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The Whittington Hospital NHS Trust
Magdala Avenue
London N19 5NF

Whittington Health Trust Board

8 January 2014

Title:	**Monthly Integrated Performance Dashboard (November data)**		
Agenda item:	**14/008**	**Paper**	**4**
Action requested:	**For discussion and information**		
Executive Summary:	The Performance Dashboard is designed to assure the Board that performance is on track within the organisation and, where there is under performance, actions are in place to improve.		
Summary of recommendations:	The Board notes progress against performance objectives.		
Fit with WH strategy:	The Trust Board performance report aligns with all five strategic goals.		
Reference to related / other documents:	NHS Trust Development Authority assurance monitoring framework.		
Reference to areas of risk and corporate risks on the Board Assurance Framework:			
Date paper completed:	23rd December 2013		

Author name and title:		**Caroline Angel, Head of Performance**		**Director name and title:**		**Sally Batley, Director of Improvement, Performance and Informaiton.**	
Date paper seen by EC		**Equality Impact Assessment complete?**	**No**	**Risk assessment undertaken?**	**No**	**Legal advice received?**	**No**

Whittington Health NHS

Performance Dashboard
Trust Board January 2014
(November data)

Priorities

Focus Areas

Improvement action plans are in place for all Board indicators and are monitored at the Whittington Health Improvement Steering Committee.

Data quality assurance process is underway for all indicators and are reported to the Audit and Risk Committee.

Maintaining focus on Referral to Treatment (RTT) during electronic patient record (EPR) reporting issues
Operational plans for Christmas period
Winter and flu planning implementation
Improve appointments being outcome completed
Outpatient improvement project led by Chief Operating Officer
HR metrics and financial metrics improvement plan

Integrated Care and Acute Medicine Division
•Emergency department (ED) performance targets and improvement plan
•Improvement in quality and complaints
•Implementation of ambulatory emergency care (AEC)
•Implementation of Tuberculosis (TB) network

Surgery, Cancer and Diagnostics Division
•Theatre improvement plan
•HR recruitment for existing positions
•Transformation projects in pre-assessment and diagnostics

Women, Children and Families Division
•Child protection training
•New birth visits

Board Aims

Focus Areas

All indicators have been mapped to the Board Aims

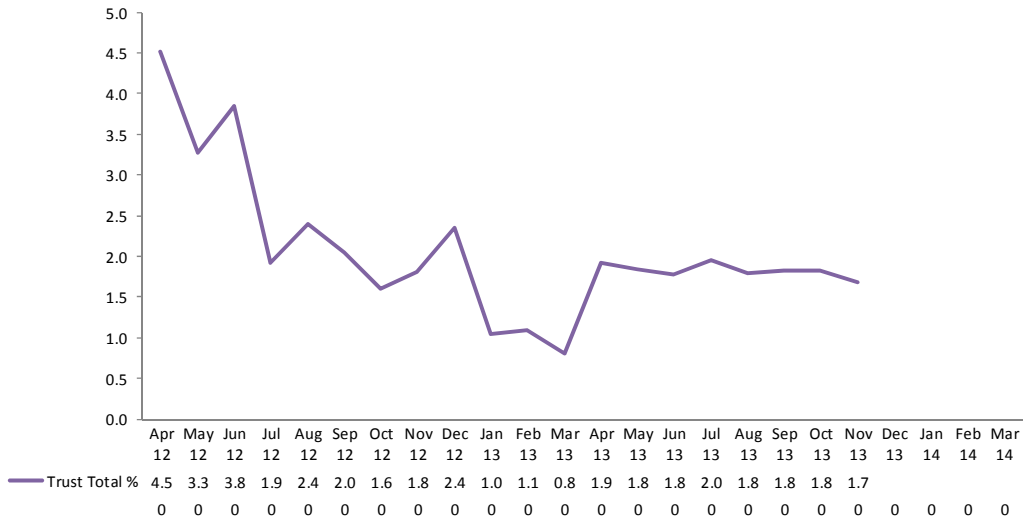
First:Follow-Up Ratio - Acute

Deliver

Focus Areas

	Transformation Board Threshold	Apr 13	May 13	Jun 13	Jul 13	Aug 13	Sep 13	Oct 13	Nov 13
Acute Trust Total	-	1.93	1.84	1.78	1.96	1.80	1.83	1.82	1.68

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



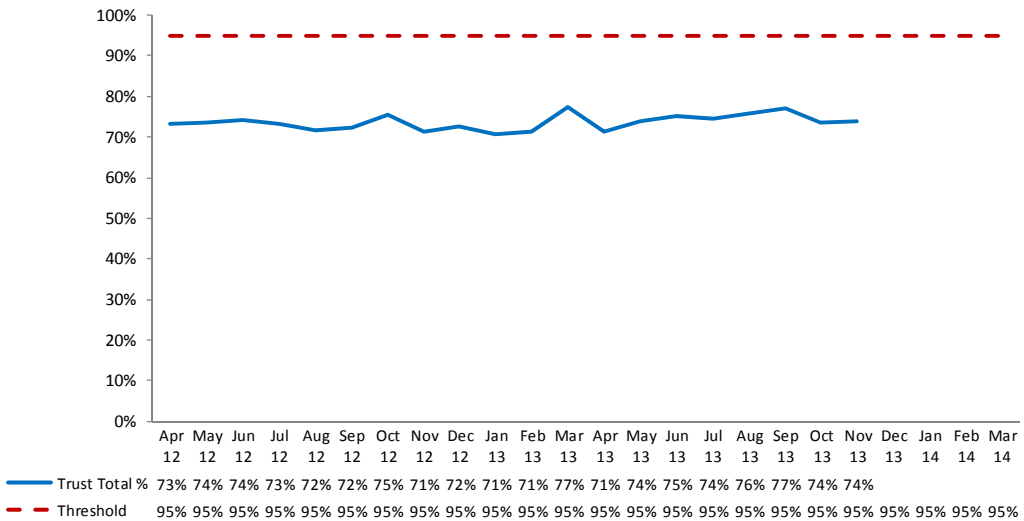
Chief Operating Officer (COO) is leading a pan-organisation improvement project around first to follow up ratio's, beginning with ensuring clinic templates are accurate on EPR in respect to first and follow up clinic slots. Project is also focusing on first appointments, outpatient service cancellations and DNA rates.

Theatre Utilisation

Deliver

Focus Areas

	Utilisation			Available Session Time (Minutes)			Time Utilised (Minutes)		
	Sep 13	Oct 13	Nov 13	Sep 13	Oct 13	Nov 13	Sep 13	Oct 13	Nov 13
Local Threshold	>95%								
Trust Total	77%	74%	74%	62,640	66,750	64,650	48,318	49,174	47,740



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.

The theatres utilisation project is underway with new data collection and reports being embedded, a permanent matron has been recruited and additional staff made available to schedule pre-admission and theatre bookings. Projections for improvement is that theatre utilisation will be 85 per cent by March and 95 per cent by June 2014

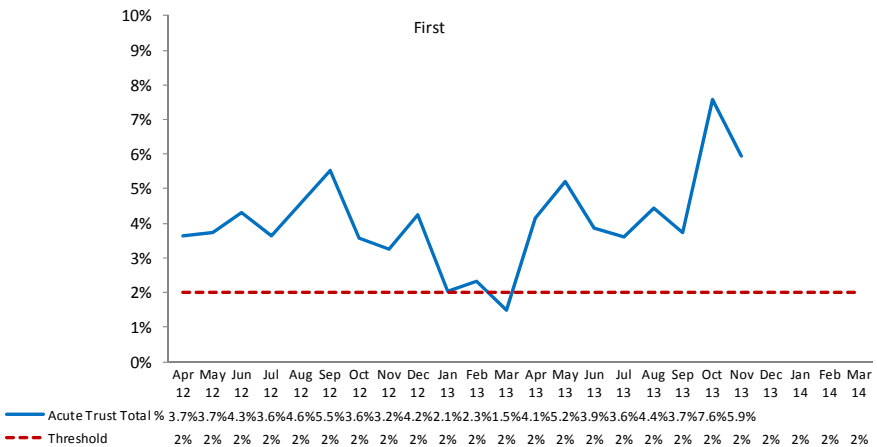
Hospital Cancellations - Acute

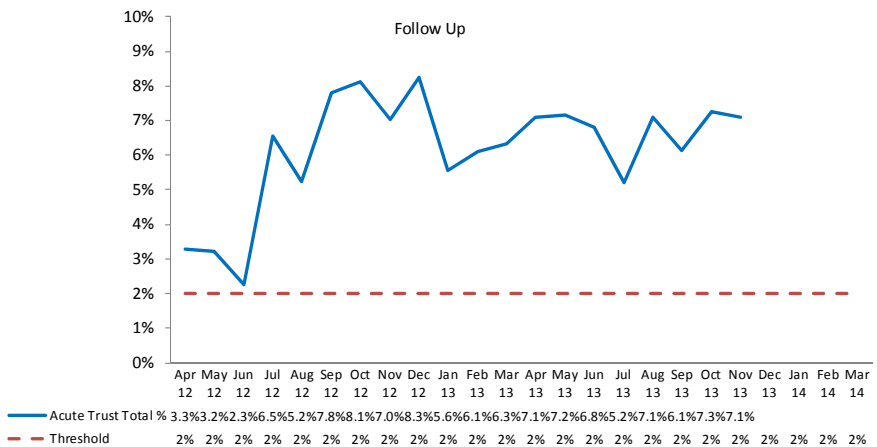
Deliver

Focus Areas

	First Appointments			Follow Up Appointments		
	Sep 13	Oct 13	Nov 13	Sep 13	Oct 13	Nov 13
Local Threshold	<2%			<2%		
Acute Trust Total	3.7%	7.6%	5.9%	6.1%	7.3%	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.





Consultant annual leave policy is now in place to prevent short notice cancellation of appointments. Clinical directors to oversee adherence to leave policy.
Clinic booking rules are being agreed with each unit and consultant to assist with pre planning.
A number of EPR shadow clinics have been cancelled and patients provided with appointments.

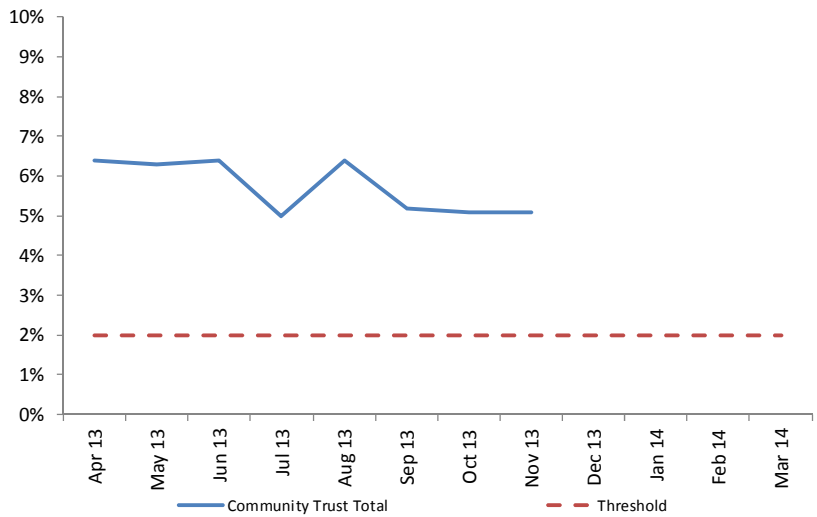
Service Cancellations - Community

Integrate

Focus Areas

	Apr 13	May 13	Jun 13	Jul 13	Aug 13	Sep 13	Oct 13	Nov 13
Local Threshold	2%							
Community Trust Total	6.4%	6.3%	6.4%	5.0%	6.4%	5.2%	5.1%	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.



Action plan is being developed that Trust Operations Board will oversee delivery of moving forward.

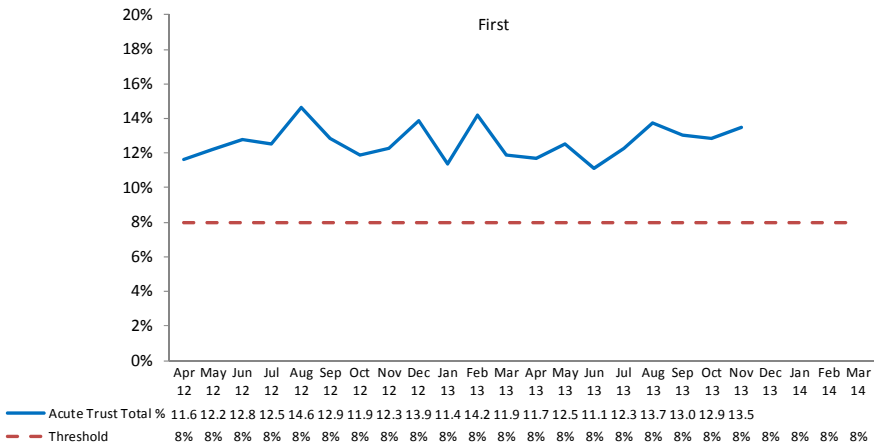
DNA Rates - Acute

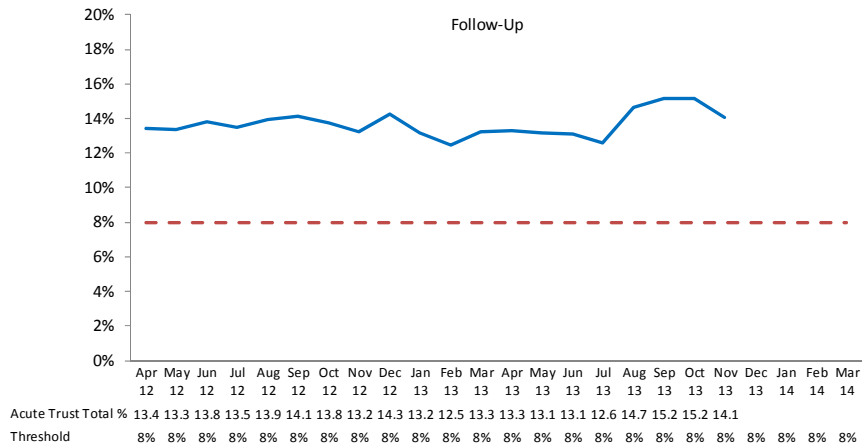
Deliver

Focus Areas

	First Appointments			Follow Up Appointments		
	Sep 13	Oct 13	Nov 13	Sep 13	Oct 13	Nov 13
Local Threshold	8%			8%		
Acute Trust Total	13.0%	12.9%	13.5%	15.2%	15.2%	14.1%

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





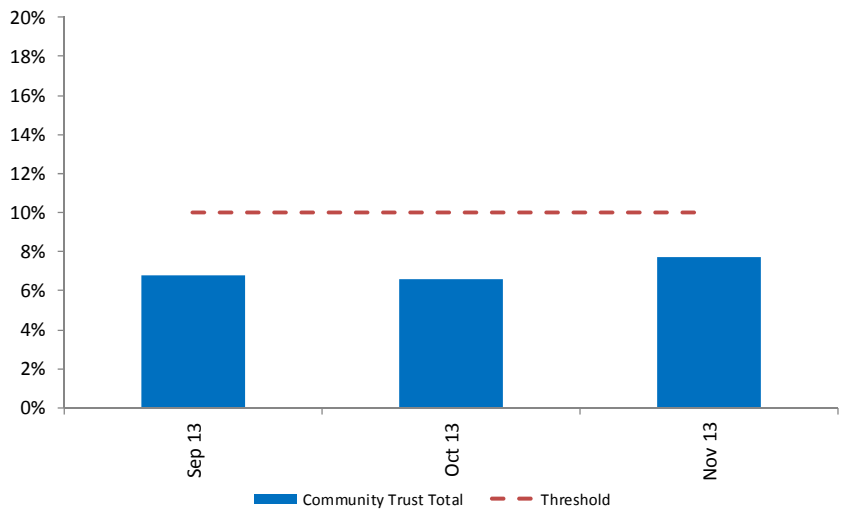
The Outpatient Improvement Programme is underway lead by the COO. This plan included completing standard operating procedure (SOP) for all steps in the appointments process, data monitoring, standardised reminder messages and calls and communication to patients in regards to the percentage of patients who arrive for their appointment. New clinic coordinator and lead in colposcopy has been appointed so will enhance managerial process.

