Month 10 – January 2013 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	Jan 13	YTD	Target	Comment/ Description of issue	Actions planned/taken to achieve target	Target date / trajectory	Accntbl./Rspnsbl. Officer for Action
WORKFORCE							
Sickness	**3.0%**	**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.	**On-going**	1. Paul Campbell 2. Mary Jamal
Appraisal	**45%**	**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 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	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 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	End of Jan Ongoing Ongoing Complete Ongoing Complete	Div. Dirs. Operations Charlotte Johnson 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.	1. An e-learning suite of PCs has been opened fr any member of	All ongoing	Paul Campbell

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					staff to use at Crouch End and		
				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.	2. Weekly information is made available to all staff and managers 3. All managers have been asked to ensure they are rostering training time for staff 4. 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 Development bulletin. 7 directorates are now over 90%. 5. Special evening and night time training for facilities staff. 6. Team level management of Mandatory Training recording with individual staff follow up. Monitoring at monthly management meetings and in 1:1s		Phil Ient
				Information Governance: 2. IG Training at 95% is a condition of level 2 of the Information Governance Toiolkit which is a prerequisite for achieving FT status. The deadline for achieving this is 28th March.	1. For those staff who are unable to complete their refresher Information Governance training on-line, a programme of face to face training will be rolled out from the 19th February. The programme will cover 14 days with over 80 sessions (approximately 30 minutes per session) targeting employees who are out of compliance or will be out of compliance by 31st March. Publicity about these sessions will be publicised	End of March	Dir Ops and Charlotte Johnson

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					through CEO briefing; Whittington Bulletin; screen savers; Learning and Development bulletin. 2. Line managers are being provided with lists of staff whose training is due.		
NATIONAL TARGETS							
Patients in ED for < 4 hours	**94.5%**	**94.97 %**	95%	See Below	See Below		
				Performance continued to be poor for the first two weeks of January. High acuity and specific periods (lasting hours) of high volumes. We did not meet the target for January and YTD performance at 18th Feb is 94.92%. 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	Ongoing Ongoing Ongoing Complete	Carol Gillen (Dir Ops – ICAM

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					grade doctor support for rapid assessment.		
Diagnostic Waiting Times	**93.8%**	**99.3%**	99%				
(% of pts waiting within 6 week standard for routine elective diagnostics)				Diagnostic waits are made up of fourteen specialties. Patients have been experiencing long waits in endoscopy which accounts for three of those specialties.	Extra administrative staff have been recruited or transferred into the department to ensure patients are booked quickly. Extra clinical capacity has been arranged to ensure reduction in waiting times to		
Cancer – 14 day 1st OP (Dec)	**90.1%**	**92.4%**	93%				
				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	- 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	End of March 18/1/13 End of Jan Complete	Mary Jamal Naser Turabi Marie Kernec Mark Rose

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				- 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.	provide more stringent standard for consultant grading - Pathway for Urology updated to ensure all pts seen within 2 weeks.	End March End of March Complete End of March	Lee Martin Mary Jamal Marie Kernac
Cancer – 14 day breast (Nov)	**87.2%**	**89.8%**	93%	See Below	See Below		
				- 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.	Complete Complete Complete 18/1/13 End of Jan	Mark Rose

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					- To liaise with local GP practices to ensure GPs are referring breast symptomatic patients with appropriate information.	TBC	TBC
% of Inpatients with Delayed Transfer of Care	**3.7%**	**2.2%**	<3.5%				
				- Primary reason for increase was the large number of patients awaiting further non-acute NHS care (rehabilitation, intermediate care or step down) and lack of available beds. This was across the five main boroughs the Trust takes patients from. - Other main reasons were placement in a care home (identifying a home and waiting for the home to assess) and - Family choice (largely related to identifying a care home or suitable placement)	- Embedded 3 x weekly Waits Escalation Meeting (matrons from all areas bring DTOCs or potential delays/internal waits and actions to resolve are agreed). This includes an escalation process to senior managers or directors, and externally. Standard Operating Procedure for this currently being completed. - Investigated purchase of additional beds at St. Pancras (for step down awaiting rehab) was not possible currently. - Review of patients in Islington Intermediate Care beds brought forward discharge date where possible - to release capacity. - Social worker proactively working to ensure no delays in discharge from St. Pancras rehabilitation beds. - Have changed process in Islington to start identifying suitable care homes for family to look at earlier in the discharge pathway.	End of Feb Complete End of Fev Ongoing Complete	Carol Gillen / Delia Thomas
Pregnant women seen	**86.6%**	**89.4%**	90%				

