Whittington Health NHS

Trust Board Report

March 2014
(January data)

Highlights

Focus Areas

Overall Operational performance of Whittington Health
•The enhance recovery and improvement plan are showing improvements across Whittington Health
•Friends and Family test is providing rich feedback for improving our services
•Improvements in Emergency, out patients and planned care pathways are being seen
•Three indicator that have been cause for concern will be reviewed at the board meeting, these being Complaints response times. Theatre utilisation and OPD DNA percentages
•Continues efforts are underway to improve HR indicators within new processes and reporting being implemented

Integrated Care and Acute Medicine Division
•TB Service – WH was chosen to be the site for the main provider of TB services for the South Hub. Working closely with UCLH and the North Hub this is a great example of integration of services across the sector. The new TB service is due for opening on 1 April 2014.
•Endoscopy – WH won the bid to work in partnership with UCLH to provide Bowel Scope Screening Service. The programme is due to start in April 2015. This is a great opportunity for the WH to expand on its already thriving Endoscopy service.

Surgery, Cancer and Diagnostics Division
•Pilot two areas for First to Follow-Up ratio reduction e.g. Dermatology and Urology

Women, Children and Families Division
•Un-outcomed appointments improving
•Service Managers more engaged with data collection. Weekly assurance in DMT.
•Audiology improved attendance.
•Community Non-RTT Patient Tracker List is now in place.

Board Aims

Focus Areas

All indicators have been mapped to the Board Aims

First:Follow-Up Ratio - Acute

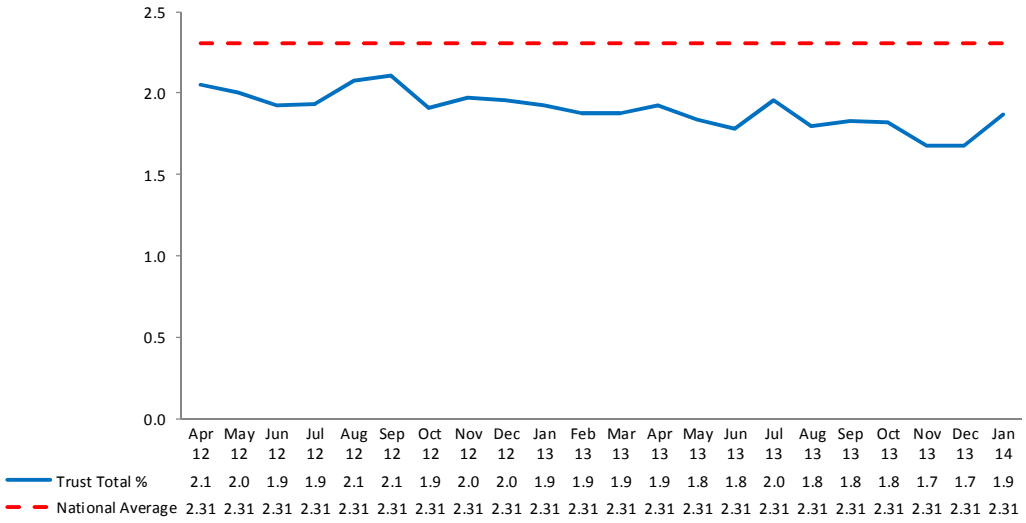
Deliver

Focus Areas

	Transformation Board Threshold	Apr 13	May 13	Jun 13	Jul 13	Aug 13	Sep 13	Oct 13	Nov 13	Dec 13	Jan 14
Acute Trust Total	-	1.93	1.84	1.78	1.96	1.80	1.83	1.82	1.68	1.68	1.87

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



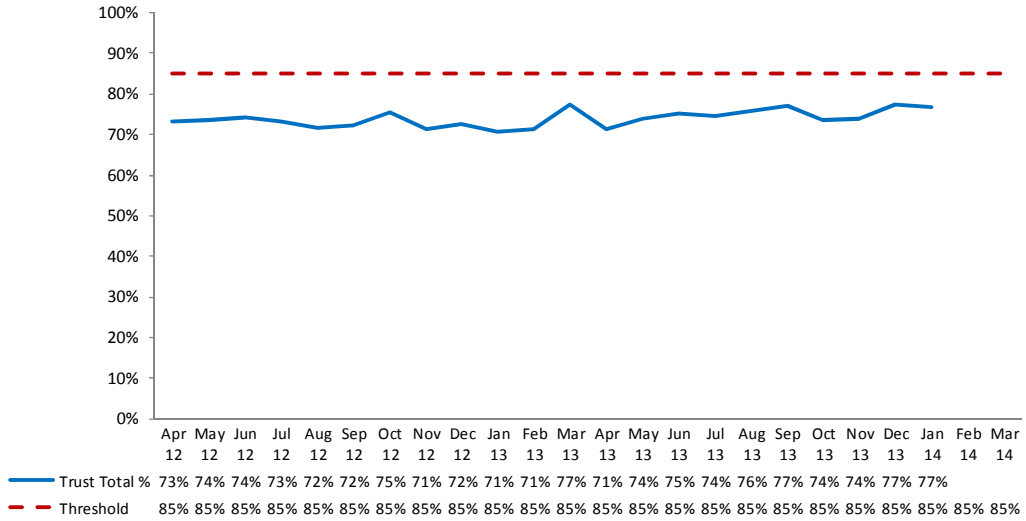
Work continues with the WH ICO-wide improvement plans, scheduled for completion in April. Divisions are identifying services to run pilot improvement schemes. Background work completed to enable front-line clinicians to increase referrals back to primary care.

Theatre Utilisation

Deliver

Focus Areas

	Utilisation			Available Session Time (Minutes)			Time Utilised (Minutes)		
	Nov 13	Dec 13	Jan 14	Nov 13	Dec 13	Jan 14	Nov 13	Dec 13	Jan 14
Local Threshold	>85%								
Trust Total	74%	77%	77%	64,650	54,450	67,650	47,848	42,191	51,993



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.

Work continues on theatre utilisation improvement plan, with projection of 85% by the end of March. Local reporting indicates February performance has improved over 80%. Productive Theatre module is being implemented to action improvement, list percentage booked is increasing weekly and lists continue to be closed if not filled at three weeks.

Community Data Quality

Deliver

Focus Areas

The activity presented in the dashboard is extracted from the Community information system, RiO.
Audiology information is extracted from Auditbase.
Sexual Health information is extracted from Lille.

There is a project underway to improve the data held in the system, but managers should be aware that there may be data anomalies contained in these reports.

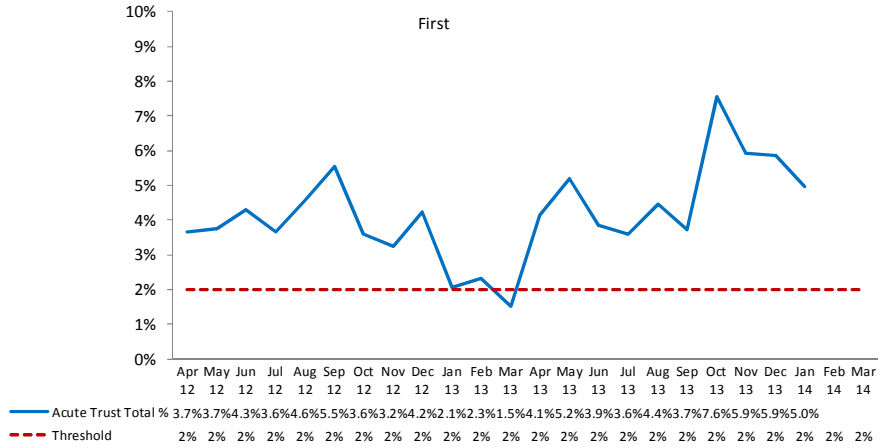
Hospital Cancellations - Acute

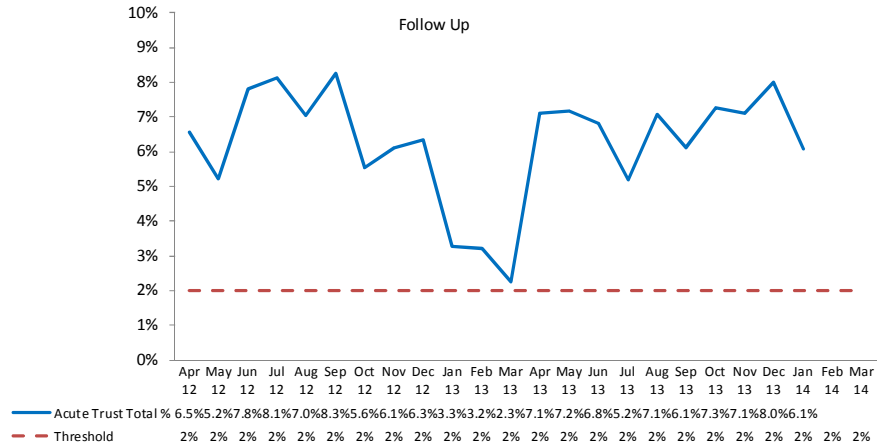
Deliver

Focus Areas

	First Appointments			Follow Up Appointments		
	Nov 13	Dec 13	Jan 14	Nov 13	Dec 13	Jan 14
Local Threshold	<2%			<2%		
Acute Trust Total	5.9%	5.9%	5.0%	7.1%	8.0%	6.1%

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





Divisions are identifying services to run pilot improvement schemes. Actions are to ensure clinics are not cancelled due to short notice consultant leave and train staff to maintain clinics in advance.
EPR coding to be adjusted to identify administration errors which will be reflected in future reporting. Notices are going to divisional boards to remind consultant staff of the policy for cancellations and annual leave planning.

Service Cancellations - Community

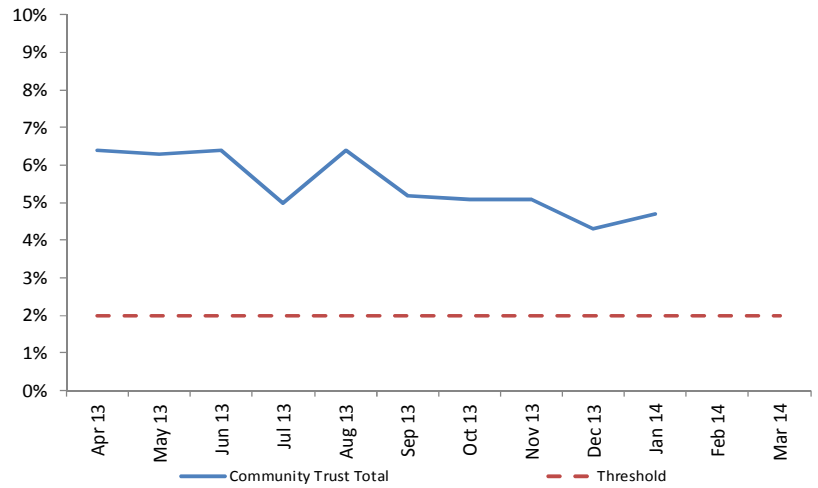
Integrate

Focus Areas

First + Follow-Up

	Apr 13	May 13	Jun 13	Jul 13	Aug 13	Sep 13	Oct 13	Nov 13	Dec 13	Jan 14
Local Threshold	2%									
Community Trust Total	6.4%	6.3%	6.4%	5.0%	6.4%	5.2%	5.1%	5.1%	4.3%	4.7%

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.



WCF have seen an increase in service cancellations in January.
A draft Standard Operating Procedure (SOP) on appointments is being reviewed as an element of the community action plan, and will be rolled out in March 2014.

DNA Rates - Acute

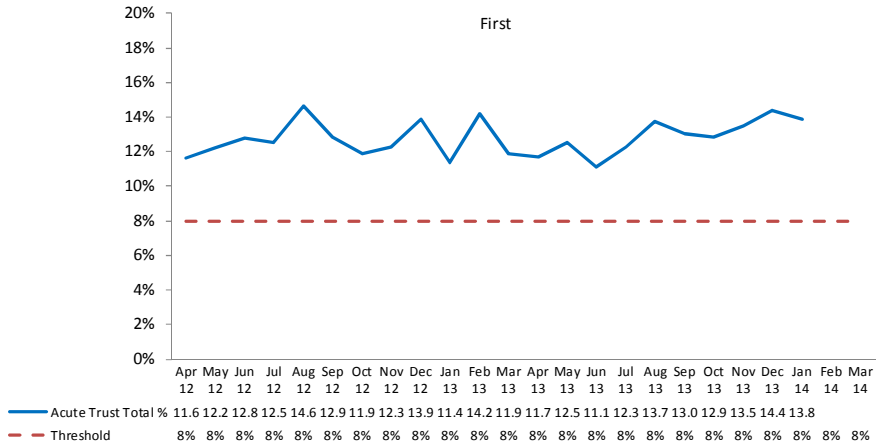
Deliver

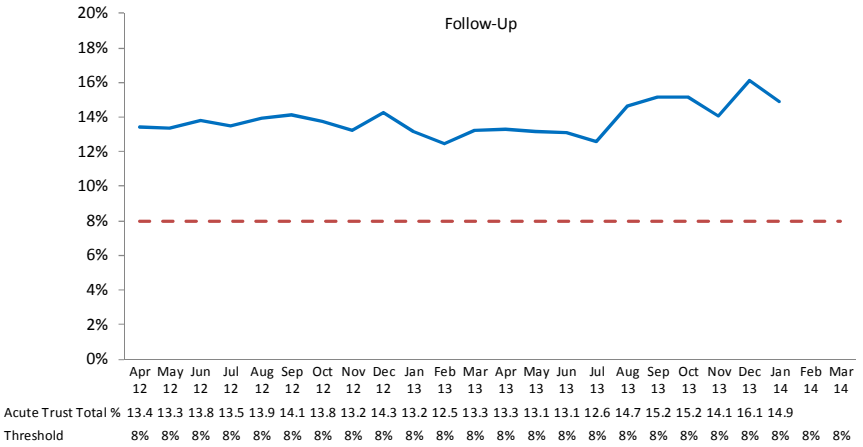
Focus Areas

	First Appointments			Follow Up Appointments		
	Nov 13	Dec 13	Jan 14	Nov 13	Dec 13	Jan 14
Local Threshold	8%			8%		
Acute Trust Total	13.5%	14.4%	13.8%	14.1%	16.1%	14.9%

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





Work continues with the WH ICO-wide improvement plans, scheduled for completion in April. Divisions are identifying services to run pilot improvement schemes. Actions are to ensure staff are adhering to SOPs in line with trust access policies and text reminders for patients in a timely manner. As improvements are being implemented an increase may be seen following the introduction of new practices. WH have seen a reduction in outpatient DNAs of 2,103 (5.4%) for April – January 2013/14 against the same period in 2012/13.

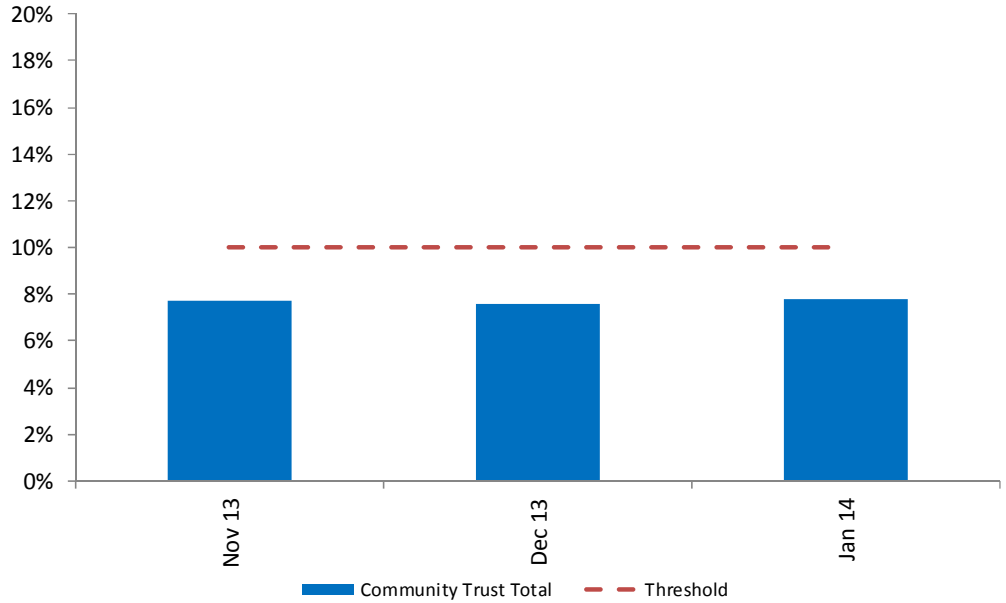
DNA Rates - Community

Integrate

Focus Areas

First + Follow-Up

	Nov 13	Dec 13	Jan 14
Local Threshold	10%		
Community Trust Total	7.7%	7.6%	7.8%



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.

