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Magdala Avenue
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Whittington Health Trust Board

24 April 2013

Title:	Month 12 Performance and exception report		
Agenda item:	**13/060**	**Paper**	**6**
Action requested:	For Trust Board to note performance		
Executive Summary:	**<u>Selected areas of success</u>** **Smoking Advice CQUIN** – the target for Q4 to date has been exceeded and the practice of offering smoking advice is becoming embedded in hospital care. **Safety Thermometer** – acute and community implementation has been 100% for the last two months. **Community Clinical Effectiveness** – of the 15 outcome measures reported, 13 have met their targets for year. **Acute Quality** – MRSA screening, VTE assessment and prophylaxis are all meeting targets; we have lower than expected C. Diff cases. **Inpatient Friends and Family Score** – we report high coverage (23%) and a high March score (58 in a range of -100 to +100) for our inpatient wards. **<u>Areas that are improving</u>** **ED Access** - After a series of high performing weeks the emergency department met the 95% target for four hour waits in March and for the whole of 2012/13. This is in the context of low performance across London as a whole. However challenges remain as ED continues to experience high attendances. **Appraisal rates** – though still below target, there has been marked improvement from 56% to 71% in one month – we expect to achieve 90% by the end of June. **New Birth Visits within 14 days** – these have been sustained above or around 80% since August following intensive recruitment and process improvement work. **Waiting times for Suspected Cancer**– performance against the 2 week wait target has been improving. Most patients who wait longer are choosing to wait beyond two weeks though this appears to have been improved by new scripts and training for booking staff. In addition we are implementing a plan to improve processes throughout our waiting list management (see below) **Community Physiotherapy Waits** – all patients who had been waiting a long time for an appointment have now been sent a letter offering them an appointment and additional capacity has been provided to get them seen quickly – backlog to be cleared by end of		

	July. **Mandatory Training** – we are steadily improving though still need to work to achieve 90% target (currently 84%) - expected by end of May. **<u>Focus areas for action</u>** **Referral to Treatment Waiting times** – we are in the process of reducing waiting times within endoscopy and are on schedule to complete this by the end of May. An integrated plan is being developed to deliver the objectives of the Patient Access Improvement Programme, responses to Intensive Support Team feedback, and present action plans. **Community waiting times** – Physiotherapy waits have been an issue and are improving (see above). We also need to assess how we can deliver reporting and managing against Referral to Treatment Standards which is mandated from April 2014. A review will be undertaken and an action plan developed with regard to access to community services. **Complaints response times** – these are still too long and we have been training more people to respond to complaints and diverting resources so that complex complaints are handled more quickly. A new operational manager in ED will help this effort.
Summary of recommendations:	For Trust Board to note performance
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.
Date paper completed:	15th April 2013

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

Whittington Health Integrated Dashboard - April 2013 (March 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 February 2013, 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	Jan	Feb	Mar	YTD	Trend
Workforce	Vacancy Rates	**<12%**	14.2%	11.7%	12.6%	11.7%	12.6%	11.1%	11.1%	11.3%	11.7%	11.7%	12.1%	11.7%	12.0%	↑
	Sickness Absence	**<3%**	2.8%	3.2%	3.1%	3.1%	2.8%	3.1%	3.5%	3.3%	3.2%	3.2%	3.2%	2.9%	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%	1.2%	1.2%	1.1%	1.2%	↑
	Turnover	**<13% [2]**	10.1%	8.9%	11.2%	11.1%	11.0%	10.8%	10.9%	11.0%	10.8%	10.9%	10.9%	10.4%	10.7%	↑
	Staff in post	**-**	3662	3644	3606	3642	3607	3655	3651	3637	3640	3647	3621	3638	3638	
	Stability Level	**>80%**	80.3%	83.8%	82.9%	83.4%	83.7%	83.6%	83.2%	86.9%	83.1%	87.1%	83.1%	84.0%	83.8%	↑
	Appraisals recorded on ESR	**90%**	-	-	20%	20%	19%	20%	26%	29%	34%	45%	56%	71%	71%	↑
	Number of case of bullying & harassment (cumulative)	**0**	1	1	1	1	1	3	3	4	4	5	6	6	6	→
	% of qualified to unqualified staff (nurses)	**70%**	77/23	76.0%	76.0%	77.0%	79.0%	79.0%	80.0%	80.0%	80.0%	79.0%	79.0%	79.0%	79.0%	→
	Mandatory Training Compliance	**90% by Dec**	69%	69%	67%	68%	69%	70%	74%	79%	84%	84%	83%	84%	83.0%	↑
	No. of staff activated on ESR		6	638	652	665	680	687	698	711	724	731	742	754	754	↑

[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] Agreed change from <10% to <13% at January Trust Board

Whittington Health Integrated Dashboard - April 2013 (March 2012 Data)

