Whittington Health NHS

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The Whittington Hospital NHS Trust
Magdala Avenue
London N19 5NF

Whittington Health Trust Board

27 Nov 2013

Title:	**Trust Board Performance Report November 2013 (October data)**		
Agenda item:	**13/153**	**Paper**	**4**
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** We are still having ongoing issues with our ability to report some indicators because of the current functionality limitations of EPR (Electronic Patient Record). We are working closely with our system provider to rectify this. This issue has effected referral to treatment (RTT) reporting, emergency department clinical quality indicators, delayed transfers of care data, 30 day emergency readmissions information, smoking and alcohol harm CQUIN collection and activity data (slides16-19, 22, 31-32, 58 and 63). In addition latest data has not been received from Pentonville in time for this report (slide 62) • Diagnostic waits (slide 20) performance has increased to over the national threshold this month. • Emergency department waits was over 95% for October (slide 22) • C Difficile infections have increased past our agreed full year trajectory of 10 (slide 34) • Smoking at time of delivery (slide 43) has improved to 3.7%, which is significantly under agreed trajectory. • Elective caesarean rates are still above the national average (slide 44) • Number of inpatient deaths have reduced (slide 48) • We are awaiting confirmation of the number of breaches of single sex accommodation we have had for October (slide 50) • Staff sickness rates have reduced to a low of 2.4% (slide 52)		

Summary of recommendations:	

Fit with WH strategy:		All five strategic aims.					
Reference to related / other documents:							
Date paper completed:		22/11/13					
Author name and title:		**Caroline Angel, Head of Performance**		**Director name and title:**		**Sally Batley, Director of Improvement, Performance & Information**	
Date paper seen by any other group/which		**Equality Impact Assessment complete?**		**Risk assessment undertaken?**		**Legal advice received?**	

#

Whittington Health NHS

Trust Board Performance Report
November 2013
October 2013 Performance

Priorities

Focus Areas

Maintaining focus on Referral to Treatment (RTT) during EPR reporting issues

Operational plans for Christmas period

Winter and Flu planning

Integrated Care and Acute Medicine Division

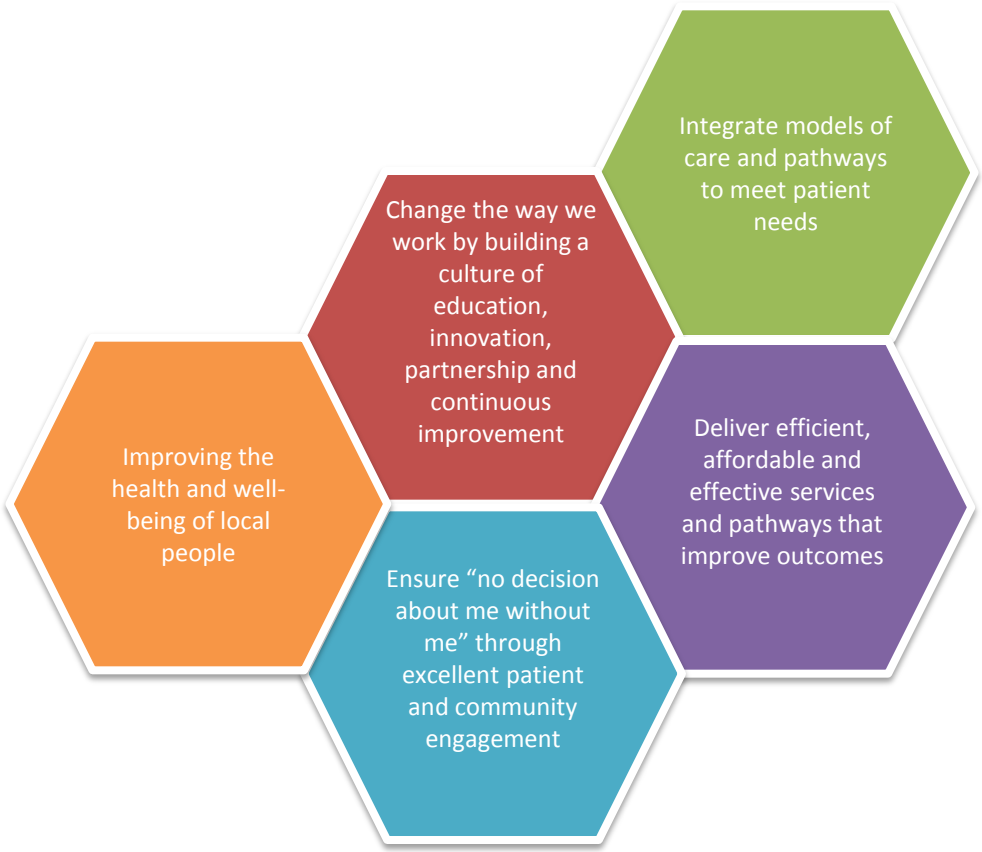
•ED performance targets and improvement plan
•Improvement in quality and complaints
•Implementation of AEC
•Implementation of TB network
•IST visit (Endoscopy)

Surgery, Cancer and Diagnostics Division
•Theatre plan for Christmas
•HR recruitment for existing positions
•Theatre utilisation improvement plan
•Quality
•Transformation Projects in Pre-Assessment and Diagnostics

Women, Children and Families Division
•Child Protection training

Board Aims

Focus Areas



All indicators have been mapped to the Board Aims

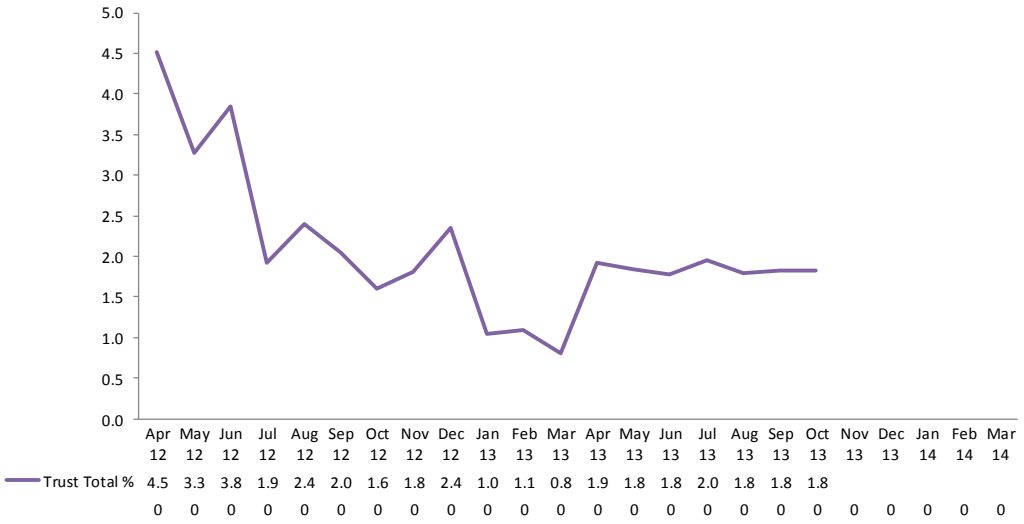
First: Follow-Up Ratio - Acute

Deliver

Focus Areas

	Transformation Board Threshold	Apr 13	May 13	Jun 13	Jul 13	Aug 13	Sep 13	Oct 13
Acute Trust Total	-	1.93	1.84	1.78	1.96	1.80	1.83	1.82

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



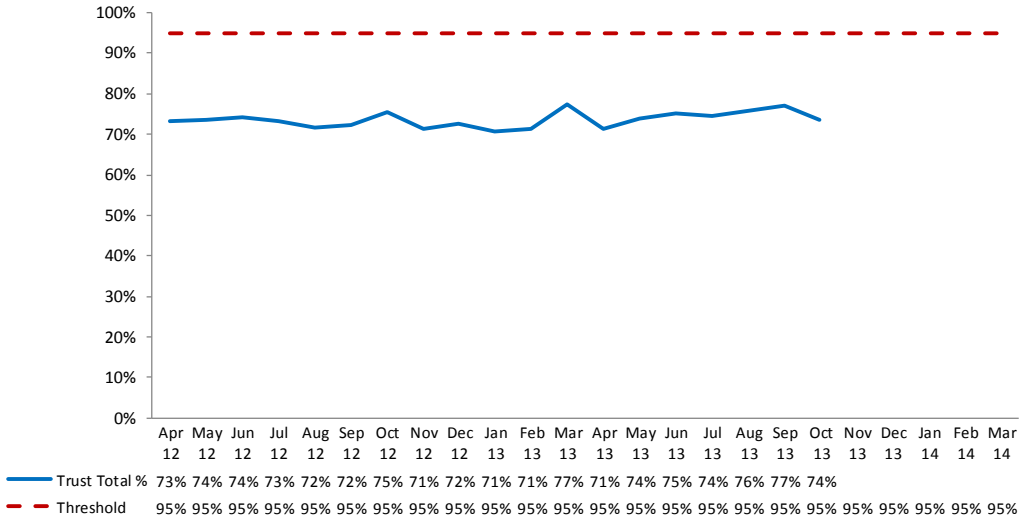
An outpatients working group has established across all divisions to deliver trust-wide improvement across outpatient elements – first appointments, follow up ratio, outpatient service cancellations and DNA rates.

Theatre Utilisation

Deliver

Focus Areas

	Utilisation			Available Session Time (Minutes)			Time Utilised (Minutes)		
	Aug 13	Sep 13	Oct 13	Aug 13	Sep 13	Oct 13	Aug 13	Sep 13	Oct 13
Local Threshold	>95%								
Trust Total	76%	77%	74%	52,500	62,640	66,750	39,846	48,318	49,174



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.

Operational weekly meetings to monitor and drive improvements in theatre efficiency in place. New weekly and individual surgeon theatre utilisation performance dashboard implemented to all theatre staff, these are also displayed in theatres for staff to see previous day's performance.

Work is underway to explore the root cause of cancellations and working with services outside of theatre to improve performance, including implementation of pre-assessment pathway controls so booking is done in conjunction with the admissions office and diagnostic intervention is timely to prevent DNAs.

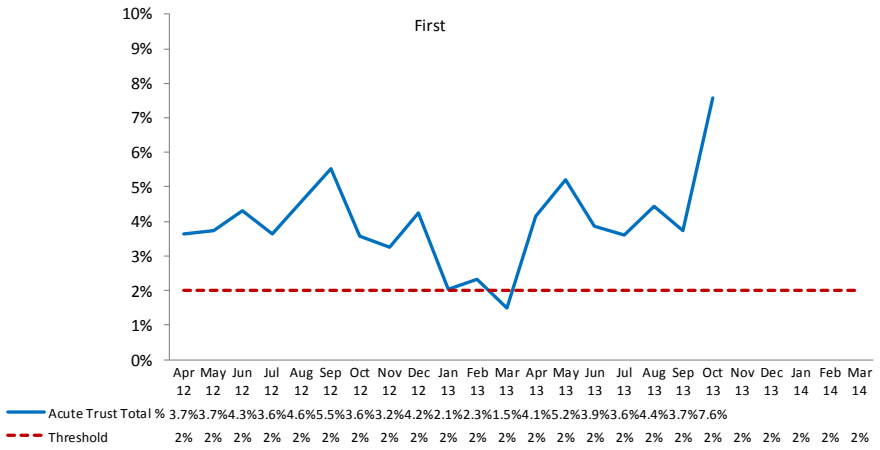
Hospital Cancellations - Acute

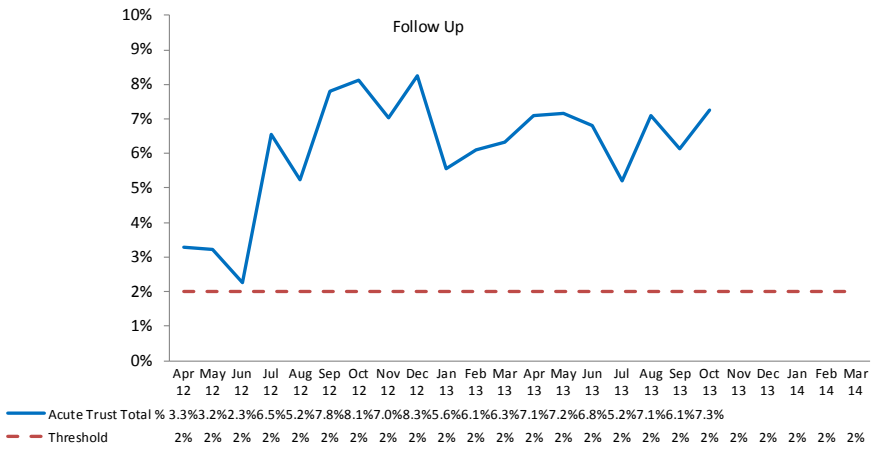
Deliver

Focus Areas

	First Appointments			Follow Up Appointments		
	Aug 13	Sep 13	Oct 13	Aug 13	Sep 13	Oct 13
Local Threshold	<2%			<2%		
Acute Trust Total	4.4%	3.7%	7.6%	7.1%	6.1%	7.3%

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





Consultant annual leave policy is now in place to prevent short notice cancellation of appointments. Telephone and text reminders are sent weekly and 48 hours beforehand. Access office is being reconfigured to allow back-office function to be carried out in a more conducive environment and with extended working hours.
As part of the EPR implementation clinics have been cancelled due to incorrect clinic dates being live on the system, this has increased the October figures.

Service Cancellations - Community

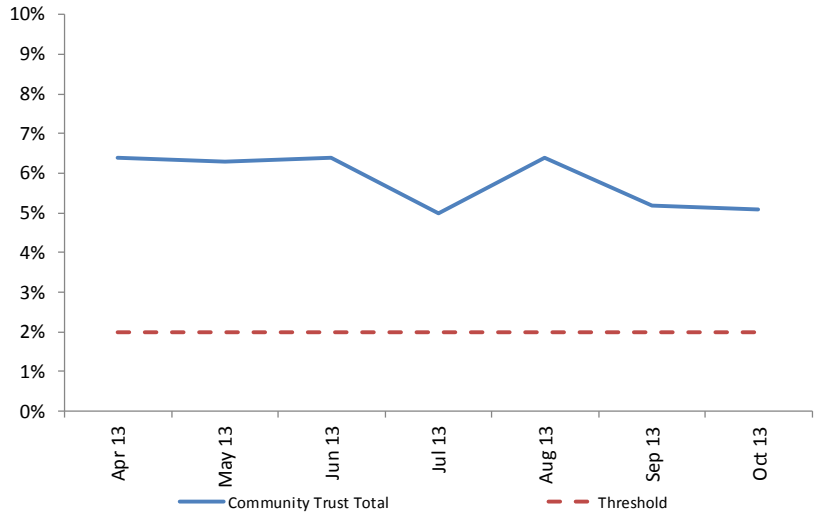
Integrate

Focus Areas

First + Follow-Up

	Apr 13	May 13	Jun 13	Jul 13	Aug 13	Sep 13	Oct 13
Local Threshold	2%						
Community Trust Total	6.4%	6.3%	6.4%	5.0%	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.



