Whittington Health NHS

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# Whittington Health Trust Board

7 May 2014

| | | | |
|---|---|---|---|
| **Title:** | Trust Board Performance Report May 2014 (March data) | | |
| **Agenda item:** | **14/086** | **Paper** | **5** |
| **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.<br><br>Key headlines<br><br>• The operational team are focusing on community waiting times, particularly in MSK and District Nursing. Improvement plans and Primary Target Lists (PTL) are being implemented over the next four weeks (slides 13-15). Detailed improvement work is underway to review, identify and implement sustainable improvements in District Nursing and MSK services. Waiting list management training is also being provided for staff who manage waiting lists in the community for both adults and paediatrics.<br>• RTT admitted and non-admitted national standards are met in March (slides 18-19)<br>• Diagnostic waits (slide 22) performance continues to achieve the threshold, for the sixth consecutive month.<br>• There were no cancelled operations in March (slide 23).<br>• Emergency Department (ED) met the full year target with 95.1 per cent of patients seen within four hours, and monthly delivery for the sixth consecutive month (slide 24).<br>• Cancer – standards were met for five of the six indicators, however the breast symptomatic standard was not achieved due to 12 out of 13 patients choosing not to attend within the 14 days (slides 25-30).<br>• Breast feeding performance has resumed to 90 per cent (slide 45).<br>• Continuation of excellent Summary Hospital-level Mortality Indicator (SHMI) score (slide 48).<br>• Patient Satisfaction (Friends and Family Test) coverage in ED continues to improve (slide 51).<br>• Sickness rate has reduced to 2.6 per cent and the number of staff with high Bradford scores has reduced by 68 in month | | |

| | |
|---|---|
| | (slide 55).<br>• The percentage of complaints responded to within 25 days has improved considerably (slide 59).<br><br>As improvements are being implemented a dip in performance will be seen following the introduction of new practices. This is due to clearing backlog or longer response times. Areas such as Did Not Attend (DNAs), first to follow-up ratios and MSK waiting times will be included in this. |
| **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:** | 28 April 2014 |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Author name and title:** | | **Caroline Angel, Head of Performance** | | **Director name and title:** | | **Lee Martin, Chief Operating Officer** | |
| **Date paper seen by EC** | | **Equality Impact Assessment complete?** | | **Quality Impact Assessment complete?** | | **Financial Impact Assessment complete?** | |

Whittington Health NHS

# Trust Board Report

## May 2014
## (March data)

# Executive Summary

Focus Areas

**Areas showing improvement**

•Emergency Department achieved the four-hour standard for 2013/14, maintaining performance above target for the last six consecutive months
•Referral to Treatment (RTT) standards for admitted and non-admitted were met in March
•Cancer standards were met for five of the six indicators
•There were no cancelled operations in March
•Ambulatory Care Centre opened on 1 April 2014
•The new TB South Hub opened on 28 April 2014
•ICAM achieved the CAPA Certificate of Excellence for best interim experience

**Areas for improvement and focus**

•MSK
•District Nursing
•Finance
•Ward Cleanliness
•Mandatory Training
•Outpatient Department including service cancellations and Did Not Attends (DNAs)

# Board Aims

Focus Areas

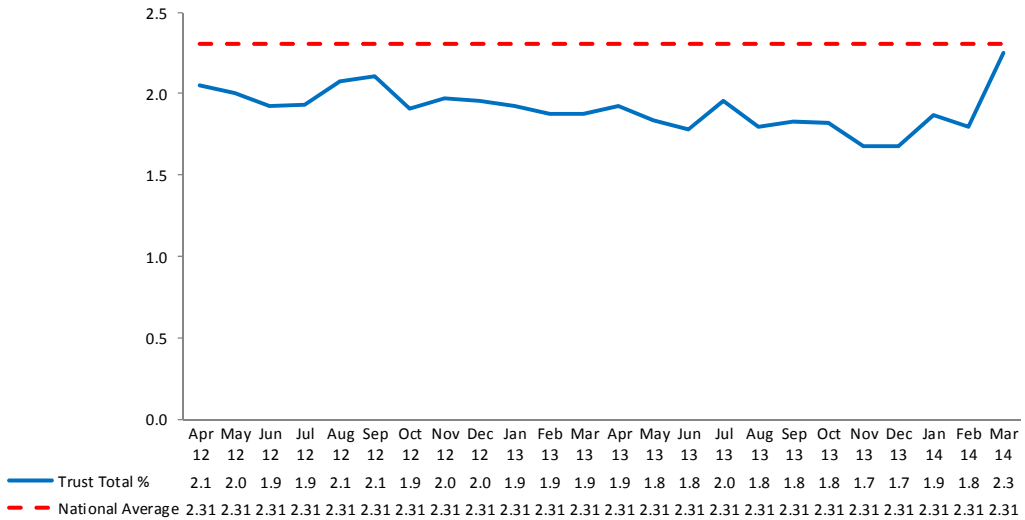

All indicators have been mapped to the Board’s aims

# 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 | Mar 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 | 2.25 |




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

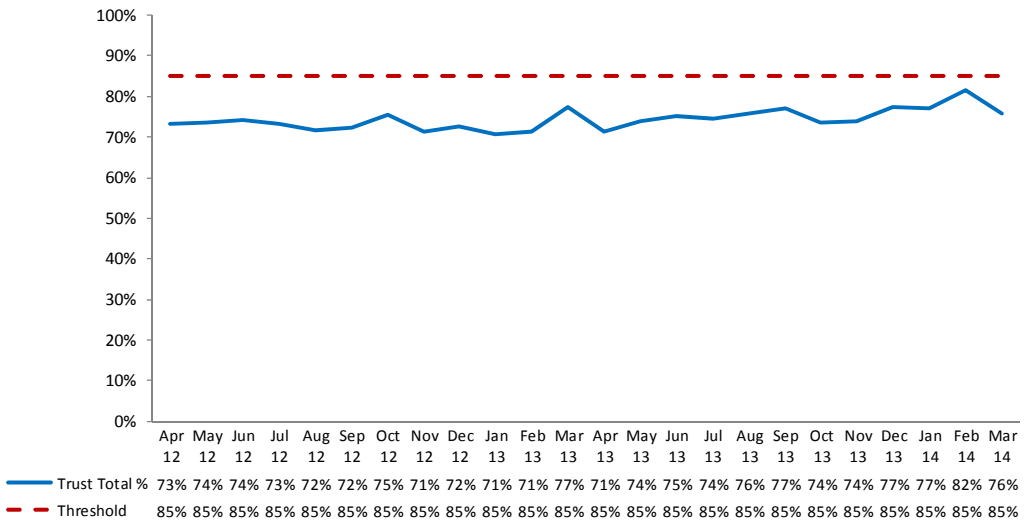
Work continues with the Whittington Health improvement plans. Pilot improvement schemes were run in urology and dermatology, however, this has highlighted potential issues with data recording in outpatients. An audit of 25 patients per specialty will commence in April to evaluate the accuracy of information.
Additional actions are to confirm, publish and implement the discharge policy for both areas, ensuring new patients are seen by a consultant rather than junior medical staff. Outpatient clinic staff have been prioritised for access policy training to ensure activity is recorded correctly, to be completed by the end of May. Clinic templates are under review to better reflect the split between new and follow-up patients. Collaborative work continues with consultants.

# Theatre Utilisation

Deliver

Focus Areas

| | Utilisation | | | Available Session Time (Minutes) | | | Time Utilised (Minutes) | | |
|---|---|---|---|---|---|---|---|---|---|
| | Jan 14 | Feb 14 | Mar 14 | Jan 14 | Feb 14 | Mar 14 | Jan 14 | Feb 14 | Mar 14 |
| Local Threshold | >85% | | | | | | | | |
| Trust Total | 77% | 82% | 76% | 67,110 | 60,840 | 62,280 | 51,690 | 49,676 | 47,134 |




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 maximising theatre utilisation. There is close monitoring of all theatre lists. We expect to see a positive impact on theatre use in April's data.

# Community Dental

Deliver

Focus Areas

| Service | Quality Indicator | Threshold | Method of Measurement | April | May | June | July | Aug | Sept | Oct | Nov | Dec | Jan | Feb | Mar | Frequency of Monitoring |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Dental | **1. Quality and Safety**: Compliance with HTM 01-05 (infection control standard) | 90% | This is a bi-annual Audit of HTM 01-05 decontamination standards at all dental sites using DH Toolkit, with written finding and an action plan produced for improvements required | | | | | | | | | | | | | 6 monthly |
| | **2. Patient Involvement**: Patient rating : were you involved as much as you wanted to be in decisions about your care and treatment ? | 90% | Real-time survey of patients at end of the appointment. Minimum 40% sample : threshold applies to those answering the question as "yes definitely" | 90% | 93% | 93% | 95% | 91% | 94% | 94% | 94% | 96% | 93% | 98% | | Monthly |
| | **3. Patient Experience:** Patients rating of the dental service : overall how would you rate your care ? | 90% | Real-time survey of patients at end of the appointment. Minimum 40% sample : threshold applies to those answering the question as "excellent or good" | 97% | 98% | 100% | 99% | 97% | 98% | 99% | 99% | 100% | 95% | 100% | | Monthly |

| | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Dental | **Number of Contacts** | 90% | Reporting Tools from software of excellence | 101% | 103% | 112% | 120% | 102% | 92% | 132% | 129% | 83% | 107% | 98% | | Monthly |
| | **Units of dental activity** | 90% | Reporting Tools from software of excellence | 98.00% | 104% | 108% | 118% | 87% | 83% | 124% | 122% | 89% | 89% | 60% | | Monthly |

Community dental services are achieving the performance threshold for three out of four monthly KPIs.

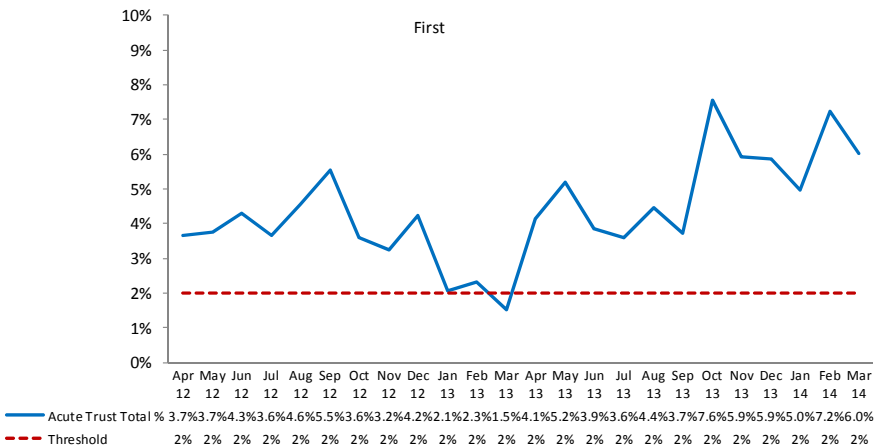
# Hospital Cancellations - Acute

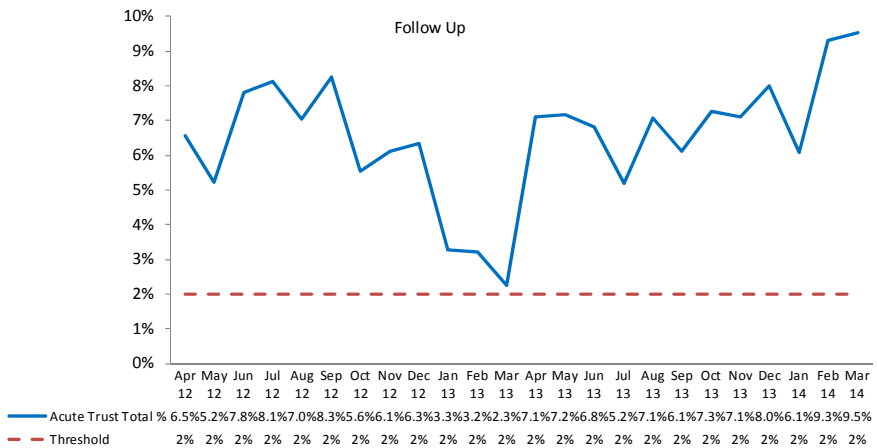
Deliver

Focus Areas

| | First Appointments | | | Follow Up Appointments | | |
|---|---|---|---|---|---|---|
| | Jan 14 | Feb 14 | Mar 14 | Jan 14 | Feb 14 | Mar 14 |
| Local Threshold | <2% | | | <2% | | |
| Acute Trust Total | 5.0% | 7.2% | 6.0% | 6.1% | 9.3% | 9.5% |

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




Cancellations for first appointment has seen a decrease to 6 per cent although this remains above the local threshold, and cancellations of follow-up appointments continues to increase. ICAM has been affected by the absence of consultants due to consultant leave and sickness, is now being addressed with additional capacity and locum appointments where required.

# Service Cancellations - Community

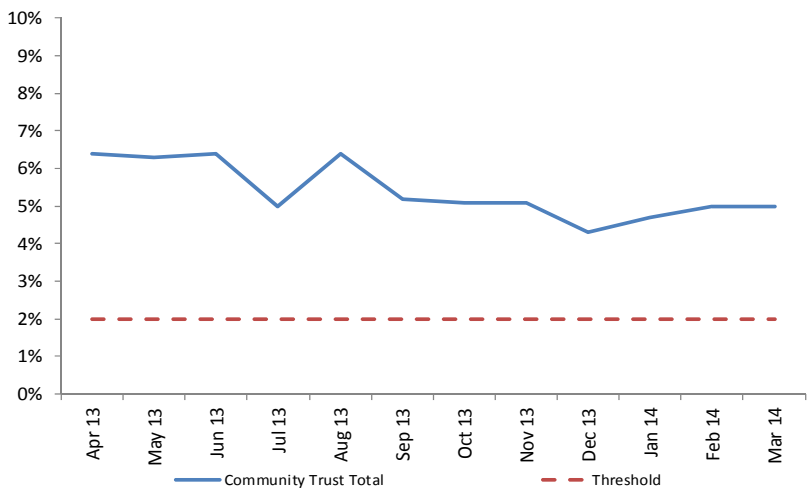
Integrate

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 | Mar 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% | 5.0% |




Performance remains above the local 2 per cent threshold at 5 per cent for March. Divisions are actively managing sickness absence and annual leave requests, although some leave has been accrued to the end of the financial year due to vacancies earlier in the year.

# DNA Rates - Acute

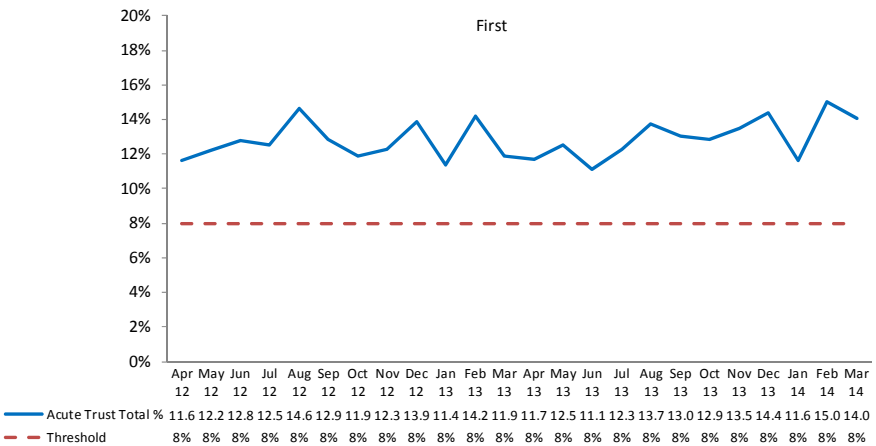
Deliver

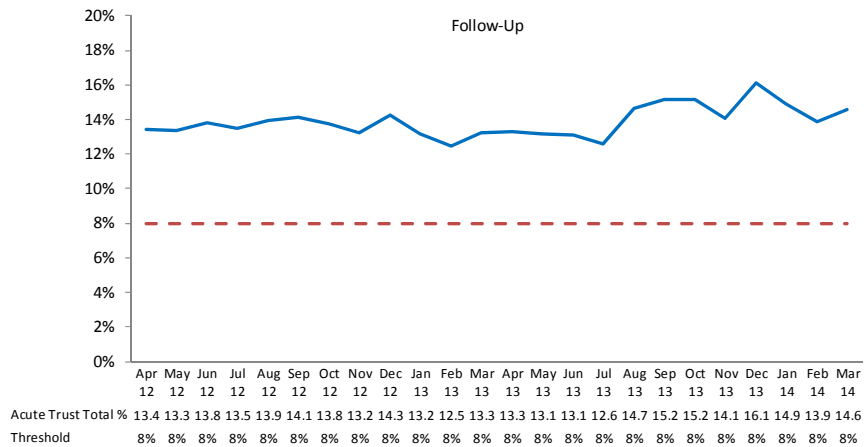
Focus Areas

| | First Appointments | | | Follow Up Appointments | | |
|---|---|---|---|---|---|---|
| | Jan 14 | Feb 14 | Mar 14 | Jan 14 | Feb 14 | Mar 14 |
| Local Threshold | 8% | | | 8% | | |
| Acute Trust Total | 11.6% | 15.0% | 14.0% | 14.9% | 13.9% | 14.6% |

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



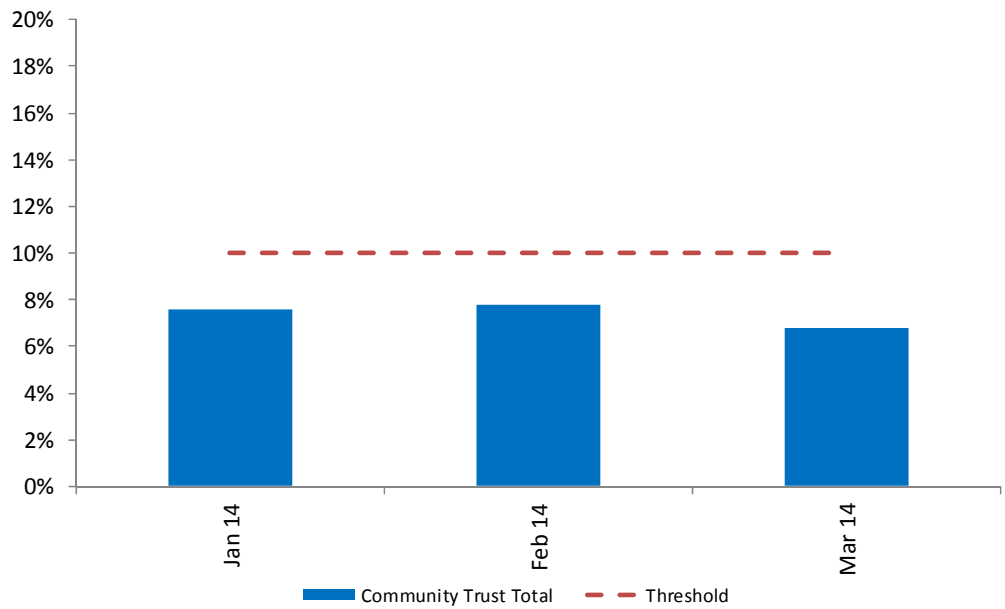

DNA rates have reduced slightly for first appointments, and increased for follow-up appointments, although both rates remain above the local threshold. Standard Operating Procedures (SOPs) are not being adhered to. SOPs are included in a suite of documents for administrative staff across the access centre, which will be responsible for each clinic area from mid-May 2014. SOP implementation and staff training has started and will be completed by the end of May.

