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The Whittington Hospital NHS Trust
Magdala Avenue
London N19 5NF

Whittington Health Trust Board

5 February 2014

Title:	Trust Board Performance Report February 2014 (December 2013 data)		
Agenda item:	**14/024**	**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, the measures being taken. **Key headlines** • Emergency department waits were over 95% for the third consecutive month (slide 23). • Diagnostic waits (slide 21) performance continues to achieve the threshold. • Achieving four out of six national cancer targets for November (slides 24 to 29). • Continued issues with EPR reporting • One never event was reported in December (slide 40). • Elective caesarean rates are still above the national average (slide 45). • The number of complaints has reduced for December, however percentage responded to within 25 days has worsened (slide 56).		
Summary of recommendations:			
Fit with WH strategy:	All five strategic aims		
Reference to related / other documents:			
Reference to areas of risk and corporate risks on the Board Assurance Framework:			
Date paper completed:	27/01/2014		
Author name and title:	**Caroline Angel, Head**	**Director name and**	**Sally Batley, Director of**

		of Performance		**title:**		**Improvement, Performance & Information**	
Date paper seen by EC		**Equality Impact Assessment complete?**		**Quality Impact Assessment complete?**		**Financial Impact Assessment complete?**	

Whittington Health NHS

Performance Dashboard
February 2014
(December data)

Priorities

Focus Areas

Overall
•Complaints response
•Reduction in DNAs and patient follow-ups
•Financial balance to run rate
•Management of serious incidents and risks
•CIP delivery

Integrated Care and Acute Medicine Division
•ED performance targets and improvement plan,
•Winter Plan
•Improvement in quality and complaints
•Implementation of AEC
•Implementation of TB network

Surgery, Cancer and Diagnostics Division
•DNA and follow up reduction for outpatient appointments
•Outpatient (OPD) Call Centre
•RTT targets and implementation plan

Women, Children and Families Division
•Management of incidents and SI through WCF Quality Committee
•DNA and Hospital Cancellations action plans including standard operating procedure and standard letters across acute and community
•Focus on mandatory training and appraisals performance
•Unoutcomed appointments action plan in place, joint working with ICAM to develop standard operating procedure

Board Aims

Focus Areas

All indicators have been mapped to the Board Aims

First:Follow-Up Ratio - Acute

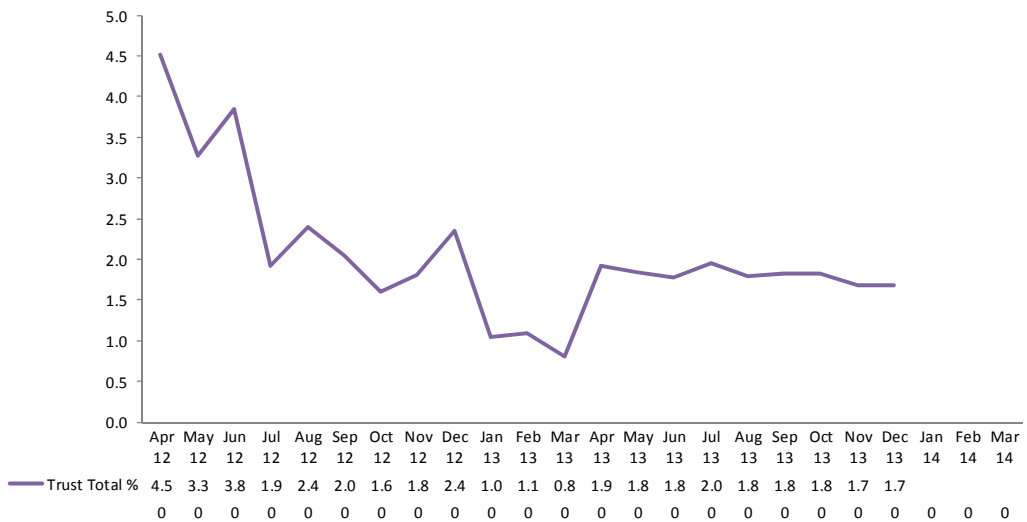
Deliver

Focus Areas

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

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

National Average April to September 2013
2.31
Source: Health and Social Care Information Centre



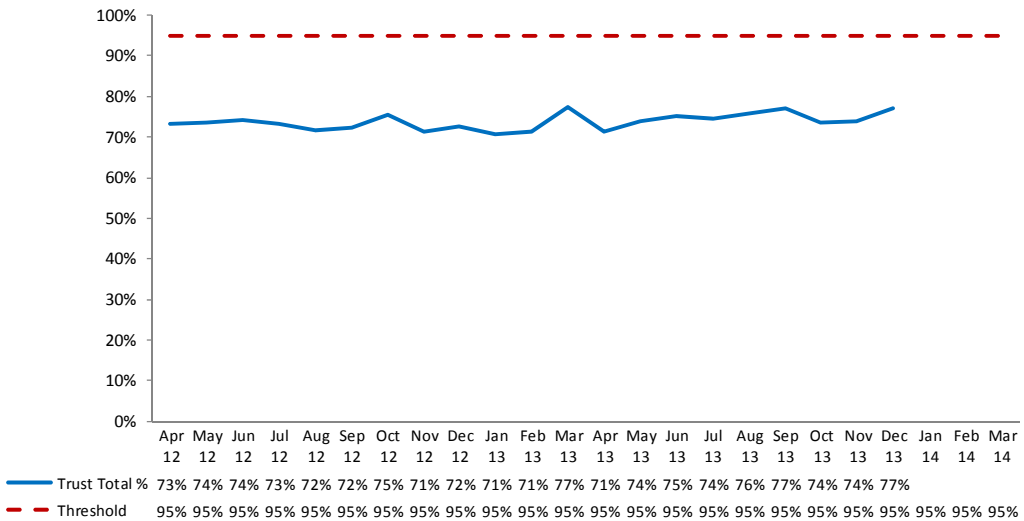
A trust wide improvement plan has been developed with trajectories for further reducing the follow up ratio. This work will continue with a deadline of completion of the end of April. The national benchmark is 2.31 which the Trust already achieve, further work is underway to maintain our improvements in this benchmark.

Theatre Utilisation

Deliver

Focus Areas

	Utilisation			Available Session Time (Minutes)			Time Utilised (Minutes)		
	Oct 13	Nov 13	Dec 13	Oct 13	Nov 13	Dec 13	Oct 13	Nov 13	Dec 13
Local Threshold	>95%								
Trust Total	74%	74%	77%	66,750	64,650	54,930	49,174	47,848	42,367



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 theatre utilisation improvement plan is underway with a projection to achieve 85% by the end of March and a stretch target to reach 95% by the end of June. Early wins are starting to be seen and consultant ownership of theatre scheduling has assisted with the implementation of booking rules. Utilisation is improving on a weekly basis with urology having a 10% improvement in the last two months, lists are being closed at three weeks if not filled, and ENT lists will be reviewed with surgeons over the next month.

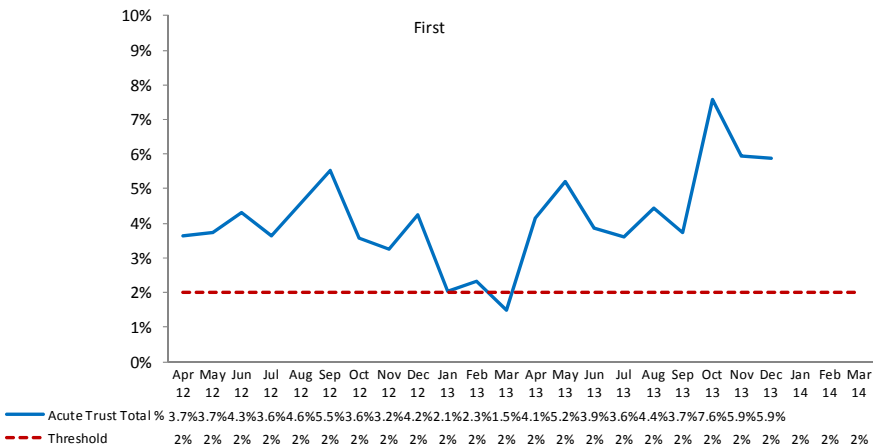
Hospital Cancellations - Acute

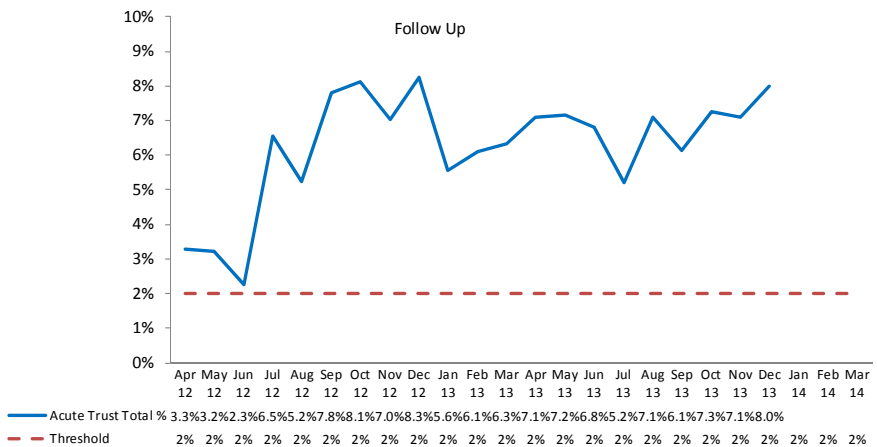
Deliver

Focus Areas

	First Appointments			Follow Up Appointments		
	Oct 13	Nov 13	Dec 13	Oct 13	Nov 13	Dec 13
Local Threshold	<2%			<2%		
Acute Trust Total	7.6%	5.9%	5.9%	7.3%	7.1%	8.0%

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





Work has commenced across the organisation to look at the processes for hospital cancellations. New standard operating procedures are being implemented to ensure the process for cancellations is the same across the Trust. Managers are meeting on a fortnightly basisto review.

Service Cancellations - Community

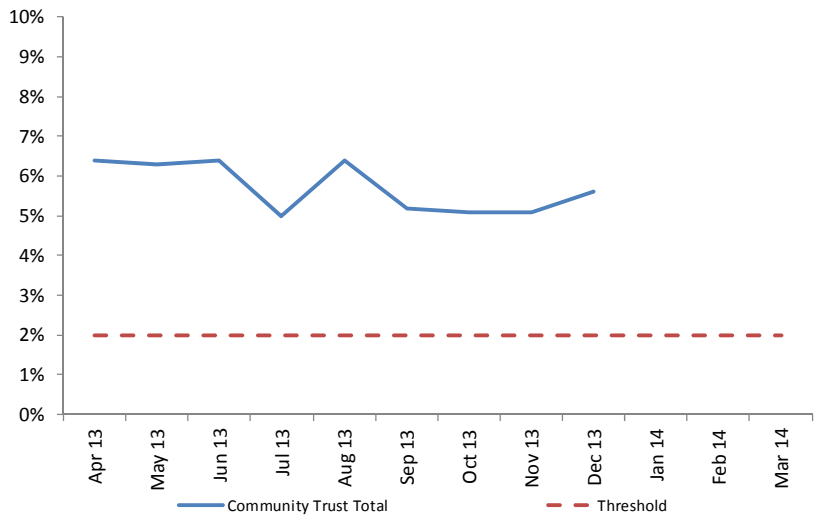
Integrate

Focus Areas

First + Follow-Up

	Apr 13	May 13	Jun 13	Jul 13	Aug 13	Sep 13	Oct 13	Nov 13	Dec 13
Local Threshold	2%								
Community Trust Total	6.4%	6.3%	6.4%	5.0%	6.4%	5.2%	5.1%	5.1%	5.6%

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.



Integrated care and acute medicine (ICAM) have seen increased service cancellations this month due to unplanned sickness. Outliers are Haringey and Islington respiratory teams, due to clinics being booked mistakenly over Christmas week but the admin coding as clinician error rather than diary error.

DNA Rates - Acute

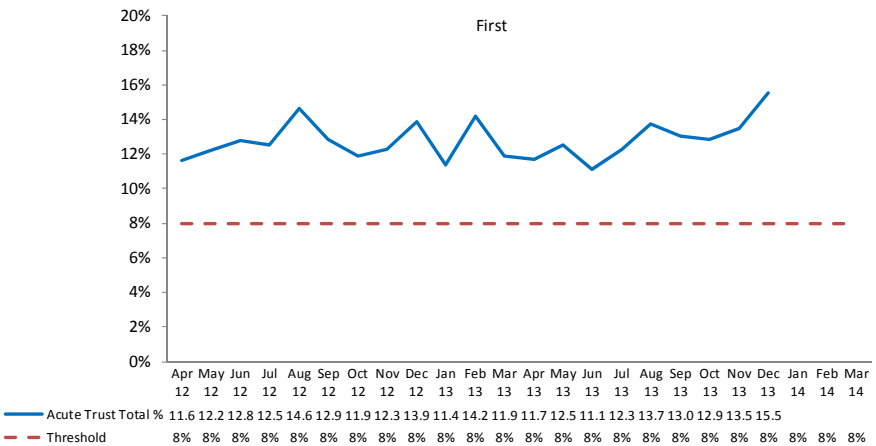
Deliver

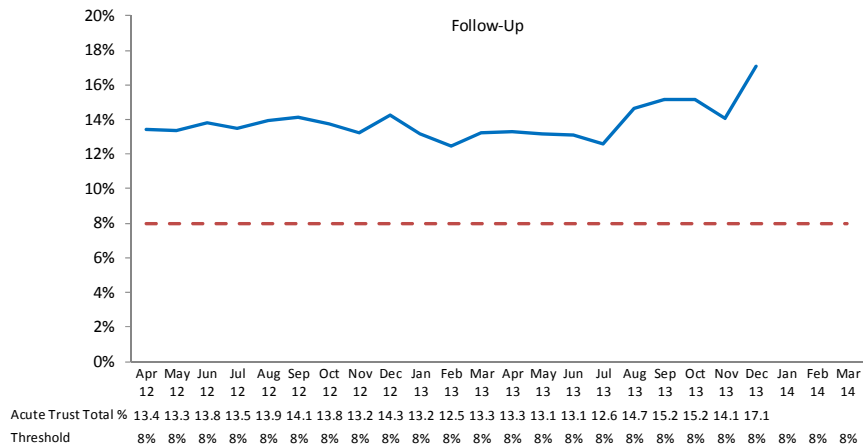
Focus Areas

	First Appointments			Follow Up Appointments		
	Oct 13	Nov 13	Dec 13	Oct 13	Nov 13	Dec 13
Local Threshold	8%			8%		
Acute Trust Total	12.9%	13.5%	15.5%	15.2%	14.1%	17.1%