Some clinics were cancelled due to bad weather (28th October) however all appointments have been rebooked. General issues will be addressed through the outpatients working group and further assurances will be given next month.

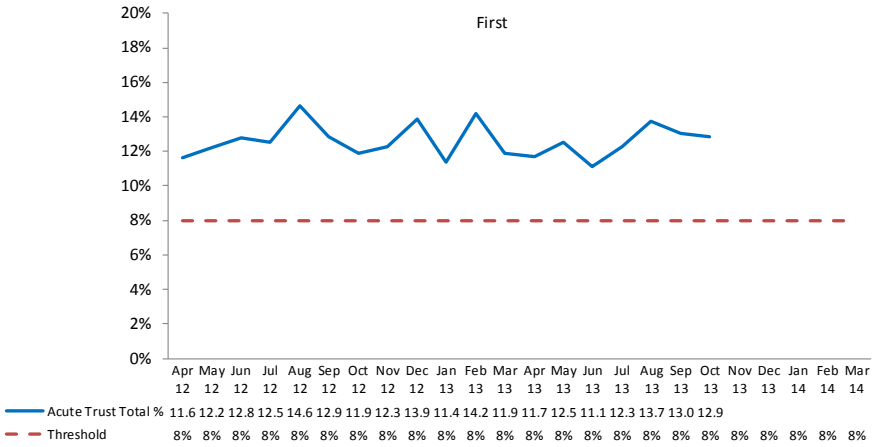
DNA Rates - Acute

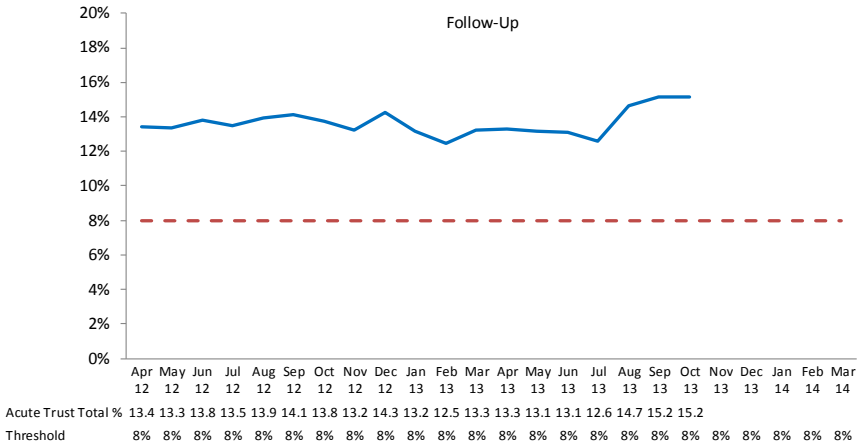
Deliver

Focus Areas

	First Appointments			Follow Up Appointments		
	Aug 13	Sep 13	Oct 13	Aug 13	Sep 13	Oct 13
Local Threshold	8%			8%		
Acute Trust Total	13.7%	13.0%	12.9%	14.7%	15.2%	15.2%

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





Access policy training remains in place along with managerial support to embed the DNA policy.
A WH improvement project is underway to reduce DNA rates and improve clinic utilisation.

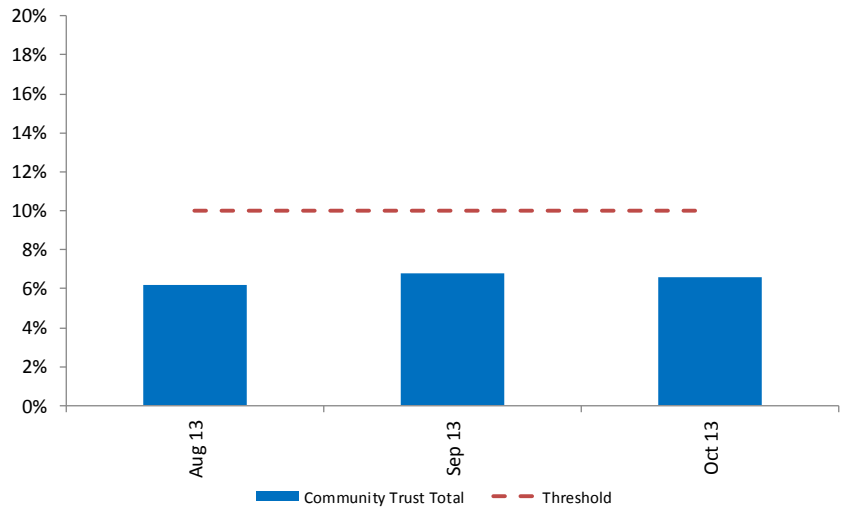
DNA Rates - Community

Integrate

Focus Areas

First + Follow-Up

	Aug 13	Sep 13	Oct 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.

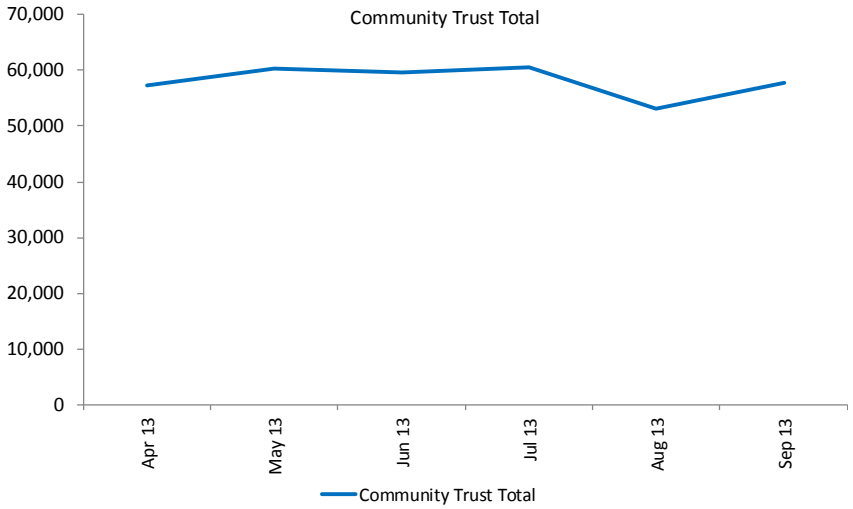
Community DNAs remain below the local threshold. Further improvements and learning across acute/community will be actioned by the outpatients working group.

Community Face-to-Face Contacts

Integrate

Focus Areas

	Aug 13	Sep 13	Oct 13	2012/13 Apr - Oct	2013/14 Apr - Oct	Variation
Threshold	n/a			n/a		
Community Trust Total	53,034	57,681	66,058	308,417	348,506	13%



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.

Community contacts continue to increase from last years position.

Community Appointment with no outcome

Integrate

Focus Areas

	Aug 13	Sep 13	Oct 13	% of Total Face-to-Face Contacts Aug 13	Sep 13	Oct 13
Local Threshold	n/a			0.5%		
Community Trust Total	885	2,336	1,572	1.7%	4.0%	2.4%

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.

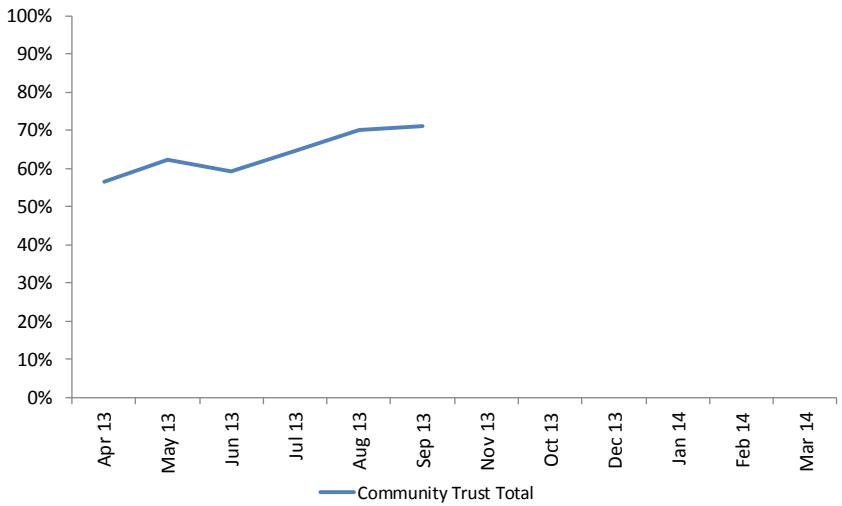
Improvement seen in appointments without an outcome, from 4.0% in September to 2.4% in October. Work is being led from the Integrated Care and Acute Medicine (ICAM) division to reduce this further.

Community Waiting Times
% waiting less than 6 weeks

Integrate

Focus Areas

	Aug 13	Sep 13	Oct 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.

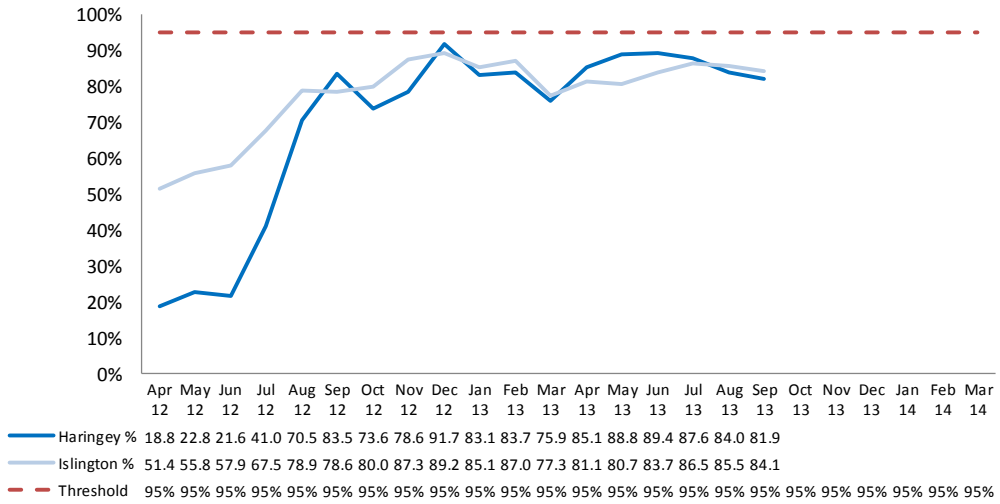
Improvement seen over the last three months, self management, group education, respiratory service, pulmonary rehab, Haringey diabetes education have locally agreed targets with up to four month waits from referral to treatment, so we will not achieve 100% in patients waiting less than six weeks under current commissioning arrangements.

New Birth Visits

Integrate

Focus Areas

	Apr 13	May 13	Jun 13	Jul 13	Aug 13	Sep 13
Local Threshold	95%					
Haringey	85.1%	88.8%	89.4%	87.6%	84.0%	81.9%
Islington	81.1%	80.7%	83.7%	86.5%	85.5%	84.1%



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

Data is 1 month in arrears due to 14 day target

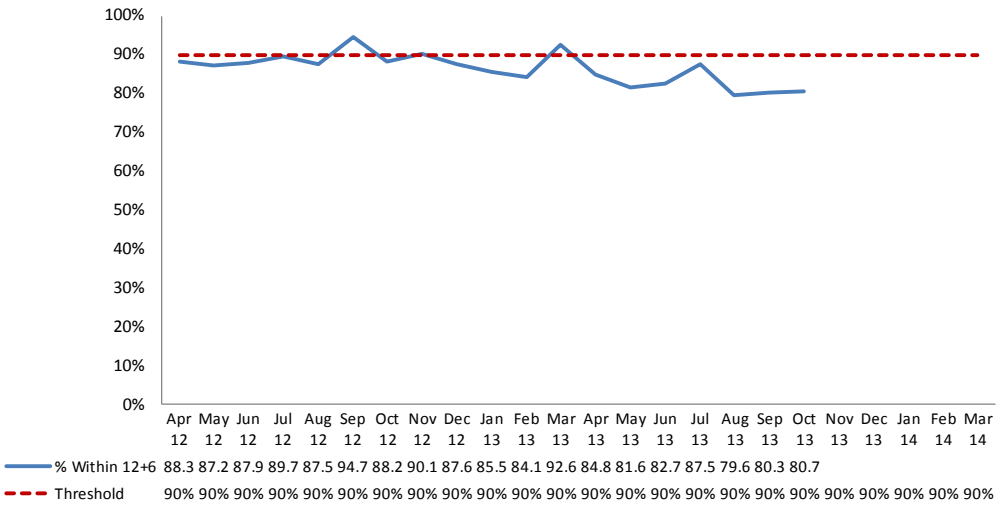
Work continues towards the target. Health visitor recruitment campaign is on-going to ensure resources and training are in place to deliver this service.

Women seen by HCP or Midwife within 12 weeks and 6 days

Deliver

Focus Areas

	Threshold	Apr 13	May 13	Jun 13	Jul 13	Aug 13	Sep 13	Oct 13
% Women seen by HCP or midwife within 12 weeks and 6 days	90%	84.8%	81.6%	82.7%	87.5%	79.6%	80.3%	80.7%
Total Number of Bookings	-	374	404	359	421	376	369	377
Referrals within 12 Weeks and 6 days	-	323	347	312	359	324	319	326



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

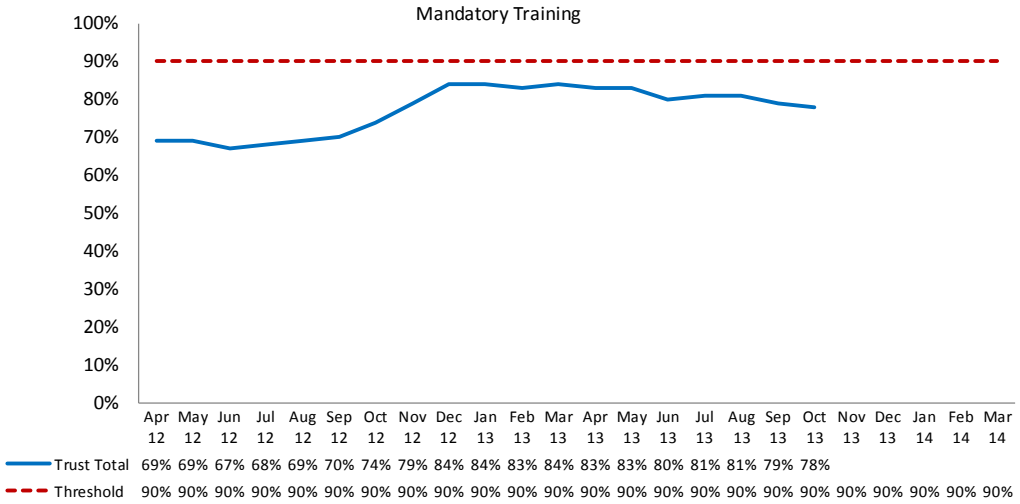
Resources have been added to telephone women to remind them of their appointment and rebook DNA'd appointments.