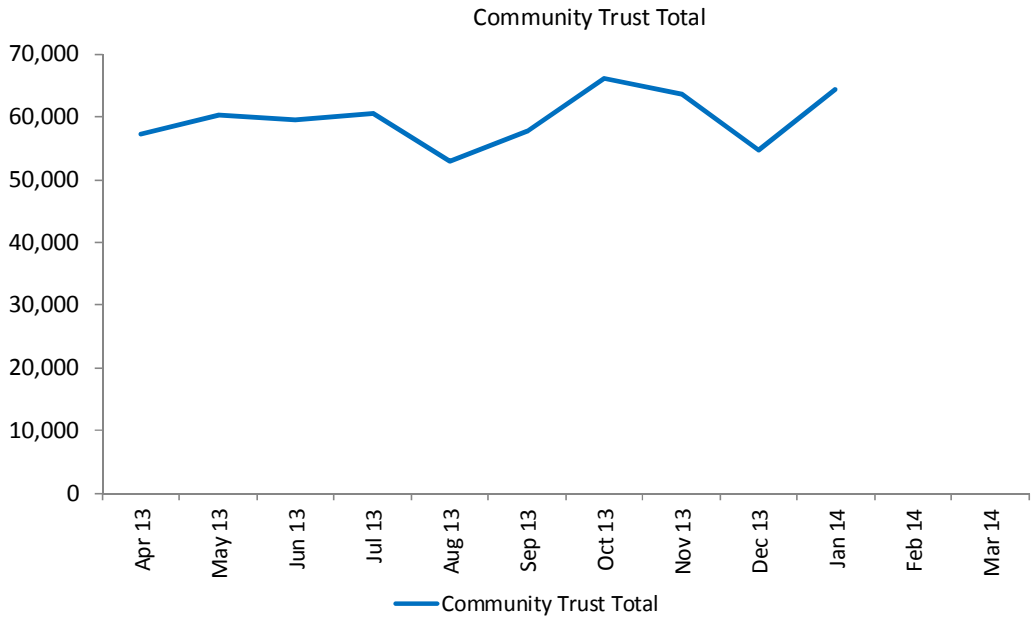
Work continues with the WH ICO-wide improvement plans, scheduled for completion in April. Services that can demonstrate improvements are sharing learning at divisional management team meetings. As improvements are being implemented an increase may be seen following the introduction of new practices.

Community Face-to-Face Contacts

Integrate

Focus Areas

	Nov 13	Dec 13	Jan 14	2012/13 Apr - Jan	2013/14 Apr - Jan	Variation
Threshold	n/a			n/a		
Community Trust Total	63,465	54,568	64,221	530,234	596,818	13%



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

Community contacts saw a increase in January of an extra 9,653 contacts. This contributes to an increase of 13% on year to date activity against the same period in 2012/13.
Work is to be done to produce phased activity plans for monitoring in 2014/15.

Community Appointment with no outcome

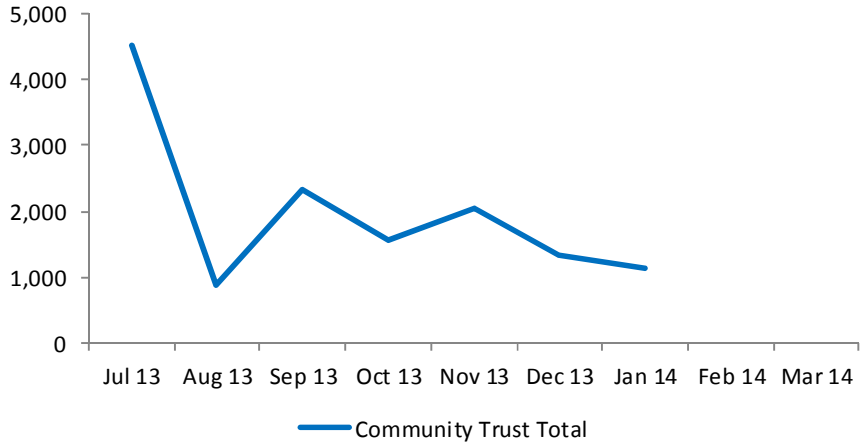
Integrate

Focus Areas

	Nov 13	Dec 13	Jan 14
Local Threshold	n/a		
Community Trust Total	2,031	1,346	1,147

% of Total Face-to-Face Contacts		
Nov 13	Dec 13	Jan 14
0.5%		
3.2%	2.5%	1.8%

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.



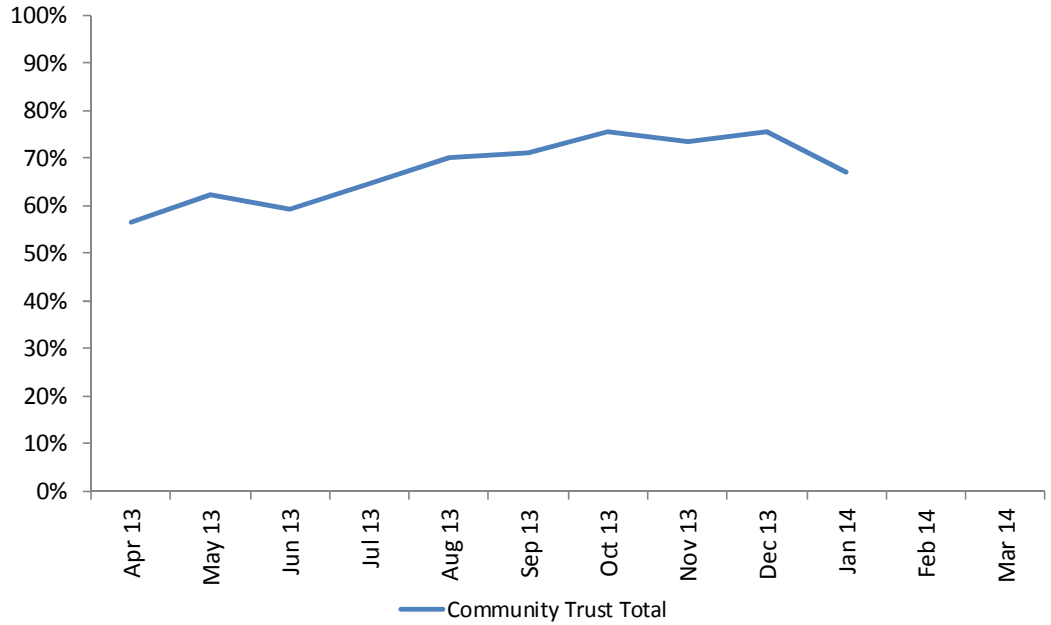
Improvements are being seen in community appointments with no outcome, however further efforts are required to move from the current 1.8% to the 0.5% local threshold. Divisions have implemented reminders to service managers two days in advance of the data deadline and a SOP is being developed to streamline the process.

Community Waiting Times
% waiting less than 6 weeks

Integrate

Focus Areas

	Nov 13	Dec 13	Jan 14
Threshold	n/a		
Community Trust Total	73.4%	75.4%	67.2%



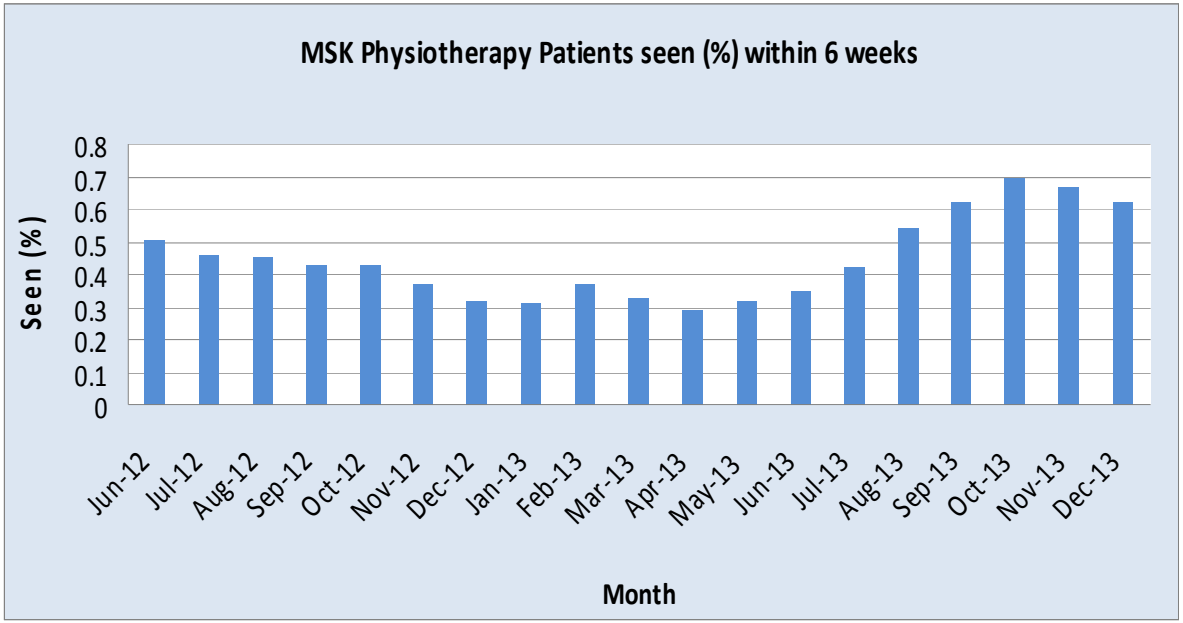
The percentage of patients waiting less than 6 weeks for attended 'Face to Face' initial appointments. The waiting time from the date the referral was received to the initial attended 'Face to Face' contact is measured for the month. Where patients DNA the waiting time is measured as the time between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

January saw a decrease in the percentage of patients waiting less than six weeks for a community appointment, at 67.2%. A community PTL has been developed for non-RTT pathways and is updated weekly for local monitoring of waiting times. Similarly a community PTL for RTT pathways has been developed in draft form.

MSK Waiting Times
% waiting less than 6 weeks

Integrate

Focus Areas



The percentage of patients waiting less than 6 weeks for attended 'Face to Face' initial appointment. 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.

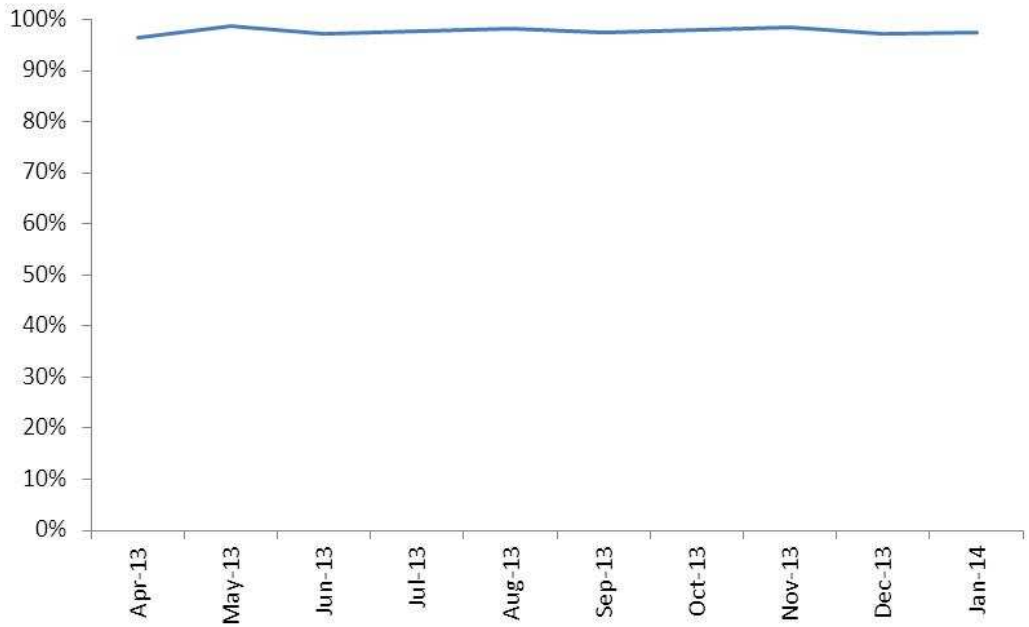
62% of patients seen in December 2013 had waited 6 weeks or less. Over the Christmas and New Year period there was a significant reduction in capacity to accommodate staff leave. Resources were pooled to the larger sites to maximise appointment availability, however there were many cancellations, re-bookings and DNAs due to the holiday season. Although appointment slots were available it was difficult to fill all appointment slots.
Patients with multiple referrals are seen by the same physiotherapist and this means that the second or third referral cannot be picked up until the first episode has been closed/completed. (January data is currently being validated by the service).

District Nursing Waiting Times
% waiting less than 6 weeks

Integrate

Focus Areas

	Nov-13	Dec-13	Jan-14
Threshold	n/a		
Community Trust Total	98.5%	97.2%	97.4%



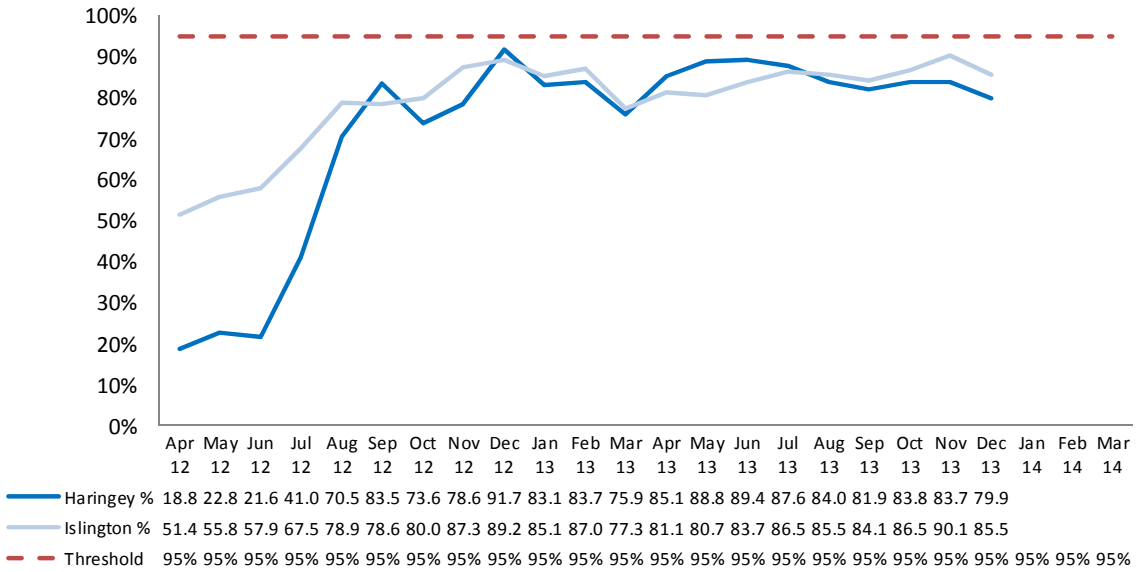
The percentage of patients waiting less than 6 weeks for attended 'Face to Face' initial appointments. The waiting time from the date the referral was received to the initial attended 'Face to Face' contact is measured for the month. Where patients DNA the waiting time is measured as the time between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

New Birth Visits

Integrate

Focus Areas

	Apr 13	May 13	Jun 13	Jul 13	Aug 13	Sep 13	Oct 13	Nov 13	Dec 13
Local Threshold	95%								
Haringey	85.1%	88.8%	89.4%	87.6%	84.0%	81.9%	83.8%	83.7%	79.9%
Islington	81.1%	80.7%	83.7%	86.5%	85.5%	84.1%	86.5%	90.1%	85.5%



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

RADAR Report Numbers:
Islington: 2262
Haringey Children 2267

Data is 1 month in arrears

December saw a decrease in the percentage of new birth visits completed against the local threshold, at 79.9%.
However this was expected due to the Christmas period and availability of families.
Health Visiting students started in January 2014 and this is expected to have an adverse affect on performance.