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

National Average April to September 2013: **8.1%**
Source: Health and Social Care Information Centre





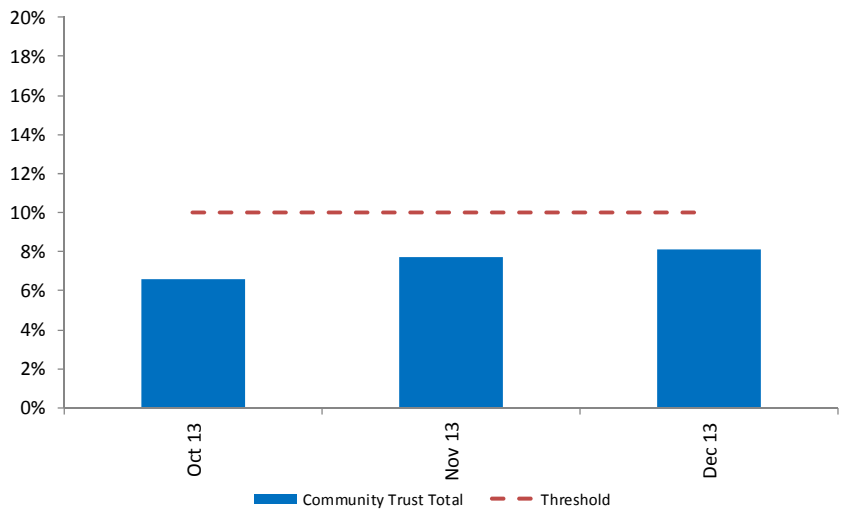
A trust-wide improvement team has been set up to implement improvements to reduce did not attend (DNA) rates across the organisation. Reminder messages and patient calls had been implemented to improve December attendance rate, however, a rise in DNAs was seen. 2013/14 Christmas activity plans will reflect learning from this year.

DNA Rates - Community

Integrate

Focus Areas

First + Follow-Up	Oct 13	Nov 13	Dec 13
Local Threshold	10%		
Community Trust Total	6.6%	7.7%	8.1%



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.

The trust-wide improvement team for reducing DNA has included community teams. A slight increase occurred in December, however this was less than the effect that acute clinics experienced.

Community Face-to-Face Contacts

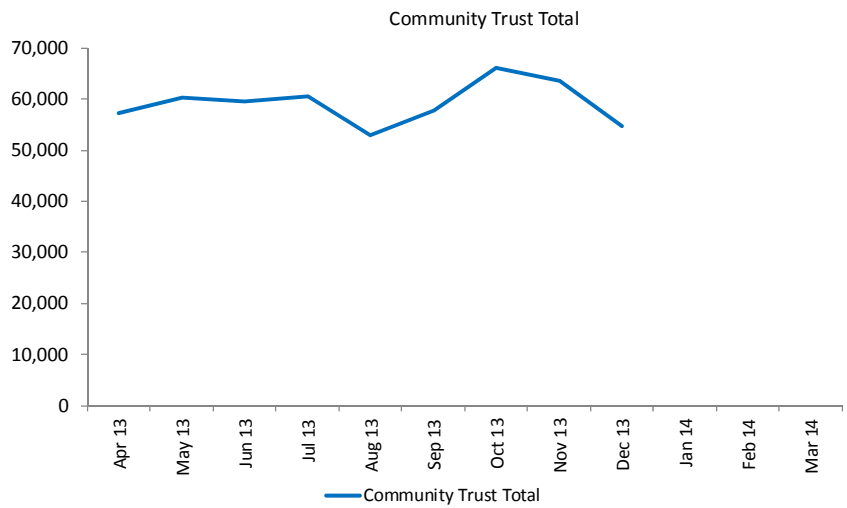
Integrate

Focus Areas

	Oct 13	Nov 13	Dec 13
Threshold	n/a		
Community Trust Total	66,058	63,465	54,568

2012/13 Apr - Dec	2013/14 Apr - Dec	Variation
n/a		
473,675	532,597	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 saw a slight decrease in December, however, year-to-date totals show a 12% increase on activity for the same period in 2012/13.

Community Appointment with no outcome

Integrate

Focus Areas

	Oct 13	Nov 13	Dec 13
Local Threshold	n/a		
Community Trust Total	1,572	2,031	1,346

% of Total Face-to-Face Contacts		
Oct 13	Nov 13	Dec 13
0.5%		
2.4%	3.2%	2.6%

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.

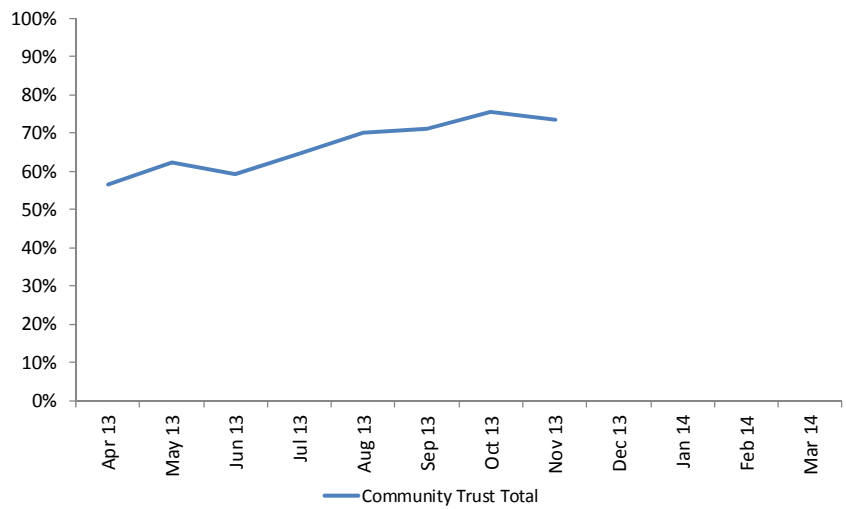
Slight improvement with appointments with no outcome. Cross divisional working between integrated care and acute medicine (ICAM) and women, children and families (WCF) to identify actions and produce a standard operating procedure to ensure appointments have an outcome in a timely manner.

Community Waiting Times
% waiting less than 6 weeks

Integrate

Focus Areas

	Oct 13	Nov 13	Dec 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.

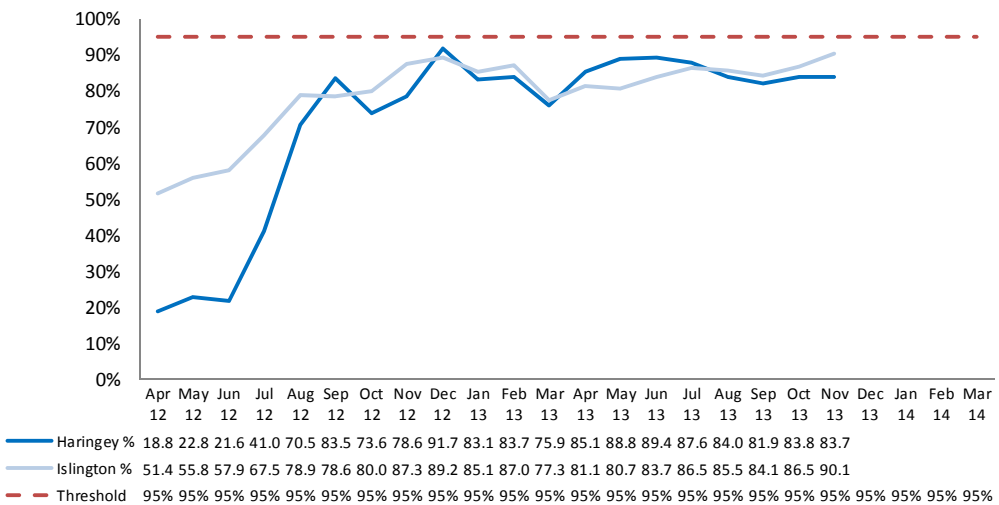
Locally agreed contracts have different waiting times for specialties or conditions, for example self management programmes. These local contracts are not reflected in Whittington Health's aspiration for all patients to be seen within 6 weeks, therefore, further discussions are on going with our commissioners to align our aspiration with their commissioning intentions.

New Birth Visits

Integrate

Focus Areas

	Apr 13	May 13	Jun 13	Jul 13	Aug 13	Sep 13	Oct 13	Nov 13
Local Threshold	95%							
Haringey	85.1%	88.8%	89.4%	87.6%	84.0%	81.9%	83.8%	83.7%
Islington	81.1%	80.7%	83.7%	86.5%	85.5%	84.1%	86.5%	90.1%



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

Health Visiting teams are currently delivering an ambitious training programme.
Seven students started in January 2014, joining the ten students already out in practice. Expansion of the workforce is expected to increase beyond the baseline establishment which will result in further improvement in the percentage of new births completed within 10-14 days.

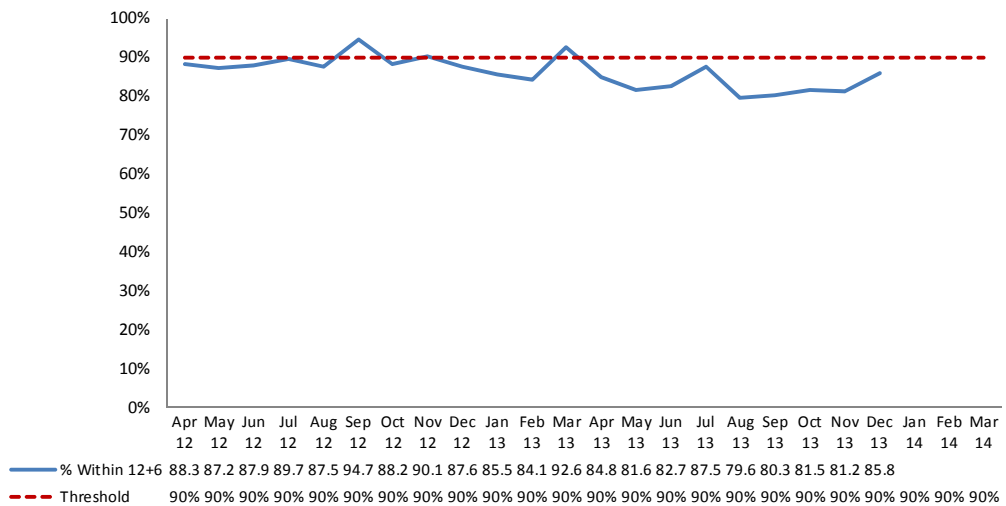
Women seen by HCP or Midwife within 12 weeks and 6 days

Deliver

Focus Areas

	Threshold	Apr 13	May 13	Jun 13	Jul 13	Aug 13	Sep 13	Oct 13	Nov 13	Dec 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%	85.8%
Total Number of Bookings	-	374	404	359	421	376	369	375	359	339
Referrals within 12 Weeks and 6 days	-	323	347	312	359	324	319	324	330	302

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



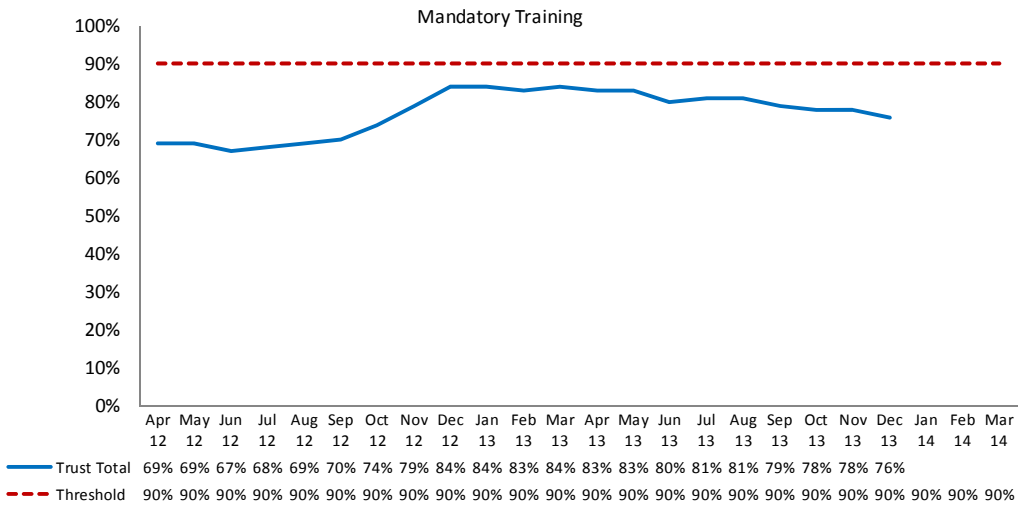
A year long project with dedicated admin support for the 12+6 is about to begin. Funded by Islington Public Health. Post will identify potential breaches, call clients to offer early appointments, and set up text alert system.
A new consultant midwife in Public Health will work with Public Health leads in local authorities to encourage women to book earlier.

Mandatory Training Compliance

Change

Focus Areas

	Mandatory Training			Information Governance			Child Protection Level 2			Child Protection Level 3		
	Oct 13	Nov 13	Dec 13	Oct 13	Nov 13	Dec 13	Oct 13	Nov 13	Dec 13	Oct 13	Nov 13	Dec 13
Local Threshold	90%			95%			90%			90%		
Trust Total	78%	78%	76%	73%	68%	68%	63%	63%	61%	66%	65%	68%



Data snapshot date
06/01/2014

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

The Trust Priority Plan identifies improved compliance as a priority. Actions have been agreed which are to be implemented withintenweeks:
1) it has been agreed to invest in the adoption of a recommended data management solution
2) it has been agreed to invest in an IPAD and Smartphone App so that staff can access Mandatory Training courses through these devices
3) improved performance management and accountability of managers to performance manage the MT compliance of their staff
4) from late January there has been 'deep dive' reporting at Executive Team, Trust Operational Board, Divisional Management Teams and other sub-groups
5) all staff are to be given one day per month to complete mandatory tasks.

