Information and Performance
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The Whittington Hospital NHS Trust
Magdala Avenue
London N19 5NF

Whittington Health Trust Board

23 October 2013

Title:	Trust Board Performance Report October 2013 (Septembers data)		
Agenda item:	**13/137**	**Paper**	**5**
Action requested:	For discussion and information		
Executive Summary:	The Trust Board Performance Report is designed to assure the Board that performance is on track within the organisation and, where performance is under agreed levels, what the service/division/organisation is undertaking to rectify. Key headlines: • Following the introduction of the new Electronic Patient Record (EPR), the Trust is still validating end-of-month data and finalising our new reporting system. This has affected data on our referral to treatment (RTT), diagnostics and Emergency Department waiting times. This will be updated for the November Board meeting. • The Trust's community face-to-face contacts have increased by more than 40,000 from the same period last year, highlighting the benefit of an integrated care organisation on our local community • Delayed transfers of care to intermediate settings have reduced to 2.5% showing the new process introduced in May is embedded and sustaining well. • A key priority for the Trust is ensuring that appointments have a timely outcome entered electronically. Performance is being checked by managers to ensure adherence to policy.		
Summary of recommendations:	None		
Fit with WH strategy:	All five strategic goals		
Reference to related / other documents:	N/A		

Date paper completed:		16/10/2013					
Author name and title:		**Karen Hayller**		**Director name and title:**		**Sally Batley**	
Date paper seen by EC		**Equality Impact Assessment complete?**		**Risk assessment undertaken?**		**Legal advice received?**	

Whittington Health NHS

Trust Board Performance Report
October 2013
September Performance

Priorities

Emergency department access a focus for all divisions.

The Referral to treatment (RTT) recovery plan is on track against projections to 21st September.

All divisions are focused on achieving the financial recovery plan.

Integrated Winter Plan

Integrated Care and Acute Medicine Division

- Emergency Department (ED) performance targets and improvement plan,
- Improvement in quality and complaints,
- Implementation of Ambulatory Care (AEC)

Surgery, Cancer and Diagnostics Division

- Theatre plan for Christmas
- HR recruitment for existing positions
- Theatre utilisation improvement plan – 85% utilisation by March 2014 and 95% by June 2014
- Quality

Women, Children and Families Division

- Maternity Staffing
- Maternity and Neonatal Strategy
- Child Protection
- The Big Lottery in partnership with Barnardos and Haringey

Board Aims

All indicators have been mapped to the Trust’s strategic goals.

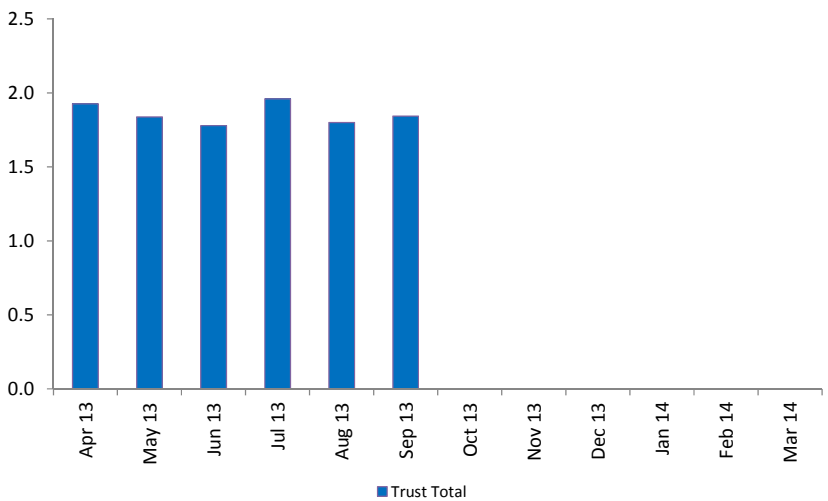
First: Follow-up ratio - Acute

Deliver

Focus Areas

	Transformation Board Threshold	Jul 13	Aug 13	Sep 13
Acute Trust Total	-	1.96	1.80	1.84

Ratio comparing the number of follow-up appointments seen in comparison to first appointments.



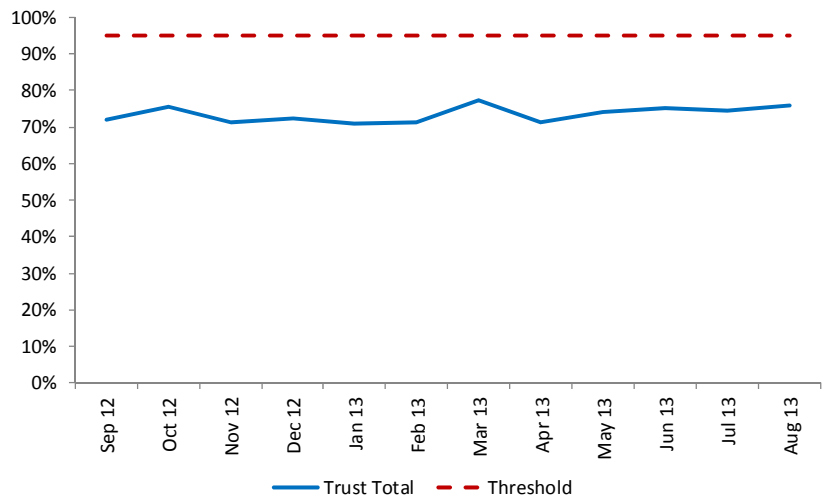
Plans are in place to reduce the follow-up ratio. The waiting list policy, DNA policy and clinic reconciliation sheets are all live, and will ensure patients are discharged in a timely way. However, because of Referral to Treatment (RTT) and long waiters being treated, the effects of these initiatives has been temporarily reduced. The second stage of the plan is for general managers to lead quality assurance programmes to ensure they are being embedded throughout the organisation as business as usual. A trust wide improvement program will commence in November to reduce follow up appointments.

Theatre Utilisation

Deliver

Focus Areas

	Utilisation			Available Session Time (Minutes)			Time Utilised (Minutes)		
	Jul 13	Aug 13	Sep 13	Jul 13	Aug 13	Sep 13	Jul 13	Aug 13	Sep 13
Local Threshold	>95%								
Trust Total	74%	76%	77%	66,750	52,500	62,640	49,671	39,846	48,318



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.

Theatre utilisation project commenced at the end of September, diagnostics are underway and a target projection of 85% utilisation has been set for March 2014. Operational weekly meeting re established and focusing on increasing theatre efficiency and staff booking correctly on to the theatre lists.
Theatre booking rules are being agreed and rapid improvement cycles in place for resolving delays.
Theatre activity was reduced in the last week of September due to EPR implementation.

Data Quality

Deliver

Focus Areas

The activity presented in the dashboard is extracted from the community information system, Rio and our new EPR There is a project underway to improve the data and data extract, but managers should be aware that there may be data anomalies contained in these reports.

Hospital Cancellations - Acute

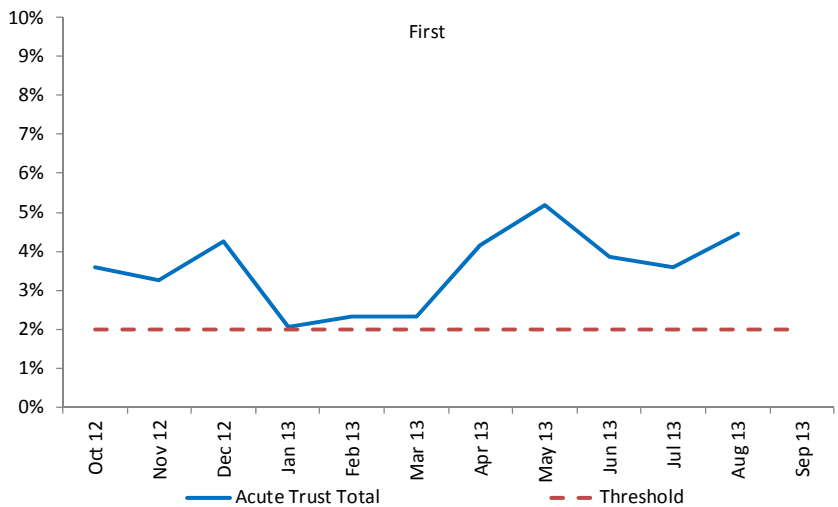
Deliver

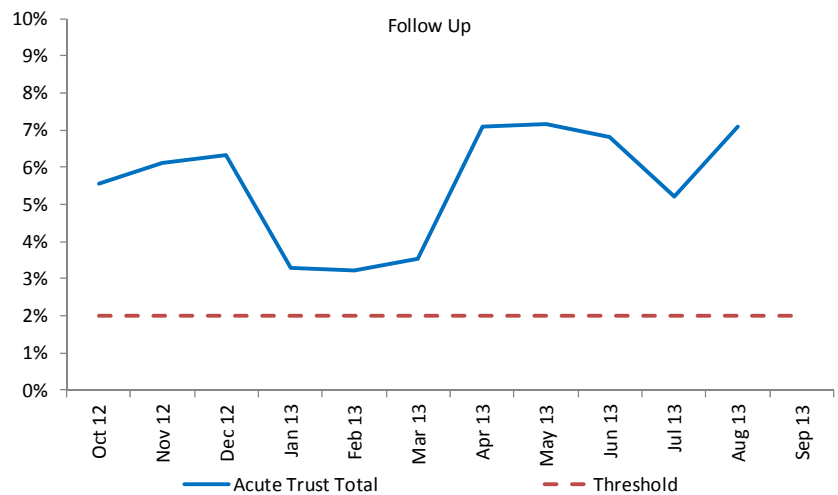
Focus Areas

Sep 2013 dataset is not complete due to EPR reporting issues

	First Appointments			Follow Up Appointments		
	Jul 13	Aug 13	Sep 13	Jul 13	Aug 13	Sep 13
Local Threshold	<2%			<2%		
Acute Trust Total	3.6%	4.4%	-	5.2%	7.1%	-

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





A new process has been put in place to manage hospital cancellation. Demand and capacity analysis has gone live and is being used effectively to take account of annual leave ensuring the planned service is still delivered to patients.

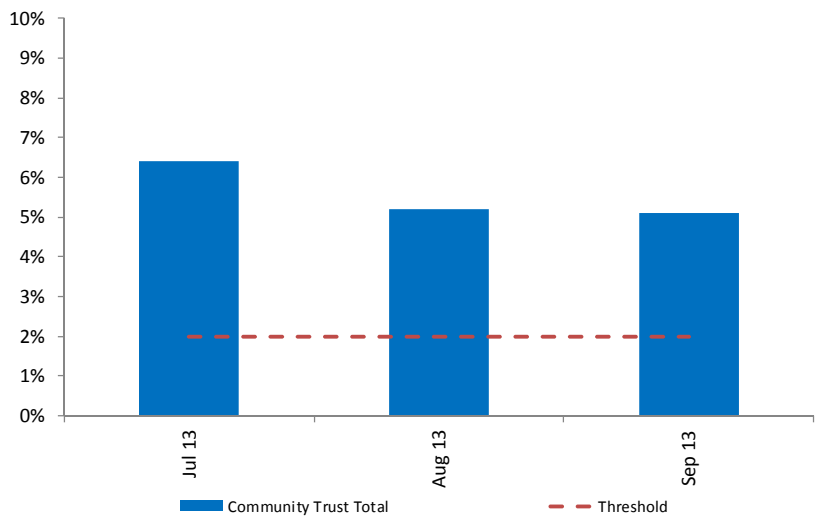
Service Cancellations - Community

Integrate

Focus Areas

	First + Follow-Up		
	Jul 13	Aug 13	Sep 13
Local Threshold	2%		
Community Trust Total	6.4%	5.2%	5.1%

The proportion of outpatient appointments that are cancelled by the Trust. Outpatient appointments are defined as all booked appointments including home visits in addition to those in a clinical setting.



A plan is being developed to manage service cancellations in the community.
Cancellations will be managed by adopting the same process of escalation as the access policy. This will mean that there is a Trust wide policy on service cancellations.