NATIONAL INDICATORS - ACUTE SERVICES

Domain	Indicator	Target	Apr	May	June	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	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%	95.4%	94.9%	94.5%	95.8%	95.7%	95.2%	↓
18 Weeks RTT	Referral to Treatment - Admitted	**90%**	93.1%	92.8%	92.6%	92.5%	90.0%	90.3%	90.2%	90.3%	91.4%	91.8%	91.0%	88.2%	91.2%	↓
	Referral to Treatment - Non Admitted	**95%**	98.8%	98.8%	99.3%	99.0%	99.1%	98.4%	98.4%	98.7%	97.8%	98.1%	99.1%	97.9%	98.6%	↓
	Referral to Treatment - Incomplete	**92%**	91.7%	96.2%	96.5%	95.5%	95.2%	92.8%	92.7%	93.5%	92.2%	92.5%	92.4%	92.5%	93.6%	↑
	Diagnostic Waiting Times	**99%**	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	99.5%	99.8%	93.8%	93.3%	94.4%	98.4%	↑
Cancer Access	14 days GP referrals - 1st Outpatients - **[1]**	**93%**	91.7%	93.6%	92.9%	92.6%	93.3%	92.2%	92.4%	92.7%	90.1%	84.8%	88.5%		91.4%	↑
	14 days GP referrals - Breast symptoms **- [1]**	**93%**	95.6%	97.7%	90.7%	86.2%	94.3%	87.8%	87.1%	85.8%	87.2%	79.7%	93.1%		89.0%	↑
	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%	100.0%	100.0%		100.0%	→
	31 days to Second or Subsequent Treatment (surgery) **- [1],[2]**	**94%**	-	-	-	-	-	-	100.0%	100.0%	100.0%	100.0%	100.0%		100.0%	→
	31 days to Second or Subsequent Treatment (drugs) **- [1],[2]**	**98%**	-	-	-	-	-	100.0%	100.0%	100.0%	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%	77.8%	93.9%	87.0%	92.0%	90.9%		86.5%	↓
	62 days Wait First Treatment from Cancer Screening - **[1]**	**90%**	-	-	100.0%	100.0%	100.0%	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%	87.5%	100.0%	91.7%	76.5%	85.7%	100.0%	81.8%	90.8%	↓
	Fractured Neck of Femur operated within <48 hours	**85%**	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	91.7%	88.2%	92.9%	100.0%	90.9%	96.5%	↓
Cancelled Operations	Cancelled Operations as percentage of elective admissions	**<0.8%**	0.0%	0.1%	0.2%	0.3%	0.5%	1.4%	1.2%	1.5%	0.5%	0.7%	1.2%	0.9%	0.7%	↑
	Cancelled Operations not rescheduled within 28 days	**0**	0	0	0	0	0	0	1	0	0	0	1	0	2	↑
Single Sex Accomm.	Single Sex Accommodation Breaches	**0**	0	0	0	0	0	0	0	0	0	0	0	0	0	→
Transfer of Care	% of Inpatients with Delayed Transfer of Care	**<3.5%**	2.3%	1.2%	1.7%	2.0%	1.7%	3.5%	1.5%	2.1%	2.2%	3.7%	3.4%	2.5%	2.3%	↑
Diagnostics	Cervical Cytology turnaround times within 14 days **[3]**	**98%**	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		100.0%	→
Maternity	% of women seen by HCP or midwife within 12 weeks and 6 days	**90%**	88.3%	88.9%	87.9%	90.8%	89.4%	94.7%	88.2%	90.1%	90.6%	86.6%	85.8%	92.0%	89.8%	↑
	1:1 care in established labour	**100%**	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	95.0%	99.5%	↓
	Breast Feeding at Birth	**90%**	90.0%	92.0%	92.0%	90.0%	88.0%	92.0%	93.0%	92.0%	93.0%	90.0%	92.0%	92.0%	92.0%	→
	Smoking during pregnancy at time of delivery	**<17%**	6.0%	8.0%	5.0%	6.0%	8.0%	8.0%	8.0%	6.0%	7.0%	8.0%	8.0%	8.0%	7.0%	→

[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 - April 2013 (March 2012 Data)

QUALITY INDICATORS - INTEGRATED CARE ORGANISATION

Domain	Indicator	Target	Apr	May	June	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	YTD	Trend
Incident Reporting	Number of Serious Incidents	**n/a**	17	11	16	16	8	12	17	5	8	9	10	5	134	↑
	Timeliness of external SI Report submission	**Green**	**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	4.0	3.8	4.0	3.7	3.6	↑
	Number of Falls - **[2]**	**[2]**	35	20	25	26	23	27	26	33	30	39	22	30	336	↓
	Number of Falls Causing Severe Harm - **[2]**	**[2]**	0	0	0	1	0	0	0	0	1	0	1	0	3	↑
	Never Events	**0**	0	2	0	0	0	0	1	0	0	0	0	0	3	→
Clinical Effectiveness	Safety Alerts Compliance	**100%**	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%		100%	→
Patient Experience	Complaints Received	**n/a**	50	62	37	59	49	39	46	37	24	41	54	34	532	↑
	Complaints Responded to within specified timeframe **[3]**	**80%**	82.0%	66.1%	86.5%	62.7%	65.3%	64.1%	26.1%	40.5%	33.3%	51.2%	37.0%		57.0%	↓