DNA Rates - Community

Integrate

Focus Areas

First + Follow-Up	Sep 13	Oct 13	Nov 13
Local Threshold	10%		
Community Trust Total	6.8%	6.6%	7.7%



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.

Although the average Did Not Attend (DNA) rate is below 10% threshold, these services have been included in the pan Whittington Health Outpatient Improvement Programme. This will be picked up through the new community access policy. However, it is worth noting that significant improvements have been made in lymphedema, tissue viability and diabetes services.

Community Face-to-Face Contacts

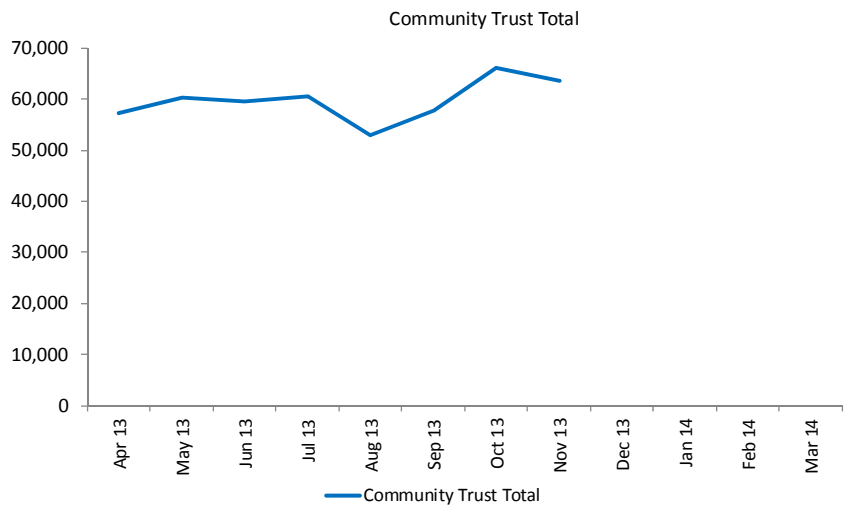
Integrate

Focus Areas

	Sep 13	Oct 13	Nov 13
Threshold	n/a		
Community Trust Total	57,681	66,058	63,465

2012/13 Apr - Nov	2013/14 Apr - Nov	Variation
n/a		
427,053	478,029	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.



Community contacts still on the increase from last year's positions. Capacity and demand is being mapped across community services and discussions with commissioners in regard to demand management

Community Appointment with no outcome

Integrate

Focus Areas

	Sep 13	Oct 13	Nov 13
Local Threshold	n/a		
Community Trust Total	2,336	1,572	2,031

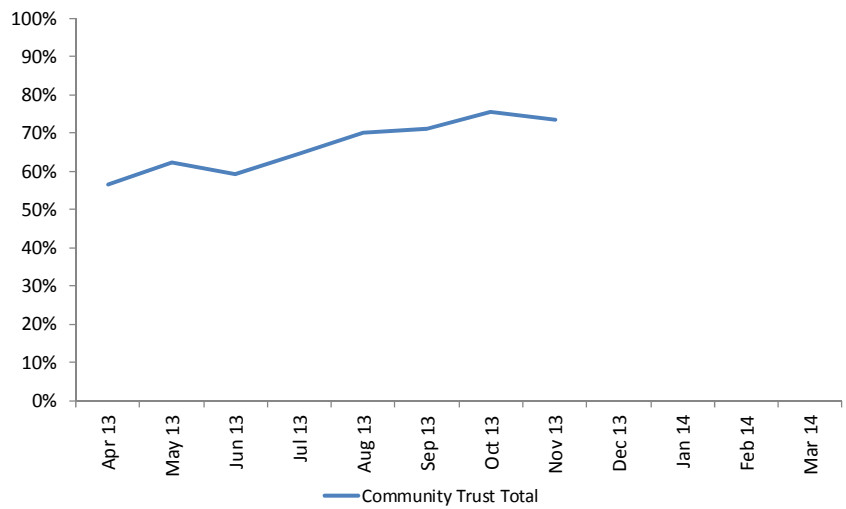
% of Total Face-to-Face Contacts		
Sep 13	Oct 13	Nov 13
0.5%		
4.0%	2.4%	3.2%

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.

Weekly report established and sent to service managers to assist with embedding the update of clinic outcomes each day. Refresher training is being implemented to ensure all staff understand their responsibilities.

Community Waiting Times
% waiting less than 6 weeks

	Sep 13	Oct 13	Nov 13
Threshold	n/a		
Community Trust Total	71.1%	75.7%	73.4%



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.

Recruitment into vacant posts is being undertaken alongside capacity and demand work to ensure patients can be seen as soon as possible. However, it is unlikely that Whittington Health will be able to achieve 100% of patients waiting less than six weeks under current commissioning arrangements, as standards for some clinics are set at higher wait levels.

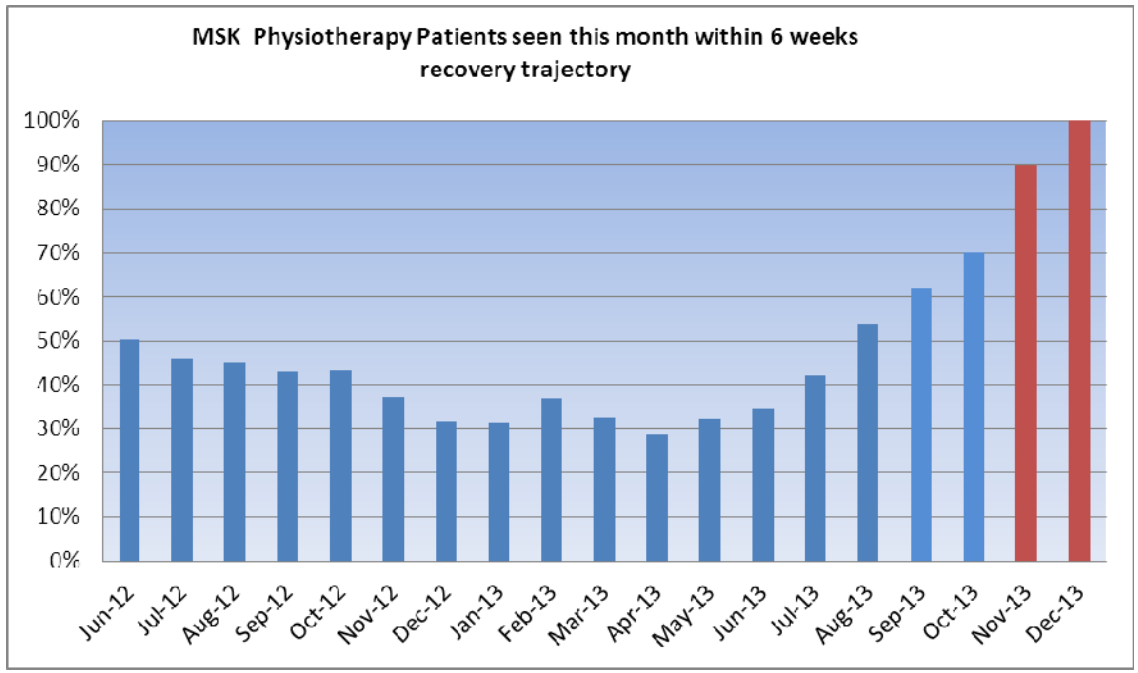
MSK Waiting Times

Integrate

Focus Areas

69.82% of patients seen in October had waited less than 6 weeks

Validation of long waiters is showing many are data quality issues rather than true waits



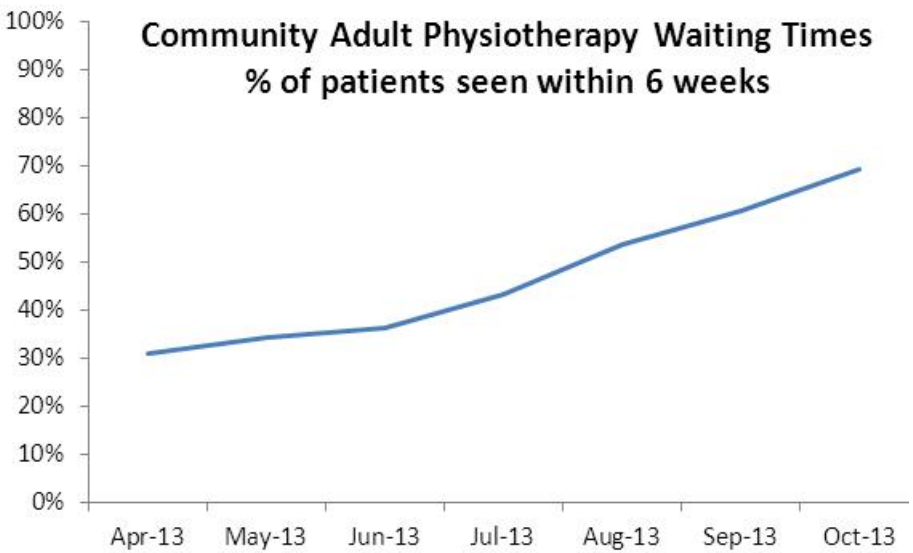
Average wait of patients with an appointment until first seen	5.5 wks
Wait if referred today to first appointment	6 wks
Number of patients waiting over 6 weeks in November	333
Number of patients waiting over 6 weeks in December	9

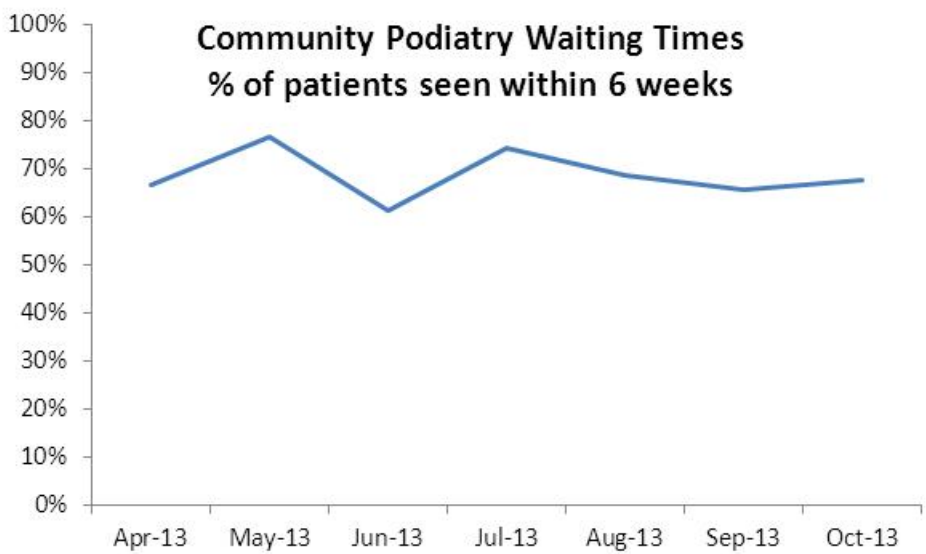
No new referrals and no patients who have opted in are waiting over 6 weeks

Physiotherapy and Podiatry Waiting Times

Integrate

Focus Areas





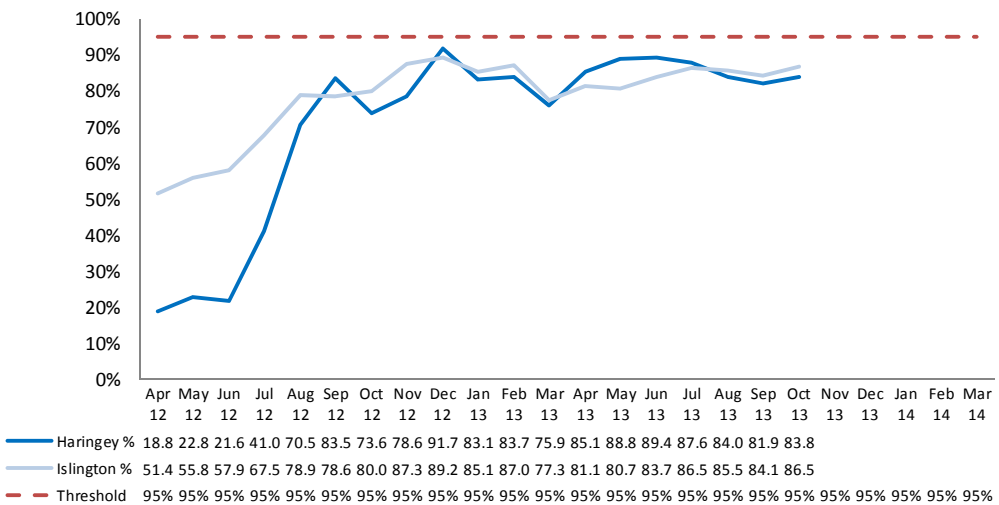
Actions plans are in place and projections for service delivery, close monitoring on actions and timescales.

New Birth Visits

Integrate

Focus Areas

	Apr 13	May 13	Jun 13	Jul 13	Aug 13	Sep 13	Oct 13
Local Threshold	95%						
Haringey	85.1%	88.8%	89.4%	87.6%	84.0%	81.9%	83.8%
Islington	81.1%	80.7%	83.7%	86.5%	85.5%	84.1%	86.5%



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

Data is 1 month in arrears due to 14 day target

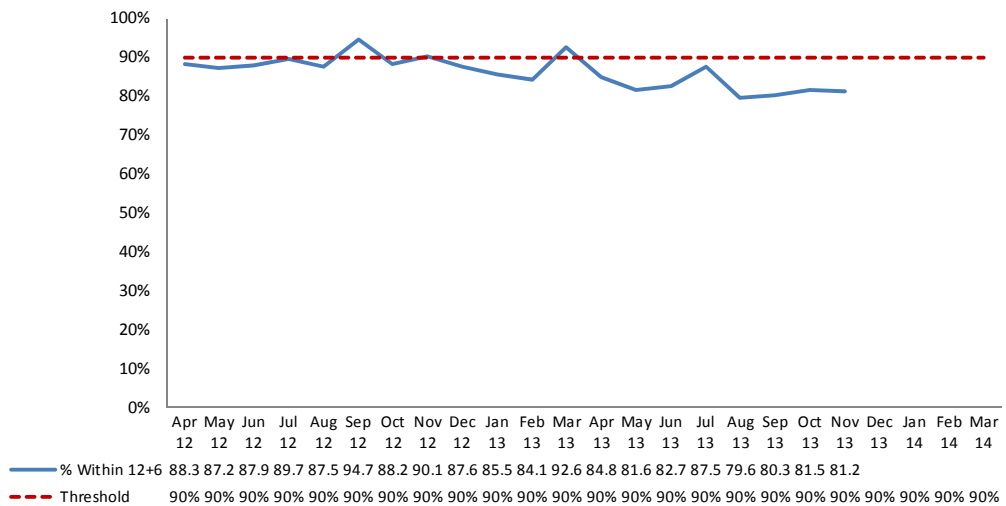
New birth visits improving slightly. More work is needed particularly around children in hospital. Health Visitor recruitment is still on-going.