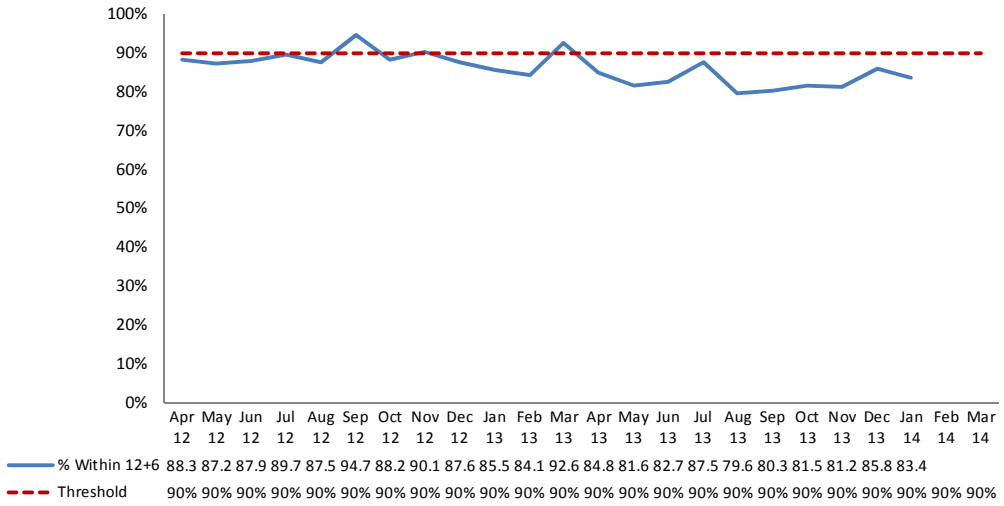
Women seen by HCP or Midwife within 12 weeks and 6 days

Deliver

Focus Areas

	Threshold	Apr 13	May 13	Jun 13	Jul 13	Aug 13	Sep 13	Oct 13	Nov 13	Dec 13	Jan 14
% 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%	83.4%
Total Number of Bookings	-	374	404	359	421	376	369	375	359	339	384
Referrals within 12 Weeks and 6 days	-	323	347	312	359	324	319	324	330	302	338

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



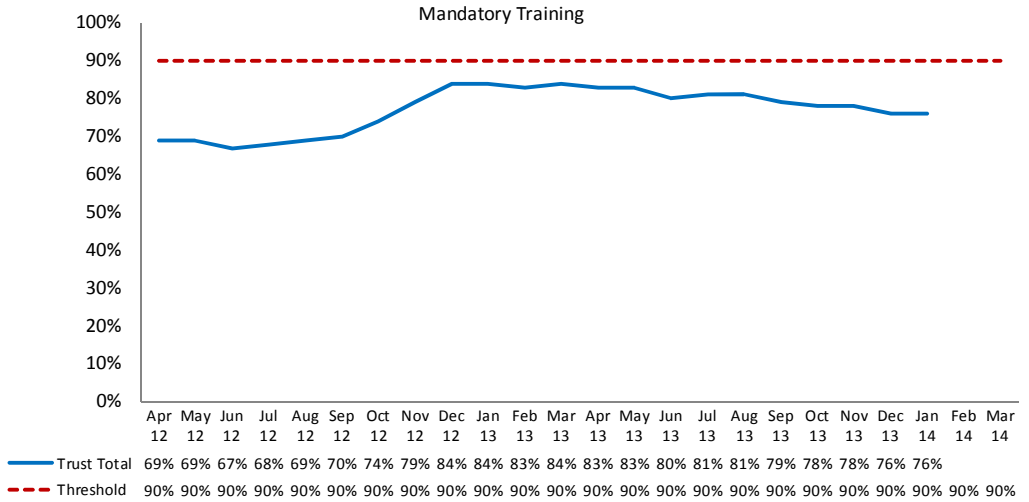
Performance has reduced in January however this is within standard variation. Data is still to be validated by the service. New Midwife Consultant focussing on Public Health issues is now in post and this is expected to improve future performance.

Mandatory Training Compliance

Change

Focus Areas

	Mandatory Training			Information Governance			Child Protection Level 2			Child Protection Level 3		
	Nov 13	Dec 13	Jan 14	Nov 13	Dec 13	Jan 14	Nov 13	Dec 13	Jan 14	Nov 13	Dec 13	Jan 14
Local Threshold	90%			95%			90%			90%		
Trust Total	78%	76%	76%	68%	68%	66%	63%	61%	63%	65%	68%	69%



Data snapshot date
29/01/2014

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

Compliance remains a priority and the actions reported last month enable the Trust to work towards the target of 90% compliance. A range of solutions have been in put in place including improved data management , the use of technology to make it easier for staff to complete the training through e enabled solutions and recently face to face training has been put in place with bank staff before they start working to speed up the process of completing the training. There have been a one day a week resource increase in the Safeguarding team to support timely recording of child protection training.

Referral to Treatment 18 weeks - Admitted

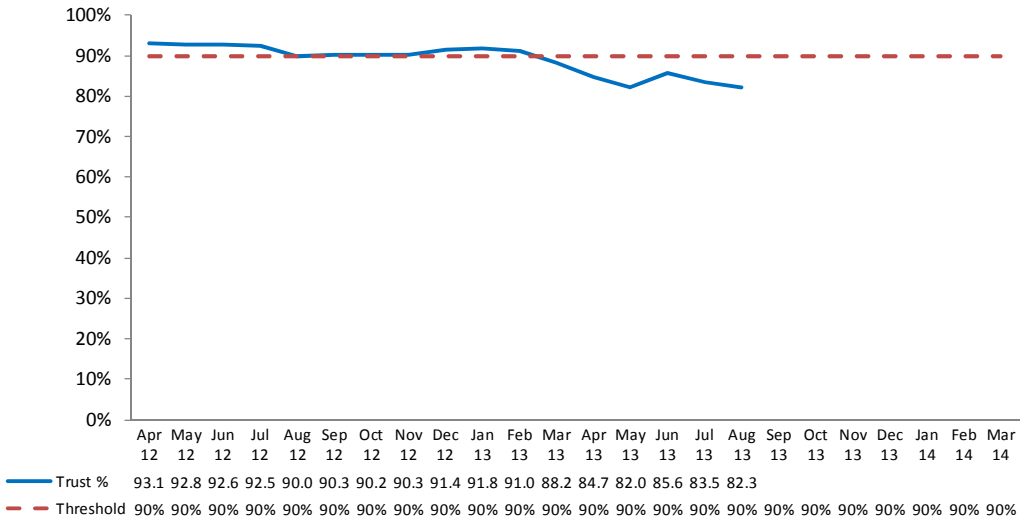
Deliver

Access Metrics

	Apr 13	May 13	Jun 13	Jul 13	Aug 13	Sep 13	Oct 13	Nov 13	Dec 13	Jan 14
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

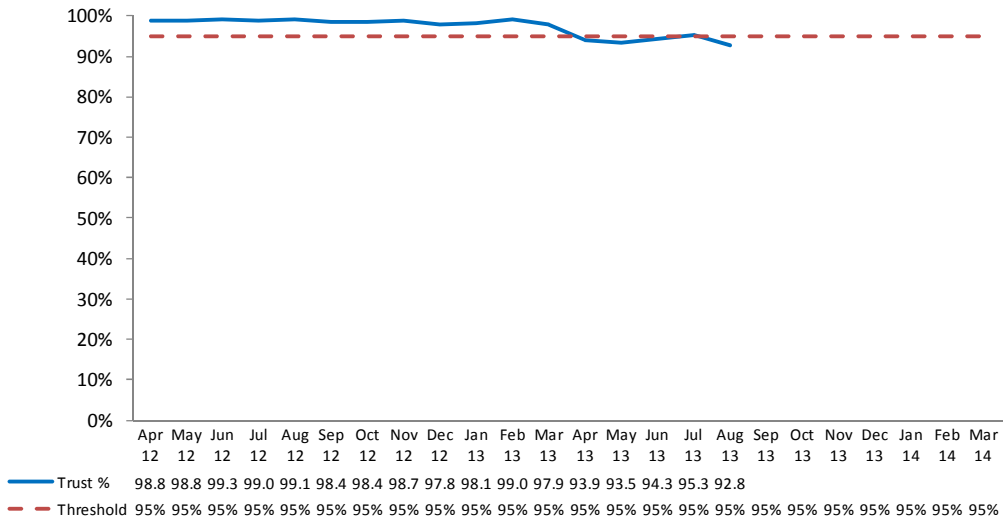
Deliver

Access Metrics

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

	Apr 13	May 13	Jun 13	Jul 13	Aug 13	Sep 13	Oct 13	Nov 13	Dec 13	Jan 14
National Threshold	>95%									
Trust Total	93.9%	93.5%	94.3%	95.3%	92.8%	-	-	-	-	-



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.

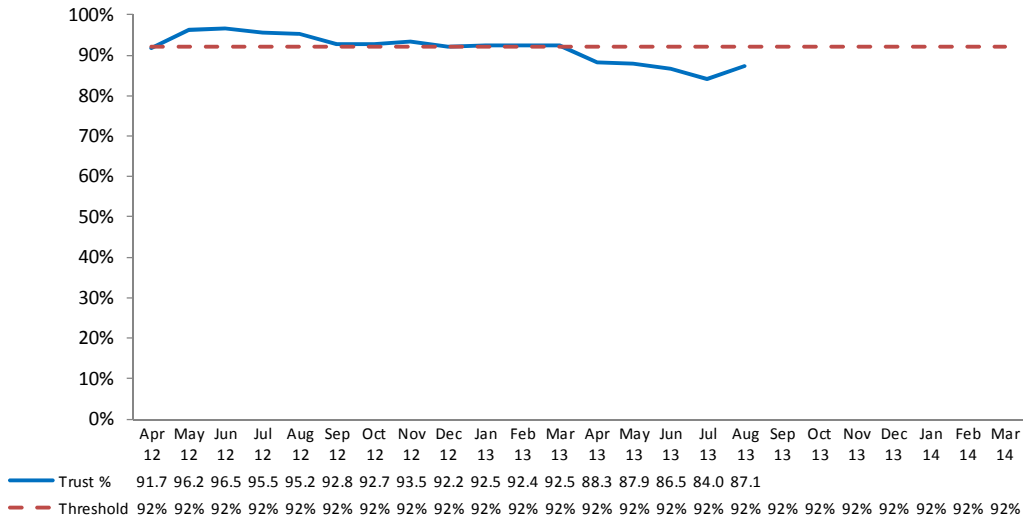
Referral to Treatment 18 weeks - Incomplete

Deliver

Access Metrics

Data currently unavailable due to EPR reporting Issues

	Apr 13	May 13	Jun 13	Jul 13	Aug 13	Sep 13	Oct 13	Nov 13	Dec 13	Jan 14
National Threshold	92%									
Trust Total	88.3%	87.9%	86.5%	84.0%	87.1%	-	-	-	-	-



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 – 52 Week Waits

Deliver

Access Metrics

Data currently unavailable due to EPR reporting Issues

	Apr 13	May 13	Jun 13	Jul 13	Aug 13	Sep 13	Oct 13	Nov 13	Dec 13	Jan 14
National Threshold	0									
Trust Total	0	61	23	41	22	-	-	-	-	-

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.
We have a simple PTL which demonstrates that no patients are waiting over 52 weeks.

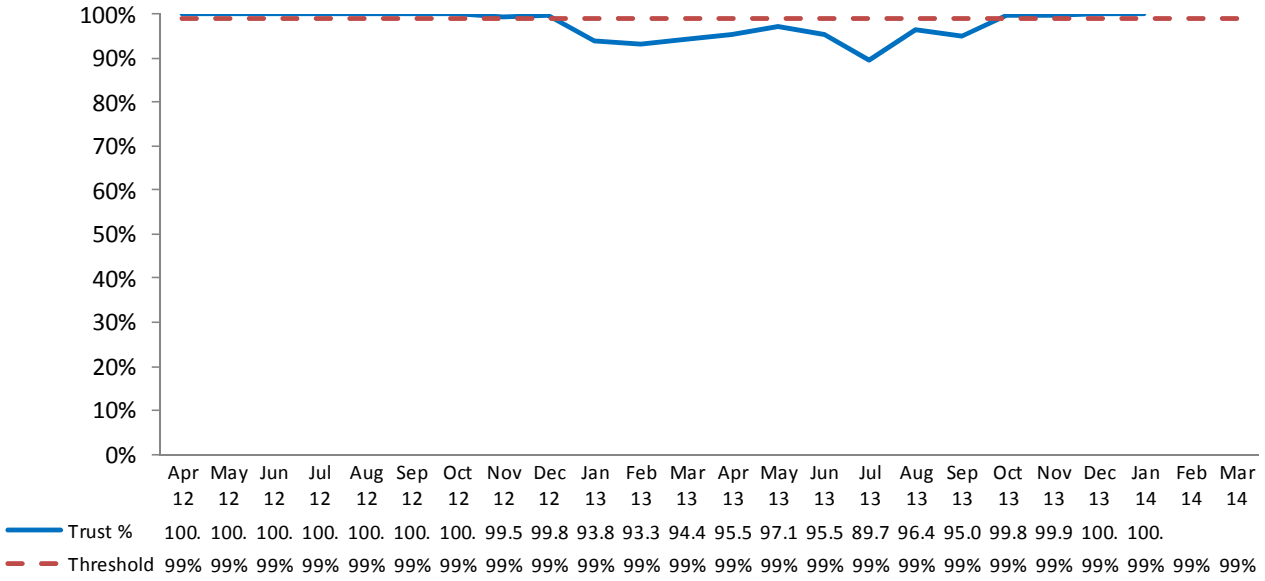
Diagnostic Waits

Deliver

Access Metrics

% Waiting <6 Weeks

	Apr 13	May 13	Jun 13	Jul 13	Aug 13	Sep 13	Oct 13	Nov 13	Dec 13	Jan 14
National Threshold	99%									
Trust Total	95.5%	97.1%	95.5%	89.7%	96.4%	95.0%	99.8%	99.9%	100.0%	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 the target for four consecutive months.

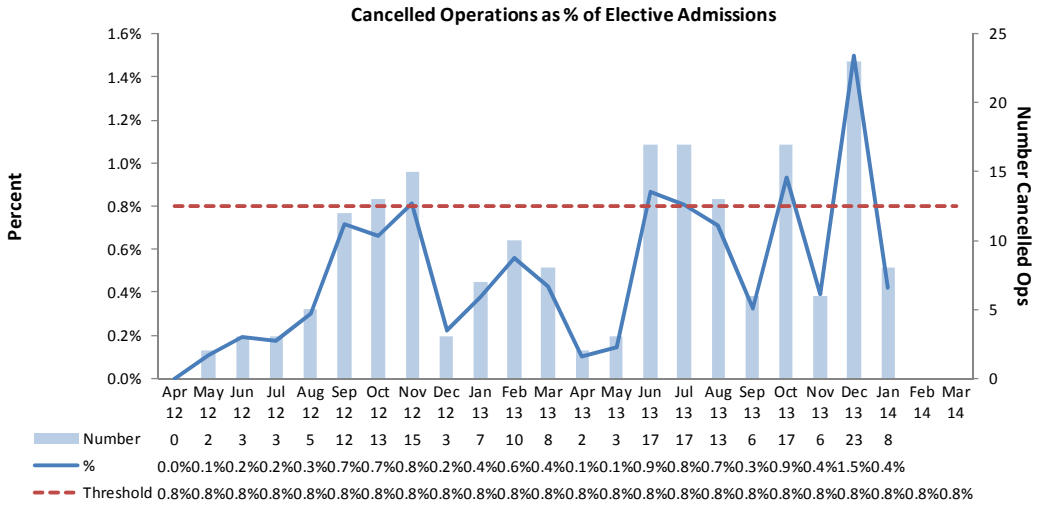
Hospital Cancelled Operations

Deliver

Access Metrics

Hospital initiated cancellations on day of operation

	Number of Cancelled Operations			Cancelled Operations as % of Elective Admissions		
	Nov 13	Dec 13	Jan 14	Nov 13	Dec 13	Jan 14
National Threshold	n/a			< 0.8%		
Trust Total	6	23	8	0.4%	1.5%	0.4%



The number of cancelled operations continues to reduce. All eight patients had their surgery either the next day or the next week depending on patient preference and consultant availability. The number of DNAs for theatre is also reducing, the most problematic area being Urology flexible cystoscopies. The process to record cancellations has been extended to include emergency operations, and reporting will be reflected in February data.

Emergency Department Waits

Deliver

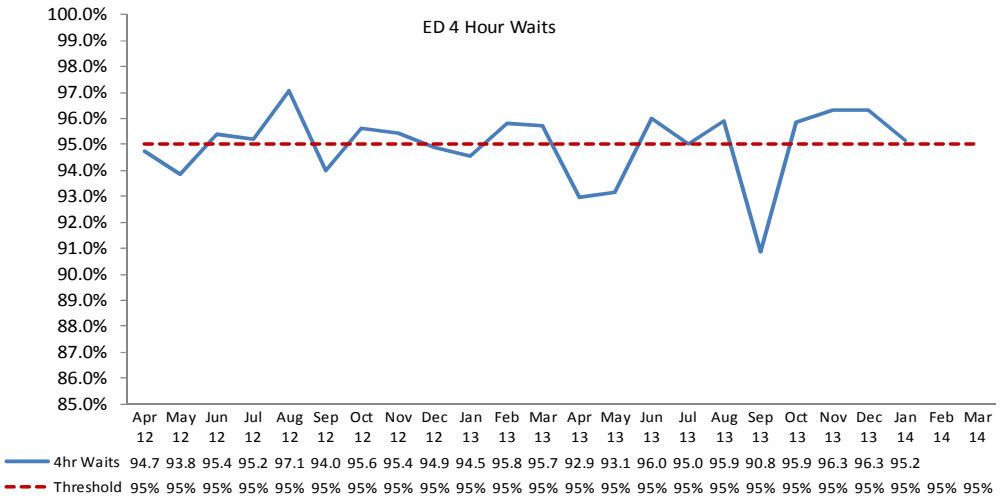
Access Metrics

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	Jan 14
National Threshold	95%									
4hr Waits	92.9%	93.1%	96.0%	95.0%	95.9%	90.8%	95.9%	96.3%	96.3%	95.2%
12hr Waits	0	0	0	0	0	1	0	0	0	1

Re-attendance rate indicator is not currently available



Clinical Quality Indicators	Nov 13	Dec 13	Jan 14
Total Time in ED (95th % Wait < 240 mins)	239	239	240
Total Time in ED - Admitted (95th % Wait < 240 mins)	364	425	650
Total Time in ED - Non-Admitted (95th % Wait < 240 mins)	236	235	236
Wait for Assessment (95th % Wait < 15 mins)	14	15	15
Wait for Treatment (Median <60 mins)	68	73	66
Left Without Being Seen Rate (<5%)	4.1%	4.6%	3.5%
Re-attendance Rate (>1% and <5%)	-	-	-

Achievement of four hour wait target for fourth consecutive month, year to date performance is at 94.74%. Need to deliver ~96.4% to achieve the threshold for the full year.
Refreshed performance improvement plan to ensure sharper focus on key areas including capacity/flow, time to treat and improved access. Plans are being developed for April and May as winter period will continue.