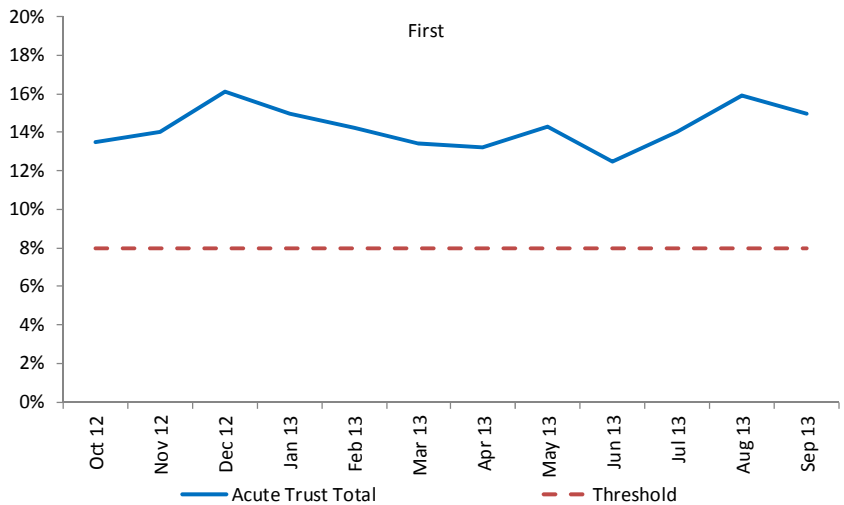
Did Not Attend (DNA) Rates - Acute

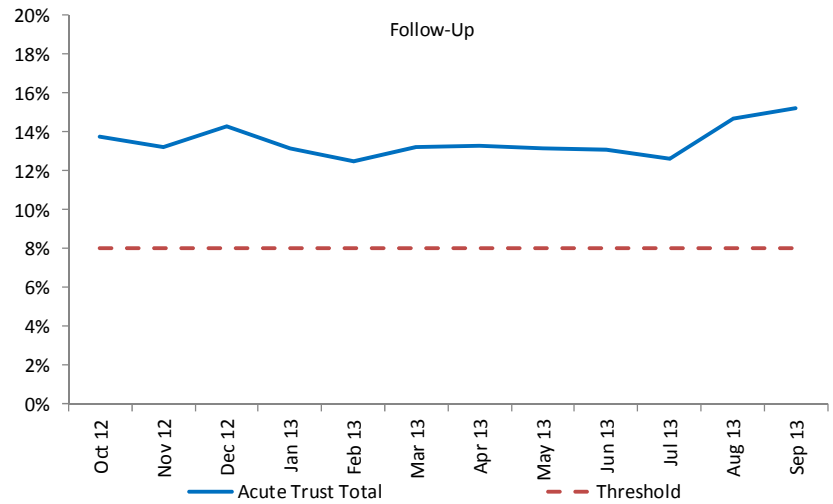
Deliver

Focus Areas

	First Appointments			Follow Up Appointments		
	Jul 13	Aug 13	Sep 13	Jul 13	Aug 13	Sep 13
Local Threshold	8%			8%		
Acute Trust Total	12.3%	13.7%	13.0%	12.6%	14.7%	15.2%

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





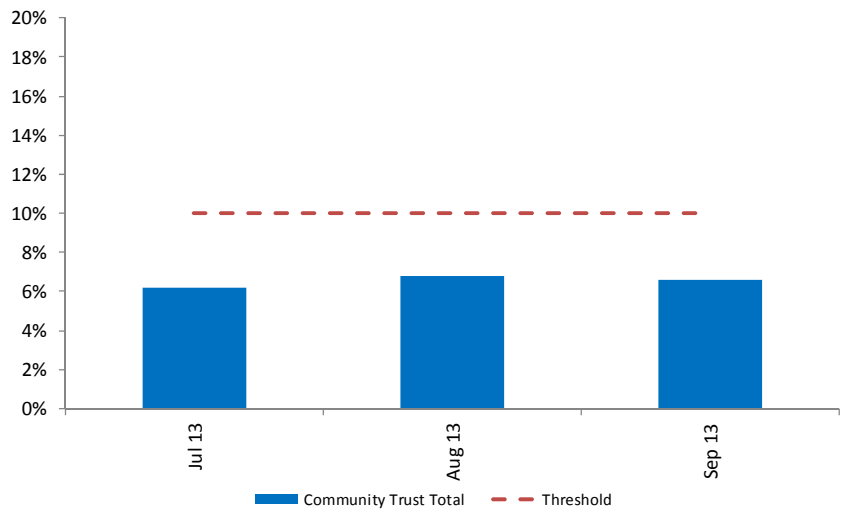
Currently the backlog of the longest waiting patients is being cleared. Unfortunately, this is having a knock on effect on the did not attend (DNA) policy.
Text messaging and reminder calls are in place with the expectation to see on-going impact on service areas.
A Organisational Improvement Plan is being designed for delivery in November to reduce DNA and patient cancelations.

DNA Rates - Community

Integrate

Focus Areas

First + Follow-Up	Jul 13	Aug 13	Sep 13
Local Threshold	10%		
Community Trust Total	6.2%	6.8%	6.6%



The proportion of outpatient appointments that result in a DNA(Did Not Attend) or UTA (Unable to Attend). Outpatient appointments are defined as all booked appointments including home visits in addition to those in a clinical setting.
DNA levels are a useful indicator of the level of patient engagement. High levels of DNAs impact on service capacity. UTAs reflect short notice cancellations by the patient where the appointment cannot be refilled.

Text messaging and reminder calls are in place with the expectation to see on-going impact on service areas.
An Organisational Improvement Plan is being design for delivery in November to reduce DNA and patient cancelations.

Community Face-to-Face Contacts

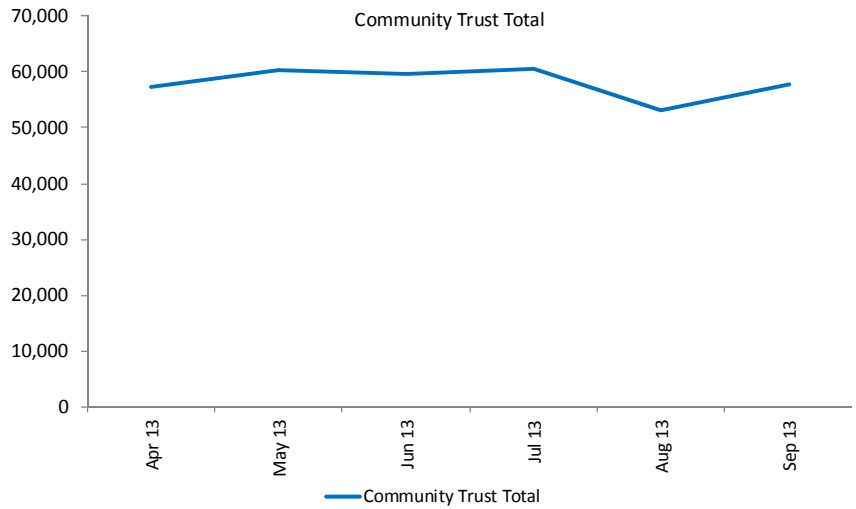
Integrate

Focus Areas

	Jul 13	Aug 13	Sep 13
Threshold	n/a		
Community Trust Total	60,536	53,034	57,681

2012/13 Apr - Sep	2013/14 Apr - Sep	Variation
n/a		
308,417	348,506	12%

The number of attended 'Face to Face' Contacts that have taken place during the month indicated. First and follow up activity. Excludes non face to face contacts such as telephone contacts.



We are above expected position in our community contacts overall and have increased our contacts by more than 40,000 compared to the same period last year.

Community appointments with no outcome

Integrate

Focus Areas

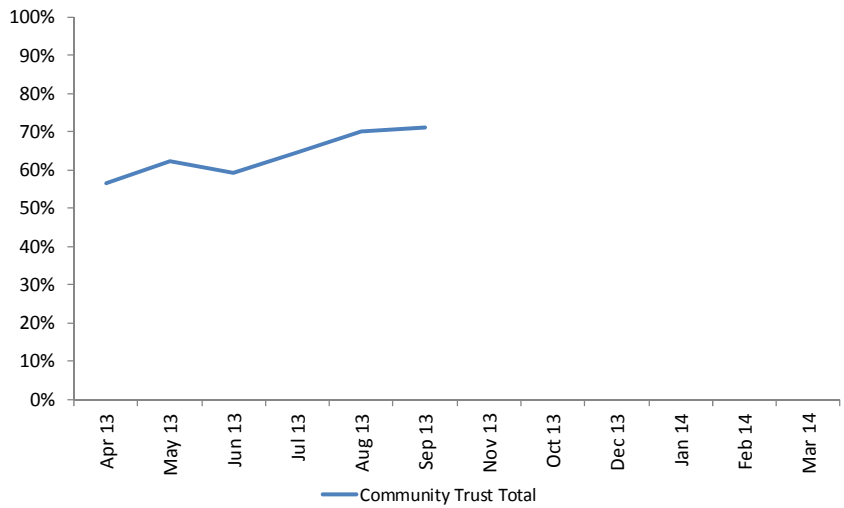
	Sep 13	% of Total Face-to-Face Contacts
Local Threshold	n/a	0.5%
Community Trust Total	2,336	4%

Appointments that do not have an outcome entered by the data deadline of the 3rd working day of the following month. Clinicians are required to complete this action. Failure to complete this field correctly impacts on a number of measures where open caseloads are used as a denominator.

This is a key priority moving forward. There is a work practice and technical issue which, could potentially be solved once we go live with community EPR (planned October 2014), currently our clinicians need to complete different screens in our patient information system to ensure an appointment has an outcome appropriately entered. We are designing reminder emails to ensure this becomes common practice and is regularly checked by managers to ensure timely outcome of appointments.

Community Waiting Times
% waiting less than 6 weeks

	Jul 13	Aug 13	Sep 13
Threshold	n/a		
Community Trust Total	64.7%	69.9%	71.1%



The percentage of patients waiting less than 6 weeks for attended 'Face to Face' initial appointments. The waiting time from the date the referral was received to the initial attended 'Face to Face' contact is measured for the month. Where patients DNA the waiting time is measured as the time between the DNA appointment and the initial attended 'Face to Face' contact.

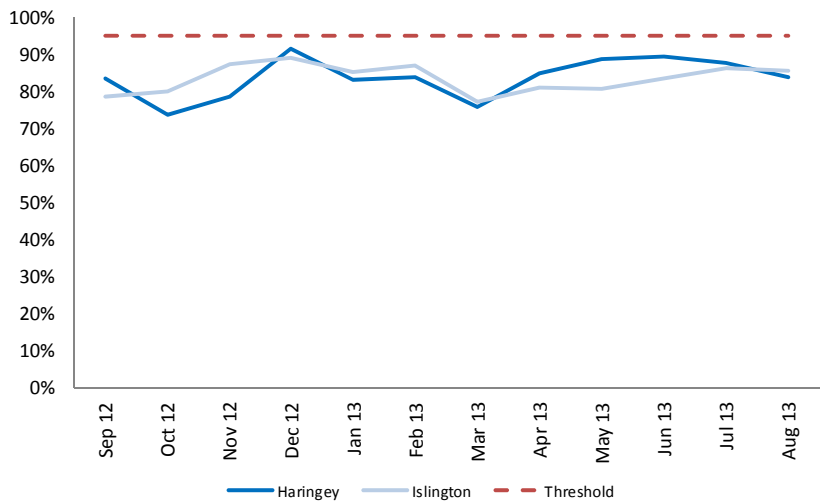
We should begin to see an overall improvement in the waiting times as our access policy starts to embed. We need to discuss with our commissioner an acceptable target for this moving forward as different specialties have a wide range of acceptable waiting times through preliminary diagnosis.

New Birth Visits

Integrate

Focus Areas

	Jun 13	Jul 13	Aug 13
Local Threshold	95%		
Haringey	89.4%	87.6%	84.0%
Islington	83.7%	86.5%	85.5%



The proportion of new mothers and their babies visited by health visiting services between 10 and 14 days inclusive after birth in accordance with recommended best practice. There is a local target to achieve 95%.

RADAR Report Numbers:
Islington: 2262
Haringey Children 2267

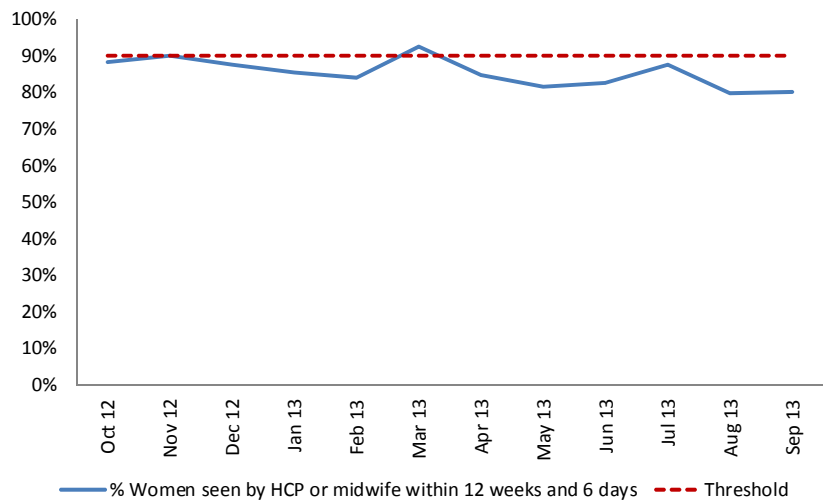
We are still working towards the 95% target. Our health visitor recruitment campaign is still underway to ensure we have the resources to achieve this important visit for parents and families.

