Whittington Health NHS

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The Whittington Hospital NHS Trust
Magdala Avenue
London N19 5NF

Whittington Health Trust Board

2 April 2014

Title:	Trust Board Performance Report April 2014 (February data)		
Agenda item:	**14/068**	**Paper**	**4**
Action requested:	For discussion and information		
Executive Summary:	The Trust Board Performance Report is designed to assure the Board that performance is on track within the organisation and, where performance is under agreed levels, what the services/division/organisation is undertaking to rectify. Key headlines As improvements are being implemented deterioration in performance will be seen following the introduction of new practices. This is due to clearing backlog or longer response times. Areas such as complaints, 'did not attends' (DNAs) and first to follow-up ratios will be included in this. We are still having on-going issues with our ability to report some indicators because of the current functionality limitations of EPR (Electronic Patient Record). However, fixes are now being applied and Referral to Treatment (RTT) data has been submitted. • RTT admitted and non-admitted national standards are met in February (slides 19-22) • Theatre utilisation continues to increase with 82 per cent utilisation in February (slide 5) • Diagnostic waits' (slide 23) performance continues to achieve the threshold, for the fifth consecutive month. • The number of cancelled operations continues to reduce (slide 24). • Emergency department (ED) waits was over 95 per cent for the fifth consecutive month (slide 25). • The high performance in delayed transfers of care continues (slide 34) • Patient satisfaction (Friends and Family Test) coverage in ED continues to improve (slide 52). • The percentage of complaints responded to within 25 days has improved considerably (slide 58).		

	Area of concern A priority plan has been underway for completion by the end of March. Several indicators need specific input to deliver improvements, these being: • Mandatory training (slide 18) • Appraisals (slide 57) • C Diff (slide 37) • Medication errors - further work to embed into operations structure (slide 48)
Summary of recommendations:	Improvement actions continue, board provides feedback on any concerns.
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:	24 March 2014

Author name and title:		**Steve Hoskins, Improvement, Performance & Information Programme Manager**		**Director name and title:**		**Sally Batley, Director of Improvement, Performance & Information**	
Date paper seen by EC		**Equality Impact Assessment complete?**		**Quality Impact Assessment complete?**		**Financial Impact Assessment complete?**	

Whittington Health NHS

Trust Board Report

April 2014
(February data)

Success Highlights

Focus Areas

Overall Operational performance of Whittington Health

•Emergency and RTT national standards being met
•The enhance recovery and improvement plan continue to show improvements across Whittington Health
•The Friends and Family Test (FFT) is providing rich feedback for improving our services
•Continued efforts are underway to improve HR indicators within new processes and reporting being implemented
•Areas of major focus, OPD and complaints, HR indicators

Integrated Care and Acute Medicine Division
•The opening of the new Ambulatory Care Centre on 31 March 2014 is on track
•The new TB South Hub Unit is due to open on 28th April 2014
•Whittington Health has been awarded the contract for provision of supporting lifestyle behaviour change training sessions

Surgery, Cancer and Diagnostics Division
•Theatre utilisation continues to improve – standard to be reached by end of March 2014 is 85%
•Achievement of admitted and non admitted RTT minimum standards
•Communicate 'no meeting days' on Friday 11th and 25th April 2014 so staff can concentrate on mandatory training
•Group appraisals paperwork being developed Nursing, the Access centre, Health Records and Transcription services

Women, Children and Families Division
•Appointments with no outcome have improved second month running
•NICU specialist CQUIN score 100% for two consecutive months

Board Aims

Focus Areas

All indicators have been mapped to the Board Aims

First:Follow-Up Ratio - Acute

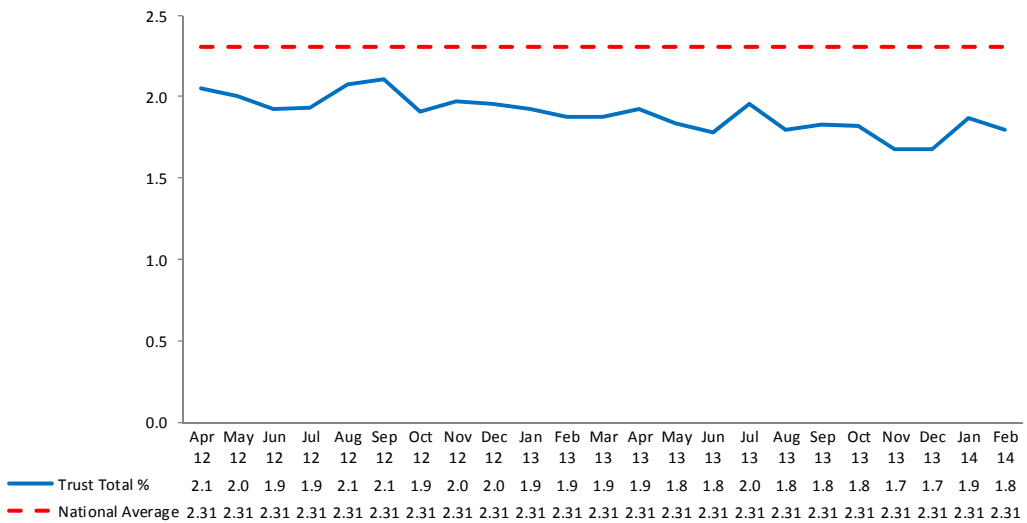
Deliver

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	Feb 14
Acute Trust Total	-	1.93	1.84	1.78	1.96	1.80	1.83	1.82	1.68	1.68	1.87	1.79

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



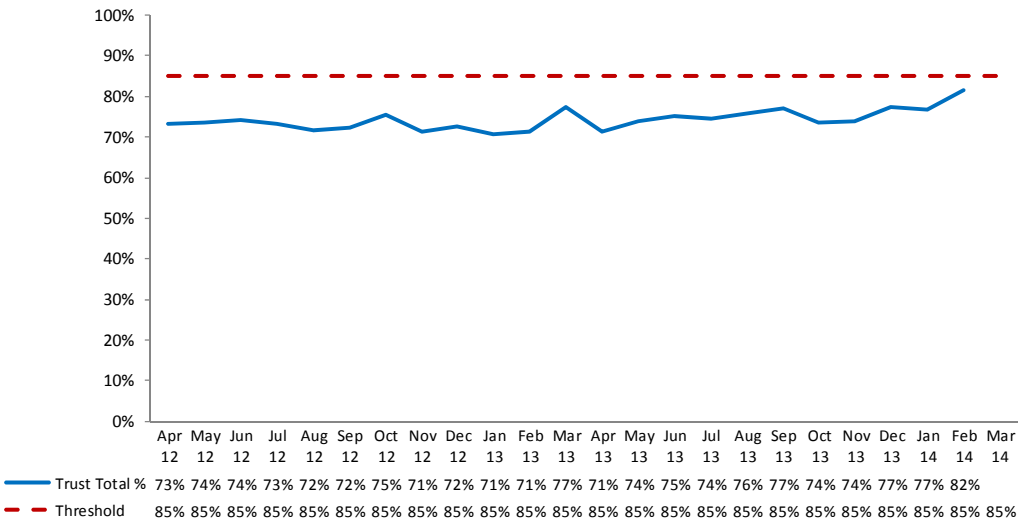
Work continues with the Whittington Health ICO-wide improvement plans, scheduled for completion in April. Divisions are identifying services to run pilot improvement schemes, with Urology and Dermatology identified for Surgery, Cancer and Diagnostics. Preparatory work is underway to describe the criteria for discharge from out patients and training for junior staff to help avoid unnecessary returns. Work is underway to remodel Gynaecology clinics pending move into community setting and Paediatrics ad-hoc clinics are being increased to address the FU backlog.

Theatre Utilisation

Deliver

Focus Areas

	Utilisation			Available Session Time (Minutes)			Time Utilised (Minutes)		
	Dec 13	Jan 14	Feb 14	Dec 13	Jan 14	Feb 14	Dec 13	Jan 14	Feb 14
Local Threshold	>85%								
Trust Total	77%	77%	82%	54,690	67,110	60,840	42,233	51,597	49,667



The target threshold currently set at 85% will be increasing to 95% from April 2014

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. Further improvement was seen in February achieving over 80% performance. A weekly review of theatre sessions using the Productive Theatre model of 2-4-6 is in place to action improvement and increase list percentage booked. Going forward, booking rules per consultants to be discussed in weekly theatre meetings and monitored.

Community Data Quality

Deliver

Focus Areas

The activity presented in the dashboard is extracted from the Community information system, RiO.
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.

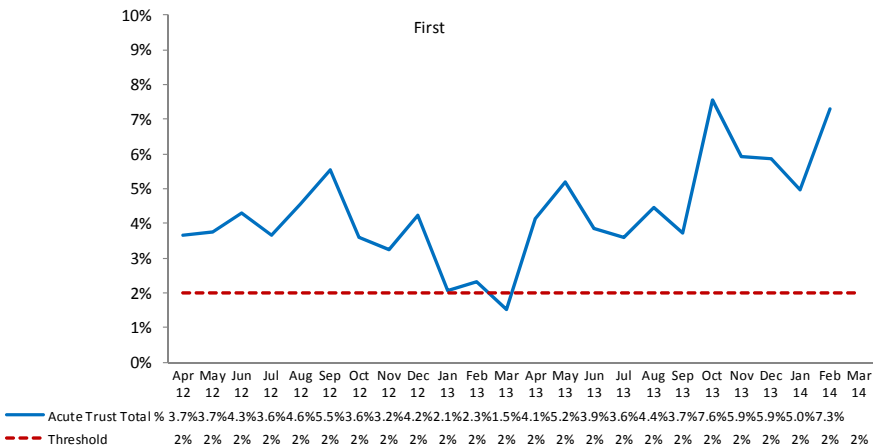
Hospital Cancellations - Acute

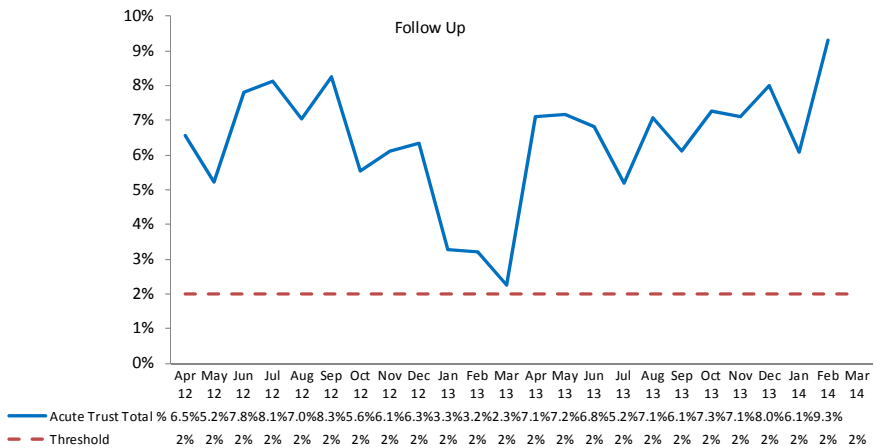
Deliver

Focus Areas

	First Appointments			Follow Up Appointments		
	Dec 13	Jan 14	Feb 14	Dec 13	Jan 14	Feb 14
Local Threshold	<2%			<2%		
Acute Trust Total	5.9%	5.0%	7.3%	8.0%	6.1%	9.3%

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





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. One service in ICAM suffered high consultant sickness in February and another saw a change of consultant which led to a high number of clinics being cancelled. The sickness is being addressed through the appointment of a locum consultant. 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

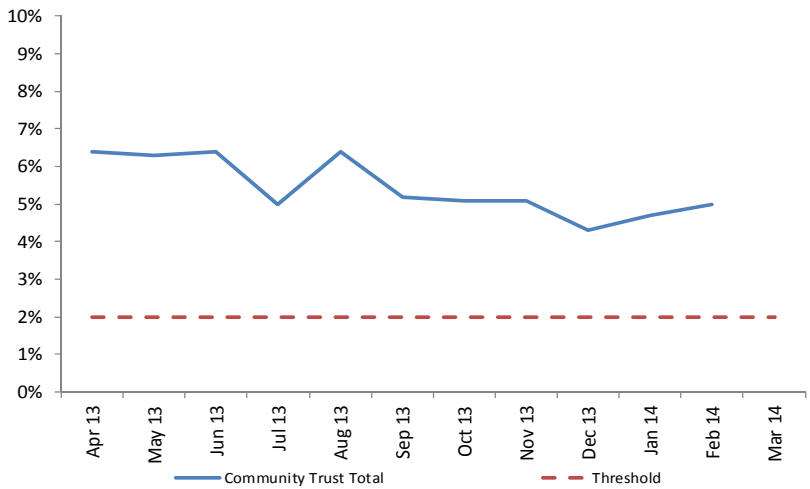
Integrate

Focus Areas

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.

First + Follow-Up

	Apr 13	May 13	Jun 13	Jul 13	Aug 13	Sep 13	Oct 13	Nov 13	Dec 13	Jan 14	Feb 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%	5.0%



Both ICAM and WCF have seen an increase in service cancellations in February resulting in a worsening position from January. A plan is in place to discuss the issues in detail at team meeting and to link with Community Data Quality Group.

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

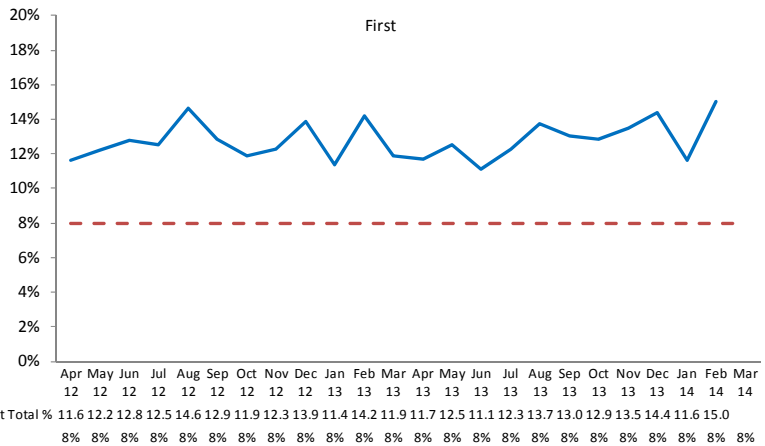
Deliver

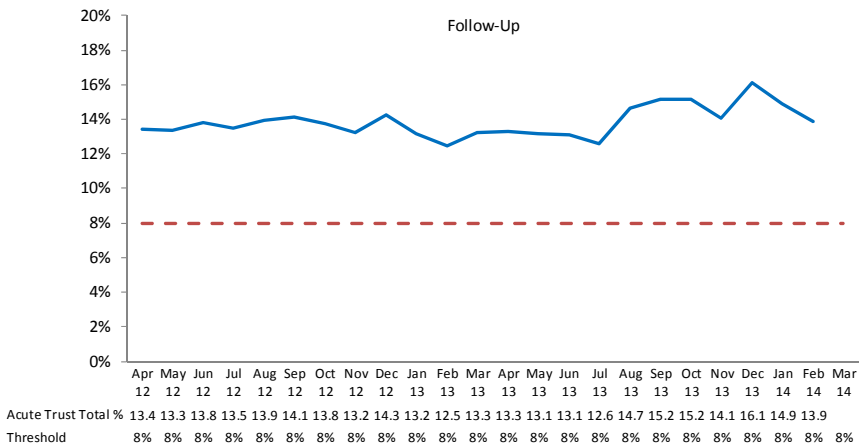
Focus Areas

	First Appointments			Follow Up Appointments		
	Dec 13	Jan 14	Feb 14	Dec 13	Jan 14	Feb 14
Local Threshold	8%			8%		
Acute Trust Total	14.4%	11.6%	15.0%	16.1%	14.9%	13.9%

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





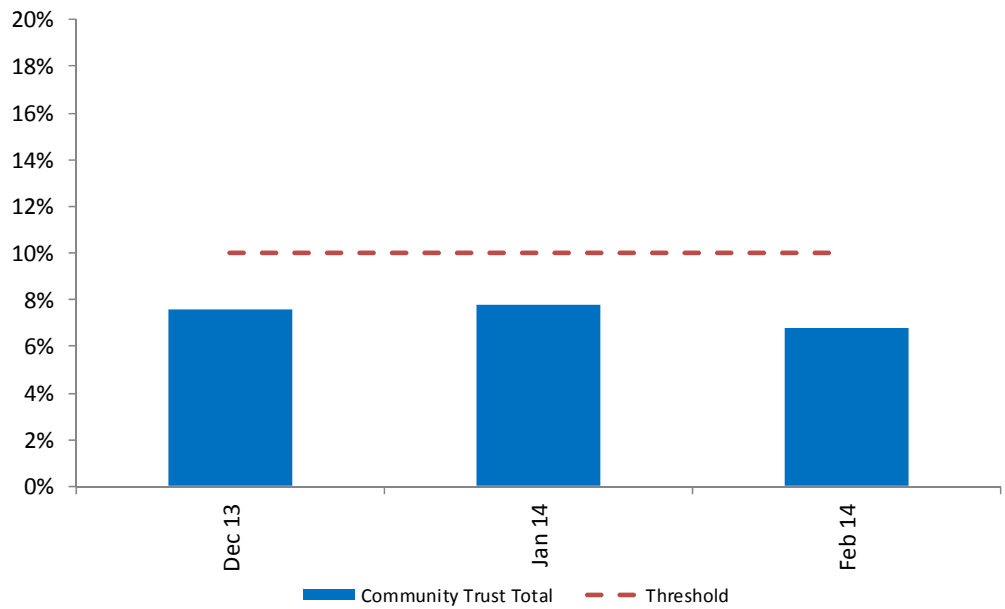
Work continues with the Whittington Health ICO-wide improvement plans, scheduled for completion in April. Divisions are identifying services to run pilot improvement schemes. Training sessions are in place to ensure staff are adhering to SOPs in line with trust access policies and text reminders for patients in a timely manner. As improvements are being implemented an increase may be seen following the introduction of new practices. FU DNAs has again decreased in February but remains above the local threshold.