Mandatory Training Compliance

Change

Focus Areas

	Mandatory Training			Information Governance			Child Protection Level 2			Child Protection Level 3		
	Aug 13	Sep 13	Oct 13	Aug 13	Sep 13	Oct 13	Aug 13	Sep 13	Oct 13	Aug 13	Sep 13	Oct 13
Local Threshold	90%			95%			90%			90%		
Trust Total	81%	79%	78%	82%	77%	73%	58%	60%	63%	60%	62%	66%



Data snapshot date 25/10/2013

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

Mandatory training action plan has been written, which includes an 85% compliance target by Dec 2013, as well as a revision of mandatory training. A working group has been established to act on issues raised by staff, which will feed into the action plan. Targeted reports are issued to service managers to target individuals at 'red' rating.
A new Child Protection Training Reporting Pathway has been devised to improve data collection and reporting of child protection training.

Referral to Treatment 18 weeks - Admitted

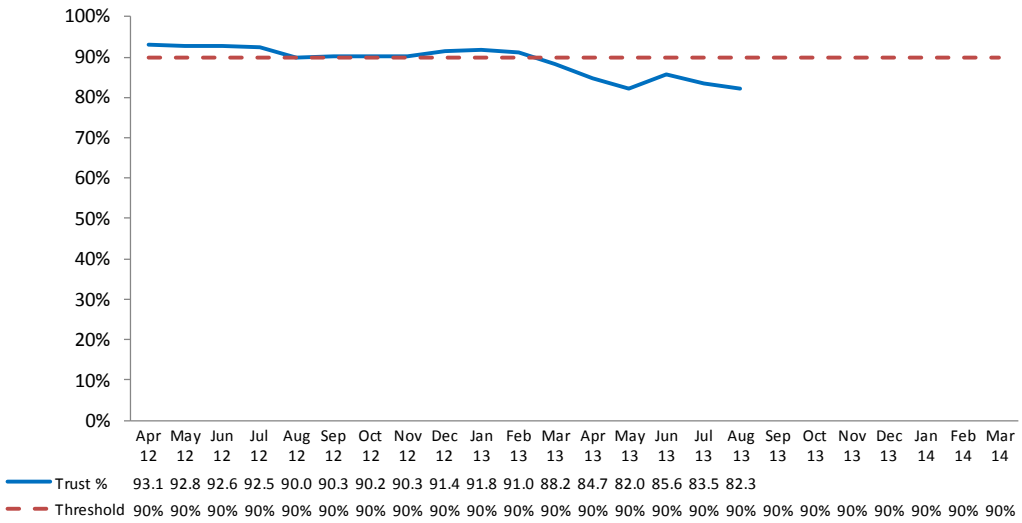
Deliver

Access Metrics

	Apr 13	May 13	Jun 13	Jul 13	Aug 13	Sep 13	Oct 13
National Threshold	90%						
Trust Total	84.7%	82.0%	85.6%	83.5%	82.3%	-	-

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

September and October is currently unavailable due to EPR reporting Issues



Due to issues related to the Electronic Patient Record (EPR) there has not been a live PTL since go-live. Information and Performance are working with the EPR provider to address the issues. We have established extra electronic and manual processes to ensure patients are clinically prioritised appropriately.

Referral to Treatment 18 weeks – Non Admitted

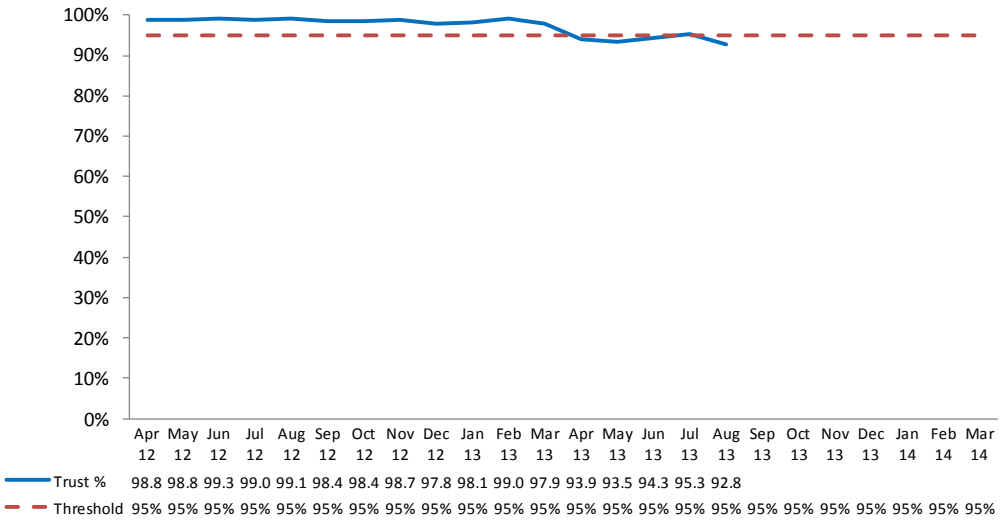
Deliver

Access Metrics

	Apr 13	May 13	Jun 13	Jul 13	Aug 13	Sep 13	Oct 13
National Threshold	>95%						
Trust Total	93.9%	93.5%	94.3%	95.3%	92.8%	-	-

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

September and October is currently unavailable due to EPR reporting Issues



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Referral to Treatment 18 weeks - Incomplete

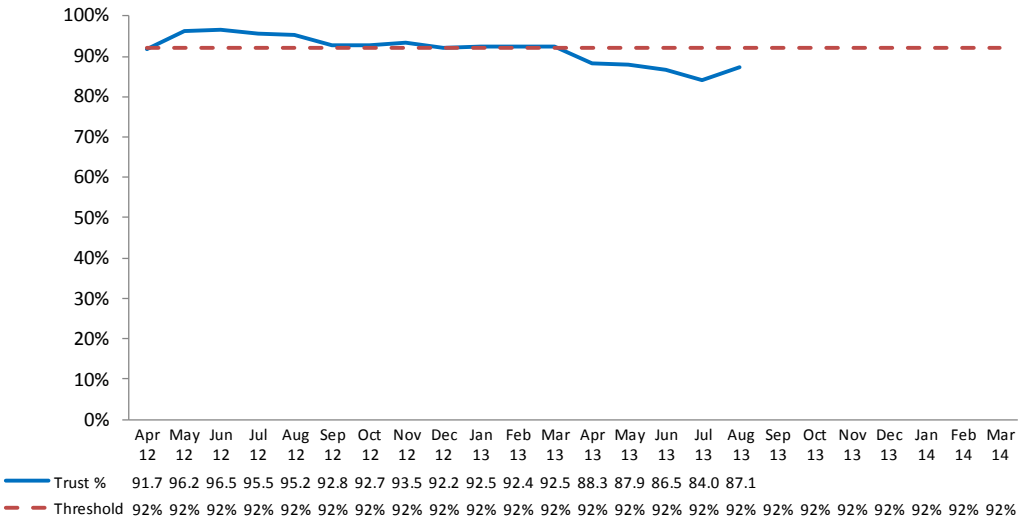
Deliver

Access Metrics

RTT Incompletes

	Apr 13	May 13	Jun 13	Jul 13	Aug 13	Sep 13	Oct 13
National Threshold	92%						
Trust Total	88.3%	87.9%	86.5%	84.0%	87.1%	-	-

September and October is currently unavailable due to EPR reporting Issues



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Referral to Treatment 18 weeks – 52 Week Waits

Deliver

Access Metrics

	Apr 13	May 13	Jun 13	Jul 13	Aug 13	Sep 13	Oct 13
National Threshold	0						
Trust Total	0	61	23	41	22	-	-

September and October is currently unavailable due to EPR reporting Issues

Due to issues related to the Electronic Patient Record (EPR) there has not been a live PTL since go-live. Information and Performance are working with the EPR provider to address the issues. We have established extra electronic and manual processes to ensure patients are clinically prioritised appropriately.

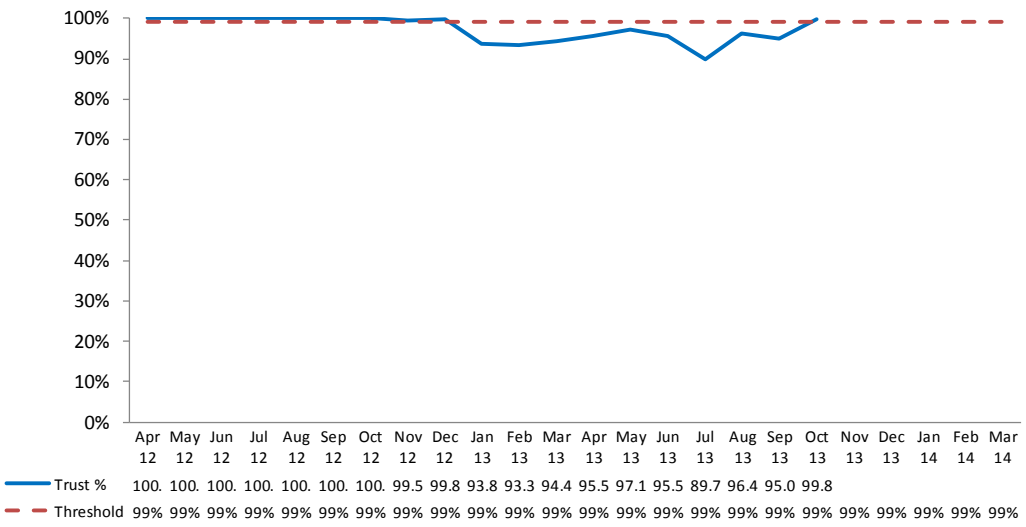
Diagnostic Waits

Deliver

Access Metrics

% Waiting <6 Weeks

	Apr 13	May 13	Jun 13	Jul 13	Aug 13	Sep 13	Oct 13
National Threshold	99%						
Trust Total	95.5%	97.1%	95.5%	89.7%	96.4%	95.0%	99.8%



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).

Oct 2013 data is the signed off position

Significant improvement has been made, meeting the national threshold for the first time since December 2012. Action plans are being developed to ensure the improvements delivered are sustained moving forward.

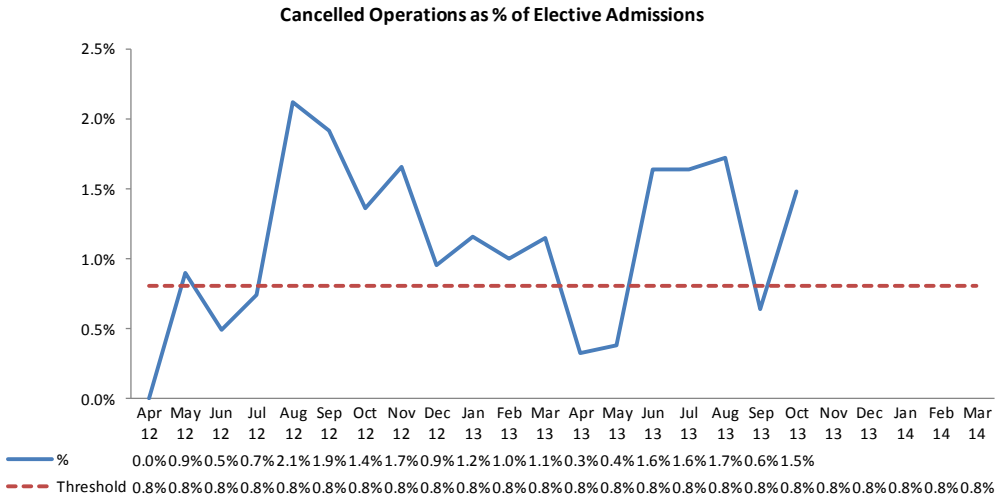
Hospital Cancelled Operations

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		
	Aug 13	Sep 13	Oct 13	Aug 13	Sep 13	Oct 13	Aug 13	Sep 13	Oct 13
National Threshold		0			< 0.8%			0	
Trust Total	13	5	14	1.7%	0.6%	1.5%	0	0	0



Hospital cancelations are reviewed at the weekly theatre utilisation meeting and actions to prevent occurrences. Revision of the standard operating procedure (SOP) for cancelations is underway. Root cause analyses is being carried out to identify lesson learnt and to ensure corrective action is put into place.

Emergency Department Waits

Deliver

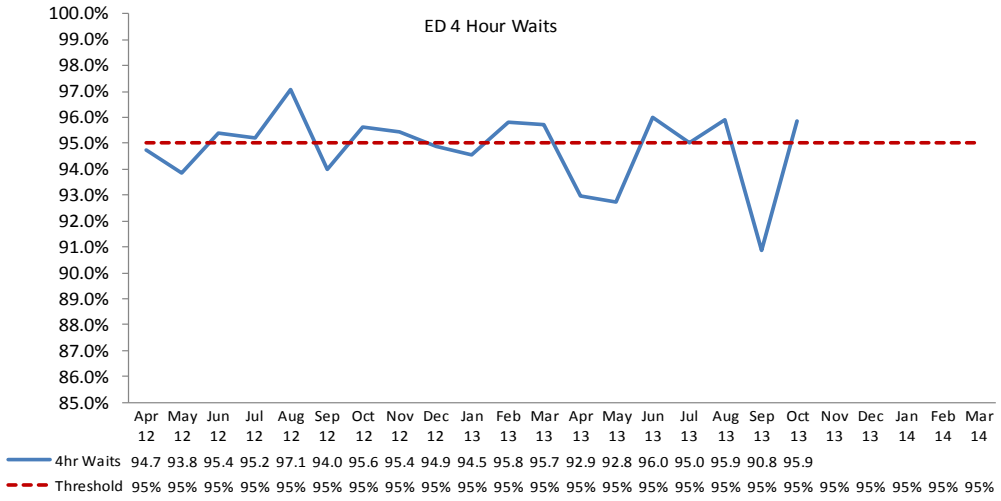
Access Metrics

The 4 hour waiting time measures the period from arrival to departure from ED, whereas the 12 hour waiting time measures the period between a decision to admit and the time of admission.
The Wait for Treatment measurement represents the period between ED arrival and the time a patient is seen by a 'decision-making clinician'.

