sub-committee)	(Monthly) Chaired by non-executive director; Delegated responsibility from Trust Board for oversight of quality (clinical effectiveness, safety and patient experience) performance by assuring risks to quality are mitigated
	Executive Committee (EC)	(Weekly) Chaired by CEO; EC is the executive management committee for the Trust; it delegates routine performance management to TOB
	Trust Operations Board (TOB)	(weekly) TOB is chaired by COO. TOB is responsible for identification of appropriate measures for inclusion on Trust Board Performance Report; approving target setting and detailed parameters for escalation; quality assuring action planning in response to adverse performance; performance can be discussed at any TOB meeting but one TOB per month is dedicated to performance (known as Performance Board, also chaired by COO) to provide dedicated time to performance issues; holds DirOps to account for their division's performance.
	Divisional Boards	(Monthly) Accountable to Trust Board via TOB and EC for divisional performance; Assures performance of division and sets divisional strategy; holds service line leaders to account.
	Divisional Management Meetings	(Weekly) place for routine performance management of service lines including problem solving and escalation to DirOps and divisional board
Individuals	Chief Operating Officer (COO)	Accountable to CEO for delivery of national KPIs, high quality patient experience, service transformation and cost improvement plans. Chair of TOB.
	Head of Performance	On behalf of COO responsible for ensuring appropriate systems are in place for managing performance; coordinating response to adverse performance
	Divisional Directors (Clinical)	Jointly accountable with Divisional Directors of Operations to COO for performance of division; chair of Divisional Boards
	Divisional Directors of Operations	Jointly accountable with Divisional Directors to COO for performance of division
	Service Line Leaders	Accountable to Divisional Boards for their area's performance. Reflecting the diverse nature of WH, service lines are in some cases led by an operational manager and a clinical director; in other cases by one person who combines both roles.