# DNA Rates - Community

Integrate

Focus Areas

| First + Follow-Up | Jan 14 | Feb 14 | Mar 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 Whittington Health ICO-wide improvement plans, scheduled for completion in April. A small improvement in the rate is evident for March at 6.8 per cent. Texting and telephone reminders continue and a standardised standard operating procedure is to be developed for community services within the access policy.

# Community Face-to-Face Contacts

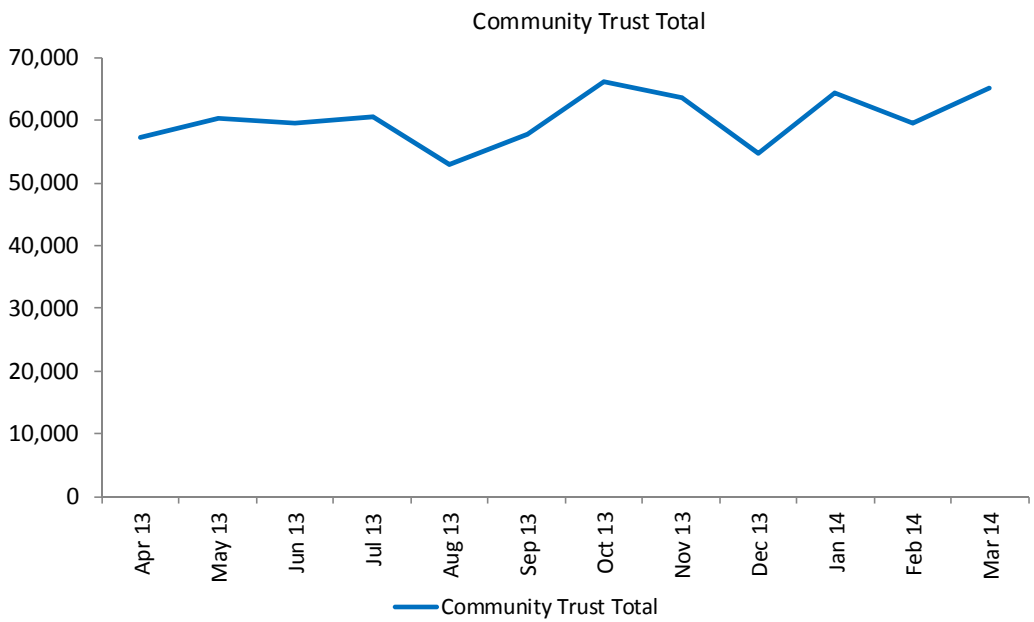
Integrate

Focus Areas

| | Jan 14 | Feb 14 | Mar 14 |
|---|---|---|---|
| Threshold | n/a | | |
| Community Trust Total | 64,221 | 59,447 | 65,046 |

| 2012/13 Apr - Mar | 2013/14 Apr - Mar | Variation |
|---|---|---|
| n/a | | |
| 582,052 | 721,311 | 24% |

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.



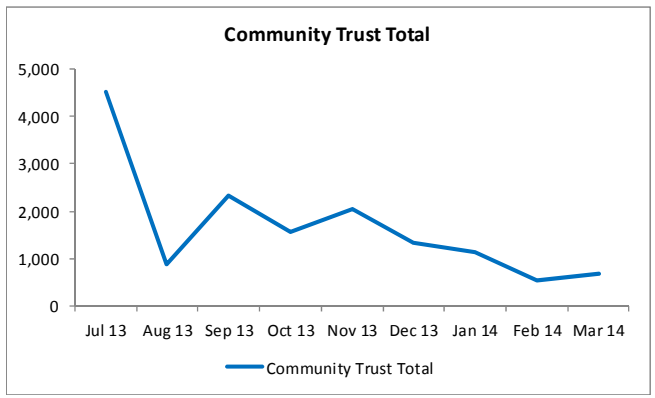

Community contacts saw an increase in March. This equates to an annual increase of 24 per cent against the 2012/13 activity.

# Community appointment with no outcome

Integrate

Focus Areas

| | Jan 14 | Feb 14 | Mar 14 | % of Total Face-to-Face Contacts Jan 14 | Feb 14 | Mar 14 |
|---|---|---|---|---|---|---|
| Local Threshold | n/a | | | 0.5% | | |
| Community Trust Total | 1,147 | 544 | 693 | 1.8% | 0.9% | 1.1% |




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.

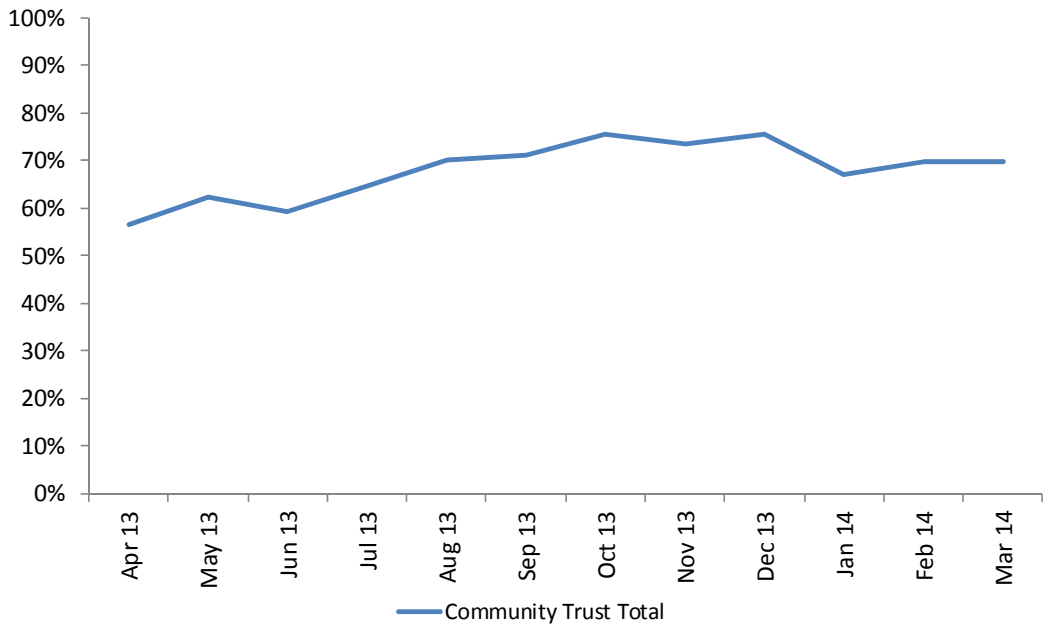
March saw a minimal increase in community appointments with no outcome, however this is still a significant improvement on the position seen in July.

# Community Waiting Times
# % waiting less than 6 weeks

Integrate

Focus Areas

| | Jan 14 | Feb 14 | Mar 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.

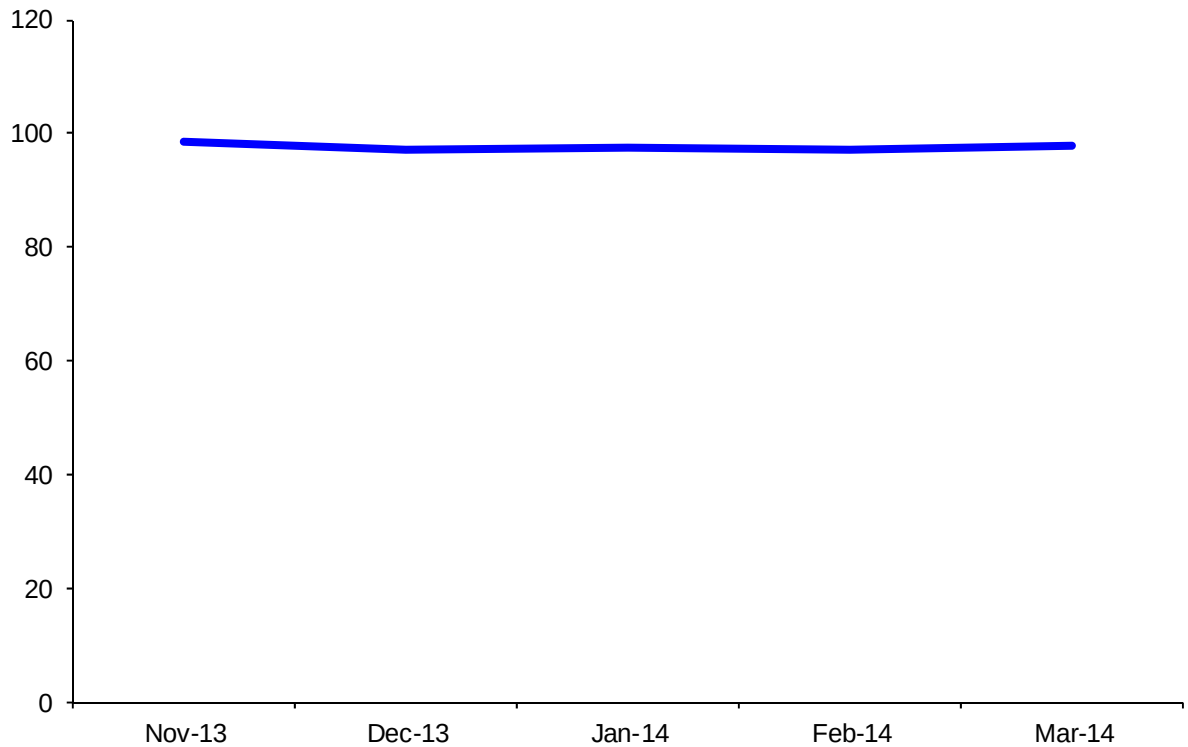
A slight increase in the percentage of patients waiting less than six weeks for a community appointment was seen in March, rising to 69.8 per cent. A community patient tracking list (PTL) is being developed for referral to treatment (RTT) and non-RTT pathways. Action plans are to be developed by service managers to improve capacity by addressing DNAs, however ,this will also be dependant upon full staffing compliments being in place. Waiting list management training is also being scheduled to promote and embed good practice.

# District Nursing Waiting Times
# % waiting less than 6 weeks

Integrate

Focus Areas

| | Nov-13 | Dec-13 | Jan-14 | Feb-14 | Mar-14 |
|---|---|---|---|---|---|
| Threshold | n/a | | | | |
| Community Trust Total | 98.5 | 97.02 | 97.4 | 97.15 | 97.95 |



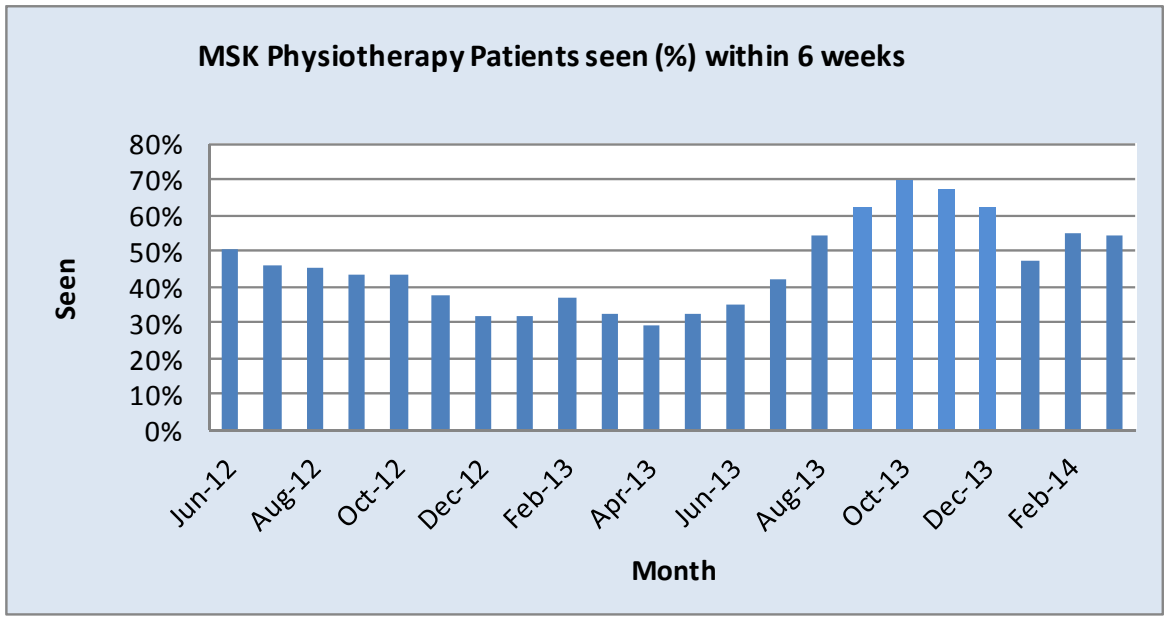

The percentage of patients waiting less than 6 weeks for attended 'Face to Face' initial appointments. The waiting time from the date the referral was received to the initial attended 'Face to Face' contact is measured for the month. Where patients DNA the waiting time is measured as the time between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

An improvement plan for district nursing has been developed and is lead by the Chief Operating Officer.

# 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.

**No sign-off procedure since December 2013**

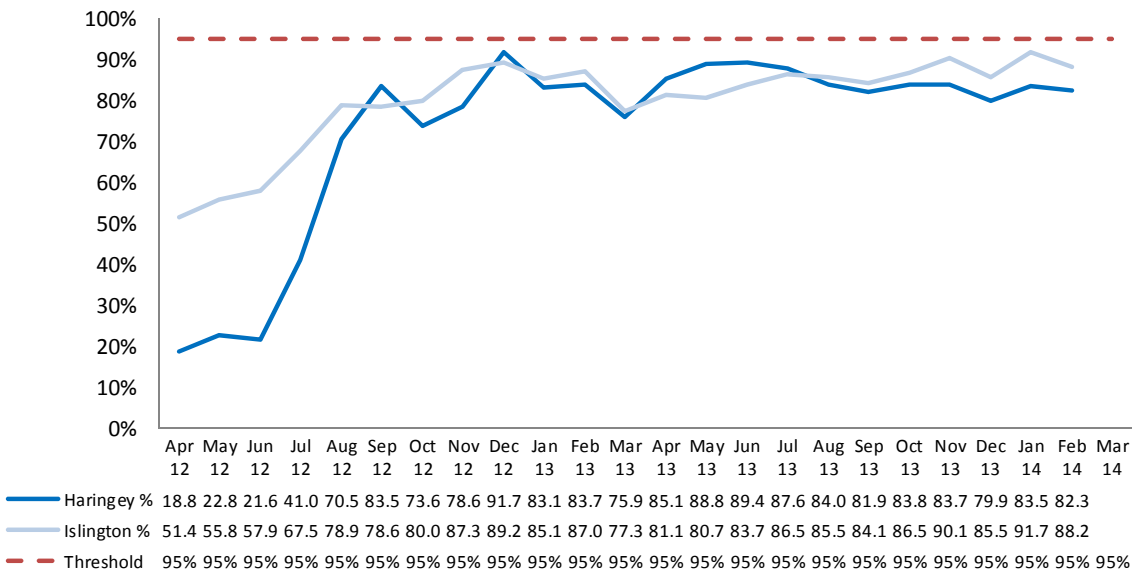
Data quality issues have been identified with the MSK information and a further data cleaning exercise is underway. There are issues with recording, definitions and understanding regarding average waits and the difference between MSK and CATS activity. Following the data cleansing exercise, reporting will be amended to separately reflect performance of the 18 weeks and non-18 weeks activity. MSK has not previously used a patient tracking list (PTL) for managing waiting lists, but this is being introduced to help with better waiting list management. An improvement plan for the whole service has been developed and is chaired by the Chief Operating Officer.

# 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 | Feb 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% | 82.3% |
| Islington | 81.1% | 80.7% | 83.7% | 86.5% | 85.5% | 84.1% | 86.5% | 90.1% | 85.5% | 91.7% | 88.2% |




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

February saw a slight decrease in the percentage of new birth visits completed against the local threshold.