DNA Rates - Community

Integrate

Focus Areas

First + Follow-Up	Dec 13	Jan 14	Feb 14
Local Threshold	10%		
Community Trust Total	7.6%	7.8%	6.8%



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, such as text reminders for patients and the development of community specific SOPs within the Access Policy, an improvement in performance may be seen.

Community Face-to-Face Contacts

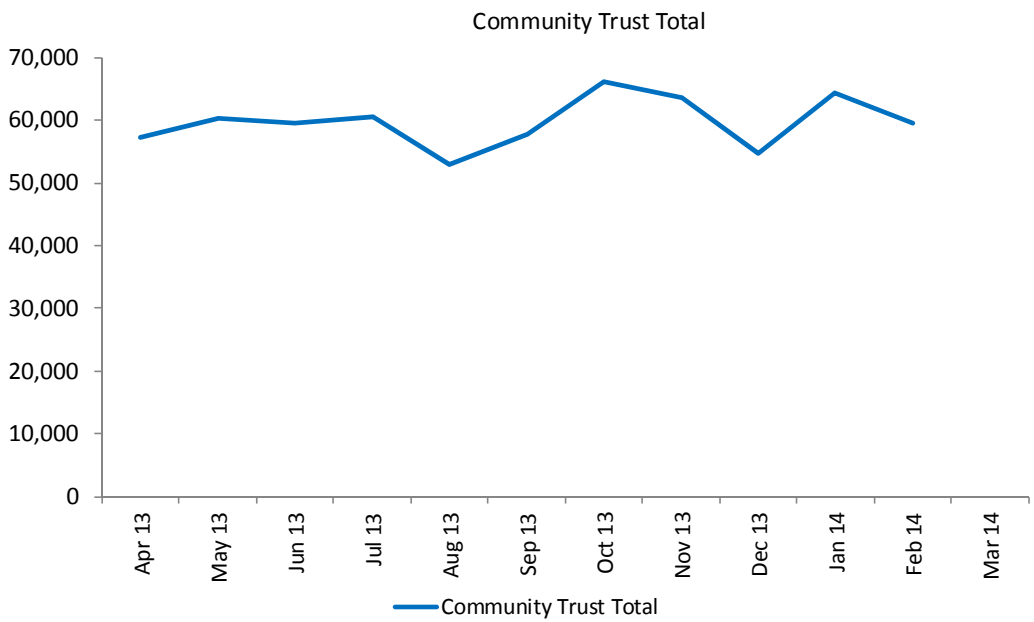
Integrate

Focus Areas

	Dec 13	Jan 14	Feb 14
Threshold	n/a		
Community Trust Total	54,568	64,221	59,447

2012/13 Apr - Feb	2013/14 Apr - Feb	Variation
n/a		
582,052	656,265	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.



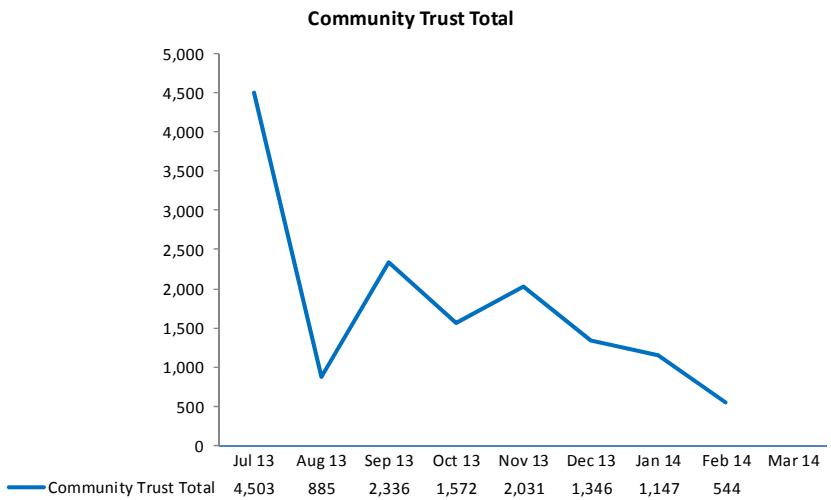
Although community contacts saw a reduction in February of almost 5,000 contacts, there is still an increase of 13% on year to date activity against the same period in 2012/13. The reduction in February is partly due to a variation in service capacity which is being addressed through staff recruitment.
Work is to be done to produce phased activity plans for monitoring in 2014/15.

Community Appointment with no outcome

Integrate

Focus Areas

	Dec 13	Jan 14	Feb 14	% of Total Face-to-Face Contacts Dec 13	% of Total Face-to-Face Contacts Jan 14	% of Total Face-to-Face Contacts Feb 14
Local Threshold	n/a			0.5%		
Community Trust Total	1,346	1,147	544	2.5%	1.8%	0.9%



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.

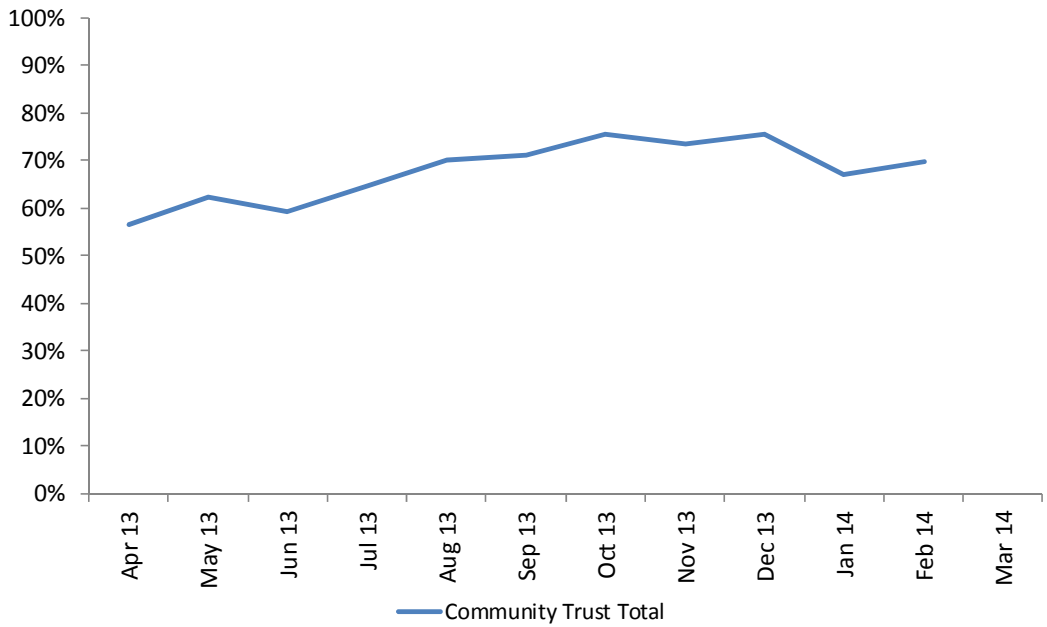
Improvements continue to be seen in community appointments with no outcome, with a significant improvement in February moving closer to the 0.5% local threshold. Divisions have implemented reminders to service managers two days in advance of the data deadline and a SOP has been developed to streamline the process.

Community Waiting Times
% waiting less than 6 weeks

Integrate

Focus Areas

	Dec 13	Jan 14	Feb 14
Threshold	n/a		
Community Trust Total	75.4%	67.2%	69.8%



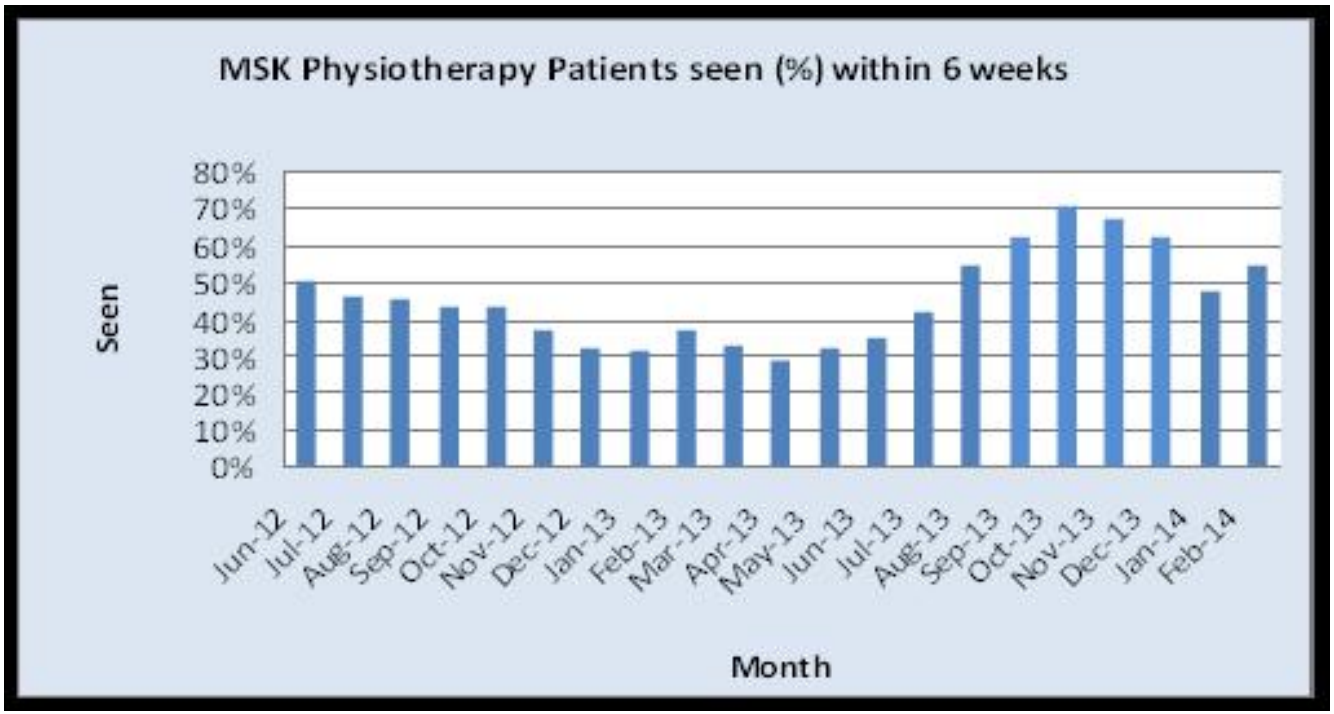
The percentage of patients waiting less than 6 weeks for attended 'Face to Face' initial appointments. The waiting time from the date the referral was received to the initial attended 'Face to Face' contact is measured for the month. Where patients DNA the waiting time is measured as the time between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

A slight increase in the percentage of patients waiting less than six weeks for a community appointment was seen in February, rising to 69.8% from 67.2% in January. 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. Work is underway to separate those services that are commissioned on a longer or shorter waiting time.

MSK Waiting Times
% waiting less than 6 weeks

Integrate

Focus Areas



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January and February data not signed-off as at 24/03/2014

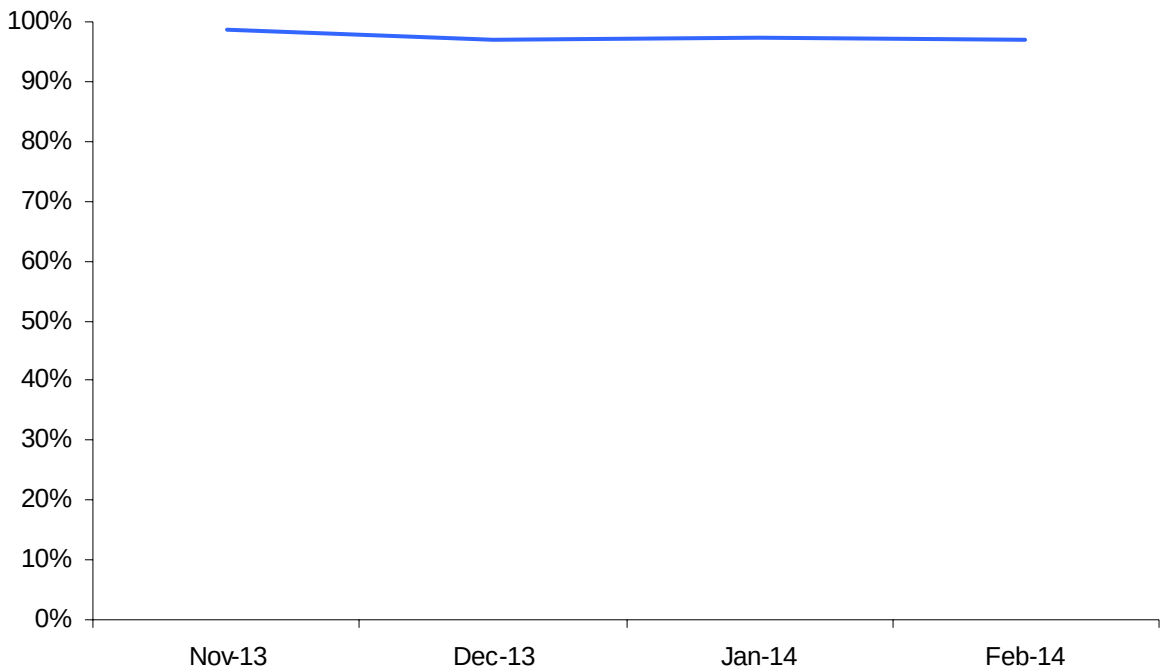
64% of patients seen in February had waited 6 weeks or less. Over the Christmas and New Year period there was a significant reduction in capacity to accommodate staff leave. Resources were pooled to the larger sites to maximise appointment availability, however there were many cancellations, re-bookings 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	Feb-14
Threshold	n/a			
Community Trust Total	98.50%	97.02%	97.40%	97.15%