Referral to Treatment 18 weeks - Admitted

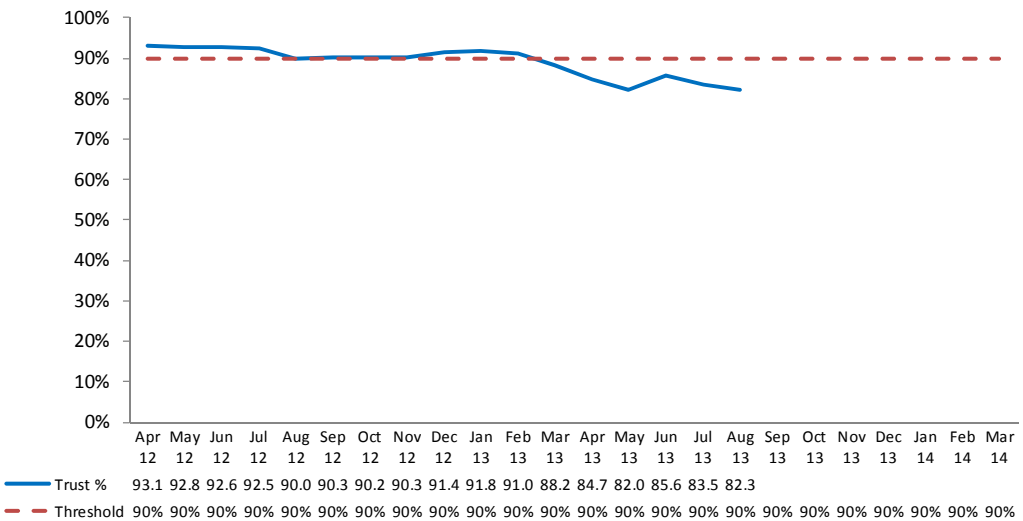
Deliver

Access Metrics

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

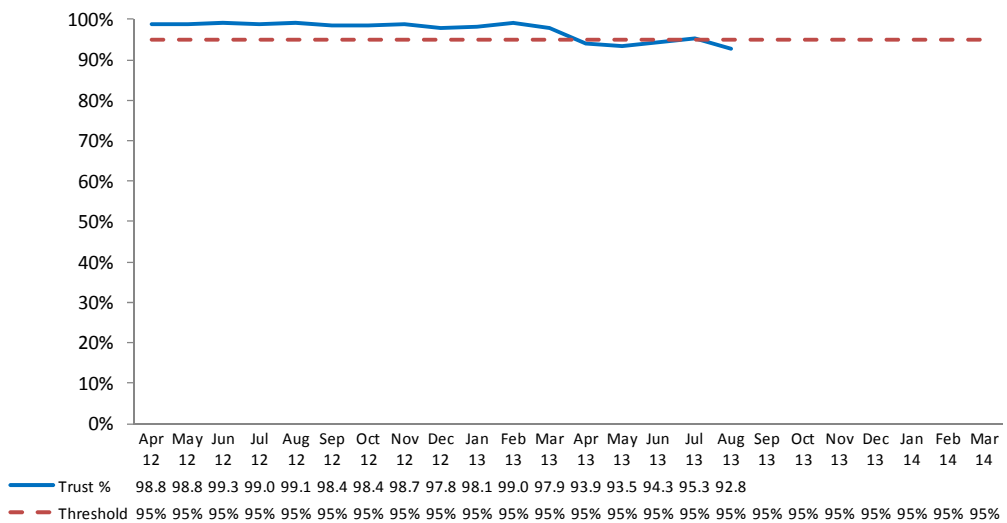
Deliver

Access Metrics

	Apr 13	May 13	Jun 13	Jul 13	Aug 13	Sep 13	Oct 13	Nov 13	Dec 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 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 prioritized appropriately.

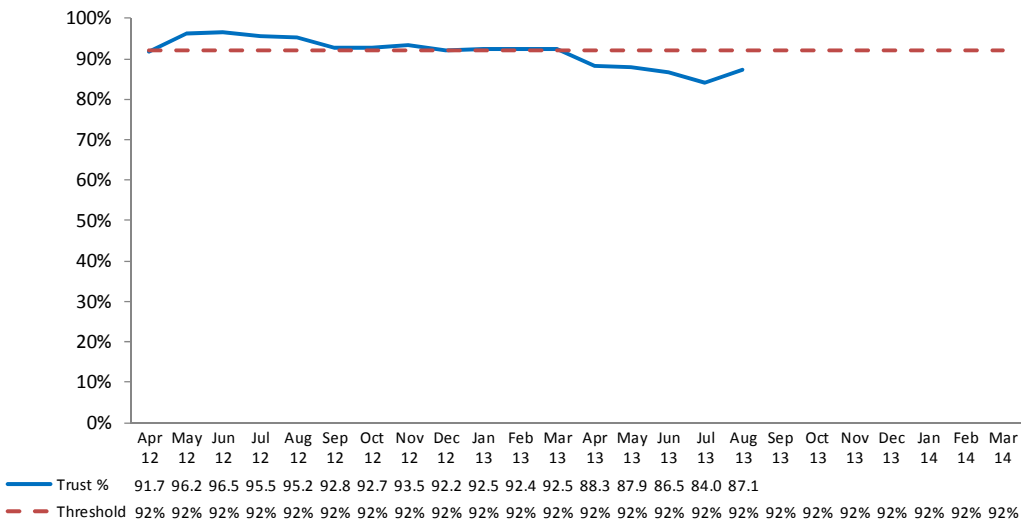
Referral to Treatment 18 weeks - Incomplete

Deliver

Access Metrics

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

Data currently unavailable due to EPR reporting Issues

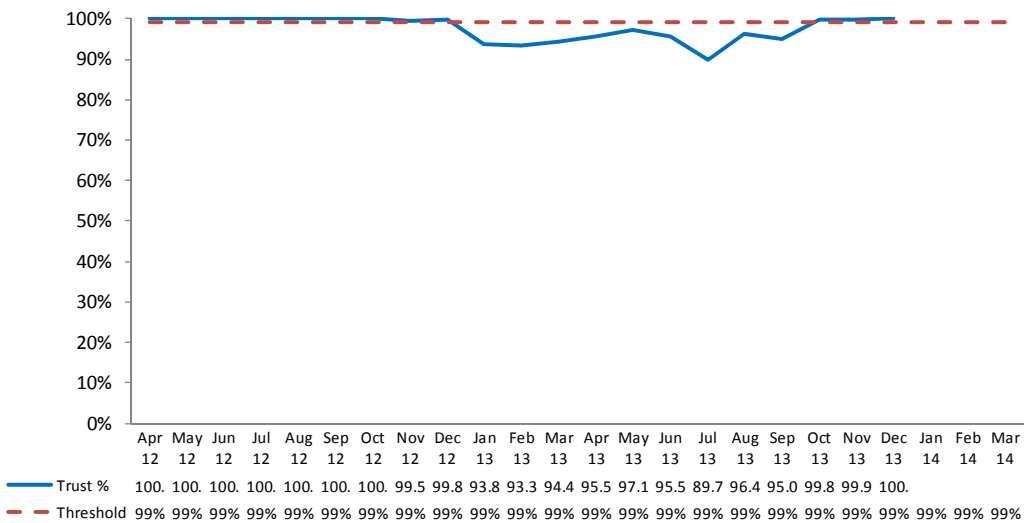
Due to issues related to the Electronic Patient Record (EPR), there has not been a live patient tracking list (PTL) since go-live. Information and performance are working with the EPR provider to address the issues. We have established extra electronic and manual processes to ensure patients are clinically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

Diagnostic Waits

Deliver

Access Metrics

	Apr 13	May 13	Jun 13	Jul 13	Aug 13	Sep 13	Oct 13	Nov 13	Dec 13
National Threshold	99%								
Trust Total	95.5%	97.1%	95.5%	89.7%	96.4%	95.0%	99.8%	99.9%	100.0%



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 100% achieved for December.

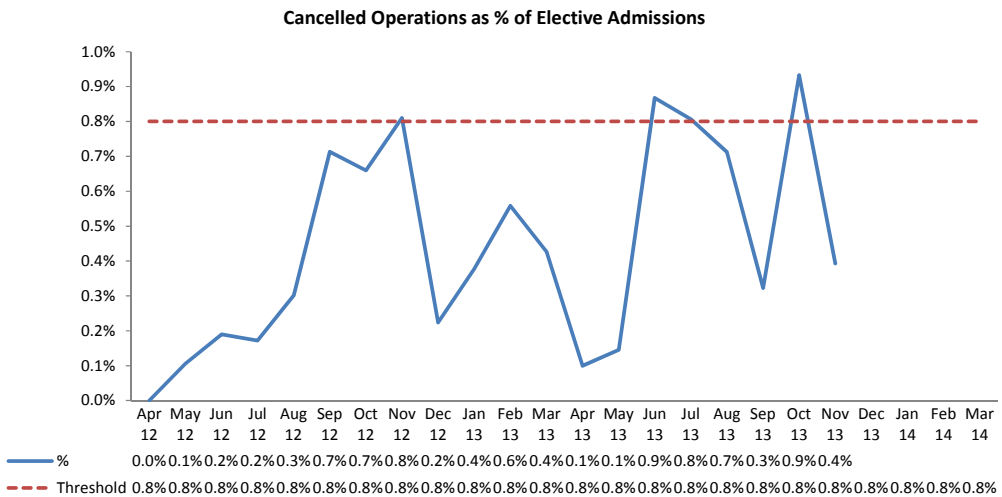
Hospital Cancelled Operations

Deliver

Access Metrics

Hospital initiated cancellations on day of operation

	Number of Cancelled Operations			Cancelled Operations as % of Elective Admissions		
	Oct 13	Nov 13	Dec 13	Oct 13	Nov 13	Dec 13
National Threshold	n/a			< 0.8%		
Trust Total	17	6	[illegible]	0.9%	0.4%	[illegible]



December data is not yet validated for inclusion in this month's report.

Emergency Department Waits

Deliver

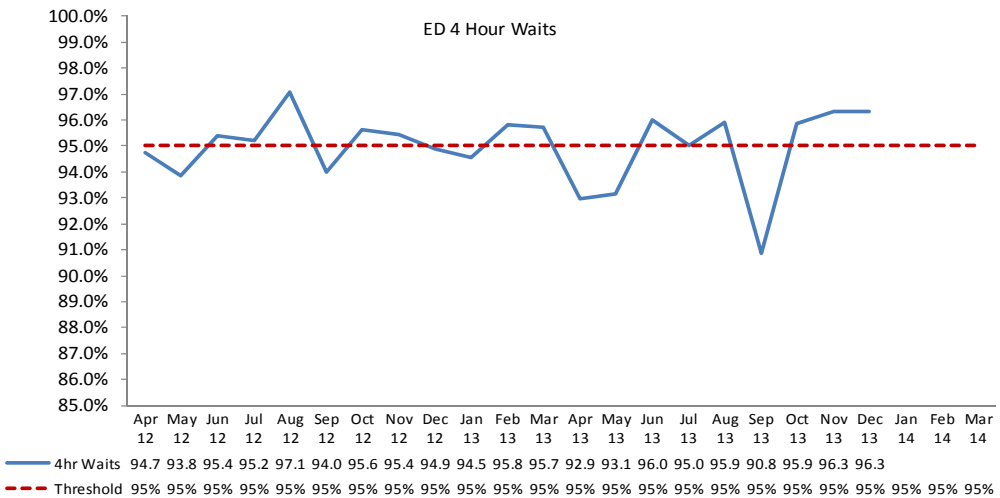
Access Metrics

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	Nov 13	Dec 13
National Threshold	95%								
4hr Waits	92.9%	93.1%	96.0%	95.0%	95.9%	90.8%	95.9%	96.3%	96.3%
12hr Waits	0	0	0	0	0	1	0	0	0

Wait for treatment and Re-attendance rate indicators not currently available due to ongoing EPR issues



Clinical Quality Indicators	Oct 13	Nov 13	Dec 13
Total Time in ED (95th % Wait < 240 mins)	239	239	239
Total Time in ED - Admitted (95th % Wait < 240 mins)	393	364	425
Total Time in ED - Non-Admitted (95th % Wait < 240 mins)	235	236	235
Wait for Assessment (95th % Wait < 15 mins)	17	16	17
Wait for Treatment (Median <60 mins)	-	-	-
Left Without Being Seen Rate (<5%)	4.16%	4.09%	4.58%
Re-attendance Rate (>1% and <5%)	-	-	-

Achievement of four hour wait target for third consecutive month.
Continue with recovery and improvement plan with bi-weekly monitoring, including monitoring impact of schemes included in the winter plan.

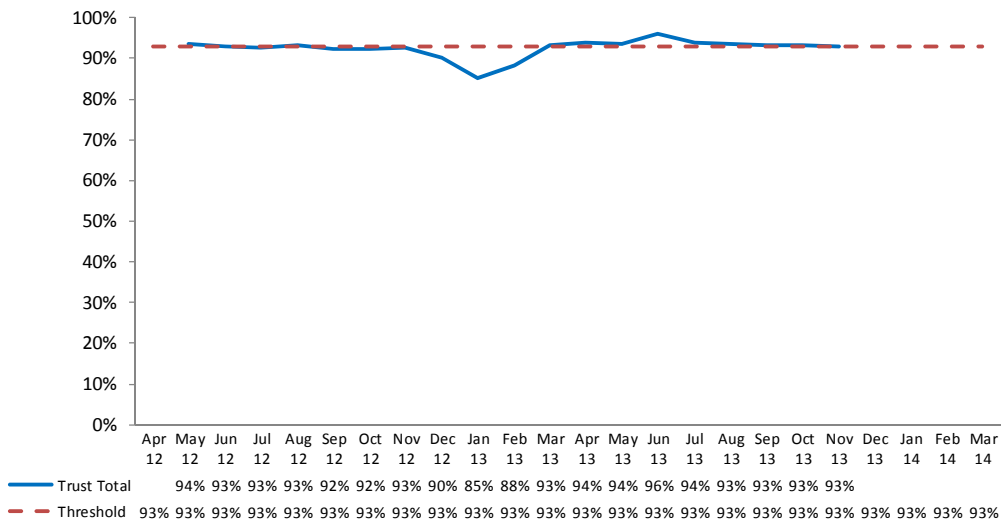
Cancer - 14 days to first seen

Deliver

Access Metrics

14 Days to First Seen

	Sep 13	Oct 13	Nov 13	Q1	Q2	Q3 TD	Q4
National Threshold	93%			93%			
Trust Total	93.1%	93.2%	92.99%	94.6%	93.5%	93.1%	-



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 December, Whittington Health missed the target by 0.01%. 24 out of 30 breaches (80%) were due to patient choice. The monthly position can still change as data is further operationally validated, until the quarterly submission is made. Quarter-to-date performance for Q3 is 93.1% which meets the national threshold.