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	Nov 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%	81.5%	81.2%
Total Number of Bookings	-	374	404	359	421	376	369	375	359
Referrals within 12 Weeks and 6 days	-	323	347	312	359	324	319	324	330



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

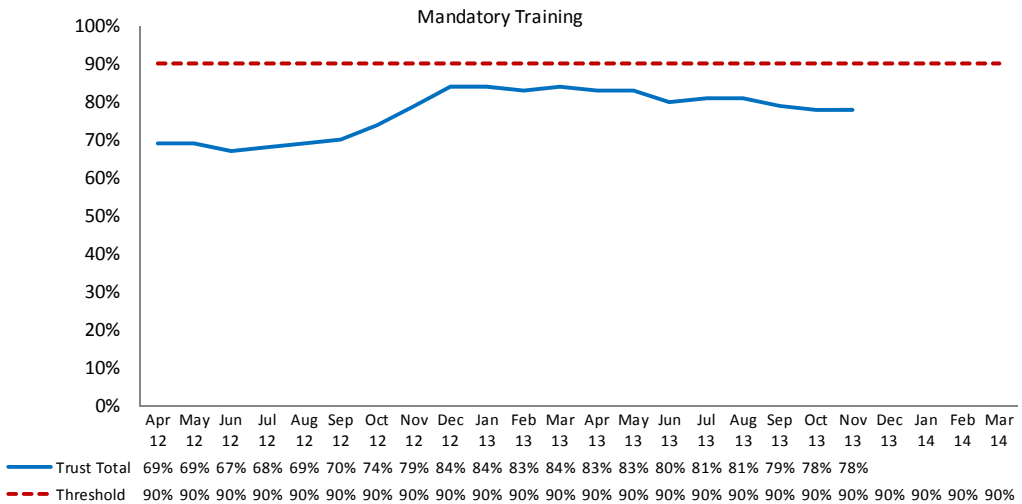
Additional administration support has been funded to ensure that all patients are contacted and reminded of the appointments and potentially rearrange.

Mandatory Training Compliance

Change

Focus Areas

	Mandatory Training			Information Governance			Child Protection Level 2			Child Protection Level 3		
	Sep 13	Oct 13	Nov 13	Sep 13	Oct 13	Nov 13	Sep 13	Oct 13	Nov 13	Sep 13	Oct 13	Nov 13
Local Threshold	90%			95%			90%			90%		
Trust Total	79%	78%	78%	77%	73%	68%	60%	63%	63%	62%	66%	65%



Data snapshot date 28/11/2013

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

Action Plan has a target to reach 85% by Jan 2014, with 90% by March 2014. Compliance remained at 78% due to training not being delivered in November. Redesigned divisional & service line reports sent directly to managers. Direct telephone calls to managers conducting survey re: low compliance. Redesigned information governance (IG) training to aid swifter access to training. Investigation re: lower compliance on child protection training revealed incorrect ESR recording script which is being rectified. Wider plans in place to explore training access via Phone/Tablet App for e-learning, as well as new starters completing all mandatory prior to on site start..

Referral to Treatment 18 weeks - Admitted

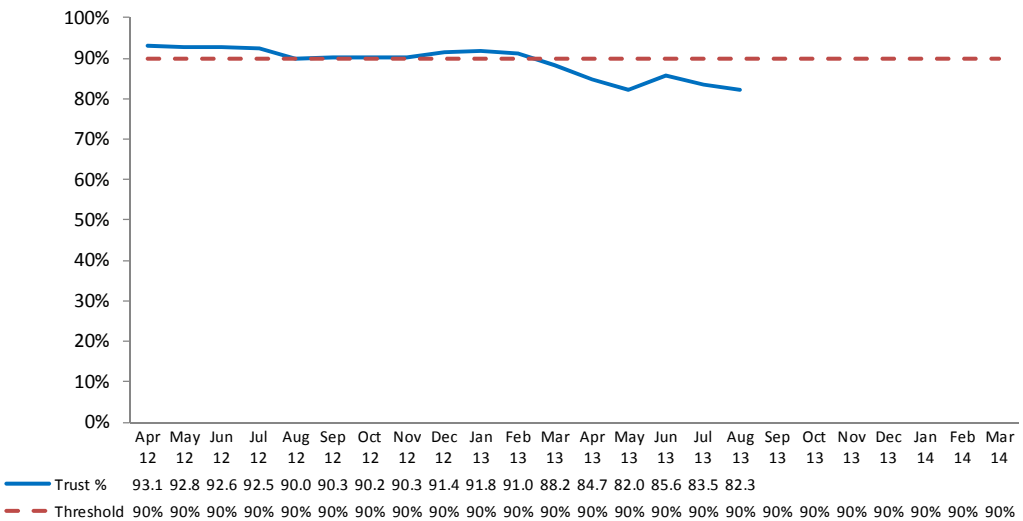
Deliver

Access Metrics

	Apr 13	May 13	Jun 13	Jul 13	Aug 13	Sep 13	Oct 13	Nov 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.

Data currently unavailable due to EPR reporting Issues



Due to issues related to the Electronic Patient Record (EPR), there has not been a live patient tracking list (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

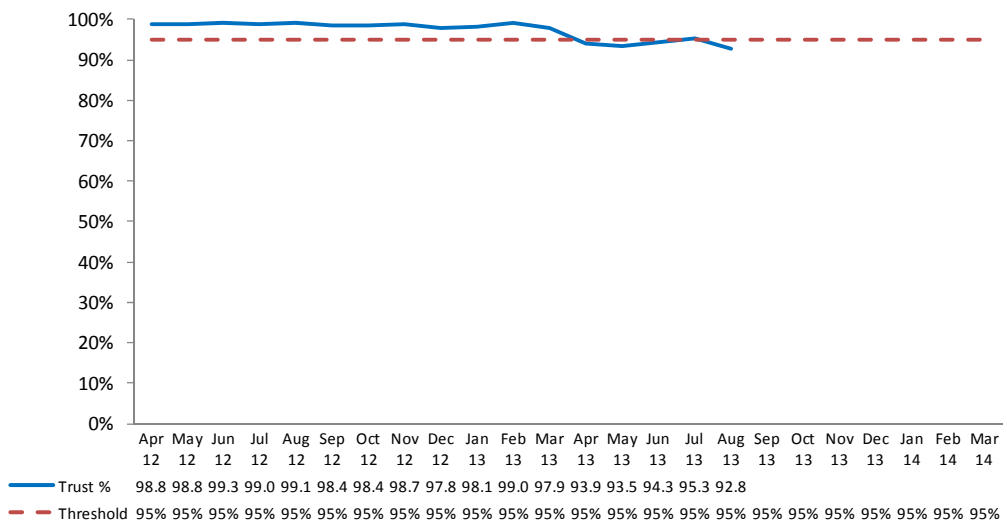
Deliver

Access Metrics

	Apr 13	May 13	Jun 13	Jul 13	Aug 13	Sep 13	Oct 13	Nov 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.

Data 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.

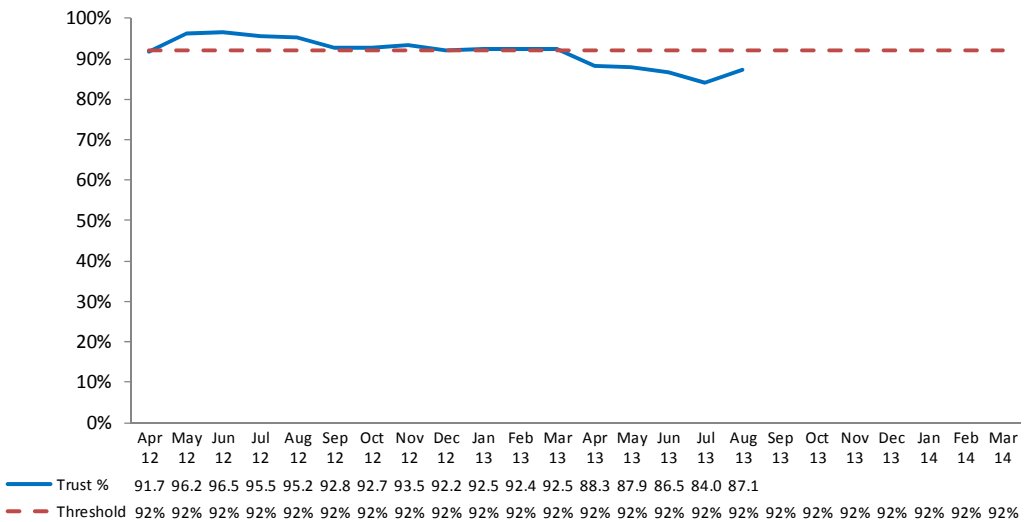
Referral to Treatment 18 weeks - Incomplete

Deliver

Access Metrics

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

Data 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 – 52 Week Waits

Deliver

Access Metrics

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

Data currently unavailable due to EPR reporting Issues

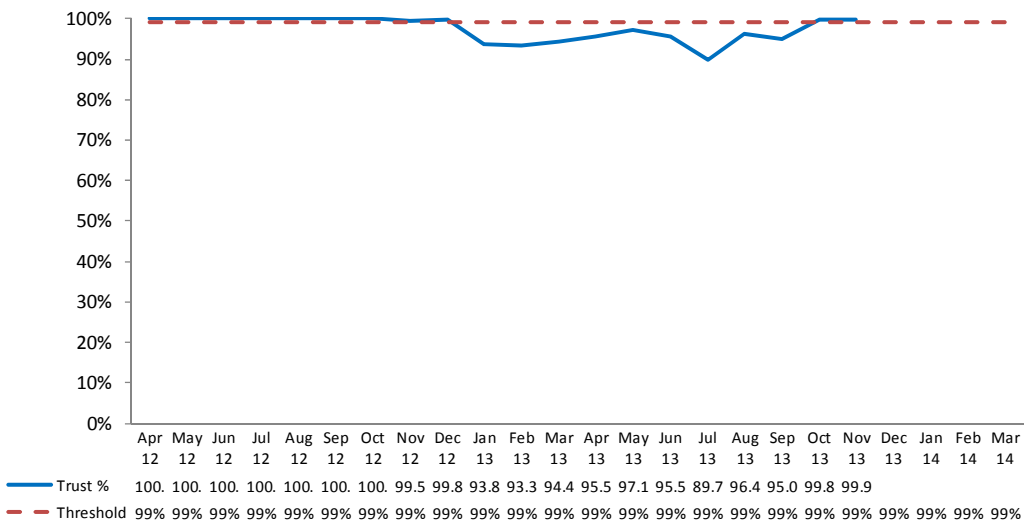
Due to issues related to the Electronic Patient Record (EPR), there has not been a live PTL since go-live. Information and performance are working with the EPR provider to address the issues. We have established extra electronic and manual processes to ensure patients are clinically prioritised appropriately.

Diagnostic Waits

Deliver

Access Metrics

	Apr 13	May 13	Jun 13	Jul 13	Aug 13	Sep 13	Oct 13	Nov 13
National Threshold	99%							
Trust Total	95.5%	97.1%	95.5%	89.7%	96.4%	95.0%	99.8%	99.9%



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).

Achieving target. Monitored weekly to ensure sustainability and 99% is achievable.

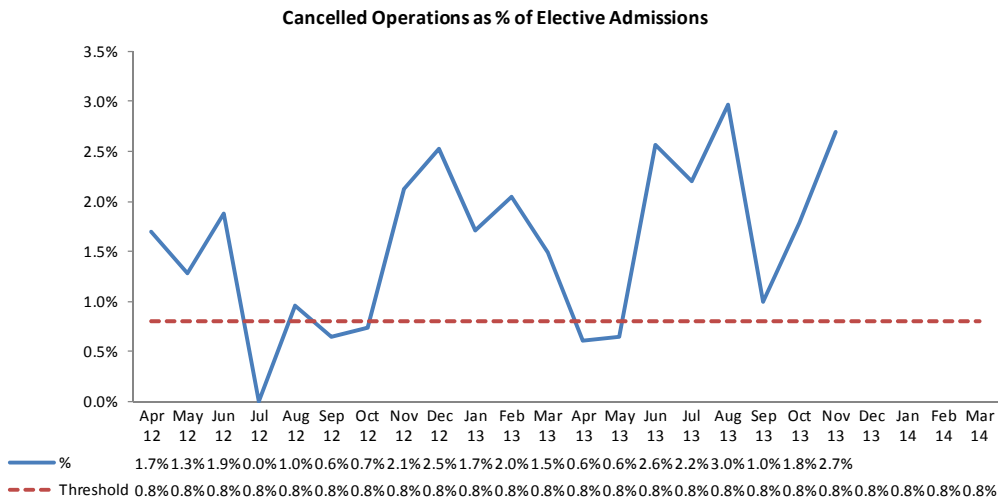
Hospital Cancelled Operations

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		
	Sep 13	Oct 13	Nov 13	Sep 13	Oct 13	Nov 13	Sep 13	Oct 13	Nov 13
National Threshold	n/a			< 0.8%			0		
Trust Total	5	13	16	1.0%	1.8%	2.7%	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. Reports are under revision alongside metric definition.

Emergency Department Waits

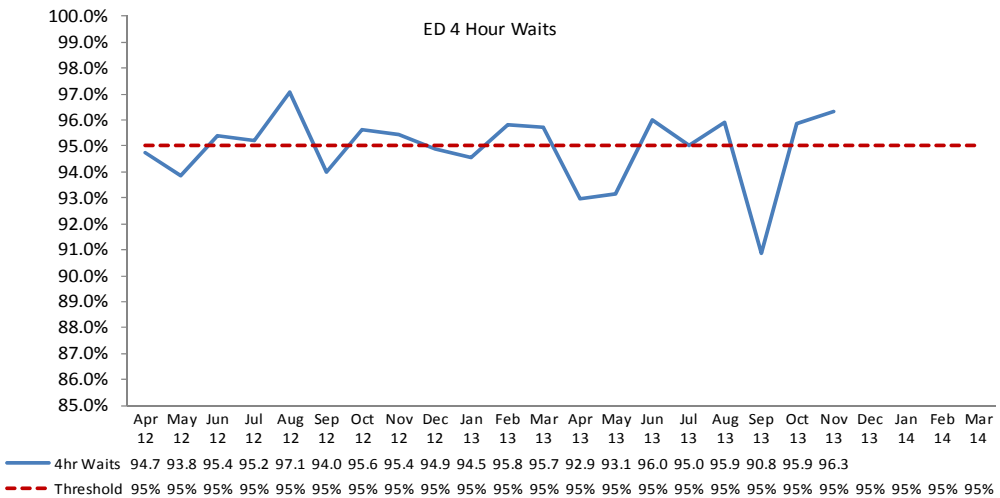
Deliver

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'.