2.2 Meetings structure

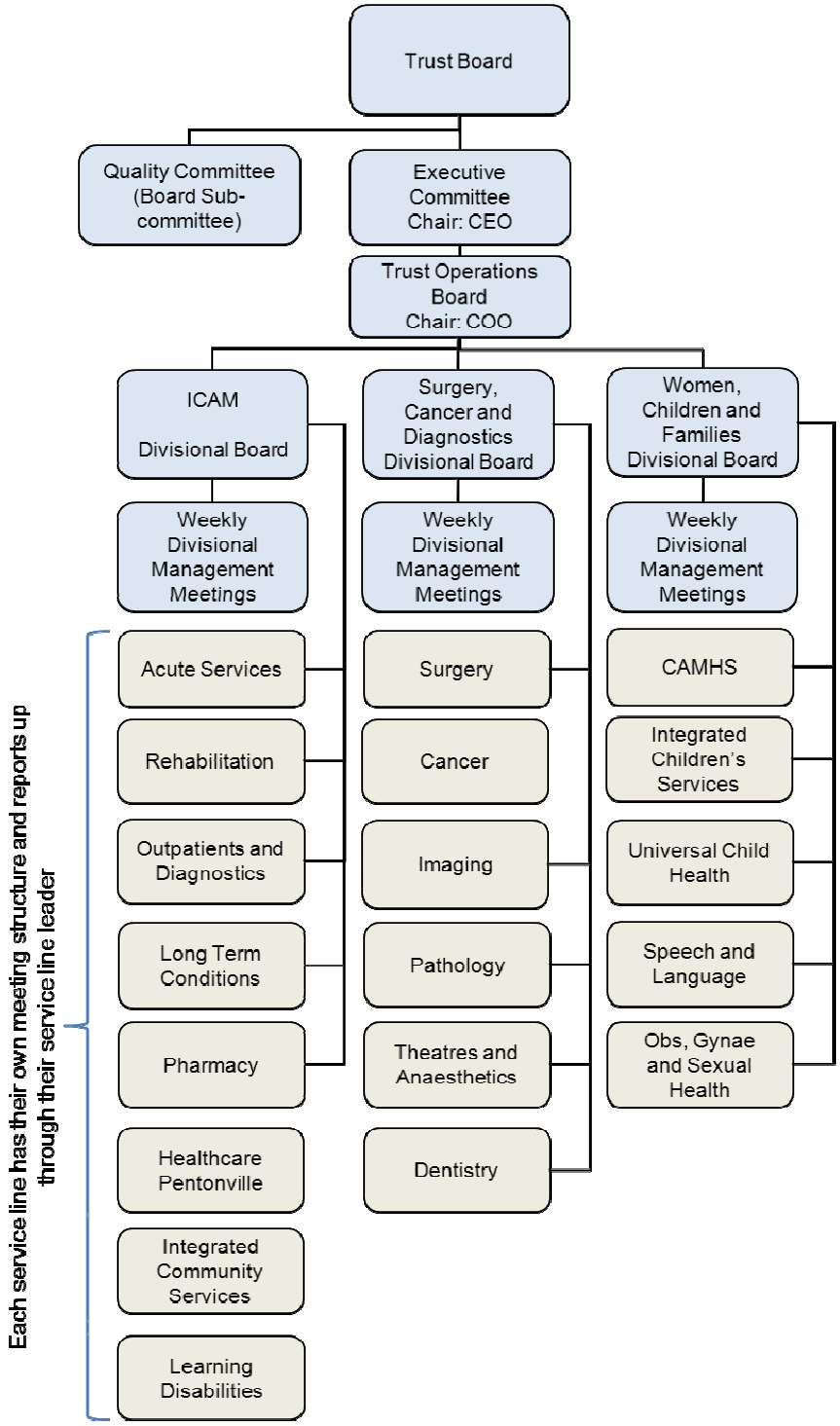

Figure 1: Business units and related meeting structures

- Divisional Boards escalate performance issues to the Trust Board via Executive Committee (which delegates responsibility for performance to Trust Operating Board).
- Weekly divisional management meetings focus on day to day operations and performance
- Each service line has its own meeting structure that reports via the service line leader to divisional board.

2.3 Individual reporting lines

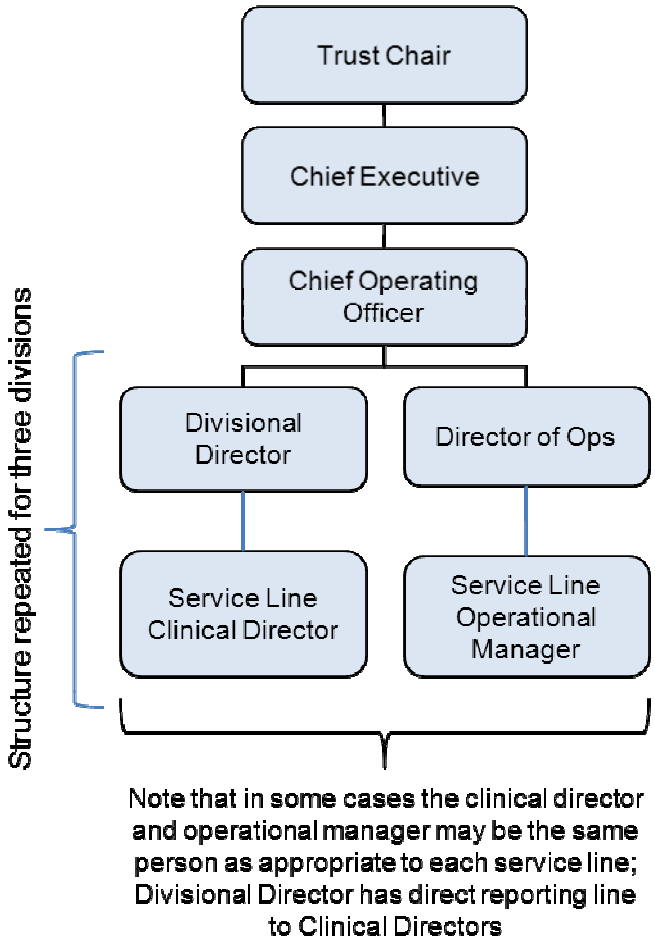

Figure 2: Individual reporting lines

- COO is accountable for performance of all three divisions and reports to Chief Exec and Board (as a Board Executive Director)
- Divisional Directors (who are clinical) and Directors of Operations have joint responsibility for the performance of their divisions and both report to the COO
- Service line leaders have devolved responsibility for delivering high performance for their department/s.