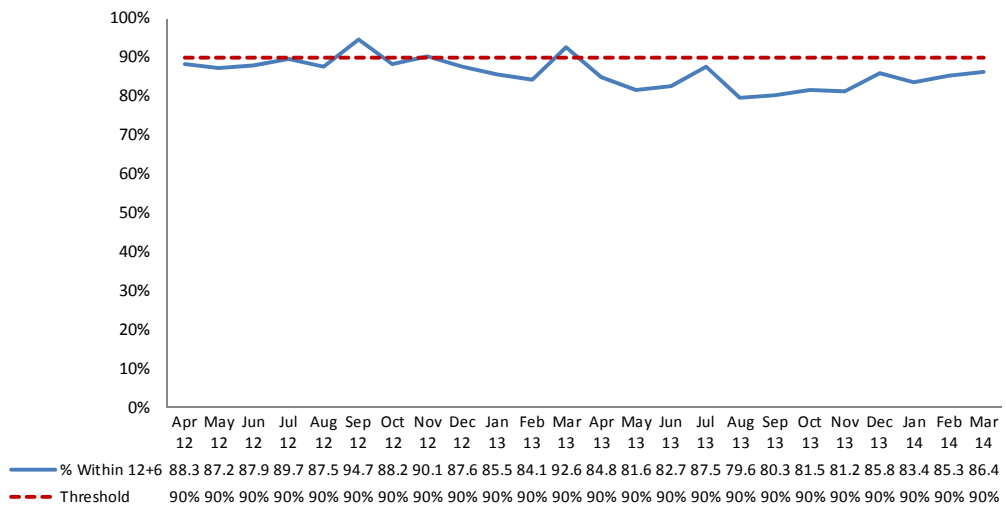
# Women seen by HCP or Midwife within 12 weeks and 6 days

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 | Mar 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% | 86.4% |
| Total Number of Bookings | - | 374 | 404 | 359 | 421 | 376 | 369 | 375 | 359 | 339 | 384 | 335 | 345 |
| Referrals within 12 Weeks and 6 days | - | 323 | 347 | 312 | 359 | 324 | 319 | 324 | 330 | 302 | 338 | 286 | 309 |

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 again seen a slight increase in March, for the third consecutive month, linked to the appointment of the new midwife consultant focussed on Public Health. The main issue is when patients choose to not attend, however, improvements have been made to ensure all referrals are allocated appointments before the 12+6 week time period. The next areas of focus is when there is a DNA, ensuring the patient is contacted on the day and given a new appointment.

# Referral to Treatment 18 weeks - Admitted

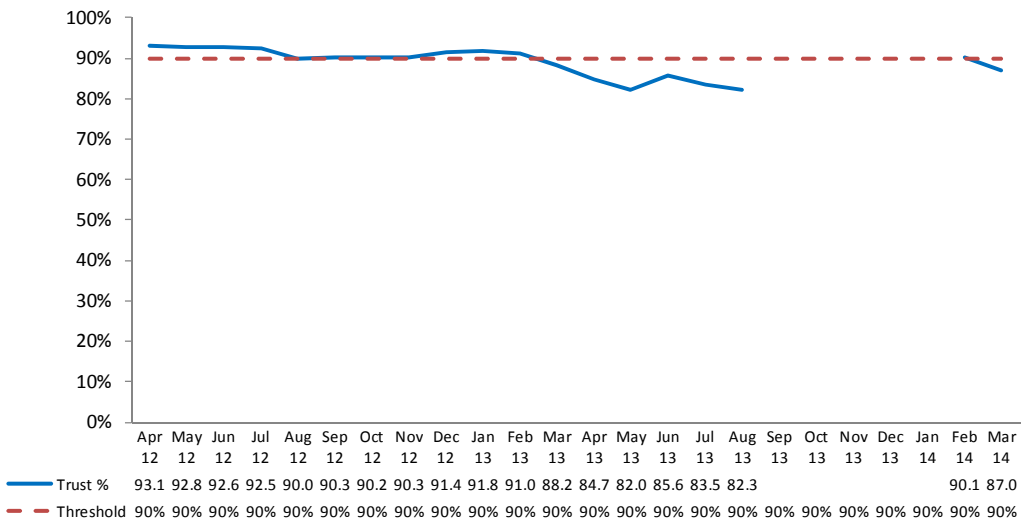
Deliver

Access Metrics

| | Apr 13 | May 13 | Jun 13 | Jul 13 | Aug 13 | Sep 13 | Oct 13 | Nov 13 | Dec 13 | Jan 14 | Feb 14 | Mar 14 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| National Threshold | 90% | | | | | | | | | | | |
| Trust Total | 84.7% | 82.0% | 85.6% | 83.5% | 82.3% | - | - | - | - | | 90.1% | 90.1% |

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

Sept – Jan figures not available due to EPR reporting Issues




Reporting has resumed for admitted clock stops with 90.1 per cent of patients admitted in March within 18 weeks, meeting the national threshold.

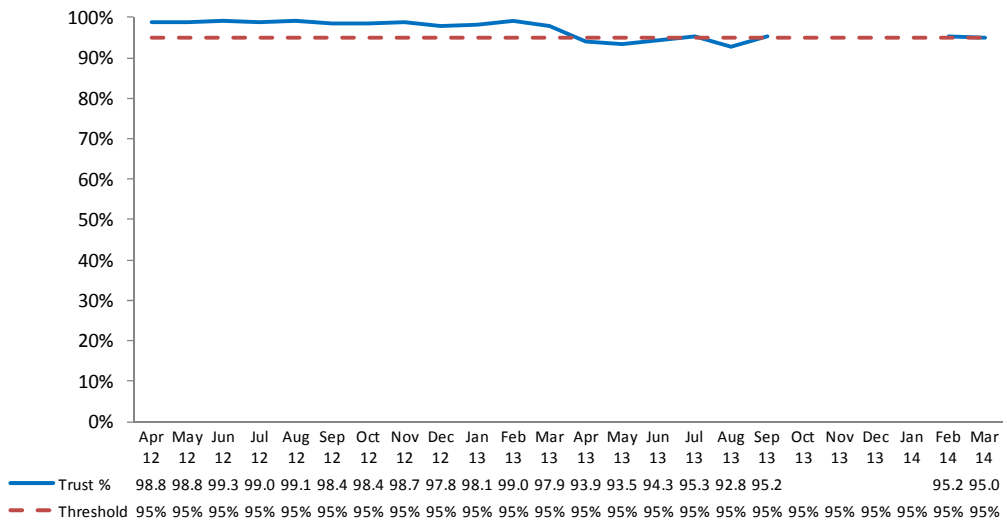
# Referral to Treatment 18 weeks – Non Admitted

Deliver

Access Metrics

| | Apr 13 | May 13 | Jun 13 | Jul 13 | Aug 13 | Sep 13 | Oct 13 | Nov 13 | Dec 13 | Jan 14 | Feb 14 | Mar 14 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| National Threshold | >95% | | | | | | | | | | | |
| Trust Total | 93.9% | 93.5% | 94.3% | 95.3% | 92.8% | 95.2% | - | - | - | - | 95.2% | 95.0% |

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




In March, 95 per cent of patients on a non-admitted pathway were seen within 18 weeks, meeting the national threshold.

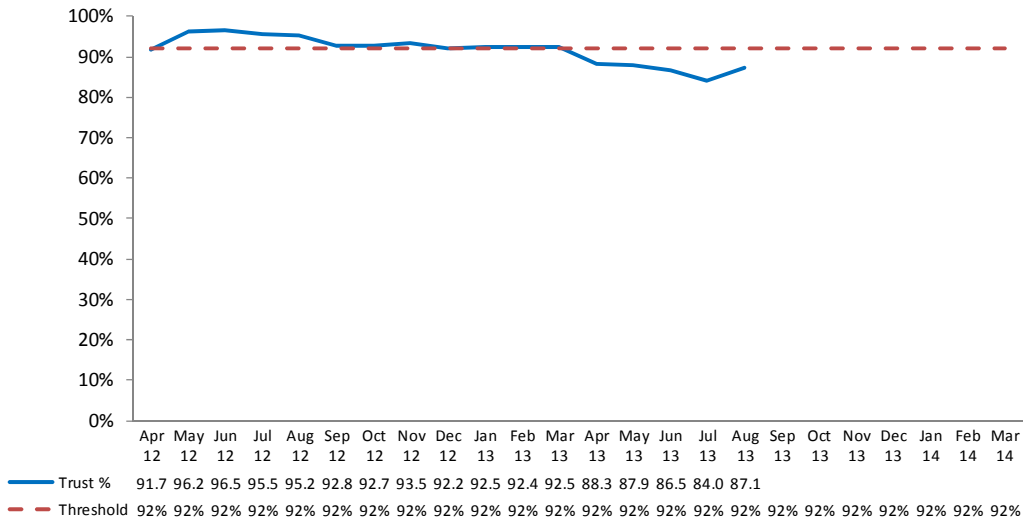
# Referral to Treatment 18 weeks - Incomplete

Deliver

Access Metrics

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

Data not available during September 2013 and February 2014 due to EPR reporting Issues




March 2014 data correct as at 8th April 2014

Due to issues related to the Electronic Patient Record (EPR), the incomplete pathway data will not be live until the version upgrade, scheduled for 3rd May, which will allow reporting to recommence. Manual processes are in place as previously stated. The ability to monitor incomplete pathways after 3 May will help with delivery of the admitted and non-admitted clock stops.

# Referral to Treatment 18 weeks – 52 Week Waits

Deliver

Access Metrics

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

Data not available during September 2013 and February 2014 due to EPR reporting Issues

There have been no 52 weeks waits.

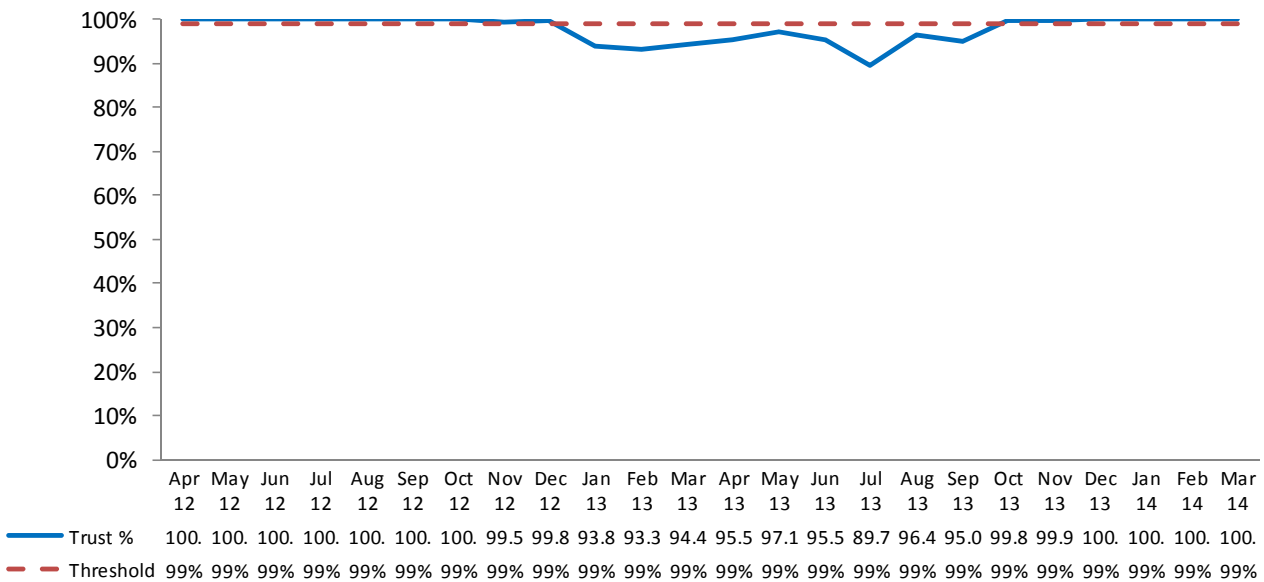
# Diagnostic Waits

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 | Mar 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% | 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).

The target has continually been met for the last six consecutive months.

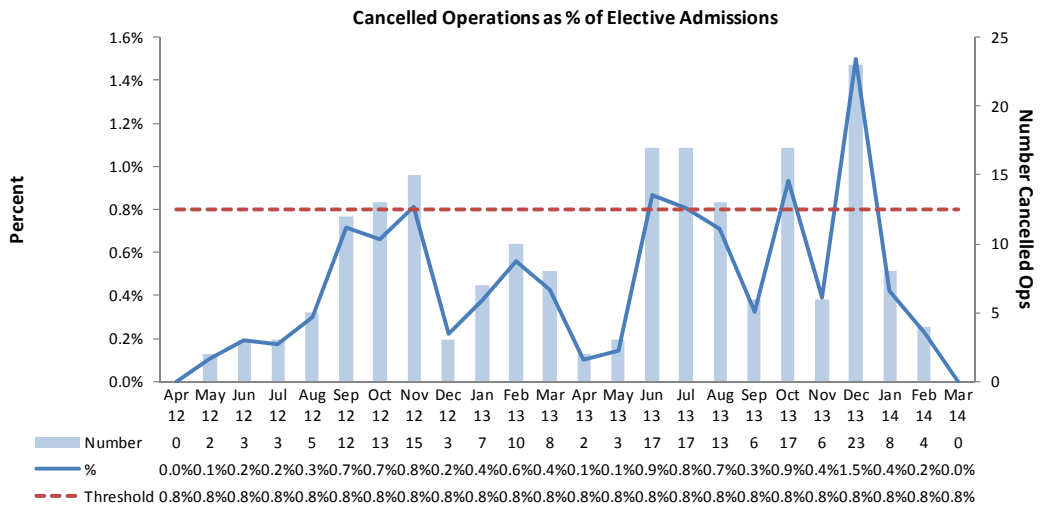
# Hospital Cancelled Operations

Deliver

Access Metrics

Hospital initiated cancellations on day of operation

| | Number of Cancelled Operations | | | Cancelled Operations as % of Elective Admissions | | |
|---|---|---|---|---|---|---|
| | Jan 14 | Feb 14 | Mar 14 | Jan 14 | Feb 14 | Mar 14 |
| National Threshold | n/a | | | < 0.8% | | |
| Trust Total | 8 | 4 | 0 | 0.4% | 0.2% | 0.0% |




There were no cancelled elective operations in March. This is the first time in the last two years that this has been achieved. Emergency cancellation rates should be reportable in April, although these are expected to be minimal numbers.

# Emergency Department Waits

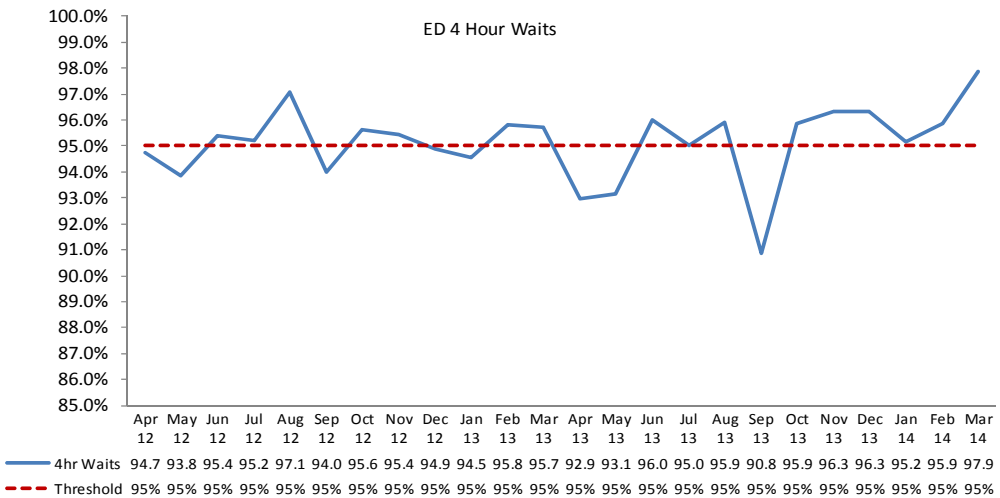
Deliver

Access Metrics

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

| | Apr 13 | May 13 | Jun 13 | Jul 13 | Aug 13 | Sep 13 | Oct 13 | Nov 13 | Dec 13 | Jan 14 | Feb 14 | Mar 14 | **2013/14** |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 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% | 97.9% | 95.1% |
| 12hr Waits | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 1 |

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




| **Clinical Quality Indicators** | Jan 14 | Feb 14 | Mar 14 |
|---|---|---|---|
| Total Time in ED (95th % Wait < 240 mins) | 240 | 240 | 239 |
| Total Time in ED - Admitted (95th % Wait < 240 mins) | 650 | 441 | 316 |
| Total Time in ED - Non-Admitted (95th % Wait < 240 mins) | 236 | 237 | 235 |
| Wait for Assessment (95th % Wait < 15 mins) | 15 | 15 | 16 |
| Wait for Treatment (Median <60 mins) | 66 | 72 | 71 |
| Left Without Being Seen Rate (<5%) | 3.5% | 4.68% | 3.92% |
| Re-attendance Rate (>1% and <5%) | - | - | - |

Achievement of the four hour waiting target for the sixth consecutive month, with a full year performance of 95.1 per cent
Further work is commencing on ambulance handover times and the front entrance to the Emergency Department.