ED Waits

	Apr 13	May 13	Jun 13	Jul 13	Aug 13	Sep 13	Oct 13
National Threshold	95%						
4hr Waits	92.9%	92.8%	96.0%	95.0%	95.9%	90.8%	95.9%
12hr Waits	0	0	0	0	0	1	0

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



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

An emergency access improvement plan and hospital wide winter action plan are underway and monitored weekly for progress.

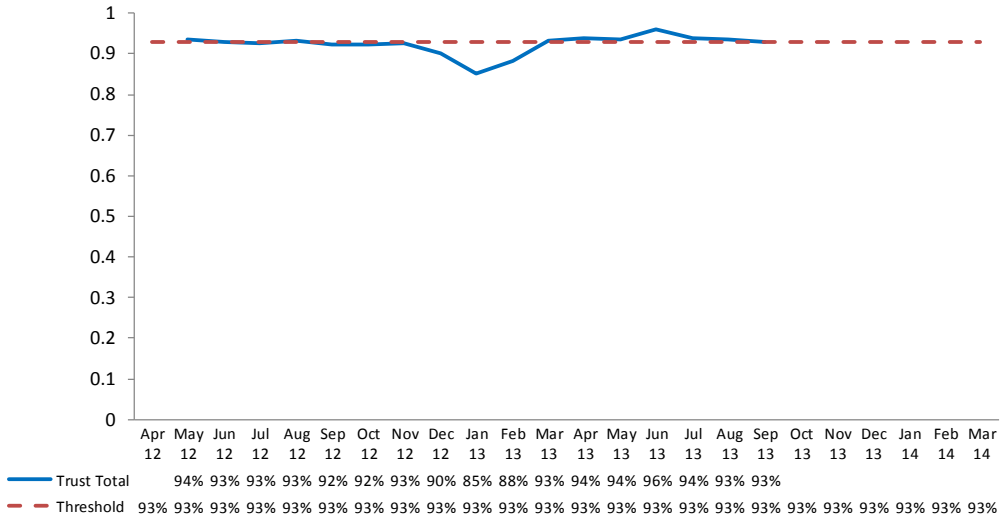
Cancer – 14 days to first seen

Deliver

Access Metrics

14 Days to First Seen

	Jul 13	Aug 13	Sep 13	Q1	Q2	Q3 TD	Q4
National Threshold	93%			93%	93%	93%	93%
Trust Total	93.8%	93.4%	92.9%	94.6%	93.4%	-	-



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

Actual performance for September was 93.1%, a reported breach was found to be incorrect after the data submission deadline. National publications will be annotated with the new performance.
Consultant leave policy will address short notice loss in capacity for cancer referrals.

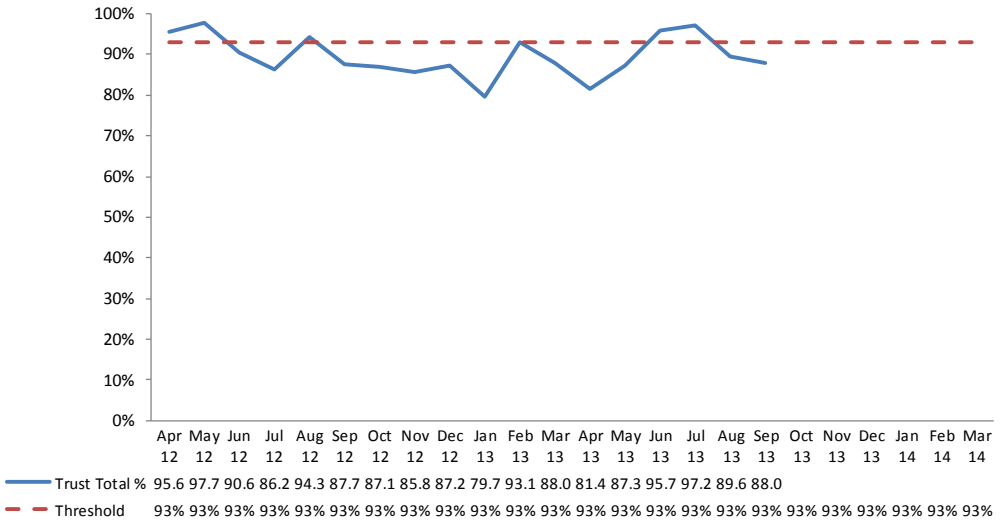
Cancer – 14 days to first seen – Breast symptomatic

Deliver

Access Metrics

14 Days to First Seen - Breast Symptomatic

	Jul 13	Aug 13	Sep 13	Q1	Q2	Q3 TD	Q4
National Threshold	93%			93%			
Trust Total	97.2%	89.6%	88.0%	88.2%	92.1%	-	-



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

In addition to patient choice, challenges relate to limited capacity for patients to receive triple assessment which is being addressed through the purchase of a new ultrasound machine. Work is on-going with GPs to ensure patients are informed of the importance of attending within the 14 day window.

Cancer – 31 Days to first treatment

Deliver

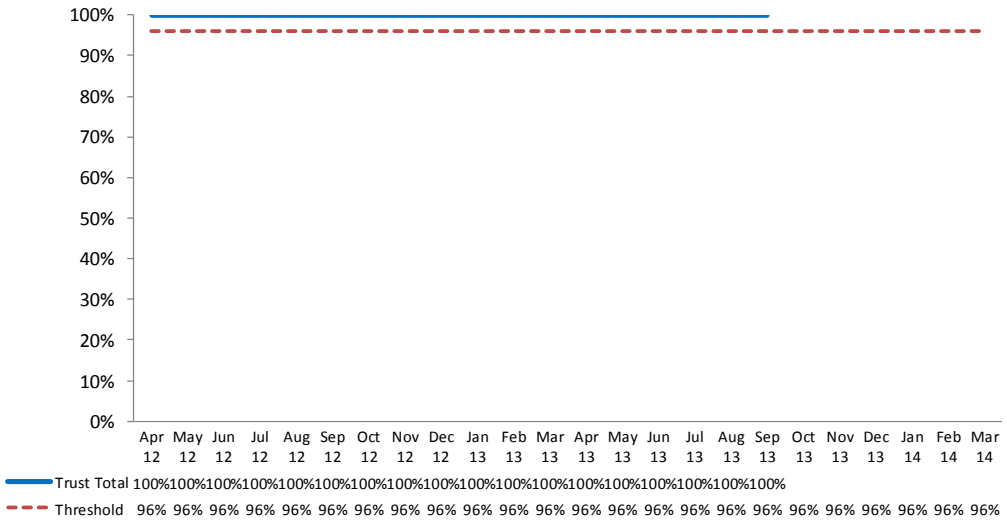
Access Metrics

31 Days to First Treatment

	Jul 13	Aug 13	Sep 13	Q1	Q2	Q3 TD	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 at 100%.

Cancer – 31 days to subsequent treatment - Surgery

Deliver

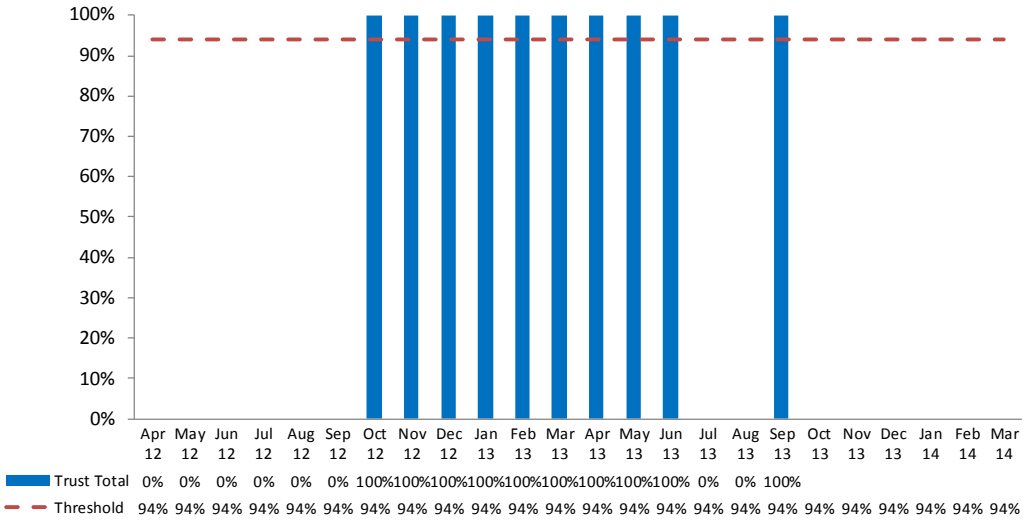
Access Metrics

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

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



Delivering to plan at 100%. There was no data for July and August as we had no patients on the surgical pathway.

Cancer – 31 days to subsequent treatment - Drugs

Deliver

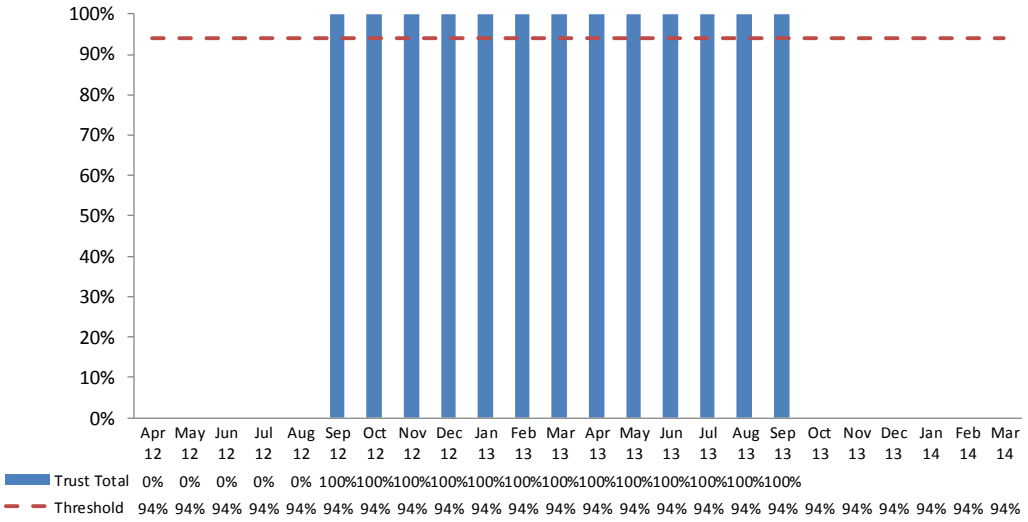
Access Metrics

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

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



Delivering to plan at 100%.

Cancer – 62 days from referral to treatment

Deliver

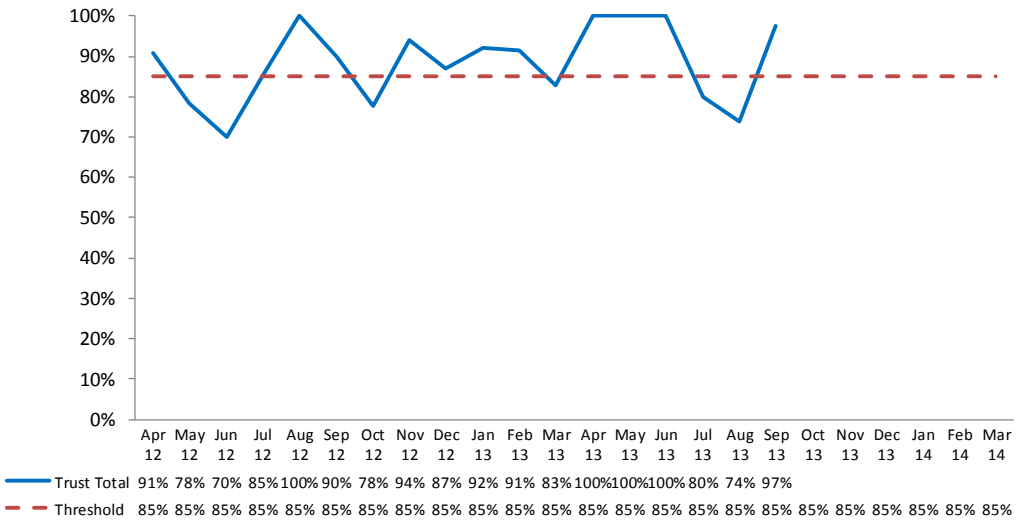
Access Metrics

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

	Jul 13	Aug 13	Sep 13	Q1	Q2	Q3 TD	Q4
National Threshold	85%			85%			
Trust Total	80%	74%	97%	100.0%	83.1%	-	-



Delivering against threshold, at 97% for September.

Cancer – 62 days from consultant upgrade

Deliver

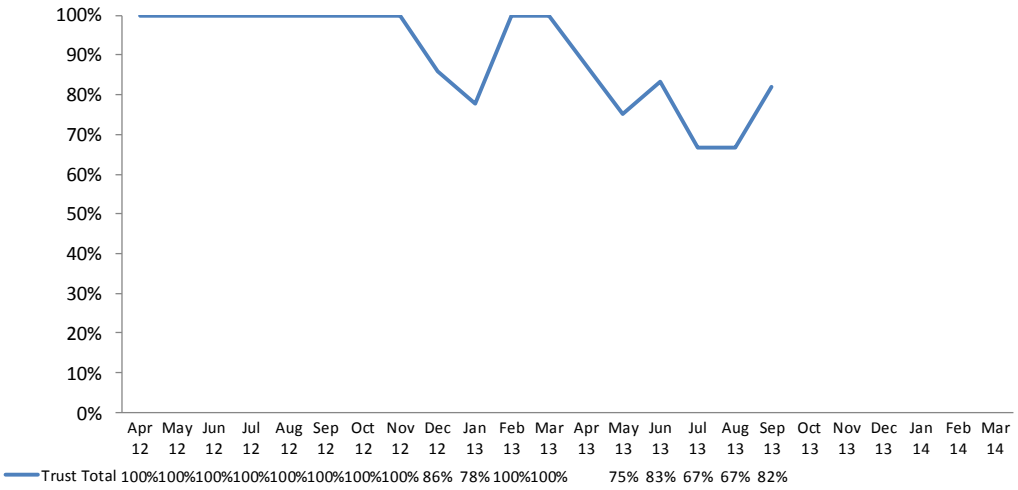
Access Metrics

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

	Jul 13	Aug 13	Sep 13	Q1	Q2	Q3 TD	Q4
Trust Total	66.7%	66.7%	81.8%	80.0%	72.4%	-	-



No national performance threshold however all delays are being analysed with clinical teams to identify areas for improvement.