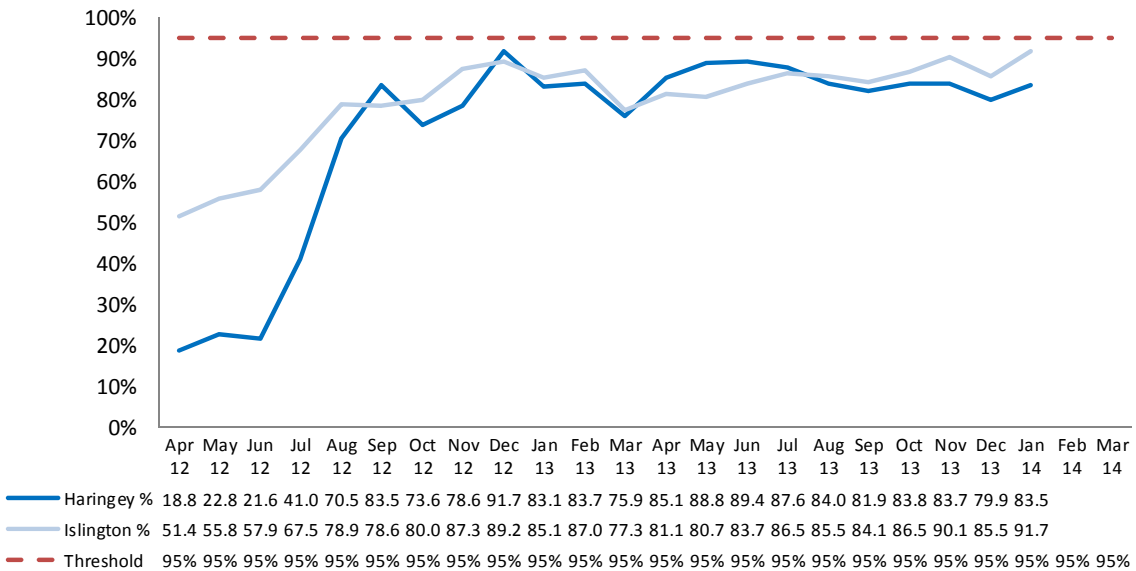
The percentage of patients waiting less than 6 weeks for attended 'Face to Face' initial appointments. The waiting time from the date the referral was received to the initial attended 'Face to Face' contact is measured for the month. Where patients DNA the waiting time is measured as the time between 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	Jan 14
Local Threshold	95%									
Haringey	85.1%	88.8%	89.4%	87.6%	84.0%	81.9%	83.8%	83.7%	79.9%	83.5%
Islington	81.1%	80.7%	83.7%	86.5%	85.5%	84.1%	86.5%	90.1%	85.5%	91.7%



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

January saw an increase in the percentage of new birth visits completed against the local threshold, with the 91.7% in Islington being the highest performance so far this calendar year.
Health Visiting students started in January 2014 and this is expected to have an adverse affect on performance.
Reports are now in place to identify un-outcomed appointments.

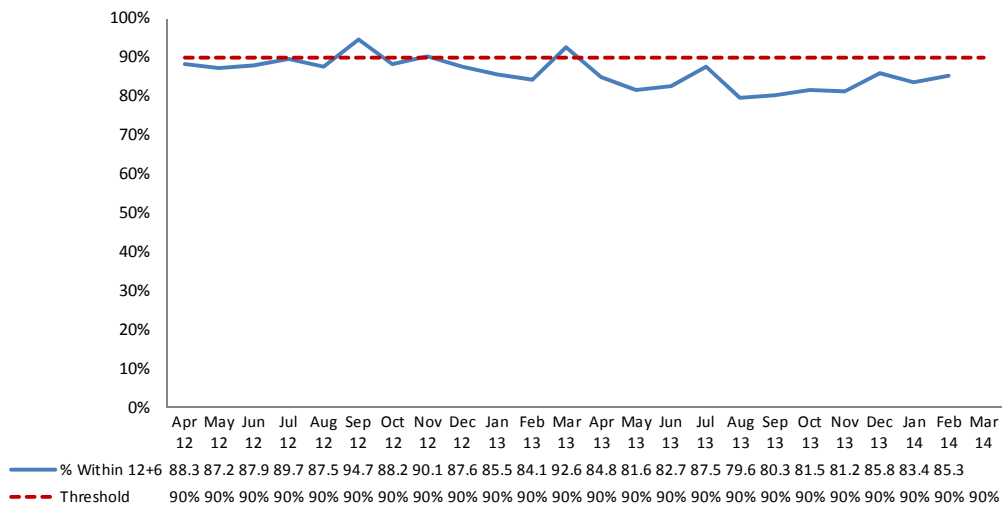
Women seen by HCP or Midwife within 12 weeks and 6 days

Deliver

Focus Areas

	Threshold	Apr 13	May 13	Jun 13	Jul 13	Aug 13	Sep 13	Oct 13	Nov 13	Dec 13	Jan 14	Feb 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%	85.3%
Total Number of Bookings	-	374	404	359	421	376	369	375	359	339	384	335
Referrals within 12 Weeks and 6 days	-	323	347	312	359	324	319	324	330	302	338	286

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



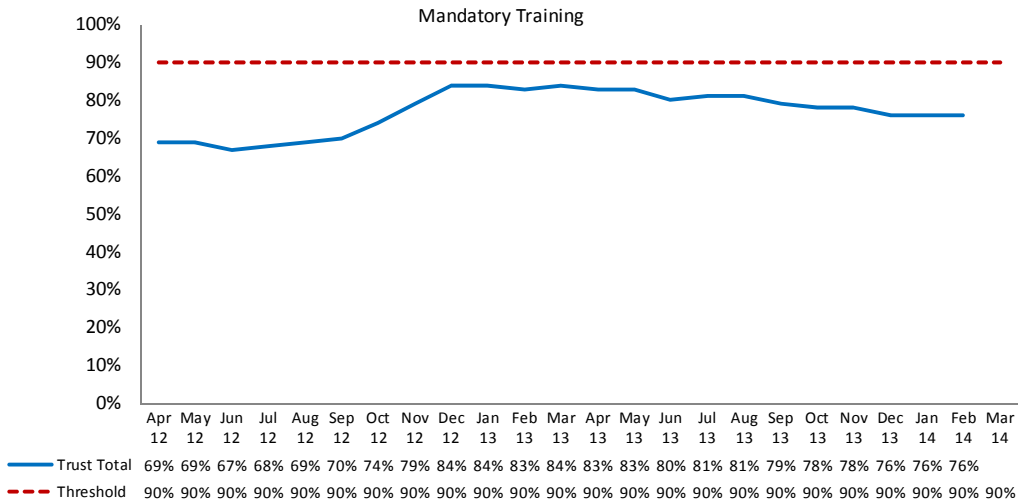
Performance has seen a slight increase in February however this is within standard variation. Data is still to be validated by the service. New Midwife Consultant focussing on Public Health issues is now in post and this is expected to improve future performance. The SOP is being reviewed to support data entering and reporting.

Mandatory Training Compliance

Change

Focus Areas

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



Data snapshot date 03/03/2014

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

76% compliance. Individual email send to all Line Managers re: assurance in accessing and performance managing team compliance. Report promoted onto Trust Noticeboard on 19th March. Implementation of the WIRED Reporting Solution for MT slightly delayed due to procurement hold up & agreement to invest in due to new awareness that the IT Directorate is in the process of procuring a wider scale ICO Reporting Solution for longer term. Agreed proposed changes to Recruitment & Induction Plan – new starters to complete all E-Learning MT prior to job commencement – April 2014. Action Plan to agree with TOB proposing all staff with 1 admin day per month that includes assurance to complete all required MT. Plan in place to target teams re: bespoke E-Learning sessions.

Referral to Treatment 18 weeks - Admitted

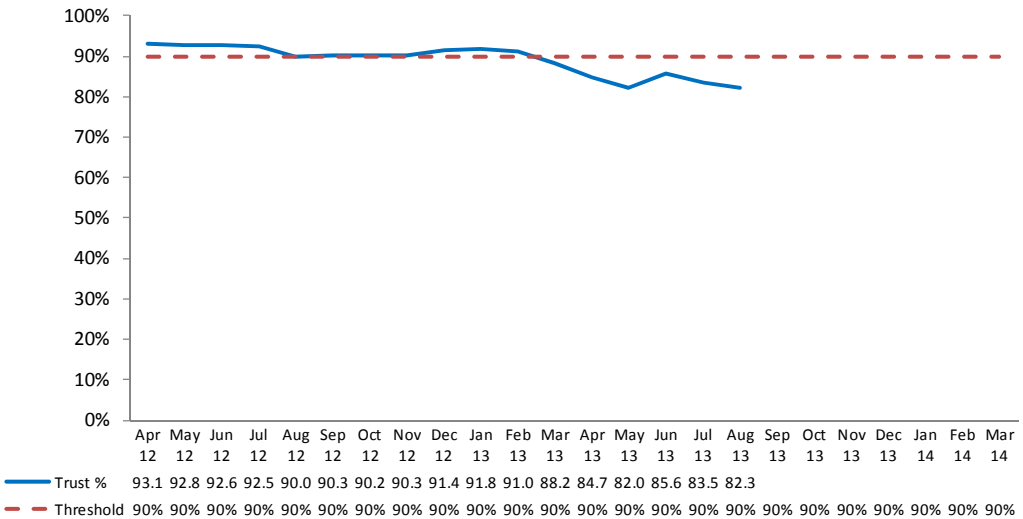
Deliver

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



The data fixes are now underway and RTT report have been submitted for February data, with a outcome of 90.1 per cent achievement for admitted patients

Data will be refreshed in the board reporting pack next month

Referral to Treatment 18 weeks – Non Admitted

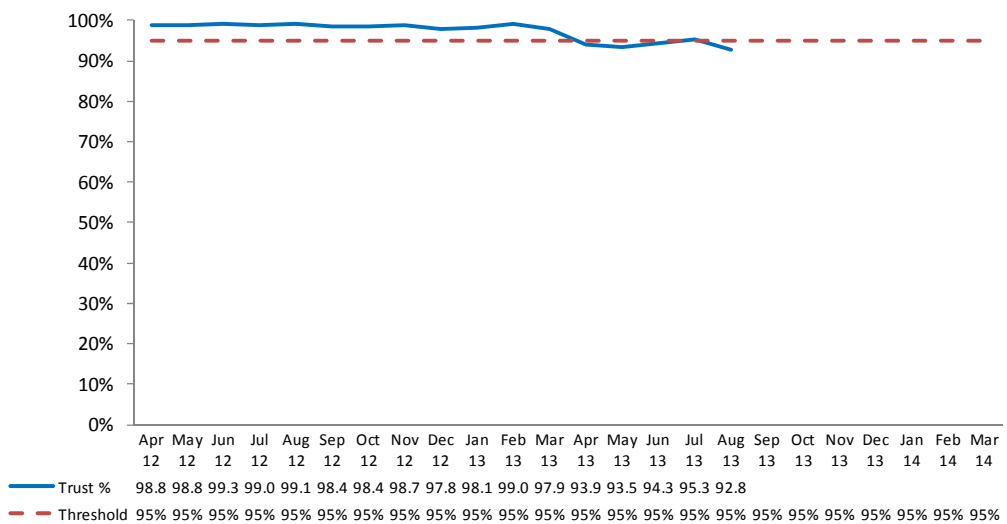
Deliver

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%	-	-	-	-	-



The data fixes are now underway and RTT report have been submitted for February data, with a outcome of 95.1 per cent achievement for non-admitted patients.

Data will be refreshed in the board reporting pack next month.

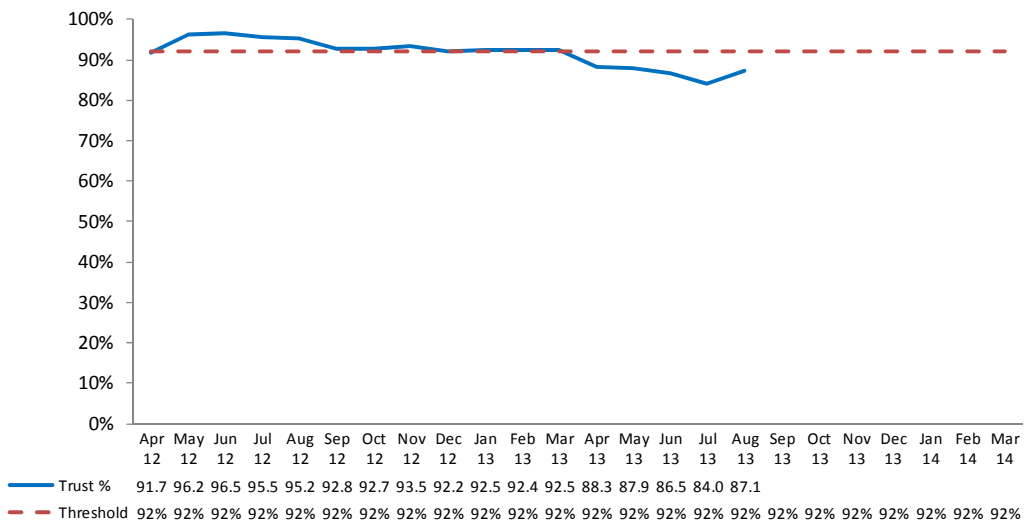
Referral to Treatment 18 weeks - Incomplete

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), the incomplete pathway data will not be live until the May version release.
Manual processes are in place as previously stated.

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	-	-	-	-	-

The data fixes are now underway and RTT report have been submitted for February data, the Trust had no over 52 week patients in February

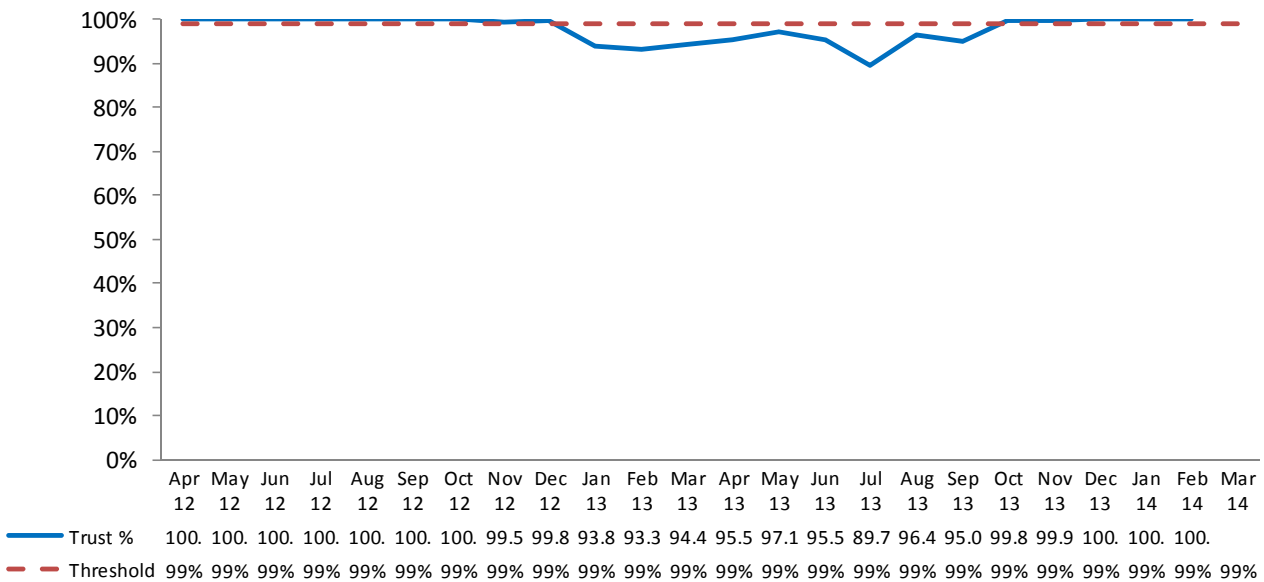
Diagnostic Waits

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	Feb 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%	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).