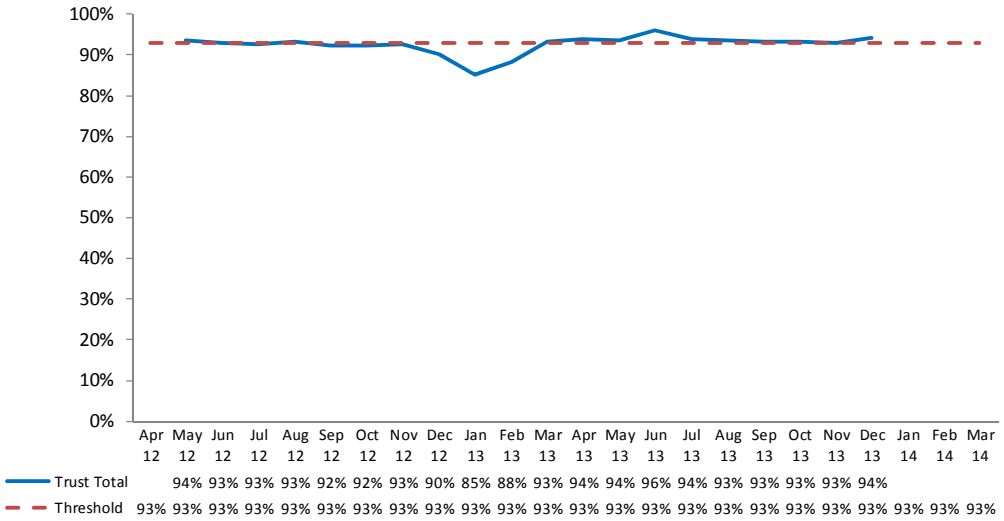
Cancer – 14 days to first seen

Deliver

Access Metrics

14 Days to First Seen

	Oct 13	Nov 13	Dec 13	Q1	Q2	Q3 TD	Q4
National Threshold	93%			93%			
Trust Total	93.2%	92.9%	94.12%	94.6%	93.5%	93.4%	-



14 day targets relate to patients referred from GP to hospital on a suspected cancer or breast symptoms pathway, timed from date of receipt of referral.

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

Achieved the threshold, however sustainable performance is dependant on patient choice policy being updated with Trust Development Authority (TDA) and Commissioner agreement.

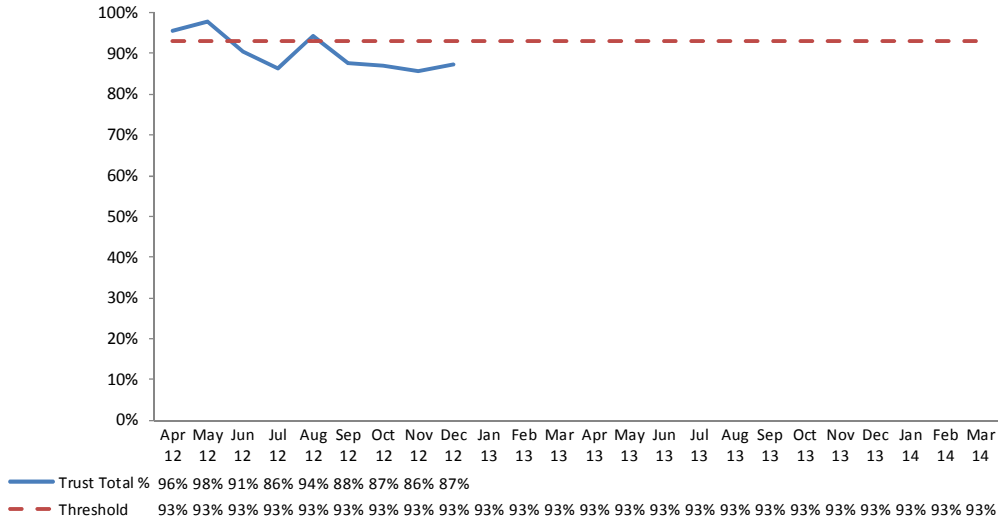
Cancer – 14 days to first seen – Breast symptomatic

Deliver

Access Metrics

14 Days to First Seen - Breast Symptomatic

	Oct 13	Nov 13	Dec 13	Q1	Q2	Q3 TD	Q4
National Threshold	93%			93%			
Trust Total	92.42%	95.1%	87.0%	88.2%	92.1%	91.6%	-



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 the standard was not achieved, with 87.0% performance. This was due to patient choice.
Sustainable compliance is dependant on patient choice policy being updated with Trust Development Authority (TDA) and Commissioner agreement.

Cancer – 31 Days to first treatment

Deliver

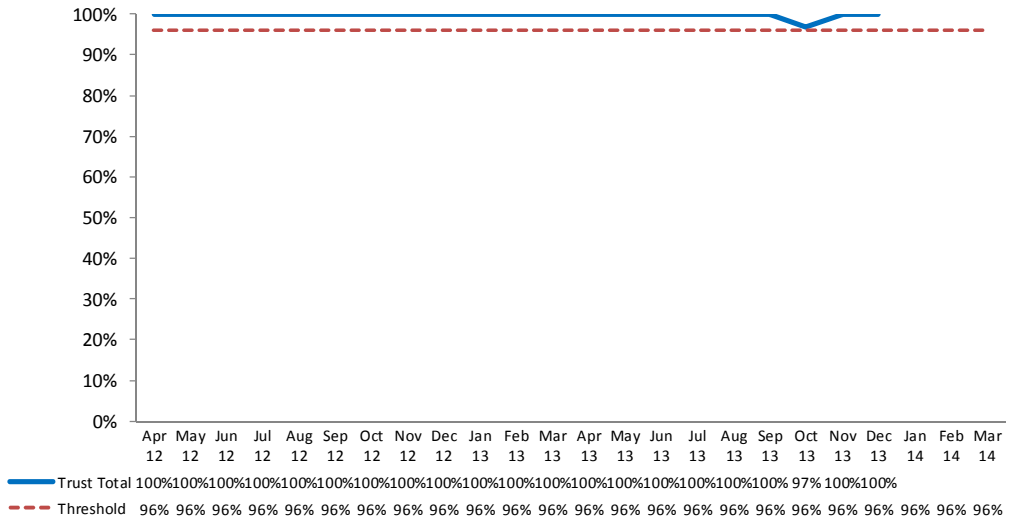
Access Metrics

31 Days to First Treatment

	Oct 13	Nov 13	Dec 13	Q1	Q2	Q3 TD	Q4
National Threshold	96%			96%			
Trust Total	97%	100.0%	100.0%	100%	100%	99.1%	-

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

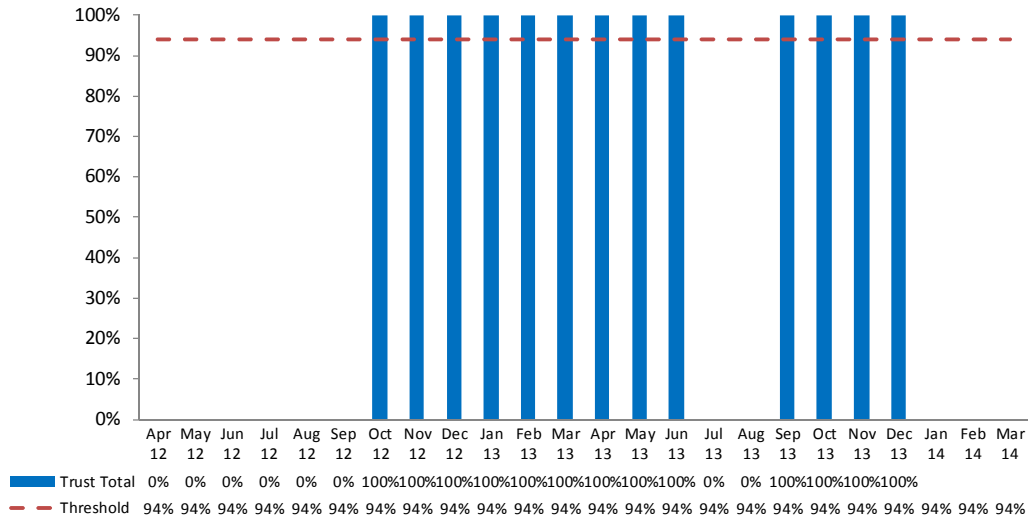
Access Metrics

31 Days to Subsequent Treatment - Surgery

	Oct 13	Nov 13	Dec 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.

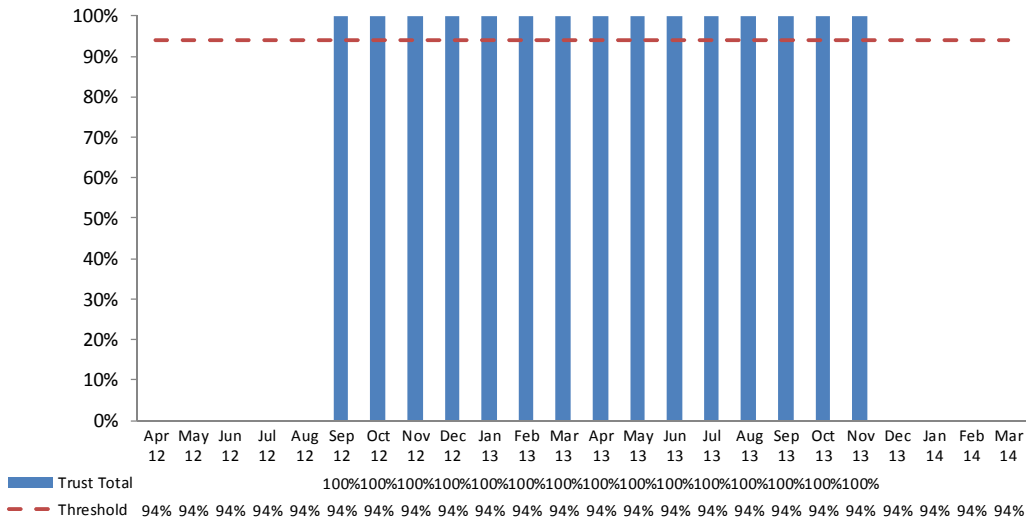
Cancer – 31 days to subsequent treatment - Drugs

Deliver

Access Metrics

31 Days to Subsequent Treatment - Drugs

	Oct 13	Nov 13	Dec 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

No patients reportable for this target in December.

Cancer – 62 days from referral to treatment

Deliver

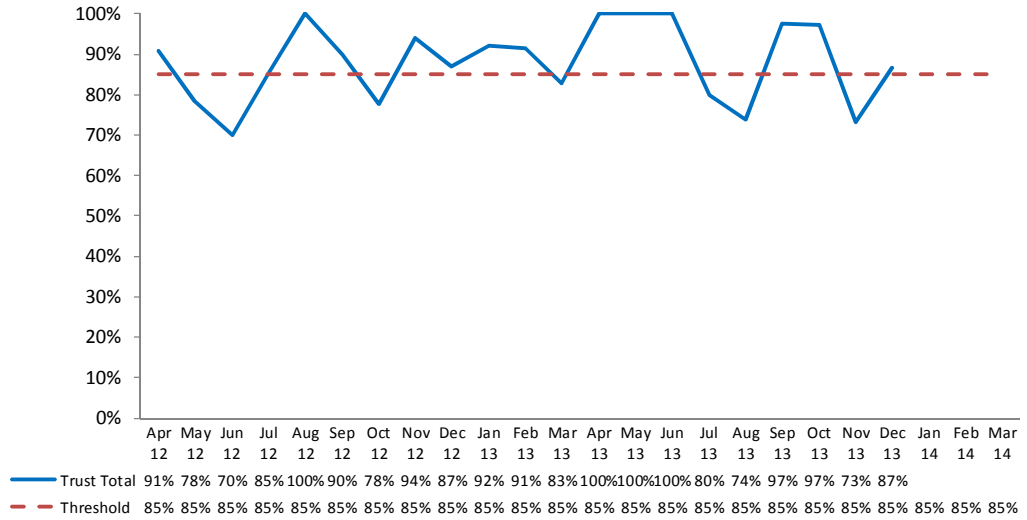
Access Metrics

62 Days from Referral to Treatment

	Oct 13	Nov 13	Dec 13	Q1	Q2	Q3 TD	Q4
National Threshold	85%			85%			
Trust Total	97.1%	73.2%	86.5%	100.0%	83.1%	85.2%	-

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

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



Trust is compliant this month at 86.5%, however treatment plans developed for Urology patients shows that there will be patients who's treatment plan is over the 62 day standard for January and February. Compliance to the standard will be in place for March. New prostate pathway has been approved by stakeholders and becomes operational at beginning of March 2014 and is essential to deliver sustainable compliance.

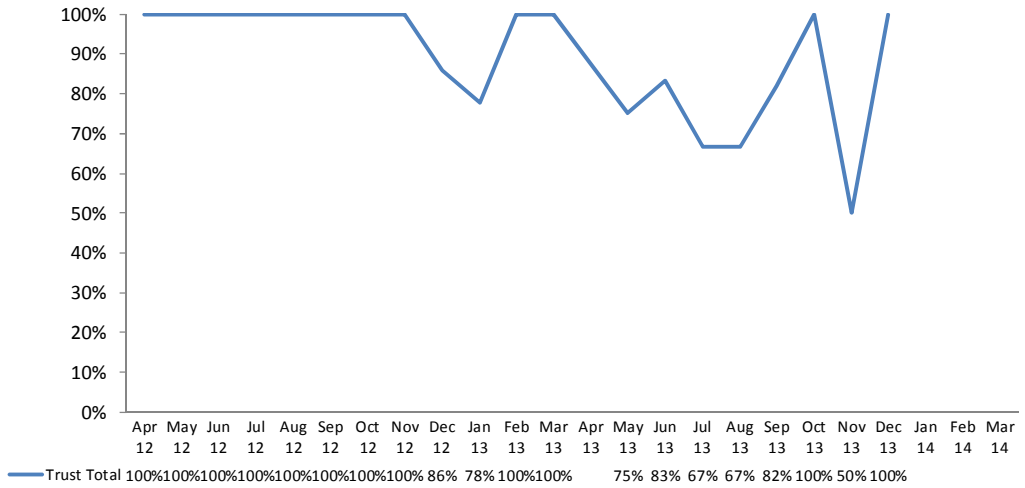
Cancer – 62 days from consultant upgrade

Deliver

Access Metrics

62 Days from Consultant Upgrade

	Oct 13	Nov 13	Dec 13	Q1	Q2	Q3 TD	Q4
Trust Total	100.0%	50.0%	100%	80%	72.4%	95.0%	-



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

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

Delivering 100% against this indicator, although there is no national standard.
Consultant upgrade procedure will change on 17 February 2014 in line with new Cancer Access Policy.
This will mean the patient will have to be upgraded by a consultant and not an automatic upgrade when a diagnostic test is requested as 'Target', as was previous custom and practice.