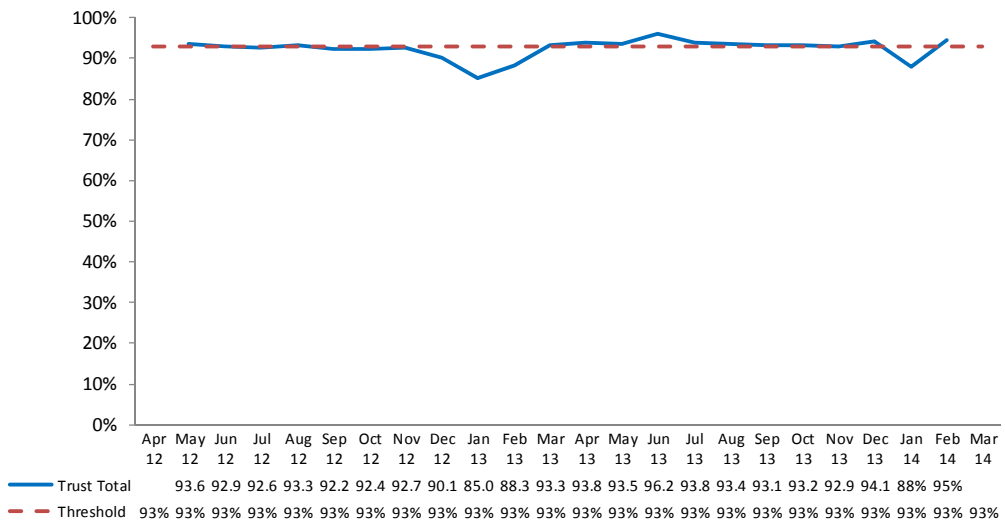
# Cancer – 14 days to first seen

Deliver

Access Metrics

**14 Days to First Seen**

| | Dec 13 | Jan 14 | Feb 14 | Q1 | Q2 | Q3 TD | Q4 TD |
|---|---|---|---|---|---|---|---|
| National Threshold | 93% | | | 93% | | | |
| Trust Total | 94.1% | 87.9% | 94.5% | 94.6% | 93.5% | 93.4% | 91.3% |




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

Delivering 94.5 per cent compliance for February, however, patient choice continues to be a challenge.

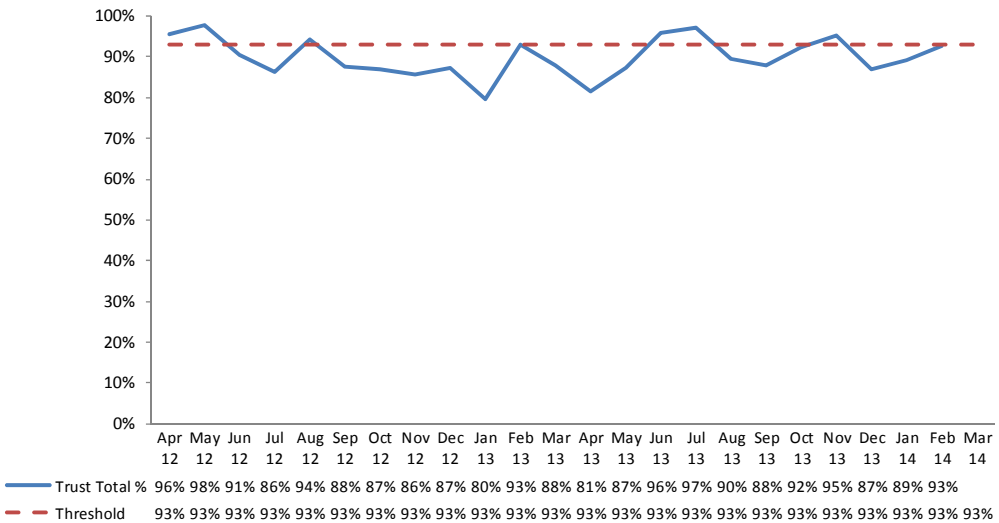
# Cancer – 14 days to first seen – Breast symptomatic

Deliver

Access Metrics

**14 Days to First Seen - Breast Symptomatic**

| | Dec 13 | Jan 14 | Feb 14 | Q1 | Q2 | Q3 TD | Q4 TD |
|---|---|---|---|---|---|---|---|
| National Threshold | 93% | | | 93% | | | |
| Trust Total | 87.02% | 89.3% | 92.5% | 88.2% | 92.1% | 91.6% | 91.0% |




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

Our performance was 92.5 per cent, predominately due to patient choice issues as previously reported. 12 out of 13 patients who were non-compliant were due to patient choice. Additional issues with availability of breast capacity due to 30 per cent rise in referrals. The new policy is in place to offer patients two dates within 14 days and, if patients are not able to attend within this timescale, they are referred back to their GP so they can be monitored. Extra capacity and relevant referral to diagnostics is being reviewed. We anticipate performance to remain non-compliant for March and April.

# Cancer – 31 Days to first treatment

Deliver

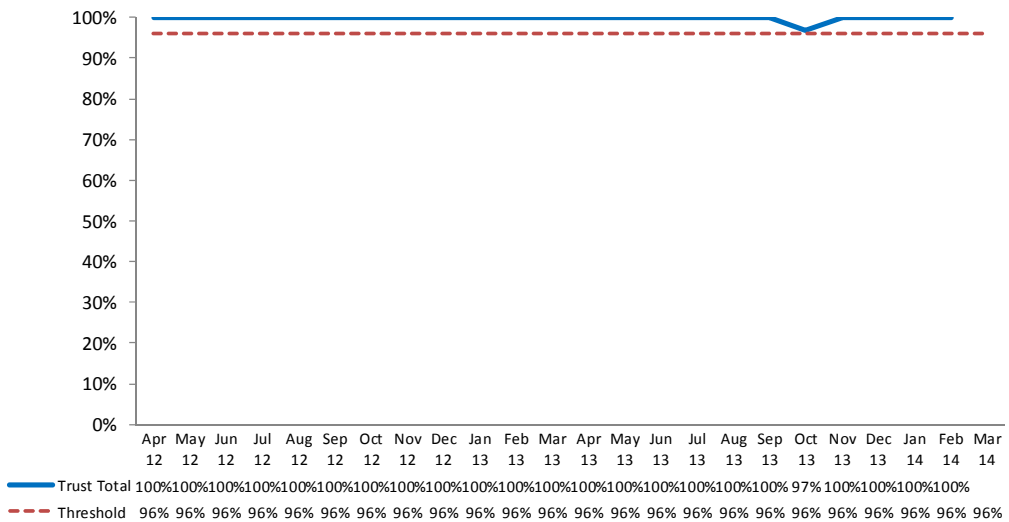
Access Metrics

**31 Days to First Treatment**

| | Dec 13 | Jan 14 | Feb 14 | Q1 | Q2 | Q3 | Q4 TD |
|---|---|---|---|---|---|---|---|
| National Threshold | 96% | | | 96% | | | |
| Trust Total | 100% | 100.0% | 100.0% | 100% | 100% | 99% | 100% |

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

31 day target is timed from diagnosis to treatment.




Delivering 100 per cent compliance and sustainably meeting the national threshold.

# Cancer – 31 days to subsequent treatment - Surgery

Deliver

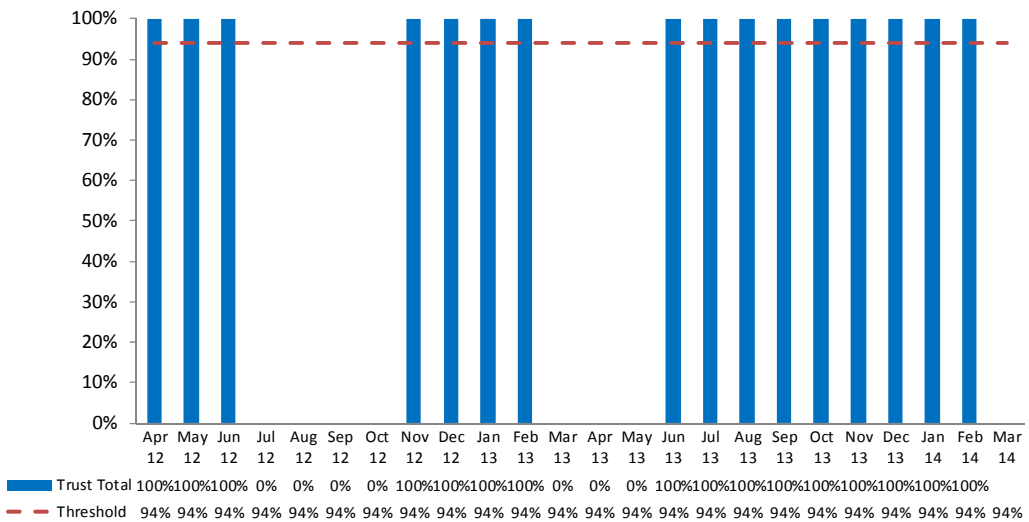
Access Metrics

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**

| | Dec 13 | Jan 14 | Feb 14 | Q1 | Q2 | Q3 | Q4 TD |
|---|---|---|---|---|---|---|---|
| National Threshold | 94% | | | 94% | | | |
| Trust Total | 100% | 100% | 100% | 100% | 100% | 99% | 100% |




Delivering 100 per cent compliance and sustainably meeting the national threshold.

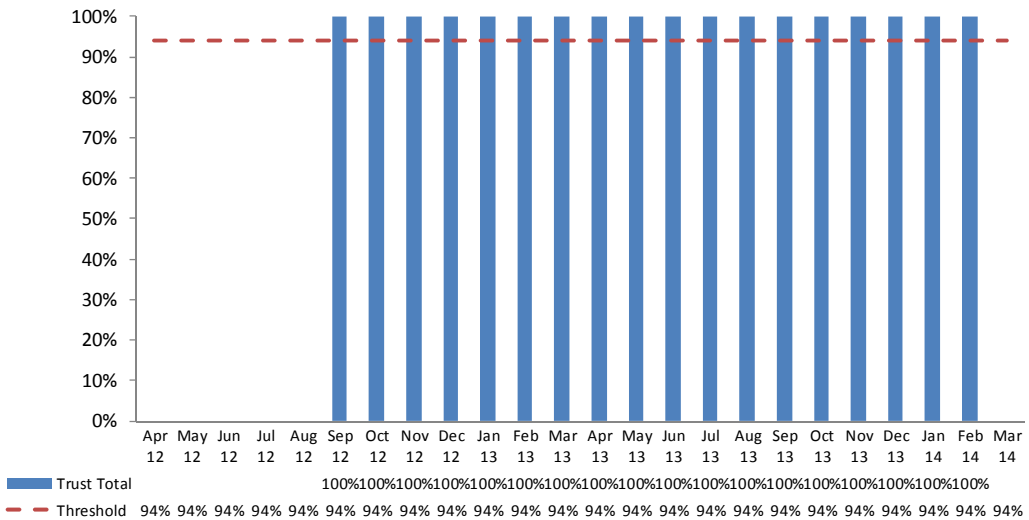
# Cancer – 31 days to subsequent treatment - Drugs

Deliver

Access Metrics

**31 Days to Subsequent Treatment - Drugs**

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




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

31 day target is timed from diagnosis to treatment.

Division broken down by Tumour Type

Delivering 100 per cent compliance and sustainably meeting the national threshold.

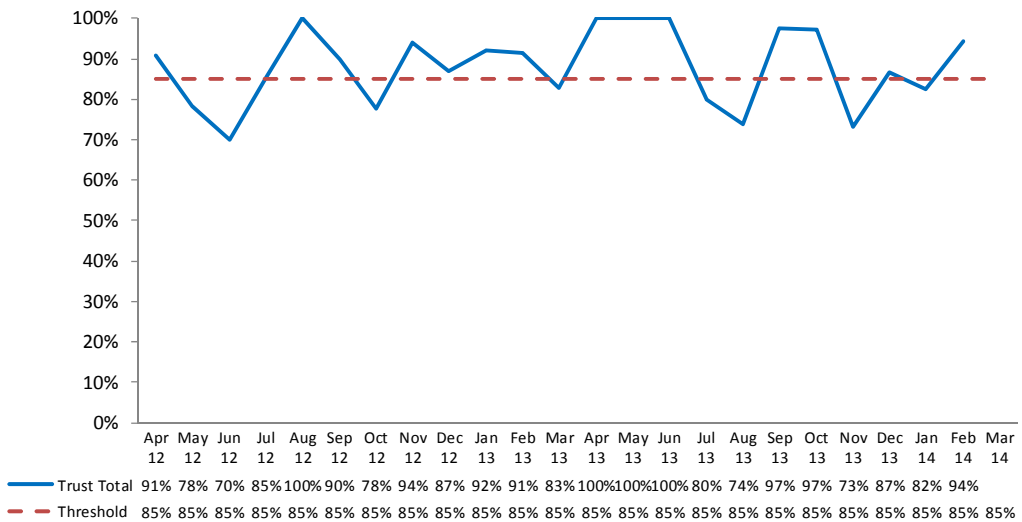
# Cancer – 62 days from referral to treatment

Deliver

Access Metrics

**62 Days from Referral to Treatment**

| | Dec 13 | Jan 14 | Feb 14 | Q1 | Q2 | Q3 | Q4 TD |
|---|---|---|---|---|---|---|---|
| National Threshold | 85% | | | 85% | | | |
| Trust Total | 86.5% | 82.4% | 94.3% | 100.0% | 83.1% | 85.2% | 87.2% |




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

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

Meeting the national threshold at 94.3 per cent.

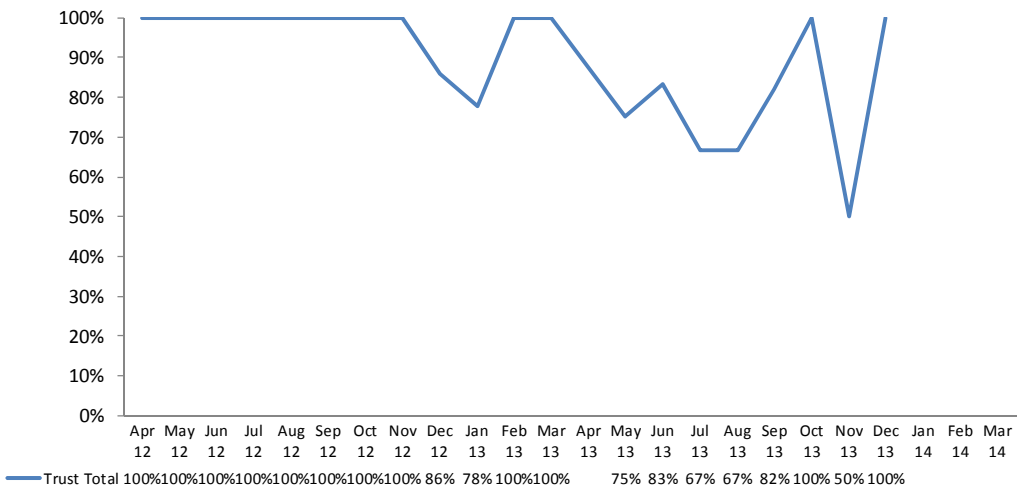
# Cancer – 62 days from consultant upgrade

Deliver

Access Metrics

**62 Days from Consultant Upgrade**

| | Dec 13 | Jan 14 | Feb 14 | Q1 | Q2 | Q3 | Q4 TD |
|---|---|---|---|---|---|---|---|
| Trust Total | 100.0% | - | - | 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.

No patients applicable under this measure for February. No national standard for this indicator.

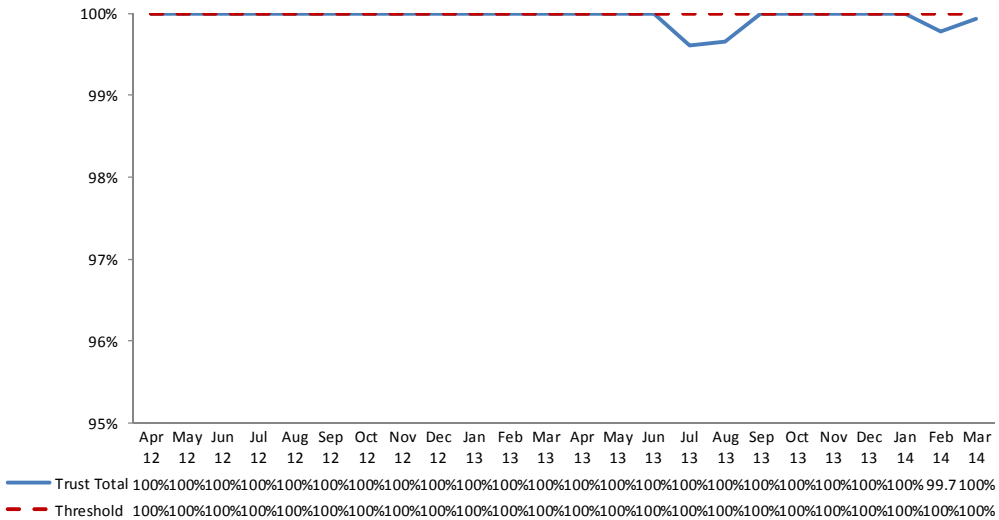
# Genito-Urinary Medicine Appointment within 2 Days

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 | Mar 14 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Trust Total | 100% | 100% | 100% | 100% | 99.6% | 99.7% | 100% | 100% | 100% | 100% | 100% | 99.78% | 99.93% |




Performance at 99.93 per cent has been submitted nationally, however, post-reporting validation identified a data entry error which amends performance to 100 per cent.