Women seen by HCP or midwife within 12 weeks and six days

Deliver

Focus Areas

	Threshold	Jul 13	Aug 13	Sep 13
% Women seen by HCP or midwife within 12 weeks and 6 days	90%	87.5%	79.6%	80.3%
Total Number of Bookings	-	421	376	369
Referrals within 12 Weeks anc 6 days	-	359	324	319



Percentage of pregnant women referred before 12 weeks 6 days of pregnancy 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

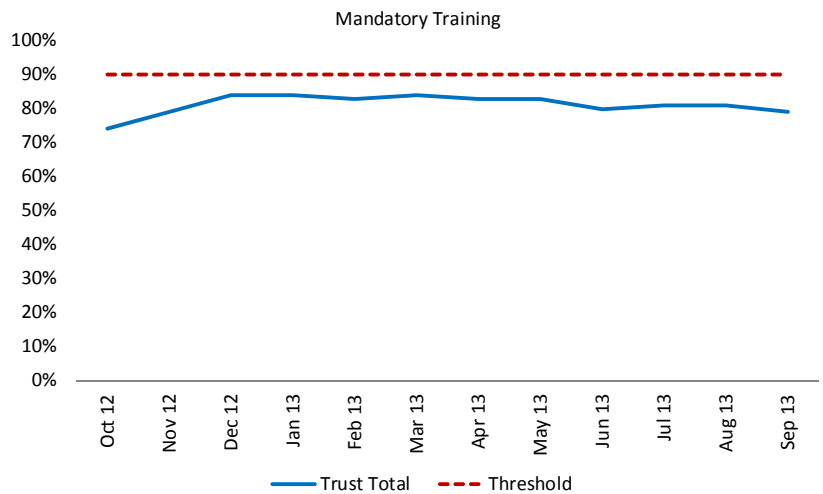
We are still working towards seeing all women within 12 weeks and six days, but historically we have women booking late. Further investigation needs to be made in midwifery as the number of bookings is reducing. Our next focus area is to work with our CCG's to ensure Primary Care refers pregnant women in a timely way.

Mandatory Training Compliance

Change

Focus Areas

	Mandatory Training			Information Governance			Child Protection Level 2			Child Protection Level 3		
	Jul 13	Aug 13	Sep 13	Jul 13	Aug 13	Sep 13	Jul 13	Aug 13	Sep 13	Jul 13	Aug 13	Sep 13
Local Threshold	90%			95%			90%			90%		
Trust Total	81%	81%	79%	82%	82%	77%	52%	58%	60%	55%	60%	62%



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

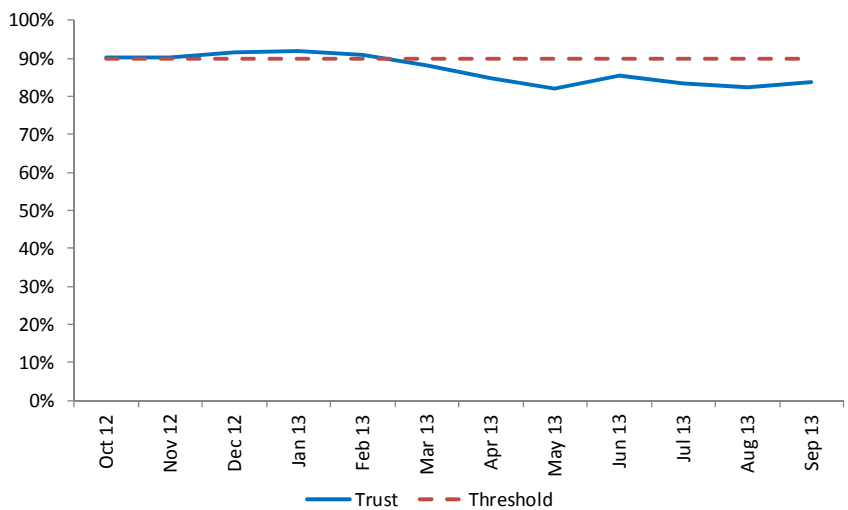
Monitoring remains in place to ensure that staff are re accredited prior to expiry to ensure a trajectory to achieve the 90% compliance. Detailed action plans will be completed and specific staff target who are non compliant.
The current safeguarding training figures reported on ESR are slightly inaccurate and the current numbers manually counted are: Level 1 82%, Level 2 59% and Level 3 64% .
We have raised the ESR issues with HR and there is a meeting arranged with the key stakeholders to work towards resolution.

Referral to Treatment 18 weeks - Admitted

Deliver

Access Metrics

	Jul 13	Aug 13	Sep 13
National Threshold	90%		
Trust Total	83.5%	82.3%	83.6%



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

Sep 2013 data is unvalidated

Following the introduction of the new Electronic Patient Record, we are still validating end of month data and finalising our new reporting system. An update will be provided in the next performance report.

Referral to Treatment 18 weeks – Non Admitted

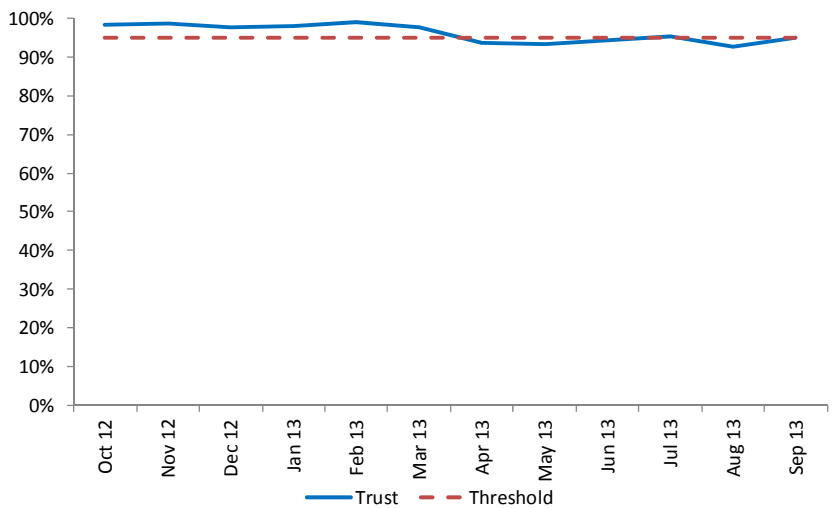
Deliver

Access Metrics

	Jul 13	Aug 13	Sep 13
National Threshold	>95%		
Trust Total	95.3%	92.8%	95.2%

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

Sep 2013 data is unvalidated



Following the introduction of the new Electronic Patient Record, we are still validating end of month data, and finalising our new reporting system. An update will be provided in the next performance report.

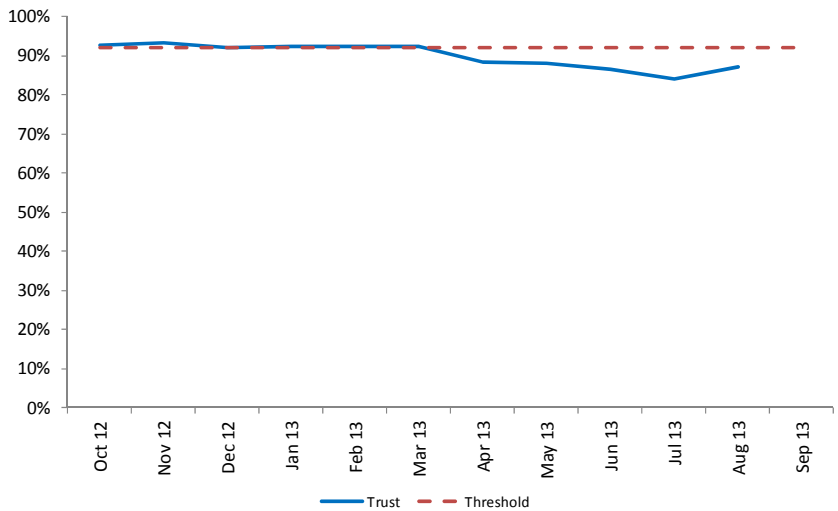
Referral to Treatment 18 weeks - Incomplete

Deliver

Access Metrics

Sep 2013 dataset is not complete due to EPR reporting issues

	Jul 13	Aug 13	Sep 13
National Threshold	92%		
Trust Total	84.0%	87.1%	-



Following the introduction of the new Electronic Patient Record, we are still validating end of month data and finalising our new reporting system. An update will be provided in the next performance report.

Referral to Treatment 18 weeks – 52 Week waits

Deliver

Access Metrics

Sep 2013 dataset is not complete due to EPR reporting issues

	Jul 13	Aug 13	Sep 13
National Threshold		0	
Trust Total	41	22	-

Following the introduction of the new Electronic Patient Record, we are still validating end of month data and finalising our new reporting system. An update will be provided in the next performance report.

Diagnostic waits

Deliver

Access Metrics

	% Waiting <6 Weeks		
	Jul 13	Aug 13	Sep 13
National Threshold	99%		
Trust Total	89.7%	96.4%	93.7%

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).

Sep 2013 data is unvalidated

These are currently being validated. Our expected performance is that they are on track to achieve performance by the end of October. Action plans are in place.

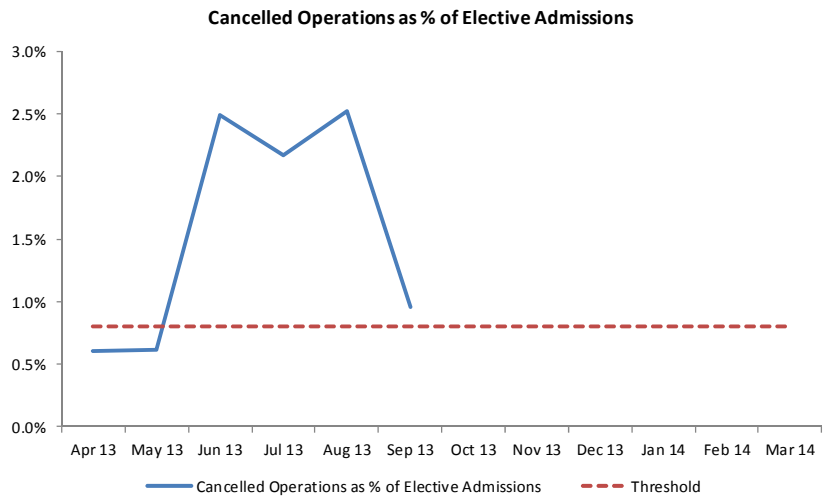
Hospital Cancelled Operations

Deliver

Access Metrics

Hospital initiated cancellations on day of operation

	Number of Cancelled Operations			Cancelled Operations as % of Elective Admissions			Cancelled Operations not rescheduled within 28 days		
	Jul 13	Aug 13	Sep 13	Jul 13	Aug 13	Sep 13	Jul 13	Aug 13	Sep 13
National Threshold	0			< 0.8%			0		
Trust Total	21	13	5	2.2%	2.5%	1.0%	0	0	0



A new process is in place. There is further work to be done but early signs of improvement can be seen.
This is monitored as part of the theatre weekly utilisation meeting to ensure that the escalation process is adhered to.
Potential on the day cancellations are escalated to the Chief Operating Officer and the Divisional Director.

Emergency Department waits

Deliver

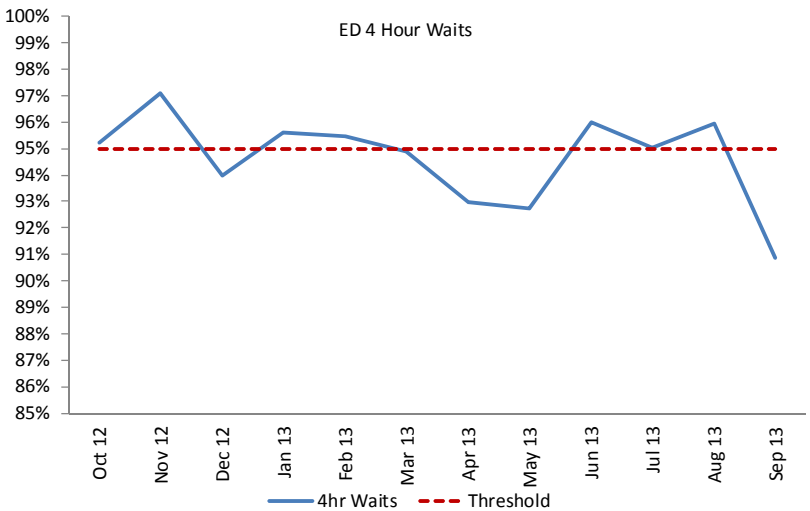
Access Metrics

Patients waiting either 4 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".

ED Waits

	Jul 13	Aug 13	Sep 13
National Threshold	95%		
4hr Waits	95.0%	95.9%	90.8%
12hr Waits	0	0	1

Sep 2013 ED Clinical Quality Indicators data is unavailable due to delay in development of reports from EPR



Clinical Quality Indicators	Jul 13	Aug 13	Sep 13
Total Time in ED (95th % Wait < 240 mins)	255	239	-
Total Time in ED - Admitted (95th % Wait < 240 mins)	388	377	-
Total Time in ED - Non-Admitted (95th % Wait < 240 mins)	238	235	-
Wait for Assessment (95th % Wait < 15 mins)	11	11	-
Wait for Treatment (Median <60 mins)	81	58	-
Left Without Being Seen Rate (<5%)	4.8%	3.2%	-
Re-attendance Rate (>1% and <5%)	2.2%	2.2%	-

We have experienced planned delays due to the launch of a new electronic patient record (EPR). Input time has increased and, while technical support has been provided, it has taken significant clinical time to embed the system. An urgent recovery plan is in place.

