Whittington Health NHS

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Whittington Health Trust Board

24 July 2013

Title:	Month 3 Performance report		
Agenda item:	**13/108**	**Paper**	**8**
Action requested:	• For Trust Board to note performance		
Executive Summary:	**Introduction** Trust Board asked for a redesign of the performance report. It has been aligned to the NHS Trust Development Authority's (TDA) Delivering High Quality Care for Patients: The Accountability Framework for Trust Boards published in April 2013. This gives the Trust Board the right level of oversight and scrutiny around the areas the Trust is being held accountable for alongside assurances the Trust is delivering high quality care to patients. The report is formatted in an easy to understand way to ensure the audience understands the data and the actions that are being put into place by the Trust to maintain or improve performance. **Selected areas of success** **Care Quality Commission (CQC) report**: The Trust received a very positive report about the care of patients on inpatient wards in The Whittington Hospital. During their visit the CQC found wards were run calmly and patients felt confident about staff on duty. Staff were observed meeting people's individual needs effectively, and staff spoke highly of team work on each ward. People they spoke to were satisfied with their care and said that they found staff caring and professional. **Areas that are improving** **Waiting times for suspected cancer**– performance against the two week wait standard was maintained above target (93%) and there were improvements in the breast symptomatic target, moving from 81.4% in April to 87.3% in May **Emergency Department access** – The Trust saw 96% of patients within four hours in the Emergency Department in June (95% target). This is significant achievement after a prolonged period of high attendances. By 14 July 2013, the Trust had met the target for seven weeks running. **Focus areas for action**		

	Referral to Treatment (RTT) waiting times management – The Trust continued to focus on treating long waiting patients. This has reduced our RTT under 18 weeks performance. However this is in line with an agreed plan with our commissioners to improve how we manage our waiting lists in the future. **Complaints response times** – Response times continue to be unsatisfactory. In April, 42% were responded to within the 25 working day standard. This increased to 58% in May. The Trust expects to achieve the 80% standard by September.
Summary of recommendations:	For Trust Board to note performance
Fit with WH strategy:	The Performance Report is a key monitoring tool for achieving Whittington Health's strategic goals, especially goal three – Efficient and Effective Care.
Reference to related / other documents:	In completing this report, we 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:	16th July 2013

<table>
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<tr><td>Date paper seen by EC</td><td>16/7/13</td><td>Equality Impact Assessment complete?</td><td>n/a</td><td>Risk assessment undertaken?</td><td>n/a</td><td>Legal advice received?</td><td>No</td></tr>
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Trust Board Performance Report
July 2013

1. SUCCESS HIGHLIGHTS

1.1. Care Quality Commission Inspection

Introduction

On 3 June 2013 the Care Quality Commission (CQC) inspected some of the hospital wards, with findings published on 6 July 2013. The inspection checked that people who use the Trust's inpatient wards experience effective, safe and appropriate care, treatment and support that meets their needs and protects their rights. This was undertaken through reviewing information, patients notes and talking with a wide range of people, those who use the service, carers, family members and staff, as well as observing how people were cared for.

Published Findings

During their visit the CQC found Betty Mansell, Mercers, Montuschi, Victoria, and Meyrick wards were run calmly and patients felt confident about staff on duty. Staff were observed meeting people's individual needs effectively, and staff spoke highly of team work on each ward. People they spoke with were satisfied with the care provided to them and said that they found staff caring and professional. Comments included : "It's been mostly brilliant," "I'm very comfortable," "I get pain relief if needed," "I think they're wonderful," "They are always looking in on us," "They come quickly," "They are nice, and will joke with me," and "It's better than a hotel".
Further information can be found at http://www.cqc.org.uk/statement/04/315501

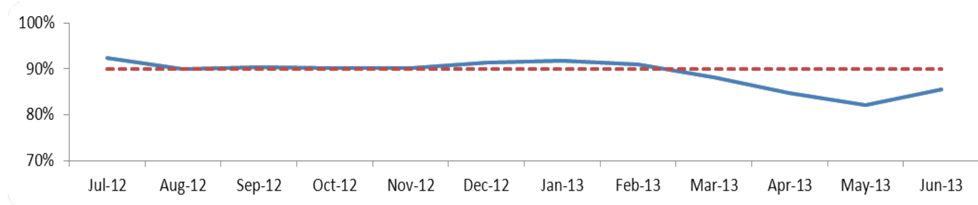
2. ACCESS METRICS

2.1. Referral to Treatment 18 Weeks

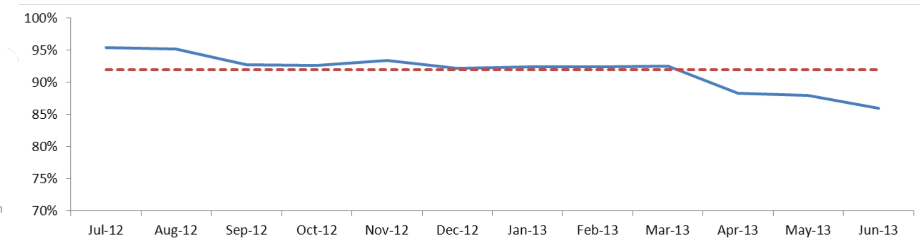
	Threshold	Apr-13	May-13	Jun-13	QTD Q1 2013/14	YTD 2013/14
Admitted	90%	84.7%	82.0%	85.6%	84.1%	84.1%
Non Admitted	95%	93.9%	92.8%	94.3%	93.6%	93.6%
Incomplete	92%	88.3%	88.0%	86.0%	87.4%	87.4%
52 Week Waits	0	27	61	23	-	-

Waiting times for referrals to consultant led services, timed from receipt of referral to treatment or discharge.

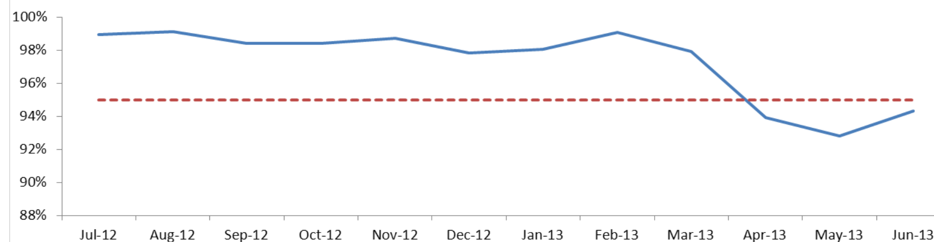
Patients completing treatment within 18 weeks in an admitted setting



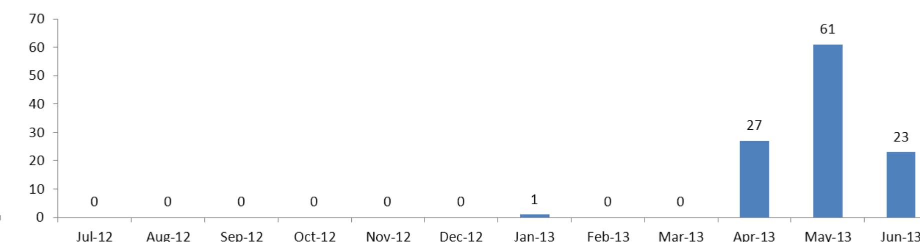
All patients awaiting treatment waiting less than 18 weeks



Patients completing treatment within 18 weeks in a non-admitted setting



52 Week Waits

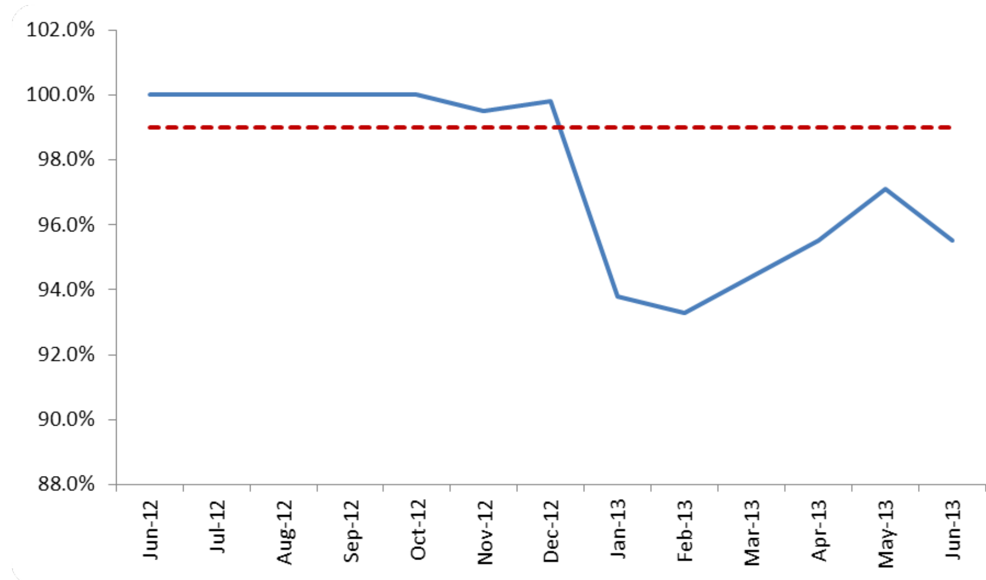


The focus on reducing the number of longer waiting patients has caused overall performance to decline, 14.4% of inpatients treated in June were longer waiters. The Trust's current endoscopy backlog has had a knock-on effect in Gastroenterology and General Surgery, resulting in high numbers of over 52 week waiters. We expect that performance will be within target by the end of September. We have strengthened our processes, the Trust is ensuring where possible people are treated in order and dependent on their clinical urgency, all acute operational managers now attend a weekly waiting list meeting chaired by the Chief Operating Officer. Extra capacity is being arranged in agreement with commissioners to treat longer waiting patients. Gastroenterology, Pain Relief, ENT, General Surgery and Trauma & Orthopaedics are the current main focus specialties.