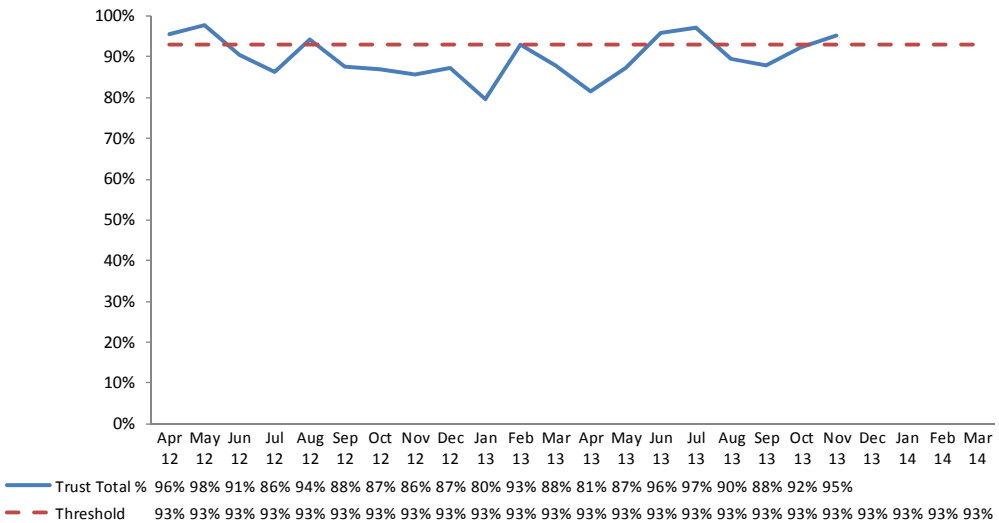
Cancer – 14 days to first seen – Breast symptomatic

Deliver

Access Metrics

14 Days to First Seen - Breast Symptomatic

	Sep 13	Oct 13	Nov 13	Q1	Q2	Q3 TD	Q4
National Threshold	93%			93%			
Trust Total	88.03%	92.4%	95.2%	88.2%	92.1%	93.9%	-



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

Achieving target, however this standard is not yet sustainably compliant and is monitored monthly. Achievement is still significantly influenced by patients agreeing to be seen within 14 days of referral.
For December, it is expected that this standard will not be achieved due to patient choice.
Action plans are in place and agreed with commissioners to reach compliance sustainably by February 2014

Cancer – 31 days to first treatment

Deliver

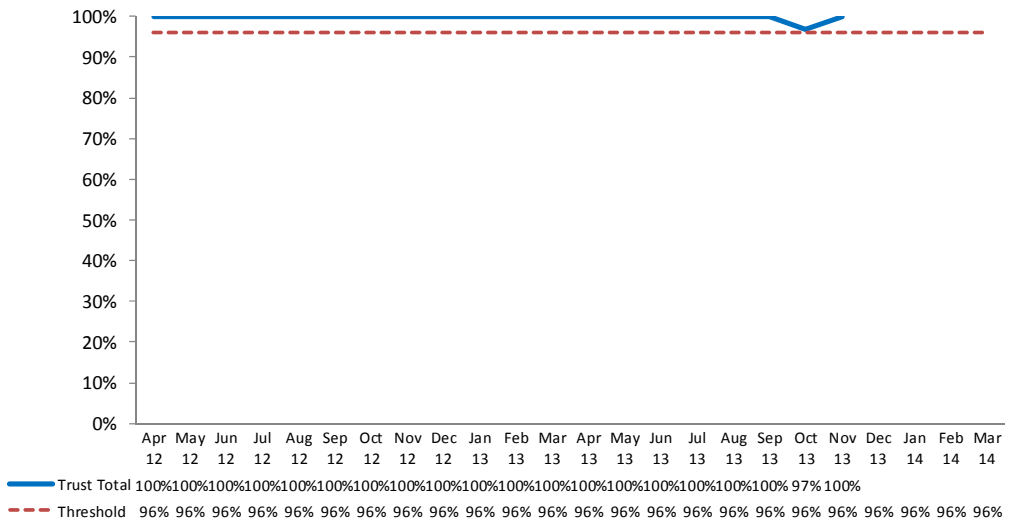
Access Metrics

31 Days to First Treatment

	Sep 13	Oct 13	Nov 13	Q1	Q2	Q3 TD	Q4
National Threshold	96%			96%			
Trust Total	100%	96.8%	100.0%	100%	100%	98.4%	-

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

31 day target is timed from diagnosis to treatment.



Delivering 100% compliance and sustainably meeting the national threshold.

Cancer – 31 days to subsequent treatment - Surgery

Deliver

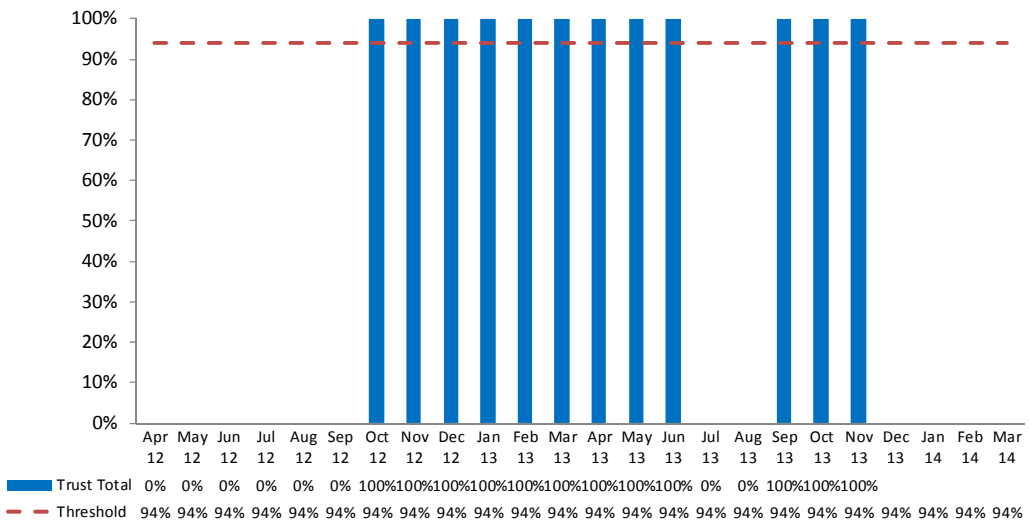
Access Metrics

31 Days to Subsequent Treatment - Surgery

	Sep 13	Oct 13	Nov 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.



Delivering 100% compliance and sustainably meeting the national threshold.

Cancer – 31 days to subsequent treatment - Drugs

Deliver

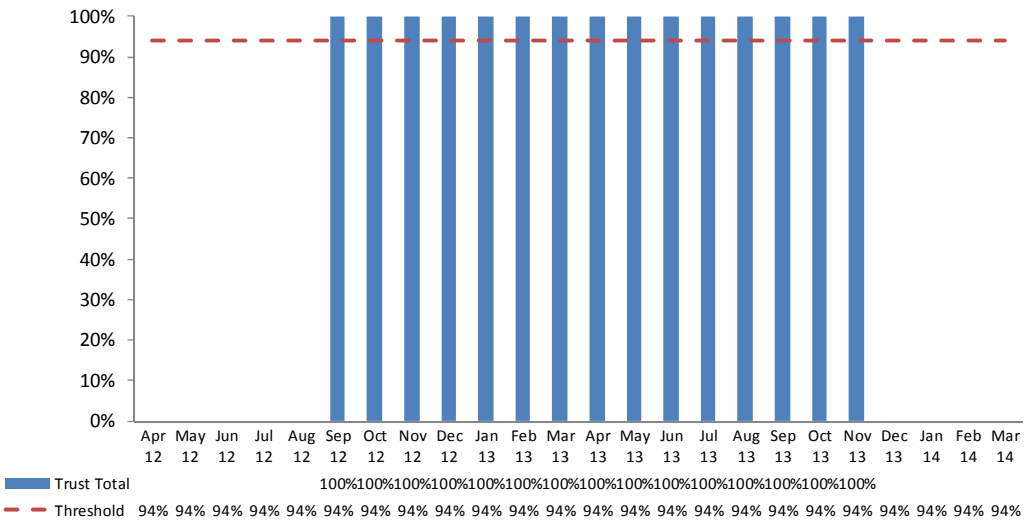
Access Metrics

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

	Sep 13	Oct 13	Nov 13	Q1	Q2	Q3 TD	Q4
National Threshold	94%			94%			
Trust Total	100%	100%	100%	100%	100%	100%	-



Delivering 100% compliance and sustainably meeting the national threshold.

Cancer – 62 days from referral to treatment

Deliver

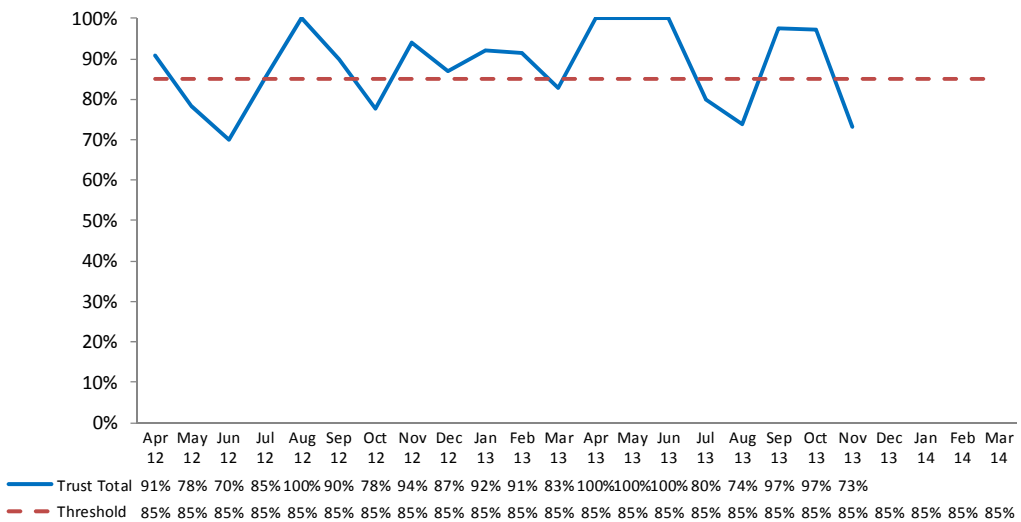
Access Metrics

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

	Sep 13	Oct 13	Nov 13	Q1	Q2	Q3 TD	Q4
National Threshold	85%			85%			
Trust Total	97.4%	97.1%	73.2%	100.0%	83.1%	84.2%	-



Non compliant at 73.2% as still working at removing the backlog of urology 62 day patients.
Action plan in place for urology and has been agreed with commissioners, pathway has been revised and anticipate sustained delivery of the standard at the end of March 2014.

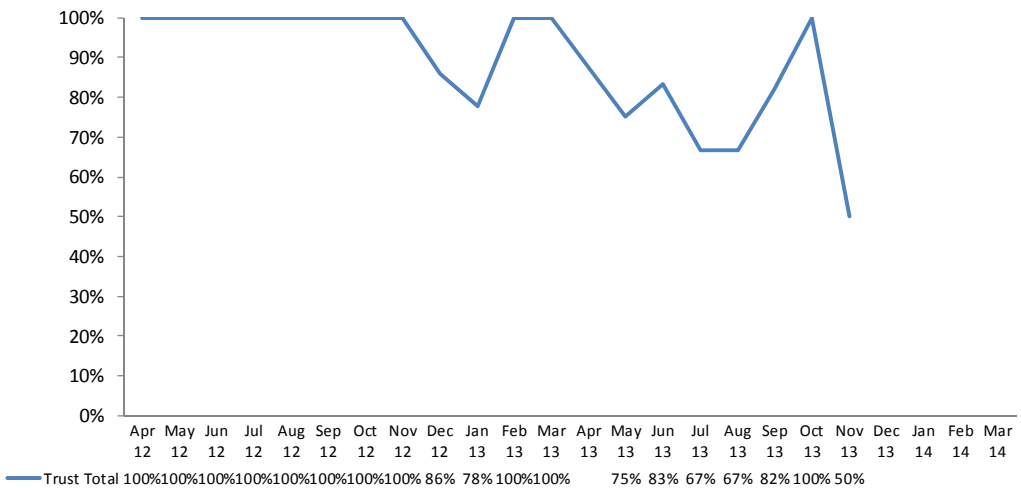
Cancer – 62 days from consultant upgrade

Deliver

Access Metrics

62 Days from Consultant Upgrade

	Sep 13	Oct 13	Nov 13	Q1	Q2	Q3 TD	Q4
Trust Total	81.8%	100.0%	50%	80%	72.4%	90.9%	-



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

New Cancer Access Policy has revised the way patients are upgraded with advice from the Intensive Support Unit and our commissioners.