Good performance has continued with the target being achieved for five consecutive months.

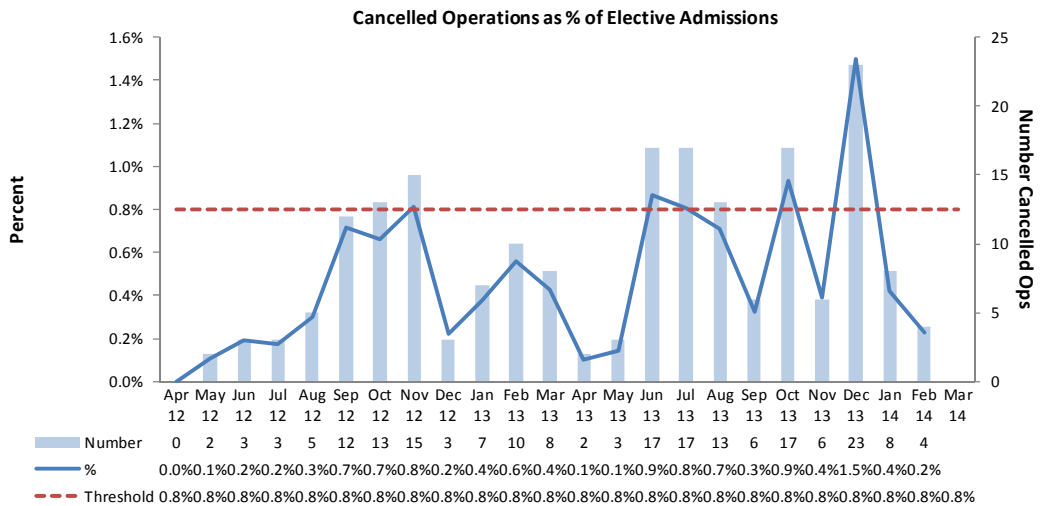
Hospital Cancelled Operations

Deliver

Access Metrics

Hospital initiated cancellations on day of operation

	Number of Cancelled Operations			Cancelled Operations as % of Elective Admissions		
	Dec 13	Jan 14	Feb 14	Dec 13	Jan 14	Feb 14
National Threshold	n/a			< 0.8%		
Trust Total	23	8	4	1.5%	0.4%	0.2%



The number of cancelled operations continues to reduce. One of the four patients cancelled was unavoidable because of clinical reasons. Hospital cancellations are continually reviewed with anaesthetic teams and is proving to show good returns. The process to record cancellations has been extended to include emergency operations, and reporting will be reflected from March 2014 onwards.

Emergency Department Waits

Deliver

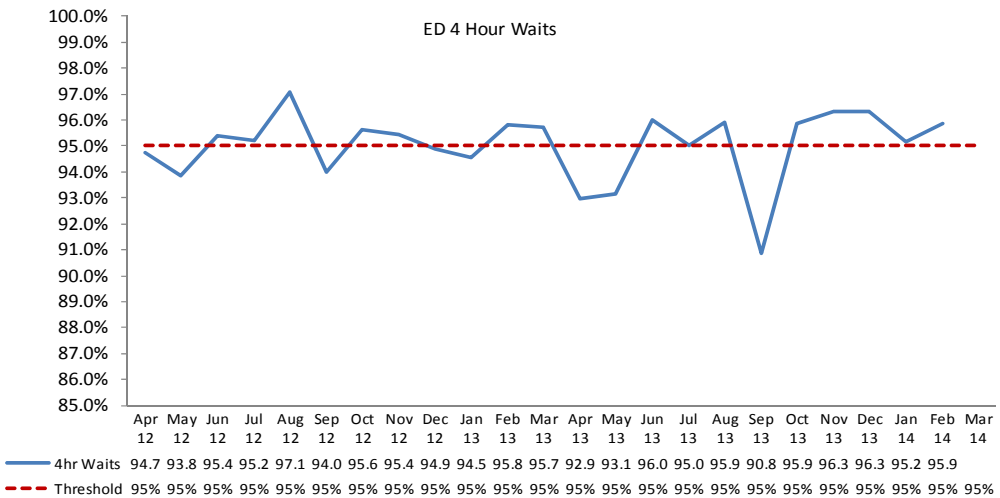
Access Metrics

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	Feb 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%	95.9%
12hr Waits	0	0	0	0	0	1	0	0	0	0	0

Wait for treatment and Re-attendance rate indicators not currently available



Clinical Quality Indicators	Dec 13	Jan 14	Feb 14
Total Time in ED (95th % Wait < 240 mins)	239	240	240
Total Time in ED - Admitted (95th % Wait < 240 mins)	425	650	441
Total Time in ED - Non-Admitted (95th % Wait < 240 mins)	235	236	237
Wait for Assessment (95th % Wait < 15 mins)	15	15	15
Wait for Treatment (Median <60 mins)	73	66	72
Left Without Being Seen Rate (<5%)	4.6%	3.5%	4.68%
Re-attendance Rate (>1% and <5%)	-	-	-

Achievement of four hour wait target for fifth consecutive month, with year to date performance over the 95% national threshold.
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.

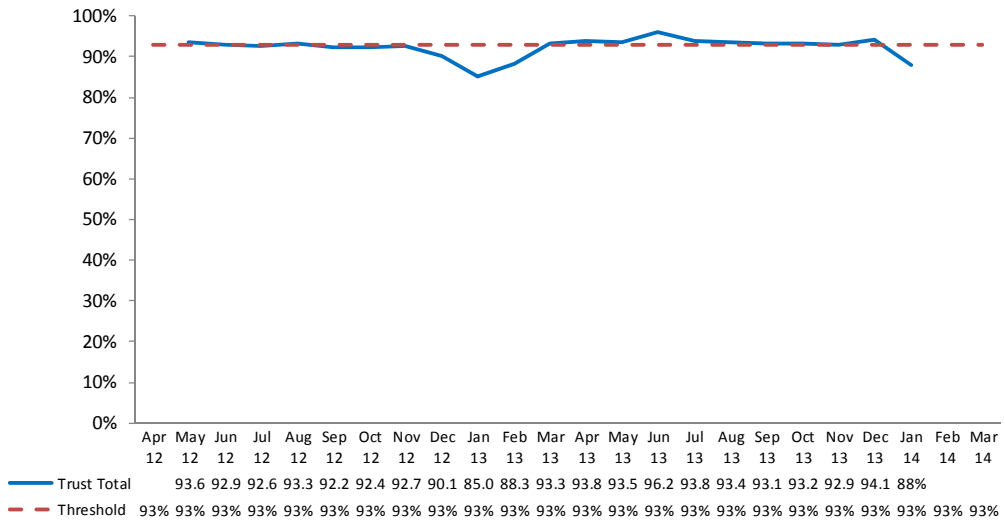
Cancer – 14 days to first seen

Deliver

Access Metrics

14 Days to First Seen

	Nov 13	Dec 13	Jan 14	Q1	Q2	Q3	Q4 TD
National Threshold	93%			93%			
Trust Total	92.9%	94.1%	87.9%	94.6%	93.5%	93.4%	87.9%



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

The threshold was not achieved in January with 42 of the 45 breaches in SCD being due to patient choice to not attend over the Christmas period. The organisation and commissioners have been informed of the non-compliance.
The Cancer team are working with GPs to improve patient awareness of the importance of attending within 14 days of referral.
A new process has been agreed to update the Cancer Access policy to offer all patients two dates within 2 weeks of referral, and if patients cannot attend they will be discharged back to their GP so they are being actively monitored. This new process starts Monday 24th March 2014.

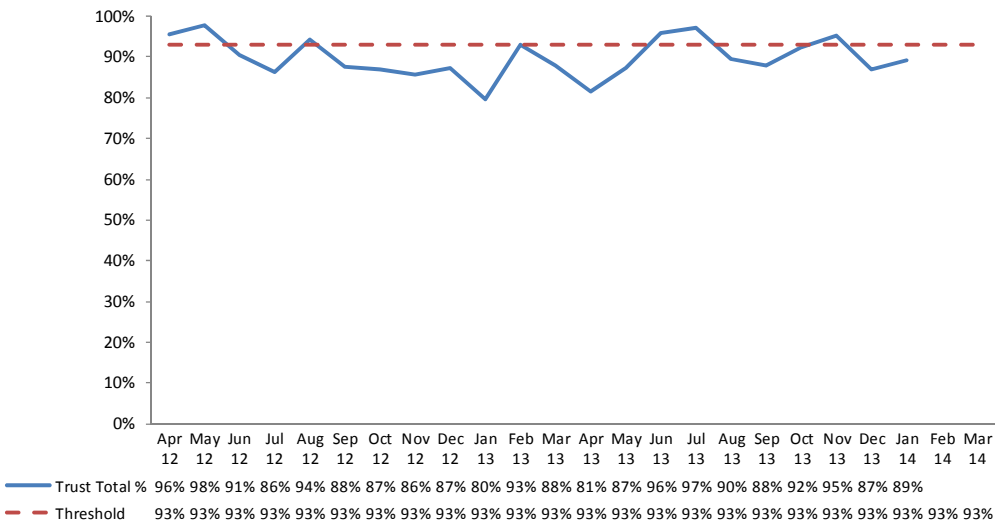
Cancer – 14 days to first seen – Breast symptomatic

Deliver

Access Metrics

14 Days to First Seen - Breast Symptomatic

	Nov 13	Dec 13	Jan 14	Q1	Q2	Q3	Q4 TD
National Threshold	93%			93%			
Trust Total	95.14%	87.0%	89.3%	88.2%	92.1%	91.6%	89.3%



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 both December and January the standard was not achieved, with 87.0% and 89.3% performance respectively. This was due to patient choice. Sustainable compliance is dependant on patient choice policy being updated with Trust Development Authority (TDA) and Commissioner agreement.
A new process has been agreed to change the Cancer Access policy to offer all patients two dates within 2 weeks of referral, and if they cannot attend they will be discharged back to their GP so they are actively being monitored. This new process starts Monday 24th March 2014.

Cancer – 31 Days to first treatment

Deliver

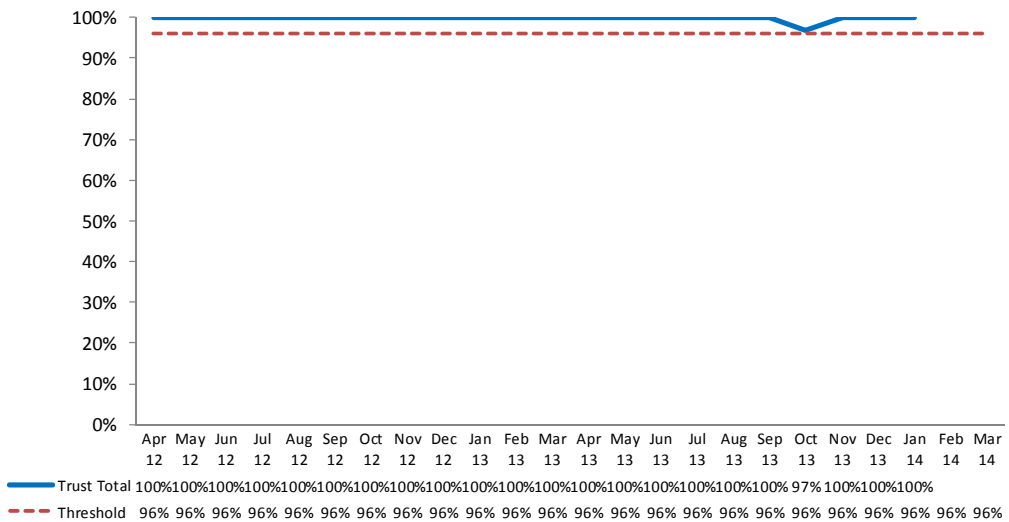
Access Metrics

31 Days to First Treatment

	Nov 13	Dec 13	Jan 14	Q1	Q2	Q3	Q4 TD
National Threshold	96%			96%			
Trust Total	100%	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

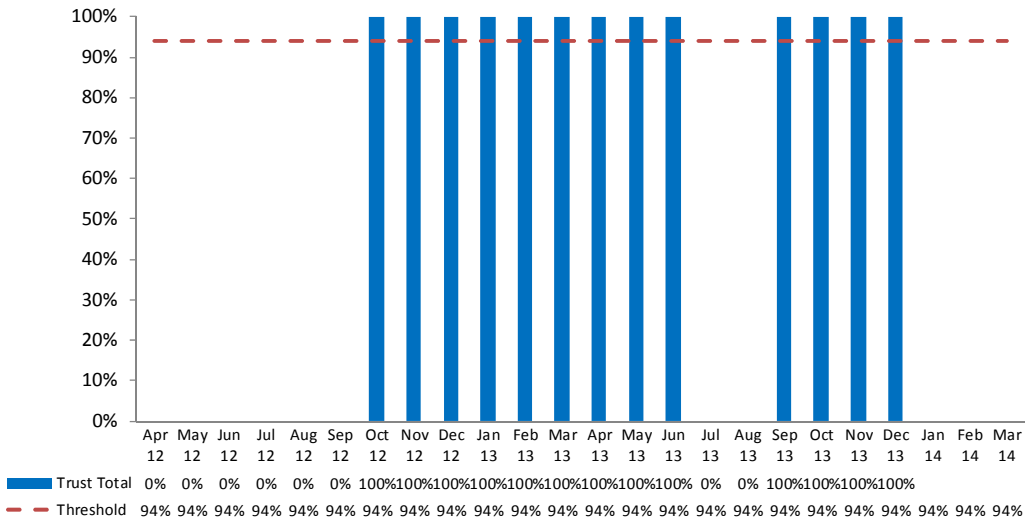
Access Metrics

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

31 day target is timed from diagnosis to treatment.

31 Days to Subsequent Treatment - Surgery

	Nov 13	Dec 13	Jan 14	Q1	Q2	Q3	Q4 TD
National Threshold	94%			94%			
Trust Total	100%	100%	-	100%	100%	100%	-



Delivering 100% compliance and sustainably meeting the national threshold.

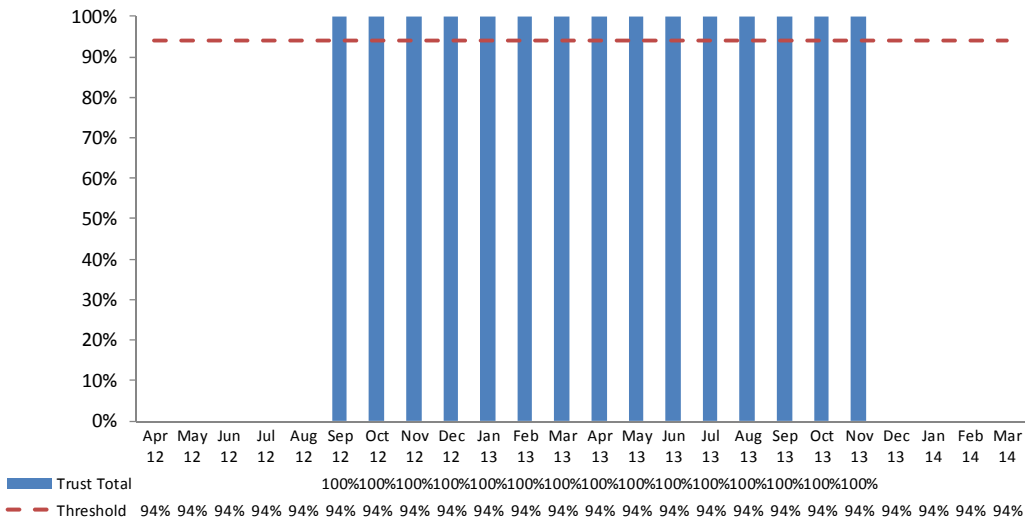
Cancer – 31 days to subsequent treatment - Drugs

Deliver

Access Metrics

31 Days to Subsequent Treatment - Drugs

	Nov 13	Dec 13	Jan 14	Q1	Q2	Q3	Q4 TD
National Threshold	94%			94%			
Trust Total	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 or January.