2.2. Diagnostic Waits

Percentage of patients waiting for a diagnostic test who are seen within six weeks. There are 15 diagnostic tests in this cohort including endoscopy and imaging . excludes laboratory tests (pathology).

	Threshold	Apr-13	May-13	Jun-13	QTD Q1 2013/14	YTD 2013/14
Diagnostic Waits	99%	95.5%	97.1%	95.5%	96.1%	96.1%

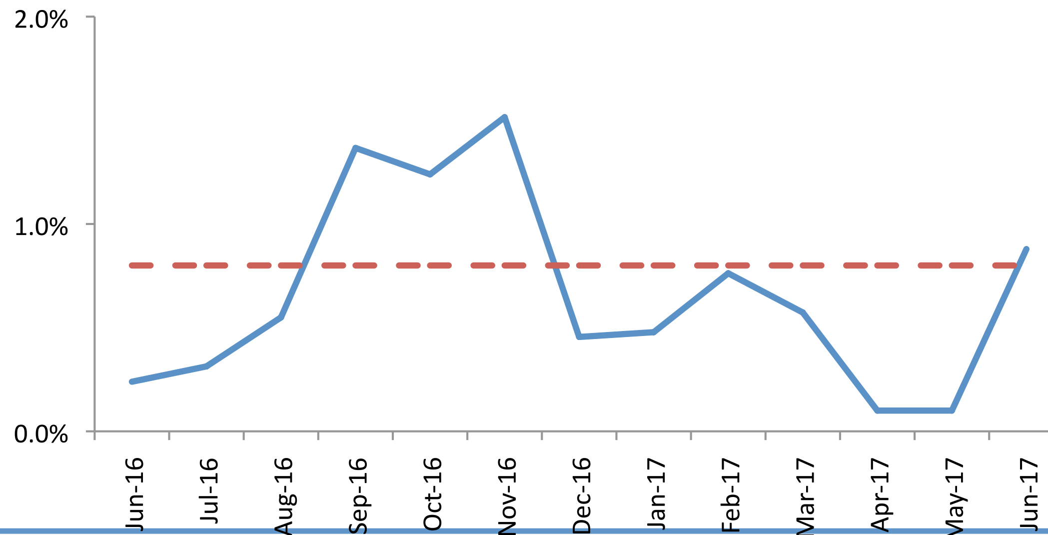


A backlog in Endoscopy and Paediatric Audiology have driven poorer performance. Extra capacity has been in place in Endoscopy since April 2013 addressing a backlog of waiting patients and the service should meet target in July.
In Paediatric Audiology 81 patients were waiting over 6 weeks in June, which is the main account for the drop in June performance. All of these patients have now been booked and will be seen by the end of August. In addition the service is planning Saturday lists to ensure no further backlog is created. In Imaging, performance is meeting the 99% standard.

2.3. Cancelled Operations

	Threshold	Apr-13	May-13	Jun-13	QTD Q1 2013/14	YTD 2013/14
Cancelled Ops as % of Elective Admissions	0.8%	0.1%	0.1%	0.9%	0.4%	0.4%
Number of Cancelled Operations	-	2	3	17	22	22
Number of Elective Admissions	-	1974	2059	1932	5965	5965
Cancelled Ops not rescheduled within 28 days	0	0	1	0	1	1

Hospital initiated cancellations on day of operation.

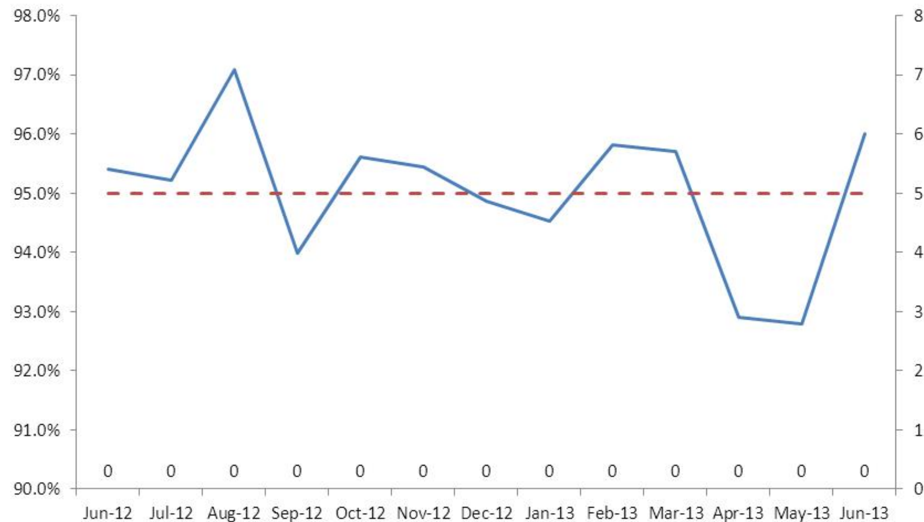


Improvements in the management of cancelled operations mean that they are all now added live onto the Theatre Management Information System (ORMIS) cancellation sheets which are sent onto admissions staff and Information department for addition into the daily situation report (sitrep). We have implemented a new standard operating procedure (SOP) to ensure that if an operation is cancelled it is now escalated directly to the new General Manager for Surgery who will ensure that all patients are offered an appointment within 28 days of cancellation. The Trust is actively managing its operating lists to minimise cancelled operations ensuring people are fully prepared and the right equipment and resources are available.

2.4. Emergency Department Waits

	Threshold	Apr-13	May-13	Jun-13	QTD Q1 2013/14	YTD 2013/14
4hr Waits	95%	92.9%	92.8%	96.0%	93.9%	93.9%
12hr Waits	0	0	0	0	0	0

Patients waiting either 4 or 12 hours in the Emergency Department, from point of registration to either discharge or transfer to inpatient ward.
Wait for Treatment records the time between ED arrival and the time when the patient is seen by a "decision-making clinician".



	Threshold	Apr-13	May-13	Jun-13
Total Time in ED (95th % Wait < 240 mins)	<240 mins	307	311	239
Total Time in ED - Admitted (95th % Wait < 240 mins)	<240	448	586	377
Total Time in ED - Non-Admitted (95th % Wait < 240 mins)	<240	240	240	237
Wait for Assessment (95th % Wait < 15 mins)	<15	13	11	10
Wait for Treatment (Median < 60 mins)	<60	100	87	85
Left Without Being Seen Rate (<5%)	<5%	5.4%	4.9%	5.3%
Re-attendance Rate (>1% and <5%)	>1% and <5%	1.3%	1.4%	2.2%

The Trust met the 95% target in June. The admitted pathway remains a challenge and the Trust's enhanced recovery programme will benefit patient flow. Data has been provided to units showing response times of specialty doctors. Changes to the timings of the medical staff rota have been made to reduce time to treatment and is being piloted during July. The improvements can be attributed to four main interventions: 1) aligning medical and nursing rotas to changing demand; 2) an additional patient flow nurse; 3) a patient flow 'chaser' member of staff; 4) more frequent escalation of issues to senior staff.

2.5. Cancer Waiting Times

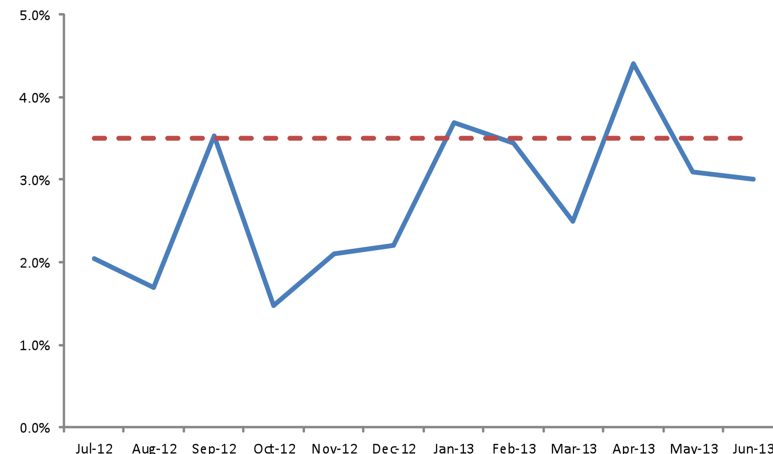
	Threshold	Mar-13	Apr-13	May-13	QTD Q1 2013/14	YTD 2013/14
14 Days GP Referrals - First Outpatient	93%	93.3%	93.8%	93.8%	93.8%	93.8%
14 Days GP Referrals - Breast Symptoms	93%	88.0%	81.4%	87.3%	84.0%	84.0%
31 Days to First Treatment	96%	100.0%	100.0%	100.0%	100.0%	100.0%
31 Days to Second or Subsequent Treatment (Surgery)	94%	100.0%	100.0%	100.0%	100.0%	100.0%
31 Days to Second or Subsequent Treatment (Drugs)	98%	100.0%	100.0%	100.0%	100.0%	100.0%
62 Days Referral to Treatment	85%	98.0%	75.7%	93.9%	84.3%	84.3%
62 Days Wait First Treatment from Screening	90%	No patients	100.0%	No patients	100.0%	100.0%
62 Days Wait First Treatment from Upgrade	n/a	100.0%	No patients	100.0%	100.0%	100.0%

14 day targets relate to patients referred from GP to hospital on a suspected cancer or breast symptoms pathway, timed from date of receipt of referral.
31 day target is timed from diagnosis to treatment.
The 62 day targets time of waits from referral to treatment.