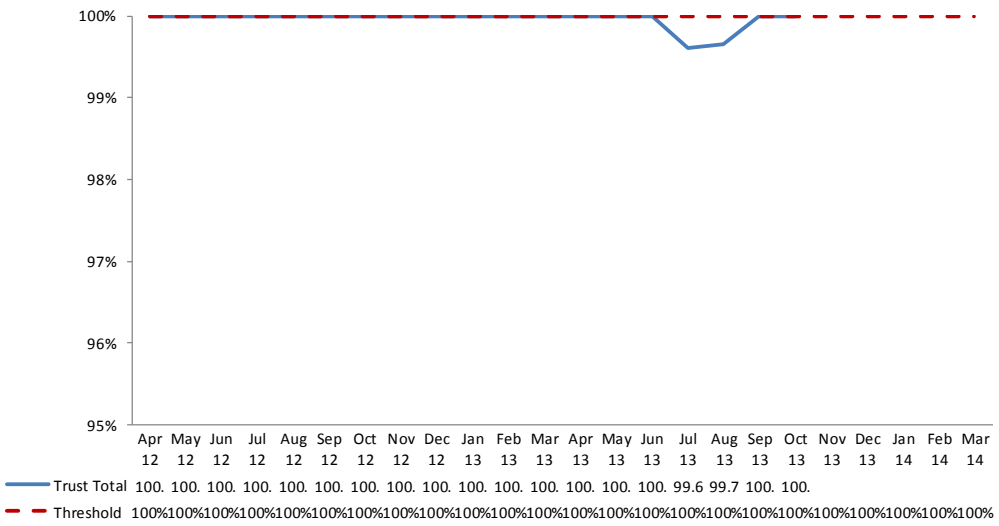
Genito-Urinary Medicine Appointment within 2 Days

Improving

Access Metrics

	Threshold	Apr 13	May 13	Jun 13	Jul 13	Aug 13	Sep 13	Oct 13
Trust Total	100%	100.0%	100.0%	100.0%	99.6%	99.7%	100.0%	100.0%

The percentage of patients offered an appointment within 2 days



Capacity and demand issues have been addressed and performance has returned to 100%.

Delayed Transfers of Care

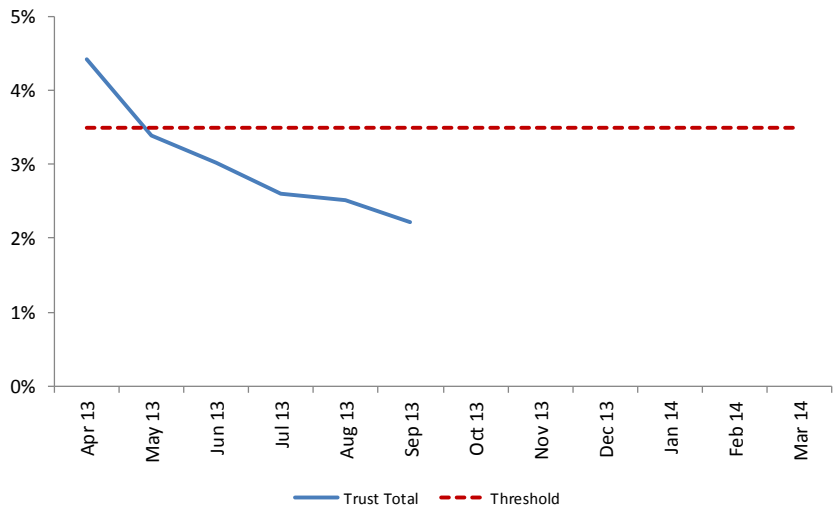
Integrate

Outcome Metrics

Number of Days Delayed

	Oct 13		
	NHS Days	Social Services	Both
Trust Total	127	74	0

	Aug 13	Sep 13	Oct 13
Local Threshold	3.5%		
Trust Total Delayed Transfers	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.

October Percentage is currently unavailable due to EPR reporting Issues

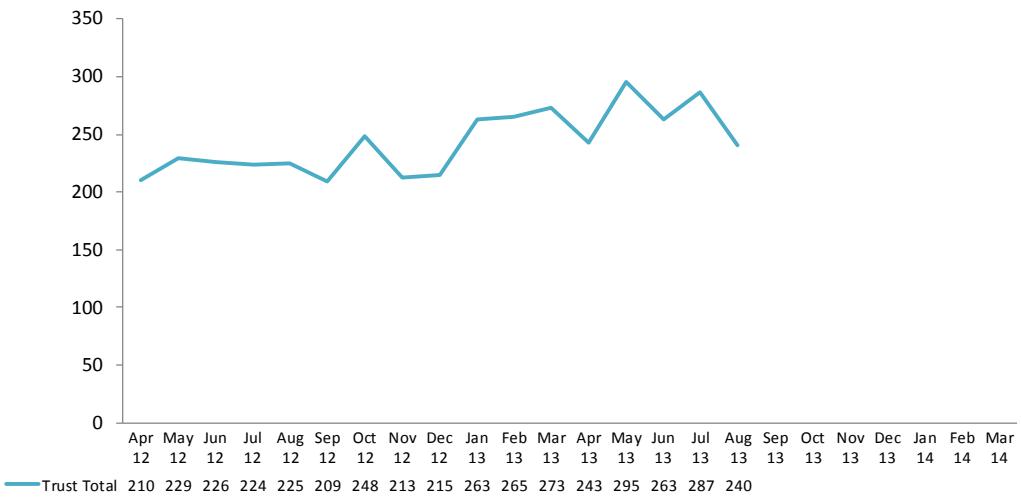
No updated position due to EPR reporting issues.
Ongoing discharge planning is in place through daily ward rounds and board rounds and continued work with London Borough of Islington (LBI) to maintain sustained improvement.

30 day Emergency Readmissions

Deliver

Outcome Metrics

	Apr 13	May 13	Jun 13	Jul 13	Aug 13	Sep 13
Trust Total	243	295	263	287	240	



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

September data is currently unavailable due to EPR reporting Issues

No updated position due to EPR reporting issues.
Divisions are auditing cases to investigate and identify actions to reduce the number of emergency readmissions.

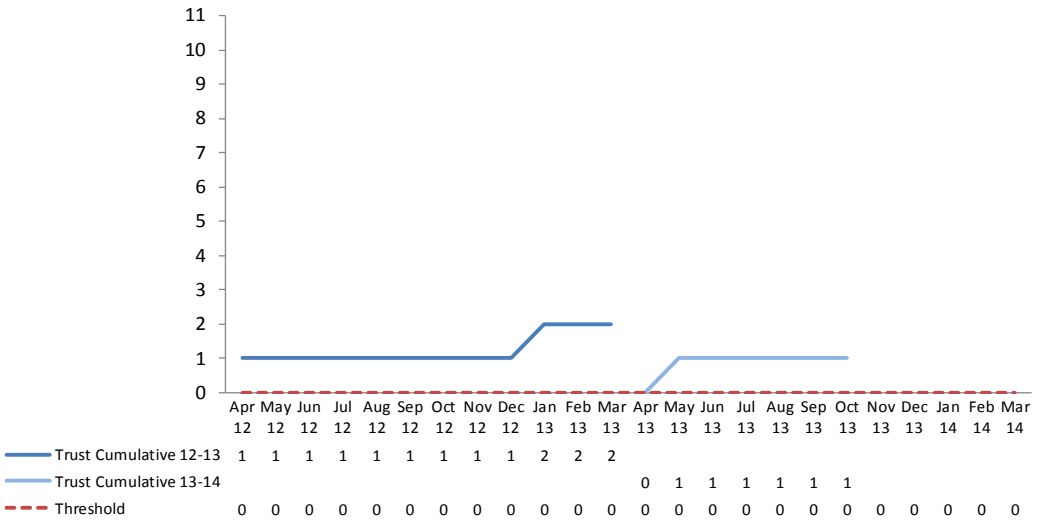
MRSA

Deliver

Outcome Metrics

	Apr 13	May 13	Jun 13	Jul 13	Aug 13	Sep 13	Oct 13
National Threshold	0						
Trust Total	0	1	0	0	0	0	0

Number of MRSA bacteraemia (bacteria in the blood)



No post 48 hours MRSA bacteraemia since May 2013. Hand hygiene audits continue and a hand hygiene campaign is due for January 2014.

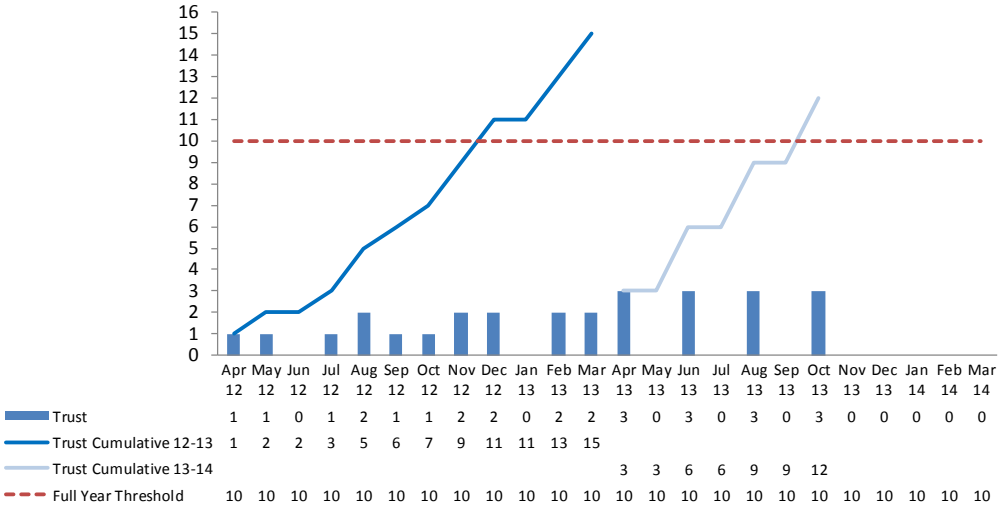
C Difficile Infections

Deliver

Outcome Metrics

	Apr 13	May 13	Jun 13	Jul 13	Aug 13	Sep 13	Oct 13
Full Year National Threshold	<=10						
Trust Total	3	0	3	0	3	0	3

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



Full year target has not been achieved with 12 cases year to date against a full year standard of 10 cases.
Test sensitivity has increased which may account for an increase in the number of positive tests. Each case has been reviewed which showed no correlation, all steps to ensure cleanliness, hand hygiene and communication have been cross checked for progress.

E.coli and MSSA

Deliver

Outcome Metrics

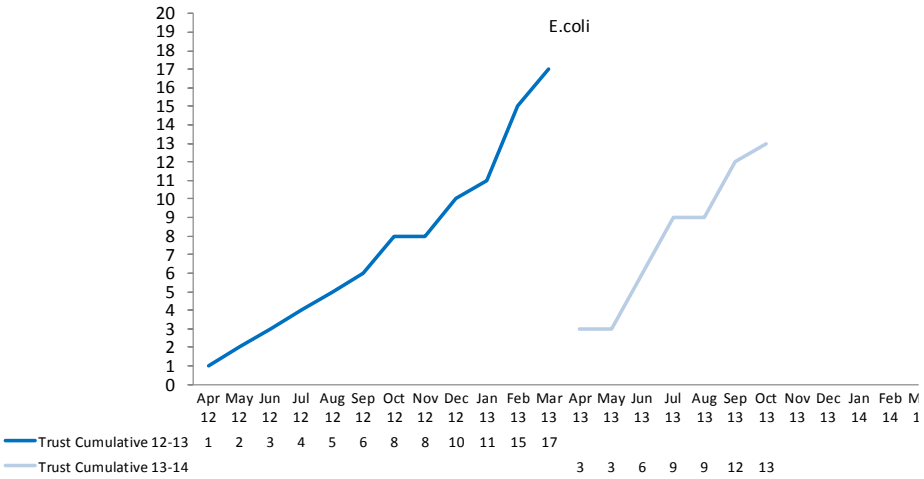
E.coli (Post 48 Hours)

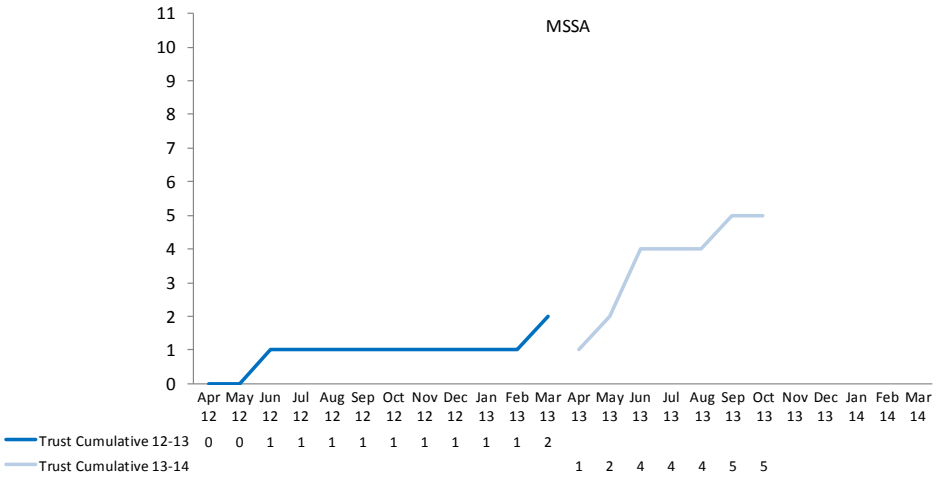
	Aug 13	Sep 13	Oct 13
Threshold			
Trust Total	0	3	1

MSSA (Post 48 Hours)

	Aug 13	Sep 13	Oct 13
Threshold			
Trust Total	0	1	0

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





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

Harm Free Care

Deliver

Outcome Metrics

	Contractual Threshold	Aug 13	Sep 13	Oct 13
% of Harm Free Care	95%	92.84%	93.93%	94.16%
Completeness of Safety Thermometer (CQUIN)	100%	100%	100%	100%
Pressure Ulcer (PU) Incidence	50% Reduction	20	18	17

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.