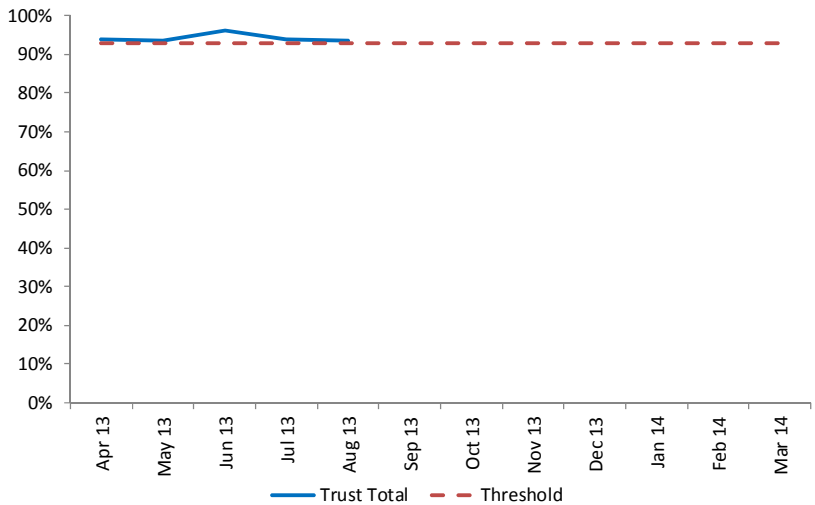
Cancer – 14 days to first seen

Deliver

Access Metrics

14 Days to First Seen

	Jun 13	Jul 13	Aug 13	Q1	Q2 TD	Q3	Q4
National Threshold	93%			93%	93%	93%	93%
Trust Total	96.2%	93.8%	93.5%	94.6%	93.7%	-	-



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.

Data is 1 month in arrears, delayed by 62 Day Reporting

Achieved as per plan

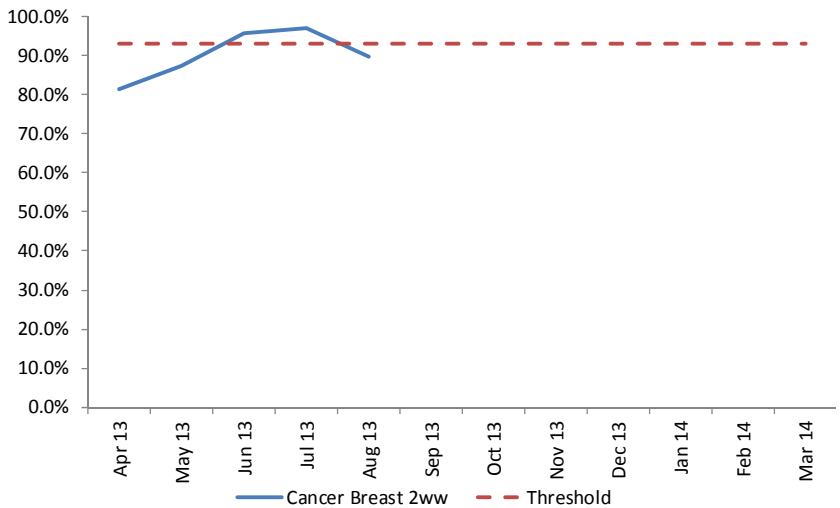
Cancer – 14 days to first seen – Breast symptomatic

Deliver

Access Metrics

14 Days to First Seen - Breast Symptomatic

	Jun 13	Jul 13	Aug 13	Q1	Q2 TD	Q3	Q4
National Threshold	93%			93%			
Trust Total	95.8%	97.2%	89.6%	88.3%	94.0%		



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.

Data is 1 month in arrears, delayed by 62 Day Reporting

This target continues to be challenging and not sustainably delivered. The major issue is patient choice. Data is being presented to the Trust Operation Board (TOB) to request help from clinical commissioning groups (CCGs) to discuss with local GPs as to expectations that patients should be willing and able to attend within 14 days of referral if they are referred by this route.

Cancer – 31 Days to first treatment

Deliver

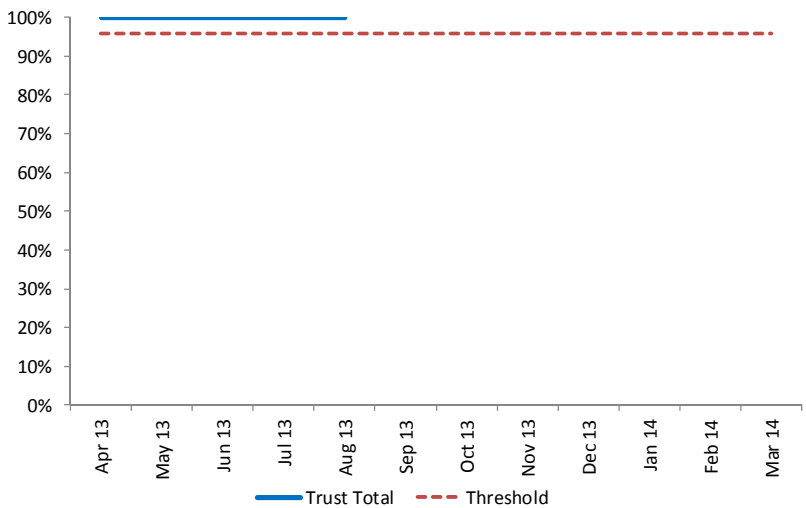
Access Metrics

31 Days to First Treatment

	Jun 13	Jul 13	Aug 13	Q1	Q2 TD	Q3	Q4
National Threshold	96%			96%			
Trust Total	100%	100%	100%	100%	100%	-	-

Data is 1 month in arrears, delayed by 62 Day Reporting

31 day target is timed from diagnosis to treatment.



Delivering to Plan – 100%

Cancer – 31 days to subsequent treatment - Surgery

Deliver

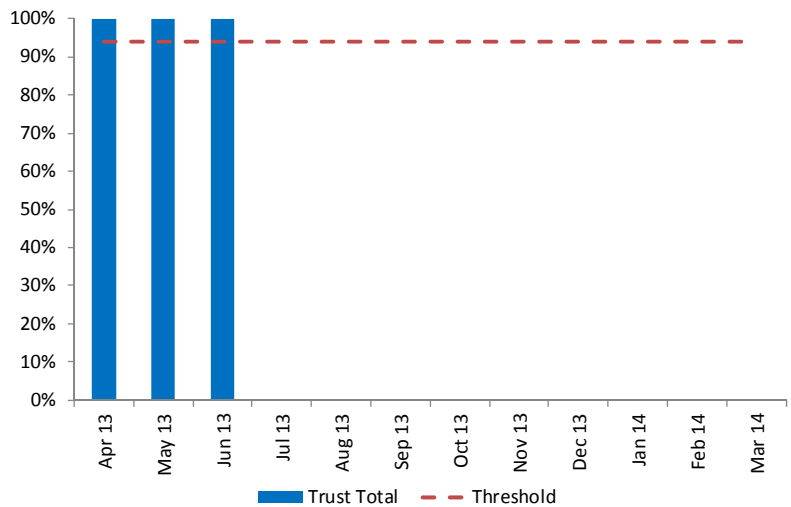
Access Metrics

Data is 1 month in arrears, delayed by 62 Day Reporting

31 day target is timed from diagnosis to treatment.

31 Days to Subsequent Treatment - Surgery

	Jun 13	Jul 13	Aug 13	Q1	Q2 TD	Q3	Q4
National Threshold	94%			94%			
Trust Total	100%	-	-	100%	-	-	-



Delivering to Plan – 100%

Cancer – 31 days to subsequent treatment - Drugs

Deliver

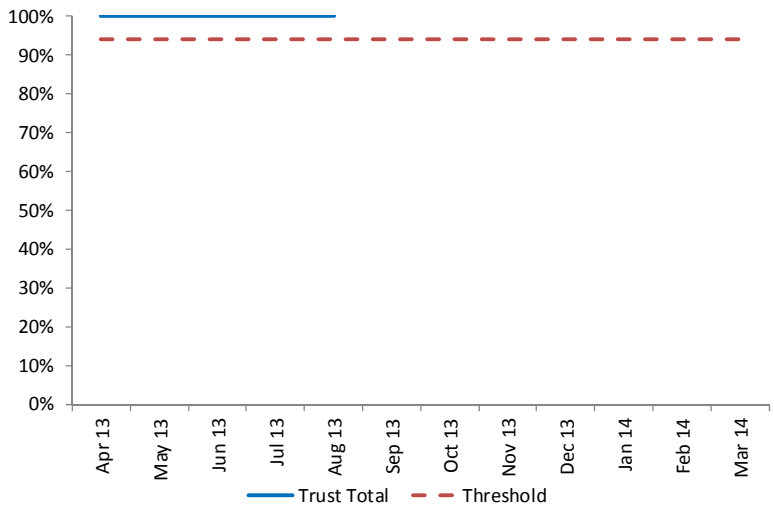
Access Metrics

Data is 1 month in arrears, delayed by 62 Day Reporting

31 day target is timed from diagnosis to treatment.

31 Days to Subsequent Treatment - Drugs

	Jun 13	Jul 13	Aug 13	Q1	Q2 TD	Q3	Q4
National Threshold	94%			94%			
Trust Total	100%	100%	100%	100%	100%	-	-



Delivering to Plan – 100%

Cancer – 62 days from referral to treatment

Deliver

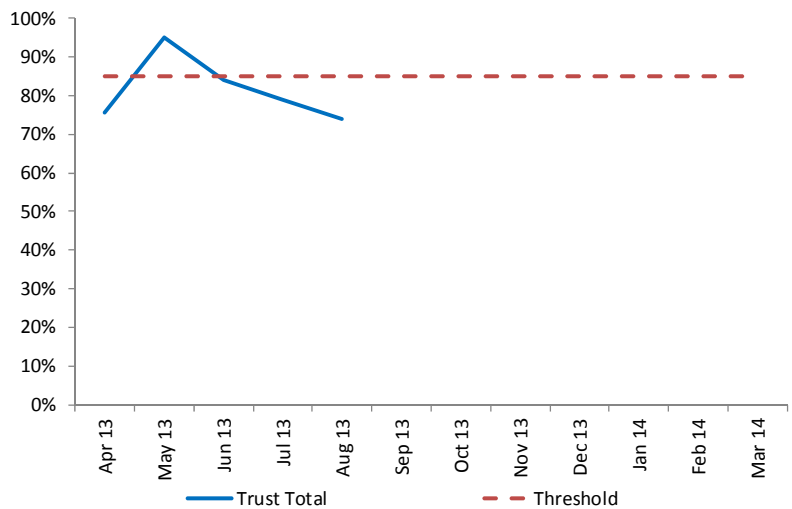
Access Metrics

Data is 1 month in arrears, delayed by 62 Day Reporting

The 62 day targets time of waits from referral to treatment.

62 Days from Referral to Treatment

	Jun 13	Jul 13	Aug 13	Q1	Q2 TD	Q3	Q4
National Threshold	85%			85%			
Trust Total	84.0%	79.1%	73.9%	85.4%	76.4%	-	-



Planned non-compliance in August to remove backlog of longer waiting patients, particularly urology. Plans are in place to be compliant in October 2013.

Cancer – 62 days from consultant upgrade

Deliver

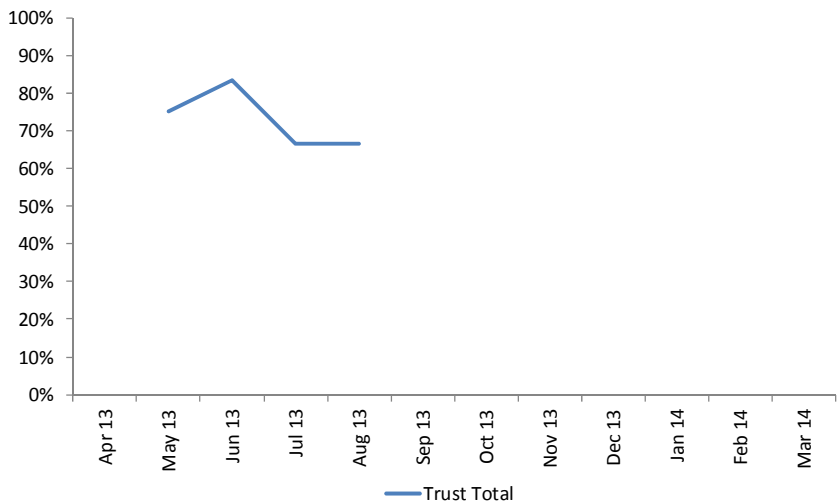
Access Metrics

Data is 1 month in arrears, delayed by 62 Day Reporting

The 62 day targets time of waits from referral to treatment.

62 Days from Consultant Upgrade

	Jun 13	Jul 13	Aug 13	Q1	Q2	Q3	Q4
Trust Total	83.3%	66.7%	66.7%	80%	66.7%	-	-



No target for this currently., however included and monitored in the performance meetings.