Eight out of ten Cancer performance indicators are meeting standards except two. The 14 day Breast Symptoms target has not been met for the last three months. Poor processes previously existed in relation to contacting patients pro-actively to give them an appointment, this has now been significantly . This target will be compliant from June 2013 onwards.
The 62 day target has not been sustainably compliant over the last few months and will not be compliant in June or July as there is a backlog of patients who are already over their breach dates. This will include patients who have cancers and some who have yet to have a decision to treat and some will not be diagnosed with cancer. At 11 July 2013, the number of patients waiting over 62 days is 36 and these are being expedited to be treated as soon as possible. It is expected that this target will be compliant in September 2013.

2.6. Delayed Transfers of Care

	Threshold	Apr-13	May-13	Jun-13	QTD Q1 2013/14	YTD 2013/14
Delayed Transfers	<3.5%	4.4%	3.1%	3.0%	3.5%	3.5%



Patients with a delayed transfer of care to an intermediate setting as defined by discharge planning team. Shown as % of all inpatients at midnight snapshot.

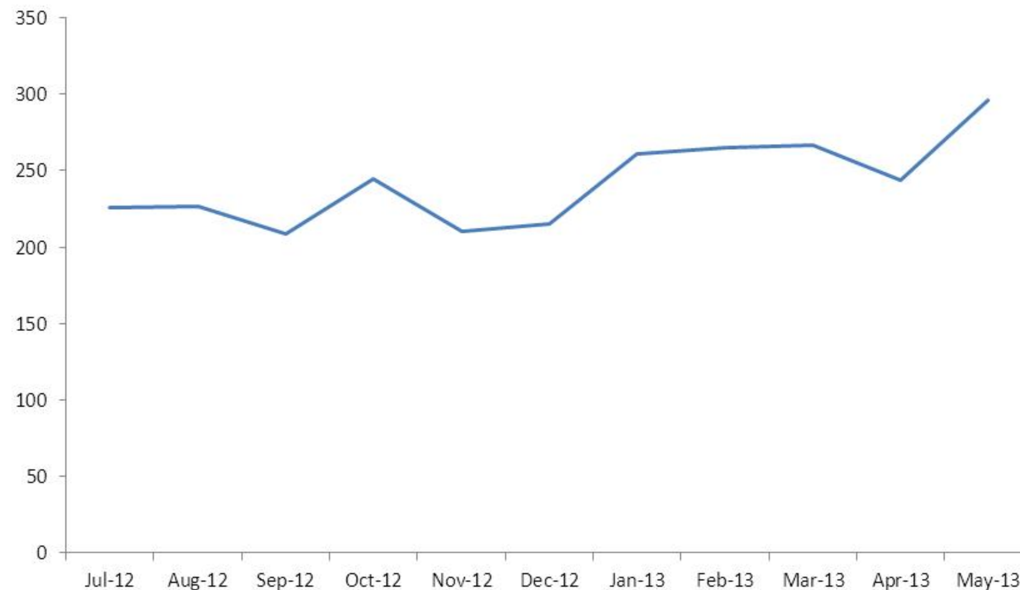
The main reason for a rise in delays in April was people waiting for non-acute NHS care i.e. inpatient rehabilitation or intermediate care beds. The second most common reason was waiting for a residential home placement to be identified.
The time taken to access inpatient rehabilitation is being followed up, and performance in May and June has returned to be on target. Meetings are held three times a week to manage delayed transfers of care (DTOCs) and agree a plan. We have had two patients with extremely long lengths of stay that have now been discharged. Escalation to Divisional Director of Ops takes place for difficult to move patients to expedite transfer. For Islington, actions are being taken to ensure fast turnaround of patients at St. Pancras Hospital, Mildmay and Cheverton Lodge, which receive patients from multiple hospitals in London. There is a teleconference for all hospital discharges, daily for Islington and three times a week for Haringey attended by the Intermediate Care Team (REACH) who 'chase' providers to ensure that spaces come up as quickly as possible. For Haringey, we refer to our own Cavell Rehabilitation Unit where systems are in place to minimise delays. In addition we have long waits for specialist Neuro-Rehabilitation as there is limited capacity in the system. These beds are controlled by a Pan-London consortium. We liaise with the individual units and review for alternative placement where possible. Whittington Health is seeking to clarify escalation procedures for specialist beds considering the changes in responsible bodies. The overall system for chasing spaces was introduced in December 2012. More work is planned to improve in this area.

3. OUTCOMES METRICS

3.1. Emergency Readmissions (30 day)

	Mar-13	Apr-13	May-13	QTD Q1 2013/14	YTD 2013/14
30 Day Emergency Readmissions	267	244	296	511	540

NB Data is one month in arrears due to requirement for clinical coded data



This is the number of patients readmitted as an emergency within 30 days of being discharged from an previous hospital admission. Certain groups are excluded from the measurement including patients with cancer, maternity patients and children under 4 years of age.

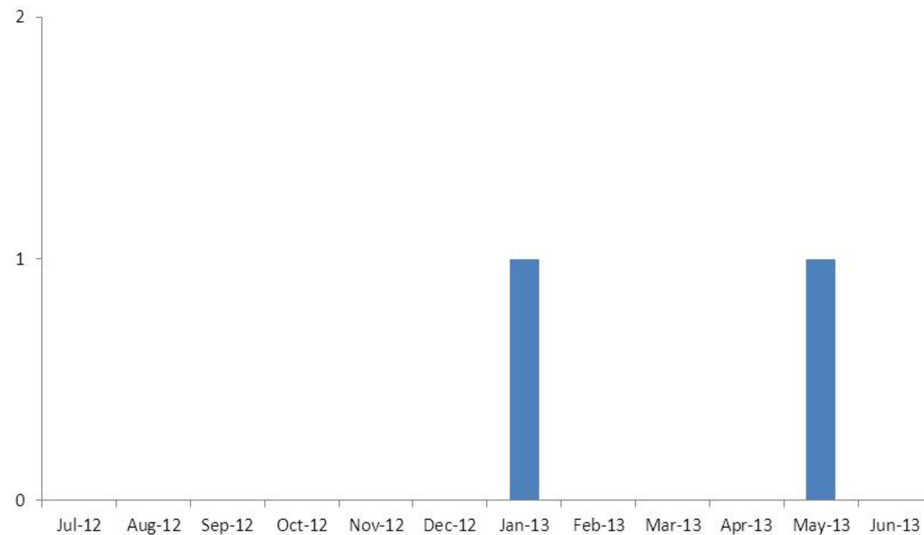
Detailed comments regarding performance against this indicator will be provided in next month's Trust Board report.

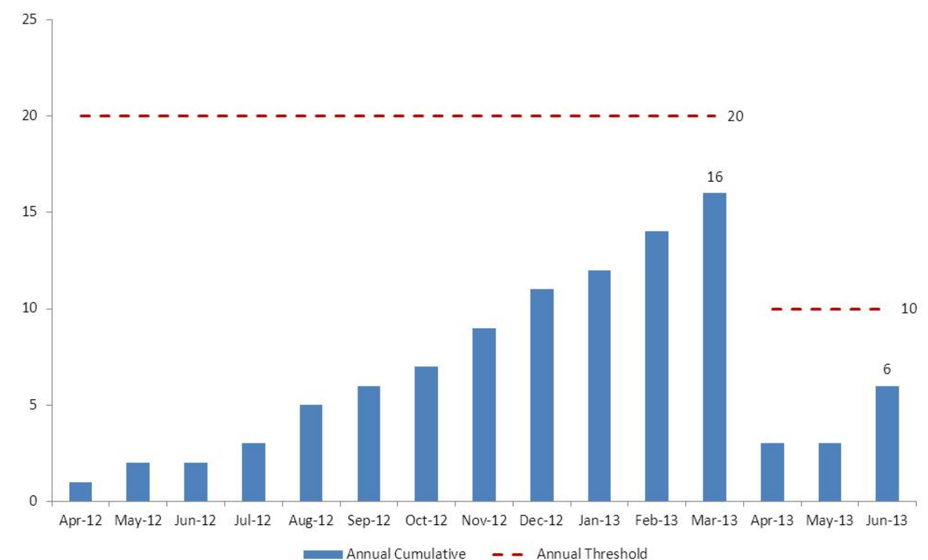
Numbers of MRSA bacteraemia (bacteria in the blood) and Clostidium Difficile infections (bacterial infection affecting the digestive system)