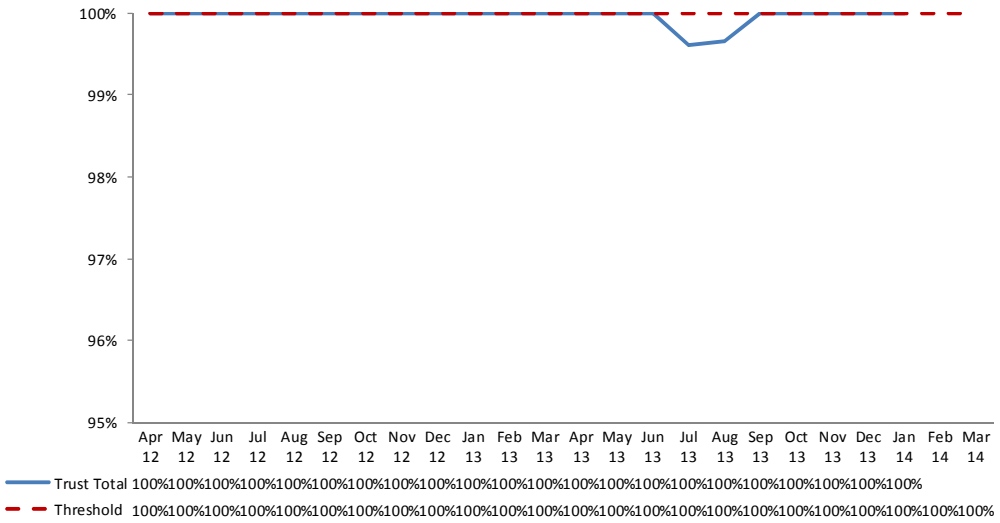
Genito-Urinary Medicine Appointment within 2 Days

Improving

Access Metrics

The percentage of patients offered an appointment within 2 days

	Threshold	Apr 13	May 13	Jun 13	Jul 13	Aug 13	Sep 13	Oct 13	Nov 13	Dec 13	Jan 14
Trust Total	100%	100%	100%	100%	99.6%	99.7%	100%	100%	100%	100%	100%



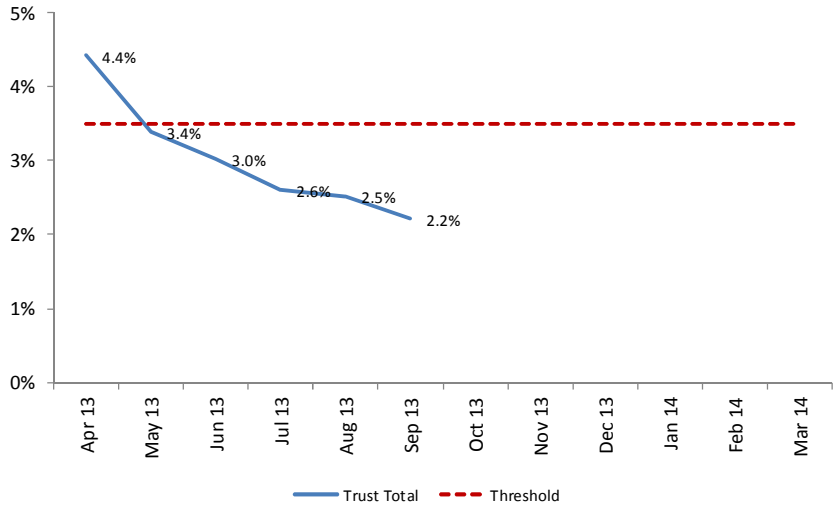
Delivering 100% compliance for the fifth consecutive month.

Delayed Transfers of Care

Integrate

Outcome Metrics

	Number of Days Delayed		
	Jan 14		
	NHS Days	Social Services	Both
Trust Total	150	51	0



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

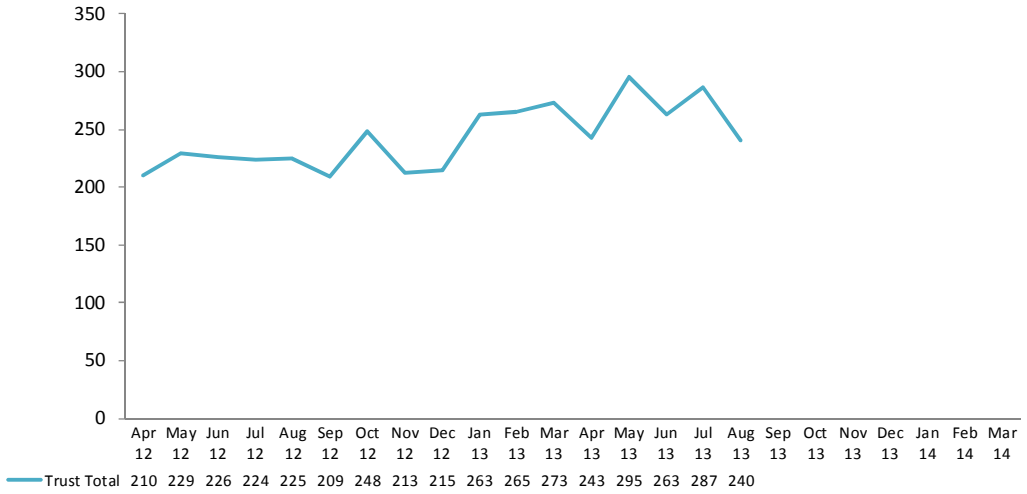
High performance maintained, actions include working with local authority partners and timely adherence to escalation policy, particularly for out of sector delays, and use of bed meetings to identify potential delays and resolve early where possible.

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.

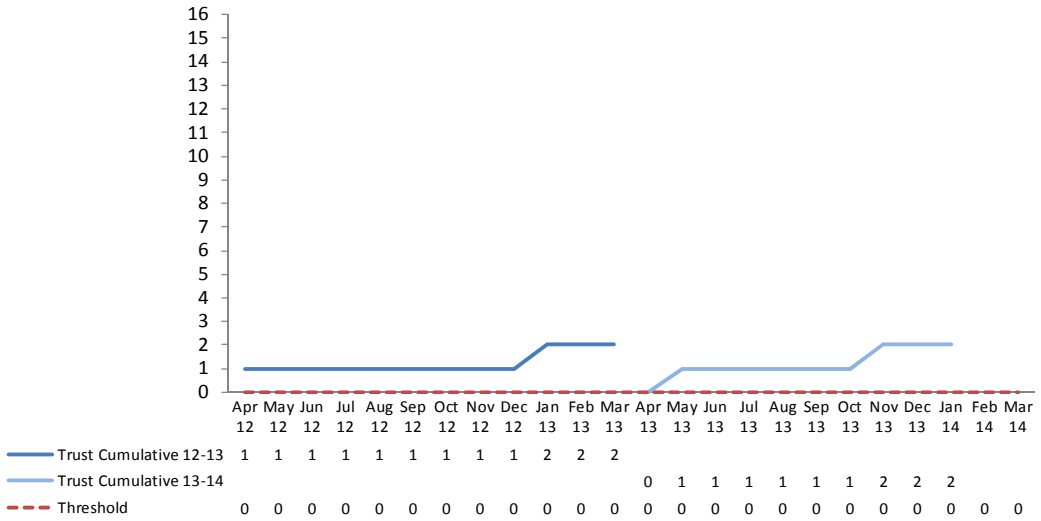
MRSA

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)



There were no cases reported in December, therefore the trust total remains at two cases year to date, against a zero tolerance threshold.

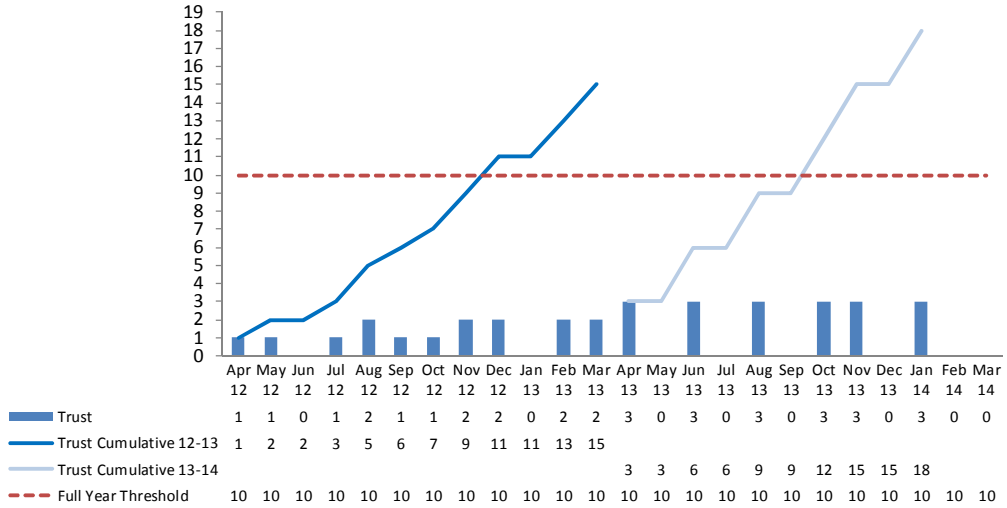
C Difficile Infections

Deliver

Outcome Metrics

	Apr 13	May 13	Jun 13	Jul 13	Aug 13	Sep 13	Oct 13	Nov 13	Dec 13	Jan 14
Full Year National Threshold	<=10									
Trust Total	3	0	3	0	3	0	3	3	0	3

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



There were three cases reported in January taking the trust total to 18 cases reported year to date, against a full year threshold of 10.All cases have been reviewed in depth and discussed with TDA. An action plan to prevent further cases has been submitted to TDA. Recommendations have been made across the trust relating to quicker isolation and timeliness of samples being taken on admission. Also the deep cleaning schedule has been reviewed to identify further improvements.

E.coli and MSSA

Deliver

Outcome Metrics

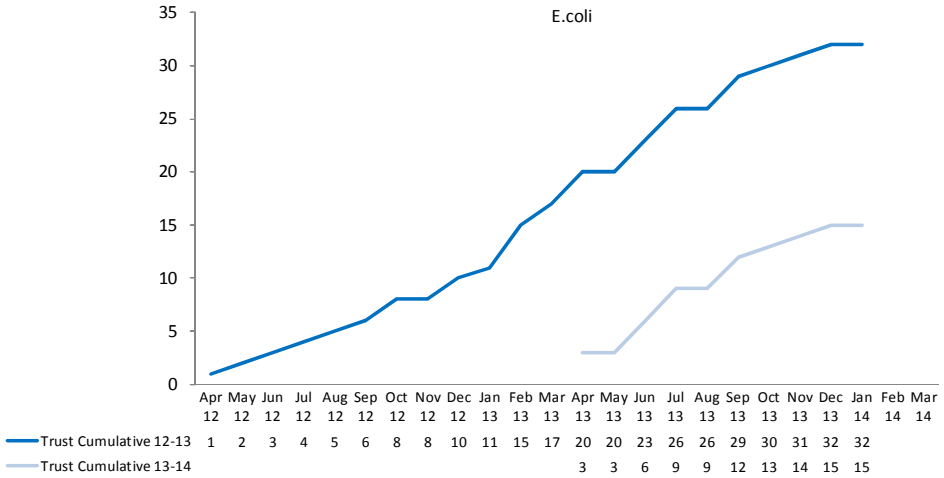
E.coli (Post 48 Hours)

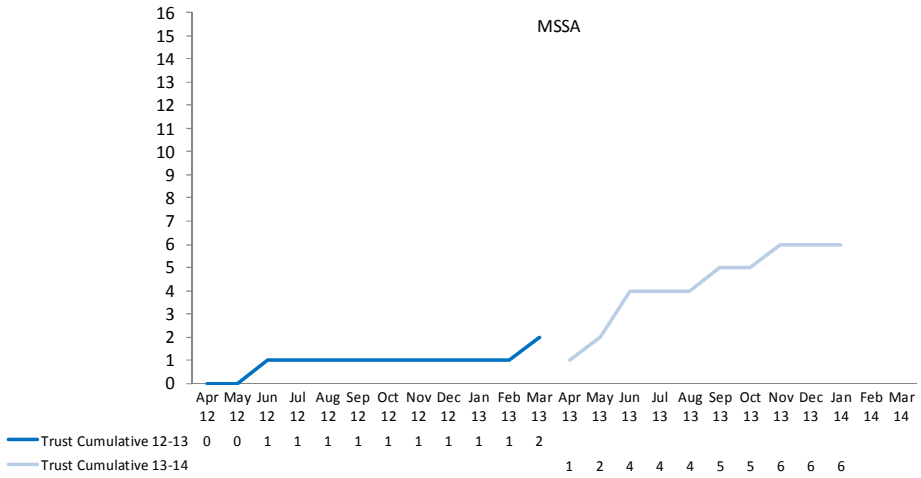
	Nov 13	Dec 13	Jan 14
Threshold	n/a		
Trust Total	1	1	0

MSSA (Post 48 Hours)

	Nov 13	Dec 13	Jan 14
Threshold	n/a		
Trust Total	1	0	0

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





The trust has reported 15 E.coli and 6 MSSA bacteraemia year to date. There are currently no national thresholds for these indicators.

Harm Free Care

Deliver

Outcome Metrics

	Contractual Threshold	Nov 13	Dec 13	Jan 14
% of Harm Free Care	95%	94.70%	94.40%	94.75%
Completeness of Safety Thermometer (CQUIN)	100%	100%	100%	100%
Pressure Ulcer (PU) Incidence	50% Reduction			

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

Jan 2013

	Patients	Harm Free		Pressure Ulcers		Falls		Catheter & UTI		New VTE	
Row Labels	Number	Number	Percentage	Number	Percentage	Number	Percentage	Number	Percentage	Number of	Percentage
ICAM	811	762	93.96%	41	5.06%	2	0.25%	6	0.74%	1	0.12%
SCD	78	76	97.44%	1	1.28%	0	-	0	-	1	1.28%
WCF	143	143	100%	0	-	0	-	0	-	0	-
Trust Total	1032	981	95%	42	4.07%	2	0.19%	6	0.58%	2	0.19%

Pressure Ulcers	Category 2	Category 3	Category 4	Total Category 2 - 4
Old	7	13	5	25
New	7	9	1	17
Total	14	22	6	42

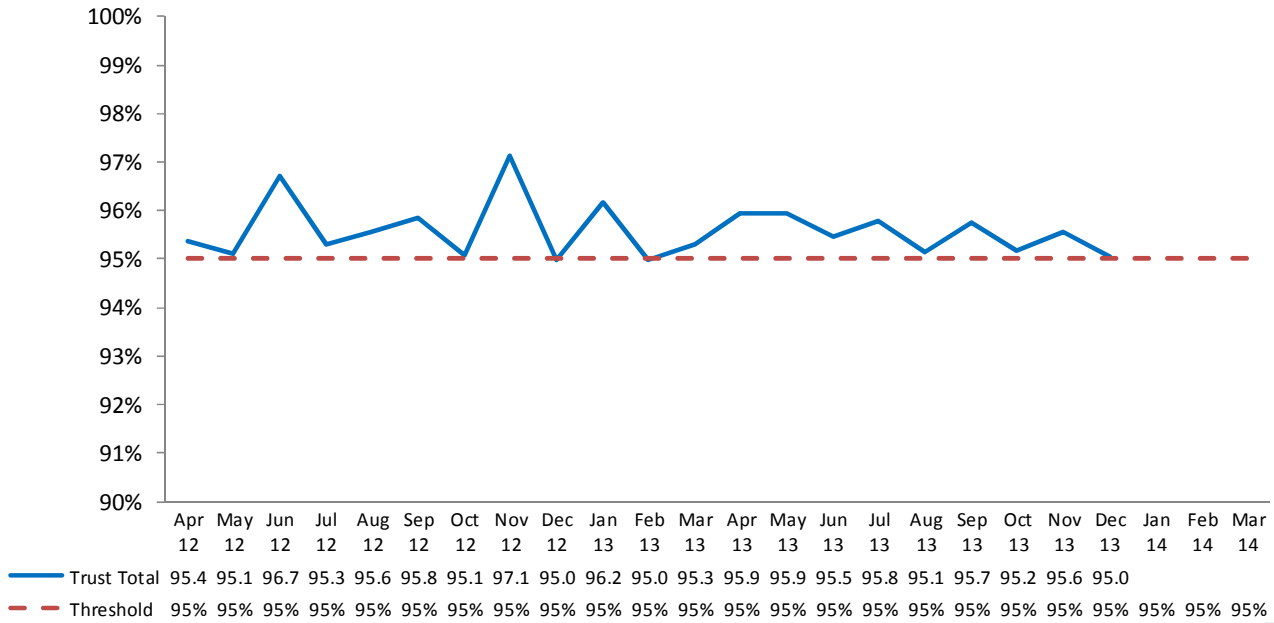
The safety thermometer identifies the prevalence of four measures of harm across all patients in trust settings on a particular day each month – urinary catheter related infection, pressure ulceration, VTE and falls. The target is to achieve 95% harm free care. In January WH achieved 94.75%

VTE Risk Assessment

Deliver

Outcome Metrics

	VTE Risk Assessed (CQUIN)			RCA for Hospital Acquired		
	Oct 13	Nov 13	Dec 13	Oct 13	Nov 13	Dec 13
CQUIN Threshold	95%			Target to be decided		
Trust Total	95.2%	95.6%	95.0%	1	1	6



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 achieve threshold however validation has been difficult this month due to other demanding pressures on CQUIN project nurse and retrospective review of notes usually identifies patients that have been assessed but have not been recorded on Anglia ICE. CQUIN Board has agreed a refreshed approach to improving data entry on ICE to minimise retrospective validation. Medical Director to support a more proactive approach to change in culture of taking responsibility within each medical team for compliance with completion or post validation carried out by the clinical teams themselves.