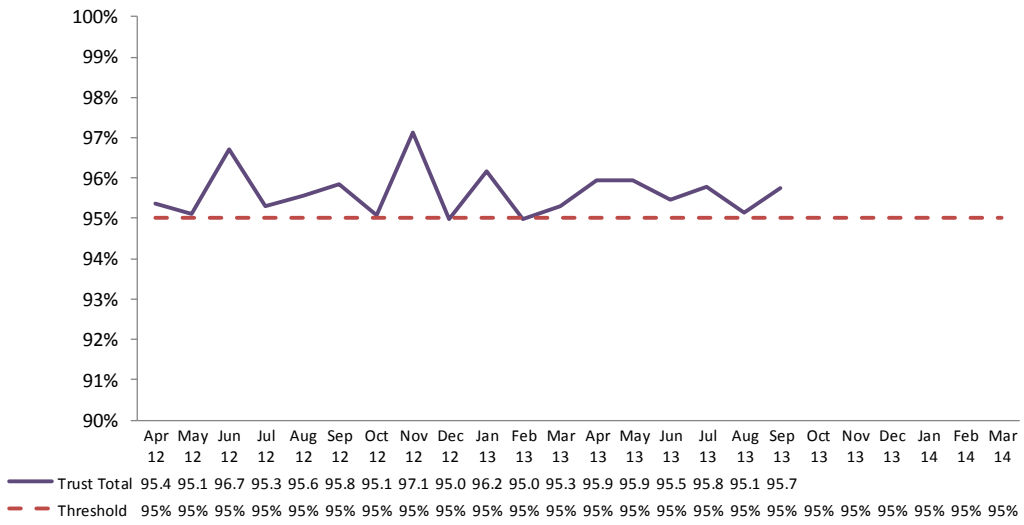
Performance is still below the target of 95% of harm free care although there is month-on-month improvement.

VTE Risk Assessment

Deliver

Outcome Metrics

	VTE Risk Assessed (CQUIN)			RCA for Hospital Acquired			VTE Incidence		
	Jul 13	Aug 13	Sep 13	Jul 13	Aug 13	Sep 13	Jul 13	Aug 13	Sep 13
CQUIN Threshold	95%			Target to be decided			-		
Trust Total	95.8%	95.1%	95.7%	2	9	3	14	-	-



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.
VTE Incidence data not currently available

Risk assessment for VTE continues to achieve the 95% threshold.

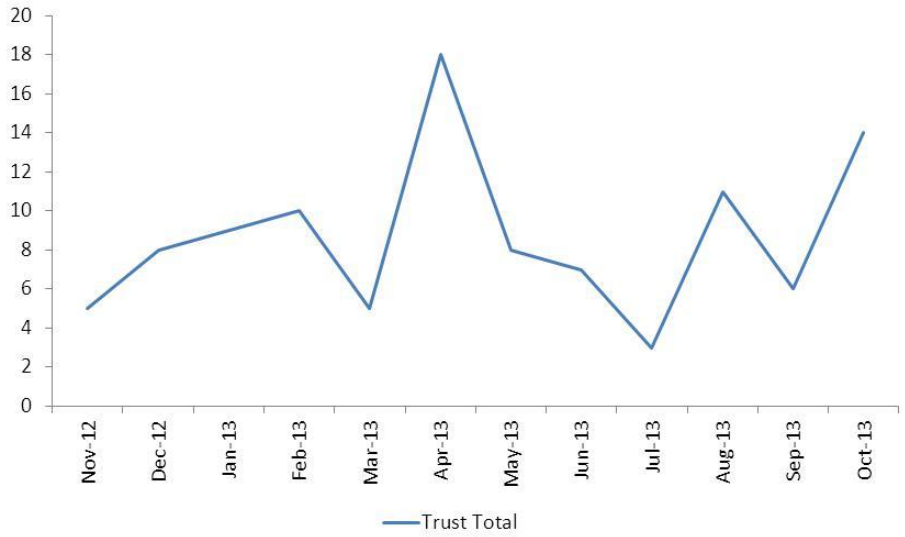
Serious Incidents

Change

Outcome Metrics

	Aug 2013	Sep 2013	Oct 2013
Trust Total	12	6	15

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



Of the 15 serious incidents reported, there were nine pressure ulcers Grade 3 or 4.

Never Events

Change

Outcome Metrics

Zero Never Events since October 2012

No change since previous report.

CAS Alerts (Central Alerting System)

Change

Outcome Metrics

Month	MDA alerts issued	Number not relevant	Action completed	Action required/ongoing	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: ongoing	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 Facilites 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.

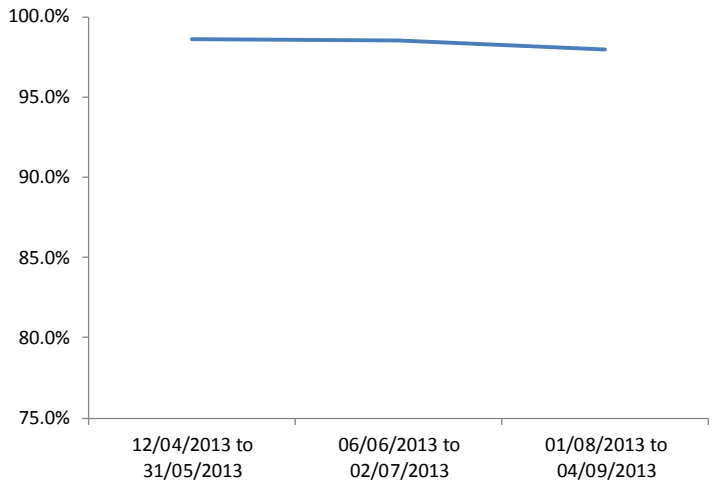
No further progress on NPSA Alert. This is a national issue, however there are existing safe systems of work in place to mitigate risk to patient safety.

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

August Latest Audit completed by Facilities

Weekly walk arounds continue, bringing a 'fresh eyes' view of the wards, helping ward staff to identify and address issues.

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

No change since previous report.

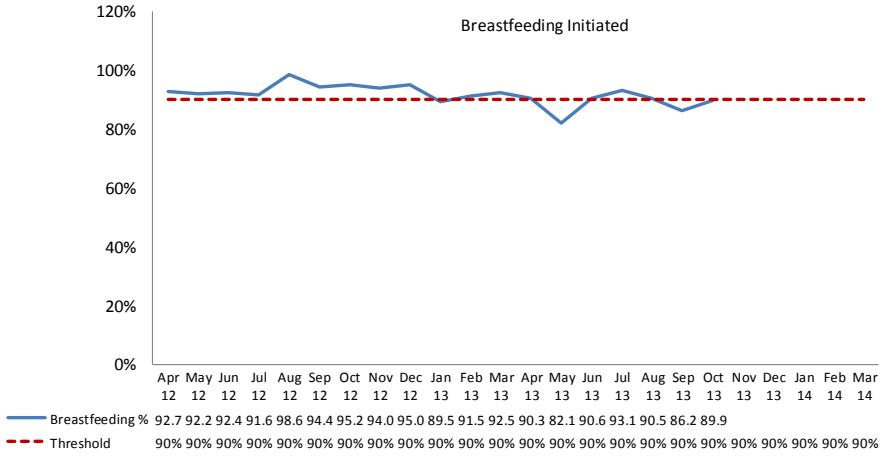
Breastfeeding and Smoking

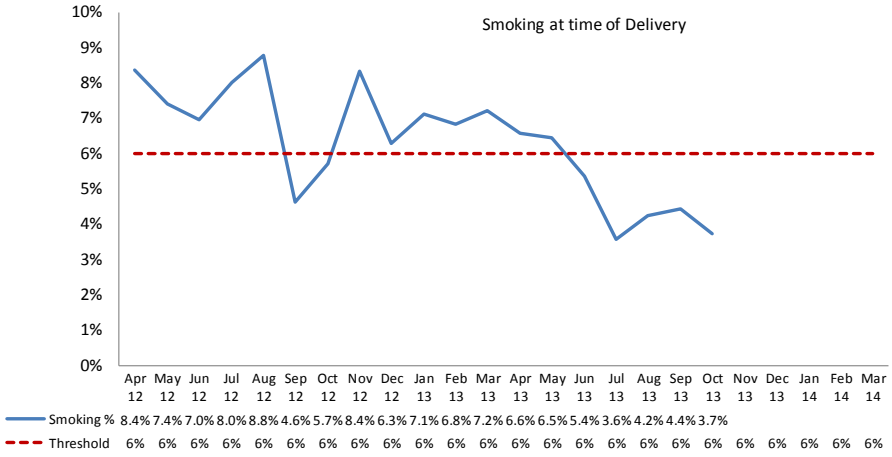
Improving

Outcome Metrics

	Threshold	Aug 13	Sep 13	Oct 13
Breastfeeding Initiated	90%	90.5%	86.2%	89.9%
Smoking at Delivery	<6%	4.2%	4.4%	3.7%

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.





Breastfeeding has improved from 86.2% to 89.9%, although slightly under the threshold of 90%.
Smoking at time of delivery has improved and continues to achieve the threshold with performance at 3.7%.

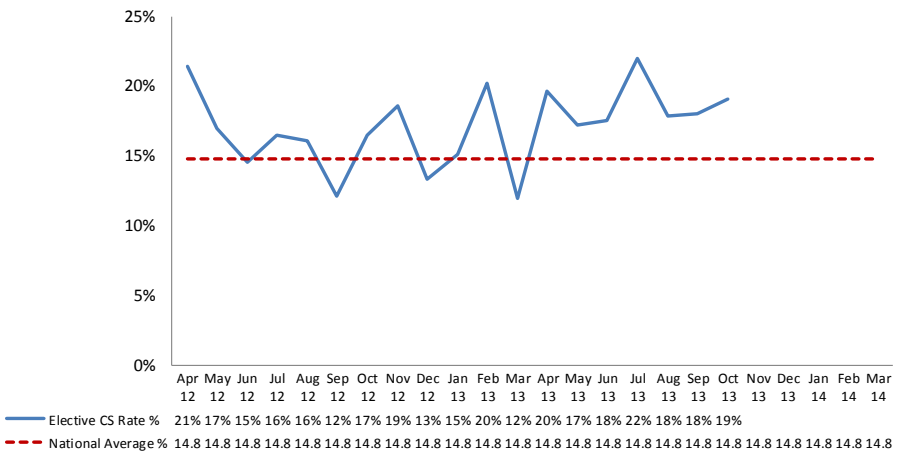
Caesarean Section Rates

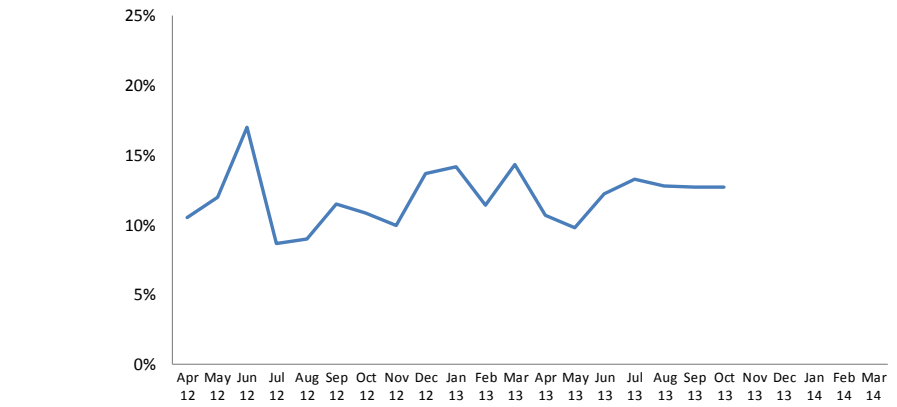
Deliver

Outcome Metrics

	National Average	Aug 13	Sep 13	Oct 13
Elective C-Section Rate	14.8%	17.9%	18.0%	19.1%
Emergency C-Section Rate	-	12.8%	12.7%	12.7%
All Deliveries	-	336	355	346

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





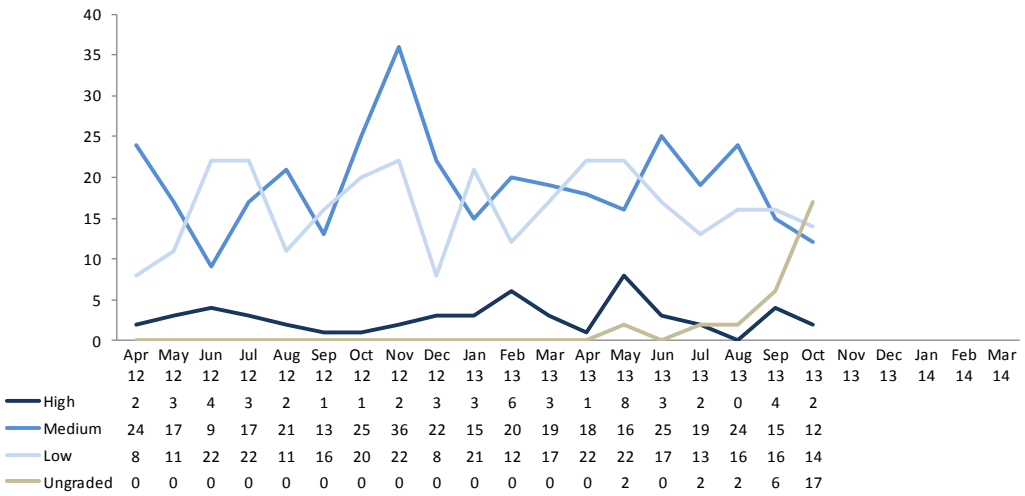
Elective caesarean section rate is at 19.1%, above the national average.
There is not a national average published for emergency caesarean section rates, however the clinical lead is investigating the possibility of establishing either a peer group or pan-London position.