# Delayed Transfers of Care

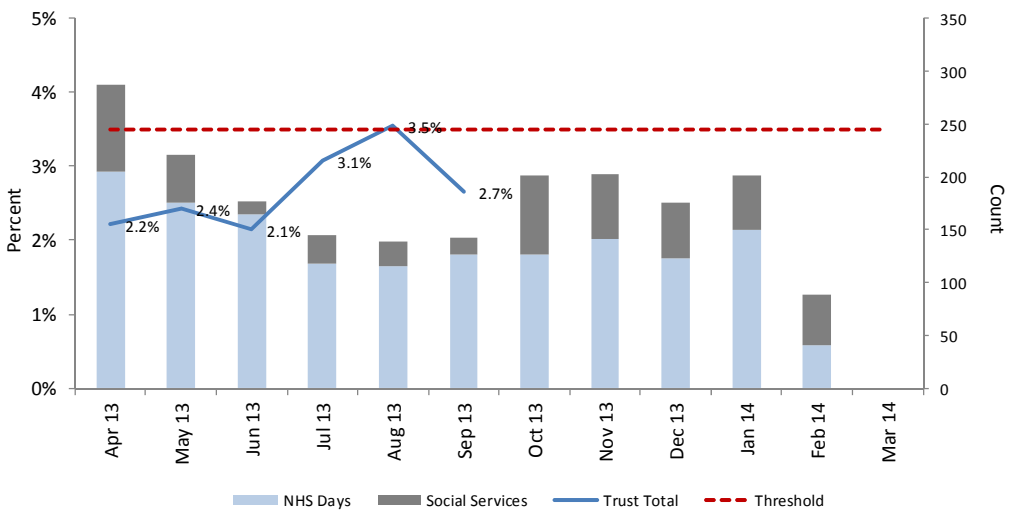
Integrate

Outcome Metrics

Number of Days Delayed

| | Mar 14 | | |
|---|---|---|---|
| | NHS Days | Social Services | Both |
| Trust Total | 165 | 50 | 0 |

| | Dec 13 | Jan 14 | Feb 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

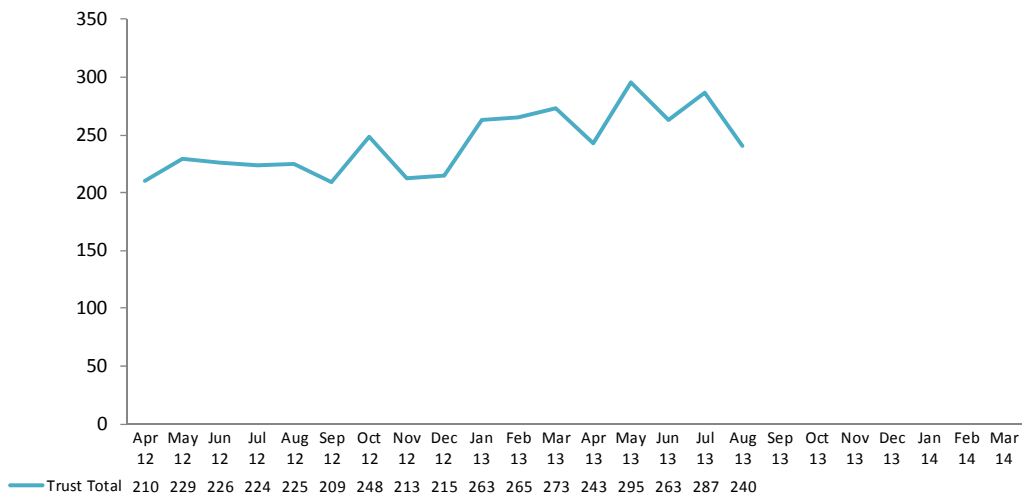
Delayed transfers of care are reviewed daily and delays escalated. We have good working practices with our local authority partners to progress any potential delays and resolve early, where possible.

# 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.

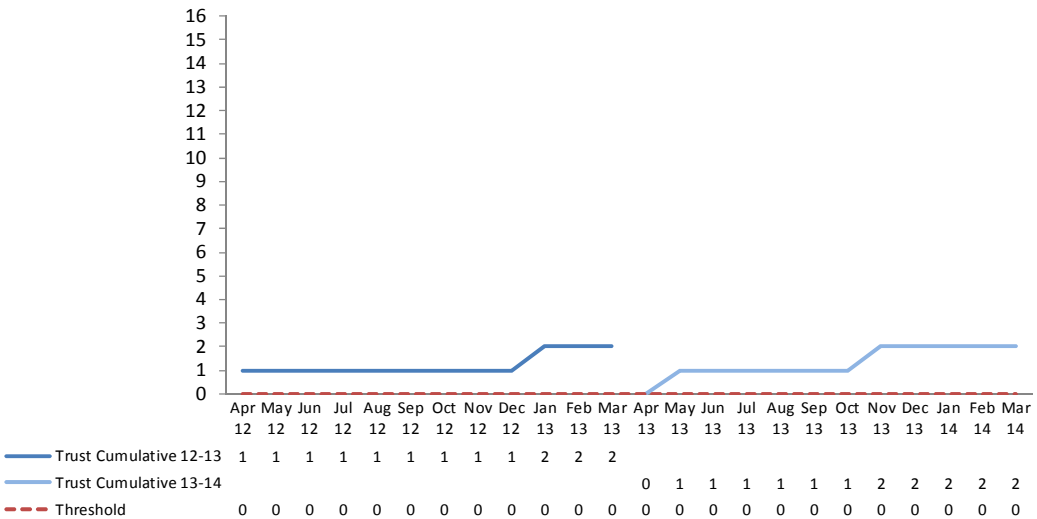
# MRSA

Deliver

Outcome Metrics

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

Number of MRSA bacteraemia (bacteria in the blood)




There were no cases reported in March. The full year total for 2013/14 is two cases, against a zero tolerance threshold.

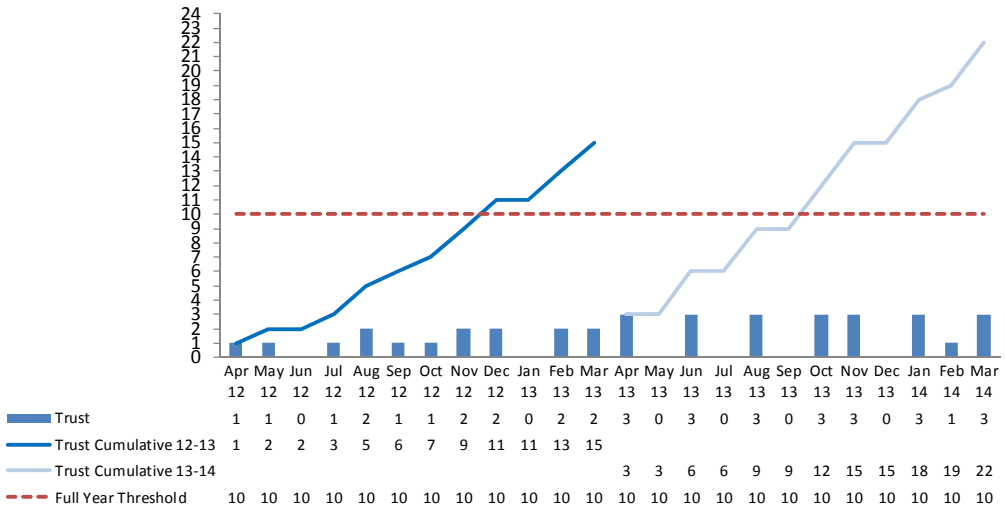
# C Difficile Infections

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 | Mar 14 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Full Year National Threshold | <=10 | | | | | | | | | | | |
| Trust Total | 3 | 0 | 3 | 0 | 3 | 0 | 3 | 3 | 0 | 3 | 1 | 3 |

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




Three cases reported in March, taking the full year 2013/14 total to 22 cases against a full year threshold of 10.
A visual cleaning plan is underway (see ward cleanliness slide 43). All cases have been reviewed in depth and discussed with the NHS Trust Development Authority (TDA). We are re-reviewing our policies regarding antibiotic prescribing, isolation, hand hygiene and cleanliness.

# E.coli and MSSA

Deliver

Outcome Metrics

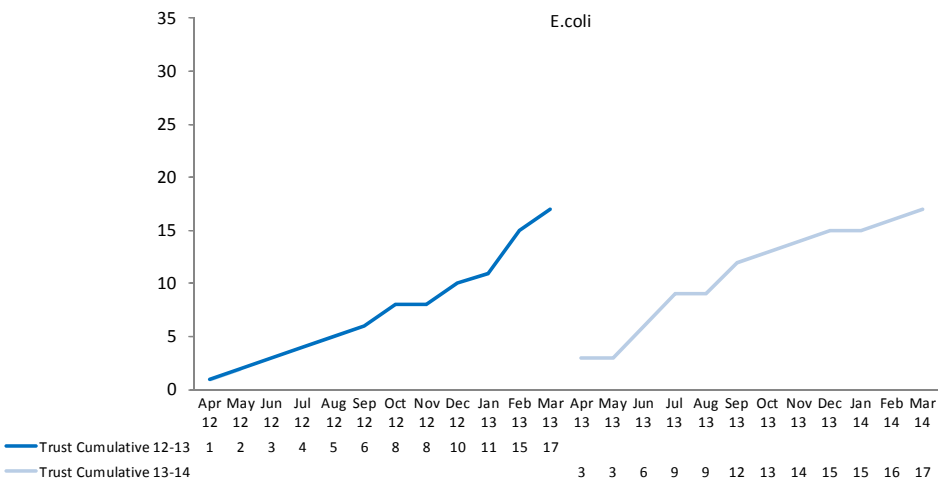
**E.coli (Post 48 Hours)**

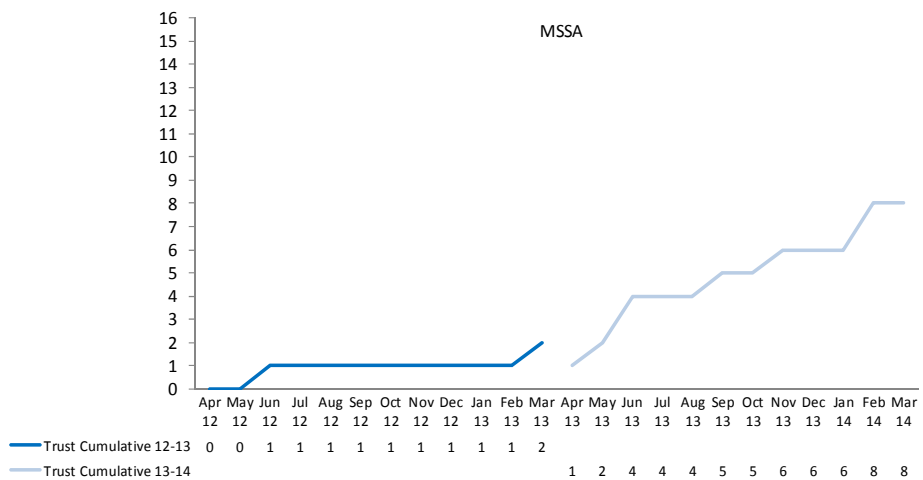
| | Jan 14 | Feb 14 | Mar 14 |
|---|---|---|---|
| Threshold | n/a | | |
| Trust Total | 0 | 1 | 1 |

**MSSA (Post 48 Hours)**

| | Jan 14 | Feb 14 | Mar 14 |
|---|---|---|---|
| Threshold | n/a | | |
| Trust Total | 0 | 2 | 0 |

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




The Trust has reported 17 E.Coli and eight MSSA bacteraemia for 2013/14. E.Coli is consistent with the total for 2012/13, however, MSSA has increased from two cases for 2012/13. There are currently no national thresholds for these indicators.

# Harm Free Care

Deliver

Outcome Metrics

| | Contractual Threshold | Jan 14 | Feb 14 | Mar 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

**Mar13**

| | 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 | 768 | 719 | 93.62% | 41 | 5.34% | 0 | 0.00% | 7 | 0.91% | 2 | 0.26% |
| SCD | 81 | 81 | 100.00% | 0 | 0.00% | 0 | - | 0 | - | 0 | 0.00% |
| WCF | 138 | 138 | 100% | 0 | - | 0 | - | 0 | - | 0 | - |
| **Trust Total** | **987** | **938** | **95%** | **41** | **4.15%** | **0** | **0.00%** | **7** | **0.71%** | **2** | **0.20%** |

| Pressure Ulcers | Cat 2-4 | Cat 2 | Cat 3 | Cat 4 |
|---|---|---|---|---|
| All | 41 | 26 | 10 | 5 |
| Old | 26 | 12 | 9 | 5 |
| New | 15 | 14 | 1 | 0 |

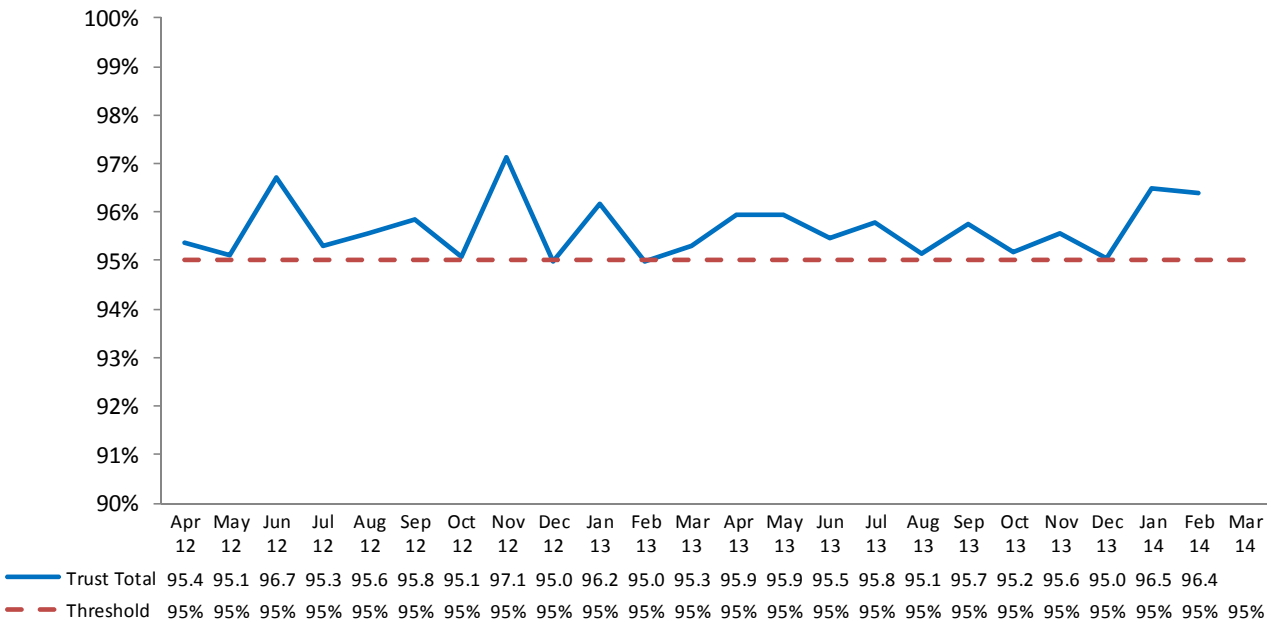
Performance has reduced for March with 91.63 per cent of patients on a particular day of the month, receiving no harm for urinary catheter related infection, pressure ulceration, VTE and falls. Pressure ulcers is the largest challenge, however, no patients were harmed by a fall. All pressure ulcers are referred to the Quality Committee.

# VTE Risk Assessment

Deliver

Outcome Metrics

| | VTE Risk Assessed (CQUIN) | | | RCA for Hospital Acquired | | |
|---|---|---|---|---|---|---|
| | Dec 13 | Jan 14 | Feb 14 | Dec 13 | Jan 14 | Feb 14 |
| CQUIN Threshold | 95% | | | Target to be decided | | |
| Trust Total | 95.0% | 96.5% | 96.4% | 6 | 0 | 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

The Trust continues to achieve the threshold, sustainably delivery 95 per cent and above.

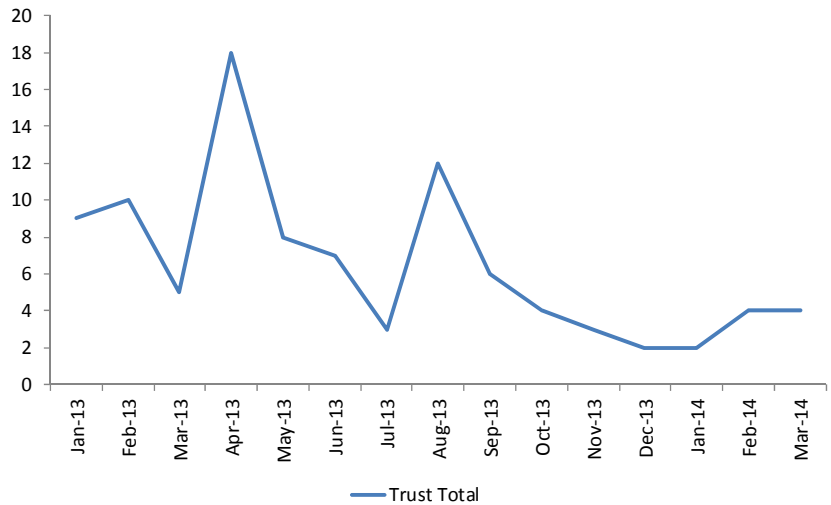
# Serious Incidents

Change

Outcome Metrics

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

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




A slight increase in reported cases occurred in March. These are under review via root cause analysis.

# Never Events

Change

Outcome Metrics

Since October 2012, there has been one never event reported to STEIS in December 2013, as outlined 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.
The Trust took immediate action 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 March 2014.

# CAS Alerts (Central Alerting System)

Change

Outcome Metrics

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 |

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

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/2014/001 Continuous renal replacement therapy (CRRT) is used in intensive care settings for patients critically ill with acute kidney injury. In three recently reported patient safety incidents, 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.

The process for CAS Alerts is under review to ensure timely action.