	Apr 13	May 13	Jun 13	Jul 13	Aug 13	Sep 13	Oct 13	Nov 13
National Threshold	95%							
4hr Waits	92.9%	93.1%	96.0%	95.0%	95.9%	90.8%	95.9%	96.3%
12hr Waits	0	0	0	0	0	1	0	0

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



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

An emergency access improvement plan and trust-wide winter action plan are underway and monitored weekly for progress. Breach reasons are being shared with divisions to ensure corrective action is forthcoming.

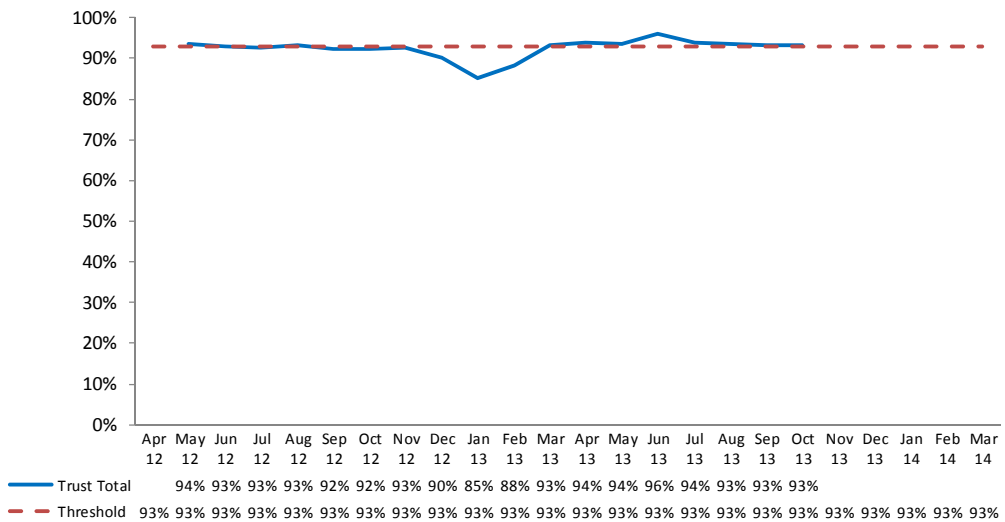
Cancer – 14 days to first seen

Deliver

Access Metrics

14 Days to First Seen

	Aug 13	Sep 13	Oct 13	Q1	Q2	Q3 TD	Q4
National Threshold	93%			93%			
Trust Total	93.4%	93.1%	93.2%	94.6%	93.5%	93.2%	-



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

Division broken down by Tumour Type

Achieving target.

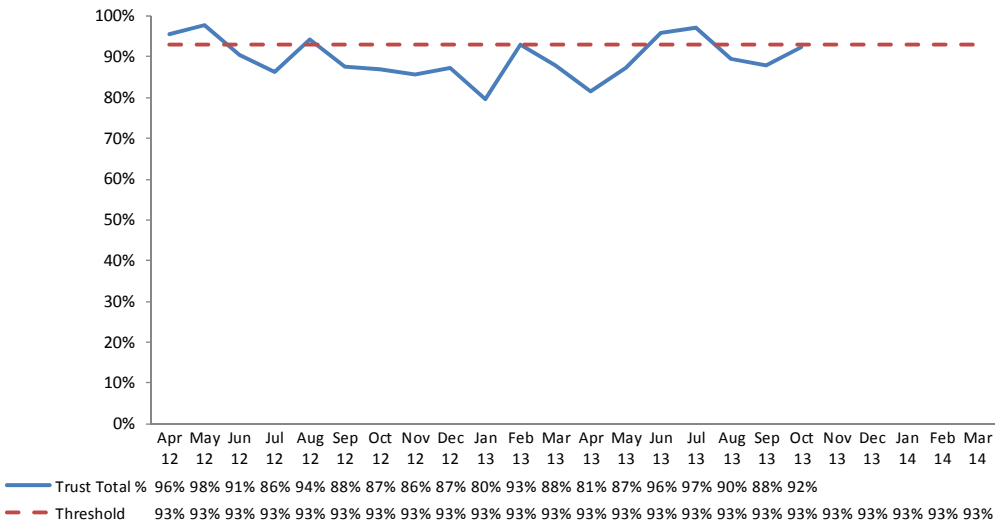
Cancer – 14 days to first seen – Breast symptomatic

Deliver

Access Metrics

14 Days to First Seen - Breast Symptomatic

	Aug 13	Sep 13	Oct 13	Q1	Q2	Q3 TD	Q4
National Threshold	93%			93%			
Trust Total	89.6%	88.0%	92.4%	88.2%	92.1%	92.4%	-



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

Division broken down by Tumour Type

Work is on-going with GPs to ensure patients are informed of the importance of attending within the 14 day window. Actions are already underway to ensure compliance from November.

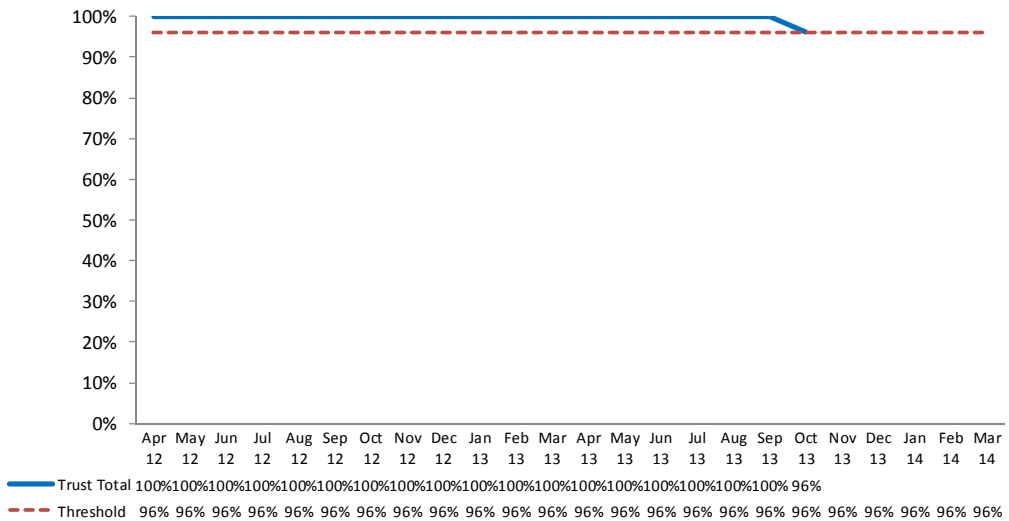
Cancer – 31 Days to first treatment

Deliver

Access Metrics

31 Days to First Treatment

	Aug 13	Sep 13	Oct 13	Q1	Q2	Q3 TD	Q4
National Threshold	96%			96%			
Trust Total	100%	100%	96.3%	100%	100%	96.3%	-



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

31 day target is timed from diagnosis to treatment.

Division broken down by Tumour Type

Delivering above plan.

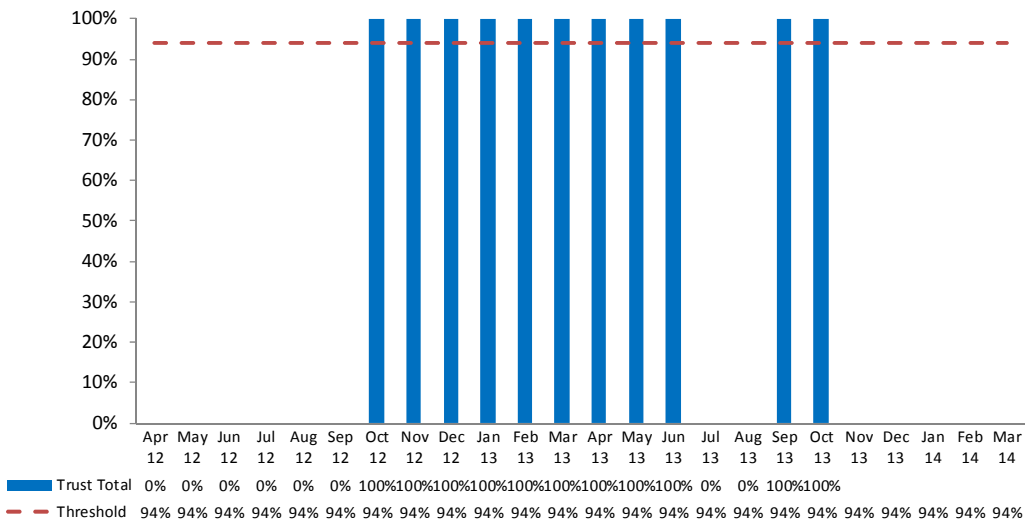
Cancer – 31 days to subsequent treatment - Surgery

Deliver

Access Metrics

31 Days to Subsequent Treatment - Surgery

	Aug 13	Sep 13	Oct 13	Q1	Q2	Q3 TD	Q4
National Threshold	94%			94%			
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.

Division broken down by Tumour Type

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

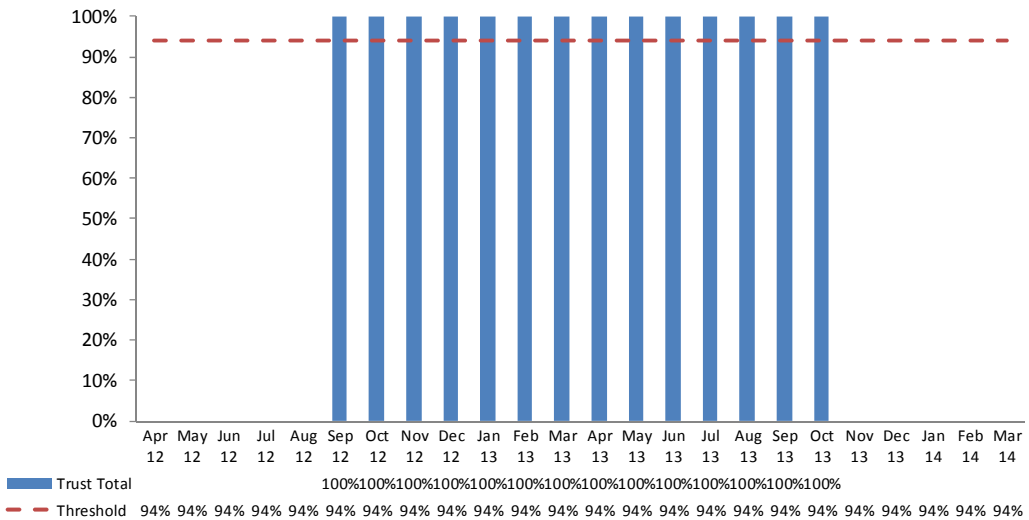
Cancer – 31 days to subsequent treatment - Drugs

Deliver

Access Metrics

31 Days to Subsequent Treatment - Drugs

	Aug 13	Sep 13	Oct 13	Q1	Q2	Q3 TD	Q4
National Threshold	94%			94%			
Trust Total	100%	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.

Division broken down by Tumour Type

Delivering to plan.

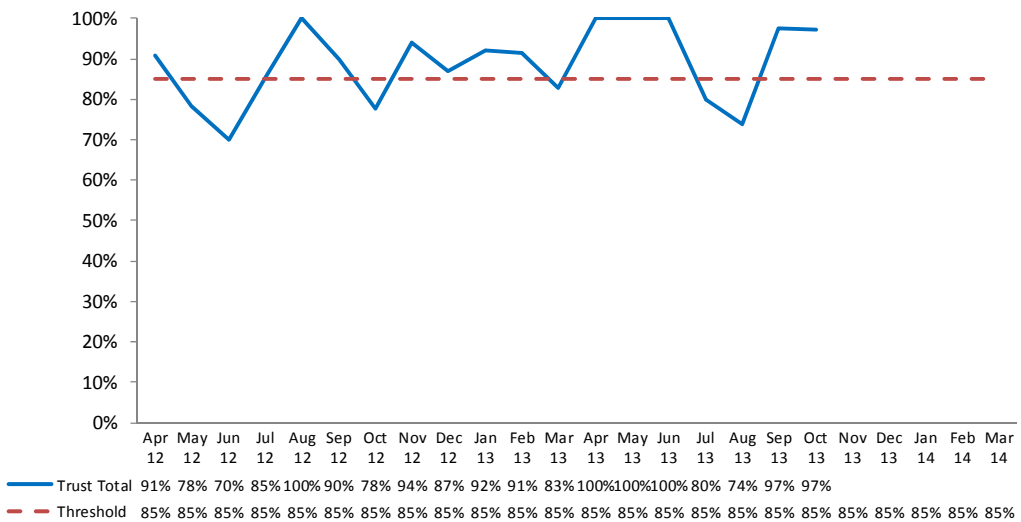
Cancer – 62 days from referral to treatment

Deliver

Access Metrics

62 Days from Referral to Treatment

	Aug 13	Sep 13	Oct 13	Q1	Q2	Q3 TD	Q4
National Threshold	85%			85%			
Trust Total	73.9%	97.4%	97.1%	100.0%	83.1%	97.1%	-



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

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

Division broken down by Tumour Type

Delivering to plan.

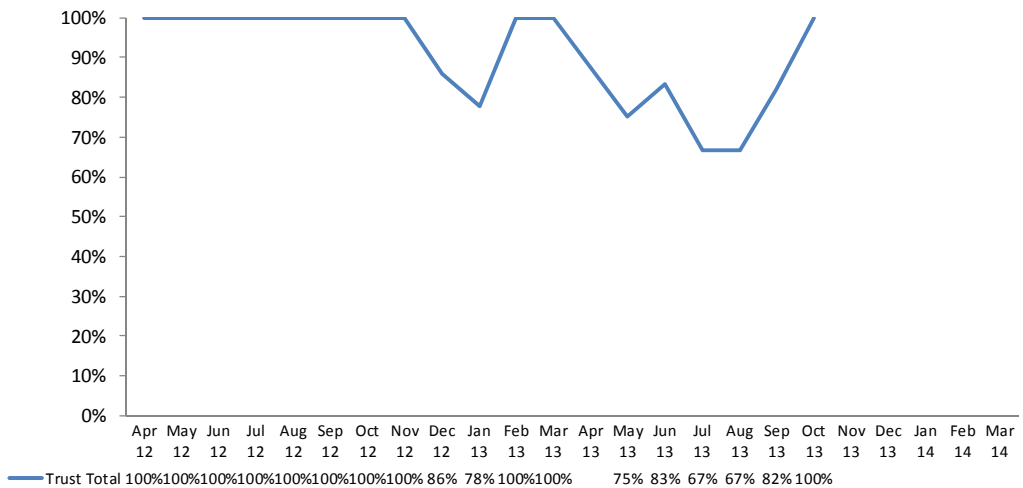
Cancer – 62 days from consultant upgrade

Deliver

Access Metrics

62 Days from Consultant Upgrade

	Aug 13	Sep 13	Oct 13	Q1	Q2	Q3 TD	Q4
Trust Total	66.7%	81.8%	100%	80%	72.4%	100%	-



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

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

Division broken down by Tumour Type

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

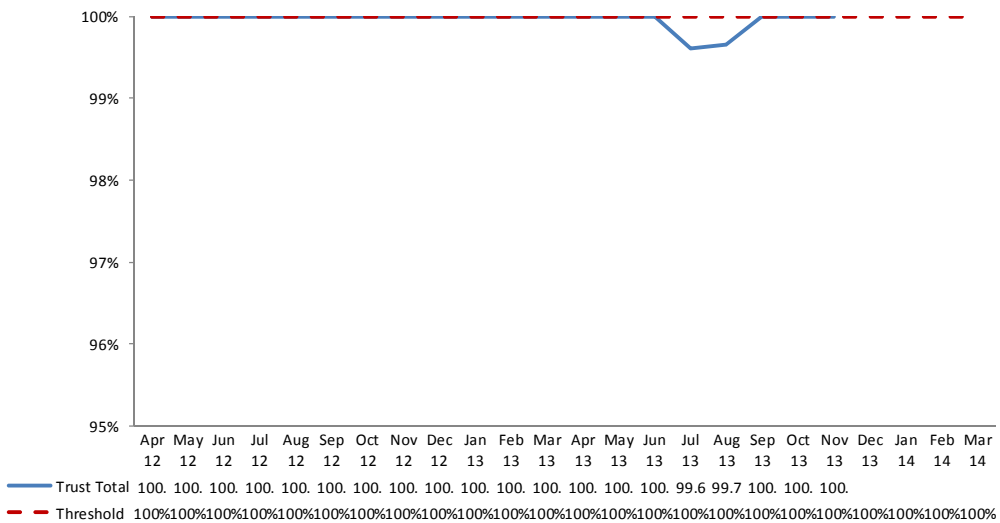
Genito-Urinary Medicine Appointment within 2 Days

Improving

Access Metrics

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

The percentage of patients offered an appointment within 2 days



Delivering to plan.