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within 12 wks and 6 days							
				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 professional early enough. In January there were a large number of bookings (100 above average). Excluding patient choice and DNA, there was only one delayed booking that was direct responsibility of WH.	1. There is a report now split by team established to support minimisation of delay in bookings.	January 2012	Dee Hackett / Claire O'Connor
QUALITY							
Complaints response < 25 working days	**33.3%**	**60.1%**	80%	See Below	See Below		
N.B Dec 12 DATA				Performance has dropped again between November and December and is 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.
MRSA Bacteraemia Cases	**1**	**2**	1/yr				

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							Bronagh Scott
Pressure Ulcers – Acute	**1**	**9**	3/yr	See Below	See Below		
GRADE3-4				Target based on 80% reduction from 2010/11 baseline Target has been exceeded as increased awareness and reporting within community teams From Q1 2012 all completed RCAs have been reported to the Serious Incident Executive Approval Group for agreement before submission to NHS London. The Pressure Ulcer Serious Incident Panel (PUSIP), chaired by the Deputy Director of Nursing and Patient Experience reviews trends and also oversees the action plans for all completed RCAs in order to gain assurance that issues are addressed and actions completed. The panel also considers initiatives for awareness raising and training about the prevention of pressure ulcers within the Trust.	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
Friends & Family Test -	**1.1%**	**0.9%**	15%	See Below	See Below		
Emergency Department Coverage				Significant increase in February expected as there had been an issue with the devices not uploading their locally held data.	Team of volunteers assisting staff and patients to deliver handhelds 20,000 postcards for people who do not like using electronic devices, then inputted afterwards Target for for all ED clinical decision makers to take at 5 people to booth each day.	Complete End of Jan	Carol Gillen / Paula Mattin
Pressure Ulcers –	**6**	**49**	21/yr	See Below	See Below		

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Community							
GRADE 3-4				Target based on a 30% reduction from 2011/12 baseline As Acute above	As Acute above	April 2013	Bronagh Scott
Diabetes	**52.2%**	**65.3%**	60%				
% of patients with at least a 1% reduction in HbA1c after 6 months				• From December not only Haringey discharges were included but also patients that were referred to service 6 months prior. • Some patients have a lower starting Hba1c therefore aim is not to reduce Hba1c by 1% in these cases • Islington - traditionally only collects data on patients that were referred 6 months prior. In July 2012 (6 months prior) majority of referral were inappropriate for IDS therefore discharged making the audit group smaller - 3 patients in Islington and 18 in Haringey	• Highlighting in report possible reasons why HbA1c has not reduced by 1% • Possibly including discharges in Islington data set but also what implications this will have on workload	End of Feb	Fiona Yung
Diabetes	**70.0%**	**84.5%**					
% of patients reporting confidence in managing their condition				• Small cohort of patients included - 5 each from Haringey and Islington	• Team recently trained in using ADP skills especially confidence in consultation and re-assessment in discharge • Reviewing whether it is appropriate and possible to increase the cohort of patients	End of Feb	Shantell Naidu
MSK	**33.1%**	**39.1%**	40%				
% of patients completing their treatment on discharge				• Issue identified where not all outcome data is captured in a way that can be extracted automatically.	• Audit of patient notes to assess real impact	End of April	Fiona Yung
NATIONAL - COMMUNITY							

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New Birth Visits Islington 14 Day (Dec)	**Isl: 89.1%;**	**Isl: 71.9%;**	95%	See Below	See Below		
Haringey 14 Day (Dec)	**Har:91.7 %**	**Har: 55.3%**	95%	See Below	See Below		
				Continued improvement across Haringey and Islington due to improved information flow and re-focus of work on early intervention.	To monitor potential impact on child protection work through audit of practice and multi-agency working.	Ongoing	Sam Page
LOCAL TARGETS							
Theatre Utilisation	**83.2%**	**82.8%**	95%	See Below	See Below		
				Drop in performance Dec to Jan.	1. Review on new General 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	Hasan Mukhtar Matthew Boazman and Nick Harper Graham Booth (agreed with David Sweetnam)
Acute DNA Rates - First	**15.2%**	**14.6%**	<8%	See Below	See Below		
- Follow Up	**15.4%**	**15.8%**	<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. Transforming Patient Experience Patient Pathway Coordinator (PPC) aimed at improving patient communication, reducing patient handoffs between functions. implementation in progress 2. All PPC post now in place, jobs are starting at the end of March 2013. Reviewing pathway	April 2013	1. TPE project

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					process already done with prospective PPC, meeting every week. 3. Paeds pilot of text messaging in Allergy clinic and epilepsy successful reduced DNA by, now rolled out to all clinics.		
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. Transforming Patient Experience Patient Pathway Coordinator (PPC) aimed at improving patient communication, reducing patient handoffs between functions. implementation in progress	April 2013	2. TPE project
SLA							
Acute Outpatients	**24.9% excess**	**27.6% 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. 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