Cancer – 62 days from referral to treatment

Deliver

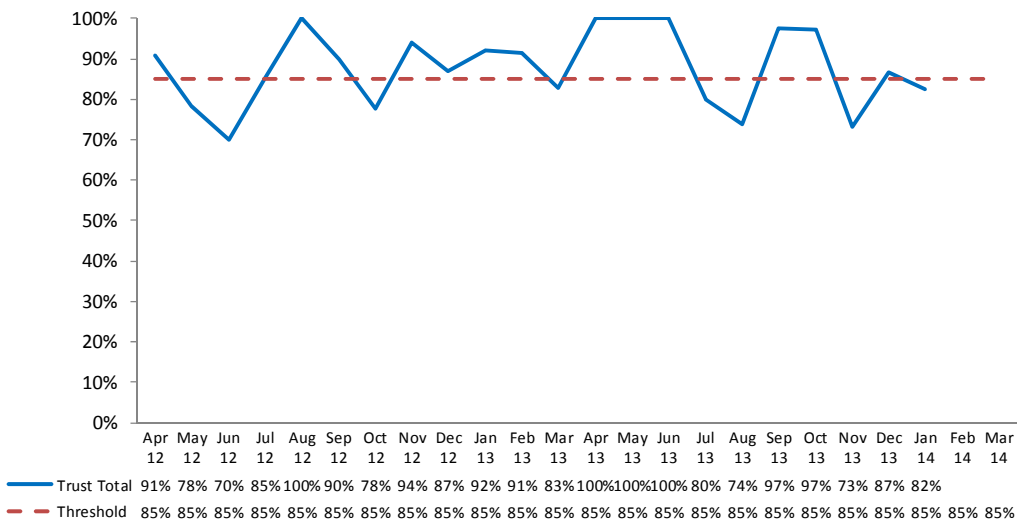
Access Metrics

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

	Nov 13	Dec 13	Jan 14	Q1	Q2	Q3	Q4 TD
National Threshold	85%			85%			
Trust Total	73.2%	86.5%	82.4%	100.0%	83.1%	85.2%	82.4%



The Trust was not compliant with the national threshold in January with performance at 82.4%, The target is being met in Haematology and Upper Gastrointestinal, however the percentage is down in Lung due to patient choice. Non-compliance is also due to continuing removal of the urology backlog. A new pathway for prostate patients has now started at the beginning of March 2014 and is already improving performance against this standard.

Cancer – 62 days from consultant upgrade

Deliver

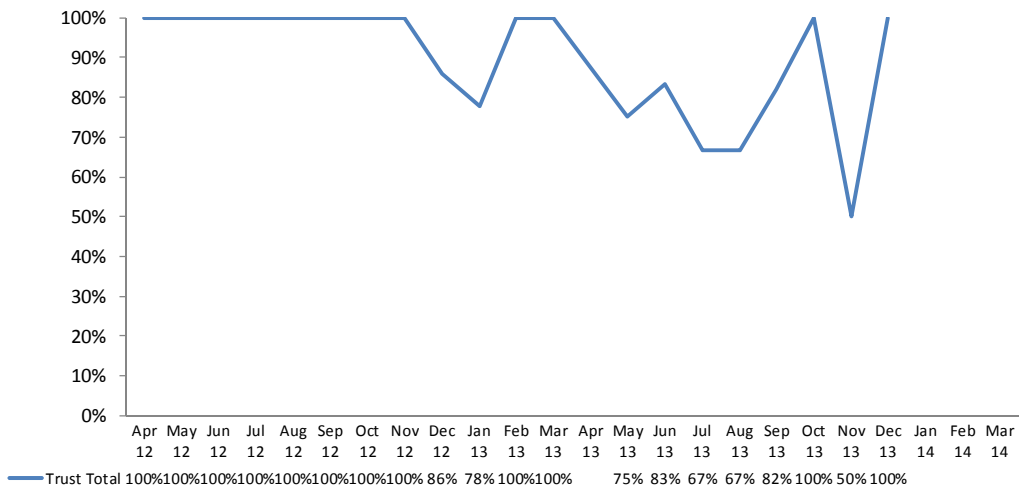
Access Metrics

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

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

62 Days from Consultant Upgrade

	Nov 13	Dec 13	Jan 14	Q1	Q2	Q3	Q4 TD
Trust Total	50.0%	100.0%	-	80%	72.4%	95.0%	-



Delivering 100% against this indicator, although there is no national standard.
Consultant upgrade procedure changed on 17 February 2014 in line with new Cancer Access Policy.
This will mean patients 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.

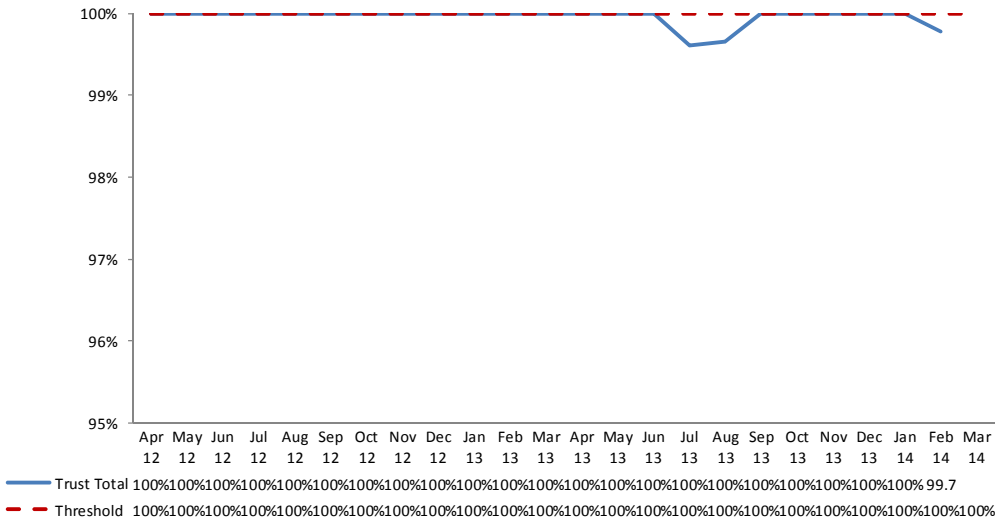
Genito-Urinary Medicine Appointment within 2 Days

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	Feb 14
Trust Total	100%	100%	100%	100%	99.6%	99.7%	100%	100%	100%	100%	100%	99.78%



Delivery slipped to 99.78% after achieving 100% compliance for the five consecutive months. There have been IT issues for five consecutive Mondays which have been escalated and added to the risk register. A solution is in the process of being identified.

Delayed Transfers of Care

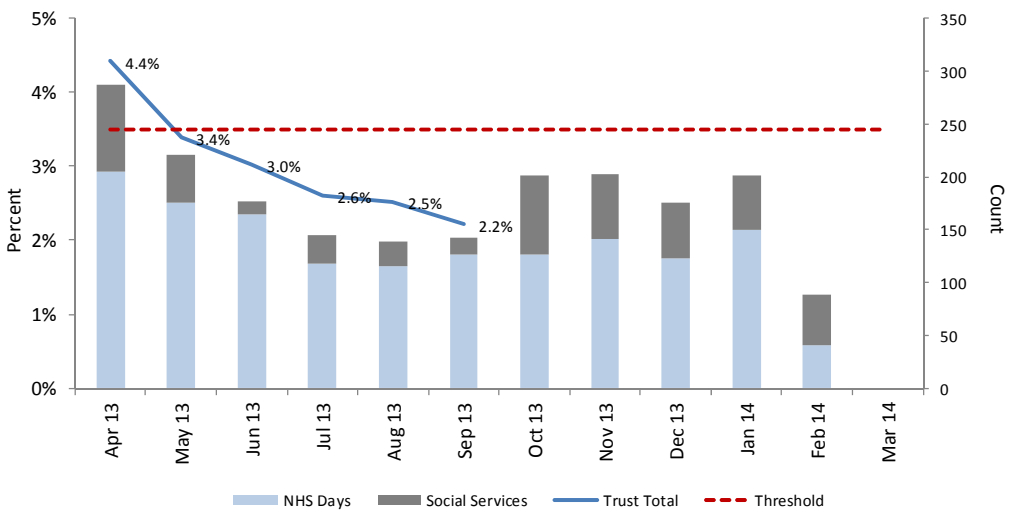
Integrate

Outcome Metrics

Number of Days Delayed

	Feb 14		
	NHS Days	Social Services	Both
Trust Total	41	47	0

	Nov 13	Dec 13	Jan 14
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

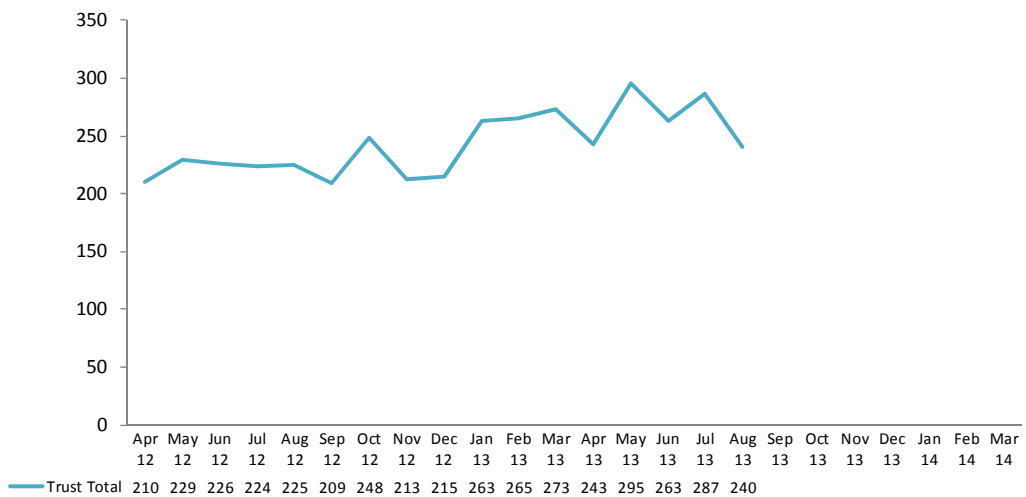
High performance maintained, with February seeing the best performance year-to-date. Actions include working with local authority partners and timely adherence to escalation policy, particularly for out of sector delays, and use of bed meetings to identify potential delays and resolve early where possible.

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.

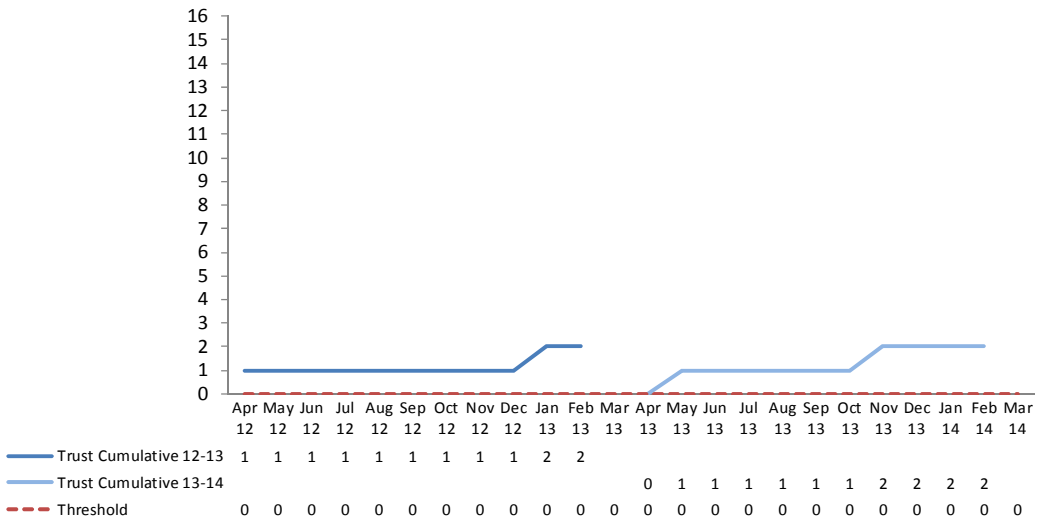
MRSA

Deliver

Outcome Metrics

Number of MRSA bacteraemia (bacteria in the blood)

	Apr 13	May 13	Jun 13	Jul 13	Aug 13	Sep 13	Oct 13	Nov 13	Dec 13	Jan 14	Feb 14
National Threshold	0										
Trust Total	0	1	0	0	0	0	0	1	0	0	0



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

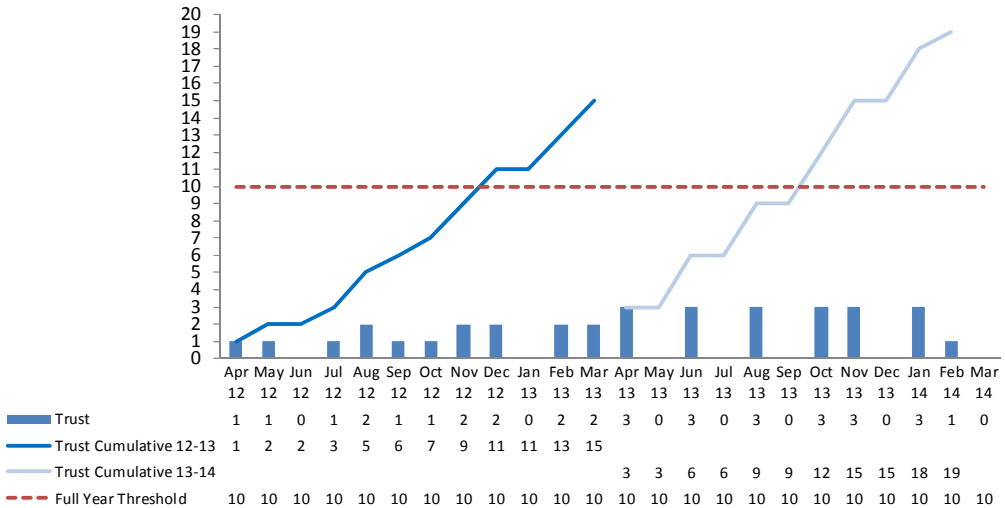
C Difficile Infections

Deliver

Outcome Metrics

	Apr 13	May 13	Jun 13	Jul 13	Aug 13	Sep 13	Oct 13	Nov 13	Dec 13	Jan 14	Feb 14
Full Year National Threshold	<=10										
Trust Total	3	0	3	0	3	0	3	3	0	3	1

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



There was one case reported in February taking the trust total to 19 cases reported year to date, against a full year threshold of 10. All cases have been reviewed in depth and discussed with the TDA. An action plan to prevent further cases has been submitted to the 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