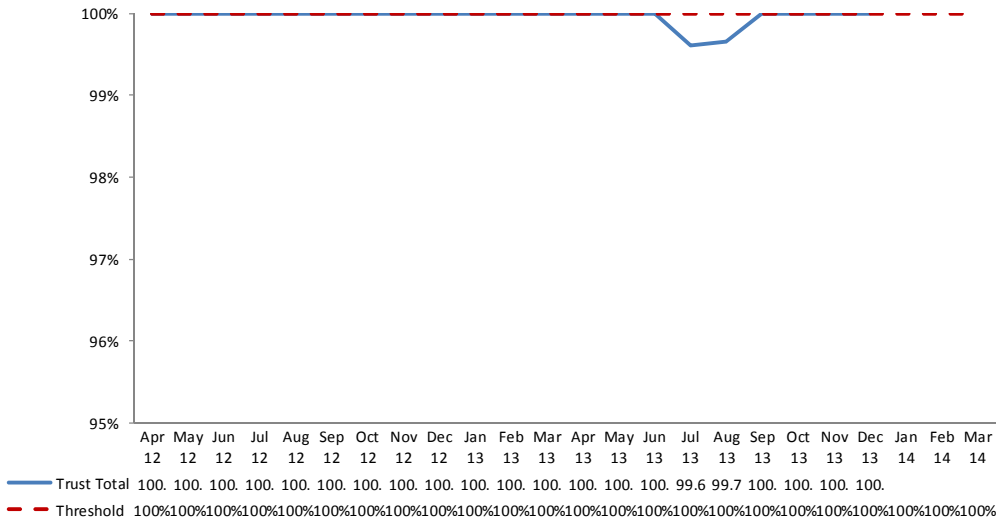
Genito-Urinary Medicine

Improving

Access Metrics

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

The percentage of patients offered an appointment within 2 days



Delivering 100% compliance and continue to meet the threshold.

Delayed Transfers of Care

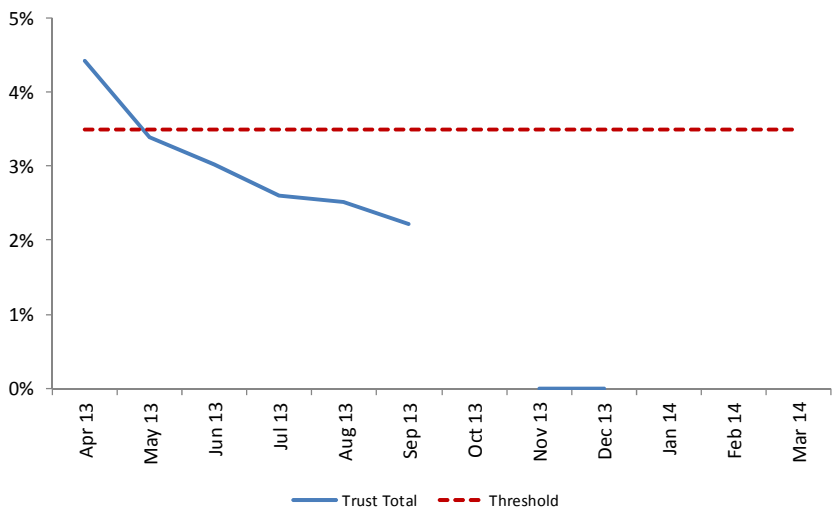
Integrate

Outcome Metrics

Number of Days Delayed

	Dec 13		
	NHS Days	Social Services	Both
Trust Total	121	55	0

	Sep 13	Oct 13	Nov 13
Local Threshold	3.5%		
Trust Total Delayed Transfers	-	-	-



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

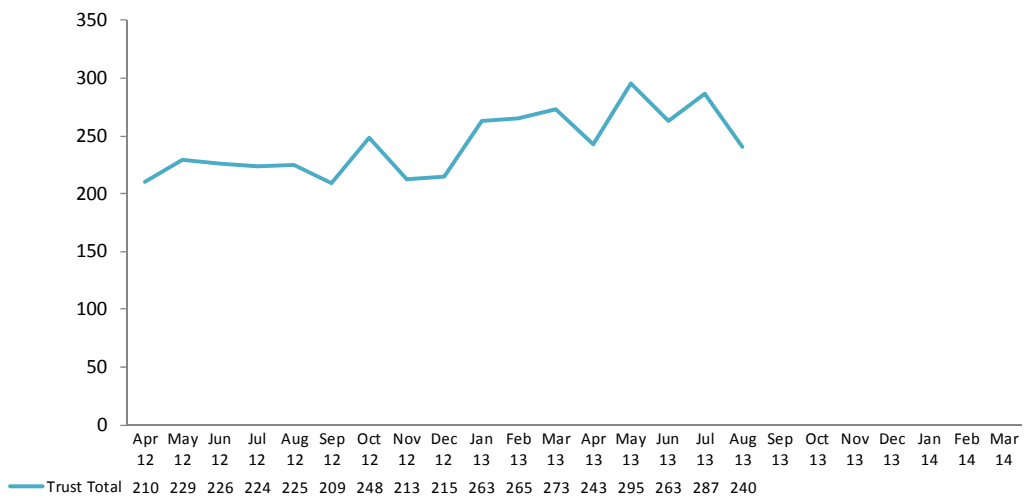
Main cause of delays was a small number of patients waiting for specialist rehabilitation or intermediate care (NHS delays) Continued dialogue with local authorities leads and escalation to Divisional Nurse of Director of Operations as per policy.

30 day Emergency Readmissions

Deliver

Outcome Metrics

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

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. Alongside an improvement project,medical staff are reviewing all new emergency readmissions to identify if there is any learning in preventing readmissions.

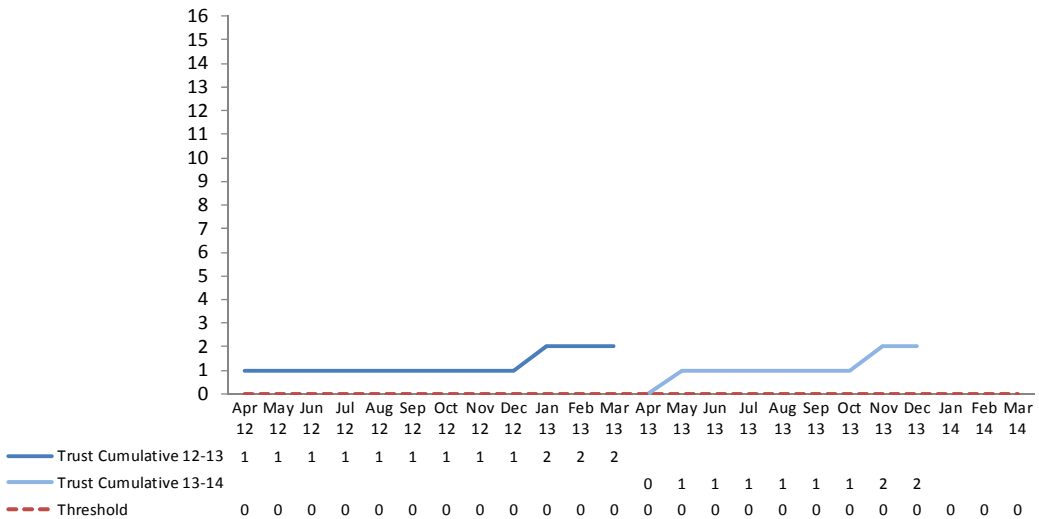
MRSA

Deliver

Outcome Metrics

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

Number of MRSA bacteraemia (bacteria in the blood)



The serious incident (SI) investigation has been completed into the one MRSA bacteraemia in November.
Action to ensure cleaning in wards and departments is up to standard, and the feeling on the ward matches the results produced from ward cleanliness audits.
A hand hygiene campaign has been planned and will start at end of January. Additional signage pointing to hand hygiene facilities across the Trust are currently being installed

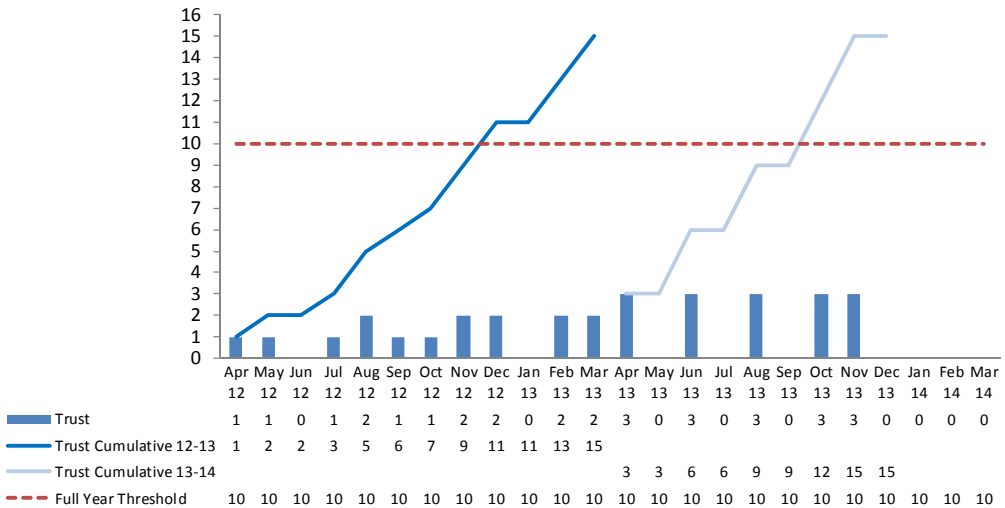
C Difficile Infections

Deliver

Outcome Metrics

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

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



There have been 15 case of C Difficile infections across the organisation up to the end of December, five cases above the full year threshold. All cases have been investigated in depth and a SI report presented to the executive panel, plus a NHS Trust Development Authority (NHS TDA) review with Trust staff. Two cases were identified as avoidable.
Action plans in place to address issues through the infection control team and leads within the clinical areas, plus test sensitivity has increased so we would expect more being identified/reported.

E.coli and MSSA

Deliver

Outcome Metrics

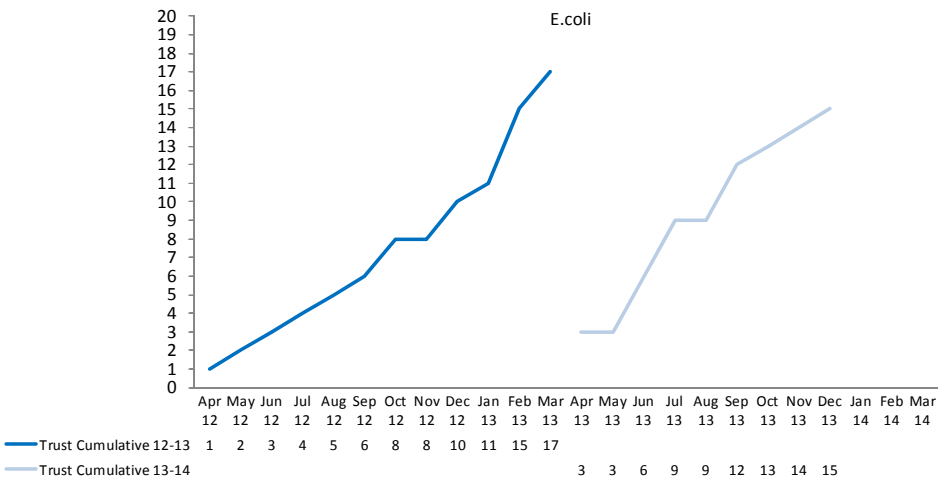
E.coli (Post 48 Hours)

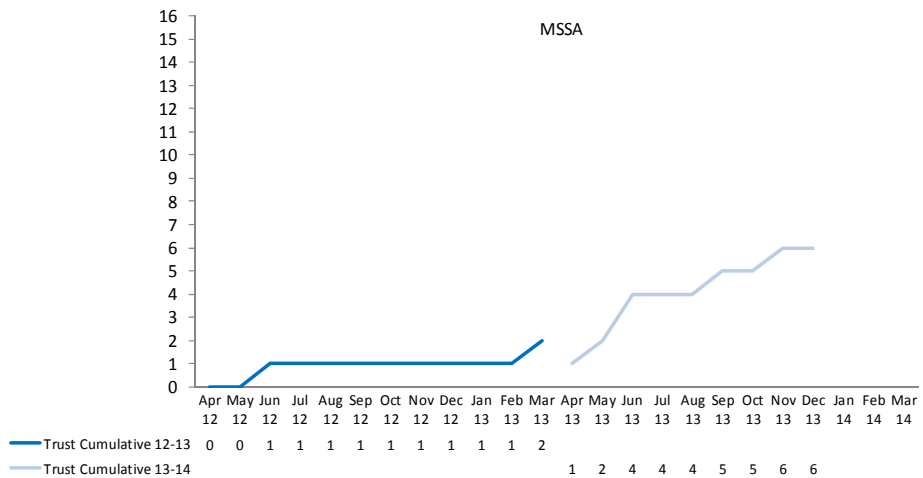
	Oct 13	Nov 13	Dec 13
Threshold	n/a		
Trust Total	1	1	1

MSSA (Post 48 Hours)

	Oct 13	Nov 13	Dec 13
Threshold	n/a		
Trust Total	0	1	0

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





Both organisms are reported via the Public Health HCAI MESS data system, there are currently no targets/thresholds for these indicators.
However the focus on Infection prevention and control practices continues across the Trust in an effort to reduce where possible health care associated infections.

Harm Free Care

Deliver

Outcome Metrics

	Contractual Threshold	Oct 13	Nov 13	Dec 13
% of Harm Free Care	95%	94.2%	94.7%	93.4%
Completeness of Safety Thermometer (CQUIN)	100%	100%	100%	100%
Pressure Ulcer (PU) Incidence	50% Reduction	17	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

The safety thermometer identifies the prevalence of four measures of harm across all patients in trust settings on a particular day each month – catheter related infection, pressure ulcer, VTE. Falls. The target is to have 95% harm free care. While the trust is slightly below this target there is only small variation month on month. The Trust can evidence significant improvements in the incidence of acquired pressure ulcers, fall catheter related infections and VTE.