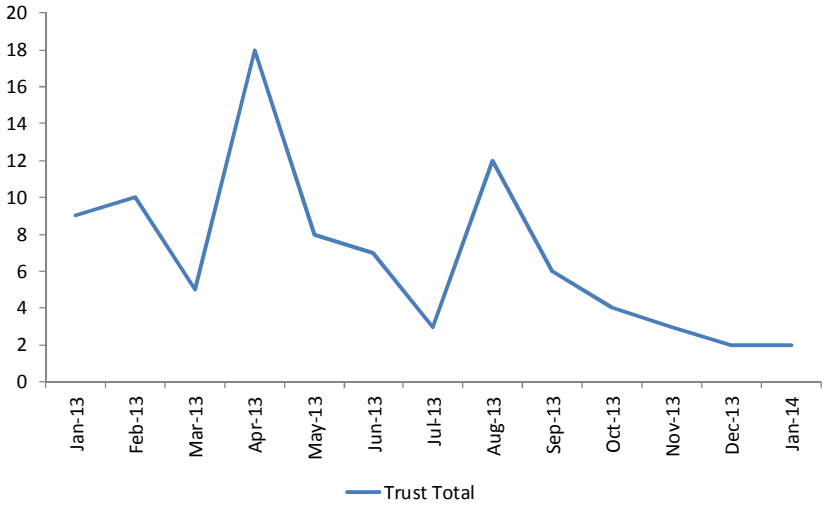
Serious Incidents

Change

Outcome Metrics

	Jul 2013	Aug 2013	Sep 2013	Oct 2013	Nov 2013	Dec 13	Jan 14
Integrated Care & Acute Medicine	2	11	5	2	0	2	2
Surgery, Cancer & Diagnostics	1	0	0	0	1	0	0
Women, Children & Families	0	1	1	2	2	0	0
Trust Total	3	12	6	4	3	2	2

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

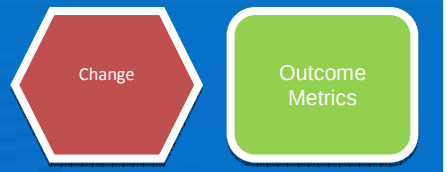


Serious Incident Tracker Current Overview as of 20/02/2014

Division	ICAM	SCD	WCF	Corporate
% overdue	13%	71%	29%	100%
No. of Open SIs	16	7	7	1
No of SIs within deadline	14	2	5	0
No. of SIs overdue	2	5	2	1
De-ecalation requests	3	0	0	0
Extensions requested	1	4	2	1

Serious incidents are monitored at Executive Serious Incidents Steering Committee and each review is presented and actions plans agreed with lessons learned cascaded to the relevant teams. Any outstanding SI is reviewed and commissioners are kept informed. The outcome of investigations is shared and discussed with patients in line with WH's Being Open Policy.

Never Events



Since October 2012, there has been one never event reported to STEIS in December 2013, as reported in February's board report. This was due to a fragment of metal from a retractor breaking and being retained in a patient. The patient had to return to theatre to have this removed and has been reviewed and all is well.
Immediate actions taken at the identification of the incident were to review all retractors in use.
A root cause analysis is being completed and a detailed action plan will be agreed.

There were no never events in January 2014.

CAS Alerts (Central Alerting System)

Change

Outcome Metrics

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 NHS England Safety Alerts Process, and the Department of Health

Alerts received between 1st October 2013 and 20th February 2014

Action Required	8
Completed	10
Immediate Action Required	1
Information Only - Staff Informed	2
No Action Required	5
Not Used By Trust	35
Grand Total	61

Patient Safety Alerts are now being issues by NHS England commencing February 2014
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, further discussions have been held with NHS England London Safety Team to identify progress on this alert.

NHS/PSA/W/2014/001Continuous renal replacement therapy (CRRT) is used in intensive care settings for patients critically ill with acute kidney injury. In three recently reported patient safety incidents1, integrated fluid warmers on CRRT equipment had been turned off and patients received large volumes of unheated fluid. Two patients became severely hypothermic and one of these patients has since died.
Immediate Action Required; Deadline for Action completed 06/03/2014.
This is under review by dedicated leads within the Trust and anticipate action will be completed within the deadline to comply with the alert.

Ward Cleanliness

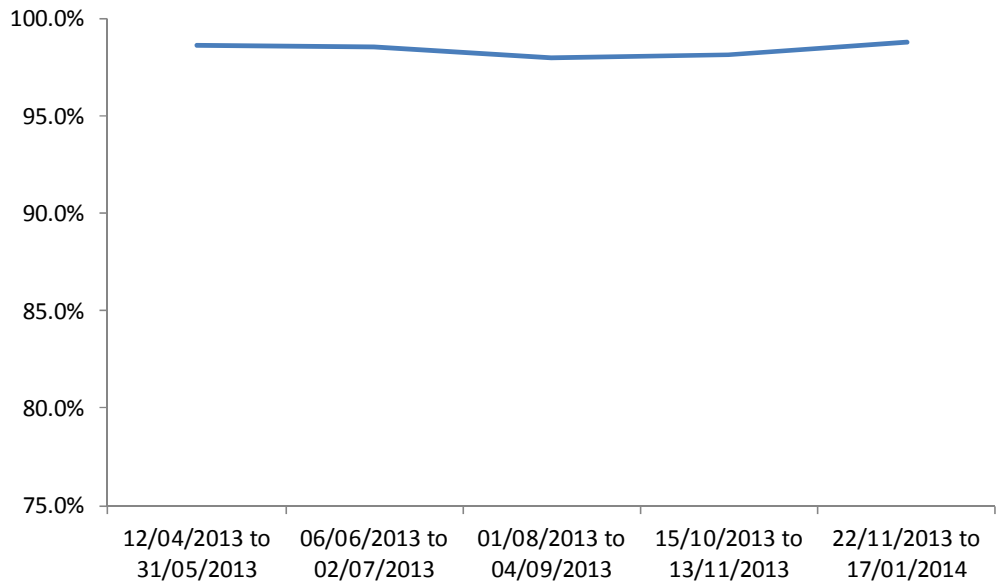
Change

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	22/11/2013 to 17/01/2014
Trust Percentage	98.6%	98.5%	98.0%	98.13%	98.8%

Ward Cleanliness calculated as actual score against possible score

Latest Audit completed by Facilities



Ward cleanliness audits have been completed and areas that are below the standard have action plans in place with monitoring by ward sisters/charge nurses and matrons.

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

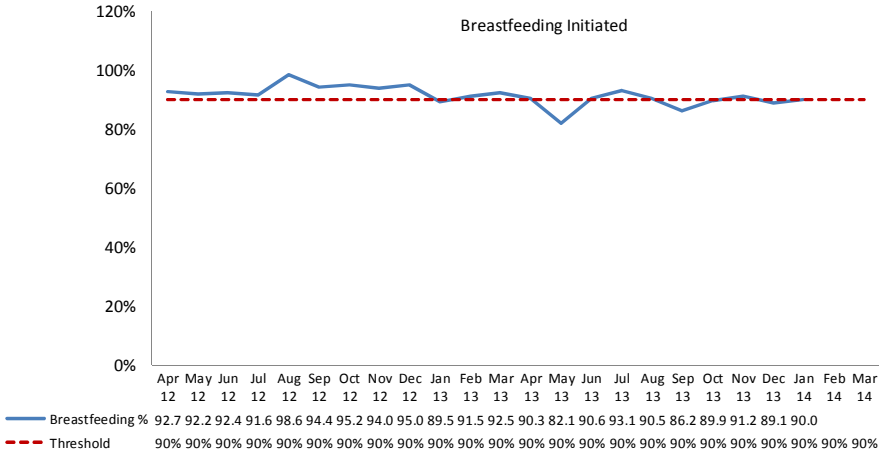
Breastfeeding and Smoking

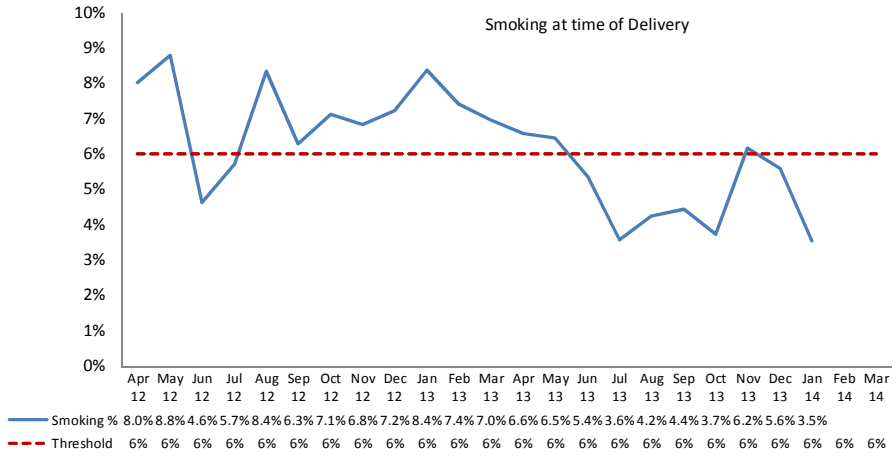
Improving

Outcome Metrics

	Threshold	Nov 13	Dec 13	Jan 14
Breastfeeding Initiated	90%	91.2%	89.1%	90.0%
Smoking at Delivery	<6%	6.2%	5.6%	3.5%

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





Breastfeeding target has been met for January at 90.0%.
Smoking at time of delivery has also met the target at 3.5%, this is the best performance reported since April 2012.

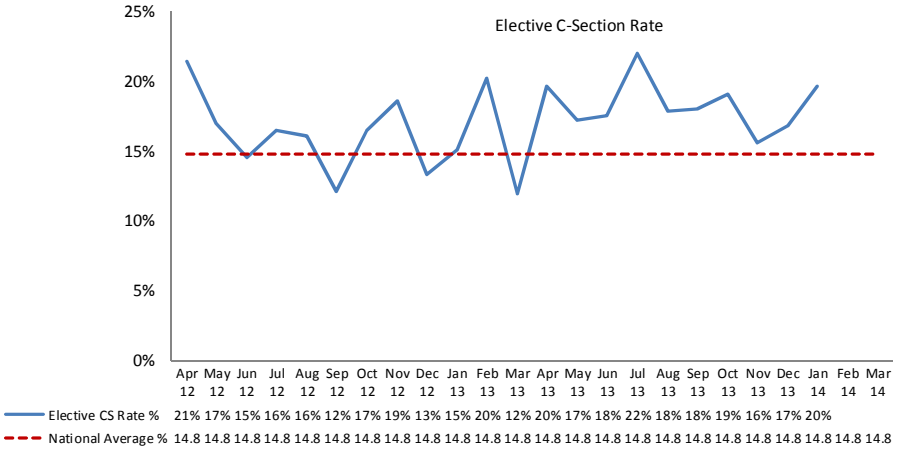
Caesarean Section Rates

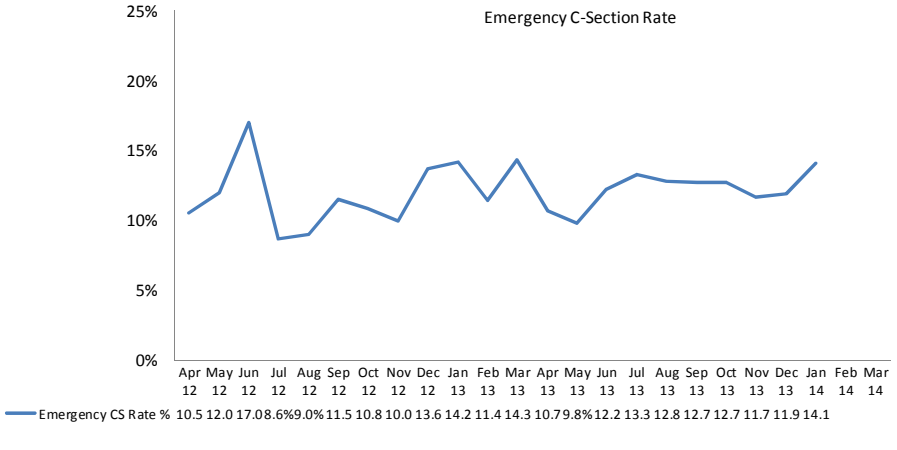
Deliver

Outcome Metrics

	National Average	Nov 13	Dec 13	Jan 14
Elective C-Section Rate	14.8%	15.6%	16.8%	19.7%
Emergency C-Section Rate	-	11.7%	11.9%	14.1%
All Deliveries	-	308	285	320

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





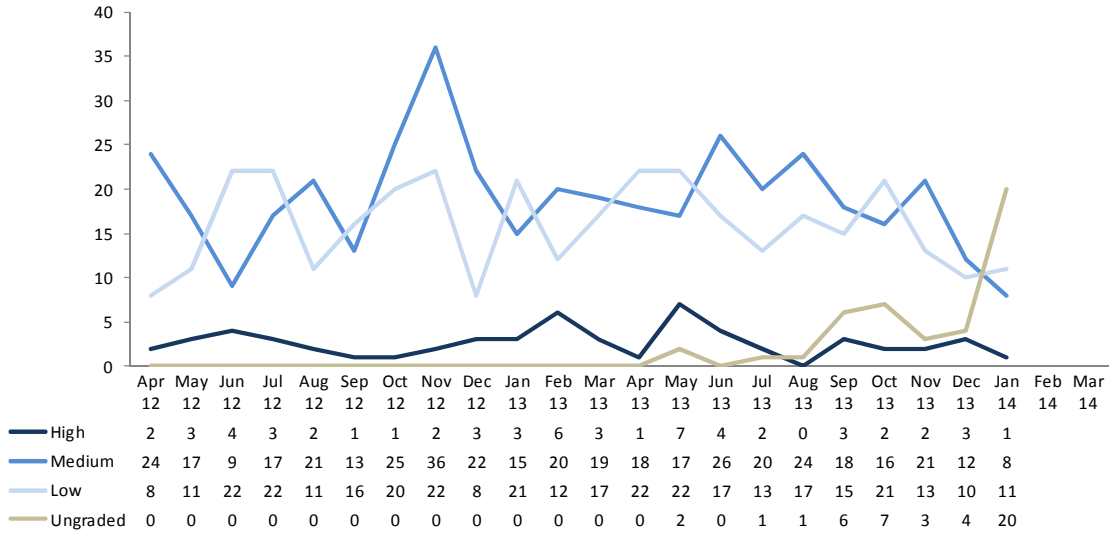
New Midwife Consultant in Public Health and Head of Maternity are part of PAN-London group focused on reducing Elective C-Section rate. Vaginal Birth after Caesarean (VBAC) clinic is in process of being set up.

Medication Errors Potentially Causing Harm

Change

Outcome Metrics

		Apr 13	May 13	Jun 13	Jul 13	Aug 13	Sep 13	Oct 13	Nov 13	Dec 13	Jan 14
Risk	High	1	7	4	2	0	3	2	2	3	1
	Medium	18	17	26	20	24	18	16	21	12	8
	Low	22	22	17	13	17	15	21	13	10	11
	Ungraded	0	2	0	1	1	6	7	3	4	20
	Total	41	48	47	36	42	42	46	39	29	40



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

The high risk medication error reported for January relates to loss of Wi-Fi and partial outage of availability of e-prescribing. This issues is being investigated in conjunction with WH IT department and the Senior Clinical Pharmacist for IT systems. Procedures are in place to deal with this issue if it occurs again, and is on the risk register for Pharmacy to ensure reviews are ongoing.

The moderate risk errors are in the process of being fully analysed and will be reported to the Drugs and Therapeutics Committee in March. Three relate to controlled drugs although none were of a serious nature or caused harm to a patient; one is a near miss and one is non-availability of stock in ED.

All risks are being reviewed within divisions as reports are provided to divisional boards.

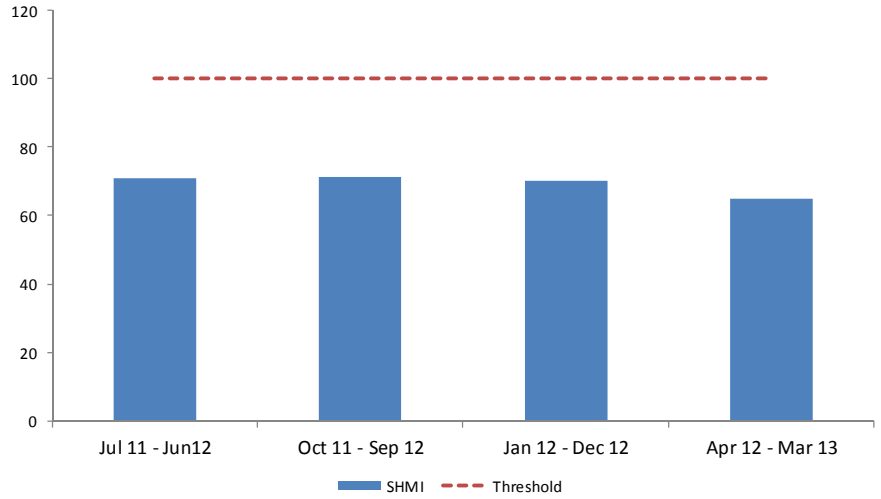
SHMI

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.