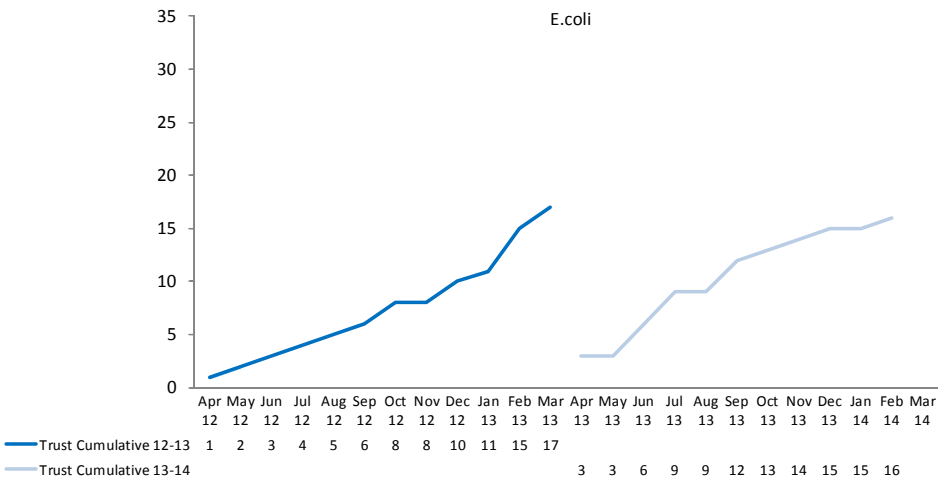
E.coli (Post 48 Hours)

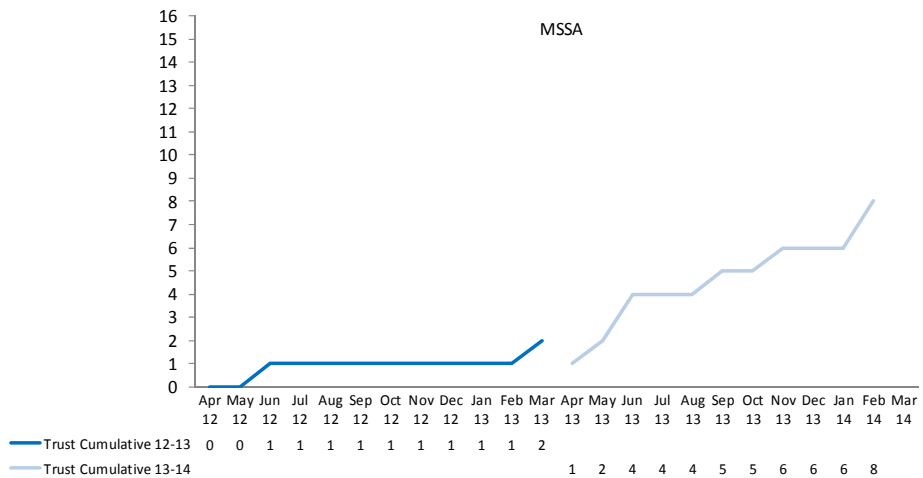
	Dec 13	Jan 14	Feb 14
Threshold	n/a		
Trust Total	1	0	1

MSSA (Post 48 Hours)

	Dec 13	Jan 14	Feb 14
Threshold	n/a		
Trust Total	0	0	2

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





The trust has reported 16 E.coli and 8 MSSA bacteraemia year-to-date. There are currently no national thresholds for these indicators.

Harm Free Care

Deliver

Outcome Metrics

	Contractual Threshold	Dec 13	Jan 14	Feb 14
% of Harm Free Care	95%	93.58%	95.06%	91.63%
Completeness of Safety Thermometer (CQUIN)	100%	100%	100%	100%
Pressure Ulcer (PU) Incidence	50% Reduction	16	20	

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

Feb 13

	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	792	711	89.77%	73	9.22%	0	0.00%	8	1.01%	2	0.25%
SCD	82	82	100.00%	0	0.00%	0	-	0	-	0	0.00%
WCF	94	94	100%	0	-	0	-	0	-	0	-
Trust Total	**968**	**887**	**92%**	**73**	**7.54%**	**0**	**0.00%**	**8**	**0.83%**	**2**	**0.21%**

Pressure Ulcers	**Cat 2-4**	**Cat 2**	**Cat 3**	**Cat 4**
All	73	42	19	12
Old	43	23	11	9
New	32	20	9	3

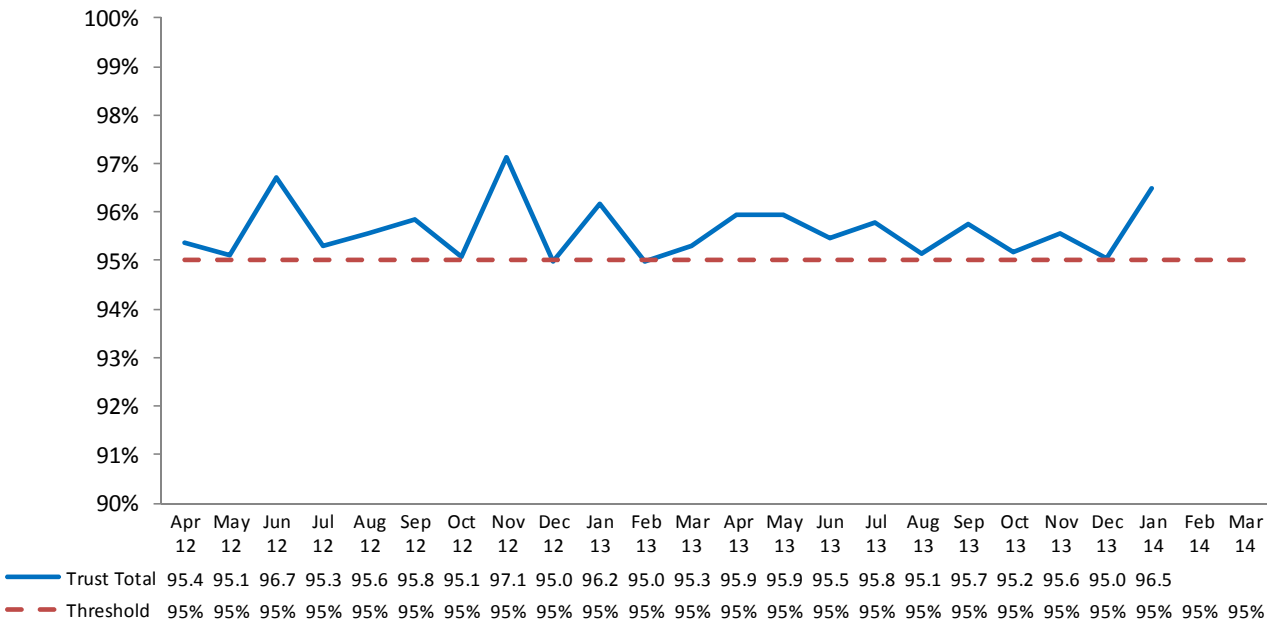
The safety thermometer identifies the prevalence of four measures of harm across all patients in trust settings on a particular day each month – urinary catheter related infection, pressure ulceration, VTE and falls. The target is to achieve 95% harm free care. In February WH achieved 91.63%.

VTE Risk Assessment

Deliver

Outcome Metrics

	VTE Risk Assessed (CQUIN)			RCA for Hospital Acquired		
	Nov 13	Dec 13	Jan 14	Nov 13	Dec 13	Jan 14
CQUIN Threshold	95%			Target to be decided		
Trust Total	95.6%	95.0%	96.5%	1	6	0



Venous Thromboembolism (VTE) is a condition in which a blood clot (thrombus) forms in a vein
Risk assessment is for all inpatients to ensure they receive appropriate interventions if high risk.

RCA is Root Cause Analysis Performed
Incidence is number of Deep Vein Thrombosis and Pulmonary Embolisms (blood clots) in month

Data is 1 month in arrears due to requirement for clinical coded data.
VTE Incidence data not currently available

Continue to achieve threshold. 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. A reminder was sent to all staff relating to the importance of completing the VTE assessments following last month's indicators. This metric has improved. It is now aimed that this is sustainably delivered.

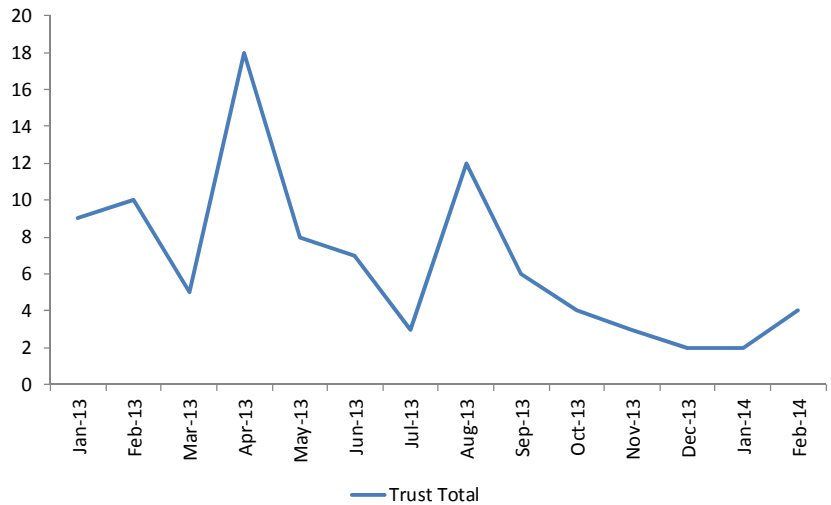
Serious Incidents

Change

Outcome Metrics

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

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



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

Change

Outcome Metrics

Never Event Reported to STEIS on 12/12/2013

Retained Retractor - Never Event

64 year old patient had a hip replacement on 13/09/2013. Operation carried out by Senior and Junior Registrars. A fragment of metal, one of the teeth of the Charnley retractor used to retract the wound, was noticed on the post op check X-Ray. This would not have been known about at the time of the first operation. Fragment was removed and patients given open disclosure of incident.

The final SI report regarding the retained part of the retractor is to be reviewed in April 2014.

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.

WCF and Information Governance to review how Alerts are cascaded down to Community Services.

Ward Cleanliness

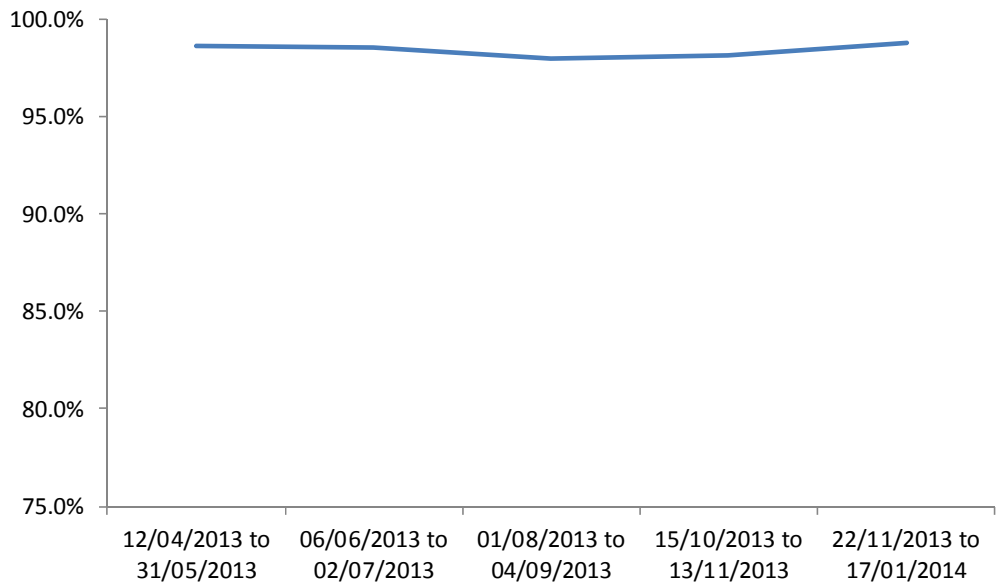
Change

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

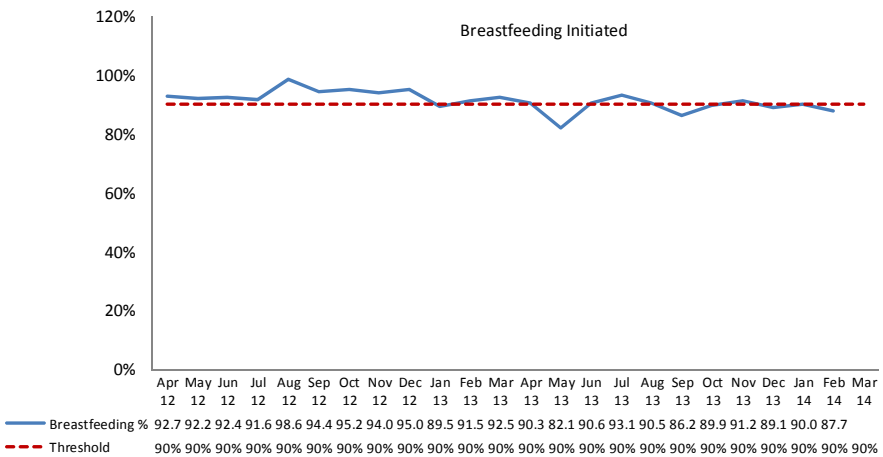
Breastfeeding and Smoking

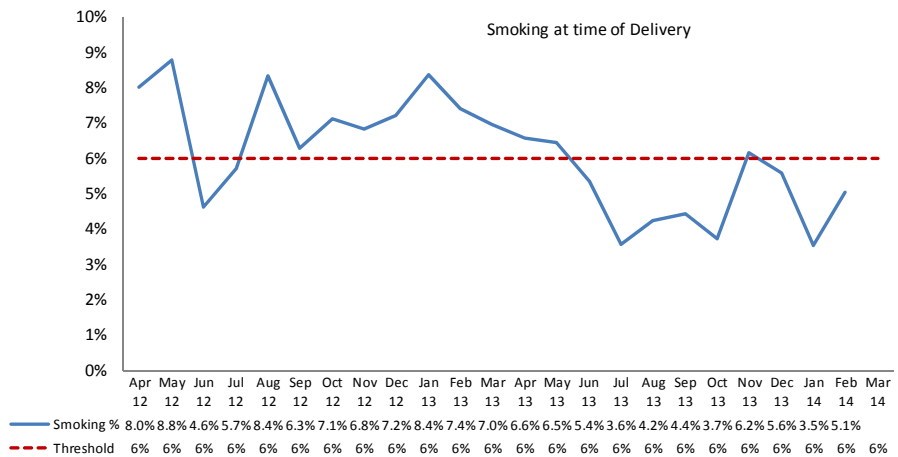
Improving

Outcome Metrics

	Threshold	Dec 13	Jan 14	Feb 14
Breastfeeding Initiated	90%	89.1%	90.0%	87.7%
Smoking at Delivery	<6%	5.6%	3.5%	5.1%

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 was not met in February at 87.7%.
Smoking at time of delivery has met the target for three consecutive months, with the performance at 3.5% being the best performance reported since April 2012.