VTE Risk Assessment

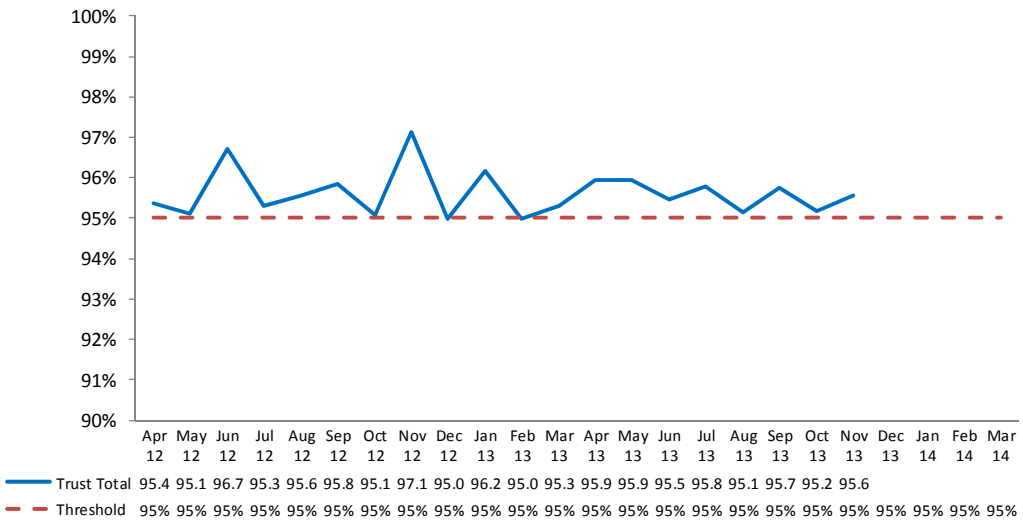
Deliver

Outcome Metrics

	VTE Risk Assessed (CQUIN)		
	Sep 13	Oct 13	Nov 13
CQUIN Threshold	95%		
Trust Total	95.7%	95.2%	95.6%

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

	VTE Incidence		
	Sep 13	Oct 13	Nov 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

Continue to deliver above threshold.

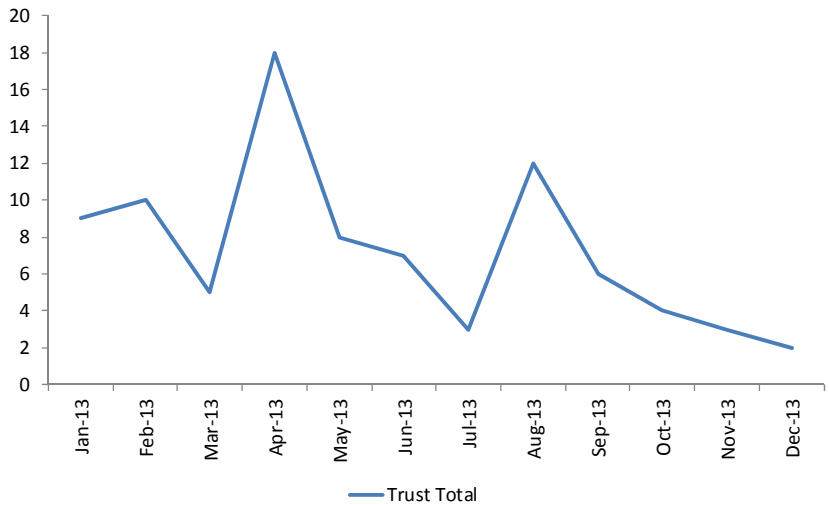
Serious Incidents

Change

Outcome Metrics

	Jul 2013	Aug 2013	Sep 2013	Oct 2013	Nov 2013	Dec 13
Integrated Care & Acute Medicine	2	11	5	2	0	2
Surgery, Cancer & Diagnostics	1	0	0	0	1	0
Women, Children & Families	0	1	1	2	2	0
Trust Total	3	12	6	4	3	2

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



Serious incidents are now reported and investigated within the targeted time limits. The quality of investigation has improved significantly and learning from incidents is now the main focus of investigations. All incident reports are shared with patients as outlined in the Being Open Policy.

Never Events

Change

Outcome Metrics

One never event has been reported to STEIS in December 2013.
A fragment of metal from a retractor broke and was retained in a patient. The patient had to return to theatre to have this removed and has been reviewed and is well.
This incident is being managed through the Root Cause Analysis and investigation process.

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 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.

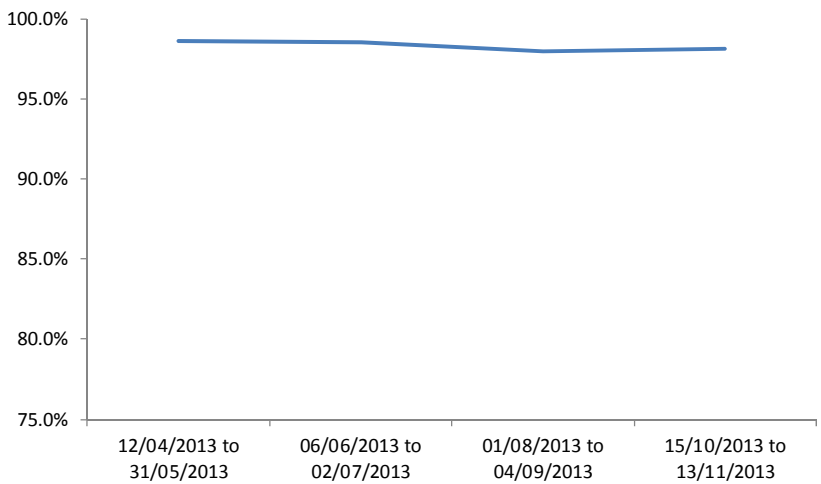
Five Estates and Facilities alerts were issued on CAS in August, all relating to various electrical switchgear hazards in high and low voltage equipment following 22 such alerts in July. All 27 have been closed on CAS within deadline. In only two cases was action required.

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

Ward cleanliness audits are conducted regularly along with other walk rounds in an effort to ensure that the environmental hygiene targets are met. This is an important element of the Trust's infection prevention and control plan and the above graph demonstrates that the audits consistently score above 95% for cleanliness.

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

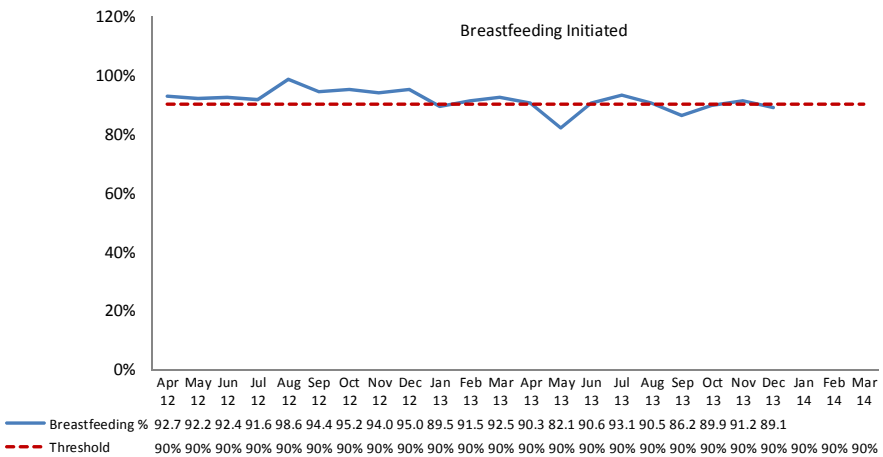
Breastfeeding and Smoking

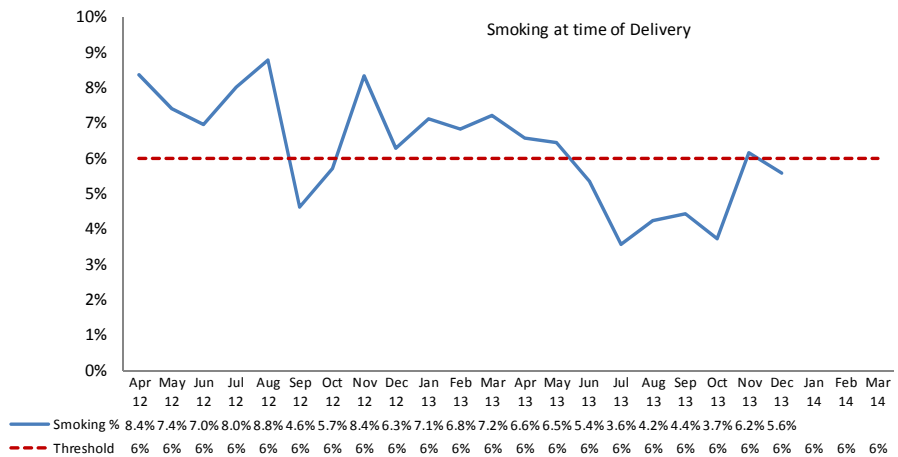
Improving

Outcome Metrics

	Threshold	Oct 13	Nov 13	Dec 13
Breastfeeding Initiated	90%	89.9%	91.2%	89.1%
Smoking at Delivery	<6%	3.7%	6.2%	5.6%

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.





Infant Feeding Team to provide support to ward staff to initiate breastfeeding. Staff to be reminded of completing information on EPR.

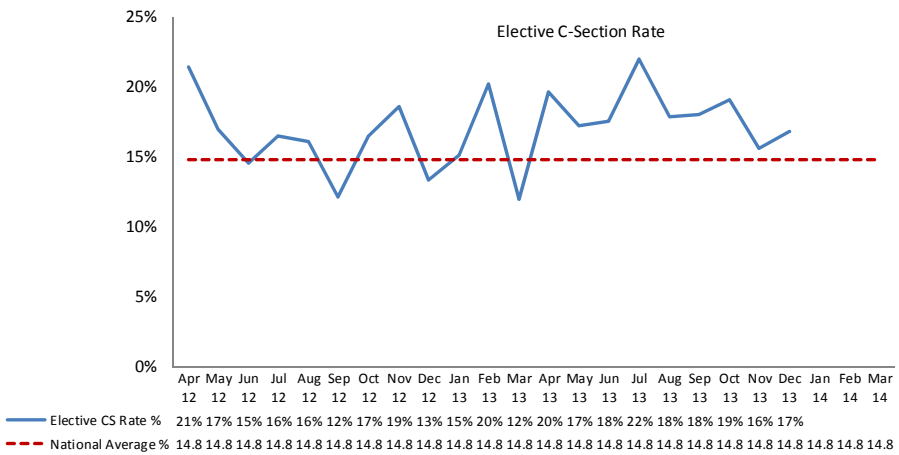
Caesarean Section Rates

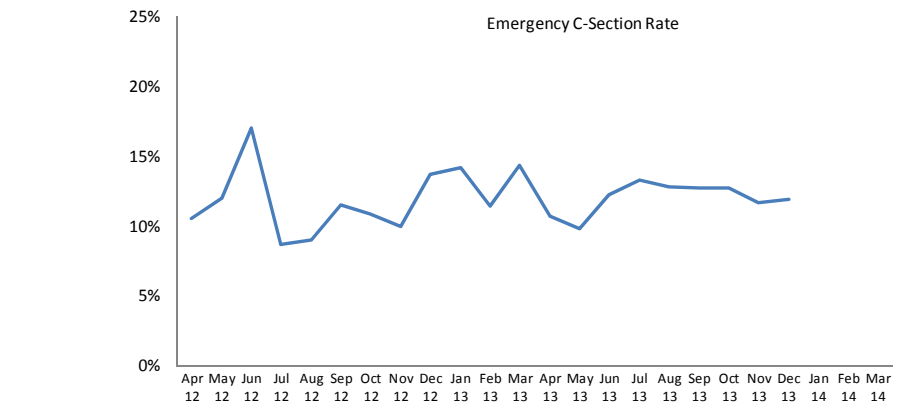
Deliver

Outcome Metrics

	National Average	Oct 13	Nov 13	Dec 13
Elective C-Section Rate	14.8%	19.1%	15.6%	16.8%
Emergency C-Section Rate	-	12.7%	11.7%	11.9%
All Deliveries	-	346	308	285

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





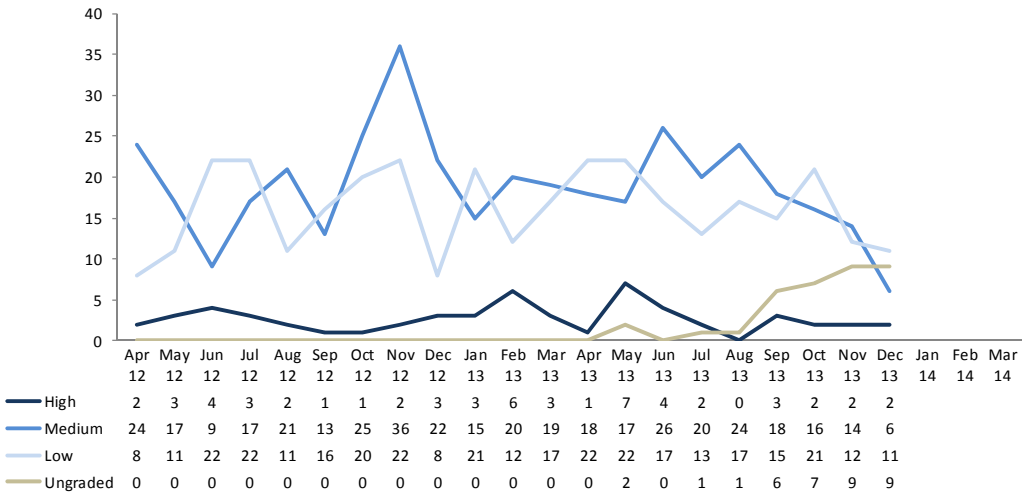
New post setting up VBAC (Virginal Birth after C-section) to ensure mothers are aware of the benefits following a previous caesarean. An action plan has been developed and is being delivered.

Medication Errors Causing Harm

Change

Outcome Metrics

		Apr 13	May 13	Jun 13	Jul 13	Aug 13	Sep 13	Oct 13	Nov 13	Dec 13
Risk	High	1	7	4	2	0	3	2	2	2
	Medium	18	17	26	20	24	18	16	14	6
	Low	22	22	17	13	17	15	21	12	11
	Ungraded	0	2	0	1	1	6	7	9	9
	Total	41	48	47	36	42	42	46	37	28



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

Divisional Heads of Quality investigating ungraded errors and ensure that investigating routes are in place. This will change the classification of the risk. Plans are in place to ensure ungraded numbers are kept to minimum where possible.