Delayed Transfers of Care

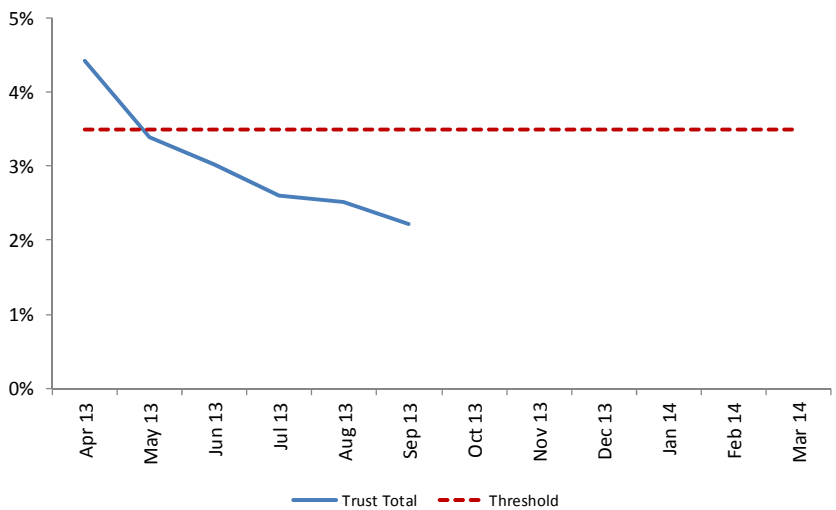
Integrate

Outcome Metrics

Number of Days Delayed

	Nov 13		
	NHS Days	Social Services	Both
Trust Total	141	62	0

	Aug 13	Sep 13	Oct 13
Local Threshold	3.5%		
Trust Total Delayed Transfers	2.5%	2.2%	-



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.

Percentage of occupied bed days is currently unavailable due to EPR reporting Issues

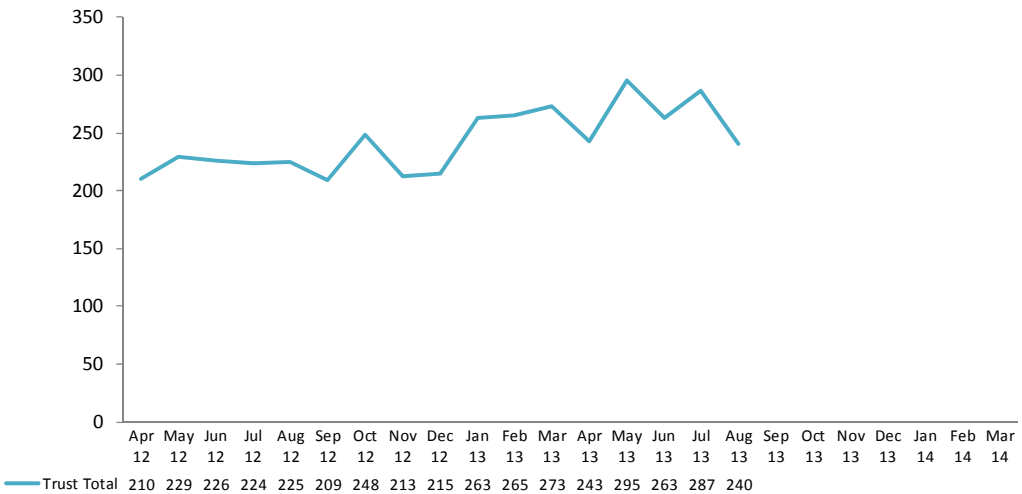
Due to issues with EPR, a temporary report has been generated. IT is leading discussions with McKesson around generating an electronic system fix that will be developed in 2014. Ongoing discharge planning is undertaken through daily ward and board rounds and continued work with our commissioners to ensure patients are expedited as soon as possible. Daily monitoring is in place via the new Access Unit

30 day Emergency Readmissions

Deliver

Outcome Metrics

	Apr 13	May 13	Jun 13	Jul 13	Aug 13	Sep 13	Oct 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 and October 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.
Medical staff have been requested to review emergency readmissions to identify if there is any learning in preventing readmissions.

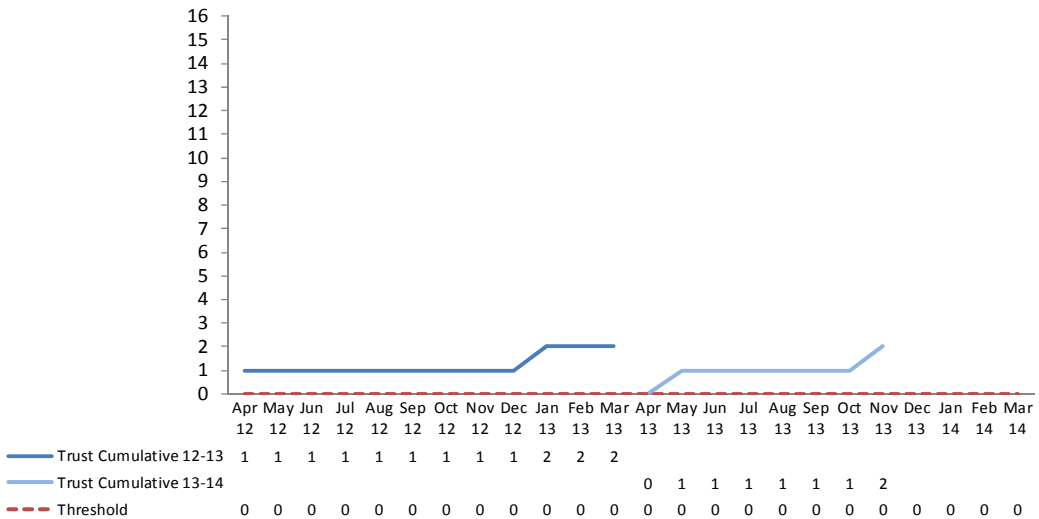
MRSA

Deliver

Outcome Metrics

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

Number of MRSA bacteraemia (bacteria in the blood)



We have had a MRSA bacteraemia case in November. A root cause analysis (RCA) is being undertaken and is reporting to the Quality Committee. Hand hygiene audits continue and a hand hygiene campaign is due for January 2014.

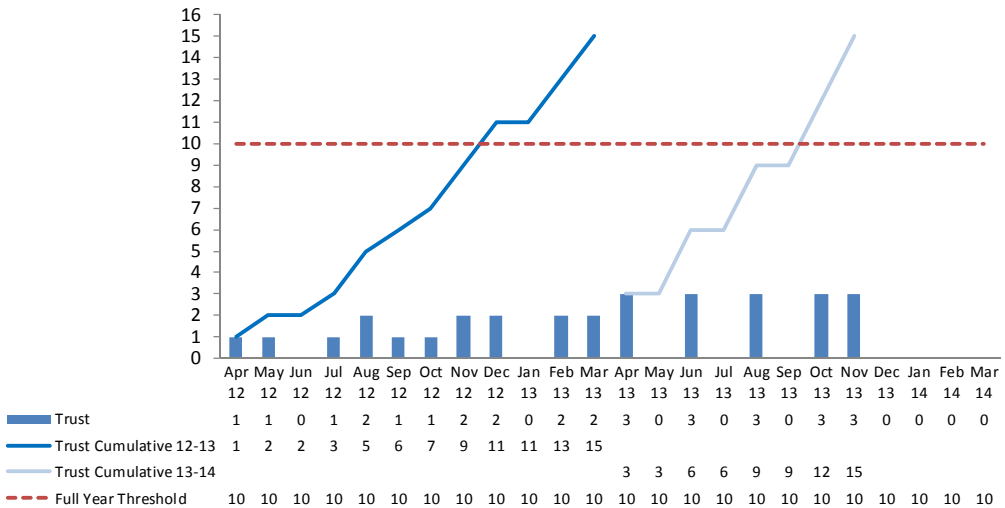
C Difficile Infections

Deliver

Outcome Metrics

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

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



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. Root cause analysis themes will be presented to the Quality Committee. Increased awareness of isolating patients quickly and testing.

E.coli and MSSA

Deliver

Outcome Metrics

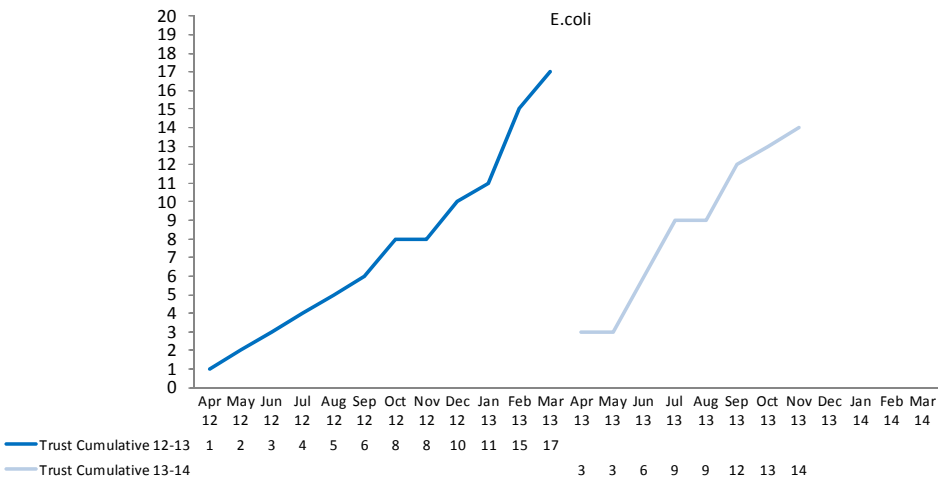
E.coli (Post 48 Hours)

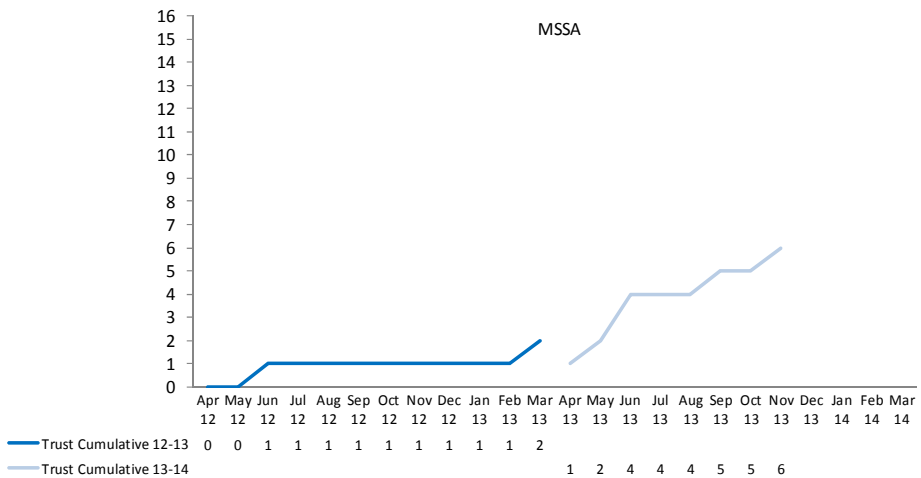
	Aug 13	Sep 13	Oct 13	Nov 13
Threshold	n/a			
Trust Total	0	3	1	1

MSSA (Post 48 Hours)

	Aug 13	Sep 13	Oct 13	Nov 13
Threshold	n/a			
Trust Total	0	1	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. However, we are experiencing more cases than last year. A report will be received by the Quality Committee.

Harm Free Care

Deliver

Outcome Metrics

	Contractual Threshold	Sep 13	Oct 13	Nov 13
% of Harm Free Care	95%	93.93%	94.16%	94.75%
Completeness of Safety Thermometer (CQUIN)	100%	100%	100%	100%
Pressure Ulcer (PU) Incidence	50% Reduction	18	17	

Data is sourced from the Safety Thermometer, a snapshot of the condition of a large number of patients, reporting on falls, catheter UTI and VTE. Pressure ulcer figure comes from incidence data

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

VTE Risk Assessment

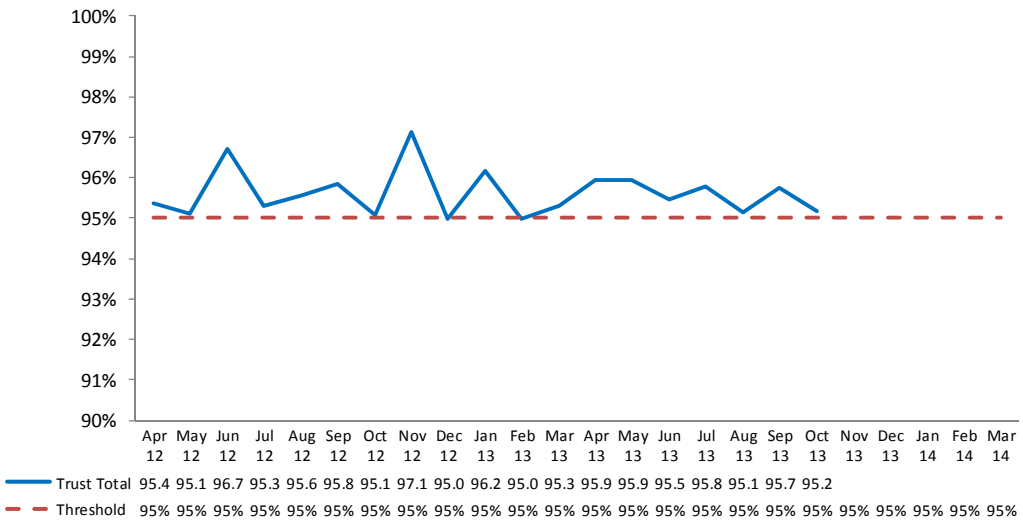
Deliver

Outcome Metrics

	VTE Risk Assessed (CQUIN)		
	Aug 13	Sep 13	Oct 13
CQUIN Threshold	95%		
Trust Total	95.1%	95.7%	95.2%

	RCA for Hospital Acquired		
	Aug 13	Sep 13	Oct 13
Target to be decided			
	9	3	1

	VTE Incidence		
	Aug 13	Sep 13	Oct 13
-			
	-	-	-



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

Delivering above plan.