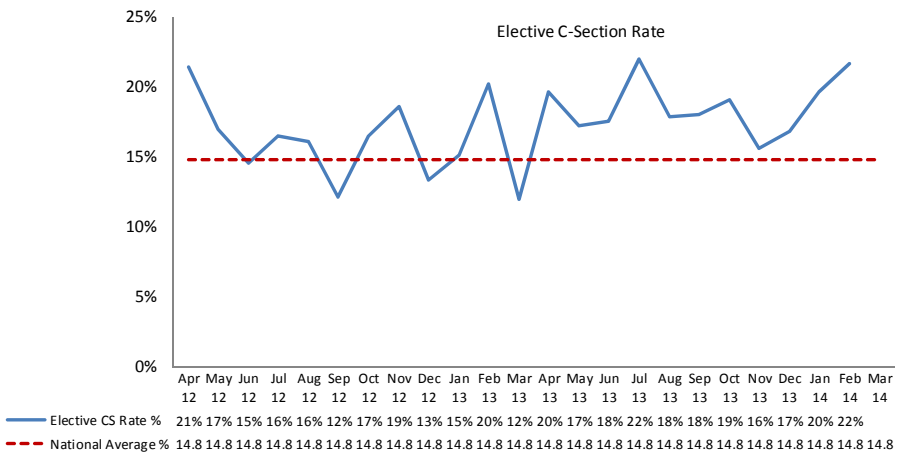
Caesarean Section Rates

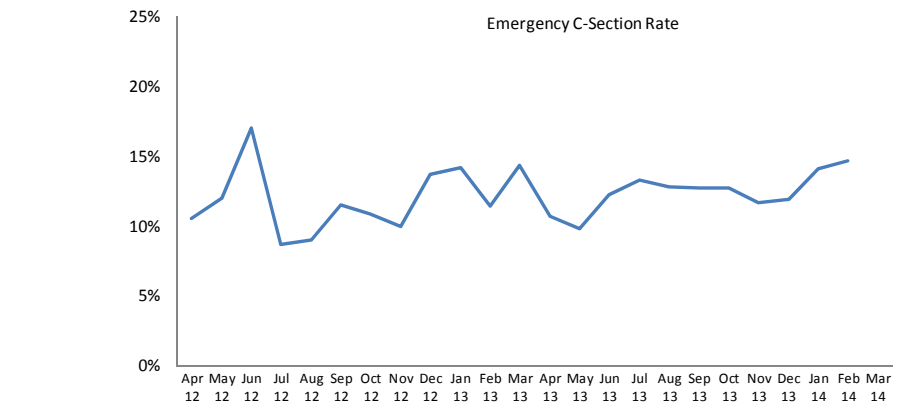
Deliver

Outcome Metrics

	National Average	Dec 13	Jan 14	Feb 14
Elective C-Section Rate	14.8%	16.8%	19.7%	21.7%
Emergency C-Section Rate	-	11.9%	14.1%	14.7%
All Deliveries	-	285	320	300

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





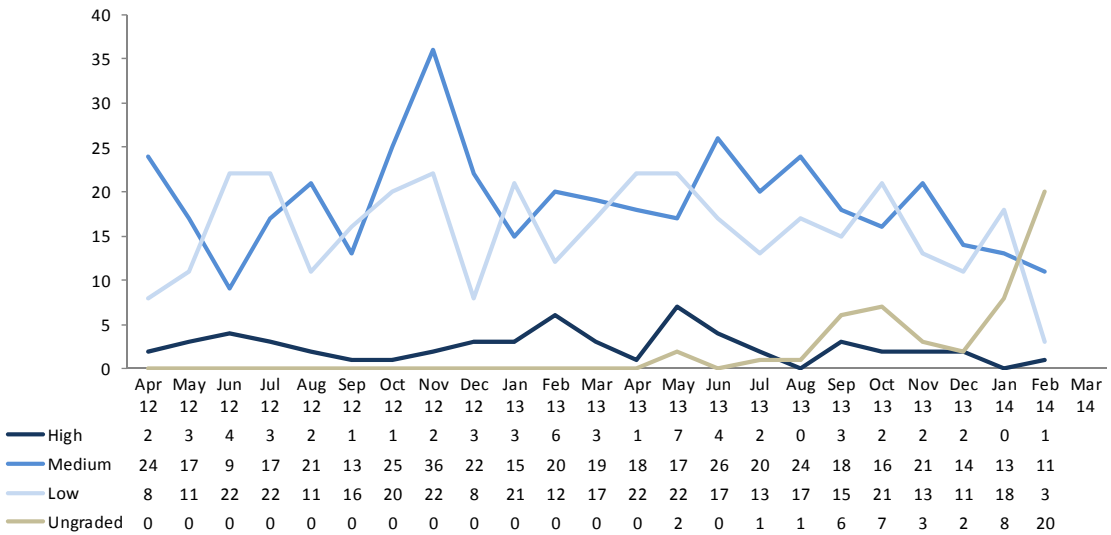
New Midwife Consultant in Public Health and Head of Maternity are part of PAN-London group focused on reducing Elective C-Section rate. Vaginal Birth after Caesarean (VBAC) clinic is in process of being set up.
An audit is being carried out on our rate of VBAC and a sections audit is also being undertaking as PAN London project.

Medication Errors Causing Harm

Change

Outcome Metrics

		Apr 13	May 13	Jun13	Jul 13	Aug 13	Sep 13	Oct 13	Nov 13	Dec 13	Jan 13	Feb 14
Risk	High	1	7	4	2	0	3	2	3	2	0	1
	Medium	18	17	26	20	24	18	16	22	14	13	11
	Low	22	22	17	13	17	15	21	13	11	18	3
	Ungraded	0	2	0	1	1	6	7	2	2	8	20
	Total	41	48	47	36	42	42	46	40	29	39	35



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 one high risk incident reported in February was in ITU which was investigated fully and relevant actions taken. The patient suffered no harm as a result. The medication safety committee have been asked to provide more detailed reports to individual divisions relating to medication errors.

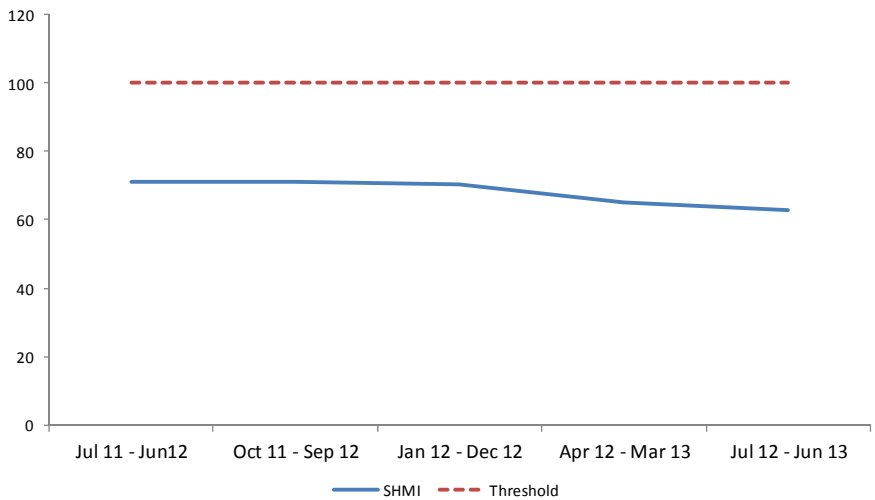
SHMI

Change

Outcome Metrics

	Threshold	Jul 11 - Jun12	Oct 11 - Sep 12	Jan 12 - Dec 12	Apr 12 - Mar 13	Jul 12 - Jun 13
SHMI	100	71.08	71.28	70.31	65	63

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



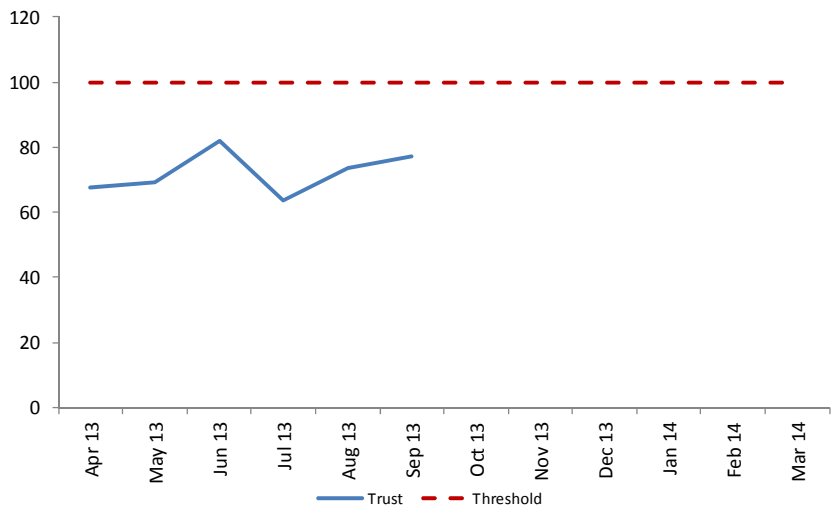
No further update on SHMI data, however, the Trust continues to achieve an excellent SHMI score.

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

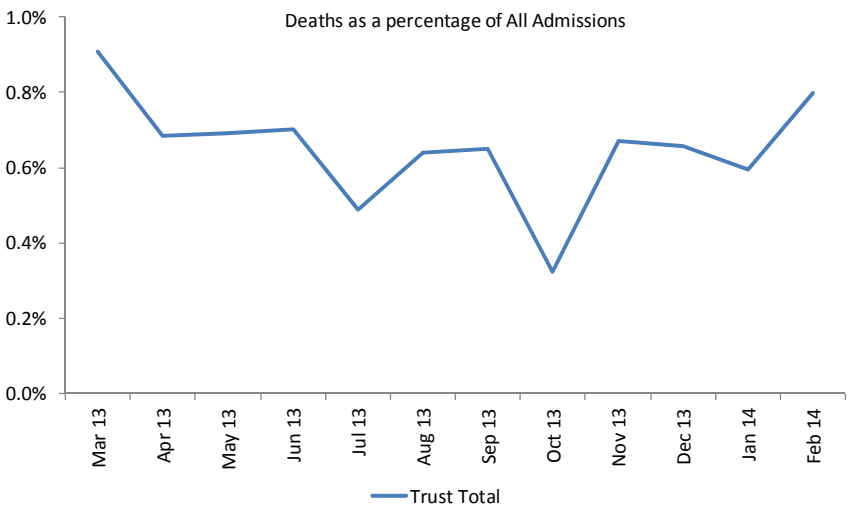
No data submitted after September 2013 due to EPR reporting issues.

Number of Inpatient Deaths

Outcome Metrics

	Deaths			Percentage of Admissions		
	Dec 13	Jan 14	Feb 14	Dec 13	Jan 14	Feb 14
Trust Total	28	28	35	0.7%	0.6%	0.8%

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 and Family)

Ensure

Quality Indicators

	Dec 13	Jan 14	Feb 14
Inpatient Coverage	49.0%	51.0%	40.0%
Emergency Department Coverage	12.5%	16.1%	16.7%
Total Coverage (IP/ED)	19.0%	21.9%	20.6%
Inpatient Net Promoter Score	62	63	70
Emergency Department Net Promoter Score	63	52	54
Total Net Promoter Score (IP/ED)	62	56	59

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

Continued 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. Deputy Head of Nursing working with wards where coverage has dipped.
The CQUIN threshold of 15% has been achieved for the third 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

Not Clinically justified occurence

	Jan-14	Feb-14
Cavell Rehabilitation Ward	0	0
Edward Drive	0	0
ISIS Ward	0	0
Mary Seacole South	49	13
Mercers	0	0
Meyrick Ward	0	0
Bridges Ward	0	0
ICAM	49	13
Coyle Ward	5	0
Intensive Care Unit	46	24
Thorogood Ward	0	0
Victoria Ward	0	0
SCD	51	24
Grand Total	100	37

Clinically justified occurence

	Jan-14	Feb-14
Cavell Rehabilitation Ward	0	0
Edward Drive	0	0
ISIS Ward	0	0
Mary Seacole South	111	39
Mercers	0	0
Meyrick Ward	0	0
Bridges Ward	0	0
ICAM	111	39
Coyle Ward	0	0
Intensive Care Unit	267	257
Thorogood Ward	0	0
Victoria Ward	0	0
SCD	267	257
Grand Total	378	296

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. Whittington Health have adopted a strict policy around MSA and part of the implementation of this is the introduction of reporting across all wards. There were 37 not clinically justified breaches reported for February, down from 100 in January. These are submitted to DH. An action plan has been agreed and shared with commissioners and TDA. There were an additional 296 clinically justified breaches for the same period, that are for local monitoring.

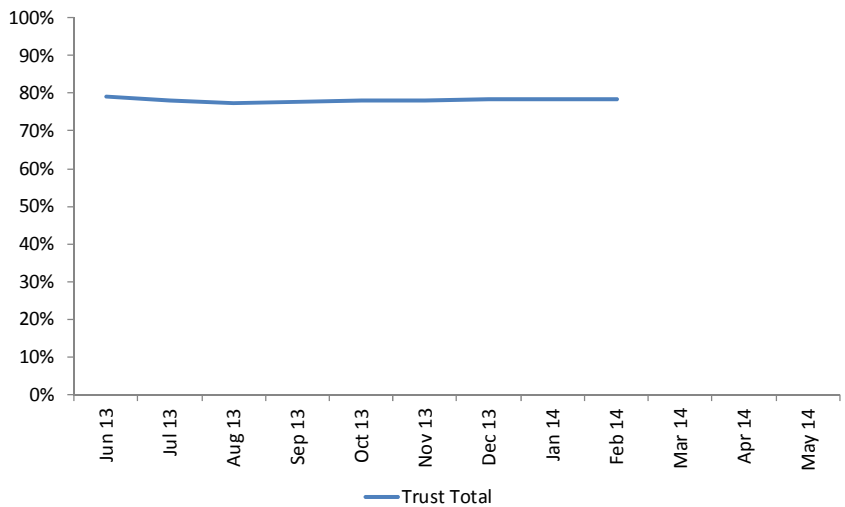
Percentage of Registered Nurses

Change

Quality Indicators

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

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



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.

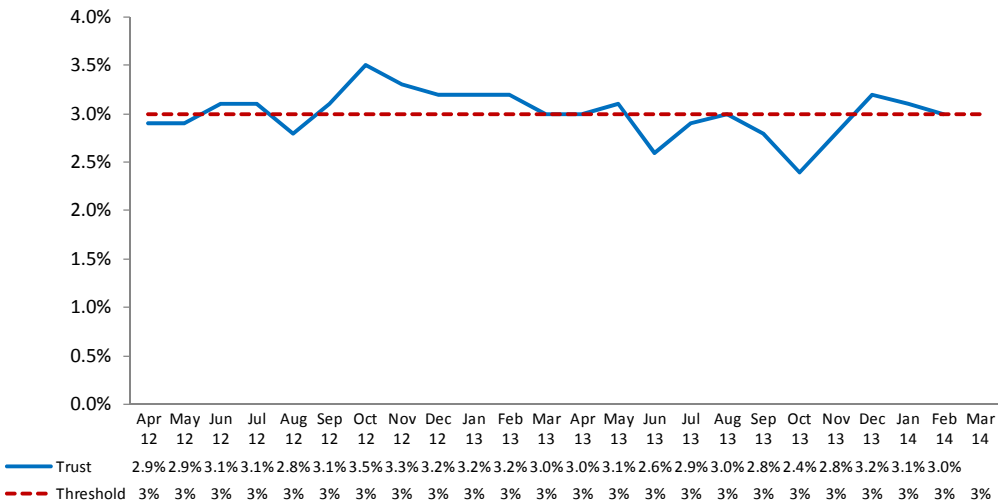
Sickness Rate

Change

Quality Indicators

	Sickness				High Bradford Scores		
	Local Threshold	Dec 13	Jan 14	Feb 14	Dec 13	Jan 14	Feb 14
Trust Total	<3%	3.2%	3.1%	3.0%	713	685	664

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



This month's sickness report has met the Trust threshold of 3%. Renewed efforts including improved sickness data being available to each Divisional Director and regular reports to the Trust Operational Board has enabled senior managers to address those areas where sickness in some areas are high and to ensure managers are held to account for reducing sickness in their services. Further, the Bradford scores are also reducing which demonstrates that managers are tackling sickness as it affects individual employees.