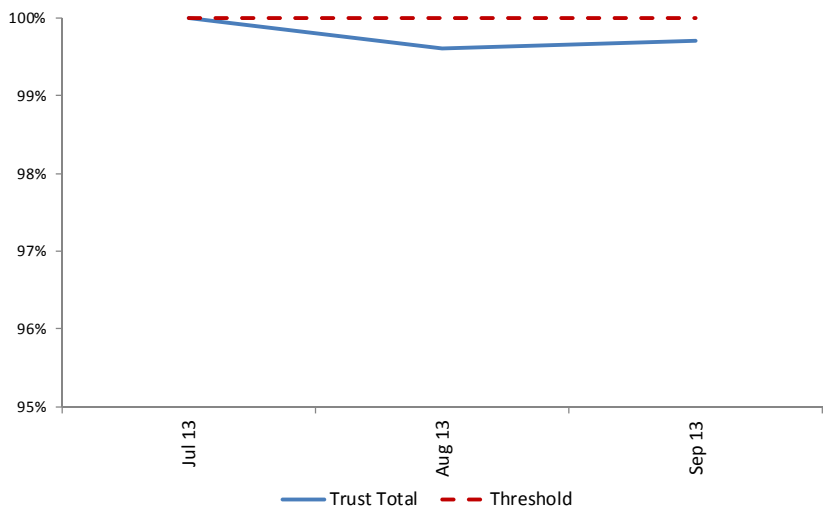
Genito-Urinary Medicine Appointment within 2 Days

Improving

Access Metrics

	Threshold	Jul 13	Aug 13	Sep 13
Trust Total	100%	100.0%	99.6%	99.7%

The percentage of patients offered an appointment within 2 days



Activity has increased. There is a capacity and demand issue in this service that will be investigated.

Delayed Transfers of Care

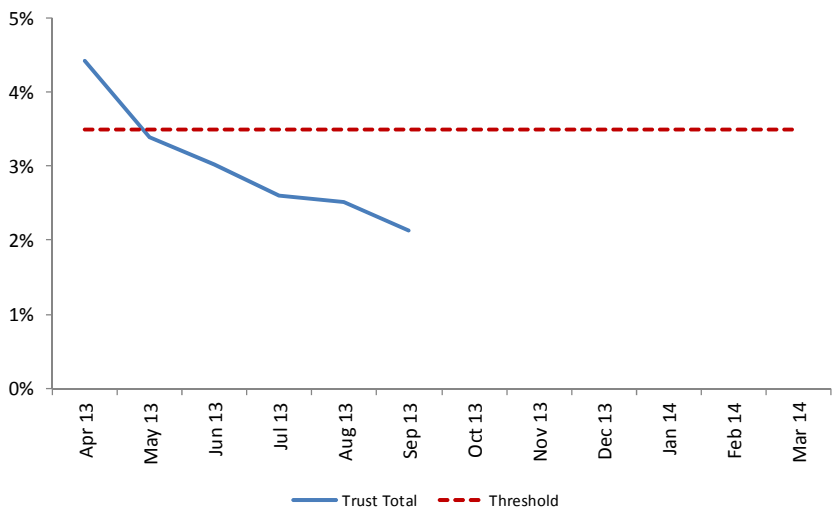
Integrate

Outcome Metrics

Number of Days Delayed

	Sep 13		
	NHS Days	Social Services	Both
Trust Total	120	17	0

	Jul 13	Aug 13	Sep 13
Local Threshold	3.5%		
Trust Total Delayed Transfers	3.0%	2.6%	2.5%



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.

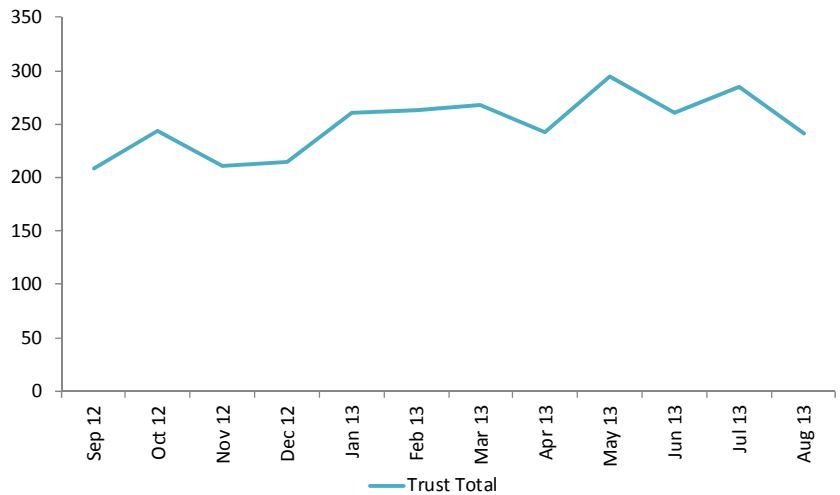
New process has been in place since May. These results show that it has been embedded. Continued close working with the access team and discharge coordinators has been build into the new access processes.

30 day Emergency Readmissions

Deliver

Outcome Metrics

	Jun 13	Jul 13	Aug 13
Trust Total	260	285	241



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

Data is 1 month in arrears due to requirement for clinical coded data

A review of the emergency admissions is commencing and improvements are being implemented as part of the Enhanced Recovery to focus on patient education (what to expect when at home) and follow up telephone calls to patients within 24 hours of discharge.

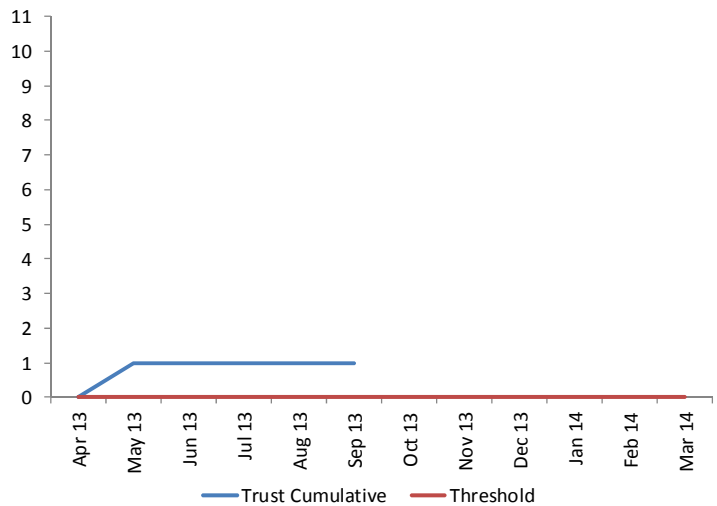
MRSA

Deliver

Outcome Metrics

Number of MRSA bacteraemia (bacteria in the blood)

	Jul 13	Aug 13	Sep 13
National Threshold		0	
Trust Total	0	0	0



No further post 48 hrs MRSA bacteraemia since May 13. Three pre 48 hrs MRSA identified to date this year. Hand hygiene audits continue and a hand hygiene campaign is due for January 14.

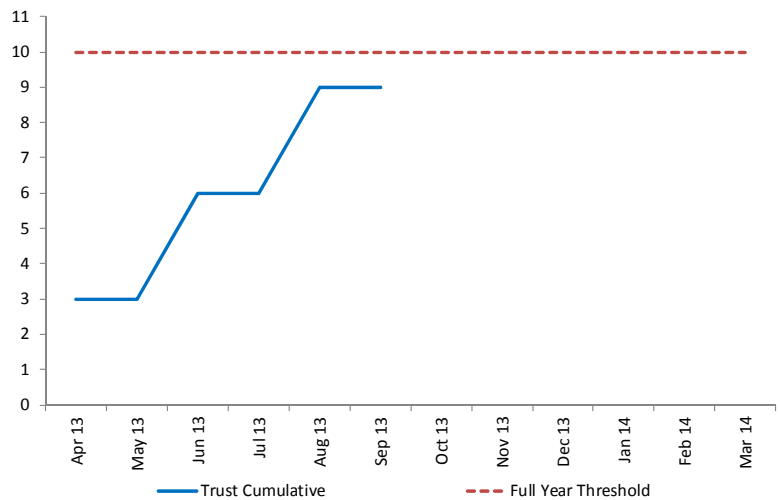
C Difficile Infections

Deliver

Outcome Metrics

	Jul 13	Aug 13	Sep 13
Full Year National Threshold	<=10		
Trust Total	0	3	0

Number of Clostridium Difficile infections (bacterial infection affecting the digestive system)



Nearing full year target for C-Diff, therefore, realistically unlikely to remain within target for full year with winter months ahead of us. None of the cases are as a result of cross infection while an in-patient. All new cases of diarrhoea are isolated as per policy immediately and this is monitored. Hand hygiene audits continue and a hand hygiene campaign is due for January 14.

E.coli and MSSA

Deliver

Outcome Metrics

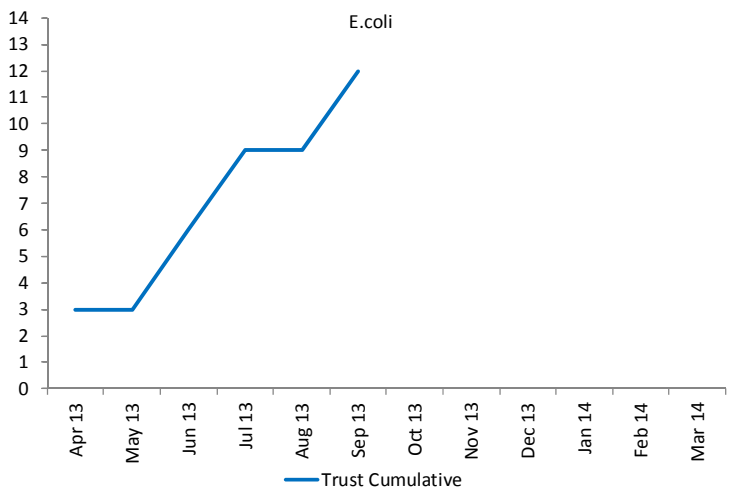
E.coli (Post 48 Hours)

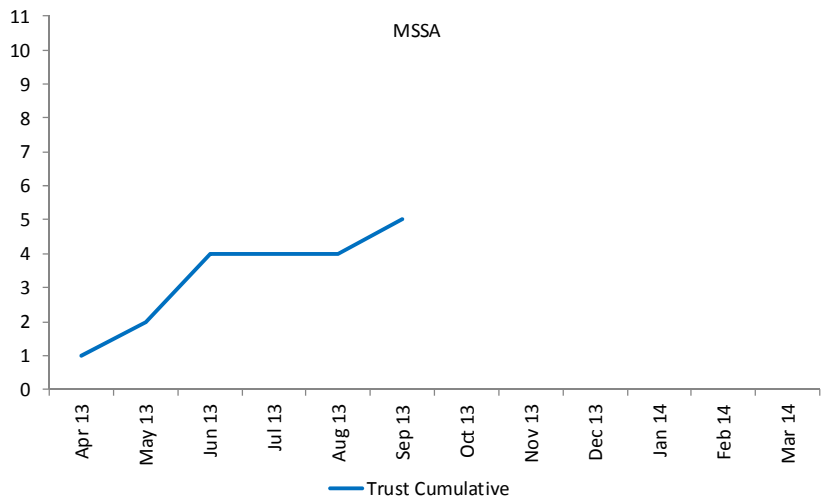
	Jul 13	Aug 13	Sep 13
Threshold	n/a		
Trust Total	3	0	3

MSSA (Post 48 Hours)

	Jul 13	Aug 13	Sep 13
Threshold	n/a		
Trust Total	0	0	1

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





There are no current targets for E.Coli and MSSA bacteraemias.

Harm Free Care

Deliver

Outcome Metrics

	Contractual Threshold	Jun 13	Jul 13	Aug 13
% of Harm Free Care	95%	94.1%	92.8%	92.8%
Completeness of Safety Thermometer (CQUIN)	100%	100%	100%	100%
Pressure Ulcer (PU) Incidence	50% Reduction	9	26	20

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.

Aug 2013	Patients	Harm Free		Pressure Ulcers		Falls		Catheter & UTI		New VTE	
Trust Total	Number	Number	Percentage	Number	Percentage	Number	Percentage	Number	Percentage	Number	Percentage
	991	920	92.8%	59	6.0%	2	0.2%	10	1.0%	2	0.2%

The target for percentage of harm free care using the Safety Thermometer is 95%. Although we have not quite reached this target, we are not an outlier compared to other trusts. The highest area of harm is pressure ulcers.

We have reached our agreed quality improvement (CQUIN) target for pressure ulcers in Q1and Q2.

There has been a significant reduction of pressure ulcers incidence in the acute setting however there continue to be enormous challenges within the community. We are working with McKinsey using improvement methodology to focus the attentions of district nursing staff and are bidding for additional resources to build improved pathways across other stakeholders and to embed our pressure ulcer strategy.