QUALITY INDICATORS - ACUTE SERVICES

Domain	Indicator	Target	Apr	May	June	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	YTD	Trend
Infection Prevention	MRSA Bacteraemia Cases	**1 (year)**	1	0	0	0	0	0	0	0	0	1	0	0	2	→
& Control	C.DIFF Cases	**21 (year)**	1	1	0	1	2	1	1	2	2	0	2	2	15	→
	E Coli Cases	**[2]**	1	1	1	1	1	1	2	1	2	1	4	2	18	↑
	MSSA Bacteraemia Cases	**[2]**	0	0	1	0	0	0	0	0	0	0	0	1	2	↓
	MRSA Screening - Elective Patients **[4]**	**95%**	98.5%	96.7%	95.8%	96.4%	95.4%	96.8%	92.9%	96.6%	100.0%	97.6%	97.0%		96.7%	↓
	Hand Hygiene Audit	**95%**	97.4%	97.4%	97.4%	97.4%	97.4%	97.4%	97.4%	97.4%	97.4%	97.4%	97.4%	99.2%	98.4%	↑
Incident Reporting	Pressure Ulcers - grade 3/4 (80% reduction from 2010/11 baseline)	**3/yr**	1	2	1	0	1	1	2	0	0	1	1	1	11	→
	VTE Assessment **[4]**	**95%**	95.4%	95.1%	96.7%	95.3%	95.6%	95.8%	95.1%	97.1%	95.0%	96.2%	95.0%		95.7%	↓
	VTE Incidence - Hospital Acquired **[4]**	**[2]**	4	1	4	4	1	3	**Audit required**						17	↓
	Appropriate Prophylaxis for VTE **[4]**	**90%**	82.8%	65.8%	94.3%	95.1%	99.2%	98.5%	94.4%	93.4%	97.8%	100.0%	92.1%		90.3%	↓
	Post Operative Sepsis **[5]**	**AE**	0	0	1	0	0	0	0	0	0	0			1	→
	Post Operative Sepsis - Hips **[5]**	**AE**	0	0	0	0	0	0	0	0	0	0			0	→
	Post Operative Sepsis - Knees **[5]**	**AE**	0	0	1	0	0	0	0	0	0	0			1	→
	Deaths After Surgery **[5]**	**AE**	1	1	2	0	0	3	1	0	0	0			8	→
	Deaths in Low Risk Conditions **[5]**	**AE**	0	0	2	1	0	3	1	0	0	0			7	→
	Deaths After Bariatric Surgery **[5]**	**AE**	0	0	0	0	0	0	0	0	0	0			0	→
	Hospital Level Mortality Indicator - Summary **[5]**	**<100**	81.0	80.8	91.0	80.5	74.0	62.6	58.5	66.5	72.3	62.3			72.1	↑
Clinical Effectiveness [7]	Emergency Admission Rate for LTC	**[6]**	152	149	127	157	141	172	187	166	147	154	120		1672	↑
	Emergency Admission Rate Paediatric (asthma, epilepsy, diabetes)	**[6]**	10	15	7	27	10	17	14	12	6	16	21		155	↓
	Emergency Admission for VTE	**[6]**	2	6	8	8	9	19	9	7	5	6	9		88	↓
Patient Experience [8]	Friends & Family Test - Inpatient Coverage	**15%**	**New measure from November 2012**							12%	10%	14%	15%	23%	16%	↑
	Friends & Family Test - Inpatient Response (Net Promoter Score)	**[7]**	**New measure from November 2012**							57	57	61	62	58	56	↑
	Friends & Family Test - Emergency Department Coverage	**15%**	**New measure from November 2012**							2%	1%	3%	5%	2%	3%	↓
	Friends & Family Test - Emergency Department Response (Net Promoter Score)	**[7]**	**New measure from November 2012**							-2	16	-13	9	16	4	↓
PTO FOR NOTES	Cleanliness Audit	**>95%**	96.1%	97.1%	97.1%		98.1%		97.3%	96.7%	96.7%	97.8%	97.9%		97.2%	↓

Whittington Health Integrated Dashboard - April 2013 (March 2012 Data)