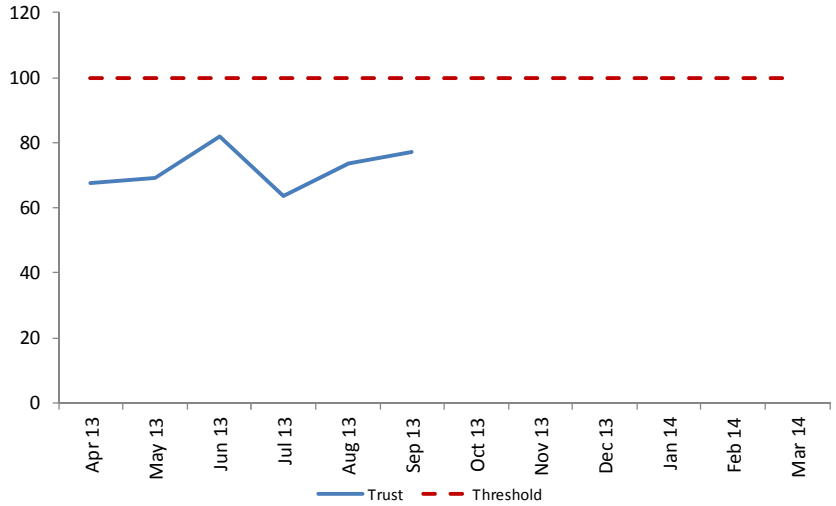
No further update on SHMI data, however continue to achieve excellent SHMI score.

HSMR

Change

Outcome Metrics

	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

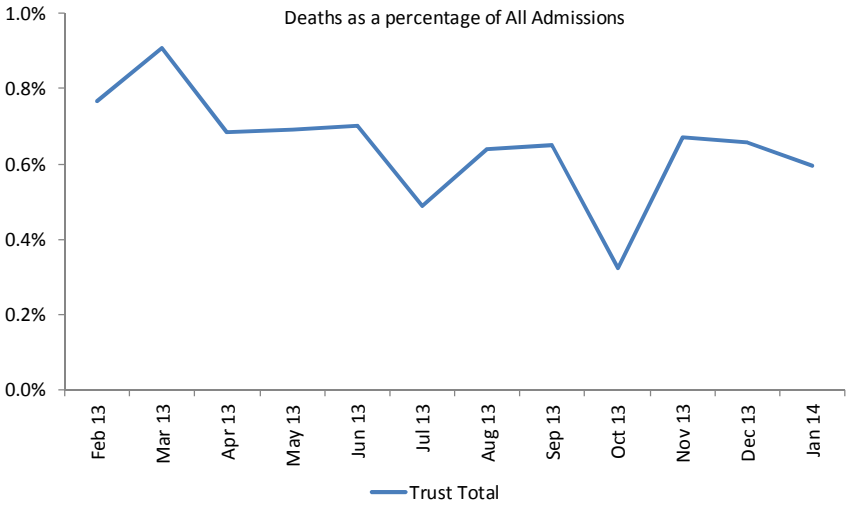
No data submitted after September 2013 due to EPR reporting issues.

Number of Inpatient Deaths

Outcome Metrics

	Deaths			Percentage of Admissions		
	Nov 13	Dec 13	Jan 14	Nov 13	Dec 13	Jan 14
Trust Total	31	28	28	0.7%	0.7%	0.6%

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



Improvements have been made in the development of a mortality and morbidity audit tools. These are now being implemented within divisions. This work has included national improvements in mortality and morbidity audit tools.

Patient Satisfaction (Friends & Family)

Ensure

Quality Indicators

	Oct 13	Nov 13	Dec-13	Jan-14
Inpatient Coverage	44.9%	42%	49%	51%
Emergency Department Coverage	6.0%	7.1%	12.5%	16.0%
Total Coverage (IP/ED)	12.7%	13.1%	19.0%	22.0%
Inpatient Net Promoter Score	68	61	62	61
Emergency Department Net Promoter Score	43	47	63	47
Total Net Promoter Score (IP/ED)	58	54	62	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

You Said

"Staff talked in front of me as if I was not there (Doctors)+ (nurses)"

We Did

Informed staff of feedback, to reiterate each morning the need include patients in their care when discussing treatment plans. To advise patients and give them the choice if they are happy for students to be present on ward rounds

You Said

"You had a positive experience with the care you received"

We Did

Shared your compliments with our staff

Improved ED coverage has been achieved through good use of volunteers - 75% of returns were through a combined effort from all staff within the department. WH continues to improve the total coverage, achieving the CQUIN threshold of 15% for the second continuous month. The free text feedback received from patients across the trust has been increase in positivity, with a lot of comments about great care, excellent nursing care, caring and kind staff, compassion, great food and cleanliness.

Mixed Sex Accommodation

Integrate

Quality Indicators

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

As part of the data assurance process, each area has been checked for MSA compliance. WH have adopted a strict policy around MSA and part of the implementation of this is the introduction of reporting across all wards.

There were 100 not clinically justified breaches reported for January. These are submitted to DH. An action plan has been agreed and shared with commissioners and TDA.

There were an additional 378 clinically justified breaches for the same period, that are for local monitoring.

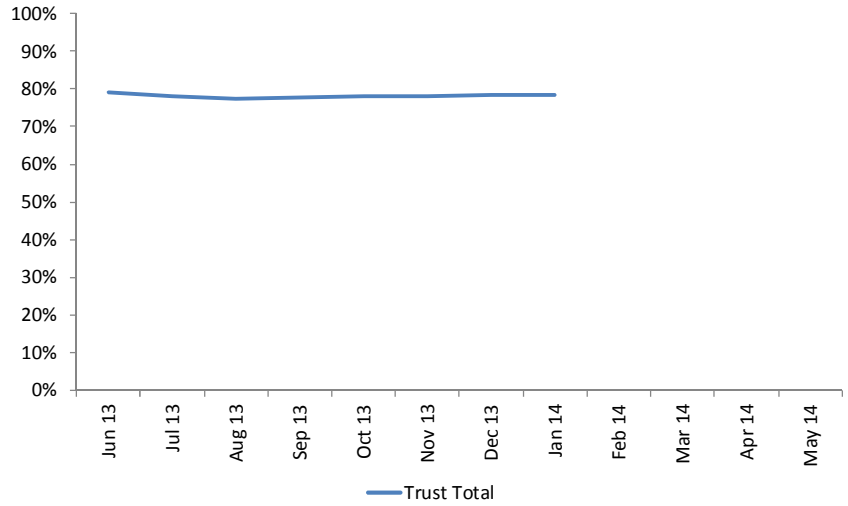
Percentage of Registered Nurses

Change

Quality Indicators

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

	Threshold	Nov 13	Dec 13	Jan 14
Trust Total	n/a	78.1%	78.3%	78.5%



A weekly meeting has been underway to implement a number of new processes to monitor and improve staffing levels across the ICO. New daily reports and a weekly vacancy tool have been implement to promote visible leadership of staffing levels and skill mix across the ICO. New processes in staffing bank office to link with the access team and staffing are now in place with escalation to Directors. Further work is underway to implement monitoring of roster builds and recruitment events have been programmed for March 2014.

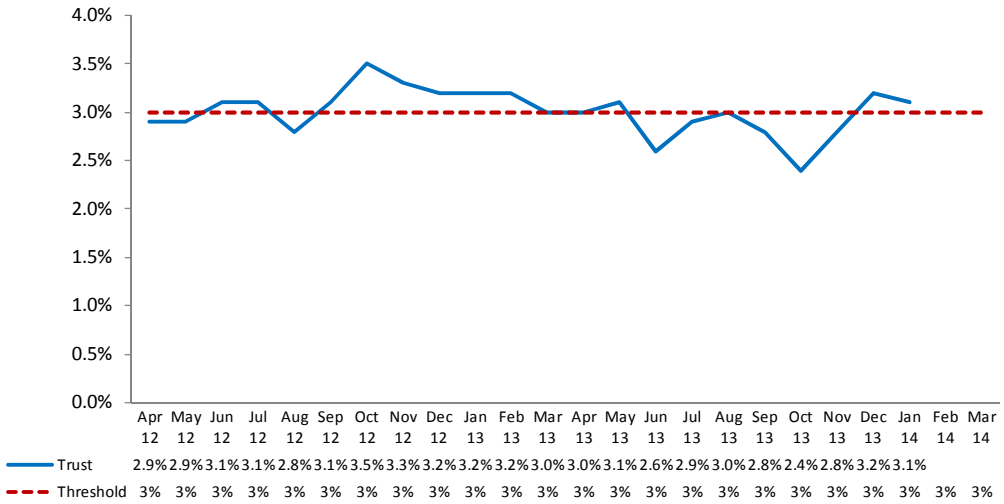
Sickness Rate

Change

Quality Indicators

	Sickness			High Bradford Scores		
	Local Threshold	Nov 13	Dec 13	Jan 14	Nov 13	Dec 13	Jan 14
Trust Total	<3%	2.8%	3.2%	3.1%	543	713	685

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



This month has shown a slight decrease in the sickness rate compared to last month's percentage and Bradford scores. Managers have been working hard to tackle sickness hot spots in their service areas. Divisional Directors now receive summary and detailed data on the sickness levels, by type and the relative Bradford scores. The Health and Well Being steering group has been re–established and a Head of HR has a corporate responsibility for implementing the action plan across the Trust.

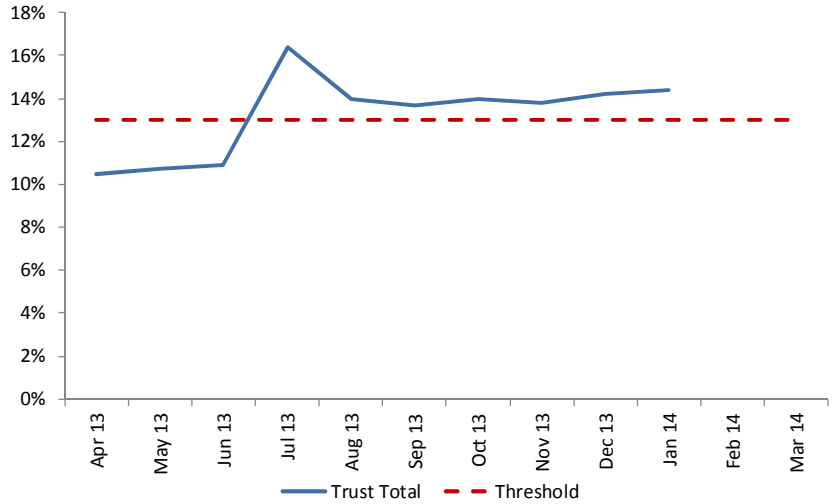
Staff Turnover

Change

Quality Indicators

	Local Threshold	Nov 13	Dec 13	Jan 14
Trust Total	<13%	13.8%	14.2%	14.4%

Proportion of workforce leaving in a given period.



Staff turnover is showing a slight increase against the target threshold. The workforce development plan includes a target of reducing turnover below the threshold within 2014/15. The succession planning strategy approved by Resources and Planning Committee in January highlights a focussed recruitment and retention strategy to reduce the numbers of interim managers and to fill nursing vacancies in particular in the acute sector.

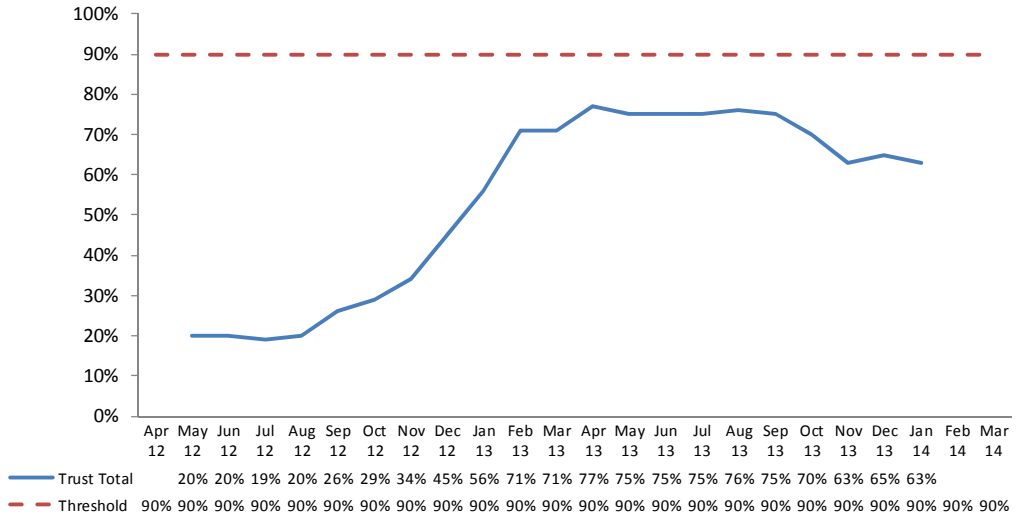
Staff Appraisal

Change

Quality Indicators

	Local Threshold	Nov 13	Dec 13	Jan 14
Trust Total	90%	63.0%	65.0%	63.0%

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



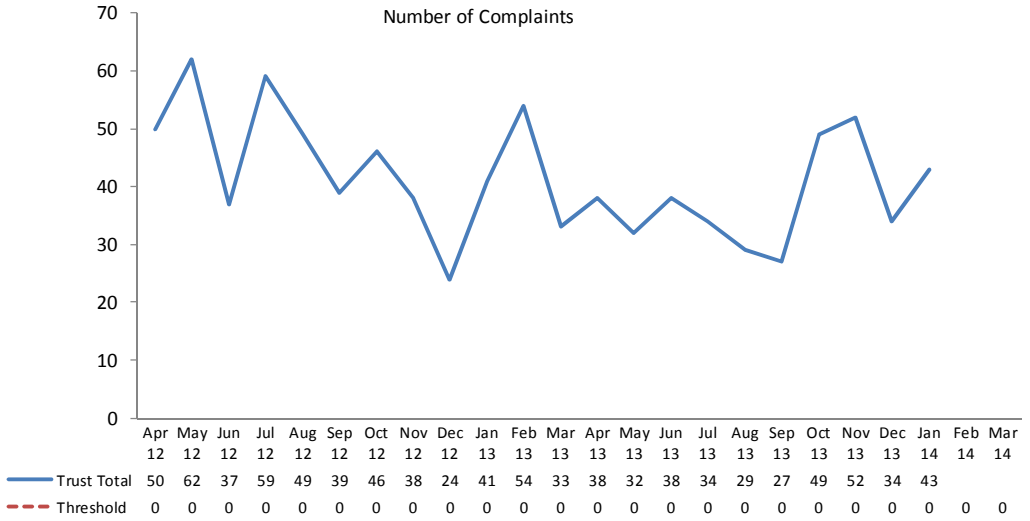
A slight decrease in the overall figures on completing staff appraisals is showing under reporting. This does not reflect the practice of undertaking appraisals as indicated by feedback from managers. A new appraisal scheme is being launched from April 2014 and will be supported by training and briefing of managers and in particular refresher training in reporting completion of appraisals on the ESR system.

Complaints

Ensure

Quality Indicators

	Complaints			Responded to in 25 days		
	Threshold	Nov 13	Dec 13	Jan 14	Oct 13	Nov 13	Dec 13
Trust Total	0	52	34	43	45%	27%	21%



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

"Responded to in 25 days" is a month in arrears

A robust action plan has been developed which is led by the Director of Nursing and COO. Weekly monitoring is in place. Projections have been developed, as the backlog of outstanding complaints is cleared performance will deteriorate in December and January until the response times are reduced. For Quarter 2, the dominant themes were clinical issues and attitude.

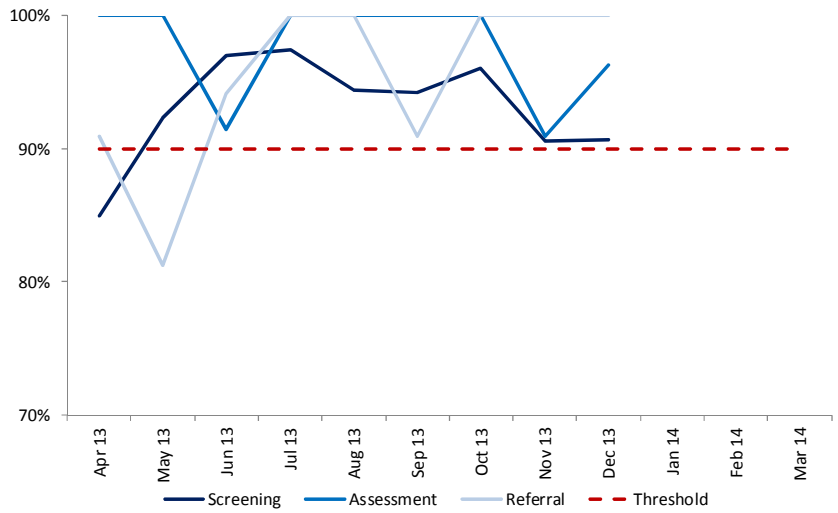
National CQUINs

Integrate

Quality Indicators

Dementia

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



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

Data is one month in arrears

Continue to achieve all three elements of the Dementia CQUIN.