3.2. MRSA; *C.difficile*

	Full Year Threshold	Apr-13	May-13	Jun-13	QTD Q1 2013/14	YTD 2013/14
MRSA	0	0	1	0	1	1

	Full Year Threshold	Apr-13	May-13	Jun-13	QTD Q1 2013/14	YTD 2013/14
C Difficile	<= 10 p/yr	3	0	3	6	6



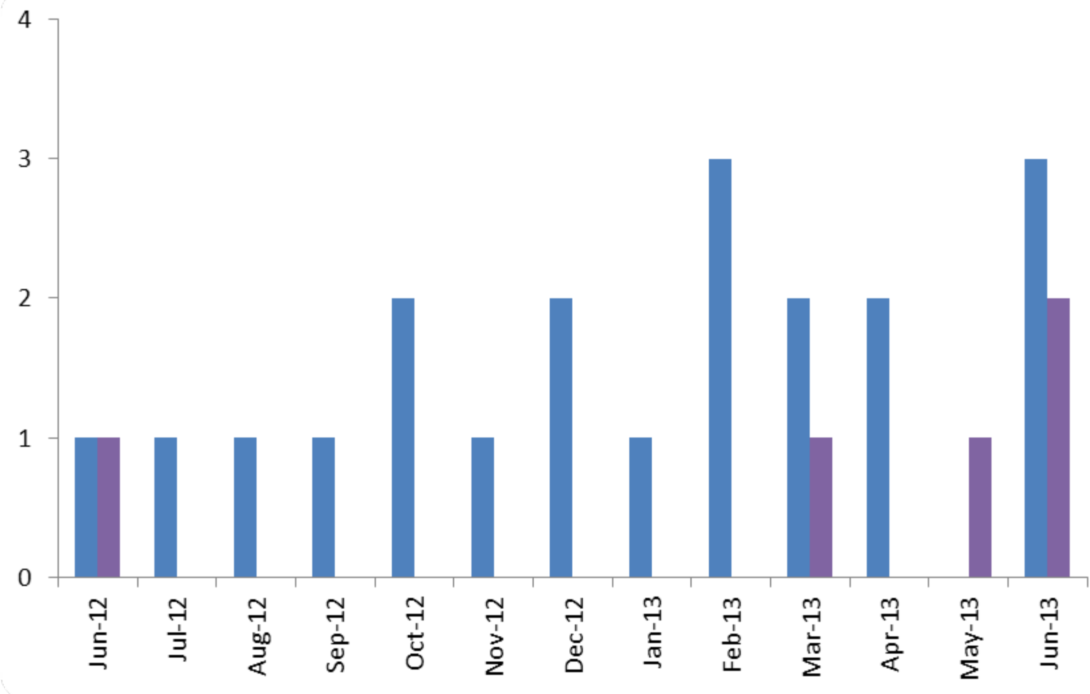


A full post infection review occurred following the MRSA bacteraemia and the learning from this has been shared widely. Each case of *C. difficile* is reviewed and any non-compliances with policy acted upon. There was no evidence of cross transmission in any of the cases. Recommendations were made concerning timely testing of symptomatic patients and speedy placement in side rooms. Antimicrobial prescribing was fully compliant. Information has been circulated to reinforce good practice. Infectious diarrhoea scenarios are taught regularly to relevant staff.

Numbers of *E.coli* and MSSA bacteraemia cases (presence of bacteria in the blood)

3.3. *E. coli* & MSSA

	Threshold	Apr-13	May-13	Jun-13	QTD Q1 2013/14	YTD 2013/14
E. coli	n/a	2	1	3	6	6
MSSA	n/a	0	1	2	3	3



There are no set objectives regarding MSSA and *E. coli* trust attributable bacteraemia episodes, however each bacteraemia case is investigated to ascertain whether there were any actions that could have been taken to prevent the event. We review information such as peripheral cannulae policy compliance, hand hygiene compliance, insertion of urinary catheter technique and antimicrobial prescribing. This information is also widely shared and we have seen a reduction in the number of MSSA bacteraemia episodes from 20 in 2011/12 to 4 in 2012/13.

3.4. Harm Free Care (CQUIN)

	Apr-13	May-13	Jun-13
% of Harm Free Care	92.1%	93.5%	94.1%
Threshold	95.0%	95.0%	95.0%

Data is sourced from the Safety Thermometer, a snapshot of the condition of a large number of patients, reporting on pressure sores, falls, catheter UTI and VTE.

Safety Thermometer (CQUIN)

	Target	Apr-13	May-13	Jun-13
Completeness	100%	100%	100%	100%

PU Incidence figures not yet confirmed

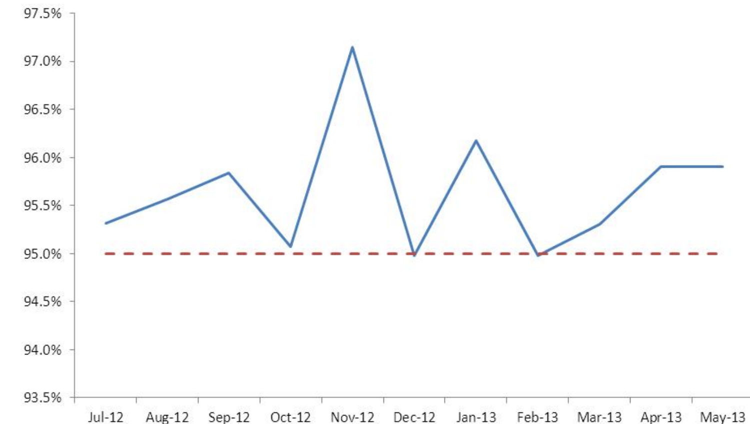
Where issues were identified investigations are in progress, especially for pressure ulcers and falls for which a root cause analysis (RCA) is undertaken and lessons learnt embedded in practice to avoid future preventable incidence. To reduce the incidence of pressure ulcers the Trust trains all nursing staff and have introduced the SKIN bundle to all teams in the community and most of the hospital wards. The Trust is due to launch a pressure ulcer prevention strategy which will engage all professions in prevention and introduce a new pathway for complex patients. We have also invested in the McKinsey campaign for pressure ulcer reduction which will support specific individuals and teams to use improvement methodology to review delivery of care. We are in the process of agreeing a Commissioning for Quality and Innovation (CQUIN) with our commissions for pressure ulcers. Further details will be provided in next month's Trust Board report. To reduce the number of falls the Trust is providing additional falls prevention training at wards level to improve post falls assessment and care plans.

3.5. VTE Risk Assessment (CQUIN)

Venous thromboembolism (VTE) is a condition in which a blood clot (thrombus) forms in a vein
Risk assessment is for all inpatients to ensure they receive appropriate interventions if high risk.
Incidence is number of Deep Vein Thrombosis and Pulmonary Embolisms (blood clots) in month

	Threshold	Mar-13	Apr-13	May-13	QTD Q1 2013/14	YTD 2013/14
VTE Risk Assessed	95%	95.3%	95.9%	95.9%	95.9%	95.9%
VTE Incidence	-	8	10	12	22	22

NB Data is one month in arrears due to requirement for clinical coded data



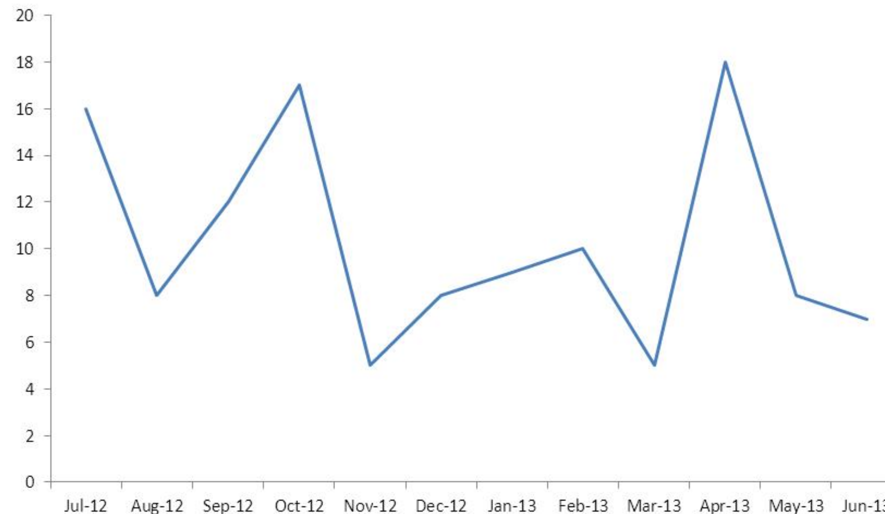
To achieve trust-wide VTE assessment performance of 95% a multipronged approach is required. Where divisions/clinical areas fall below the required standard the following strategies/interventions are employed to address low performance

- Real-time daily e-VTE assessment reports e-mailed to all relevant clinical areas
- High-level detailed 3-weekly VTE report e-mailed to clinicians and divisional managers
- VTE consultant lead sends e-mails identifying clinical consequences of poor compliance to consultant colleagues
- VTE clinical walkabouts by VTE lead to drive up performance with high-level front-line engagement fostering and encouraging leadership
- Daily review of trust wide VTE performance by VTE nurse specialist to identify areas of poor compliance, which is followed up by face-to-face engagement with front-line clinicians responsible for completing VTE risk assessments to ascertain barriers to VTE assessment completion
- Weekly audits with feedback to medical, nursing, midwifery and pharmacy staff
- Root case analysis on all VTEs by the clinical teams overseen by the VTE lead

In addition, recording issues have been identified where clinicians are recording the VTE assessment in the patient's notes but not on Anglia ICE. The Trust runs a continuous educational/awareness programme through screen savers, face to face meetings

3.6. Serious Incidents

	Apr-13	May-13	Jun-13	QTD Q1 2013/14	YTD 2013/14
Serious Incidents	18	8	7	33	33



Number of Serious Incidents (Sis) using national framework for reporting agreed by executive directors.