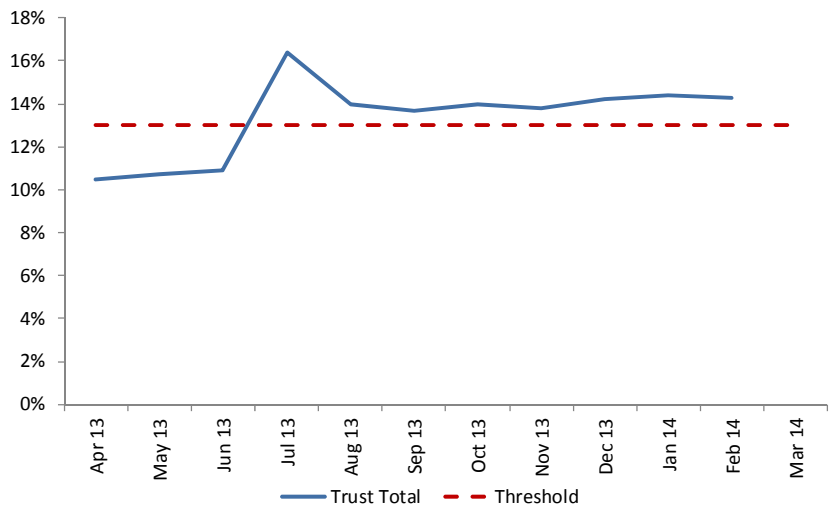
Staff Turnover

Change

Quality Indicators

	Local Threshold	Dec 13	Jan 14	Feb 14
Trust Total	<13%	14.2%	14.4%	14.3%

Proportion of workforce leaving in a given period.

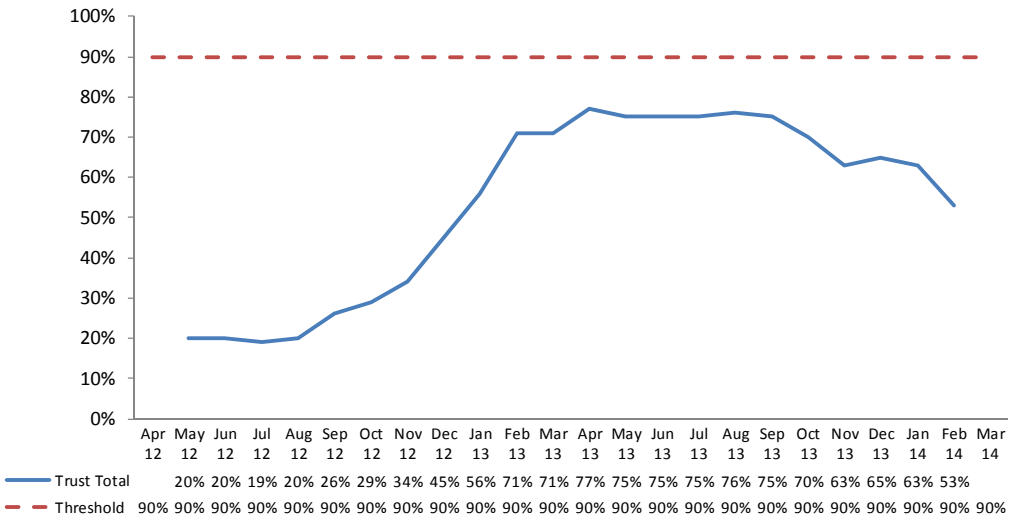


Staff turnover is slightly less than the previous month. The recruitment and retention plans which are a key part of the Succession planning strategy aim to address staff turnover figures and move to the threshold. They include a strategic approach to filling nurse vacancies which was set out in the workforce plan and discussed at the Trust Board seminar, improving the numbers of exit interviews, reducing the reliance on agency workers and ensuring succession for key posts across the Trust.

Staff Appraisal

	Local Threshold	Dec 13	Jan 14	Feb 14
Trust Total	90%	65.0%	63.0%	53.0%

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



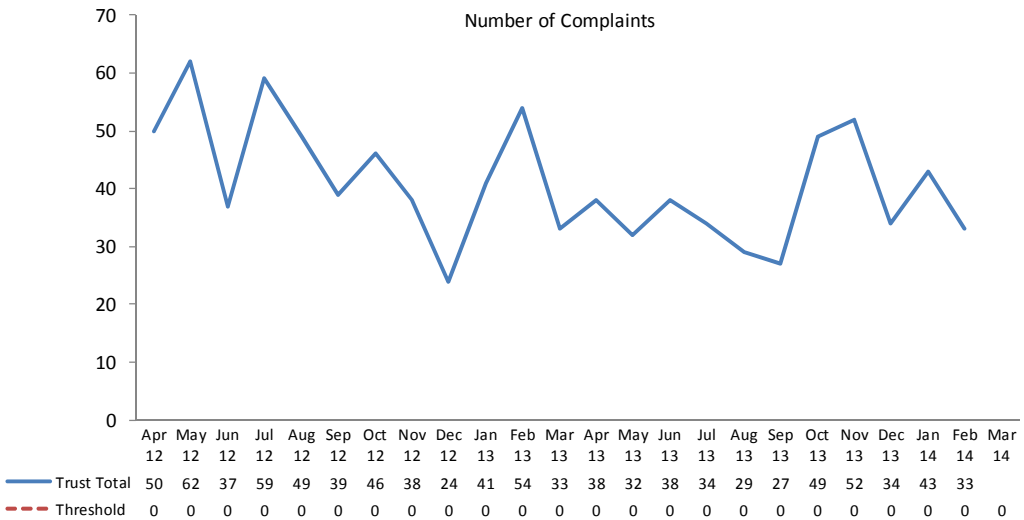
ESR data entries has experienced problems in not being recorded to match 28th of the month snapshot. Target reports out to Divisional managers showing service teams not meeting compliance. Recommendation to Trust Operation Board for Divisional leads to take swift action to performance manage. Compliance target will be met in 2014-2015 due to new Appraisal Framework launched in April linked to pay progression.

Complaints

Ensure

Quality Indicators

	Complaints				Responded to in 25 days		
	Threshold	Dec 13	Jan 14	Feb 14	Nov 13	Dec 13	Jan 14
Trust Total	0	34	43	33	27%	21%	49%



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.
Although performance is not as high as desired, a significant improvement has been made in complaints responses.

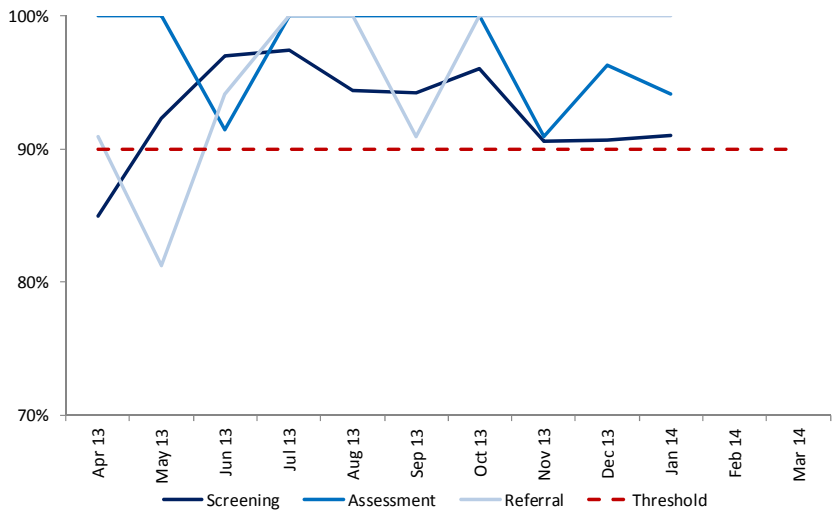
National CQUINs

Integrate

Quality Indicators

Dementia

	Contractual Threshold	Nov 13	Dec 13	Jan 14
Screening	90%	91%	91%	91%
Assessment	90%	91%	96%	94%
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	Jan	Feb
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%	100%	100%
Timely Administration of Total Parenteral Nutrition in Preterm Infants	95%	100%	-	100%	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 has achieved 100% for two consecutive months.
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	Q4
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%	85.6%			
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%	95.7%			
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%				
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%	19.3%		8.0%
Brief Intervention	90%	0.0%	72.7%	78.9%	76.7%	61.9%	84.9%		78.4%				-	100.0%	100.0%		100.0%
GP Communication	90%	0.0%	90.9%	89.5%	90.0%	91.9%	83.0%		77.0%				-	74.7%	82.0%		74.7%
Crime Reduction Partnerships	Report by public health of anonymised dataset on alcohol related																
Audit	Plan for audit submitted and agreed Q1																

Latest data available for both CQUINs due to EPR reporting issues

Stop Smoking continue to sustainably deliver all elements of the CQUIN, however, there was a dip in performance against inpatient smoking status in January.
Alcohol screening is currently at 19.3% for February, which is a significant improvement on January. This performance is dues to actions being put in place at the end of December. 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	Jan	Feb	Mar	Q4
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%	100%			
Community COPD Bundle	75%	100%	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	Oct	Nov	Dec	Q3	Oct	Nov	Dec	Q3
Multidisciplinary Working - Haringey	4 MDT Case conferences a month MDT case conference membership	n/a	n/a	n/a	n/a	4 per week				4 per week				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				4 per month				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%	-			100%	-			96%
Multidisciplinary Actions - Islington	90% of actions completed	n/a	n/a	n/a	n/a	n/a	n/a	n/a	69%	-			69%	-			76%
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				A.E.C.S is co-located with Emergency Dept				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%	Qtr 2 Figs CMs only			18%	CMs & LTC nurses			60%
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%	Qtr 2 Figs CMs only			38%	Qtr 3 fig LTC6 received. Combined denominator to be determined			1900%

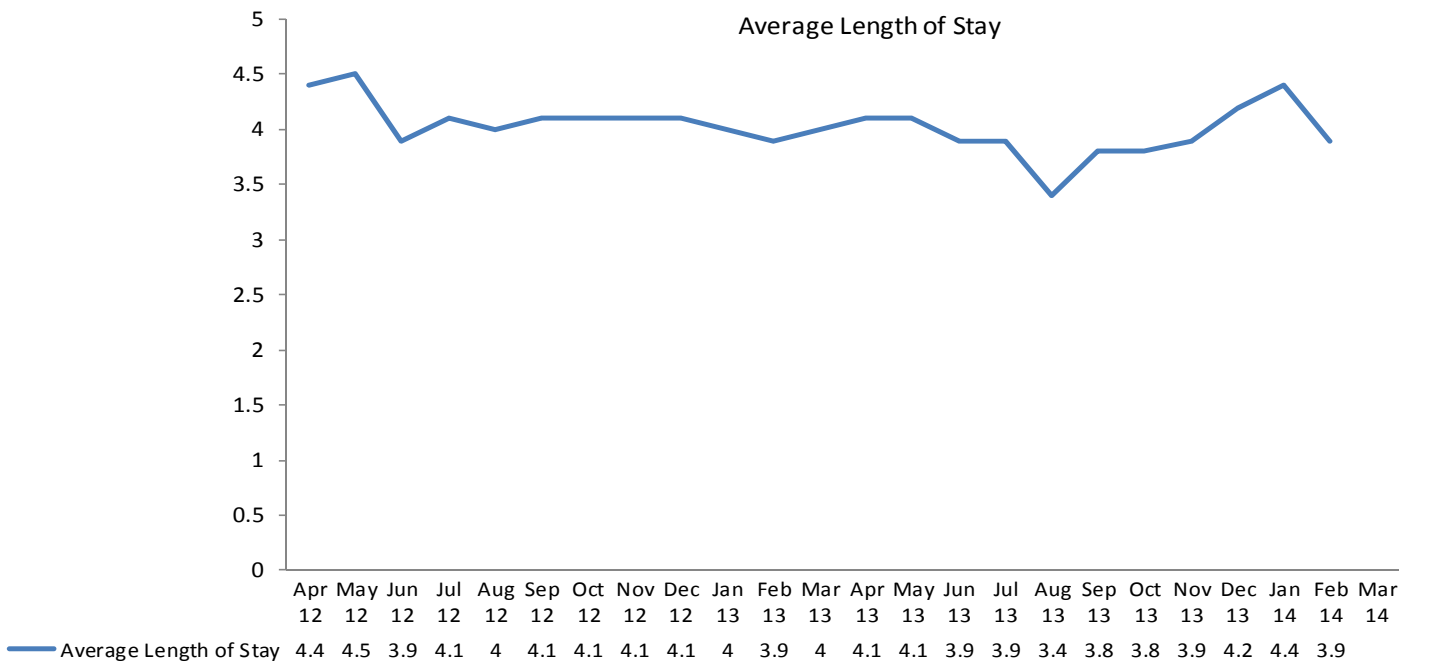
Work is in progress to address the underperformance re MDT action plans (Islington) which currently includes actions from Paediatrics MDT.

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	Feb 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	3.9



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.

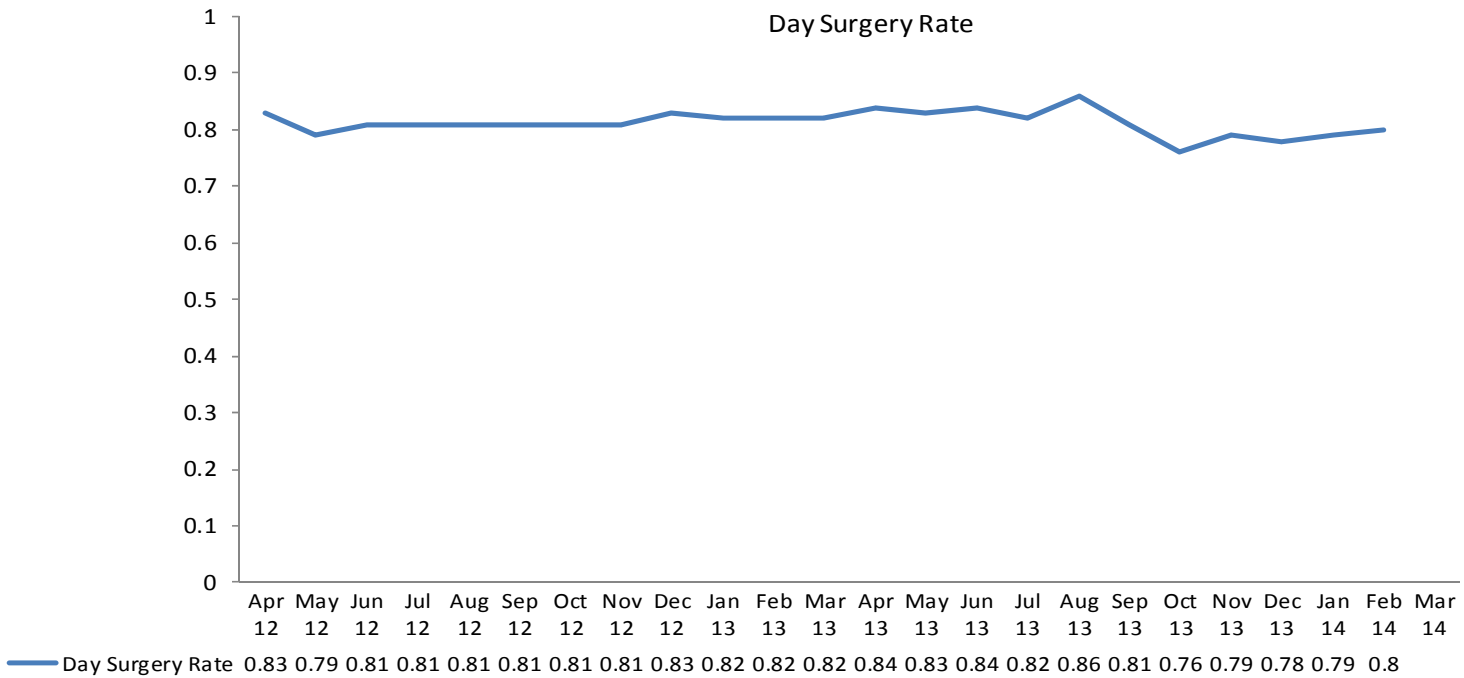
Day Surgery Rate

Deliver

Quality Indicators

	Threshold	Apr 13	May 13	Jun 13	Jul 13	Aug 13	Sep 13	Oct 13	Nov 13	Dec 13	Jan 14	Feb 14
Trust Total	n/a	84%	83%	84%	82%	86%	81%	76%	79%	78%	79%	80%

Proportion of total elective surgeries carried out as a daycase



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

Activity

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