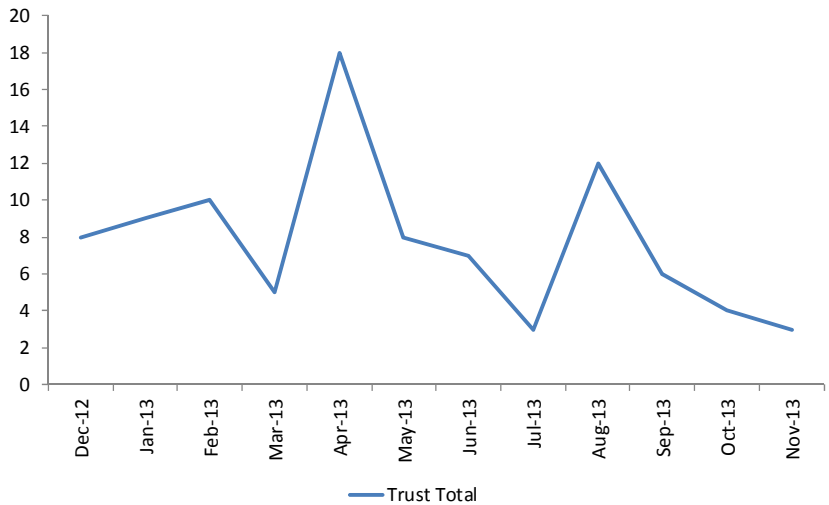
Serious Incidents

Change

Outcome Metrics

	Jul 13	Aug 13	Sep 13	Oct 13	Nov 13
Integrated Care & Acute Medicine	2	11	5	2	0
Surgery, Cancer & Diagnostics	1	0	0	0	1
Women, Children & Families	0	1	1	2	2
Trust Total	3	12	6	4	3

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



Performance is improving and back to a low level around serious incidents.

Never Events

Change

Outcome Metrics

Zero Never Events since October 2012

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 estates 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.

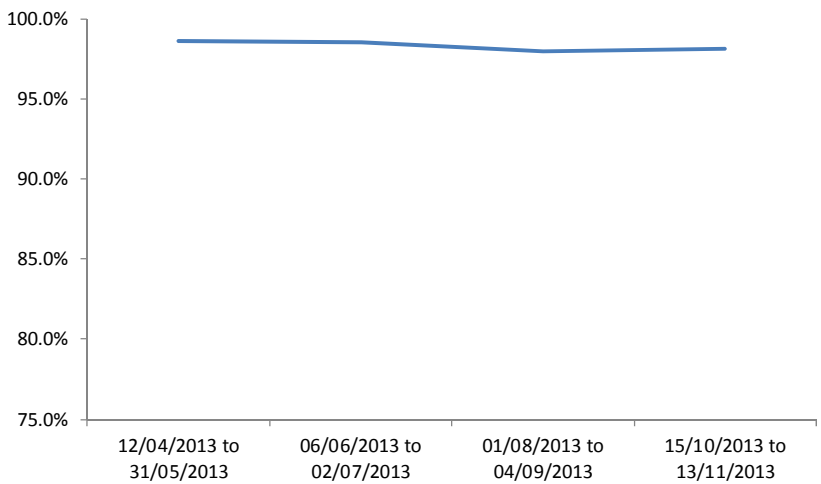
No further progress on NPSA Alert. This is a national issue, however there are existing safe systems of work in place to mitigate risk to patient safety.

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	15/10/2013 to 13/11/2013
Trust Percentage	98.6%	98.5%	98.0%	98.13%



Ward Cleanliness calculated as actual score against possible score

Latest Audit completed by Facilities

Weekly walk rounds 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

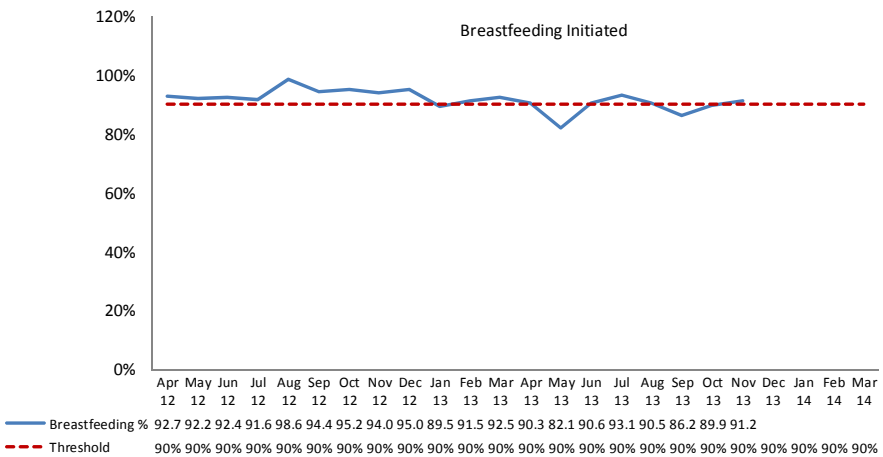
Breastfeeding and Smoking

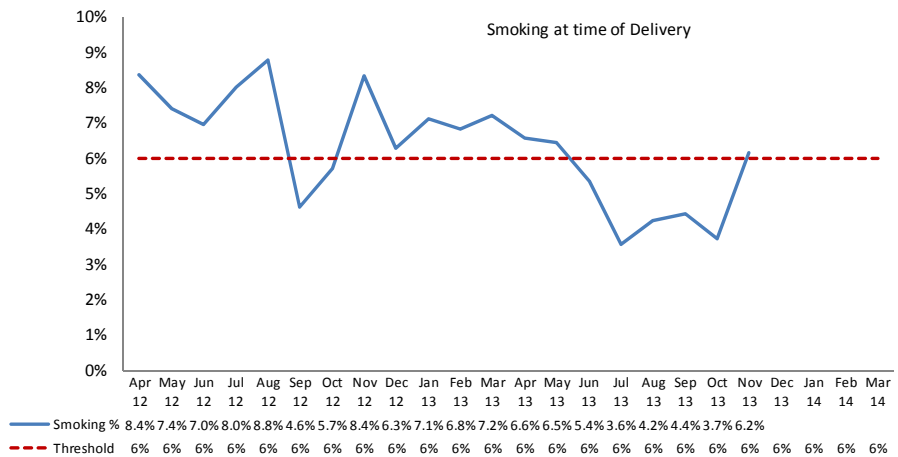
Improving

Outcome Metrics

	Threshold	Sep 13	Oct 13	Nov 13
Breastfeeding Initiated	90%	86.2%	89.9%	91.2%
Smoking at Delivery	<6%	4.4%	3.7%	6.2%

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.





Divisional director is reminding staff of the importance of smoking cessation in pregnancy and pre-pregnancy. More targeted work needs to be undertaken with the commissioners and primary care. An action plan has been developed.

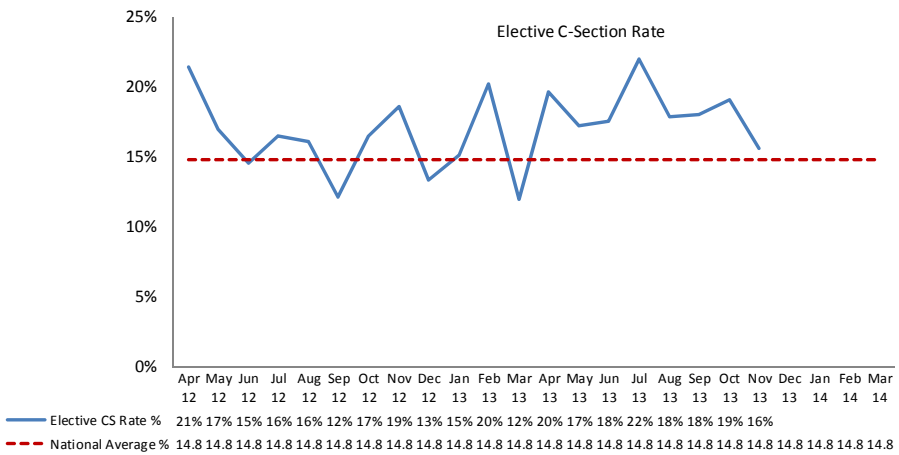
Caesarean Section Rates

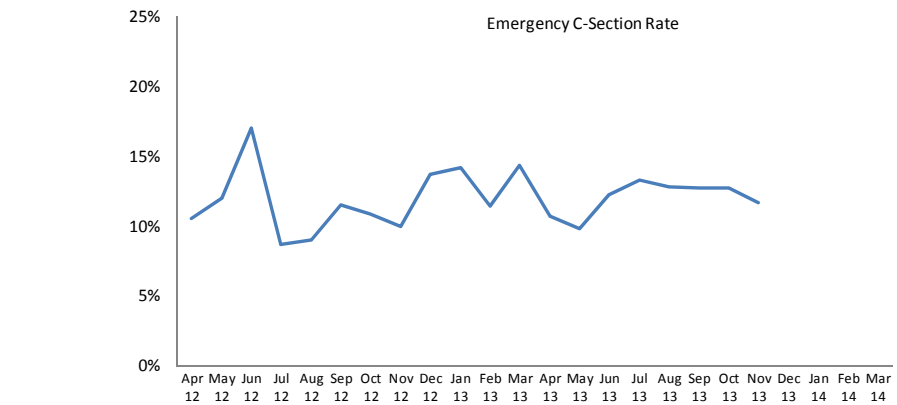
Deliver

Outcome Metrics

	National Average	Sep 13	Oct 13	Nov 13
Elective C-Section Rate	14.8%	18.0%	19.1%	15.6%
Emergency C-Section Rate	-	12.7%	12.7%	11.7%
All Deliveries	-	355	346	308

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





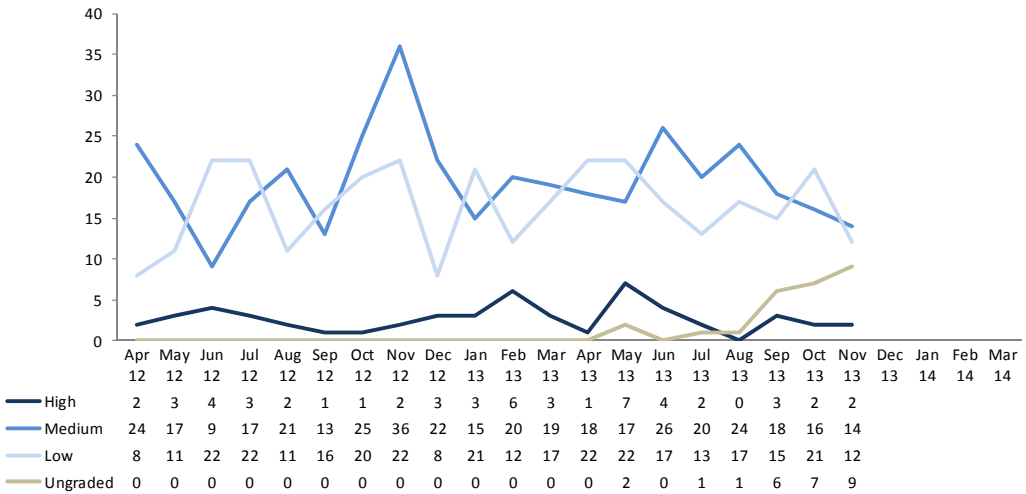
C section rate is the lowest compared to our neighbouring colleagues, comparison data in My Health London website.

Medication Errors Causing Harm

Change

Outcome Metrics

		Apr 13	May 13	Jun 13	Jul 13	Aug 13	Sep 13	Oct 13	Nov 13
Risk	High	1	7	4	2	0	3	2	2
	Medium	18	17	26	20	24	18	16	14
	Low	22	22	17	13	17	15	21	12
	Ungraded	0	2	0	1	1	6	7	9
	Total	41	48	47	36	42	42	46	37



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

Medication 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.

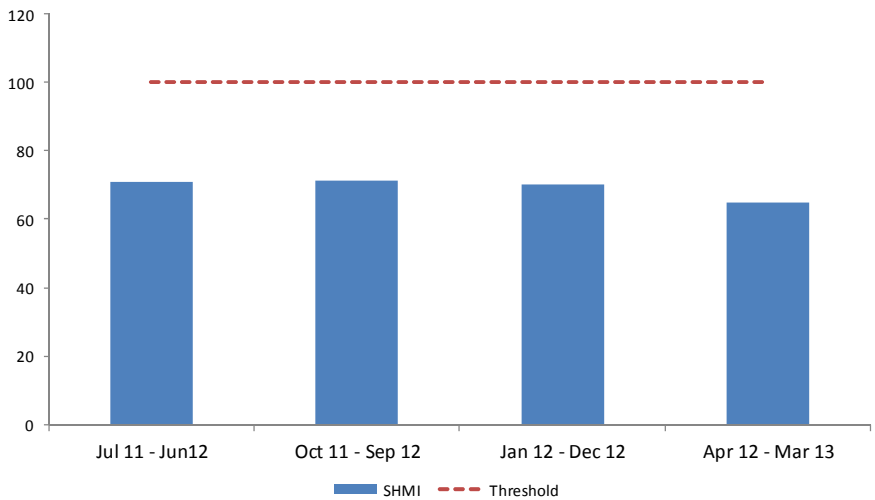
SHMI

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.



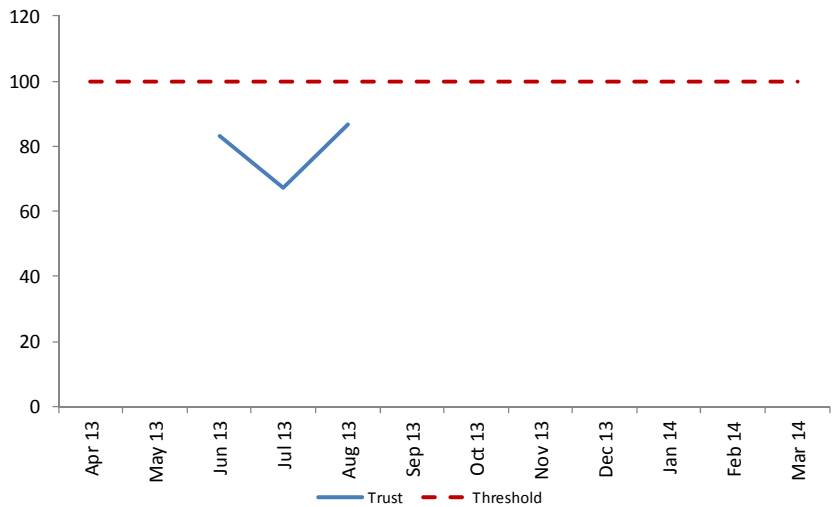
Even though we have a great track record with our mortality. Benchmarking will be undertaken in the New Year, to see where we could improve.