VTE Risk Assessment

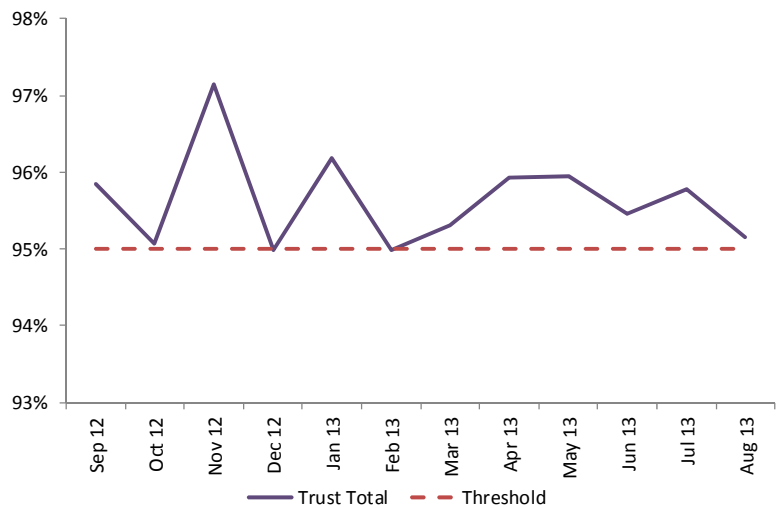
Deliver

Outcome Metrics

	VTE Risk Assessed (CQUIN)		
	Jun 13	Jul 13	Aug 13
CQUIN Threshold	95%		
Trust Total	95.5%	95.8%	95.1%

	RCA for Hospital Acquired		
	Jun 13	Jul 13	Aug 13
Target to be decided			
	2	0	0

	VTE Incidence		
	Jun 13	Jul 13	Aug 13
-			
	4	14	0



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.

RCA is Root Cause Analysis Performed

Incidence is number of Deep Vein Thrombosis and Pulmonary Embolisms (blood clots) in month

Data is 1 month in arrears due to requirement for clinical coded data

Risk assessments for VTE continue to reach target levels of over 95%.

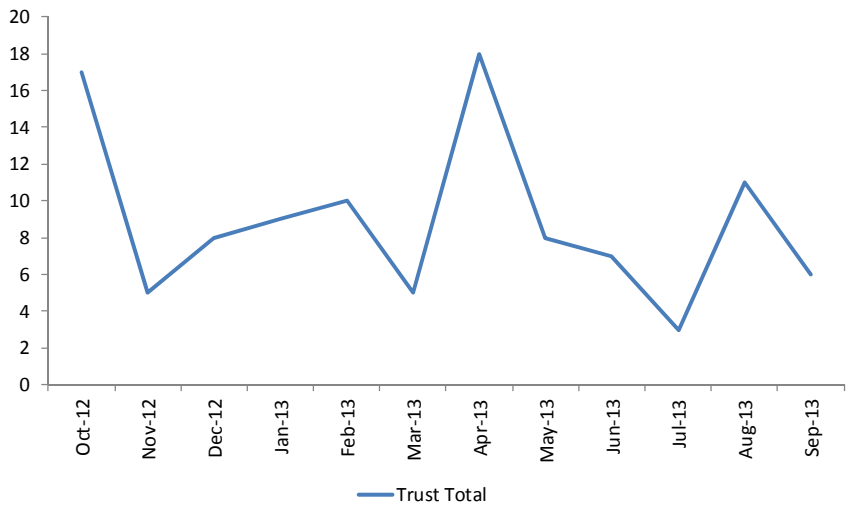
Serious Incidents

Change

Outcome Metrics

	Jul 2013	Aug 2013	Sep 2013
Trust Total	3	12	6

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



We have two overdue Serious Incidents (Sis) outside their time frame, (1) relates to the Referral To Treatment Time SI which we have routine meetings with the Commissioner via a panel approach and an agreed trajectory is in place due to the complexity of the investigation, (2) a Prison Healthcare Serious Incident which is being submitted for approval to the Serious Incident Executive Approval Group on the 16th October 2013.

Never Events

Change

Outcome Metrics

Zero Never Events since October 2012

No change since last report.

CAS Alerts (Central Alerting System)

Change

Outcome Metrics

Month	MDA alerts issued	Number not relevant	Action completed	Action required/on-going	Acknowledged/Still assessing relevance
September 2013	2	0	0	0	2
August 2013	12	8	3	0	1
April to July 2013	40	30	10	0	0
Alert carried over from 2012/13	1	0	0	1	0

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

No open Medical Device alerts are overdue on CAS. The 7 open alerts on the CAS website are:

Reference	Alert Title	Issue Date	Response	Deadline
MDA/2013/072	Implantable Cardioverter defibrillators (ICD) and cardiac resynchronisation therapy devices	27-Sept-13	Acknowledged	25-Oct-13
MDA/2013/071	Growth hormone pens Nordipen used with 5mg and 10 mg Nordipen Simplexx	5-Sept-13	Acknowledged	03-Oct-13
MDA/2013/070	Insulin infusion sets and reservoirs used with Paradigm ambulatory insulin pumps.	28-Aug-13	Completed	02-Oct-13
MDA/2013/069	Vacutainer® Flashback blood collection needle 21G. Catalogue number 301746.	28-Aug-13	Not used by us	25-Sep-13
MDA/2013/068	Single use syringes: PlastipakTM 50ml Luer Lok syringe – sterile. Manufactured by BD Medical.	21-Aug-13	Completed	18-Sep-13
MDA/2013/067	Protect-A-Line IV extension set (supplied with vented caps) Product code: 0832.04	19-Aug-13	Not used by us	16-Sep-13
MDA/2013/060	Wheeled and non-wheeled walking frames (all models). Manufactured by Patterson Medical.	01-Aug-13	Acknowledged	01-Nov-13
MDA/2013/057	Spectra series powered wheelchairs Manufactured by Invacare	25-Jul-13	Completed	25-Oct-13
MDA/2013/019	Detergent and disinfectant wipes used on reusable medical devices with plastic surfaces. All manufacturers.	27-Mar-13	Action required: on-going	26th Sep 2013

NPSA Alerts

None issued since March 2012. There remains one open alert on CAS: **NPSA 2009/PSA004B** Safer spinal (intrathecal), epidural and regional devices - Part B **(Deadline 01/04/2013) This is now past the deadline. It is included on the Corporate Risk Register with mitigation.**

Three Estate and Facilities alerts were issued on CAS in September, all relating to various electrical switchgear hazards in high and low voltage equipment and all of them have been closed on CAS within deadline. Out of 3 none of applies to us.

Five Estates and Facilities alerts were issued on CAS in August, all relating to various electrical switchgear hazards in high and low voltage equipment following 22 such alerts in July. All 27 have been closed on CAS within deadline. In only two cases was action required.

Further assurance is being sought on the compliance status of Medical Device Alerts MDA/2013/071 and MDA/2013/070. We are aiming to receive this assurance in October and then subsequently close these alerts. Alerts received into the organisation are reviewed for relevance by a combination of central governance team review and appropriate cascade to clinical leads or topic experts for assessment of relevance, completion of mitigating actions and monitoring until compliance is achieved.

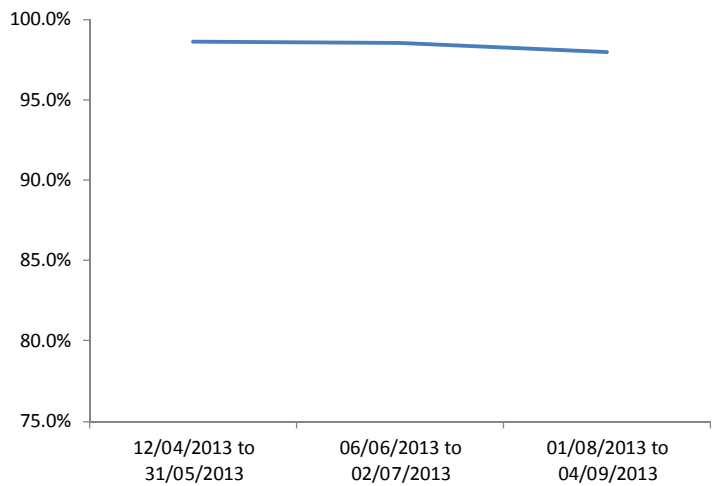
Ward cleanliness

Change

Outcome Metrics

	12/04/2013 to 31/05/2013	06/06/2013 to 02/07/2013	01/08/2013 to 04/09/2013
Trust Percentage	98.6%	98.5%	98.0%

Ward Cleanliness calculated as actual score against possible score



The only area in Surgery Cancer and Diagnostics (SCD) to fall below trajectory was Victoria. This has been addressed by the Assistant Director of facilities. A recent spot audit has shown the ward to be above 95%, actions are still being embedded to increase this further.

Maternal Deaths

Deliver

Outcome Metrics

Zero maternal deaths reported across the Trust

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

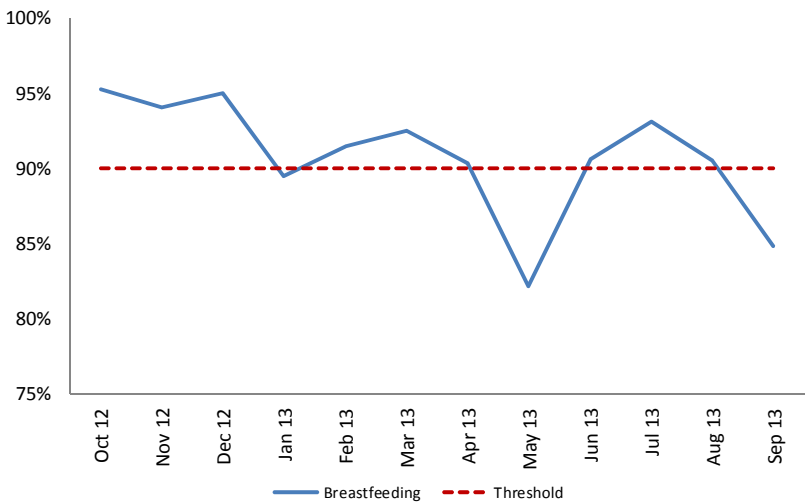
Breastfeeding and Smoking

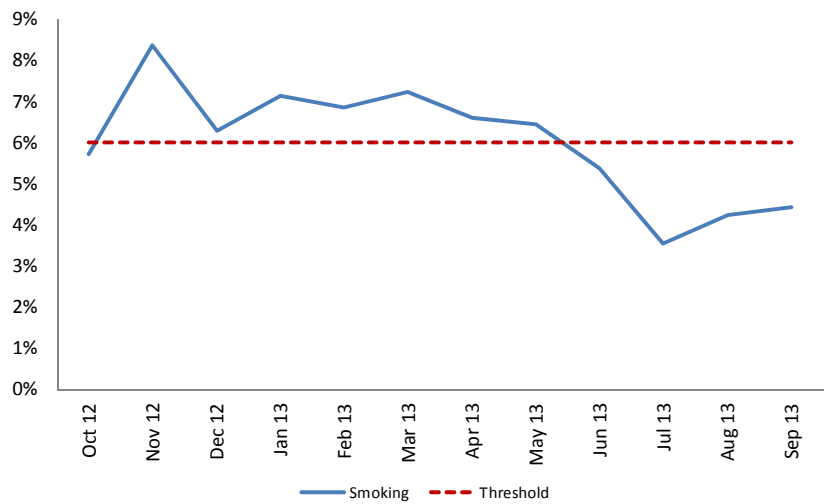
Improving

Outcome Metrics

	Threshold	Jul 13	Aug 13	Sep 13
Breastfeeding Initiated	90%	93.1%	90.5%	84.8%
Smoking at Delivery	<6%	3.6%	4.2%	4.4%

Breastfeeding initiated before discharge as a percentage of all deliveries and women who smoke at delivery against total known to be smoking or not smoking.