QUALITY INDICATORS - COMMUNITY SERVICES

Domain	Indicator	Target	Apr	May	June	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	YTD	Trend
Infection Prevention & Control	Dentistry Compliance with Infection Control Standard	**90%**	95%			96%			95%			97%			96%	↑
Incident Reporting	Pressure Ulcers - grade 3/4 (30% reduction from 2011/12 baseline)	**21/yr**	5	6	6	7	7	3	6	6	4	5	6	4	65	↓
Patient Experience	Friends & Family Test (Net Promoter Score) **[8]**	**[8]**	**Under development**													→
	Dentistry - Patient Involvement	**90%**	90%	95%	92%	90%	98%	95%	88%	87%	98%	94%	91%	88%	92%	↓
	Dentistry - Patient Experience	**90%**	97%	90%	100%	98%	100%	100%	100%	95%	98%	97%	97%	93%	97%	↓
Clinical Effectiveness	Respiratory - number of admissions avoided	**25 / Qtr**	9	3	3	18	13	8	8	9	12	14	11	17	125	↑
	Diabetes - % of patients with at least a 1% reduction in HbA1c after 6 months	**60%**	57.0%	83.0%	42.0%	80.0%	80.0%	68.8%	61.0%	65.0%	63.6%	52.2%	68.2%	50.0%	64%	↓
	Diabetes - % of patients reporting confidence in managing their condition	**85%**	100.0%	60.0%	100.0%	100.0%	71.0%	72.7%	100.0%	90.0%	80.9%	70.0%	50.0%	92.9%	82%	↑
	Heart Failure / Cardiology - % of patients on optimum Ace Therapy	**80%**	90.0%	90.0%	88.0%	90.0%	86.0%	85.0%	89.0%	83.0%	83.0%	85.8%	84.8%	84.9%	87%	↑
	Heart Failure / Cardiology - % of patients on optimum Beta Blocker Therapy	**80%**	85.0%	83.0%	84.0%	87.0%	86.0%	85.0%	85.0%	80.0%	83.0%	84.9%	83.3%	82.5%	84%	↓
	Rehab Intermediate Care - % of patients with self-directed goals set	**70%**	60.0%	75.0%	60.0%	71.0%	78.0%	73.0%	77.0%	74.1%	70.0%	71.4%	64.6%	73.3%	71%	↑
	Rehab Intermediate Care - % of patients with improved or maintained function	**70%**	75.0%	71.0%	67.0%	76.0%	80.0%	77.0%	90.0%	80.5%	90.8%	86.7%	88.1%	92.7%	81%	↑
	MSK - % of patients who have completed the Patient Specific Functional Scale	**40%**	1.7%	13.4%	14.3%	26.9%	47.3%	62.6%	45.1%	57.1%	63.2%	66.7%	54.5%	68.3%	43%	↑
	MSK - % of patients completing their treatment on discharge	**40%**	48.0%	48.4%	37.8%	37.2%	38.3%	38.7%	39.5%	34.9%	35.3%	33.1%	23.7%	37.6%	38%	↑
	CAMHS - % of Cases where mental health problems resolved or improved	**60%**	73%			71%			67%			Q			70%	↑
	CAMHS - % of Cases where severity of mental health at end of treatment is normal	**80%**	89%			87%			87%			Q			88%	↑
	% of new patients with an HIV test within preceding 90 days	**60%**	84.9%	84.1%	83.0%	85.1%	83.3%	83.0%	82.7%	85.1%	87.1%	88.5%	88.9%	89.9%	86%	↑
	% of women 18 to 25 years old attending for contraception given LARC	**20%**	28.4%	28.7%	25.5%	30.3%	31.5%	29.4%	28.1%	30.7%	29.3%	24.7%	30.1%	26.9%	28%	↓
	% of new male patients who had an STI screen who were under 25 years	**20%**	29.6%	30.2%	33.9%	31.1%	29.9%	30.3%	34.6%	28.6%	27.4%	32.8%	33.2%	30.7%	31%	↓
	% of new female patients who had an STI screen who were under 25 years	**20%**	45.5%	45.8%	46.7%	46.5%	43.2%	48.2%	46.3%	45.4%	46.4%	46.4%	47.2%	44.9%	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.
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.
community data was not available fo

[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 - April 2013 (March 2012 Data)

NATIONAL INDICATORS - COMMUNITY

Domain	Indicator	Target	Apr	May	June	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	YTD	Trend
Health Visiting	Prevalance of breast feeding at 6-8 weeks	**74%**	75.9%			72.8%			76.6%			Q			75%	↑
	New Birth Visits - Islington	**95% <=14 days**	51.4%	55.8%	57.9%	67.5%	78.9%	78.6%	80.0%	87.3%	89.2%	85.1%	87.0%		74.3%	↑
	New Birth Visits - Haringey	**95% <=14 days**	18.8%	22.8%	21.7%	41.0%	70.5%	83.5%	73.6%	78.6%	91.7%	83.1%	83.7%		59.7%	↑
Child Heath	% of Immunisation - Islington	**80%**	88.5%			89.3%			Q			Q			88.9%	→
	% of Immunisation - Haringey	**80%**	88.5%			87.3%			Q			Q			87.9%	→
Community Sexual Health	GUM: Patients offered appointment within 2 days	**100%**	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	→
	% positivity for all Chlamydia Screening	**5%**	13.5%	10.6%	7.6%	14.8%	8.9%	7.3%	7.1%	9.0%	10.5%	6.6%	4.9%	3.8%	8.3%	↓
	% 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%	12.6%	11.9%	10.9%	11.2%	↑
	% 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%	28.5%	30.1%	29.0%	31.2%	↑
Primary Care Psychology	IAPT - Number entering psychological therapies	**[4]**	466			251	348	325	354	404	257	373	270	283	3331	↑
	IAPT - Number moving off sick pay and benefits	**90 per year**	23			13	9	19	9	15	11	22	16	31	168	↓
Stop Smoking	Actual 4 Week Quitters	**952 for Qtr 1 & 2**	594			432			Q			Q			1026	→
Dental	Units of Dental Activity	**90% of contract**	92%	122%	96%	146%	116%	95%	123%	116%	84%	128%	117%	109%	112%	↓
	Contacts	**90% of contract**	99%	127%	99%	129%	111%	103%	108%	103%	82%	111%	109%	107%	107%	↓
Drugs & Alcohol	% of Treatment Starts	**80%**	-	-	100.0%	100.0%	100.0%	90.0%	82.0%	82.6%	100.0%	100.0%	87.8%	100.0%	94.2%	↑
	% of treatment Reviews	**80%**	-	-	100.0%	96.0%	100.0%	92.0%	83.0%	80.4%	80.7%	93.5%	96.7%	93.0%	91.5%	↓