High Risk Medication Errors

Change

Outcome Metrics

	Apr 13	May 13	Jun 13	Jul 13	Aug 13	Sep 13	Oct 13
High	1	8	3	2	0	4	2
Medium	18	16	25	19	24	15	12
Low	22	22	17	13	16	16	14
Ungraded	0	2	0	2	2	6	17
Total	41	48	45	36	42	41	45



Medication Errors recorded on Datix graded by risk. Information is submitted to National Reporting and Learning Service and the trust is ranked as a medium Acute Trust with a median percentage of medication errors of all incidents

Errors are reviewed by a Medicines Safety Pharmacist who facilitates an action plan to reduce the likelihood of further medication errors. This data is also presented at the Medicines Safety Group who are part of the Drug and Therapeutics Committee. Our medication error rate is approximately 45 a month but reporting is encouraged, including near misses to enable us to highlight areas to target. It should also be noted that all errors including controlled drugs are automatically classed as high grade.

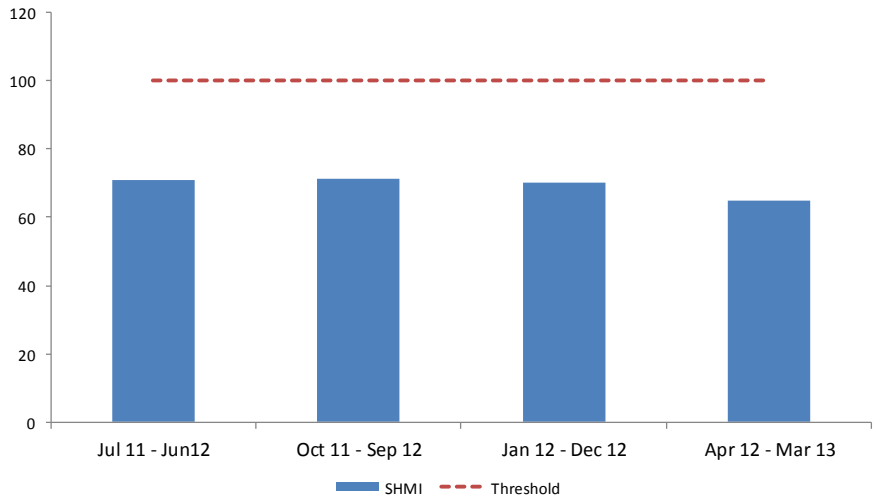
SHMI

Change

Outcome Metrics

	Threshold	Jul 11 - Jun12	Oct 11 - Sep 12	Jan 12 - Dec 12	Apr 12 - Mar 13
SHMI	100	71.08	71.28	70.31	65

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



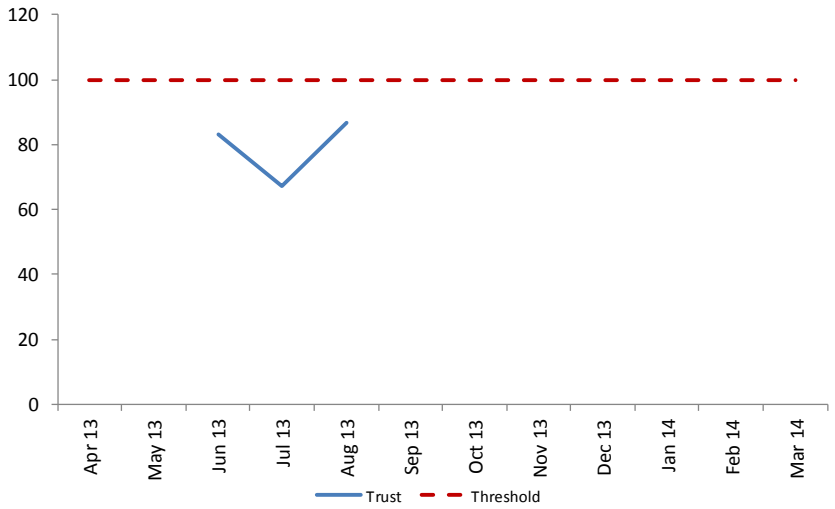
We have the best SHMI in England.

HSMR

Change

Outcome Metrics

	Jun 13	Jul 13	Aug 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.

August Latest Data Available from Dr Foster

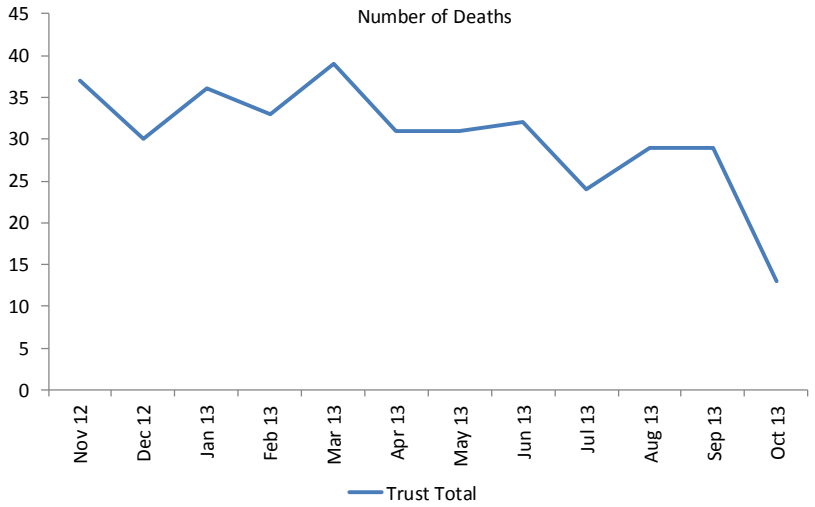
No change since previous report.

Number of Inpatient Deaths

Outcome Metrics

	Deaths			Percentage of Admissions		
	Aug 13	Sep 13	Oct 13	Aug 13	Sep 13	Oct 13
Trust Total	29	29	13	0.6%	0.6%	0.3%

Includes all types of admission
Patient death defined as discharge method = died



Significant reduction of inpatient deaths has been reported for October, equating to a reduction of 16 deaths or 0.3%. Crude mortality is a good indicator of clinical and operational excellence.

Patient Satisfaction (Friends & Family)

Ensure

Quality Indicators

	Jul-13	Aug-13	Sep-13
Total Coverage (CQUIN Threshold >=15%)	10.20%	12.60%	12.70%
Inpatient Coverage	36%	43.5%	45%
Emergency Department Coverage	5.40%	7.4%	6.0%
Inpatient Net Promoter Coverage	66	62	68
Emergency Department Net Promoter Score	15	51	43

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

Emergency Department action plan has been revised and will be overseen by the ED Matron.
Actions include greater signage, staff been held accountable for giving postcards out on each shift and monitored on a weekly basis. Targeted focus on UCC and Emergency Department.

Mixed Sex Accommodation

Integrate

Quality Indicators

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

Awaiting confirmation of breaches reported across the Trust for October

A review is underway to cross check compliance and national guidance definitions, due to building works compliance maybe difficult to maintain for shared bathrooms. Estates, commissioners and nursing are working with operations to review areas,

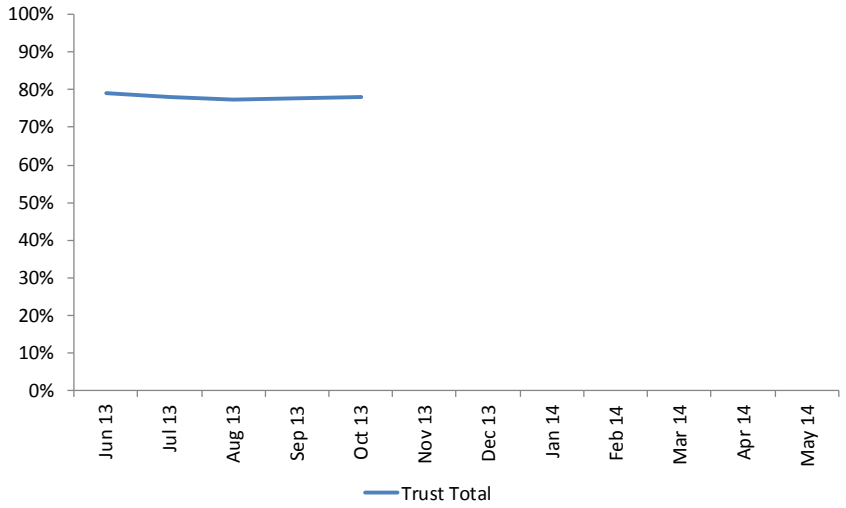
Percentage of Registered Nurses

Change

Quality Indicators

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

	Threshold	Aug 13	Sep 13	Oct 13
Trust Total	n/a	77.4%	77.8%	78.1%



Wards have reviewed establishment levels, currently awaiting Executive Committee signoff.

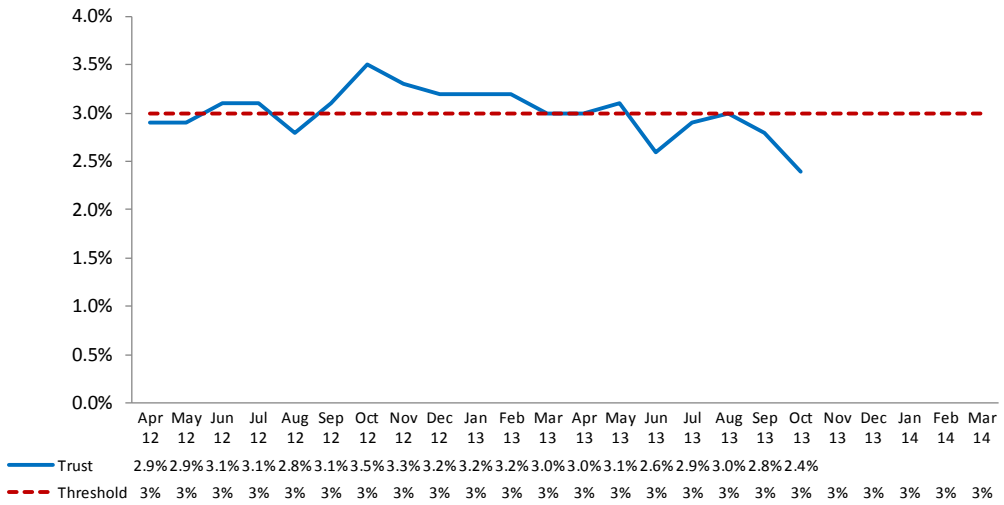
Sickness Rate

Change

Quality Indicators

	Sickness				High Bradford Scores		
	Local Threshold	Aug 13	Sep 13	Oct 13	Aug 13	Sep 13	Oct 13
Trust Total	<3%	3.0%	2.8%	2.4%	734	730	692

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



Sickness rate remains below the local threshold. Managers are liaising with Human Resources department to discuss ways to further address staff with high Bradford scores. Targeted training to specific areas.

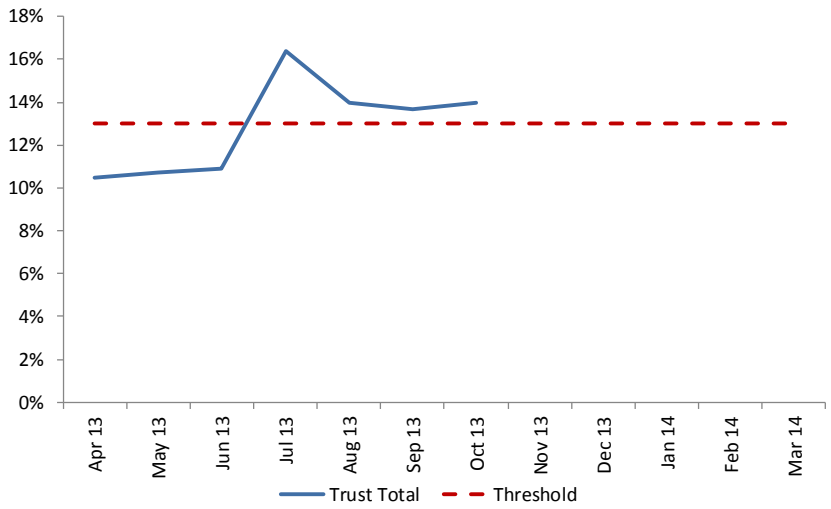
Staff Turnover

Change

Quality Indicators

	Local Threshold	Aug 13	Sep 13	Oct 13
Trust Total	<13%	14.0%	13.7%	14.0%

Proportion of workforce leaving in a given period.



Further work to agree the data definitions is required. The percentage currently includes fixed term appointments with the exception of junior doctors.
Expectation is that division will see a continued reduction in agency spend as posts are substantively filled.

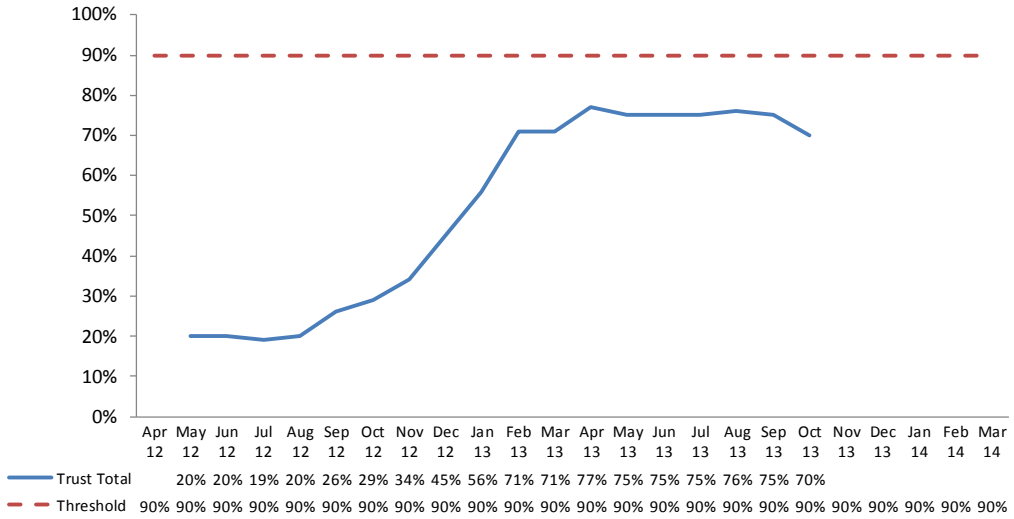
Staff Appraisal

Change

Quality Indicators

	Local Threshold	Aug 13	Sep 13	Oct 13
Trust Total	90%	76.0%	75.0%	70.0%

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



New appraisal action plan in place. Plan to target specific service lines at low rate. Trust currently has three different appraisal cycles, which is being redesigned into one. Action plan to redesign appraisal approach and process, with full launch by April 2014.