3 Setting standards and monitoring performance[1]

3.1 Defining indicators, metrics and targets

Trust Operating Board, with delegated authority from Executive Committee, has overall responsibility for ensuring that appropriate performance measures are in place.

In addition the Trust Board and the Quality Sub-Committee of the Trust Board has the power to recommend performance measures.

There are two main sources for the identification of appropriate performance measures:

- **Externally mandated or agreed indicators**: All national (e.g. with DH) or locally (e.g. with commissioners) mandated metrics will form part of the trust's performance framework – external targets will constitute a minimum standard.
- **Internally set performance metrics**: in order to manage the achievement of strategic goals, WH will put in place performance metrics. In many cases these will be set (usually with a trajectory)

Standards are expressed through targets that are approved by TOB (though may be proposed by relevant senior managers or committees). External targets will constitute a minimum standard. Where performance is below the standard required, a trajectory will be defined by the relevant committee for that domain with oversight from TOB (see section 4).

[1] An ongoing programme of work to renew performance management information is currently being implemented. The plan will split out divisional dashboards according to service lines and implement new domain specific reports as required. This constitutes a reorganisation of existing reporting to better align with accountability along service lines.

3.2 Information for performance management

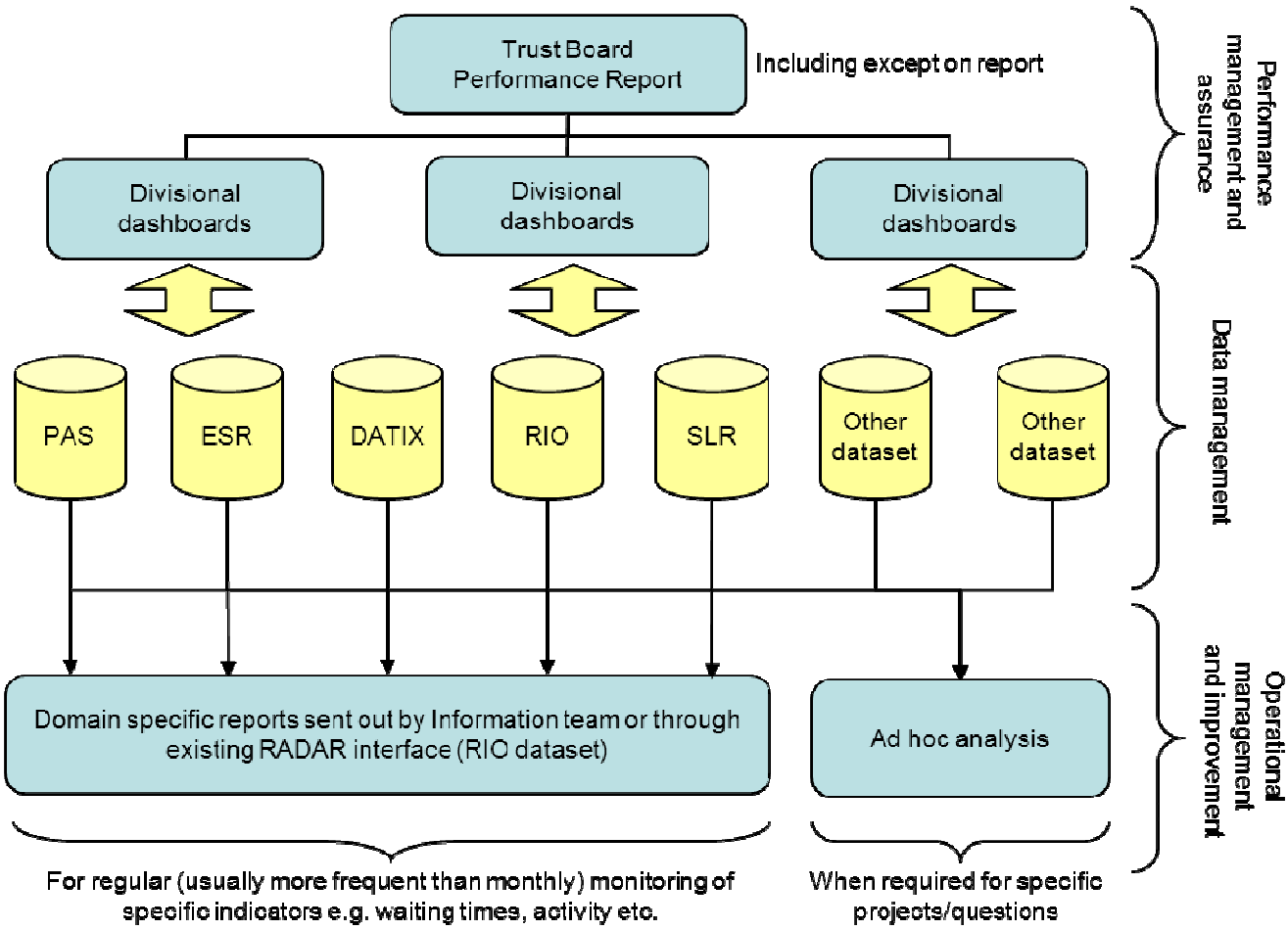

Figure 3: Management information for performance

The diagram above shows the core information tools for performance monitoring at WH. These are:

- **Trust Board Performance Report** (Monthly) (has in past been known as Trust Board Dashboard) – discussed at Trust Board, Quality Committee, TOB and Performance Board