Whittington Health Integrated Dashboard - April 2013 (March 2012 Data)

LOCAL INDICATORS - ACUTE

Domain	Indicator	Target	Apr	May	June	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	YTD	Trend
Inpatient	Consultant 7 Day Ward Rounds	**Y**	N	N	N	N	N	N	N	N	N	N	N	Y	N	→
	Consultant presence every day 8am - 8pm (Acute Medicine)	**Y**	N	N	N	N	N	N	N	Y	Y	N	N	Y	Y	↑
	Discharge Before 11am - Surgery / Medicine	**40% by Mar '13**	27.1%	31.7%	19.4%	24.4%	26.0%	28.7%	25.6%	23.9%	19.4%	20.9%	19.5%	19.2%	23.9%	↓
	Average Length of Stay - Medicine - **[1]**	**[1]**	7.9	8.2	7.1	8.3	7.2	7.2	7.0	6.8	6.9	6.9	7.0	7.5	7.3	↑
	Bed Days - Medicine - **[1]**	**[1]**	4754	4953	4026	4965	4411	4560	4867	4794	4492	4872	4379	4876	55949	↑
	Average Length of Stay - Surgery - **[1]**	**[1]**	4.8	4.8	3.9	4.0	3.3	3.0	3.77056	3.85129	5.0343	4.3	4.0	3.7	4.0	↓
	Bed Days - Surgery - **[1]**	**[1]**	1954	2155	1718	1917	1452	1395	1742	1787	1908	1893	1553	1490	20964	↓
	Theatre Session Utilisation	**95%**	77.0%	77.3%	85.6%	87.3%	80.6%	83.5%	83.9%	83.2%	91.0%	84.0%	79.5%	88.5%	83.1%	↑
Outpatients	Number of First Appointments - **[2]**	**[2]**	4906	5922	4826	5528	5077	4763	6092	5677	4382	5620	5110	5107	63010	↓
	Number of Follow-Up Appointments - **[2]**	**[2]**	12736	15046	11406	13299	13047	11686	13974	12953	9611	13031	11847	11414	150050	↓
	DNA Rates - First Appointments	**8%**	11.6%	12.2%	12.8%	12.5%	14.6%	12.9%	11.9%	12.3%	13.9%	13.2%	12.5%	11.9%	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%	13.3%	12.5%	13.5%	13.6%	↓
	Hospital Cancellation Rate - First Appointments	**2%**	3.2%	3.1%	3.6%	3.2%	4.0%	5.0%	3.1%	2.6%	3.2%	3.2%	3.8%	3.9%	3.5%	↓
	Hospital Cancellation Rate - Follow-up Appointments	**2%**	5.8%	4.1%	6.4%	7.0%	6.0%	6.9%	4.4%	5.0%	5.4%	5.4%	5.2%	5.6%	5.6%	↑
	% Waiting less than 30 minutes in clinic	**90%**	84.5%	83.6%	84.0%	85.9%	87.7%	85.8%	87.2%	85.7%	88.0%	85.0%	86.4%	83.8%	85.6%	↓
Data Quality - Acute	NHS Number Completeness - Acute	**99%**	97.3%	97.3%	96.8%	96.9%	96.6%	97.4%	97.3%	96.5%	95.9%	96.6%	96.3%	95.8%	96.7%	↓
	Outcomes not recorded - Acute	**<0.5%**	0.0%	0.0%	0.0%	0.4%	0.4%	0.4%	0.4%	0.9%	1.3%	0.8%	1.4%	1.3%	0.6%	↑

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

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

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

Whittington Health Integrated Dashboard - April 2013 (March 2012 Data)

LOCAL INDICATORS - COMMUNITY

Domain	Indicator	Target	Apr	May	June	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	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%	10.7%	9.1%	8.1%	9.7%	↑
	DNA Rates - Community Children Services	**10%**	12.7%	11.6%	11.7%	12.0%	11.7%	9.0%	6.9%	10.1%	12.9%	10.7%	9.0%	7.0%	10.4%	↑
	Community Average Waiting Times - Adults	**6wks**	7.3	6.6	7.5	6.2	5.5	5.7	5.8	5.8	5.5	5.8	5.7	6.1	6.1	↓
	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	13.3	11.3	12.1	13.2	↑
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%	99.7%	99.9%	99.9%	99.8%	↓
	Outcomes not recorded - Community **[2]**	**<0.5%**	0.6%	0.6%	1.2%	1.0%	0.8%	1.2%	0.9%	1.2%	2.1%	2.6%	6.0%	2.9%	1.7%	↑