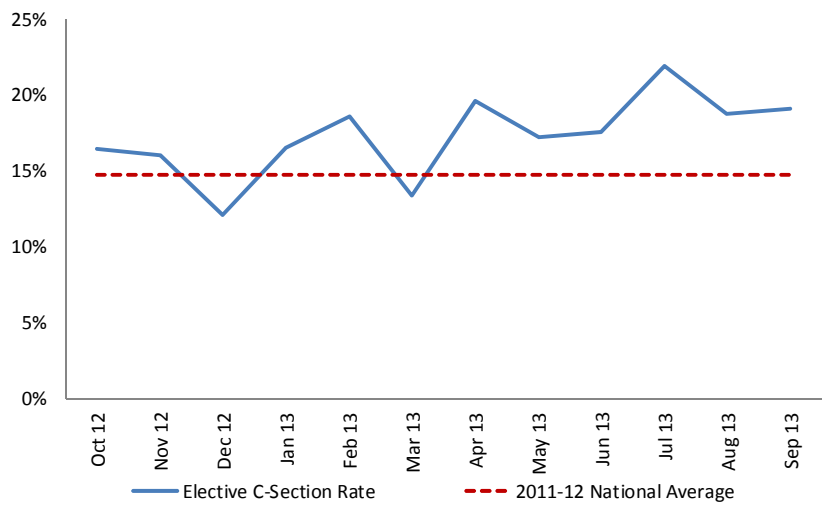
Caesarean Section Rates

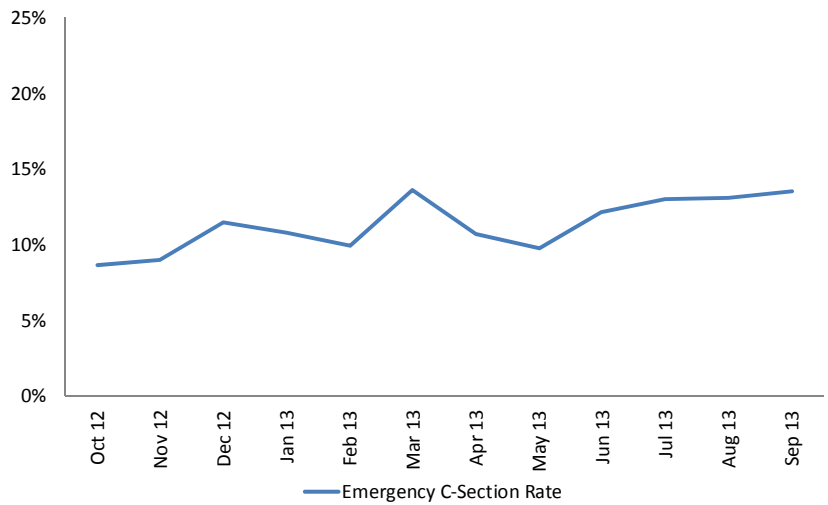
Deliver

Outcome Metrics

	National Average	Jul 13	Aug 13	Sep 13
Elective C-Section Rate	14.8%	22.0%	18.8%	19.2%
Emergency C-Section Rate	-	13.0%	13.1%	13.5%

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





A high proportion of elective choice. Benchmarking will be undertaken with other local maternity units.

Medication Errors Causing Serious Harm

Change

Outcome Metrics

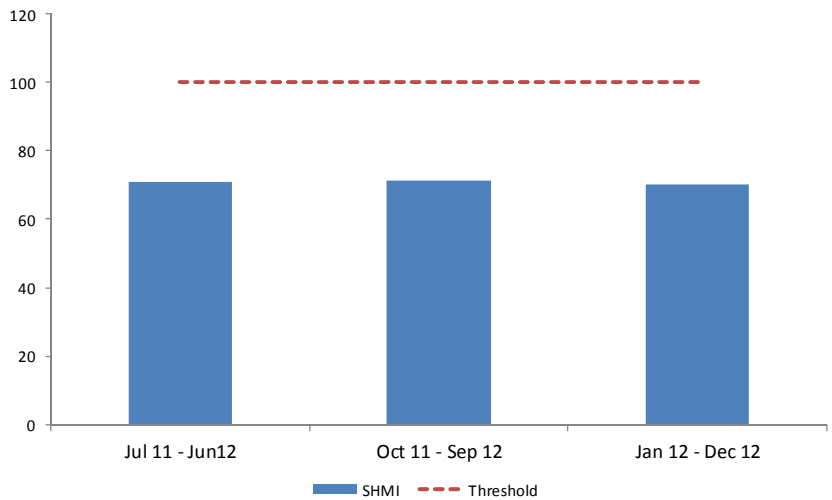
Zero errors reported across the Trust
Further work to be done regarding more detailed work

Summary Hospital-level Mortality Indicator (SHMI)

Change

Outcome Metrics

	Threshold	Jul 11 - Jun12	Oct 11 - Sep 12	Jan 12 - Dec 12
SHMI	100	71.08	71.28	70.31



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

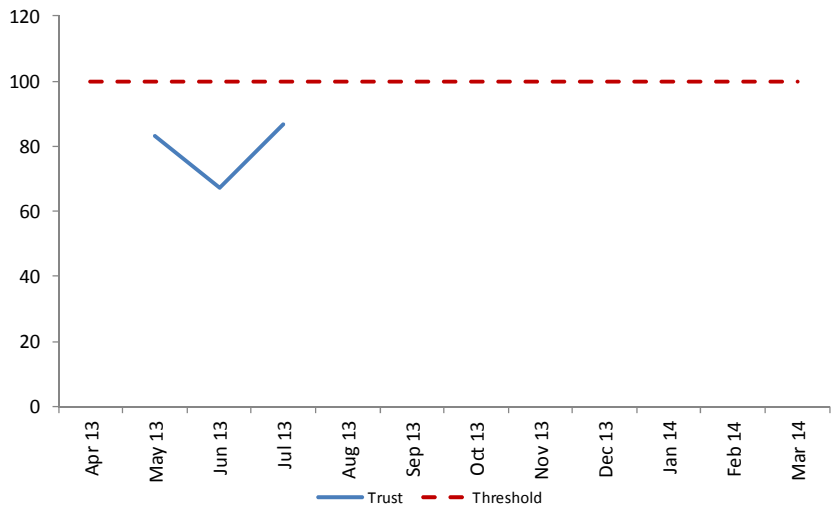
This is the most recent data available publically available.

Hospital Standardised Mortality Ratio (HSMR)

Change

Outcome Metrics

	May 13	Jun 13	Jul 13
Local Threshold	<100		
Trust Total	83.1	67.3	86.85



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

This is the most recent data available from Dr Fosters.

Patient Satisfaction (Friends & Family)

Ensure

Quality Indicators

	Jun 2013	Jul 2013	Aug 2013
Total Coverage (CQUIN Threshold >= 15%)	9.1%	10.2%	12.6%
Inpatient Coverage	44.0%	36.0%	43.5%
Emergency Department Coverage	3.4%	5.4%	7.4%
Inpatient Net Promoter Score	67	66	62
Emergency Department Net Promoter Score	10	15	51

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

The increase in Emergency Department net promoter score reflects the change in how the survey is being conducted. Patients are being issued with the cards at the end of their treatment. Senior staff continue to promote the use of the Friends and Family Surveys. A set of boxes have been fitted by the main exit points for patients to leave completed surveys.

All inpatient areas in Surgery, Cancer and Diagnostics are above the 15% response rate and have positive net promoter scores. The comments results are used to inform the “you said, we did” programme where local improvements are driven by the feedback from patients.

Mixed Sex Accommodation

Integrate

Quality Indicators

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

Zero breaches reported across the Trust

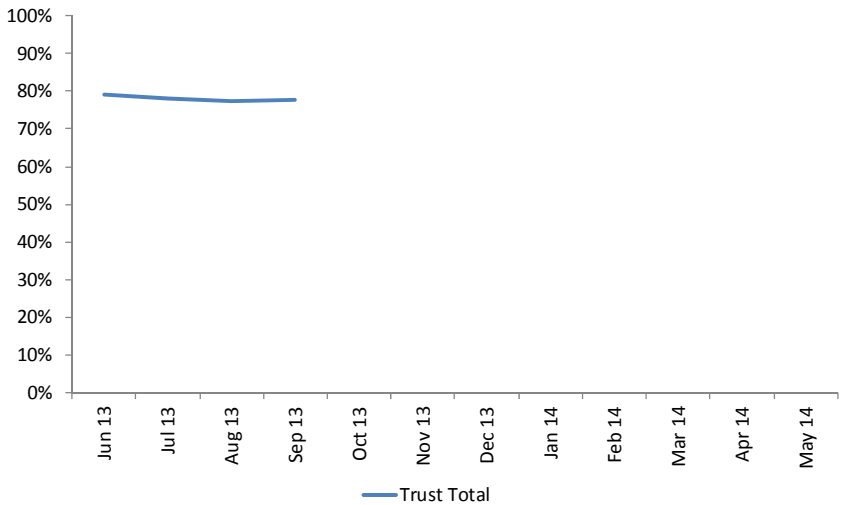
Percentage of Registered Nurses

Change

Quality Indicators

Registered Nurses as a proportion of total registered nurses and healthcare assistants

	Threshold	Jul 13	Aug 13	Sep 13
Trust Total	n/a	79.1%	78.1%	77.4%



Proactive recruitment to vacant posts is being driven by Integrated Care and Acute Medicine Head of Human Resources.

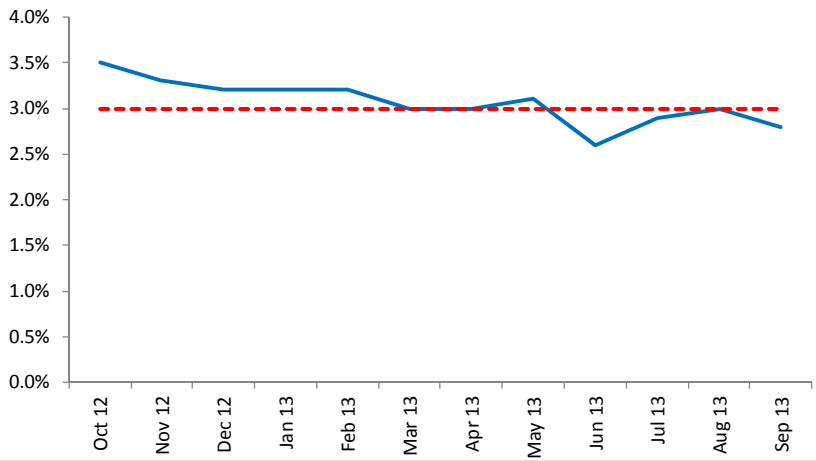
Sickness Rate

Change

Quality Indicators

	Sickness				High Bradford Scores		
	Local Threshold	Jul 13	Aug 13	Sep 13	Jul 13	Aug 13	Sep 13
Trust Total	<3%	2.9%	3.0%	2.8%	743	734	730

Proportion of sick days as total available days worked. High Bradford Score is defined as 128 and above

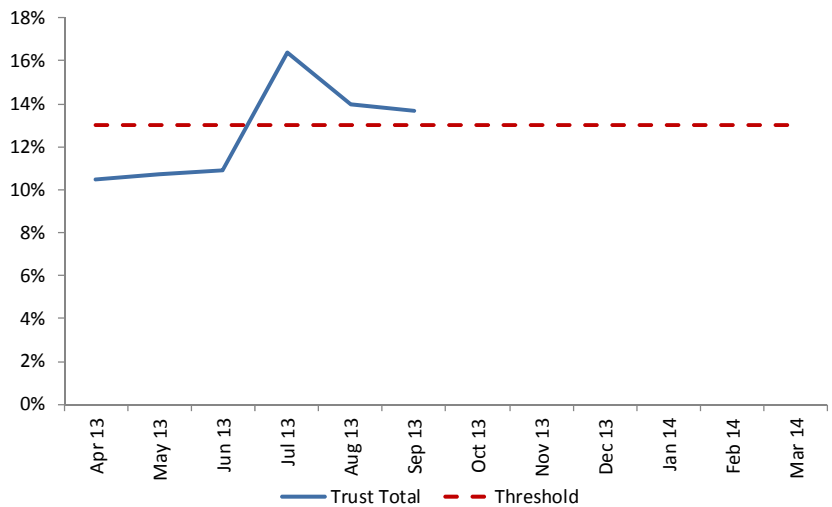


Work being undertaken to further reduce sickness. Plans will be in place for staff wellness through winter. This includes training, monitoring and other processes include completion of return to work interviews. Sickness absence continues to be a concern. There is a view held in Organisational Development that the Trust is under reporting and that the sickness absence reported is a better position than in reality. Work is being lead by the Deputy Director of HR (Chris Goulding) to review the attendance management policy, reviewing all sickness absence cases, assessing the total cost of absences and training all managers where necessary in managing absenteeism. There is very little reported medical absence; this area will be investigated fully to ensure data quality. The current methodology of Bradford Scoring is being reviewed to ensure all short and long term cases are on divisional dashboards with managers supported by named HR Managers.

Staff Turnover

	Local Threshold	Jul 13	Aug 13	Sep 13
Trust Total	<13%	16.4%	14.0%	13.7%

Proportion of workforce leaving in a given period.



The target for turnover is to be below 13% across the Trust; the current figure is 13.7% average across the Trust. Between divisions there is evidence of low and high turnover, e.g. low quartile – 8% in SCD through to 16% in ICAM. The methodology for reporting turnover has changed, excluding all but voluntary turnover to including all turnover except junior doctors. Some of the reasons for high turnover include internal / external promotion, retirement, career breaks as well as leavers. Data needs to be defined and backdated to show accurate performance. The response rate to exit questionnaires needs to improve and is now part of the HR work programme.