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%	50%	67%	67%	61%	50%	38%	88%	60%
Timely Administration of Total Parenteral Nutrition in Preterm Infants	95%	100%	-	100%	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	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.

NICU is showing improvement at 88% for December. Early local data indicates 100% will be achieved in January.
TPN consistently reporting 100% for the year against a threshold of 95%.
CAHMS continue to achieve their CQUIN.

Local CQUINs for Prevention

Deliver

Quality Indicators

Stop Smoking	Year End Target	Apr	May	Jun	Q1	Jul	Aug	Sep	Q2	Oct	Nov	Dec	Q3	Jan	Feb	Mar	Q3
Inpatient - Smoking Status	90%	95.8%	94.0%	95.5%	94.8%	93.8%	93.6%	92.8%	93.4%	93.5%	92.1%	89.6%	91.8%				91.8%
Inpatient- Brief Advice	90%	94.3%	90.4%	92.9%	92.5%	96.0%	94.3%	95.8%	95.4%	94.6%	94.7%	96.2%	95.2%				95.2%
Inpatient- Referral	15%	35.1%	29.1%	32.4%	32.1%	32.6%	31.8%	17.1%	27.0%	23.5%	21.3%	25.5%	23.4%				23.4%
Outpatient - Smoking status	Definition to be set																
Outpatient - Brief Advice	Definition to be set																
Staff Stop Smoking	Definition to be set																

Alcohol Harm	Year End Target	Apr	May	Jun	Q1	Jul	Aug	Sep	Q2	Oct	Nov	Dec	Q3	Jan	Feb	Mar	Q4
Screening in ED	Jul 10%, +10% each month to 70% by Jan 2014	0.0%	2.1%	3.7%	2.0%	5.1%	10.9%		8.0%				7.9%	7.9%			8.0%
Brief Intervention	90%	0.0%	72.7%	78.9%	76.7%	61.9%	84.9%		78.4%				-	100.0%			100.0%
GP Communication	90%	0.0%	90.9%	89.5%	90.0%	91.9%	83.0%		77.0%				-	74.7%			74.7%
Crime Reduction Partnerships	Report by public health of anonymised dataset on alcohol related																
Audit	Plan for audit submitted and agreed Q1																

Stop Smoking continue to sustainably delivery all element of the CQUIN.
Alcohol screening is currently at 7.9% for January, however actions were put in place at the end of December and it is anticipated that improvement will be demonstrated in February performance. Due to issues with EPR reporting, the methodology for alcohol reporting has changed.

Local CQUINs for Prevention

Deliver

Quality Indicators

COPD	Year End Target	Apr	May	Jun	Q1	Jul	Aug	Sep	Q2	Oct	Nov	Dec	Q3
Acute COPD Bundle	90%	100%	92.3%	93.8%	96%	100%	100%	100%	100%	100%	100%	100%	100%
ACUTE CAP Bundle	80%	100%	0%	77.8%	83%	63.6%	100%	100%	86%	100%	100%	100%	100%
Community COPD Bundle	75%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

Integrated Care	Year End Target	Apr	May	Jun	Q1	Jul	Aug	Sep	Q2
Multidisciplinary Working - Haringey	4 MDT Case conferences a month	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	n/a	n/a	n/a	100%
Multidisciplinary Actions - Islington	90% of actions completed	n/a	n/a	n/a	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%

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

Work is in progress to address the underperformance re MDT action plans (Islington) which currently includes actions from Paediatrics MDT.

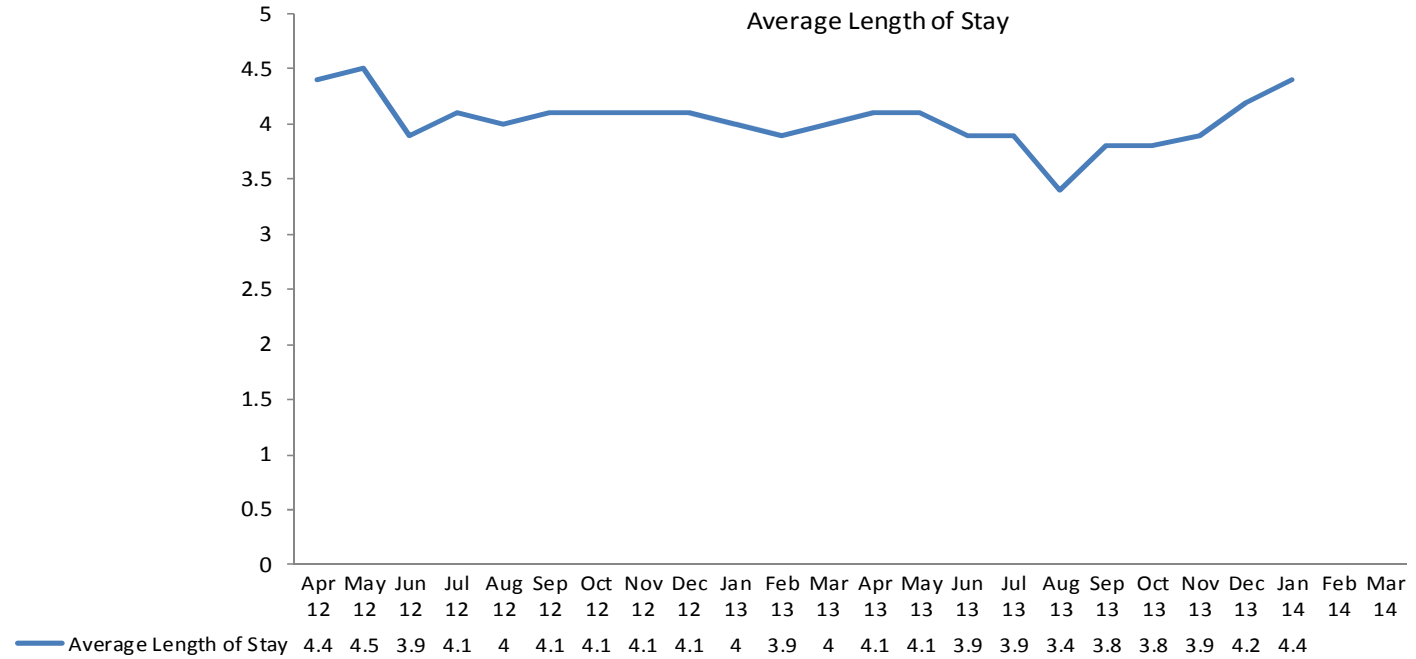
Average Length of Stay (days)

Deliver

Quality Indicators

	Threshold	Apr 13	May 13	Jun 13	Jul 13	Aug 13	Sep 13	Oct 13	Nov 13	Dec 13	Jan 14
Trust Total (days)	tbc	4.1	4.1	3.9	3.9	3.4	3.8	3.8	3.9	4.2	4.4

Average length of stay for patients within a given month



A comprehensive action plan has been developed to improve patient flow across acute adult and paediatric beds. The introduction of patient flow lead nurse, discharge bundle, electronic discharge record, discharge lounge and a long-stay review group is assisting with maintaining no delays in patient flow. The introduction of escalation plans for delays to care and Delayed Transfers of Care (DTOC) are in place. The increase in length of stay is attributed to higher acuity patients which have necessitated increased clinical support from senior clinical staff, clinical directors and senior operational leads.

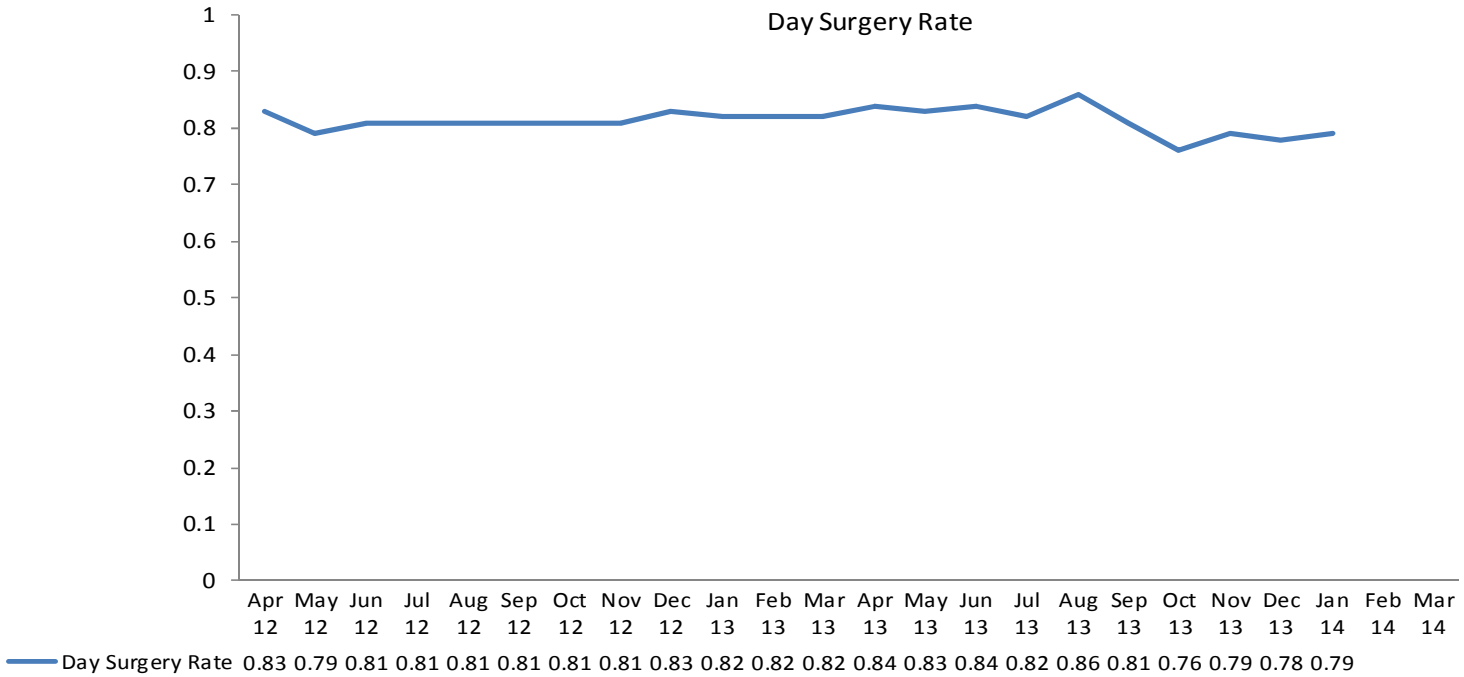
Day Surgery Rate

Deliver

Quality Indicators

	Threshold	Apr 13	May 13	Jun 13	Jul 13	Aug 13	Sep 13	Oct 13	Nov 13	Dec 13	Jan 14
Trust Total	n/a	84%	83%	84%	82%	86%	81%	76%	79%	78%	79%

Proportion of total elective surgeries carried out as a daycase



We continue to deliver over 76% of elective surgeries as a daycase. Further work is to develop innovations to increase day surgery type procedures in addition to the national basket of day surgery.

Activity

Deliver

Finance & Activity

Due to EPR Reporting Issues with SLAM CDS, this indicator cannot be reported this month

Activity data taken from SLAM Finance Activity. All data, except A&E attendances, is reported by spells. A spell relates to the whole hospital stay of the patient.

Divisional Financial Performance

Deliver

Finance & Activity

Division		Month 10			Year to Date		
		Actual	Budget	Variance	Actual	Budget	Variance
		£'000	£'000	£'000	£'000	£'000	£'000
Integrated Care & Acute Medicine	Income	1,538	950	588	12,777	9,532	3,245
	Expenditure	8,104	6,685	(1,419)	75,944	66,997	(8,948)
	Total	**(6,566)**	**(5,736)**	**(830)**	**(63,167)**	**(57,465)**	**(5,702)**
Surgery, Cancer & Diagnostics	Income	629	286	342	3,403	2,918	485
	Expenditure	4,961	4,536	(425)	49,596	45,180	(4,416)
	Total	**(4,332)**	**(4,249)**	**(82)**	**(46,193)**	**(42,261)**	**(3,932)**
Women, Children & Families	Income	1,351	1,150	201	11,982	11,503	479
	Expenditure	5,526	5,361	(165)	54,383	53,241	(1,143)
	Total	**(4,176)**	**(4,212)**	**36**	**(42,401)**	**(41,738)**	**(663)**
Corporate	Income	21,617	21,256	361	215,934	210,885	5,049
	Expenditure	5,296	5,438	142	52,135	53,905	1,770
	Total	**16,321**	**15,818**	**503**	**163,799**	**156,981**	**6,818**
TOTAL	Income	**25,134**	**23,642**	**1,493**	**244,097**	**234,839**	**9,258**
	Expenditure	**23,887**	**22,020**	**(1,866)**	**232,059**	**219,322**	**(12,737)**
	EBITDA	**1,248**	**1,621**	**(374)**	**12,037**	**15,517**	**(3,479)**

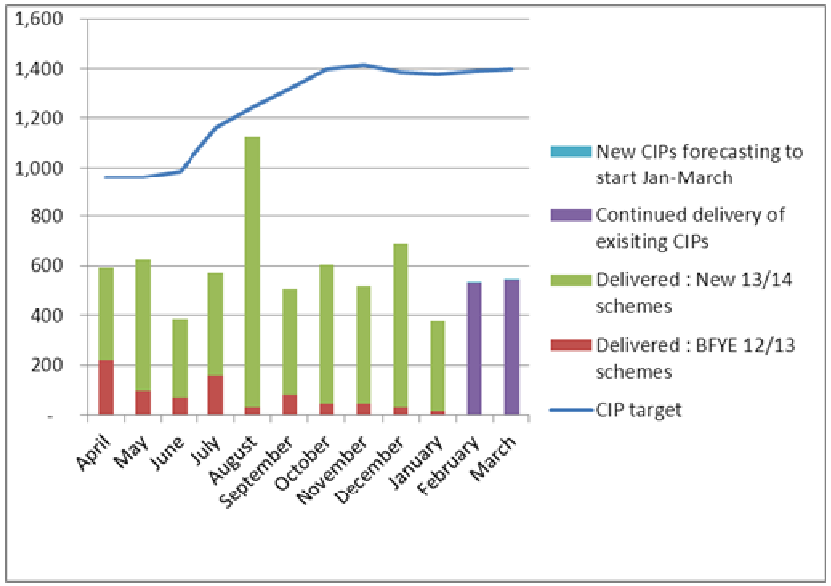
Divisional finance performance shows most areas to be below target levels. This is the consequence of cost pressures resulting from RTT and A&E four-hour wait targets delivery and the increasing acuity of patients, which have all led to increased costs. In addition, under-delivery against CIP targets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

CIP Year to Date

Deliver

Finance & Activity

Fig 2. CIP by Division	Plan 2013/14 £'000	Plan YTD £'000	Actual YTD £'000	Variance from Plan £'000	YTD delivered % of profiled plan
ICAM	3,046	2,601	1,069	-1,532	41%
SCD	1,549	1,331	747	-584	56%
WCF	1,238	963	541	-422	56%
Estates & Facilities	615	503	499	-4	99%
Finance	403	333	297	-37	89%
HR	97	80	80	0	100%
Nursing Directorate	278	206	141	-66	68%
IT	160	133	54	-79	41%
Procurement	875	729	411	-318	56%
Trust-wide schemes	4,146	3,411	1,871	-1,541	55%
Potential to be identified	2,594	1,920	0	-1,920	0%
Income offset against CIP target	0	0	286	286	
	15,000	**12,213**	**5,996**	**-6,216**	**49%**



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 CFO and COO. Further development of CIP development, planning and implementation is underway as part of the 2014/15 Planning process – see Operational Plan paper to the February meeting of the Trust Board.

Temporary Staffing Spend by Division

Deliver

Finance & Activity

Temporary staffing	Division	Month10 £000's	Trend to M9 £000's	Variance £000's
Agency	Corporate	341	287	(54)
	IC&AM	843	743	(100)
	SC&D	197	127	(70)
	WC&F	249	240	(9)
Agency Total		**1,631**	**1,398**	**(233)**
Locum	Corporate	3	6	3
	IC&AM	90	77	(13)
	SC&D	50	58	8
	WC&F	9	18	9
Locum Total		**151**	**158**	**7**
Bank	Corporate	311	321	11
	IC&AM	507	470	(37)
	SC&D	311	332	21
	WC&F	335	332	(3)
Bank Total		**1,463**	**1,455**	**(8)**
Total		**3,246**	**3,011**	**(234)**

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.