SLA INDICATORS

Domain	Indicator	Target	Apr	May	June	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	YTD	Trend
	Outpatient Follow-up Ratio - % excess follow-ups	**<1%**	29.8%	28.4%	26.4%	25.3%	29.5%	32.1%	25.3%	27.6%	27.4%	24.9%	24.9%	24.9%	27.2%	↓
	Consultant to Consultant Activity (Upper Quartile) - % excess firsts	**<1%**	2.9%	2.0%	2.5%	1.4%	1.8%	1.7%	2.1%	3.0%	2.5%	2.7%	2.4%	1.4%	2.2%	↑
	Emergency Readmissions - from original elective admissions	**[1]**	33	39	31	31	49	23	40	34	29	22	35		366	↓
	Emergency Readmissions - from original emergency admissions **[2]**	**[1]**	178	190	202	195	178	186	205	176	186	239	228		2163	↑
	Excess Beddays **[2] [3] [4]**	**SLA Plan = 100%**	89.2%	107.0%	82.0%	95.0%	97.8%	143.0%	69.7%	86.3%	68.1%	76.2%	94.3%		100.0%	↑

CQUIN 2012/13

Domain	Indicator	Target	Apr	May	June	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	YTD	Trend
CQUINS [5]	VTE 24 Hr Risk Assessment **[8],[6]**	**70% in Q4**	16%	18%	17%	19%	25%	27%	21%	45%	53%	44%	55%			↑
	NHS Safety Thermometer for Acute **[6]**	**100%**	-	-	-	100.0%	100.0%	99.7%	100.0%	100.0%	100.0%	100.0%	100.0%			→
	NHS Safety Thermometer for Community **[6]**	**100%**	-	-	-	95.1%	87.8%	86.7%	98.3%	100.0%	99.8%	100.0%	100.0%			→
	Smoking advice **[8],[6]**	**70% in Q4**	-	-	-	5.0%	47.0%	78.0%	77.0%	80.0%	84.0%	87.0%	87.0%	80.0%	79.0%	↓
	COPD Care Bundle **[8],[6]**	**85%**	94.4%	100.0%	93.8%	94.4%	94.4%	100.0%	100.0%	93.8%	100.0%	97.0%	94.0%		97.0%	↓

[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. Outcome

[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 12 – March 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	Mar 13	YTD	Target	Comment/ Description of issue	Actions planned/taken to achieve target	Target date / trajectory	Accntbl./Rspnsbl. Officer for Action
WORKFORCE							
Sickness	**2.9%**	**3.1%**	**<3%**	See Below	See Below		
				Sickness absence has been at around the target for the whole of FY 12/13 with a high of 3.5% in October and meeting target in April, August and March.	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 areas of high Bradford scoring staff members are reviewing action plans with their operational manager and HR lead to address sickness rates. WCF has appointed a manager to support areas with high sickness rates New ED service Manager taking forward management actions in that department.	End of March Complete End of March Complete New action - complete Started	Paul Campbell DirOps/Heads of HR Dee Hackett Carol Gillen
Appraisal	**71%**	**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. Current performance (16/4/13) is 74%	Dirs. Ops. are ensuring that all data is up to date. ESR super users have been designated and trained in each division to support recording on ESR Following the development of divisional objectives and plans, these will form the basis of appraisals for 13/14. All to be complete by end of June.	End of March Complete End of June	Div. Dirs. Operations Div. Dirs. Operations
Mandatory Training	**84%**	**83%**	90% (Dec'12)	See below	See below		
				Staff turnover is accounted for by the 90% target.	1. Emails sent to all non-compliant staff by end of April requiring	End of April	Dir Ops

Month 12 – March 2013 Whittington Health Performance Dashboard Exception Report

Indicator	Mar 13	YTD	Target	Comment/ Description of issue	Actions planned/taken to achieve target	Target date / trajectory	Accntbl./Rspnsbl. Officer for Action
				Target for December 12 not met. Key gaps remain in Facilities directorate. Special training organised at night. Deadline for IG Training compliance has been extended to end of May	compliance 2. The study leave policy for consultants is implemented, allowing no study leave before all mandatory training is completed.	April – complete	DirOps
NATIONAL TARGETS							
Referral to Treatment Admitted	**88.2%**	**91.2%**	90%				
				A proportion of patients waiting for diagnostic endoscopy had been added to the inpatient waiting list for treatment following their delayed diagnostic procedure. In addition we have been bringing forward some longer waiting patients. We expect further long waiters as the endoscopy backlog is cleared.	1. Review of acute patient access policies and procedures 2. Weekly review of the inpatient waiting list to ensure patients are being prioritised correctly	End of June April - complete	Dir Ops
Diagnostic Waiting Times	**94.4%**	**98.4%**	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.	Endoscopy backlog is being cleared as per plan, though 122 patients have chosen to wait beyond the of March into May	End of May	L. Martin
Cancer – 14 day 1st OP (Feb)	**88.5%**	**91.4%**	93%				
				Cancer waiting times have not been met due to a number of issues including patient choice to be seen	- Review arrangements for CNS cover to ensure capacity contact all patients	End of March	Mary Jamal