- **Divisional Dashboard** (Monthly) – Discussed at divisional board
- **Domain Specific reports** (frequency varies) e.g. 18 weeks waiting list, ED Quality reports – discussed at various performance related meetings
- **Ad Hoc Analysis** (as required) – when relevant to specific discussions

The Trust Board Performance Report is the top level report. All indicators represented on the Trust Board Performance Report are included on the Divisional Dashboard to ensure vertical coherence i.e. satisfactory performance in divisional dashboards will lead to satisfactory performance on Trust Board Performance Report.

In addition there are further indicators on the Divisional Dashboards to enable more detailed oversight by divisional boards.

All reports contain data for the most recent month available. The Divisional Dashboards and Trust Board Performance Report are produced within 10 days of month end.

4 Responding to adverse performance

4.1 Prioritising focus for remedial actions

The Trust uses a red/amber/green system to facilitate the appropriate prioritisation and escalation of performance issues. Broadly these are defined as:

- **Green**: meeting target with little/no risk of missing target in subsequent periods
- **Amber**: At risk of missing target in subsequent periods/ or missing target but on agreed performance improvement trajectory
- **Red**: Missing target

Performance according to these traffic lights is reviewed at TOB/Performance Board, and Divisional Boards.

The calibration of red/amber/green status for specific performance measures is proposed by relevant senior managers or committees and approved by TOB as part of the target setting process (see 3.1).

4.2 Remedial actions

The core process for identifying poor performance and implementing remedial action uses the Trust Board Performance Report as the key tool for highlighting poor performance.