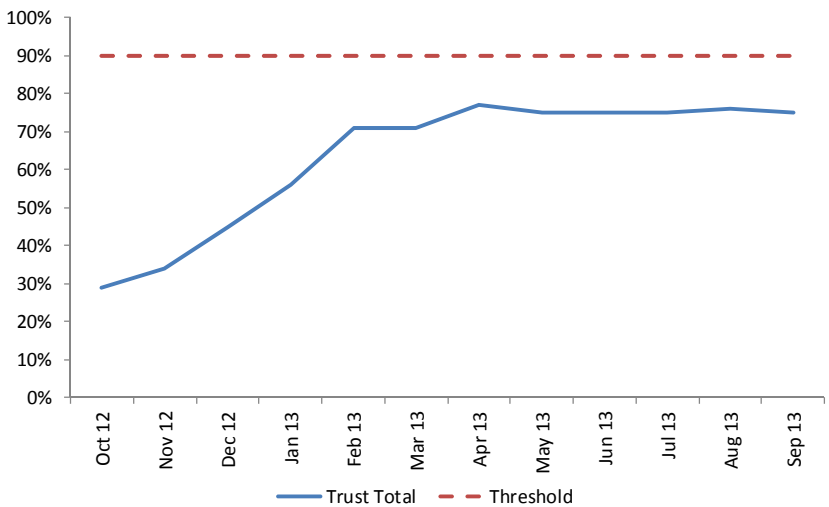
Staff Appraisal

Change

Quality Indicators

	Local Threshold	Jul 13	Aug 13	Sep 13
Trust Total	90%	75.0%	76.0%	75.0%

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



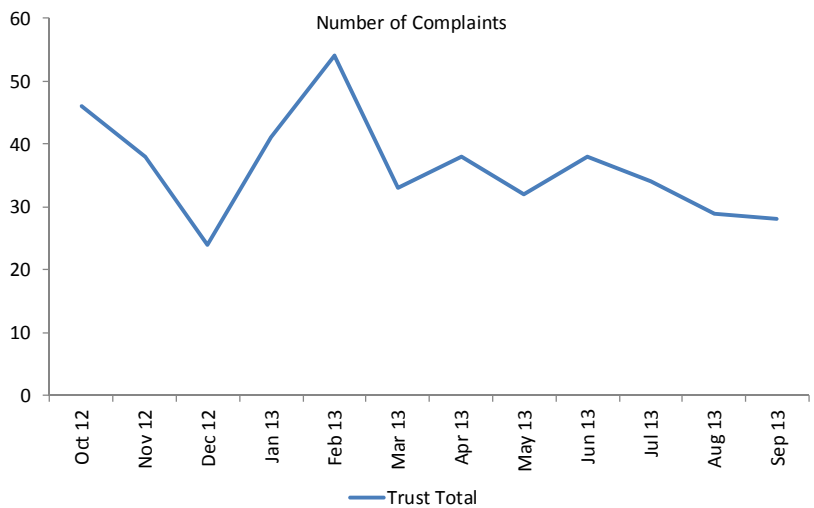
Current performance reporting at September 2013 shows appraisal completion at an average of 75%, with pockets of services below this. It must be acknowledged that divisions and service lines have differing workforce establishments. Lower compliant service lines will be targeted to raise their rates to 85% by December 2013 and 90% by March 2014. A new appraisal action plan has been devised to meet the statutory 90% target, implementing a much richer approach based upon values and leadership behaviours. Performance in this area was presented at EC on 15th Oct. Performance by division and by staff group is now produced and presented a divisional board.

Complaints

Ensure

Quality Indicators

	Complaints				Responded to in 25 days		
	Threshold	Jul 13	Aug 13	Sep 13	Jun 13	Jul 13	Aug 13
Trust Total	0	34	29	28	58%	74%	55%



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

Quarterly compliments data to be added in October report

All areas have seen some improvement but this continues to be proactively monitored.
Work is continuing with the complaints department and investigators to improve the number of responses sent to patients within 25 working days.

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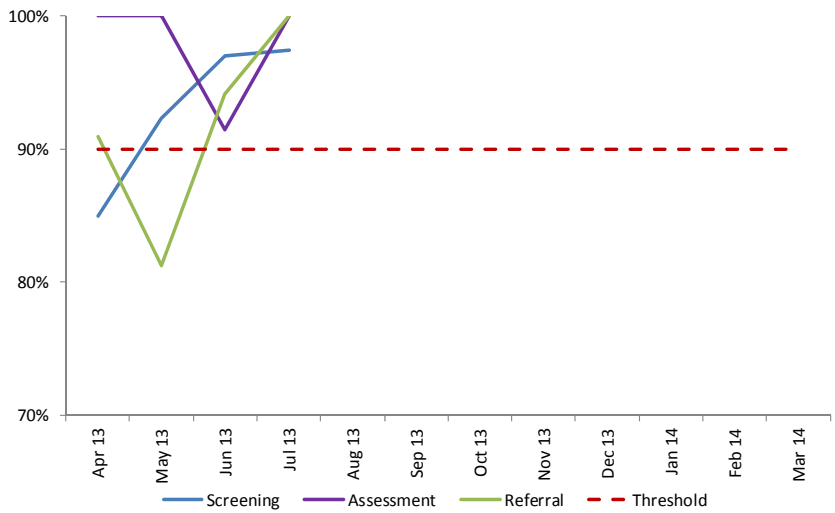
National CQUINs

Integrate

Quality Indicators

Dementia

	Contractual Threshold	May 13	Jun 13	Jul 13
Screening	90%	92%	97%	97%
Assessment	90%	100%	91%	100%
Referral	90%	81%	94%	100%



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

Aug data not available due to EPR reporting issues

We are making good progress on the Dementia CQUIN.

Specialist Commissioning CQUINs

Deliver

Quality Indicators

NICU	Year End Target	Apr	May	Jun	Q1				Q2
Improvement Access to Breast Milk in Preterm Infants	95%				94.7%				
Timely Administration of Total Parenteral Nutrition in Preterm Infants	62%				75%				

CAMHS	Year End Target				Q1				Q2
Optimising Pathways	-	Data not yet finalised							
Physical Healthcare	-	Data not yet finalised							

Data is being collected but is not available by month yet. This should be backdated next month.

Local CQUINs for Prevention

Deliver

Quality Indicators

Stop Smoking	Year End Target	Apr	May	Jun	Q1	Jul	Aug	Sep	Q2
Inpatient - Smoking Status	90%	95.0%	94.0%	96.0%	94.7%	94.0%			
Inpatient- Brief Advice	90%	94.0%	90.0%	93.0%	92.0%	96.0%			
Inpatient- Referral	15%	32.0%	29.0%	31.0%	31.0%				
Outpatient - Smoking status	Definition to be set								
Outpatient - Brief Advice	Definition to be set								
Staff Stop Smoking	Definition to be set								

Alcohol Harm	Year End Target	Apr	May	Jun	Q1	Jul	Aug	Sep	Q2
Screening in ED	Jul 10%, +10% each month to 70% by Jan 2014	0%	2%	4%	2%	5%	11%		8%
Brief Intervention	90%	0%	73%	79%	77%	62%	85%		78%
GP Communication	90%	0%	91%	90%	90%	62%	83%		
Crime Reduction Partnerships	Report by public health of anonymised dataset on alcohol related								
Audit	Plan for audit submitted and agreed Q1								

Good progress is being made on stop smoking.
There are still some issues around the screening component of the alcohol CQUIN. Plans are in place to overcome these issues. A clinical champion has been identified (band 7) as well as a clinical lead (Richard Jennings) as well as support from VTE clinical lead. Emergency Department staff are working to increase screening.

Local CQUINs for Prevention

Deliver

Quality Indicators

COPD	Year End Target	Apr	May	Jun	Q1	Jul	Aug	Sep	Q2
Acute COPD Bundle	95%	100%	92%	94%	96%	100%			
ACUTE CAP Bundle	80%	100%	0%	78%	83%				
Community COPD Bundle	75%	100%	100%	100%	100%	100%			

Integrated Care	Year End Target	Apr	May	Jun	Q1	Jul	Aug	Sep	Q2
Multidisciplinary Working	95% of actions completed	n/a	n/a	n/a					
Ambulatory Care Management	95% of management plans sent to GP within 24hrs (Q2 onwards)	n/a	n/a	n/a					
Supporting self-care - training	25% of community matrons, LTC nurses trained in year	n/a	n/a	n/a					
Supporting self-care - responses to LTC6	at least 35% of new patients completed LTC6	n/a	n/a	n/a					

COPD CQUIN progressing well.
Integrated Care CQUIN – data not yet available.

Average Length of Stay (days)

Deliver

Quality Indicators

	Threshold	Jun 13	Jul 13	Aug 13
Trust Total (days)	tbc	3.94	3.91	3.53

Average length of stay for patients within a specialty, within a given month

Sep data not available due to EPR reporting issues

ICAM :- Post of ‘flow nurse ‘ is being recruited to as part of winter challenge funding. This post will be working to coordinate before 11am discharges and substitution models for inpatient stays.
The responsibility of post holder will include progressing pre 11am discharge and progressing discharge of non complex discharges. Expected start date – beginning of December. We have multiple projects underway which we believe will impact upon length of stay over the next year. This will ensure patients get better quicker and go home earlier.

Day Surgery Rate

Deliver

Quality Indicators

	Threshold	Jun 13	Jul 13	Aug 13
Trust Total	n/a	77%	76%	83%

Proportion of total elective surgeries carried out as a day case

Sep data not available due to EPR reporting issues

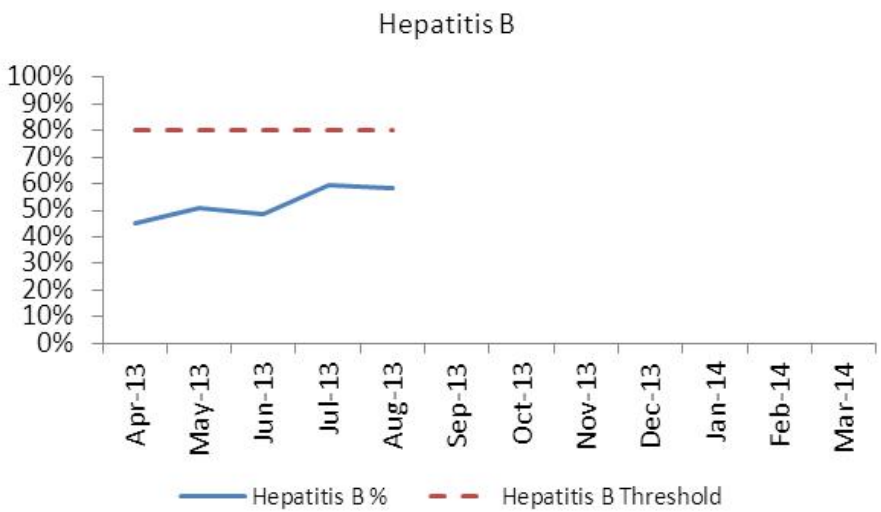
The surgical access team have been improving day surgery rate and this will continue into the new year

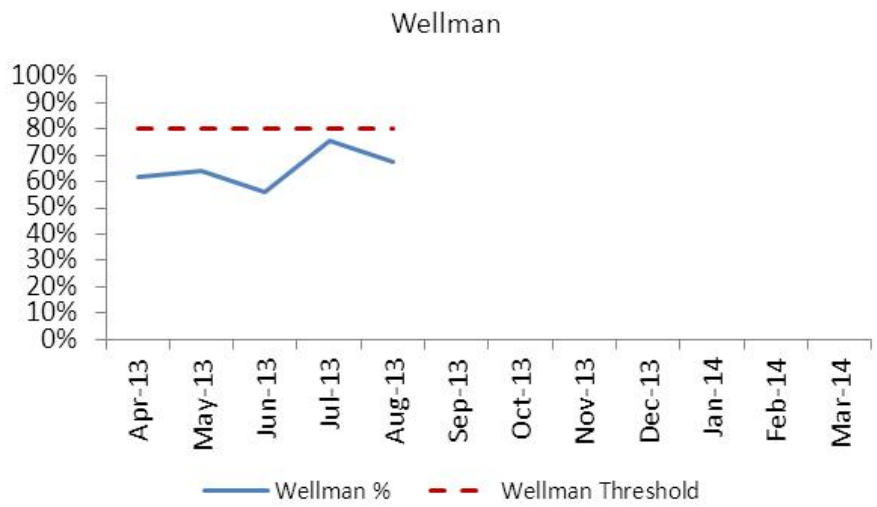
HMP Pentonville

Integrate

Quality Indicators

	KPI Threshold	Jun-13	Jul-13	Aug-13
Receptions (Adjusted)	-	496	580	482
Number of eligible prisoners given Hepatitis B vaccination	-	240	345	282
Hepatitis B %	80%	48%	59%	59%
Number of prisoners attending a Wellman appointment	-	279	439	326
Wellman %	80%	56%	76%	68%





These are two KPIs - performance has been challenged as attending clinics not a priority for prisoners.
The NWOW (new ways of working) in prison will make it easier (protected time for health) to deliver against targets.
These will be in place from November 2013.

Activity

Following the introduction of the new Electronic Patient Record, we are still validating end of month data and finalising our new reporting system. An update will be provided in the next performance report.

		Jul 13				YTD Jul 13			
		Actual	Plan	Variation (number)	Variation (%)	Actual	Plan	Variation (number)	Variation (%)
Trust Total	A&E Attendances	8,695	7,945	750	9%	33,317	31,289	2,028	6%
	Daycase	1,835	1,681	154	8%	7,189	6,363	826	11%
	Elective	255	234	21	8%	899	884	15	2%
	Non Elective	3,233	2,764	469	15%	12,387	10,563	1,824	15%
	Outpatient	25,581	20,596	4,985	19%	96,882	78,180	18,702	19%