Month 12 – March 2013 Whittington Health Performance Dashboard Exception Report

Indicator	Mar 13	YTD	Target	Comment/ Description of issue	Actions planned/taken to achieve target	Target date / trajectory	Accntbl./Rspnsbl. Officer for Action
				beyond two weeks and capacity issues in endoscopy.	- Audit skin referrals to decide whether to implement full grading of cancer referral letters. - The National Intensive Support Team will be reporting in April on recommendations for improvement - There have been several improvements to cancer referral management. These include; - Realignment of management staff - Allocation of admin staff to manage receipt of referral and bookings - New data reports to promote proactive management with daily and weekly reports - Escalation process each day for demand management - Capacity and demand is also underway Cancer access policy has been drafted and is being agreed via workshops and task and finish groups.	End of April Mid April End April – however completed End April – however completed for monitoring By end of June End April	Mark Rose Maria Da Silva Lee Martin
Cancer – 14 day breast (Feb)	**93.1%**	**89.0%**	93%	See Below	See Below		
				- Management – there is now a dedicated cancer manager who is undertaking daily chasing of cancer pathway patients - 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	- A realignment of management supervisors will ensure that daily chasing of cancer pathway patients is completed. - The National Intensive Support Team will be reporting in April on recommendations for improvement	End of April Completed Mid April	L Martin Maria Da Silva

Month 12 – March 2013 Whittington Health Performance Dashboard Exception Report

Indicator	Mar 13	YTD	Target	Comment/ Description of issue	Actions planned/taken to achieve target	Target date / trajectory	Accntbl./Rspnsbl. Officer for Action
				cancelled a scheduled 2WW appointment and re-booked it outside of two weeks.			
Pregnant women seen within 12 wks and 6 days	**92.0%**	**89.8%**	90%				
				Note: This figure includes all women who have booked before 12+6 weeks (not women who have booked after 12+6).	Maternity now using new proactive reports to ensure that DNAs or cancelled patients are being actioned	End of April	Dee Hackett
1:1 care in established labour	**95.0%**	**99.5%**	**100%**				
				100% of women are reporting satisfaction with their care during labour, and maternity are reviewing whether 100% target for 1:1 care is appropriate as national target is set at 90%	Review of most appropriate targets and indicators to reflect excellent patient experience.	End of April	Dee Hackett
QUALITY							
Complaints response < 25 working days	**37.0%**	**57.0%**	80%	See Below	See Below		
N.B Feb 12 DATA				Performance has begun to improve after a low of 33% in Dec. However it is still well below target. Ongoing capacity issues results in a slight decrease in response times in year to date. Reasons for this are unchanged and have a cumulative effect.	1. Extra focus and monitoring by divisions of timeliness and quality of responses 2. Further training to increase pool of responders. 3. Review of process to streamline and introduce phone call to complainant within 3 working days (to resolve some queries) 4. Completion of outstanding complaints responses 5. Further clarity around process in Prison Healthcare 6. New ops manager recruited in	End of April Complete End of march complete End of March complete End of June April – complete April -	Div. Dirs. Ops

Month 12 – March 2013 Whittington Health Performance Dashboard Exception Report

Indicator	Mar 13	YTD	Target	Comment/ Description of issue	Actions planned/taken to achieve target	Target date / trajectory	Accntbl./Rspnsbl. Officer for Action
					ED	complete	
Friends & Family Test -	**2%**	**3%**	15%	See Below	See Below		
Emergency Department Coverage				There is now sufficient coverage of volunteers and admin capacity to support the process. All staff have daily quota for completion Extra hand held with wifi in place	Achievement of 15% target	June 2013	Carol Gillen / Paula Mattin
Diabetes	**50%**	**64%**	60%				
% of patients with at least a 1% reduction in HbA1c after 6 months				Importantly we have achieved the year-end target of 60% of patients at 6 months or discharge will have at least 1% reduction in Hba1c by achieving 64% Total of 22 patients audited in March 2013 in both Haringey and Islington. 11 had >1% reduction in Hba1c, 7 0.1-0.9% reduction and 4 no change or increase in Hba1c due to poor compliance	1. Ensure DSN are following care package – intensive management over short period of time which is process in Haringey but newer to Islington 2. Small group of patients with poor compliance who are difficult to manage, encourage staff to use ADP skills to increase self-management	End of May	Carol Gillen
NATIONAL - COMMUNITY							
Islington New Birth Visits (Feb)	**87.0%**	**74.3%**	95%	See Below	See Below		
Haringey (Feb)	**83.7%**	**59.7%**	95%	See Below	See Below		
				Continued improvement across Haringey and Islington due to improved information flow and re-focus of work on early intervention WCF identified incorrect percentage	To monitor potential impact on child protection work through audit of practice and multi-agency working.	Ongoing	Sam Page