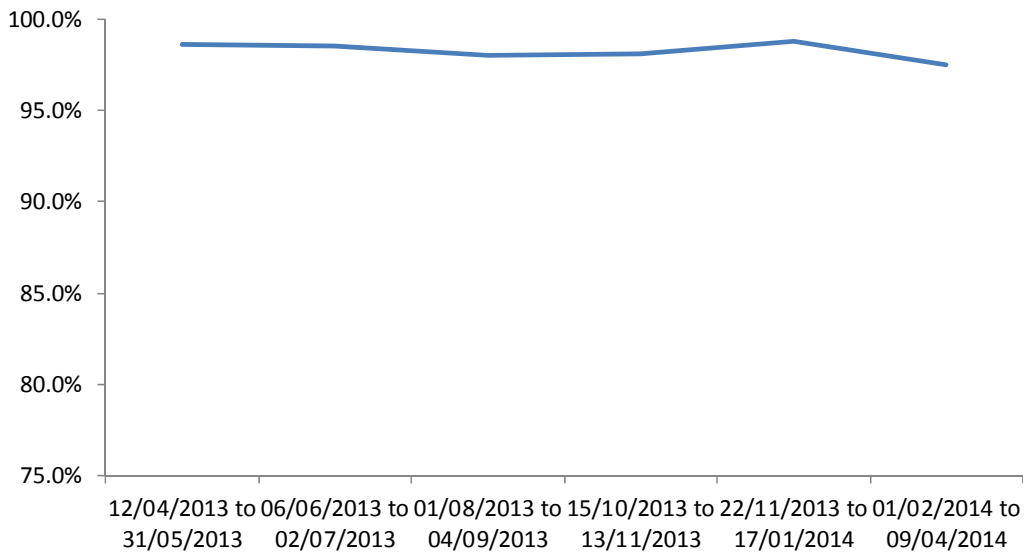
# Ward Cleanliness

Change

Outcome Metrics

**Ward Cleanliness**

| | 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 | 01/02/2014 to 09/04/2014 |
|---|---|---|---|---|---|---|
| Trust Percentage | 98.6% | 98.5% | 98.0% | 98.13% | 98.8% | 97.5% |




Ward Cleanliness calculated as actual score against possible score

Latest Audit completed by Facilities

Despite audit compliance being high, the cleanliness and environments seen on wards was felt to be less than satisfactory. Detailed monitoring by Heads of Nursing and the Infection, Prevention and Control team has been undertaken and actions taken with immediate effect. Plans to change the audit are being discussed to ensure the quality of the results.

# 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

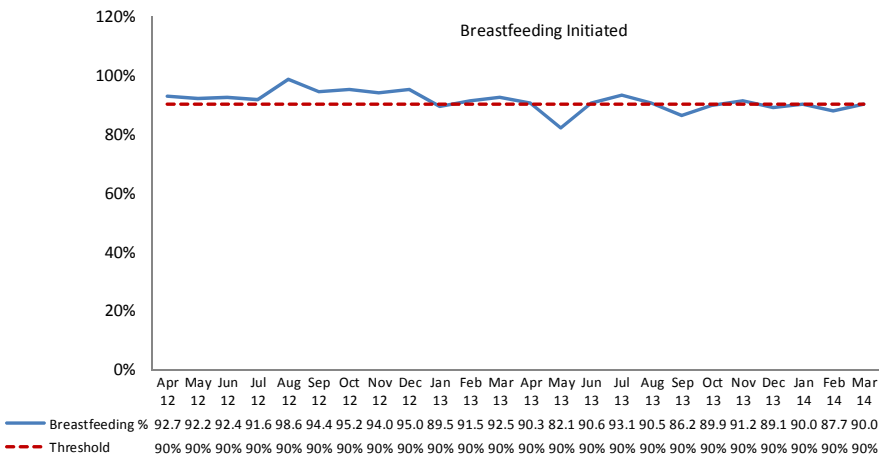
# Breastfeeding and Smoking

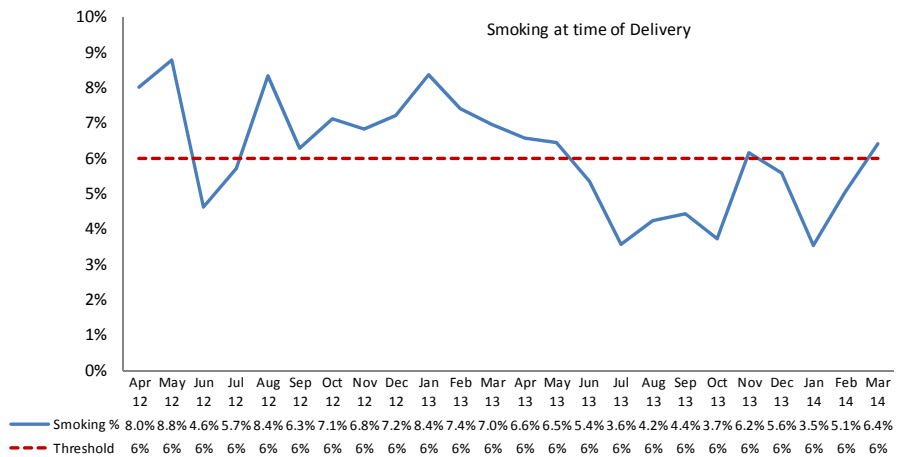
Improving

Outcome Metrics

| | Threshold | Jan 14 | Feb 14 | Mar 14 |
|---|---|---|---|---|
| Breastfeeding Initiated | 90% | 90.0% | 87.7% | 90.0% |
| Smoking at Delivery | <6% | 3.5% | 5.1% | 6.4% |

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 met in March at 90.0 per cent.
Smoking at time of delivery did not meet the target, at 6.4 per cent. The Public Health Midwifery Consultant is working with Haringey and Islington Public Health teams to evaluate the work required to reduce the smoking levels of pregnant women.

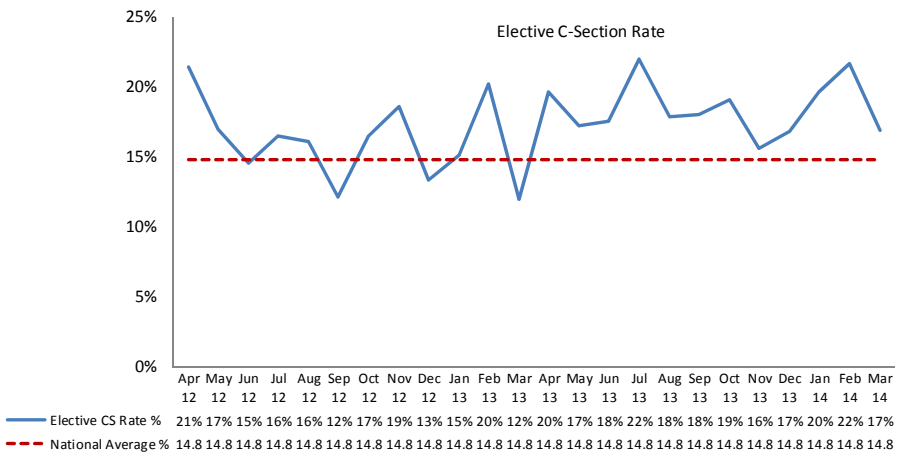
# Caesarean Section Rates

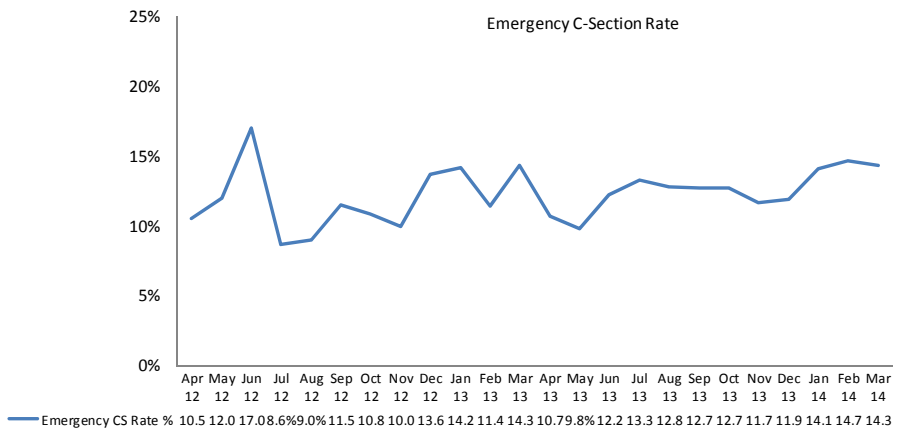
Deliver

Outcome Metrics

| | National Average | Jan 14 | Feb 14 | Mar 14 |
|---|---|---|---|---|
| Elective C-Section Rate | 14.8% | 19.7% | 21.7% | 16.9% |
| Emergency C-Section Rate | - | 14.1% | 14.7% | 14.3% |
| All Deliveries | - | 320 | 300 | 301 |

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



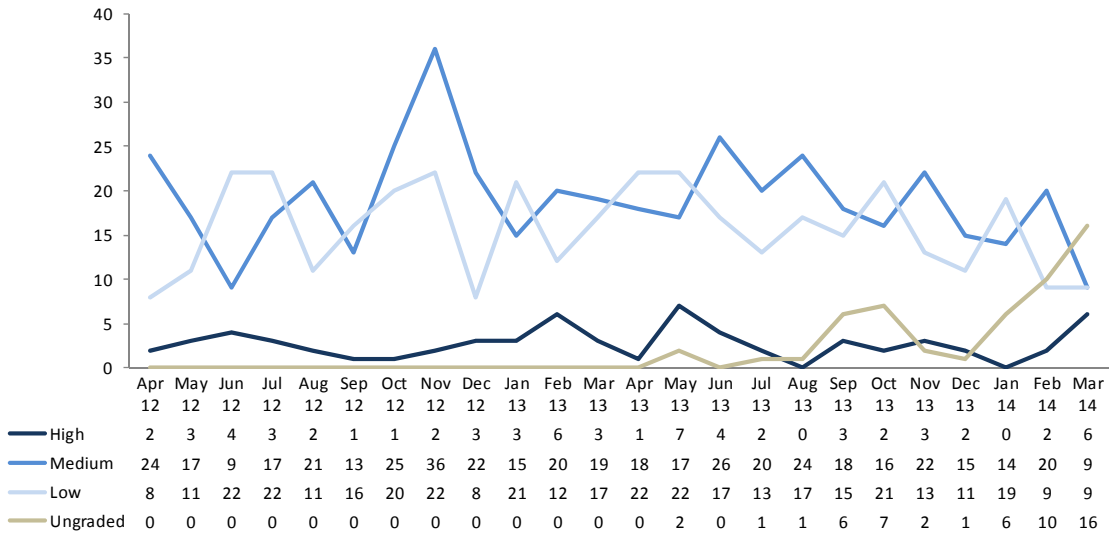

Work streams have been created to review the caesarean section toolkit with the intention of reducing the caesarean section rates. This is a multi-disciplinary project, working with women throughout their pregnancy, reviewing processes and involving all staff. It is a north-central London and pan-London maternity target.

# 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 | Feb 14 | Mar 14 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Risk | High | 1 | 7 | 4 | 2 | 0 | 3 | 2 | 3 | 2 | 0 | 2 | 6 |
| | Medium | 18 | 17 | 26 | 20 | 24 | 18 | 16 | 22 | 15 | 14 | 20 | 9 |
| | Low | 22 | 22 | 17 | 13 | 17 | 15 | 21 | 13 | 11 | 19 | 9 | 9 |
| | Ungraded | 0 | 2 | 0 | 1 | 1 | 6 | 7 | 2 | 1 | 6 | 10 | 16 |
| | Total | 41 | 48 | 47 | 36 | 42 | 42 | 46 | 40 | 29 | 39 | 41 | 40 |




| | Apr 12 | May 12 | Jun 12 | Jul 12 | Aug 12 | Sep 12 | Oct 12 | Nov 12 | Dec 12 | Jan 13 | Feb 13 | Mar 13 | Apr 13 | May 13 | Jun 13 | Jul 13 | Aug 13 | Sep 13 | Oct 13 | Nov 13 | Dec 13 | Jan 14 | Feb 14 | Mar 14 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| High | 2 | 3 | 4 | 3 | 2 | 1 | 1 | 2 | 3 | 3 | 6 | 3 | 1 | 7 | 4 | 2 | 0 | 3 | 2 | 3 | 2 | 0 | 2 | 6 |
| Medium | 24 | 17 | 9 | 17 | 21 | 13 | 25 | 36 | 22 | 15 | 20 | 19 | 18 | 17 | 26 | 20 | 24 | 18 | 16 | 22 | 15 | 14 | 20 | 9 |
| Low | 8 | 11 | 22 | 22 | 11 | 16 | 20 | 22 | 8 | 21 | 12 | 17 | 22 | 22 | 17 | 13 | 17 | 15 | 21 | 13 | 11 | 19 | 9 | 9 |
| Ungraded | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 2 | 0 | 1 | 1 | 6 | 7 | 2 | 1 | 6 | 10 | 16 |

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

These are where an incident had the potential to cause harm and is, therefore a risk. However, in the last 12 months, no medication errors caused severe harm, 8.5 per cent (42 out of 492) caused moderate harm and 85 per cent (417) caused no harm.

The total number of potential incidents is similar to previous months. Of the six high-risk, three have been downgraded. The remaining three high risk medication errors reported for March were: patient not prescribed regular medication resulting in hypertension, penicillin-allergic child prescribed Co-Amoxiclav orally in ED which resulted in no harm and Heparin infusion incorrectly administered in ITU with no harm to the patient. All three incidents have been followed up and closed. Medications management is one of Whittington Health's quality standards that the trust is focusing on.

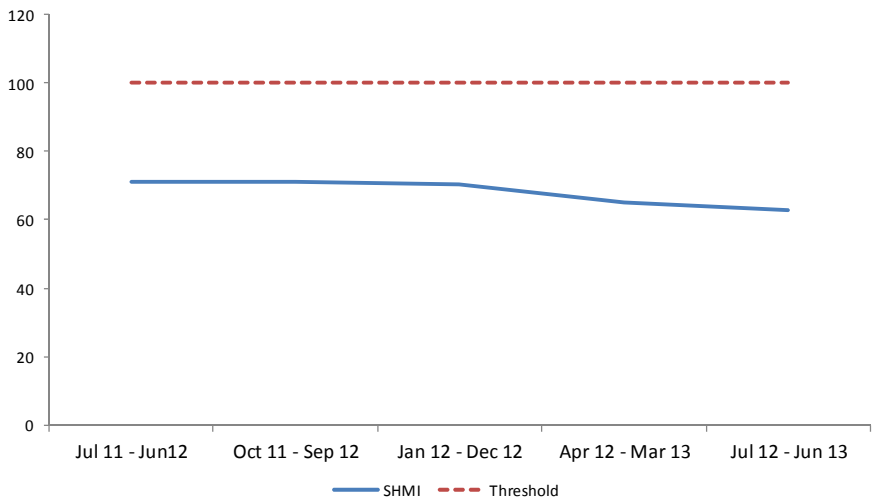
# SHMI

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.



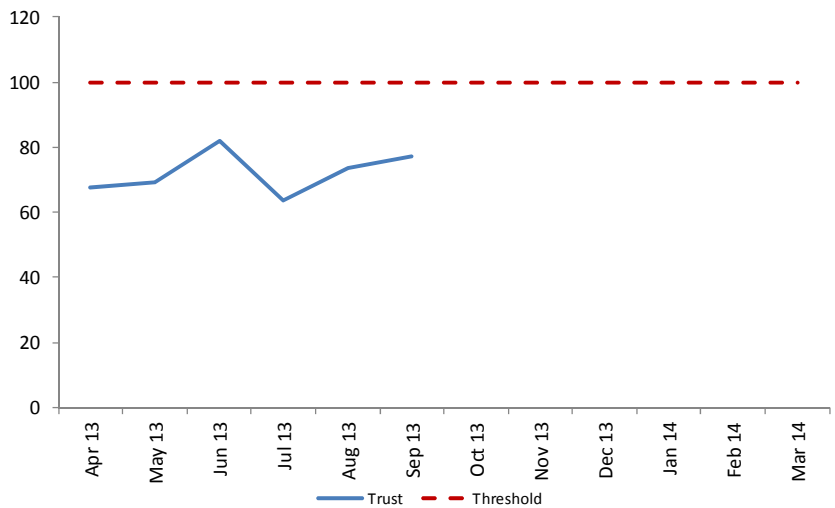

SHMI data has been updated, and we continue to delivery an excellent score.

# 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

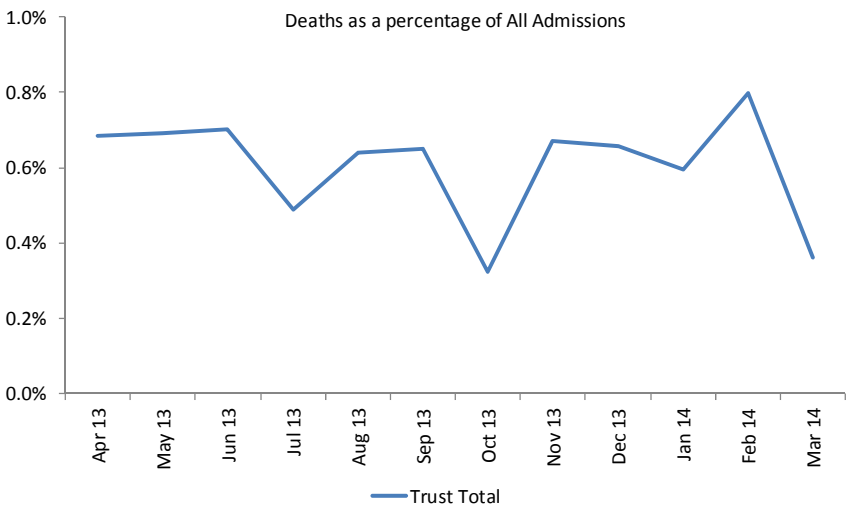
No data submitted after September 2013 due to EPR reporting issues.

# Number of Inpatient Deaths

Outcome Metrics

| | Deaths | | | Percentage of Admissions | | |
|---|---|---|---|---|---|---|
| | Jan 14 | Feb 14 | Mar 14 | Jan 14 | Feb 14 | Mar 14 |
| Trust Total | 28 | 35 | 17 | 0.6% | 0.8% | 0.4% |

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




All inpatient deaths are processed through the mortality and morbidity audit tools. This work has included national improvements in mortality and morbidity audit tools.