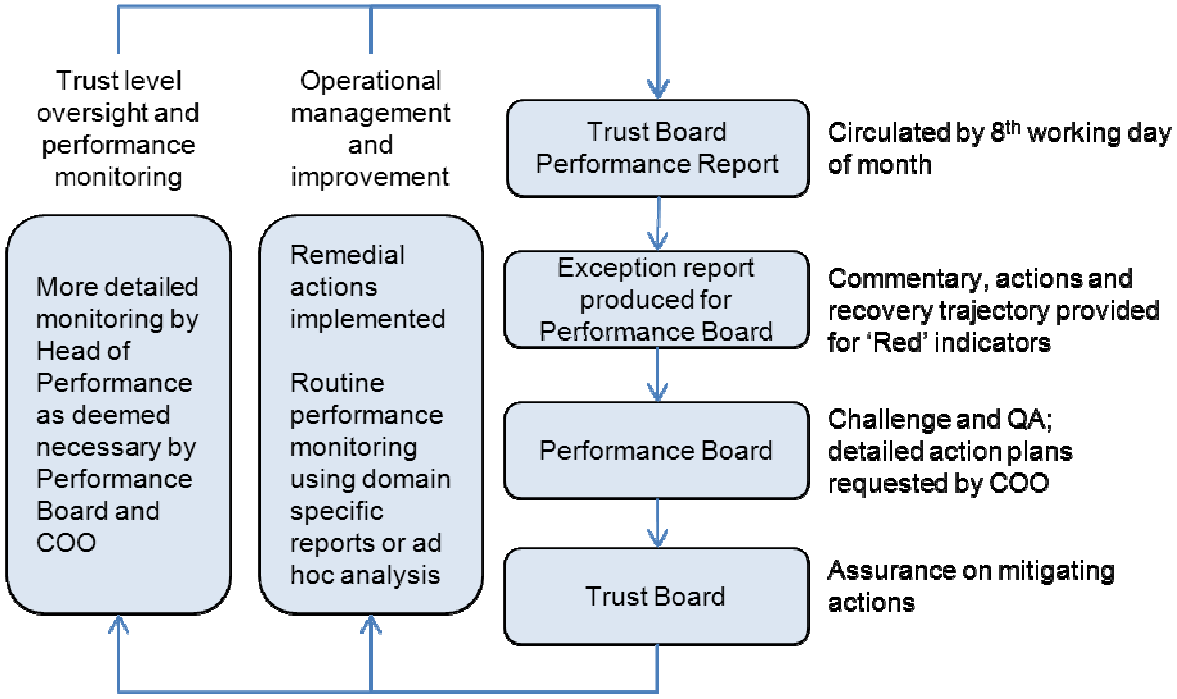

Figure 4: Process for highlighting poor performance and implementing remedial actions

The process described in Figure 4 describes the failsafe mechanism for managing performance. In addition, rapid action outside the monthly is taken to address performance issues if and when they arise.

4.2.1 Procedure for 'Red' performance

Performance on any indicator that is 'red' on the Trust Board Performance Report requires either:

- An **exception report** to be submitted as part of the Trust Board Performance Exception Report, stating the reasons for poor performance, remedial actions and trajectory for recovery, or
- An **action plan** – this is a more detailed submission to the COO when performance is considered a major risk to achieving strategic goals. The COO may institute meetings about specific topics with Divisional Director and/or Dir Ops about specific performance issues. All action plans must include a trajectory for improvement and designate review points.

'Reds' are discussed at TOB prior to Trust Board to decide whether they require commentary or action plan. TOB signs off action plans before escalation to Trust Board.

‘Red’ performance issues must be considered when developing and updating divisional risk registers.

Divisional Directors and Directors of Operations are held to account for ‘red’ performance at TOB/Performance Board.

For areas of persistent under performance, measures may be put in place by the COO for targeted improvement, usually implemented by the Head of Performance.

4.2.2 Procedure for ‘Amber’ performance

‘Amber’ performance denotes areas where there is risk of not meeting the target in the future. In some exceptional cases, specifically agreed by TOB, some indicators may be marked amber if they are missing the target but performance is on agreed improvement trajectory.

An amber rating will be managed using the red process if decided at TOB/Performance Board at the discretion of the COO.

Amber indicators will be performance managed using the same process as for ‘red’ indicators if a significant sub set of any indicator is performing at ‘red’ level.

4.2.3 Performance not reported on Trust Performance report

Some indicators are not reported directly in the Trust Board Performance report. Divisional Dashboards include all relevant indicators from the Trust Board Performance report but also contain a subset that is not included.

Where poor performance is highlighted on divisional dashboards (or team or service line performance reports), Divisional Boards have a responsibility to highlight to COO and/or Head of Performance directly.

5 Promoting excellent performance

This section describes proactive measures to ensure good performance.

5.1 Removing barriers to good performance

In complex organisations like Whittington Health a common problem is 'fire fighting' i.e. focusing on addressing urgent problems at the expense of addressing underlying drivers of poor performance.

WH works to avoid this by focusing on three key priorities in each 12 month planning period (as agreed by Trust Operating Board), in order to resolve underlying drivers of poor performance.

The purpose of this is to commit resources to solving problems and use a programme and project management approach to ensure that work is completed to a high standard. Examples of areas of focus include:

- Waiting list management
- Management information
- Workforce training and appraisals

5.2 Linking personal to organisational performance

Whittington Health's approach to staff development aims to ensure that personal objectives are consistently and explicitly aligned to organisational key performance indicators. Through the planned renewal of the Performance Development Framework (led by HR), WH will ensure that achievement of agreed personal objectives will result in achievement of excellent organisational performance.