Month 12 – March 2013 Whittington Health Performance Dashboard Exception Report

Indicator	Mar 13	YTD	Target	Comment/ Description of issue	Actions planned/taken to achieve target	Target date / trajectory	Accntbl./Rspnsbl. Officer for Action
				for February on Trust Dashboard in both Haringey and Islington; corrected figures indicate both boroughs have improved since last month.			
Chlamydia	**3.8%**	**8.3%**	>5%	See Below	See Below		
% positivity for all Chlamydia Screening					The Chlamydia positivity rate has gone down and seems to coincide with the path service move to Whittington. When going through diagnosis checks recently there was a suspicion that this would be the case and this data confirmed it. It will be investigated further and to look at the trend next month.	End of April	Dee Hackett
MSK Community Waits			<6 weeks	See Below	See Below		
These are currently reported on the Trust dashboard as part of the overall community waits.				Routine and acute patients who have waited longer than 6 weeks in Community MSK have all been contacted (apart from 40~ on the BG IWS. Their invite letters have been sent out. There has been a redesign of the access pathway for Community MSK to prevent future problems. All patients on backlog have now been sent a letter inviting them to contact service for an appointment (achieved with additional capacity in service)	1. Demand and Capacity modelling in progress in order for service to meet ongoing demand including AQP response times 2. Improvement programme has commenced including call management system, improved processes around triage, group classes, APPs for activated patients and Choose & Book.	End of July End of July	Fiona Yung / Carol Gillen
LOCAL TARGETS							
Theatre Utilisation	**88.5%**	**83.1%**	95%	See Below	See Below		

Month 12 – March 2013 Whittington Health Performance Dashboard Exception Report

Indicator	Mar 13	YTD	Target	Comment/ Description of issue	Actions planned/taken to achieve target	Target date / trajectory	Accntbl./Rspnsbl. Officer for Action
				While there has been sporadic improvement, this has not been sustained and a more wide ranging plan is being developed.	1. A theatre improvement plan will be formed over the next month for full implementation by the end of July 2. A new theatre management meeting has been established to drive improvements in theatre utilisation	End of July End of April – however underway	L Martin L Martin
Hospital Cancellations (First)	**3.9%**	**3.5%**	**<2%**	See Below	See Below		
(Follow Up)	**5.6%**	**5.6%**	**<2%**				
				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 2. A Trust wide plan will be developed to address the high cancelations	Rolling programme of implementation for next 4 months Full implementation by July	TPE project Lee Martin and Carol Gillen
Acute DNA Rates - First	**11.9%**	**12.7%**	<8%	See Below	See Below		
- Follow Up	**13.5%**	**13.6%**	<8%	See Below	See Below		
				Maternity and Paediatric have a local policy due to safeguarding issues and therefore those who DNA are offered alternative appointments. WCF are implementing the new DNA policy (Was Not Brought) for children.	1. Transforming Patient Experience Patient Pathway Coordinator (PPC) aimed at improving patient communication, reducing patient handoffs between functions. implementation in progress 2. A specific DNA reduction campaign will be initiated following a pilot to test which improvement works for the local population 3. reminder calls for new and follow up patients in two specialities with high DNA	Rolling programme of implementation for next 4 months July 2013 Started	1. TPE project Lee Martin and Carol Gillen Lee Martin

Month 12 – March 2013 Whittington Health Performance Dashboard Exception Report

Indicator	Mar 13	YTD	Target	Comment/ Description of issue	Actions planned/taken to achieve target	Target date / trajectory	Accntbl./Rspnsbl. Officer for Action
Outcomes not recorded - Acute	**1.3%**	**0.6%**	<0.5%	See Below	See Below		
				There is a particular issue in Acute Paeds with 2 staff being investigated. Cover for these posts has been challenging hence an increase in un-outcomed appointments. Investigation into 2 staff not yet closed. Cover for the two posts has been challenging this month again and un-outcomed appointments has gone up slightly.	• Cross cover being arranged through extra training. Position expected to improve by end of May (pushed back from end of April)	End of May	Dee Hackett
Outcomes not recorded - Community	**2.9%**	**1.7%**	<0.5%	See Below	See Below		
				Significant improvement month to month (6% last month) Highest numbers of un-outcomed appointments associated with poor IT access Number of un-outcomed appointments continues to fall with better access on sites	All un-outcomed appointments emailed to staff with urgent request to action.	April - complete	Dee Hackett
SLA							
Acute Outpatients	**24.9%**	**27.2%**	<1%	See Below	See Below		
FOLLOW-UP RATIO – percentage excess follow ups				Clinical Directors and Divisional Directors working with individual clinical leads to continue to work reviewing pathway protocols to reduce towards upper quartile targets. 7 specialties accounted for 83% of excess follow ups	1. Reviewing each specialty with high new to follow up ratio for action 2. the new access policy will promote the discharge of patient by to primary provider 3. New clinic form introduced to track patients outcomes from clinic	End of April End of May End of May	1. Dir Ops. L Martin L Martin

Month 12 – March 2013 Whittington Health Performance Dashboard Exception Report

Indicator	Mar 13	YTD	Target	Comment/ Description of issue	Actions planned/taken to achieve target	Target date / trajectory	Accntbl./Rspnsbl. Officer for Action
Consultant to Consultant Activity	**1.4%**	**2.2%**	**<1%**				
(Upper Quartile) - % excess firsts				• Significant improvement in March. • Some C2C referrals can be attributed to consultant sickness	SCD and ICAM are reviewing their positions and developing action plans to reduce such referrals.	End of April	Carol Gillen and L. Martin.