In June there were two serious incidents in Women, Children and Families division (WCF) and five in Integrated Care and Acute Medicine (ICAM) division. All investigations are in progress and actions have been taken to address any immediate safety concerns. These include two community pressure ulcers. All SIs are reported to divisional boards and investigations are facilitated by the Trust's Clinical Governance team.

3.7. Never Events

There are 25 Never Events specified by the DH – they are adverse events that are unambiguous (clearly identifiable and measurable), serious (resulting in death or significant disability), and usually preventable.

No never events have been reported this financial year.

3.8. Central Alerting System (CAS)

	Apr-13	May-13	Jun-13	QTD Q1 2013/14	YTD 2013/14
Number of Outstanding Alerts	1	1	1	1	1

Issued alerts include safety alerts, Chief Medical Officer (CMO) messages, drug alerts, Dear Doctor letters and Medical Device Alerts issued on behalf of the Medicines and Healthcare products Regulatory Agency, the National Patient Safety Agency, and the Department of Health

This outstanding CAS alert relates to safer spinal, epidural and regional devices. This alert is the subject of a national discussion regarding the most appropriate way to implement this and a London-wide working group has been formed to address this issue. The Trust's position has been risk assessed as there is not enough information to make a safe and informed decision. The Trust is in contact with the NHS Trust Development Authority and NHS England with regards to the matter and local commissioners have been informed. While this is happening, the non-implementation is on the Trust risk register and discussions are on-going with relevant clinicians to mitigate accordingly.

3.9. World Health Organisation (WHO) Surgical Checklist Compliance

Implementing pre-operative checklist.

Whittington Health is fully compliant with the alerts relating to the WHO Surgical Checklist. (NPSA/2009/PSA002/U1 and NPSA/2009/PSA002)

3.10. Medication Errors Causing Serious Harm

Where there is severe harm or death

Zero errors reported across the Trust

3.11. Admissions of Full-Term Babies to Neonatal Care

All term babies (>=37 weeks gestation) admitted to neonatal care.

This indicator will be reported in the next Trust Board report.

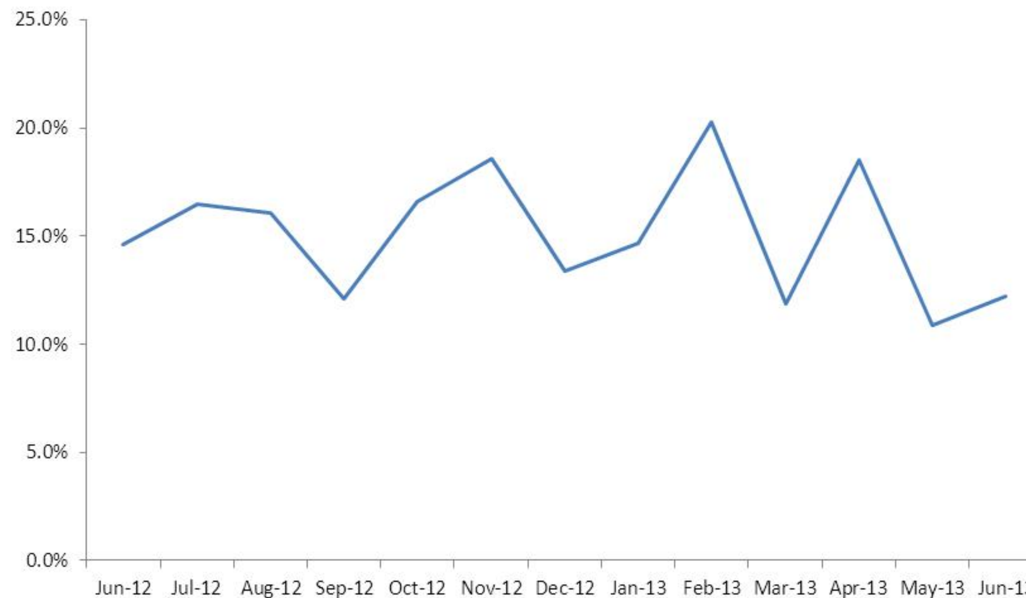
3.12. Maternal Deaths

Any death of a woman which occurs during or within one year of pregnancy, childbirth, miscarriage or termination, from any cause related to or aggravated by the pregnancy or its management.

Zero maternal deaths in hospital (June 2012 – June 2013)

3.13. Caesarean Section Rates

	Threshold	Apr-13	May-13	Jun-13	QTD Q1 2013/14	YTD 2013/14
Elective C-Section Rate	Not set	18.5%	10.9%	12.2%	13.9%	13.9%

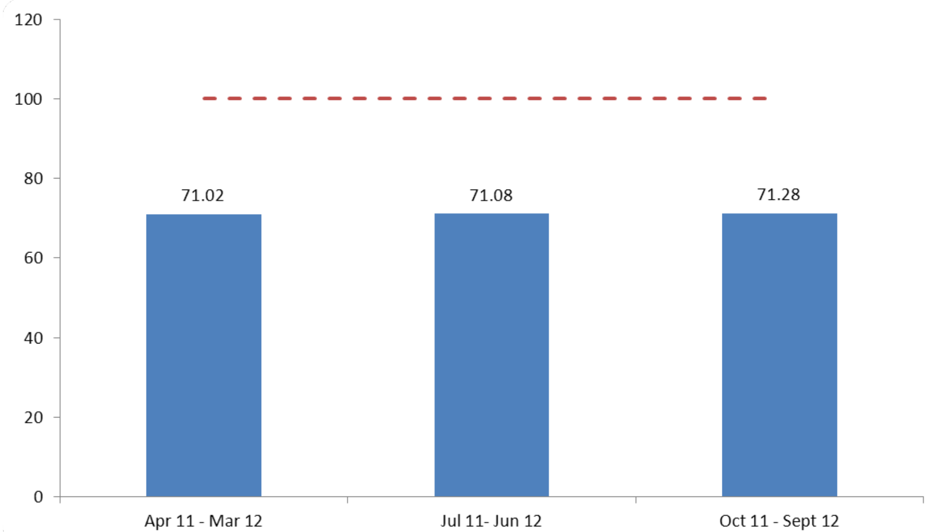


Women who deliver by elective caesarean section as a percentage of all deliveries.

Whittington Health is not an outlier in regards to our caesarean section rate. In addition the rate of vaginal births after a caesarean is good compared to other London hospitals.

3.14. SHMI

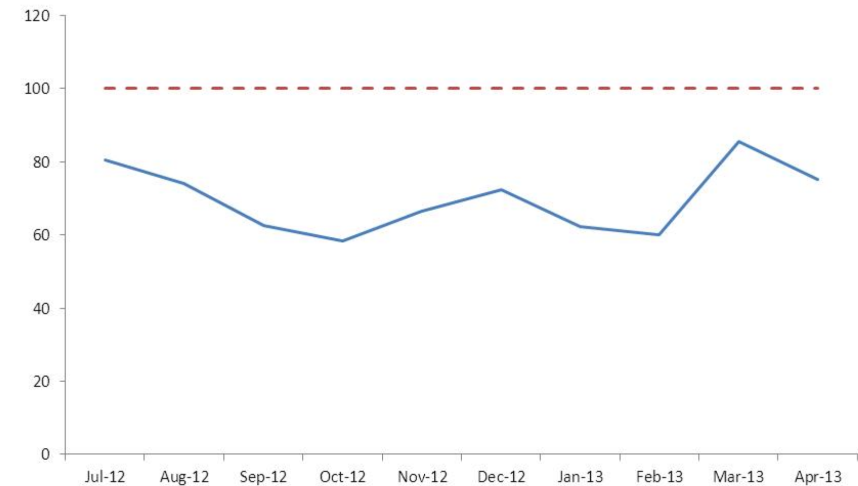
	Threshold	Apr 11 - Mar 12	Jul 11- Jun 12	Oct 11 - Sept 12
SHMI	100	71.02	71.08	71.28



SHMI is Summary Hospital-level Mortality Indicator and measures whether hospital deaths are higher or lower than expected. Methodology varies from HSMR.