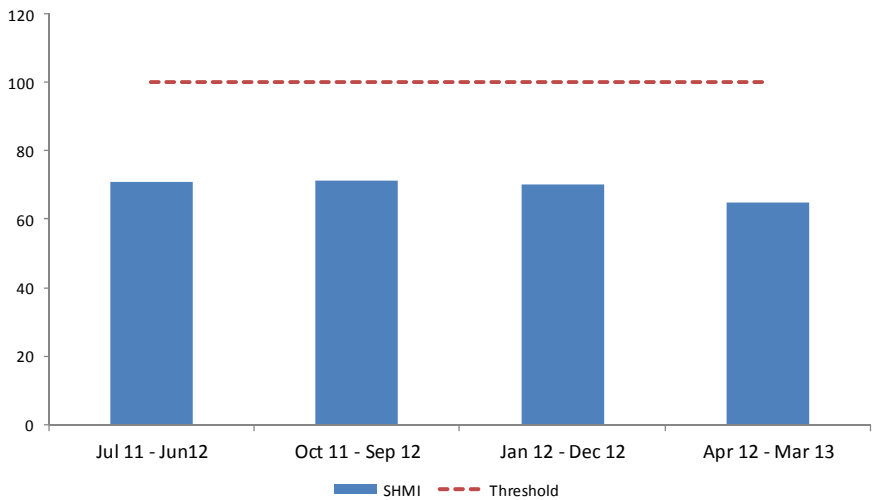
SHMI

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.



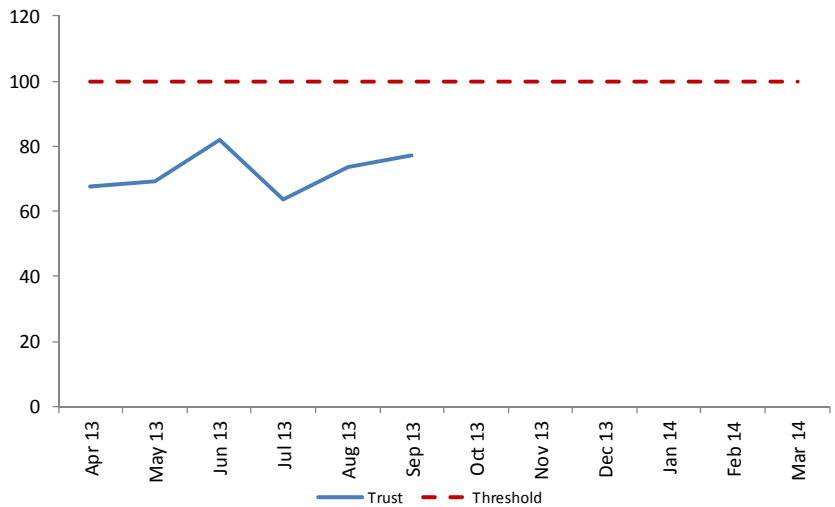
Achieving excellent Summary Hospital Mortality Index.

HSMR

Change

Outcome Metrics

HSMR	Jul 13	Aug 13	Sep 13
Local Threshold	<100		
Trust Total	63.6	73.42	77.07



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.

September latest SUS data sent to Dr Foster due to EPR go-live

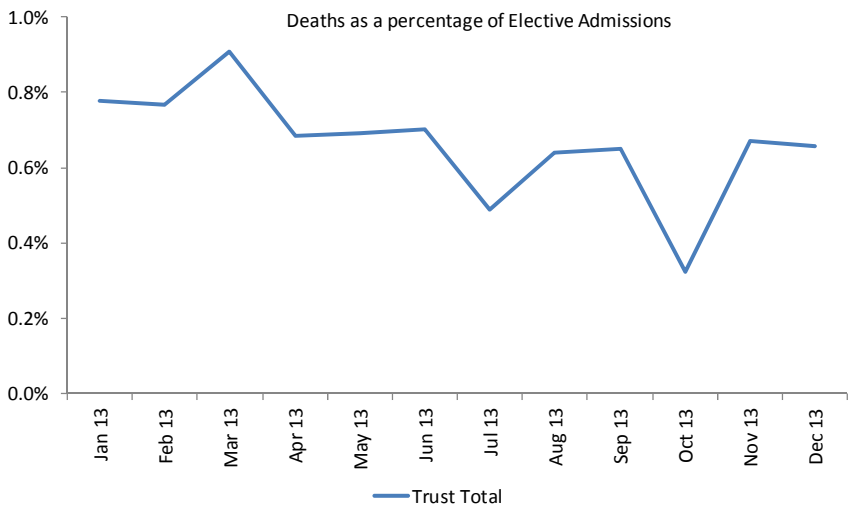
No data submitted after September due to ongoing EPR reporting issues.

Number of Inpatient Deaths

Outcome Metrics

	Deaths			Percentage of Admissions		
	Oct 13	Nov 13	Dec 13	Oct 13	Nov 13	Dec 13
Trust Total	15	31	28	0.3%	0.7%	0.7%

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



Mortality and morbidity audit process has been reviewed and further developments made to ensure all inpatient deaths are reviewed

Patient Satisfaction (Friends & Family)

Ensure

Quality Indicators

	Oct 13	Nov 13	Dec 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

The FFT score across all inpatient wards and ED continues to improve. While ED remains below the target response of 15% focused actions are now being implemented to improve this, and improvement is inline with trajectory.
The Net Promoter Score and free text comments which accompany the FFT continue to show improvement in the patient experience.

Mixed Sex Accommodation

Integrate

Quality Indicators

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

As part of the cross check of all performance measures a check of mixed sex accommodation was completed. This showed that the ISIS (emergency admission) ward needed to be improved to achieve mixed sex accommodation guidance. Bays in ISIS have now been allocated to male and female bays.
Potential breaches may occur due to clinical demand.

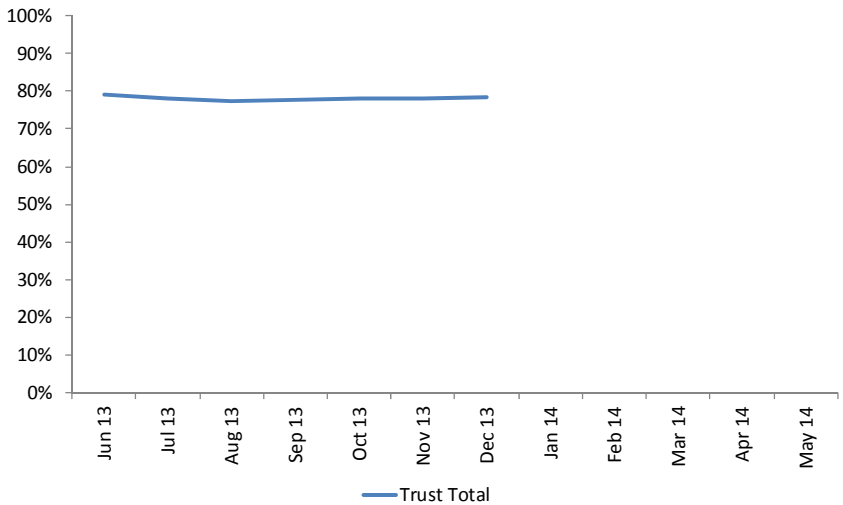
Percentage of Registered Nurses

Change

Quality Indicators

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

	Threshold	Oct 13	Nov 13	Dec 13
Trust Total	n/a	78.1%	78.2%	78.3%



A review of nurse staffing levels is currently underway. There has been an increase in the skill mix and number of registered nurses in both Meyrick and Cloudsley Wards in the past six months

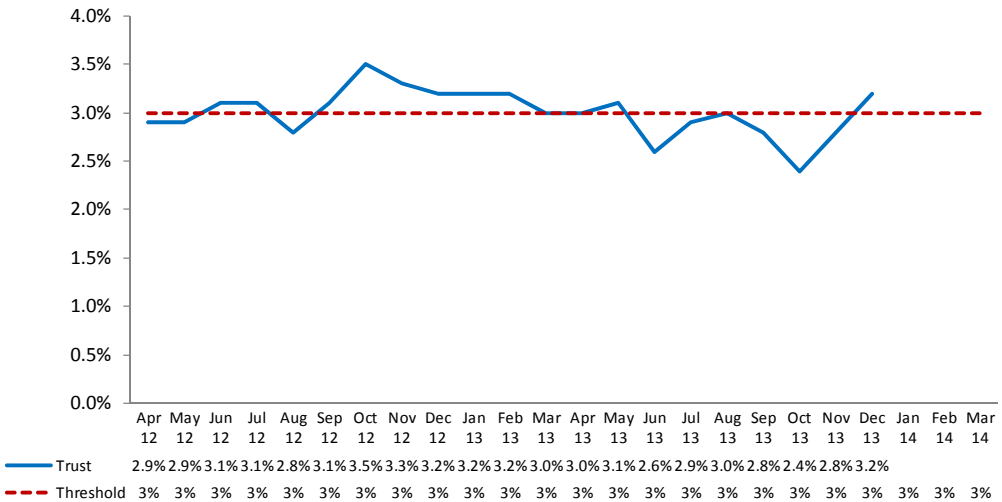
Sickness Rate

Change

Quality Indicators

	Sickness				High Bradford Scores		
	Local Threshold	Oct 13	Nov 13	Dec 13	Oct 13	Nov 13	Dec 13
Trust Total	<3%	2.4%	2.8%	3.2%	692	543	713

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



The flu jab vaccination target of 75% has now been met. Sickness data is showing an increase from last month due in part to the seasonal fluctuations typical for this time of year. The action plan to address sickness levels is being implemented. Sickness data has been escalated to each Divisional Director and Directors in Corporate Services. Summary data showing days lost, breakdown between long and short term sickness and reasons for sickness is now available. This will now be produced monthly. Follow up meetings with TOB and Divisional Management meetings will focus on areas where sickness is disproportionately high. Briefings and training sessions will be planned over a rolling period of three months focussing on return to work interviews, Bradford scores and how to use triggers and case conferences where necessary.

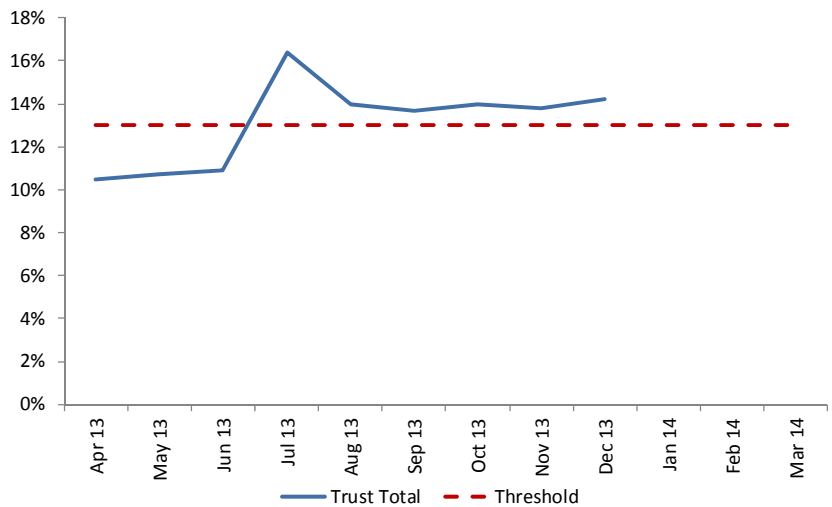
Staff Turnover

Change

Quality Indicators

	Local Threshold	Oct 13	Nov 13	Dec 13
Trust Total	<13%	14.0%	13.8%	14.2%

Proportion of workforce leaving in a given period.



A slight increase on last month. The improvement programme will tackle better recording of exit interviews and provide feedback on the reasons for staff leaving. Recruitment and retention is central to reducing turnover. Report to Resources and Planning Committee in January showed a steadily decline in the numbers of interim senior positions. The focus remains on securing permanent appointments and reducing agency usage. These steps together with the succession plan also agreed at the committee in January will contribute to a more sustainable workforce.

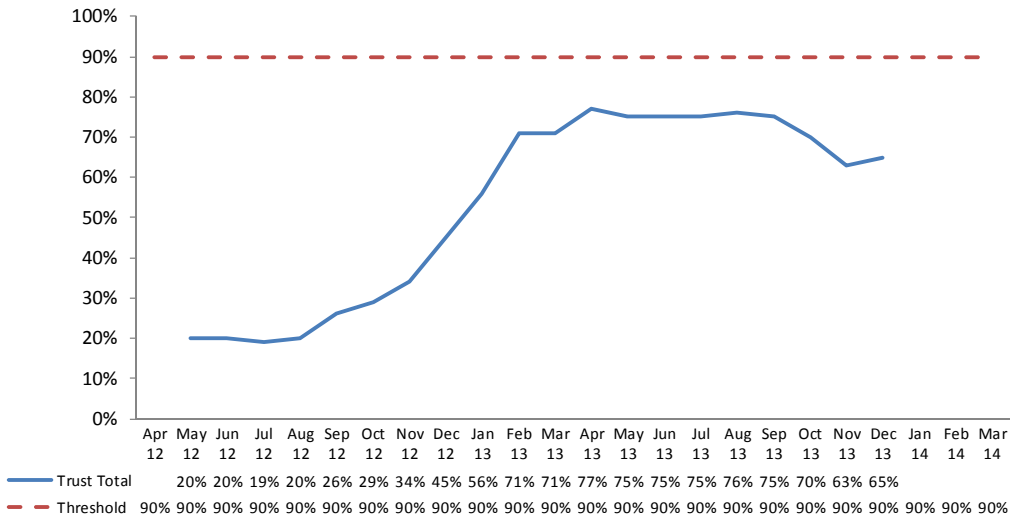
Staff Appraisal

Change

Quality Indicators

	Local Threshold	Oct 13	Nov 13	Dec 13
Trust Total	90%	70%	63%	65%

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



A new appraisal performance action plan is now in place, and divisions are now receiving more detailed reports. The target is to achieve 85% compliance by 31 March 2014. There will be improved performance management and accountability of managers to performance manage compliance of their staff, with 'deep dive' reporting at Executive Team, Trust Operational Board, Divisional Management Teams and other sub-groups. The new appraisal framework ('Potential & Performance') will be in place for 2014/15; linked to pay progression. This is being developed in partnership with University College London Hospitals NHS Foundation Trust (UCLH) and the London Human Resources (HR) /Organisational Development (OD) Network.)