HSMR

Change

Outcome Metrics

	HSMR		
	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

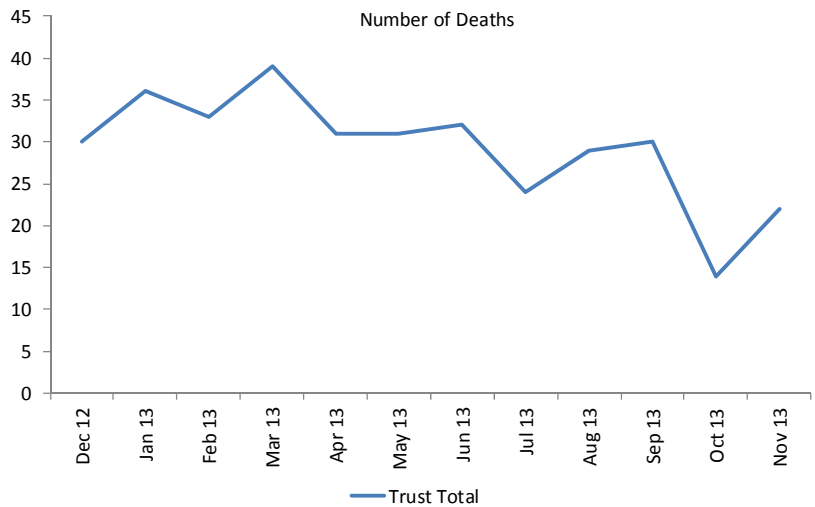
No change since previous report. Figures not updated nationally.

Number of Inpatient Deaths

Outcome Metrics

	Deaths			Percentage of Admissions		
	Sep 13	Oct 13	Nov 13	Sep 13	Oct 13	Nov 13
Trust Total	30	14	22	0.7%	0.3%	0.5%

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



Crude mortality rates are a good indicator of clinical and operational excellence.

Patient Satisfaction - Friends and Family Test (FFT)

Ensure

Quality Indicators

	Sep 13	Oct 13	Nov 13
Inpatient Coverage	39.4%	44.9%	42.2%
Emergency Department Coverage	6.7%	6.0%	7.1%
Total Coverage (IP/ED)	11.7%	12.7%	13.1%
Inpatient Net Promoter Score	64	68	61
Emergency Department Net Promoter Score	36	43	47
Total Net Promoter Score (IP/ED)	50	58	54

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 FFT 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 Urgent Care Centre and Emergency Department. ICAM clinical director is going to lead by example and be seen to go to the department and hand out questionnaires. A meeting has also been held with ICAM leadership team and COO to identify how to improve and how to use the valuable information.

Mixed Sex Accommodation

Integrate

Quality Indicators

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

New data collect system underway – awaiting results

A walk round of ISIS with Commissioners, COO and senior nursing staff identified potential breaches and improvements in mixed sex accommodation. ISIS will not be split into male and female bays. Further work to implement a ward level measurement system has been established so breaches of single sex accommodation can be understood and action plans developed to rectify both ward level practice as well as structural changes necessary.

Nurse:Bed Ratio

Placeholder

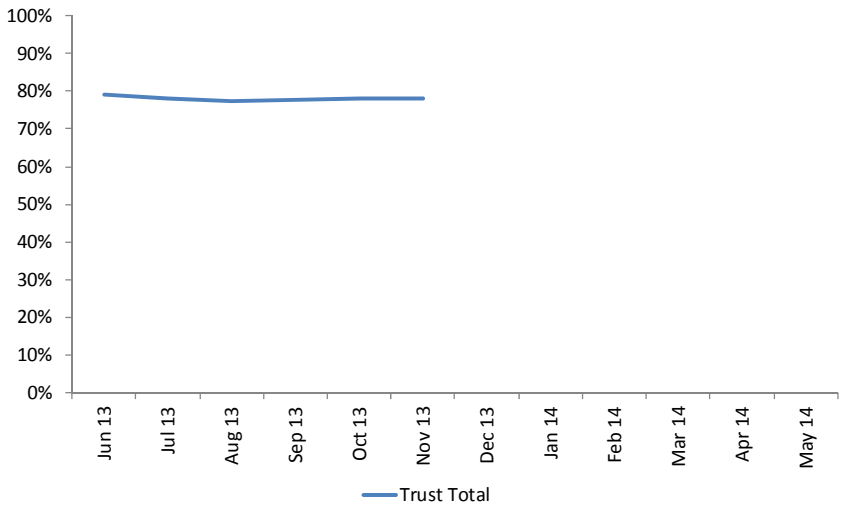
Percentage of Registered Nurses

Change

Quality Indicators

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

	Threshold	Sep 13	Oct 13	Nov 13
Trust Total	n/a	77.8%	78.1%	78.2%



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

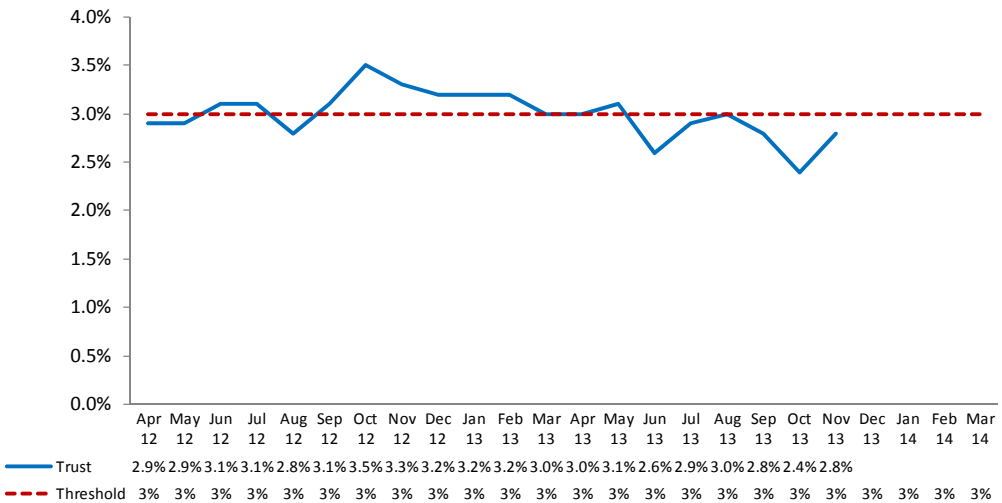
Sickness Rate

Change

Quality Indicators

	Sickness				High Bradford Scores		
	Local Threshold	Sep 13	Oct 13	Nov 13	Sep 13	Oct 13	Nov 13
Trust Total	<3%	2.8%	2.4%	2.8%	730	692	543

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



Despite the below benchmark since August the Attendance strategy is focussed on delivery of key priorities: staff wellbeing through winter, which is on target. Reviewing both long and short term sickness and Bradford score triggers at Divisional level and taking remedial actions, renewed impetus on the return to work interviews via training and review all sickness cases in the formal procedure and taking management action. Reviewing the health and Wellness Being strategy with the occupational health service and refocusing on sickness management.

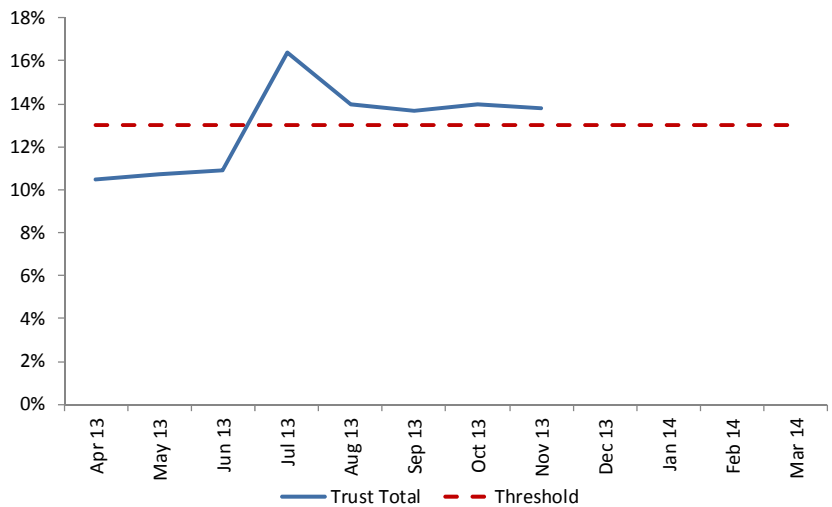
Staff Turnover

Change

Quality Indicators

	Local Threshold	Sep 13	Oct 13	Nov 13
Trust Total	<13%	13.7%	14.0%	13.8%

Proportion of workforce leaving in a given period.



The pattern of staff turnover has remained static since August. The strategy to move to benchmark includes devise trust and divisional targets, develop guidance to improve exit interviews, assess the reasons for turnover and set up focus groups to identify areas for improvement. Strengthen the retention of staff through the retention strategy being considered by this committee at this committee.

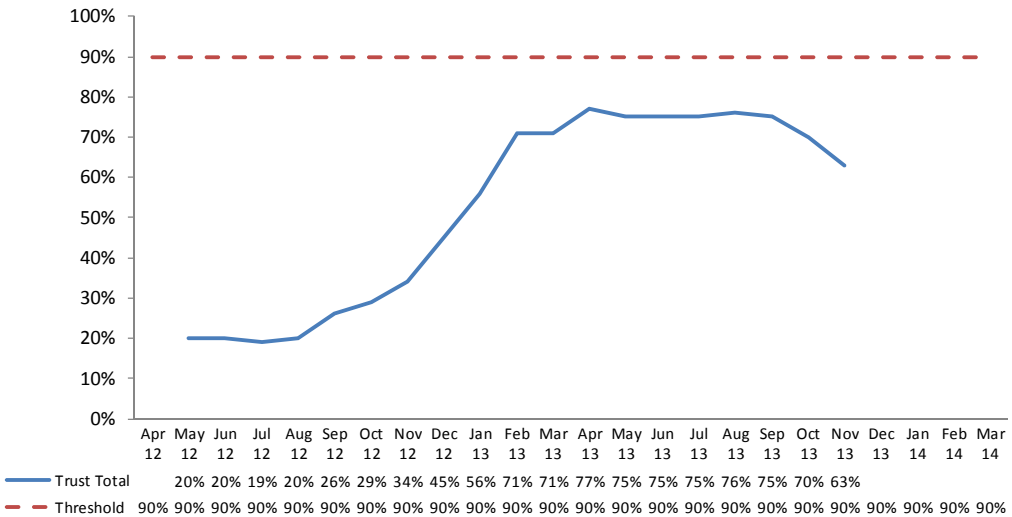
Staff Appraisal

Change

Quality Indicators

	Local Threshold	Sep 13	Oct 13	Nov 13
Trust Total	90%	75.0%	70.0%	63.0%

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



The Trust's 90% compliance target is based upon a whole year's total. The Trust has three differing appraisal cycles within the year, two of which occur April – Sept. There are no appraisal cycles during Oct – Dec, hence decrease in % compliance. The Board is to make note of this. Future actions are that the appraisal framework is to be redesigned from April 2014 onwards. We are in a scoping and consultation phase for this at present; essentially moving to a framework that may base pay progression upon tightened performance criteria, the acute and community appraisal cycles moving to just one April - June, and the medical appraisal being linked to job planning and appraisal. This will thus ensure performance and pay are fully aligned to Trust annual financial and strategic planning.

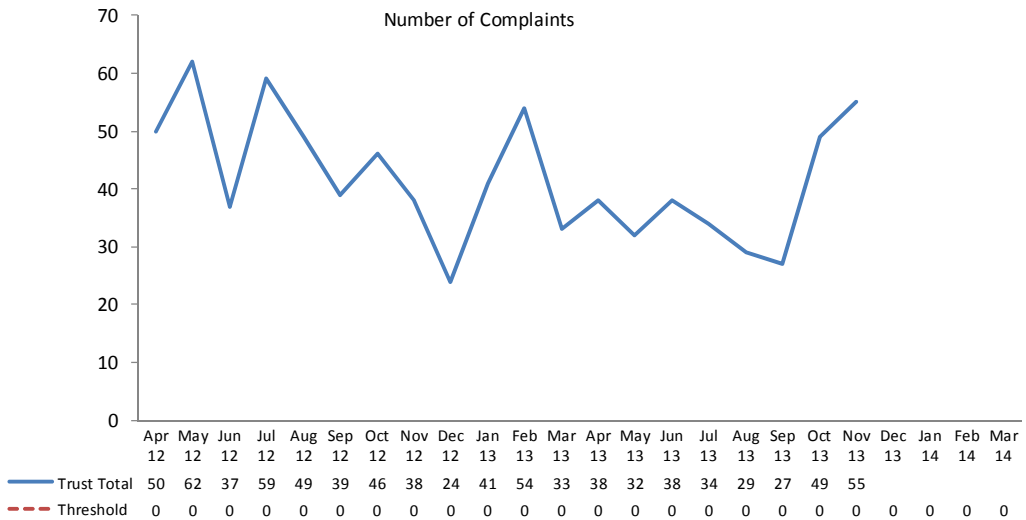
Complaints

Ensure

Quality Indicators

	Complaints				Responded to in 25 days		
	Threshold	Sep 13	Oct 13	Nov 13	Aug 13	Sep 13	Oct 13
Trust Total	0	27	49	55	55%	48%	45%

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



Women, children and families (WCF) have appointed a complaints manager to help discover themes, monitor progress and chase managerial response within agreed timeframes.
An action plan has been developed to assist with achieving complaints resolution targets.

Proportion of Temporary Staff (Clinical & Non-Clinical)

Change

Quality Indicators

Placeholder

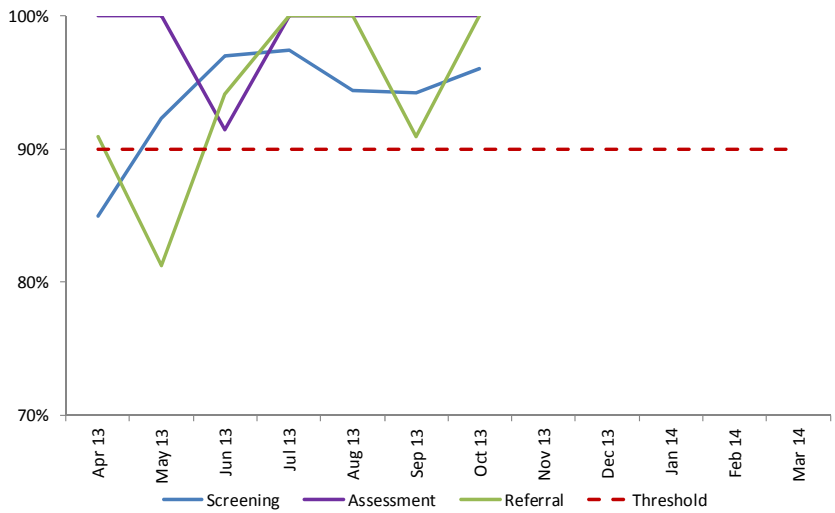
National CQUINs

Integrate

Quality Indicators

Dementia

	Contractual Threshold	Aug 13	Sep 13	Oct 13
Screening	90%	94%	94%	96%
Assessment	90%	100%	100%	100%
Referral	90%	100%	91%	100%



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

Data is one month in arrears

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	Nov
Improve Access to Breast Milk in Preterm Infants	62%	100%	0%	57%	60%	50%	67%	33%	61%	33%	25%
Timely Administration of Total Parenteral Nutrition in Preterm Infants	95%	100%	-	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.

Action plan in place to improve access to breast milk. Divisional director is overseeing deliver through WCF board.