3.15. HSMR

	Threshold	Apr-13	May-13	Jun-13	QTD Q1 2013/14	YTD 2013/14
HSMR	<100	75.1			75.1	75.1



HSMR is Hospital Standardised Mortality Ratio and measures whether hospital deaths are higher or lower than expected. There is a significant time delay in data publication. Methodology varies from SHMI.

The Trust has been number one for two years on SHMI and in these figures has slipped to number two. However, the Trust is among the very best hospitals in the country for both these measures and recently won the CHKS Patient Safety Award.

4. QUALITY GOVERNANCE INDICATORS

4.1. Patient Satisfaction (Friends & Family)

The Net Promoter Score ranges from -100 to + 100 and the closer to +100, the better. Improvement is shown by the number being positive and getting higher

	Apr-13	May-13	Jun-13
Total Coverage	8.3%	9.2%	9.1%
Inpatient Coverage	23.6%	25.2%	44.0%
ED Coverage	5.7%	4.6%	3.4%
Inpatient Net Promoter Score	71	64	67
ED Net Promoter Score	11	27	10

Friends & Family Test (CQUIN)

	Target	Apr-13	May-13	Jun-13
Coverage	>=15%	8.3%	9.2%	9.1%

The Trust is performing well on the Friends and Family test (Net Promoter Score), which measures patient satisfaction, on inpatient wards both in terms of coverage (response rate) and results. In addition the Trust will introduce the Friends and Family Test (FFT) in Maternity from October 2013.
Achieving the externally mandated 15% coverage continues to be challenging in our Emergency Department (ED). They are reviewing the process for issuing opinion cards and exploring use of other tools to promote uptake. Each clinician will be expected to issue at least ten cards per shift. An additional wireless device has been purchased. The department is meeting with the Patient Experience team to agree an action plan to improve This will be covered in more detail in the next report.
The Trust is looking at implementing reporting of FFT in each clinical area, along with 'you said, we did' feedback. The trust believes rapid transparent patient feedback will help provide crucial insight, improvement ideas and assurance.

4.2. Trust Board Turnover

Proportion of board members who leave each year

As of 1st July 2012 there were the following members of Whittington's Trust Board:

- Non-Executives: Joe Liddane, Jane Dacre, Peter Freedman, Paul Lowenberg, Sue Rubenstein, Anita Charlesworth, Robert Aitken
- Executives: Yi Mien Koh, Maria Da Silva, Richard Martin, Bronagh Scott and Greg Battle and Martin Kuper

During the year the following executive changes were made:

- In September 2013 Martin Kuper (Medical Director) replaced Celia Ingham-Clark and in June 2013 Lee Martin (Chief Operating Officer) replaced Maria Da Silva
- Additional Executive recruited: Jo Ridgeway

This is equivalent to a 14.3% turnover rate.

4.3. Mixed Sex Accommodation

Zero breached reported across the Trust

Unjustified mixing of genders (i.e. breaches) in sleeping accommodation

4.4. Nurse to Bed Ratio

Data quality is being improved and will be reported in next months report

4.5. Ratio of qualified to unqualified nurses

	Jun-13
% of Registered Nurses	75.3%

Registered Nurses as a proportion of Total Registered Nurses and Healthcare Assistants.

The Trust continues to maintain a high proportion of Registered Nurses to ensure high levels of expertise on wards. There was a change in methodology in June so we have not reported previous months.

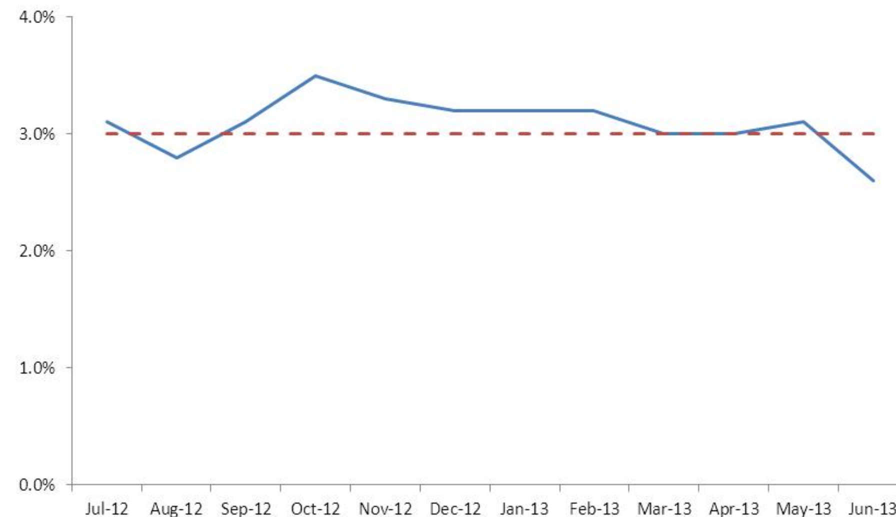
4.6. Proportion of Temporary Staff

This will be reported in next month's Trust Board report.

4.7. Sickness Rate

Proportion of sick days as total available days worked

	Threshold	Apr-13	May-13	Jun-13	QTD Q1 2013/14	YTD 2013/14
Sickness Rate	<3%	3.0%	3.1%	2.6%	2.9%	2.9%

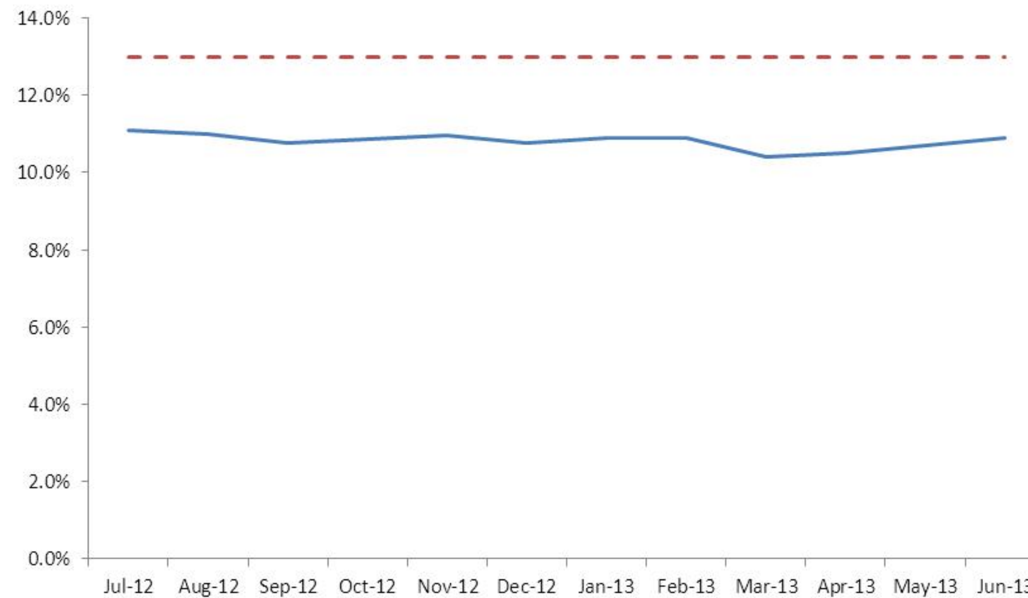


In all divisions, managers are focusing on staff with high Bradford Scores, which highlights frequent short periods of sick leave. Short term, last minute sick leave is the most disruptive to patient care and is monitored carefully by divisional management teams. Training in managing our sickness policy process is available to all managers.

Proportion of workforce leaving in a given period.

4.8. Staff Turnover

	Threshold	Apr-13	May-13	Jun-13	QTD Q1 2013/14	YTD 2013/14
Staff Turnover	<13%	10.5%	10.7%	10.9%	10.7%	10.7%

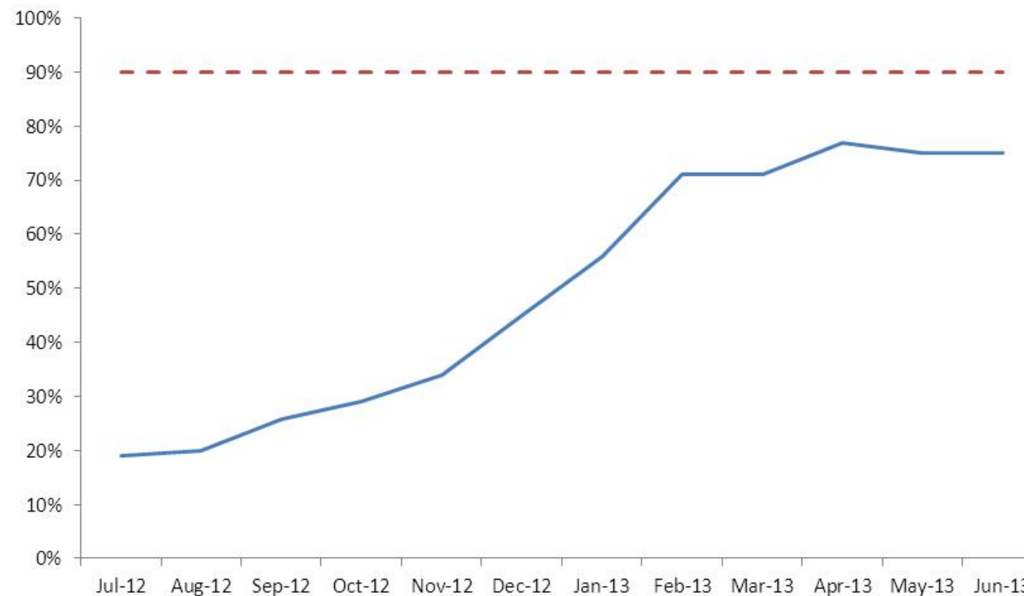


Staff turnover has been maintained below target levels.