# Patient Satisfaction (Friends and Family)

Ensure

Quality Indicators

| | Jan 14 | Feb 14 | Mar 14 |
|---|---|---|---|
| Inpatient Coverage | 49.0% | 51.0% | 42.2% |
| 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

Inpatient coverage has declined to 42.2 per cent coverage, although ED coverage sustains the recent improvements at 16.7 per cent. The inpatient and ED net promoter scores have both improved against the February position, with a total net promoter score of 59 for March.
Wards continue to display the “you said, we did” feedback comments. The focus this month has been on enforcing visiting hours and the number of visitors, in response to patient feedback.

# Mixed Sex Accommodation

Integrate

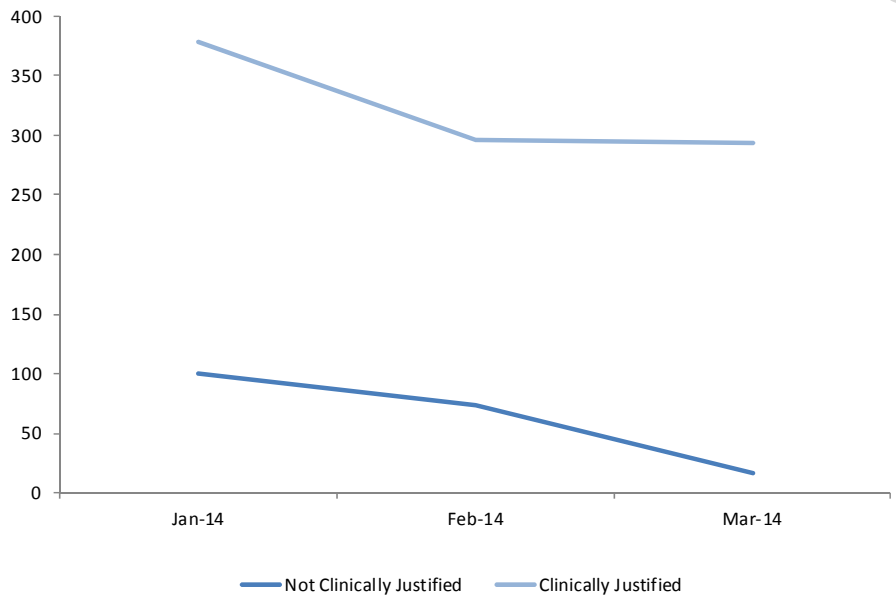
Quality Indicators

**Not Clinically justified occurence**

| | Jan-13 | Feb-13 | Mar-14 |
|---|---|---|---|
| ICAM | 49 | 49 | 2 |
| Cavell Rehabilitation Ward | 0 | 0 | 0 |
| Edward Drive | 0 | 0 | 0 |
| ISIS Ward | 0 | 0 | 0 |
| Mary Seacole South | 49 | 13 | 0 |
| Mercers | 0 | 0 | |
| Meyrick Ward | 0 | 0 | 0 |
| Bridges Ward | 0 | 0 | 0 |
| SCD | 51 | 24 | 14 |
| Coyle Ward | 5 | 0 | 0 |
| Intensive Care Unit | 46 | 24 | 14 |
| Thorogood Ward | 0 | 0 | 0 |
| Victoria Ward | 0 | 0 | 0 |
| Grand Total | 100 | 73 | 16 |

**Clinically justified occurence**

| | Jan-13 | Feb-13 | Mar-14 |
|---|---|---|---|
| ICAM | 111 | 39 | 35 |
| Cavell Rehabilitation Ward | 0 | 0 | 0 |
| Edward Drive | 0 | 0 | 0 |
| ISIS Ward | 0 | 0 | 0 |
| Mary Seacole South | 111 | 39 | 0 |
| Mercers | 0 | 0 | |
| Meyrick Ward | 0 | 0 | 0 |
| Bridges Ward | 0 | 0 | 0 |
| SCD | 267 | 257 | 259 |
| Coyle Ward | 0 | 0 | 0 |
| Intensive Care Unit | 267 | 257 | 259 |
| Thorogood Ward | 0 | 0 | 0 |
| Victoria Ward | 0 | 0 | 0 |
| Grand Total | 378 | 296 | 294 |




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

Following the data assurance process and the 100 not clinically justified occurrences of mixed sex accommodation in January, significant reductions have been made since, with 16 not clinically justified occurrences in March.
The 294 clinically justified occurrences for March are for local monitoring. Work is underway in the Day Treatment Centre to ensure compliance with MSA standards.

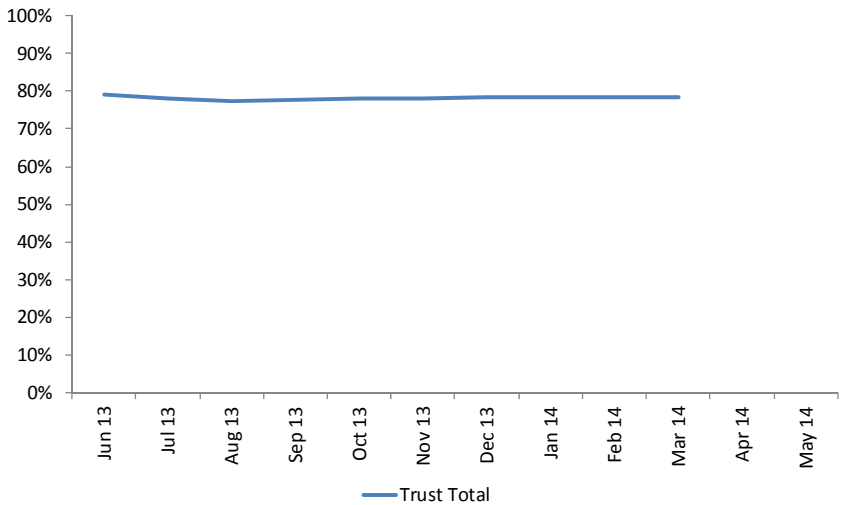
# Percentage of Registered Nurses

Change

Quality Indicators

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

| | Threshold | Jan 14 | Feb 14 | Mar 14 |
|---|---|---|---|---|
| Trust Total | n/a | 78.5% | 78.3% | 78.3% |




Matrons on wards are reviewing staffing levels on each ward and developing a recruitment plan where required.

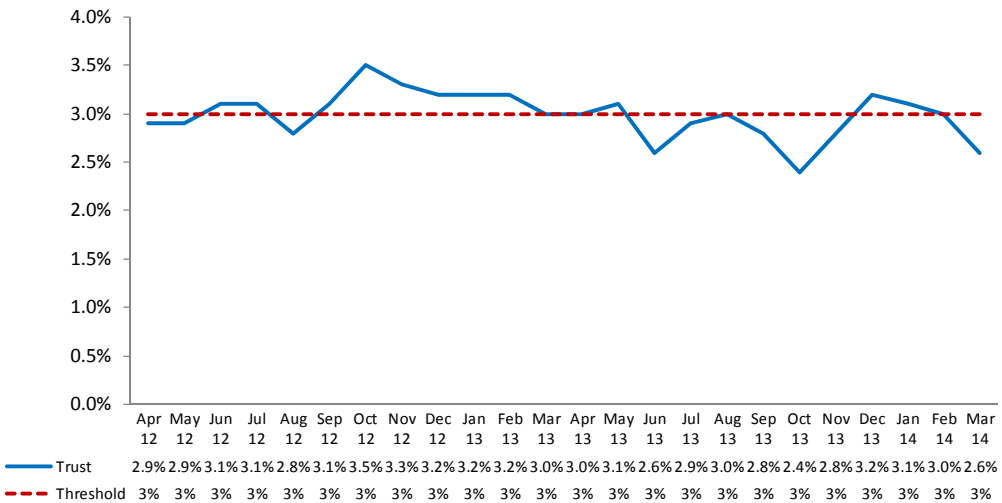
# Sickness Rate

Change

Quality Indicators

| | Sickness | | | | High Bradford Scores | | |
|---|---|---|---|---|---|---|---|
| | Local Threshold | Jan 14 | Feb 14 | Mar 14 | Jan 14 | Feb 14 | Mar 14 |
| Trust Total | <3% | 3.1% | 3.0% | 2.6% | 685 | 664 | 596 |

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




This month's sickness rate for the Trust is reporting a welcome reduction against the threshold. There is also a reduction in the high Bradford scores which provides the triggers to managers to meet with their staff and agree action. The reductions in part are due to joint working between HR and the Operations Divisional Directors. Workforce statistics including sickness rates are reported each month to the Trust Operational Board which has resulted in action being taken. Also guidance for managers and staff has been circulated setting out the actions required in managing and reporting sickness.

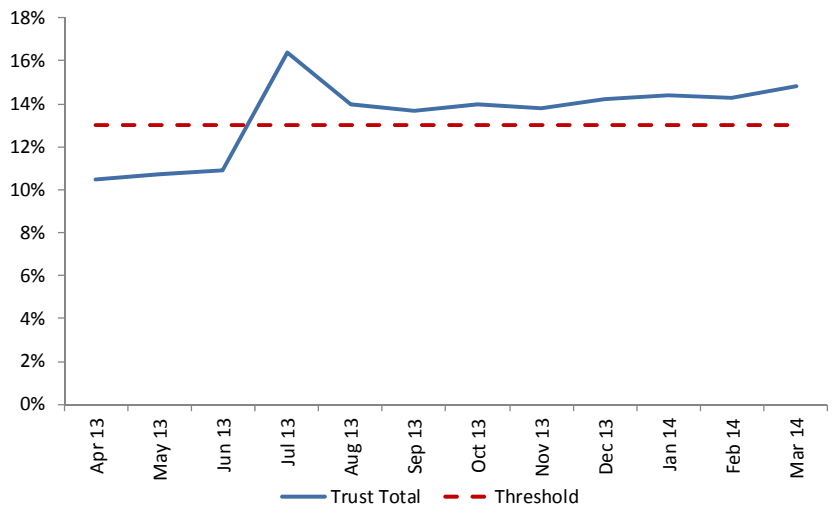
# Staff Turnover

Change

Quality Indicators

| | Local Threshold | Jan 14 | Feb 14 | Mar 14 |
|---|---|---|---|---|
| Trust Total | <13% | 14.4% | 14.3% | 14.8% |

Proportion of workforce leaving in a given period.




This month's trend shows a slight increase over the Trust threshold. The level of turnover relates to staff retention which now requires a "deep dive" analysis to understand better the key areas of the Trust where turnover is particularly high. The intention is to discuss this issue at the Trust Operational Board in May and to agree actions that will bring the trend back to the threshold.

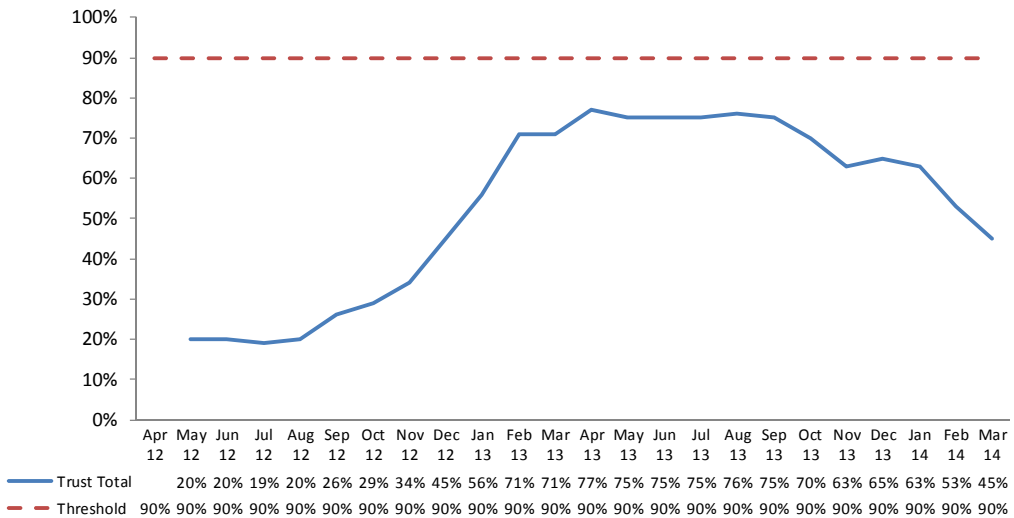
# Staff Appraisal

Change

Quality Indicators

| | Local Threshold | Jan 14 | Feb 14 | Mar 14 |
|---|---|---|---|---|
| Trust Total | 90% | 63.0% | 53.0% | 45.0% |

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



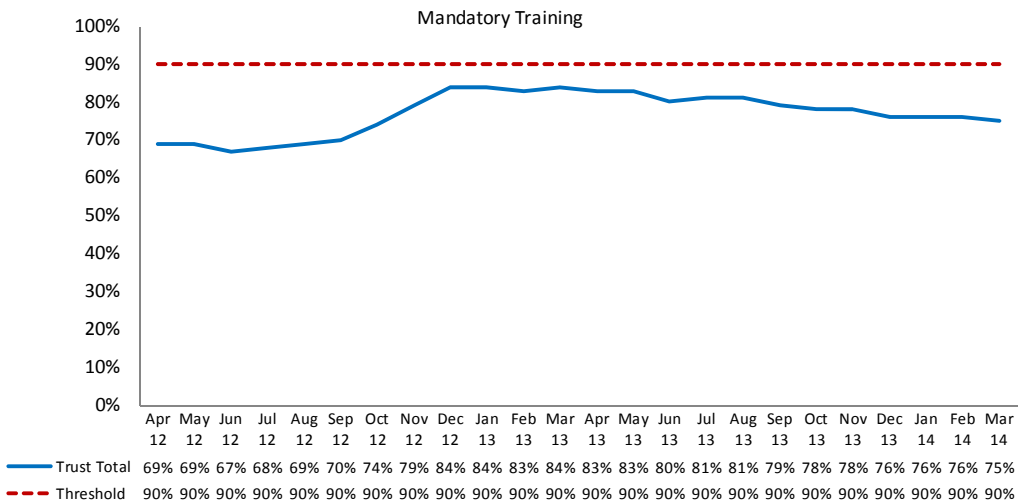

There is a disappointing downward trend in March for reported appraisal compliance. Actions taken include:
1. Trust divisional leads have received appraisal performance reports highlighting results in their areas.
2. The Deputy Director of Leadership and Talent is leading investigations into the apparent mismatch between "on the ground" feedback of appraisal completion rates and what is reported via ESR. There is a much lower reporting via ESR. The review will be completed by the end of June 2014.
3. Bespoke support has been offered to divisional teams in the short term to upload completed appraisals onto ESR.
4. Additional appraisal training is taking place across the organisations, available to all staff.
5. Commencing May 2014, the Trust launches its improved appraisal scheme. Coaching Conversation training is taking place.
6. The new appraisal scheme will bring together the three previous systems into one Trust scheme with one timeline which dovetails with the annual business planning cycle.

# Mandatory Training Compliance

Change

Focus Areas

| | Mandatory Training | | | Information Governance | | | Child Protection Level 2 | | | Child Protection Level 3 | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Jan 14 | Feb 14 | Mar 14 | Jan 14 | Feb 14 | Mar 14 | Jan 14 | Feb 14 | Mar 14 | Jan 14 | Feb 14 | Mar 14 |
| Local Threshold | 90% | | | 95% | | | 90% | | | 90% | | |
| Trust Total | 76% | 76% | 75% | 66% | 70% | 69% | 63% | 59% | 69% | 69% | 69% | 74% |




Data snapshot date 28/03/2014

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

Although mandatory training overall compliance has dropped by 1 per cent since the previous report in February, there have been improvement in child protection level two (increase of 10 per cent) and child protection level three (increase of 5 per cent).

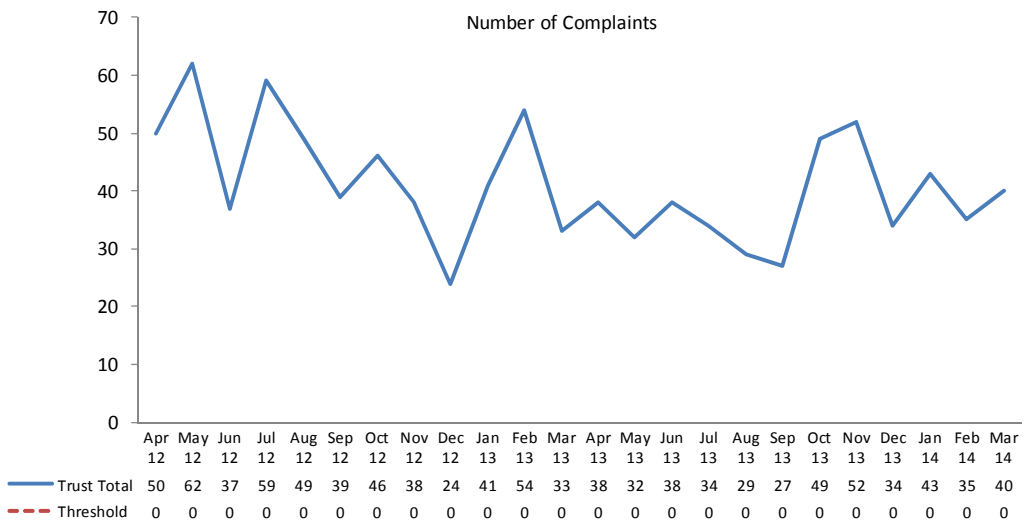
Discussions to set up a high level working group to be chaired by a non-executive director or the chief operating officer, to review the governance of mandatory training is underway following a discussion at the Trust Board in early April 2014.