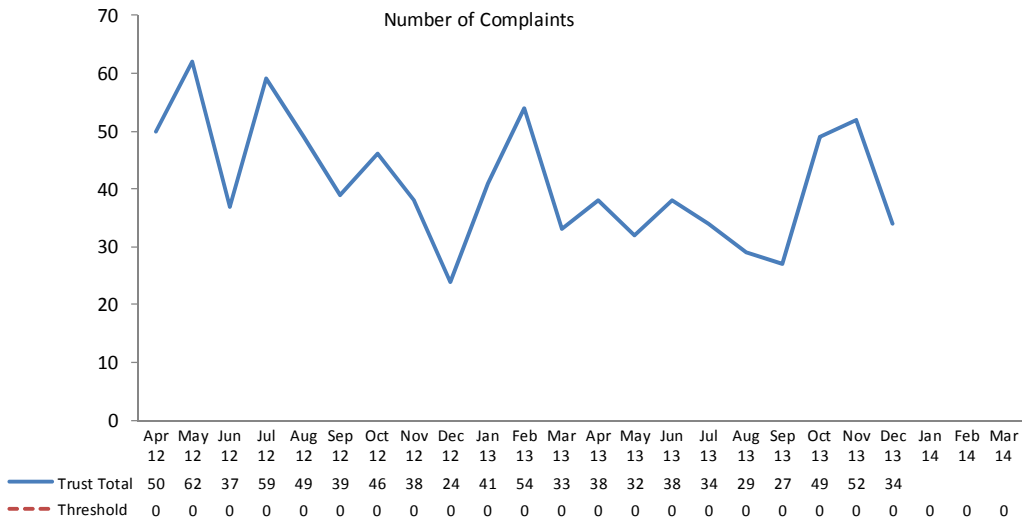
Complaints

Ensure

Quality Indicators

	Complaints				Responded to in 25 days		
	Threshold	Oct 13	Nov 13	Dec 13	Sep 13	Oct 13	Nov 13
Trust Total	0	49	52	34	48%	45%	27%

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



Performance against the target response time of 25 days remains poor. A detailed review of processes at both corporate and divisional level has been undertaken and a robust action plan has been implemented. There is an executive-led weekly review meeting with the divisional responsible officers and head of patient experience to highlight progress and problems and provide solutions. Both the Chief Operating Officer and Director of Nursing have given a commitment that the target will be met by the end of March 2014. Additional resource has been provided to both divisional teams and the complaints team to address the issues.

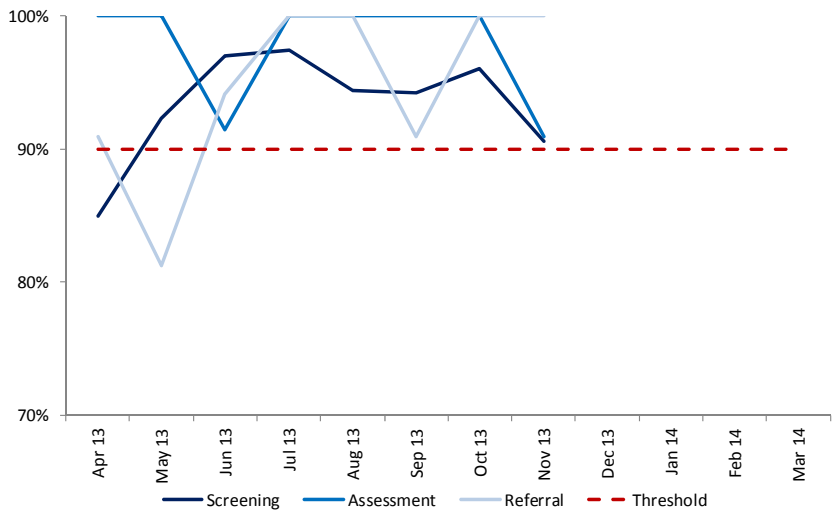
National CQUINs

Integrate

Quality Indicators

Dementia

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



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

Data is one month in arrears

Achieving target. Clarity from commissioners is currently being sought in relation to the rules for achievement. At present, documentation received suggests that 90% of patients aged over 75 years admitted non-electively for 72 hours+ should be screened, assessed and reviewed. The metric is monitored monthly, Commissioning for Quality and Innovation (CQUIN) Co-ordinator (currently vacant), CQUIN Clinical lead and CQUIN Delivery Board (chaired by COO).

Specialist Commissioning CQUINs

Deliver

Quality Indicators

NICU	Year End Target	Apr	May	Jun	Q1	Jul	Aug	Sep	Q2	Oct	Nov	Dec	Q3
Improve Access to Breast Milk in Preterm Infants	62%	100%	0%	57%	60.0%	50.0%	67.0%	33.0%	61%	50%	43%	88%	57%
Timely Administration of Total Parenteral Nutrition in Preterm Infants	95%	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	Q3
Optimising Pathways	-	Report Submitted	Report Submitted	Report Submitted
Physical Healthcare	-	Report Submitted	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.

Neonatal Intensive Care Unit (NICU) action plan developed for both CQUINs in November, key actions include increasing staff awareness, instigating checks and reminders.
These CQUINs are more pathway specific, making these easier to perform and monitor. All areas are being monitored and reported to commissioner. We expect to be paid in full based on current performance. Performance is being monitored by CQUIN Delivery Board (chaired by COO).

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								

Stop Smoking – inpatient assessment being met; some clarification being south from CCGs on outpatients, assumed being met.
Alcohol Harm – continuing with screening action plan agreed that was put in place in November. Daily individualised reports on number of screens and addressing under performance through supervision. Scratch cards in place and screening is now universal, as opposed to previous targeted screening. Further work to ensure this data is collected is required in preparation for next year's contract. Monitored by CQUIN Delivery Board (chaired by COO), supported by CQUIN Co-ordinator and clinical leads.

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%

COPD – all CQUIN targets are being met. Led and monitored by CQUIN Delivery Board (chaired by COO).

Integrated Care – metrics monitored monthly by CQUIN Delivery Board and predominately on track. Work underway to establish shortfall in Islington, led by the clinical team.

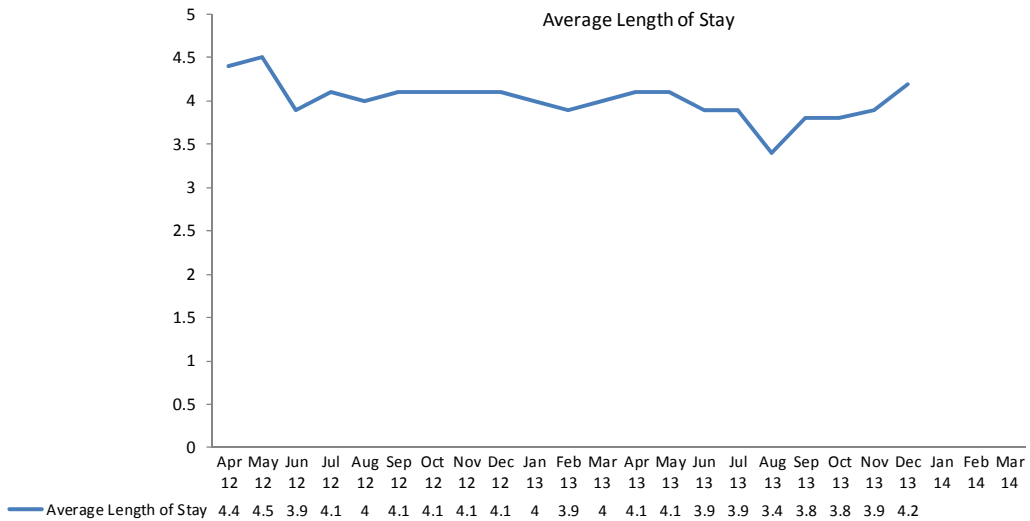
Average Length of Stay (days)

Deliver

Quality Indicators

	Threshold	Apr 13	May 13	Jun 13	Jul 13	Aug 13	Sep 13	Oct 13	Nov 13	Dec 13
Trust Total (days)	tbc	4.1	4.1	3.9	3.9	3.4	3.8	3.8	3.9	4.2

Average length of stay for patients within a given month



Further investigation to be carried out using peer group benchmarking.

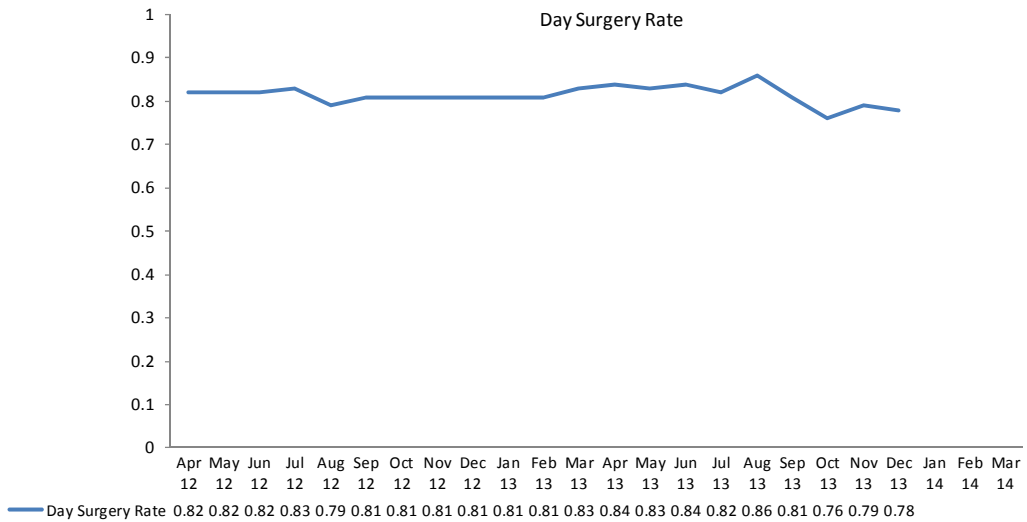
Day Surgery Rate

Deliver

Quality Indicators

	Threshold	Apr 13	May 13	Jun 13	Jul 13	Aug 13	Sep 13	Oct 13	Nov 13	Dec 13
Trust Total	n/a	84%	83%	84%	82%	86%	81%	76%	79%	78%

Proportion of total elective surgeries carried out as a daycase



Further investigation to be carried out using peer group benchmarking.

Activity

Deliver

Finance & 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

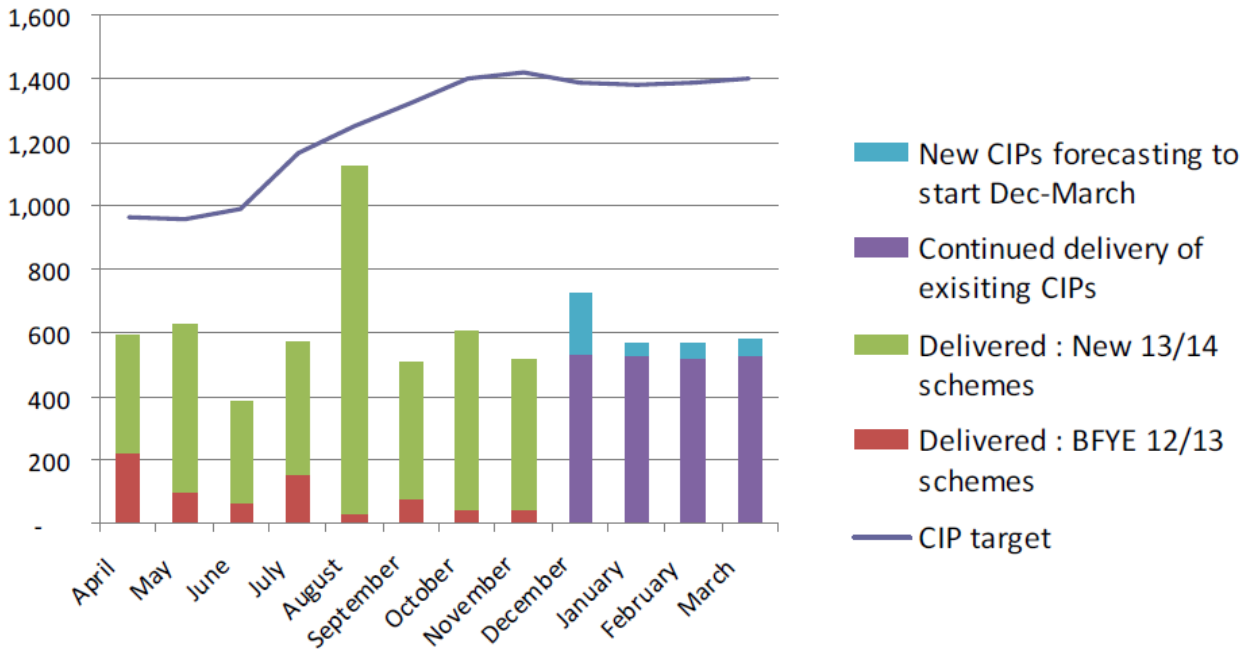
Division		Month 8			Year to Date		
		Actual	Budget	Variance	Actual	Budget	Variance
		£'000	£'000	£'000	£'000	£'000	£'000
Integrated Care & Acute Medicine	Income	1,514	966	548	9,774	7,634	2,140
	Expenditure	8,066	6,678	(1,388)	60,061	53,643	(6,418)
	Total	**(6,552)**	**(5,712)**	**(840)**	**(50,287)**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

Divisional finance performance shows most areas to be below target levels. This is the consequence of cost pressures resulting from Referral to treatment (RTT) and A&E four-hour wait targets delivery and the increasing acuity of patients, which have all led to increased costs. In addition, under-delivery against CIP targets have caused overspends against the budgets. Further targets have been established to mitigate the position, together with discussions with clinical commission groups (CCGs) to recognise contract over performance.

CIP Year to Date and Forecast

Deliver

Finance & Activity



CIP remains 50% below target. Further savings targets established across all divisions. Performance monitoring of this target is monthly through the finance team. Performance is monitored by the CIP Steering Group, led by Chief Finance Officer and Chief Operating Officer. Further development of CIP development, planning and implementation is underway as part of the 2014/15 Planning process –will be further covered in the Operational Plan paper to the February meeting of the Trust Board.