4.9. Staff Appraisal

% of substantive staff members with an up to date appraisal recorded on ESR.

	Threshold	Apr-13	May-13	Jun-13	QTD Q1 2013/14	YTD 2013/14
Staff Appraisals	90%	77%	75%	75%	75%	75%

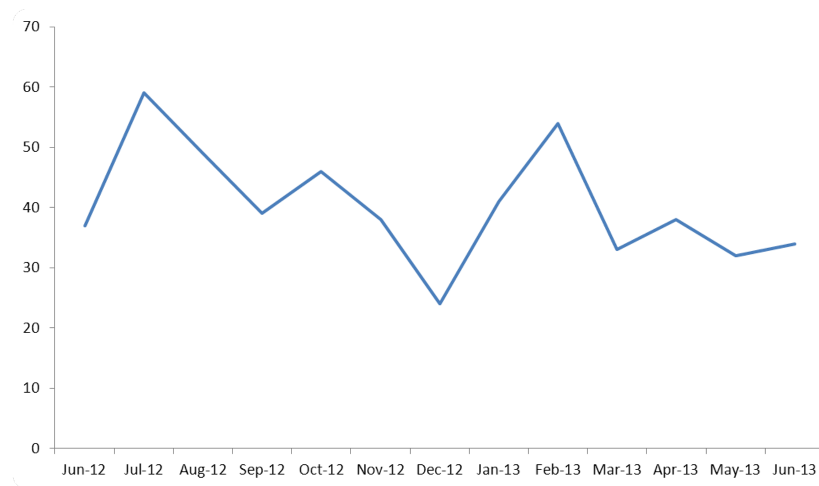


Appraisal rates are closely monitored at divisional level and issues have been identified with staff not completing the sign off process on the Electronic Staff Record (ESR). Manual counts show higher rates and this issue is being resolved in conjunction with Human Resources (HR)

4.10. Complaints

	Apr-13	May-13	Jun-13	QTD Q1 2013/14	YTD 2013/14
Complaints received	38	32	34	104	104
Percentage of complaints responded to within required timeframe	42.1%	59.4%	See note	50.0%	50.0%

Note: Complaints response times data is available one month in arrears as 25 working days must have elapsed.



Formal complaints made about Trust services. The standard response time is 80% within 25 working days

The most pressing issue regarding complaints continues to be unsatisfactory response times. In April, 42% were responded to within the 25 working day standard. This increased to 58% in May. The Trust expects to achieve the 80% standard by September. A new process for managing complaints was implemented three months ago which includes phoning the complainant within 24 hours of receipt of the complaint and the implementation of simple and complex letters. This has improved performance. Divisions are working with the PALS team to facilitate a quicker response time, e.g. by pulling notes more quickly. In addition the complaints team are developing a top ten tips guide with some good examples of complaint responses that can be circulated to staff.

4.11. Dementia (CQUIN)

Agreed target for screening, assessing and referring inpatients aged over 75 years.

	Threshold	Apr-13	May-13	QTD Q1 2013/14	YTD 2013/14
Screening	90%	85%	92%	89%	89%
Assessment	90%	100%	100%	100%	100%
Referral	90%	91%	81%	85%	85%

The Dementia CQUIN group monitors performance monthly, and mid-month Dr. Rosaire Gray (Clinical Director and Lead for Dementia) checks progress against each indicator from an interim patient identifiable list.
Screening is encouraged by a daily list that identifies patients who are over 75 years and who have not been screened, and this is actively followed up with the wards and doctors to ensure that they ask the screening question and record the answer.
In April a couple of wards did not do well on screening, this has been followed up and performance has improved. The plan is to remind all consultants and doctors of the dementia CQUIN target, to reinforce the importance of doing this, and to incorporate this into the induction of new junior doctors in August.
In May performance dropped for referral, but it should be recognised that with a maximum of 16 patients identified in the month as requiring referral, not referring 2 patients out of 16 potential referrals, or not recording why they were appropriately not referred would make performance drop to miss the target. At the dementia CQUIN meeting on 11 July it was agreed to send a list of reasons where it would not be appropriate to refer and to remind doctors of the importance of recording reasons for not referring as well as recording referrals.
Early signs are that we will meet all the performance targets in the June report. Because numbers are small a quarterly report would be preferable. This has been achieved by the daily screening list, and proactive checking of assessments and referrals.

5. CQC CONCERNS & 3RD PARTY REPORTS

5.1. CQC Concerns

- There are no CQC concerns in place for the Trust.

5.2. Inquests

- As of 12 July 2013, the Trust was involved in a total of 25 active inquests for patients. This is because the Trust was in some way involved with these people when they died. There are currently no adverse issues with respect to Whittington Health arising from these inquests.

6. FINANCE & ACTIVITY

6.1. Activity

	Apr-13	May-13	Jun-13	YTD
Non Elective FFCEs	1,591	1,711	1,595	4,897
GP Written Referrals	3,479	3,844	3,459	10,782
Other Referrals for a First Outpatient Appointment	1,828	1,821	1,733	5,382
First Outpatient Attendances following GP Referral	2,651	2,783	2,689	8,123
All First Outpatient Attendances	4,402	4,471	4,402	13,275
Elective FFCEs	1,974	2,059	1,932	5,965
A&E Attendances	8,012	8,536	8,086	24,634
Community Contacts	59,633	62,714	60,613	182,960
Numbers Waiting on an Incomplete RTT Pathway	15,307	15,799	15,766	n/a

FFCEs means First Finished Consultant Episodes We are currently working with commissioners to sign off planned activity and this will be presented once agreed.

7. OTHER FOCUS AREAS

7.1. Data Quality

- The Trust is making a concerted effort to ensure data quality undergoes continuous improvement across a number of key areas. To this end a Data Quality Improvement Plan (2013/14) has been agreed by the Trust Audit and Risk Committee and they will receive monthly updates.
- It will focus on the following areas, implementing or renewing assurance programmes for each:
  - Clinical coding accuracy (Dec 13)
  - Key outpatient data (Sept 13)
  - Emergency Department timing points (Sept 13)
  - Referral to treatment (RTT) status (Sept 13)
  - Patient demographics (Dec 13)
  - Admission /discharge date (Sept 13)
  - Cancer data (Sept 13)
- This work will be coordinated by the Trust's Data Quality Group, which has representation from Operations, Performance, Information and IT.

7.2. Community Waiting times

Waiting times for our community services are subject to a wide ranging project to improve data quality. This includes planning the introduction of referral to treatment rules for measuring and managing community waiting times in April 2014. All community waiting times are being reviewed to ensure good data quality.

7.3. Theatre Utilisation

	Threshold	Apr-13	May-13	Jun-13	QTD Q1 2013/14	YTD 2013/14
Theatre Utilisation	>90%	71.5%	74.0%	75.0%	73.4%	73.4%

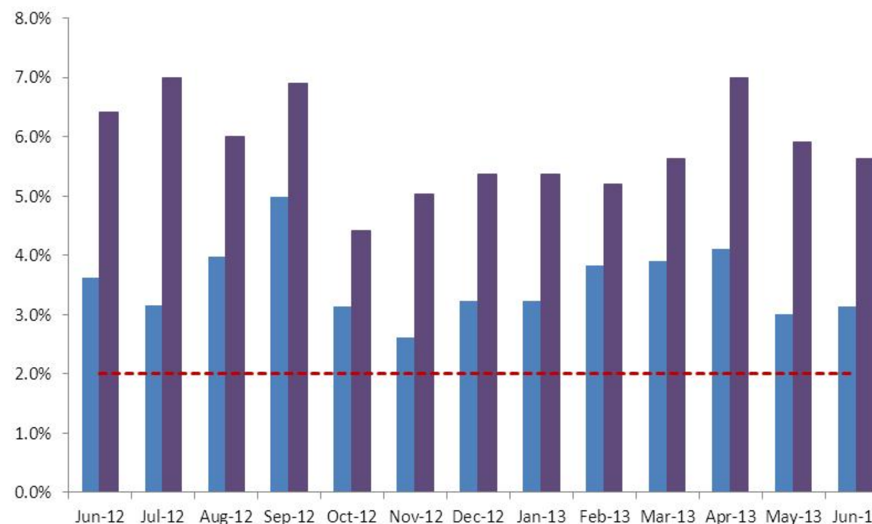
	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13	Apr-13	May-13	Jun-13
Theatre Utilisation	73%	72%	72%	75%	71%	72%	71%	71%	77%	71%	74%	75%
Threshold	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%

Theatre Utilisation is based on total time spent within the scheduled theatre session for each individual patient divided by the available session time. For example, during week ending 30/06/2013, 175 hours out of 233 hours scheduled time in theatres was utilised.