# Complaints

Ensure

Quality Indicators

| | Complaints | | | | Responded to in 25 days | | |
|---|---|---|---|---|---|---|---|
| | Threshold | Jan 14 | Feb 14 | Mar 14 | Dec 13 | Jan 14 | Feb 14 |
| Trust Total | 0 | 43 | 35 | 40 | 21% | 49% | 71% |




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

Response times have improved to 71 per cent within 25 days and an action plan is in place to recruit dedicated staff to manage complaints for each division.

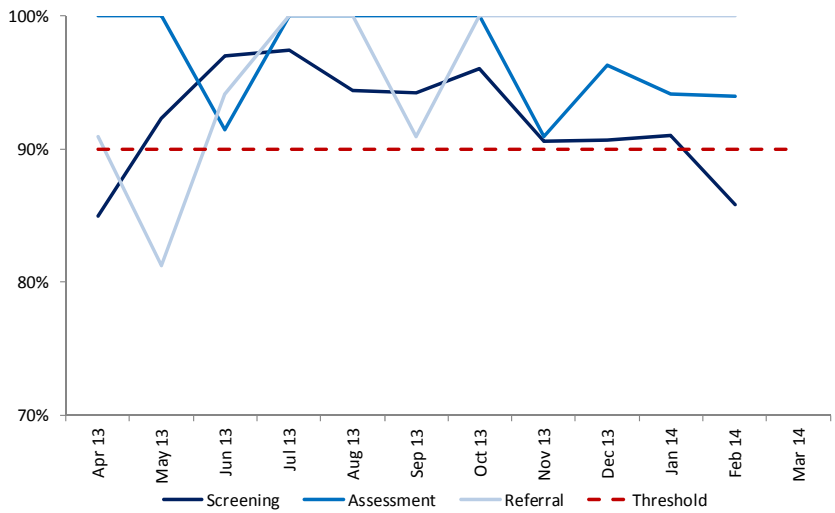
# National CQUINs

Integrate

Quality Indicators

**Dementia**

| | Contractual Threshold | Dec 13 | Jan 14 | Feb 14 |
|---|---|---|---|---|
| Screening | 90% | 91% | 91% | 86% |
| Assessment | 90% | 96% | 94% | 94% |
| Referral | 90% | 100% | 100% | 100% |




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

Data is one month in arrears

Delivery of the screening element of the dementia CQUIN has fallen below threshold at 86 per cent. The Chief Operating Officer has requested a sustainable plan be implemented by the end of May.

# 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.

Improved access to breast milk in preterm infants has seen a significant improvement from 33 per cent in September 2013 to 100 per cent in February 2014. There are two leads identified for the NICU CQUINs, a clinician and a matron. Action plans have been developed including raising awareness of these CQUINs with all medical and nursing staff and adding this as a standing agenda item at all senior neonatal nurse meetings.

# 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% | 86.8% | | 86.1% |
| 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% | 95.8% | | 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% | 24.1% | 28.4% | | 26.2% |
| 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% | 26.3% | 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% | 100.0% |
| GP Communication | 90% | 0.0% | 90.9% | 89.5% | 90.0% | 91.9% | 83.0% | | 77.0% | | | | - | 74.7% | 82.0% | 75.8% | 74.7% |
| Crime Reduction Partnerships | Report by public health of anonymised dataset on alcohol related | | | | | | | | | | | | | | | | |
| Audit | Plan for audit submitted and agreed Q1 | | | | | | | | | | | | | | | | |

Smoking – due to data issues with EPR implementation, it has proved difficult to monitor poor performing areas. Day Treatment Centre changes in management and personnel has caused a dip in performance. This has been rectified by the Theatre Manager and the new lead to ensure the assessment and handing out of patient information leaflet occurs.

Alcohol – continual improvement is seen with March at 26.3 per cent. The department have implemented the use of alcohol scratch cards that are issued shortly after arrival and reviewed by the examining clinician. The senior staff within the Emergency Department are now provided with a list of staff and the number of screens they have undertaken, which provides an opportunity to provide individual feedback and support performance.

# 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% | 91% | 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% | 100% | | |

| Integrated Care | Year End Target | 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 | 4 per week | | | | 4 per week | | | | 4 per week | | | |
| Multidisciplinary Working - Islington | 5 MDT Case conferences a month MDT case conference membership | 4 per month | | | | 4 per month | | | | 4 per month | | | |
| Multidisciplinary Actions - Haringey | 90% of actions completed | n/a | n/a | n/a | 100% | - | | | 100% | - | | | 96% |
| Multidisciplinary Actions - Islington | 90% of actions completed | n/a | n/a | n/a | 69% | - | | | 69% | - | | | 76% |
| Ambulatory Care Management | Alternative to admission for ACSC attending ED | 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) | | | | | | | | | | | | |
| Supporting self-care - training | 25% of community matrons, LTC nurses trained in year | 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 | Qtr 2 Figs CMs only | | | 38% | Qtr 2 Figs CMs only | | | 38% | Qtr 3 fig LTC6 received. | | | 19% |

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

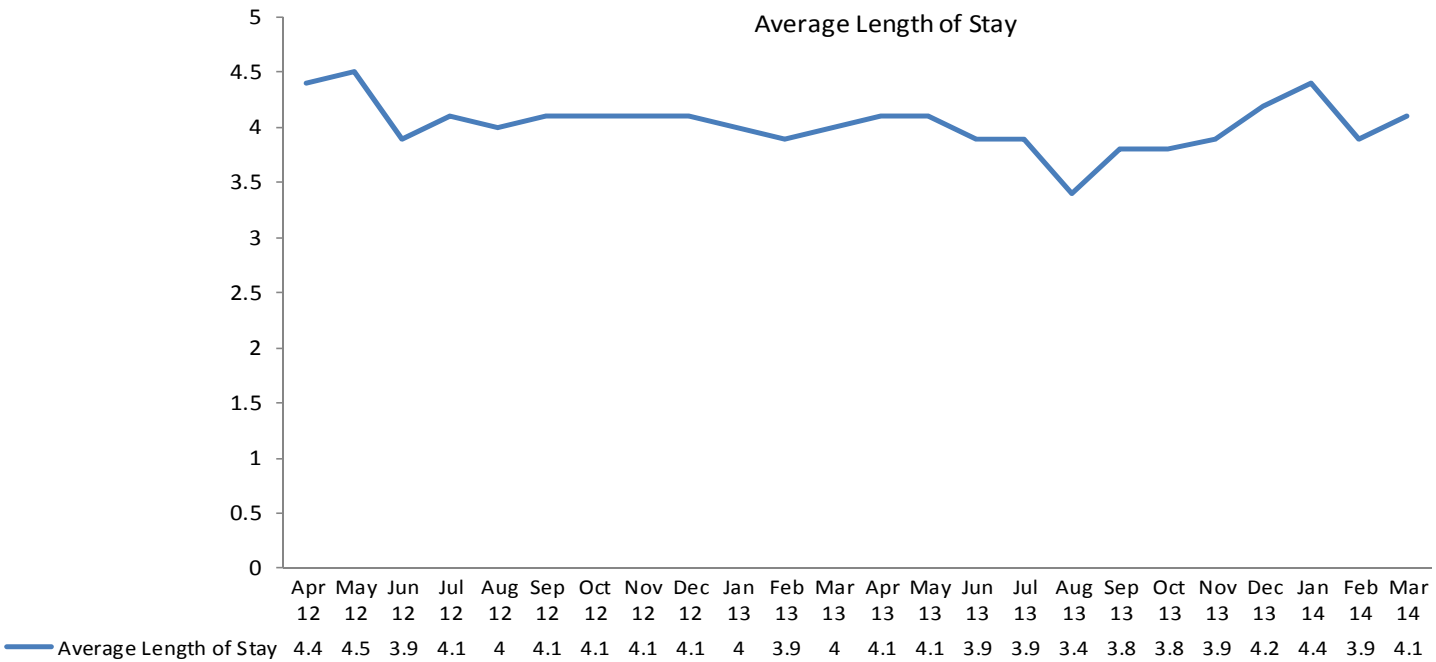
# Average Length of Stay (days)

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 | Mar 14 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Trust Total (days) | 4.2 (SHA average for 2012/13 - NHS Comparators) | 4.1 | 4.1 | 3.9 | 3.9 | 3.4 | 3.8 | 3.8 | 3.9 | 4.2 | 4.4 | 3.9 | 4.1 |

Average length of stay for patients within a given month




March average length of stay is 4.1 days, against a benchmark of 4.2 for 2012/13. The Access Centre is now embedded with a revised team and the Patient Flow Lead Nurse with commence permanently in May, which should deliver an improvement.

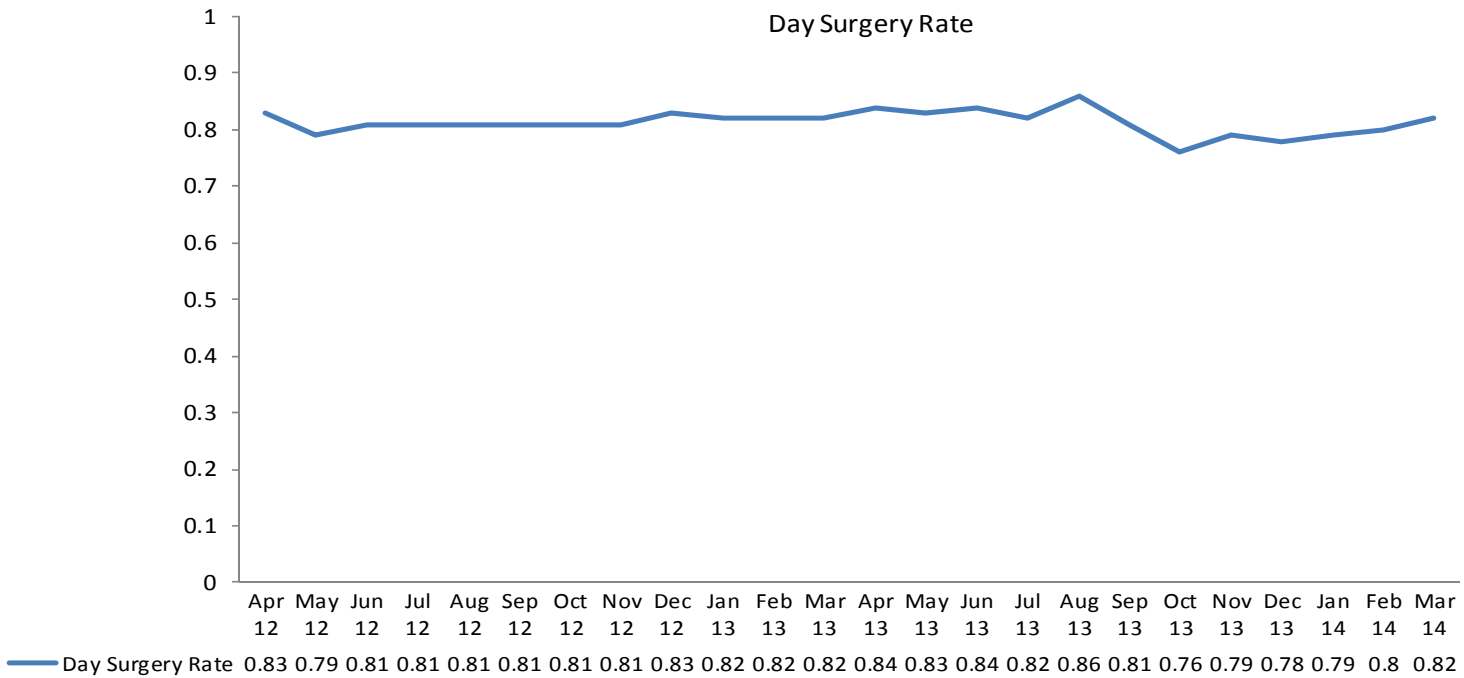
# Day Surgery Rate

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 | Mar 14 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Trust Total | n/a | 84% | 83% | 84% | 82% | 86% | 81% | 76% | 79% | 78% | 79% | 80% | 82% |

Proportion of total elective surgeries carried out as a daycase




Review of patient flow in the Day Treatment Centre is underway as the potential to improve this measure is limited by the current physical space.

# Activity

Deliver

Finance & Activity

Due to EPR reporting problems, this indicator cannot be reported this month.

# Divisional Financial Performance

Deliver

Finance & Activity

| Division | | Month 12 | | | Year To Date | | |
|---|---|---|---|---|---|---|---|
| | | Budget | Actuals | Variance | Budget | Actuals | Variance |
| | | £'000 | £'000 | £'000 | £'000 | £'000 | £'000 |
| Integrated Care & Acute Medicine | Income | 965 | 1,805 | (841) | 11,445 | 16,145 | (4,700) |
| | Expenditure | 6,640 | 8,070 | (1,430) | 80,289 | 91,650 | (11,360) |
| Integrated Care & Acute Medici Total | | 5,675 | 6,265 | (589) | 68,844 | 75,504 | (6,660) |
| Surgery, Cancer & Diagnostics | Income | 288 | 452 | (164) | 3,492 | 4,324 | (832) |
| | Expenditure | 4,529 | 5,578 | (1,049) | 54,256 | 60,229 | (5,973) |
| Surgery, Cancer & Diagnostics Total | | 4,241 | 5,126 | (885) | 50,764 | 55,905 | (5,141) |
| Women, Children & Families | Income | 1,142 | 1,408 | (265) | 13,754 | 14,645 | (891) |
| | Expenditure | 5,481 | 5,753 | (272) | 64,015 | 65,574 | (1,559) |
| Women, Children & Families Total | | 4,339 | 4,345 | (7) | 50,261 | 50,929 | (668) |
| Grand Total | | 14,254 | 15,736 | (1,481) | 169,869 | 182,338 | (12,469) |

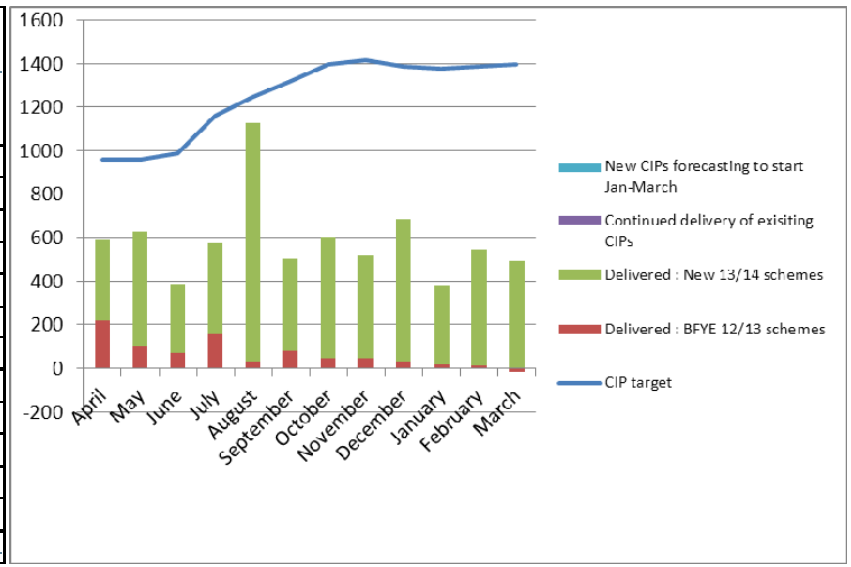
Divisional finance performance shows most areas to be below target levels. This is the consequence of cost pressures resulting from RTT and ED four-hour wait targets delivery and the increasing acuity of patients, which have all led to increased costs. In addition, under-delivery against CIP targets 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

| Division | Plan 2013/14 £'000 | Plan YTD £'000 | Actual YTD £'000 | Variance from Plan £'000 | YTD delivered % of profiled plan |
|---|---|---|---|---|---|
| ICAM | 3,046 | 3,046 | 1,317 | 1,730 | 43% |
| SCD | 1,549 | 1,550 | 866 | -683 | 56% |
| WCH | 1,238 | 1,238 | 638 | -600 | 52% |
| Estates & Facilities | 615 | 615 | 570 | -45 | 93% |
| Finance | 403 | 403 | 356 | -47 | 88% |
| HR | 97 | 97 | 0 | -97 | 0% |
| Nursing Directorate | 278 | 278 | 179 | -99 | 65% |
| IT | 160 | 160 | 65 | -95 | 41% |
| Procurement | 875 | 875 | 498 | -377 | 57% |
| Trust-wide schemes | 4,146 | 4,143 | 2,242 | -1,901 | 54% |
| Potential to be identified | 2,594 | 2,594 | 0 | -2,594 | 0% |
| Income offset against CIP target | 0 | 0 | 286 | 286 | |
| **Total** | **15,000** | **14,997** | **7,017** | **-7,981** | **47%** |




CIP finished the year 53 per cent below target. Further savings and additional income negotiated with commissioners has also been achieved. 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 | Month12 £000's | Trend to M11 £000's | Variance £000's |
|---|---|---|---|---|
| **Agency** | Corporate | -897 | 283 | 1,180 |
| | IC&AM | 1,081 | 764 | (316) |
| | SC&D | 121 | 137 | 16 |
| | WC&F | 321 | 233 | (87) |
| **Agency Total** | | **625** | **1,417** | **793** |
| **Locum** | Corporate | 1 | 5 | 4 |
| | IC&AM | -127 | 75 | 202 |
| | SC&D | 107 | 58 | (50) |
| | WC&F | 32 | 16 | (16) |
| **Locum Total** | | **14** | **154** | **140** |
| **Bank** | Corporate | 334 | 321 | (14) |
| | IC&AM | 568 | 471 | (97) |
| | SC&D | 482 | 337 | (146) |
| | WC&F | 418 | 332 | (85) |
| **Bank Total** | | **1,802** | **1,461** | **(341)** |
| **Total** | | **2,440** | **3,032** | **592** |

This data includes the winter agency staff costed and agreed in the winter plan.
A revised improvement programme is underway including actions to reduce agency costs with new nursing establishments being proposed, a lead nurse in Operations to drive recruitment and a task and finish group led by an Executive.