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%	94%	96%	94.7%	94%	93.6%		93.8%
Inpatient- Brief Advice	90%	94%	90%	93%	92%	96%	94.3%		95.2%
Inpatient- Referral	15%	31.5%	29.1%	32.8%	31%				
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 and 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	Oct
Acute COPD Bundle	90%	100%	92%	94%	96%	100%	100%	100%	100%	100%
ACUTE CAP Bundle	80%	100%	0%	78%	83%	64%	100%	100%	86%	100%
Community COPD Bundle	75%	100%	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

Integrated Care	Year End Target	Apr	May	Jun	Q1	Jul	Aug	Sep	Q2
Multidisciplinary Working - Haringey	4 MDT Case conferences a month MDT case conference membership	n/a	n/a	n/a	n/a	4 per week			
Multidisciplinary Working - Islington	5 MDT Case conferences a month MDT case conference membership	n/a	n/a	n/a	n/a	4 per month			
Multidisciplinary Actions - Haringey	90% of actions completed	n/a	n/a	n/a	n/a				100%
Multidisciplinary Actions - Islington	90% of actions completed	n/a	n/a	n/a	n/a				69%
Ambulatory Care Management	Alternative to admission for ACSC attending ED	n/a	n/a	n/a	n/a	A.E.C.S is co-located with Emergency Dept			
Ambulatory Care Management	95% of management plans sent to GP within 24hrs (Q2 onwards)	n/a	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	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	n/a	Qtr 2 Figs CMs only			38%

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

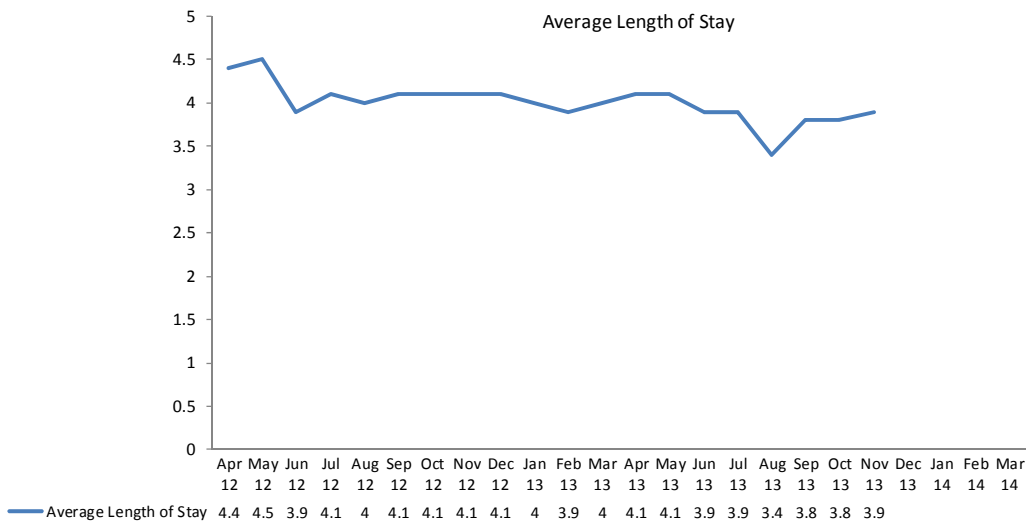
Average Length of Stay (days)

Deliver

Quality Indicators

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

Average length of stay for patients within a given month



We have seen an increase over the last few months around gynaecological patients length of stay. Nursing within surgical wards will be provided with further updates and training, a meeting is scheduled with WCF and senior nurses to further discuss care pathways and discharge planning. 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. Benchmarking to be undertaken in the new year.

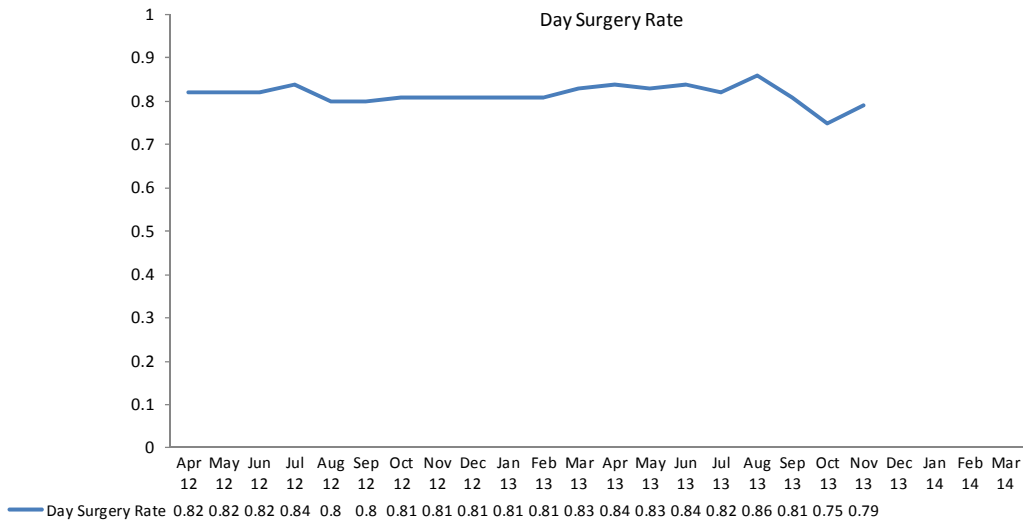
Day Surgery Rate

Deliver

Quality Indicators

	Threshold	Apr 13	May 13	Jun 13	Jul 13	Aug 13	Sep 13	Oct 13	Nov 13
Trust Total	n/a	84%	83%	84%	82%	86%	81%	75%	79%

Proportion of total elective surgeries carried out as a daycase



A project has been underway to increase day surgery rates which are high at Whittington Health. Further improvements will be commenced in the New Year following increase of inpatients requests.

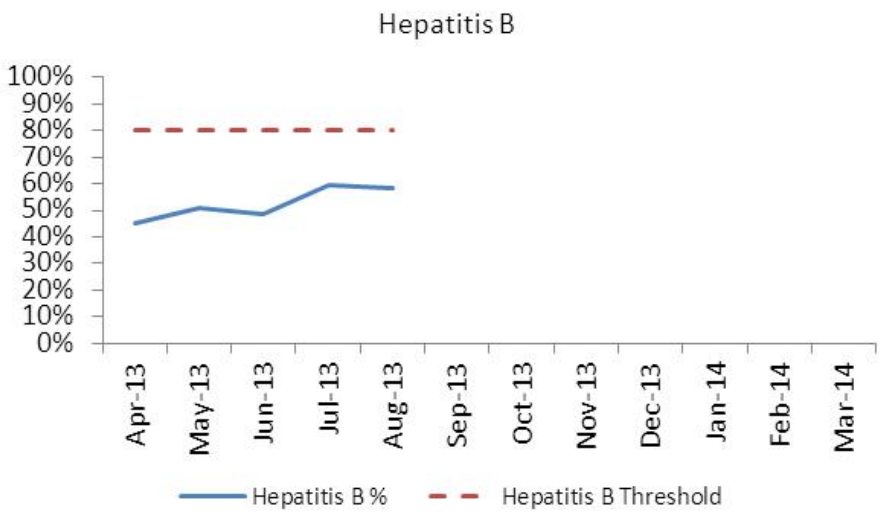
Pentonville Prison

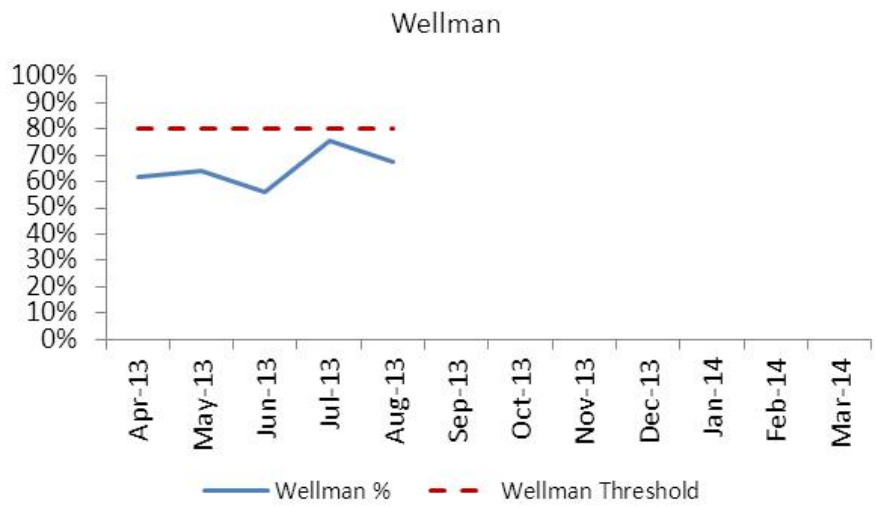
Integrate

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 next month

Divisional Financial Performance

Deliver

Finance & Activity

Division		Month 8			Year to Date		
		Actual	Budget	Variance	Actual	Budget	Variance
		£'000	£'000	£'000	£'000	£'000	£'000
	Income	1,514	966	548	9,774	7,634	2,140
	Expenditure	8,066	6,678	(1,388)	60,061	53,643	(6,418)
Integrated Care & Acute Medicine	**Total**	**(6,552)**	**(5,712)**	**(840)**	**(50,287)**	**(46,009)**	**(4,278)**
	Income	373	286	87	2,430	2,341	89
	Expenditure	5,008	4,544	(464)	39,748	36,118	(3,629)
Surgery, Cancer & Diagnostics	**Total**	**(4,635)**	**(4,258)**	**(377)**	**(37,318)**	**(33,778)**	**(3,540)**
	Income	1,230	1,143	87	9,304	9,183	121
	Expenditure	5,549	5,432	(117)	43,511	42,547	(964)
Women, Children & Families	**Total**	**(4,319)**	**(4,288)**	**(30)**	**(34,208)**	**(33,365)**	**(843)**
	Income	21,843	21,349	494	172,158	169,088	3,070
	Expenditure	5,077	5,435	359	40,925	42,880	1,955
Corporate	**Total**	**16,766**	**15,914**	**853**	**131,233**	**126,208**	**5,025**
	Income	**24,960**	**23,745**	**1,216**	**193,665**	**188,246**	**5,420**
	Expenditure	**23,699**	**22,090**	**(1,610)**	**184,245**	**175,189**	**(9,056)**
TOTAL	**EBITDA**	**1,261**	**1,655**	**(394)**	**9,421**	**13,057**	**(3,636)**

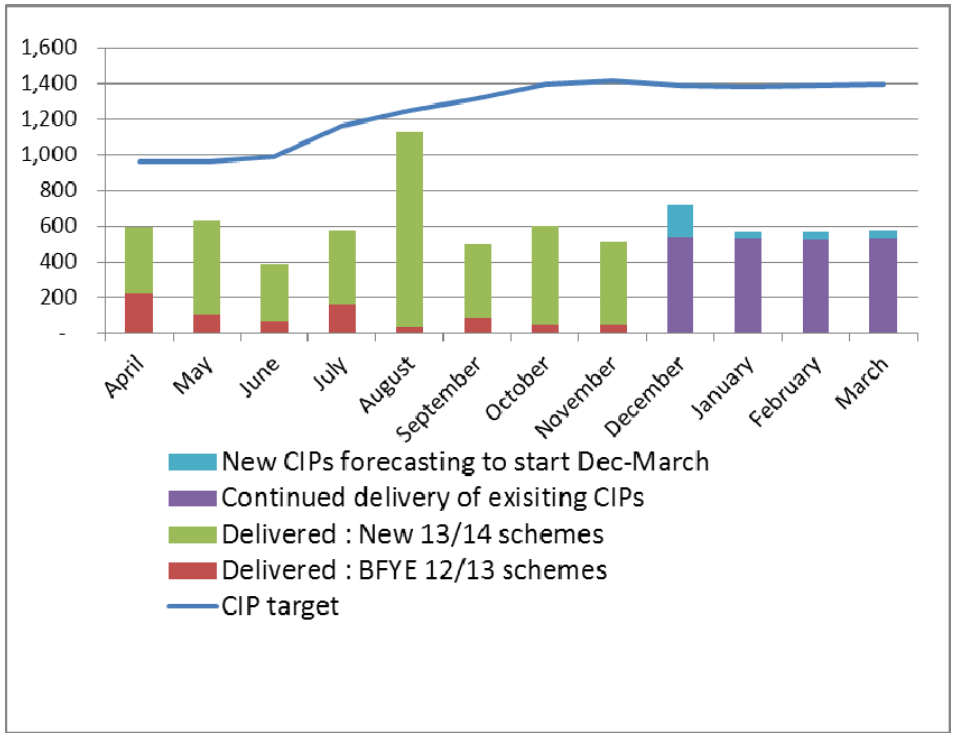
This table covers all operating costs and income. The bottom-line position for the year-to-November (including depreciation, interest and PDC dividend) is break-even, which is a £2.3m adverse variance from the plan for the same period. In order to address the in-year financial position, the Trust has developed additional savings in order to deliver a break even position by the year-end.

CIP Year to Date

Deliver

Finance & Activity

Division	Plan 2013/14 £'000	Plan YTD £'000	Actual YTD £'000	Variance from Plan £'000	YTD delivered % of profiled plan
ICAM	3,046	2,156	1,013	-1,144	47%
SCD	1,549	1,095	609	-485	56%
WCF	1,238	734	432	-302	59%
Estates & Facilities	615	392	244	-148	62%
Finance	403	264	237	-26	90%
HR	97	64	64	0	100%
Nursing Directorate	278	135	102	-33	76%
IT	160	107	43	-63	41%
Procurement	875	583	343	-241	59%
Trust-wide schemes	4,146	2,671	1,555	-1,115	58%
Potential to be identified	2,594	1,245	0	-1,245	0%
Income offset against CIP target	0	0	286	286	
	15,000	**9,446**	**4,930**	**-4,516**	**52%**
Included in the above : balance to fye of 2012/13 CIP projects	1,602	1,480	744	-736	
Performance reported to TDA (new 2013/14 schemes only)	13,398	7,965	4,186	-3,780	53%



A number of schemes within the original CIP plan will no longer deliver the required savings and in order to deliver the desired income and expenditure (I&E) run rate reduction to the end of the year, a separate schedule of targets has been determined and allocated to divisions.

Each division has been working on a number of schemes to contribute towards a new £4.2m savings target which have been collated into a new tracking document . Schemes with a YTD planned value of £429k have been identified and are reflected in the year-to-date financial position.

Temporary Staffing Spend by Division

Deliver

Finance & Activity

Temporary Staffing	Division	Month 8 £'000	Trend to M7 £'000	Variance £'000
Agency	Integrated Care & Acute Medici	1,160	669	(491)
	Surgery, Cancer & Diagnostics	109	138	29
	Women, Children & Families	271	255	(16)
	Corporate	352	271	(81)
Agency Total		1,892	1,333	(559)
Bank	Integrated Care & Acute Medici	537	455	(82)
	Surgery, Cancer & Diagnostics	347	330	(17)
	Women, Children & Families	346	324	(22)
	Corporate	347	315	(32)
Bank Total		1,576	1,424	(153)
Locum	Integrated Care & Acute Medici	81	78	(3)
	Surgery, Cancer & Diagnostics	39	59	20
	Women, Children & Families	6	20	14
	Corporate	0	4	4
Locum Total		126	161	35
Total		3,594	2,918	(676)

A weekly steering group meeting continues to challenge the project leads of various agency reduction work streams to ensure that expenditure is being controlled and that action plans are firmly in place to rationalise agency usage wherever possible. On a weekly basis, highlight reports are presented to the committee by each of the project leads along with agency booking data. Financial data is presented monthly.