A new report has been designed for theatre utilisation and has been discussed at surgery board and will be displayed in theatres.
Intense daily monitoring has commenced with theatre coordinators tasked to identify on the day delay reasons.
Work is ongoing via the admissions team and service managers to fill operating lists with appropriate patients to ensure full lists.
The Assistant Service Manager for Anaesthetics is to commence contacting surgeons 72 hours prior to the start of the operating lists to ensure that there are no changes to the lists on the day of surgery.

7.4. Hospital Cancellation Rates

	Threshold	Apr-13	May-13	Jun-13	QTD Q1 2013/14	YTD 2013/14
First	2%	3.7%	4.4%	3.1%	3.8%	3.8%
Follow-Up	2%	6.2%	6.2%	5.6%	6.0%	6.0%



Percentage of total first and follow up outpatient appointments that the hospital cancels and the rebooked appointment results in a delay to the patient.

Work is underway to review templates to ensure that booking is appropriately done and therefore minimise risk of cancellation due to overbookings. This work is already beginning to reduce cancellation rates for new bookings. As a result of wider work to reduce the number of longer waiters a significant number of patient appointments have been brought forward and other shorter waiters have been pushed back slightly to accommodate. A number of services will move to partial booking with the full implementation of Transforming Patient Experience programme and this will have a beneficial impact on unnecessary hospital cancellations.

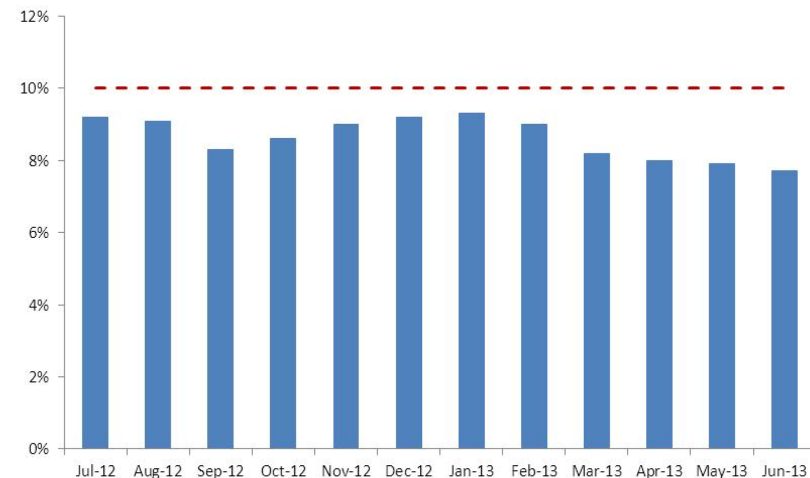
7.5. Did Not Attend (DNA) Rates

Combined First & Follow Up	Threshold	Apr-13	May-13	Jun-13	QTD Q1 2013/14	YTD 2013/14
Acute	<=8%	12.8%	12.9%	12.7%	12.7%	12.7%
Community	<=10%	8.0%	7.9%	7.7%	7.9%	7.9%

Percentage of outpatient appointments where the patient does not attend without contacting the trust to cancel the appointment before the appointment time.

Acute

Community

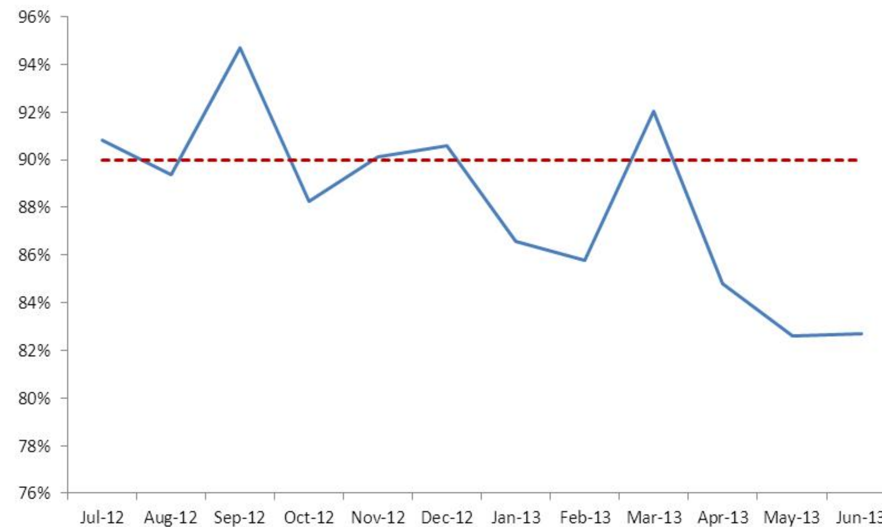


A whole system review of DNA rates is currently underway as part of the wider Referral to Treatment Improvement Programme. It is anticipated that improvements in adherence to access policy, booking rules, reminders, and partial booking will have a positive impact on DNA Rates. In addition letters to patients now include an explicit reference to the new access policy that states that if the patient does not attend, they will be discharged back to their GP. Paediatrics have recently introduced a "was not brought" policy and have seen a reduction in DNAs as a result.

7.6. Women seen by Health Care Professional (HCP) within 12 weeks and 6 days (12+6)

	Threshold	Apr-13	May-13	Jun-13	QTD Q1 2013/14	YTD 2013/14
% Women seen by HCP or midwife within 12 weeks and 6 days	>=90%	84.8%	82.6%	82.7%	83.0%	83.0%

Percentage of pregnant women who have seen a midwife or a maternity healthcare professional, for health and social care assessment of needs, risks and choices by 12 weeks and 6 days of pregnancy



39 women in total were seen beyond 12+6 weeks. Of those, 25 chose to be seen later and 14 did not. Of those who chose to wait longer the majority were seen within 15 weeks. Referrals for three women were received within a week of breaching and capacity was not available to see them within target. Some 'breaches' were due to delays in administrators passing on referrals to midwives or miscalculating gestations resulting in delays. IT have been asked to install the online obstetric calculator onto computers to assist the midwives in double checking dates. The booking team have also been told to ensure they are not delaying the sending of referrals to midwives. In addition there have been reporting issues associated with the new Maternity EPR introduced in May that means that one of the 'breaches' should not form part of the cohort.

7.7. Mandatory Training Compliance

	Threshold	Apr-13	May-13	Jun-13	QTD Q1 2013/14	YTD 2013/14
Mandatory Training Compliance	90%	83%	83%	80%	80%	80%
Information Governance Training Compliance	95%	83%	83%	84%	84%	84%

Percentage of all outstanding training courses that have been completed. Includes: Child Protection L1; Child Protection L2; Child Protection L3;Equality & Diversity; Fire Safety; Health & Safety; Infection Prevention and Control; Information Governance; Moving & Handling; Resuscitation; Risk Management; Safeguarding Adults; Conflict Avoidance

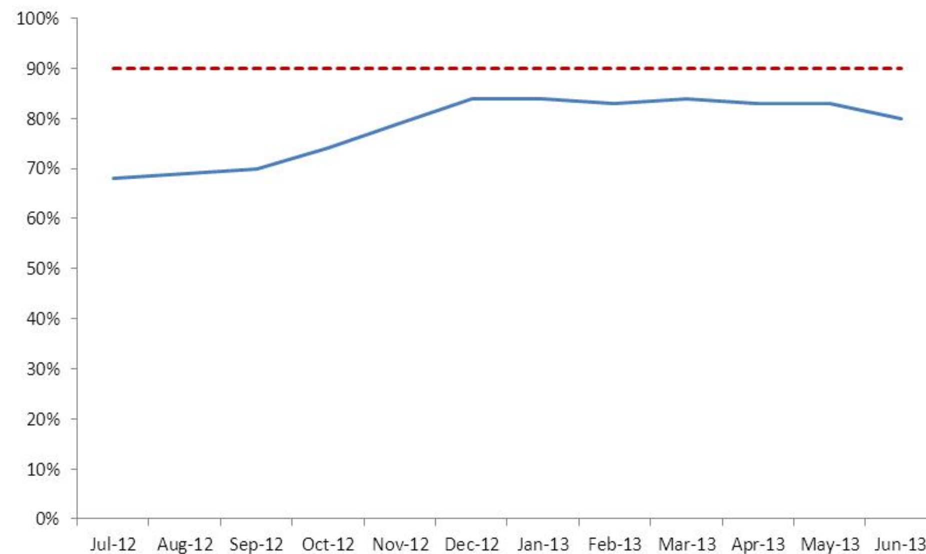


Chart shows overall compliance

Ensuring all staff have completed mandatory training continues to be a focus for the Trust. Staff are receiving emails from the Trust Learning and Development team and their managers to follow up on non compliance. Progress is closely monitored at divisional level. The methods of delivering mandatory training are being reviewed Trust-wide to look at other methods to ensure better compliance. In addition, annual training plans will be implemented across all areas within divisions to ensure a systematic approach to managing training is achieved. A trajectory is to be agreed in time for the next Trust Board report.