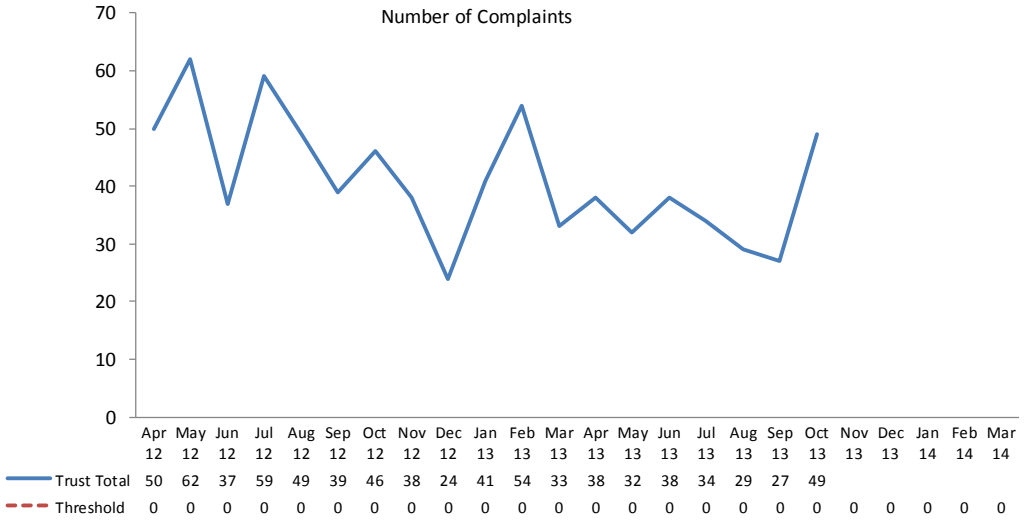
Complaints

Ensure

Quality Indicators

	Complaints				Responded to in 25 days		
	Threshold	Aug 13	Sep 13	Oct 13	Jul 13	Aug 13	Sep 13
Trust Total	0	29	27	49	74%	55%	48%

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



Complaints have increased due to the implementation of EPR and the effect on waiting times, queues and increased telephone calls.
Staff were reallocated to front line services during this period to discuss patient concerns face-to-face.

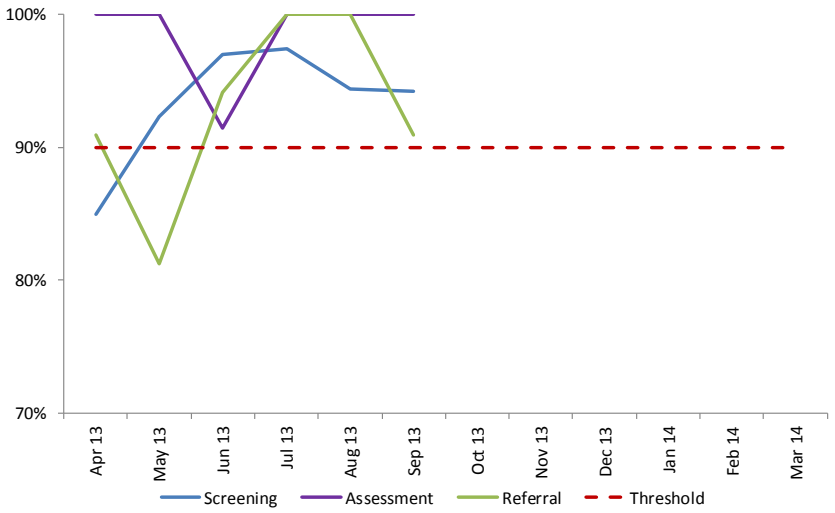
National CQUINs

Integrate

Quality Indicators

Dementia

	Contractual Threshold	Jul 13	Aug 13	Sep 13
Screening	90%	97%	94%	94%
Assessment	90%	100%	100%	100%
Referral	90%	100%	100%	91%



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

Performance for the three elements of the Dementia CQUIN remain above the contractual thresholds.

Specialist Commissioning CQUINs

Deliver

Quality Indicators

NICU	Year End Target	Apr	May	Jun	Q1	Jul	Aug	Sep	Q2	Oct
Improve Access to Breast Milk in Preterm Infants	62%	100%	0%	57%	60%	50%	67%	33%	61%	33%
Timely Administration of Total Parenteral Nutrition in Preterm Infants	95%	100%	-	100%	100%	100%	100%	-	100%	100%

Improve Access to Breast Milk in Preterm Infants: Number of low weight babies up to and including 32+6 weeks exclusively fed on mother's breast milk against total number of low weight babies up to and including 32+6 weeks discharged.
Total Parenteral Nutrition: Number of low weight babies up to and including 29+6 weeks where TPN has been administered against total number of low weight babies up to and including 29+6 weeks discharged.

Child and Adolescent Mental Health Service	Year End Target	Q1	Q2
Optimising Pathways	-	Report Submitted	Report Submitted
Physical Healthcare	-	Report Submitted	Report Submitted

Physical Healthcare - Physical exam within 24 hours is offered, when a physical exam is refused we offer this again on a regular basis taking into account the young person's mental state. E.g. a patient with severe OCD would be likely to feel very distressed if he/she was continually offered a physical examination if they had a fear of contamination.
2. Physical observations on discharge – There have been some N/A but this was only applicable after the CQUIN reporting information was finalised.

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								

Latest data available for both CQUINs due to EPR reporting issues

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								

No updated position due to EPR reporting issues.
Stop Smoking - Service lead accountable for maintaining performance against target.
Alcohol – Actions have not improved performance. Reviewed by senior clinical & management team. Identify clinical champion and FY1 /2 to support wider update. Targeted as opposed to universal screening to remain and review in three months.

Local CQUINs for Prevention

Deliver

Quality Indicators

COPD	Year End Target	Apr	May	Jun	Q1	Jul	Aug	Sep	Q2
Acute COPD Bundle	90%	100%	92%	94%	96%	100%	100%	100.0%	100%
ACUTE CAP Bundle	80%	100%	0%	78%	83%	64%	100%	100%	86%
Community COPD Bundle	75%	100%	100%	100%	100%	100%	100%	100%	100%

ACUTE CAP bundle figure for may 13 - note that there was only a single CAP patient in May who legitimately required a COPD bundle

Quarter 2 COPD figures not yet signed off

Integrated Care	Year End Target	Apr	May	Jun	Q1	Jul	Aug	Sep	Q2
Multidisciplinary Working	90% of actions completed	n/a	n/a	n/a					85%
Ambulatory Care Management	95% of management plans sent to GP within 24hrs (Q2 onwards)	n/a	n/a	n/a					66%
Supporting self-care - training	25% of community matrons, LTC nurses trained in year	n/a	n/a	n/a		Qtr 2 Figs CMs only			18%
Supporting self-care - responses to LTC6	at least 35% of new patients completed LTC6	n/a	n/a	n/a		Qtr 2 Figs CMs only			38%

Associate director and service lead accountable for sustained improvement in performance target.

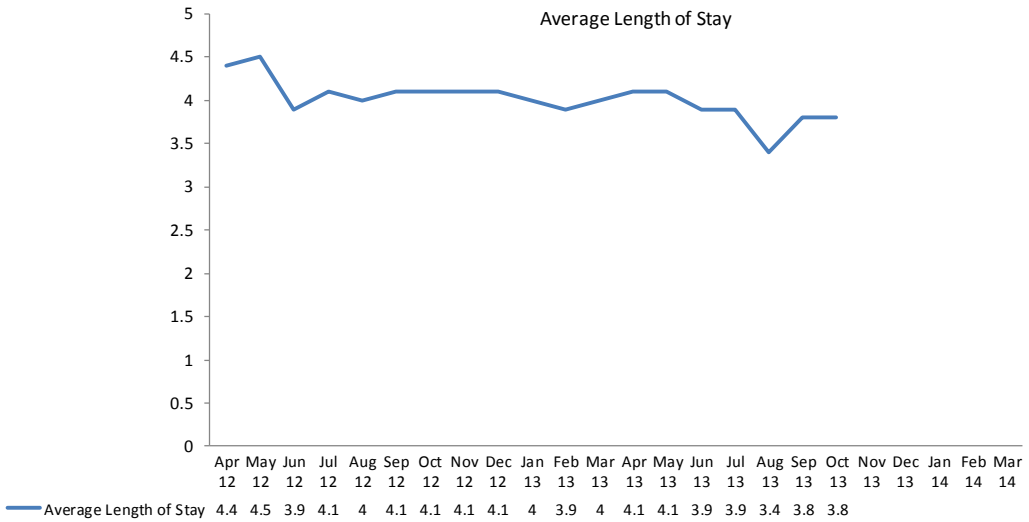
Average Length of Stay (days)

Deliver

Quality Indicators

	Threshold	Apr 13	May 13	Jun 13	Jul 13	Aug 13	Sep 13	Oct 13
Trust Total (days)	tbc	4.1	4.1	3.9	3.9	3.4	3.8	3.8

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



Average length of stay has remained stable this month, however the trend seen since April 2012 demonstrates an improvement overtime.
Discharge planning arrangements and monitoring remains in place with ongoing daily board and ward rounds to ensure patients leave hospital when clinically ready or escalated as appropriately.

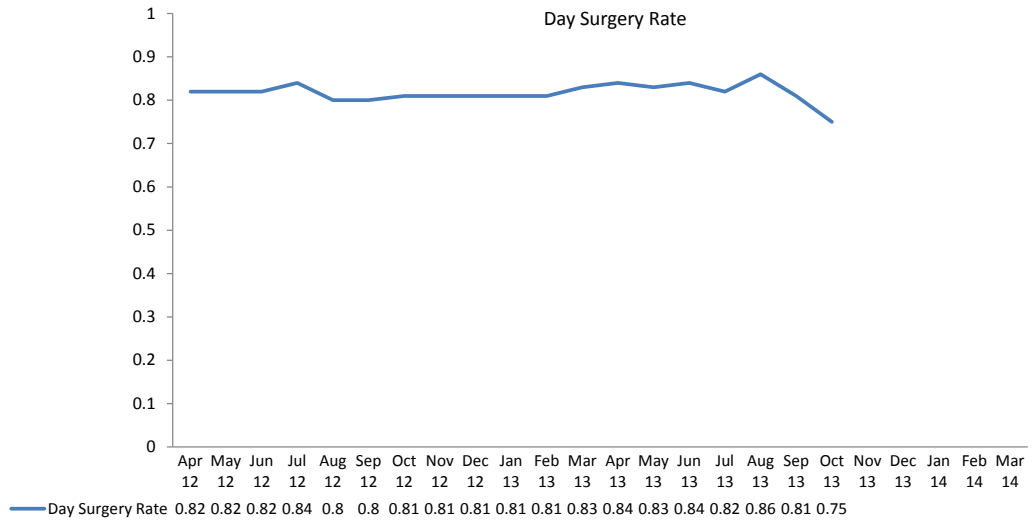
Day Surgery Rate

Deliver

Quality Indicators

	Threshold	Apr 13	May 13	Jun 13	Jul 13	Aug 13	Sep 13	Oct 13
Trust Total	n/a	84%	83%	84%	82%	86%	81%	75%

Proportion of total elective surgeries carried out as a daycase



Further work will be done on this indicator against the national 'basket of daycase indicators'. Improvements are being seen in the new theatre templates agreed with consultants, as part of the theatre improvement work which will impact future performance.

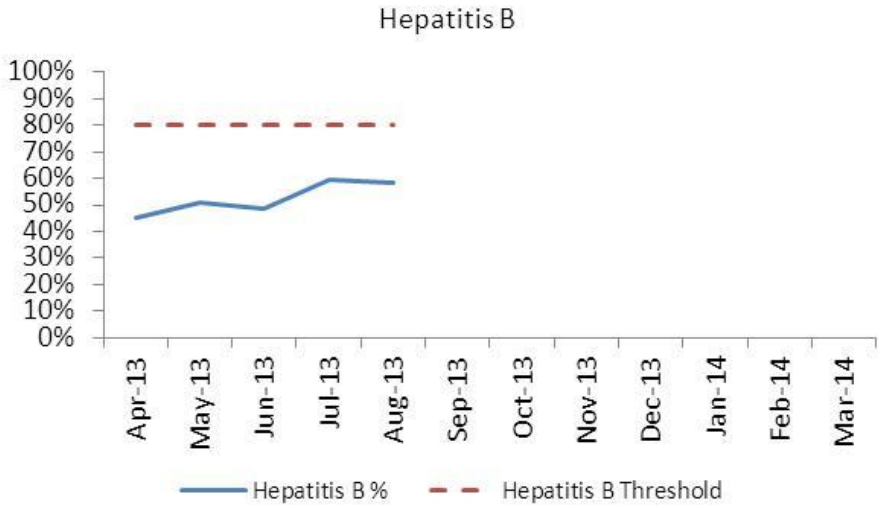
Pentonville Prison

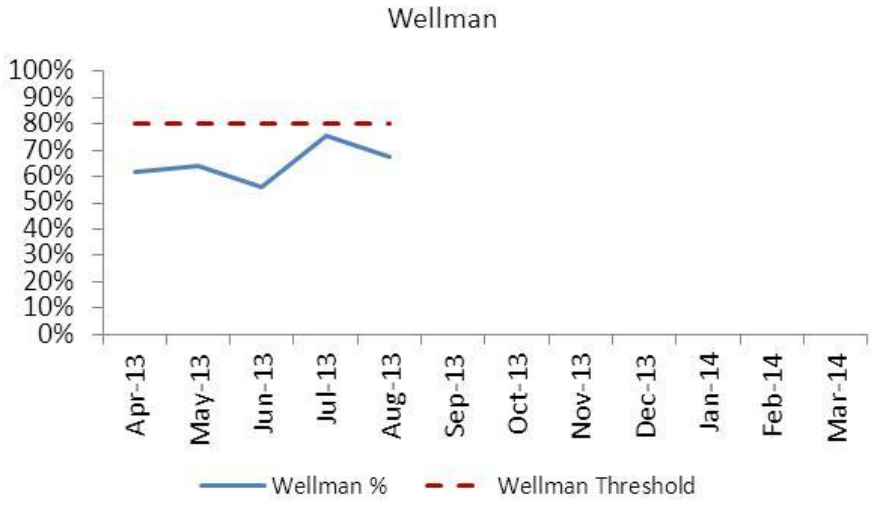
Integrate

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%

Latest data not yet received from Pentonville





Activity

Due to EPR Reporting Issues, this indicator cannot be reported this month but will be reported retrospectively when available.