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The Whittington Hospital NHS Trust
Magdala Avenue
London N19 5NF

Whittington Health Trust Board

4 June 2014

Title:	Trust Board Performance Report June 2014 (April data)		
Agenda item:	**14/102**	**Paper**	**6**
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 Attend (DNAs) and first to follow-up ratios will be included in this. Following the EPR (Electronic Patient Record) upgrade, data quality issues were identified with the waiting list affecting the Referral to Treatment (RTT) incomplete metric. An action plan has been developed and reporting is expected to resume in July. • Reporting for MSK data validation is well underway (slide 15). • RTT admitted and non-admitted national standard are met in April (slides 18-19) • Diagnostic waits (slide 22) did not meet the national threshold. • There was one cancelled operation in April (slide 23). • Emergency department continues to achieve the four hour target for the seventh consecutive month indicating improvements have been embedded and the target is sustainable (slide 24). • Cancer – standards were met for five of the six indicators, however the Breast Symptomatic standard was not achieved due to patient choice. Further work is being done to improve capacity and to provide more choice for patients (slides 25-30). • Genito-Urinary medicine performance has returned to 100 per cent of patients offered an appointment within two days (slide 32).		

	• Elective caesarean section rates have reduced to 10.7 per cent, below the national average of 14.8 per cent (slide 46). • Mixed sex accommodation of not clinically justified breaches continues to reduce (slide 52). • Chronic obstructive pulmonary disease(COPD)Commissioning for Quality and Innovation (CQUIN) has achieved all inpatient year end thresholds for smoking status, brief advice and referral (slide 61).
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:	23 May 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
Performance Report

June 2014
(April Data)

Executive Summary

Focus Areas

Whittington Health joint Diabetes and thalassasemia clinic were awarded a special commendation for their 'potentially global impact' at the recent BMJ awards ceremony. *The judges commended 'this excellent team on their work, which has huge relevance, particularly when considering global healthcare needs'*

Whittington Health (WH) improving access to psychological therapies (IAPT) were given very positive feedback from London IAPT on their recent clinical assurance test. The panel were clear in their appreciation of IAPT standards of work and the 'consistent and highly valued training environment that WH IAPT have provided'

The Whittington Health respiratory team were used as an excellent example of integrated care in the Royal College of Physicians (RCP), Future Hospitals Commission Report and as a result have been invited to apply to be a development site for the on-going program.

The new born hearing screening service have implemented a new booking system with effect from 1 May 2014. Babies now get an appointment date agreed before leaving hospital.

Improvement to the complaints process are being embedded and we have achieved the following responses within 25 days: 100 per cent women, children and families; 67 per cent Integrated Care and Acute Medicine (ICAM) and 36 per cent and surgery, cancer and diagnostics, who are implementing further improvements. This gave an overall rate of 61 per cent for the organisation.

<u>Areas of focus</u>
MSK (slide 15)
District Nursing (slide 14)
First to follow up appointments – acute (slide 4)
DNA (slide 9)

Board Aims

Focus Areas

All indicators have been mapped to the Board Aims

First:Follow-Up Ratio - Acute

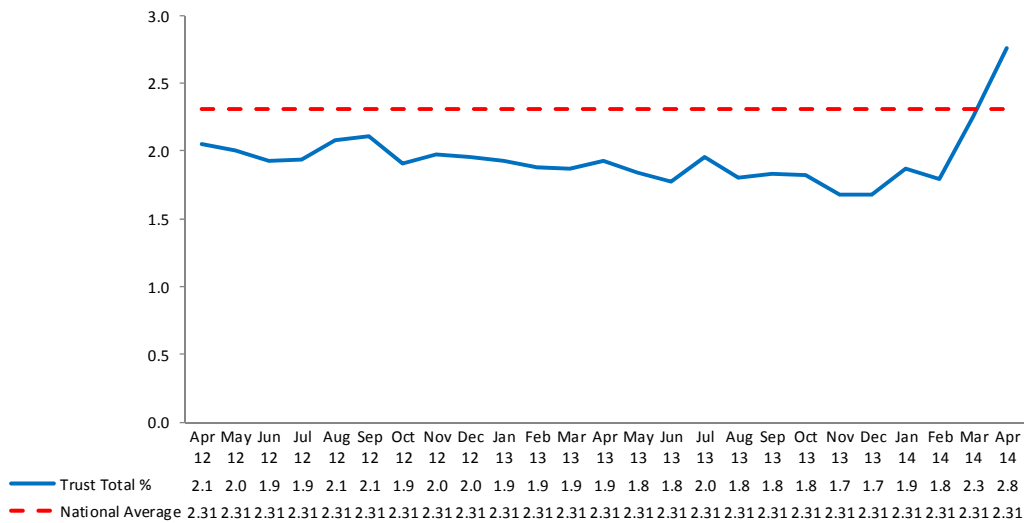
Deliver

Focus Areas

	Transformation Board Threshold	May 13	Jun 13	Jul 13	Aug 13	Sep 13	Oct 13	Nov 13	Dec 13	Jan 14	Feb 14	Mar 14	Apr 14
Acute Trust Total	-	1.84	1.78	1.96	1.80	1.83	1.82	1.68	1.68	1.87	1.79	2.25	2.76

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

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



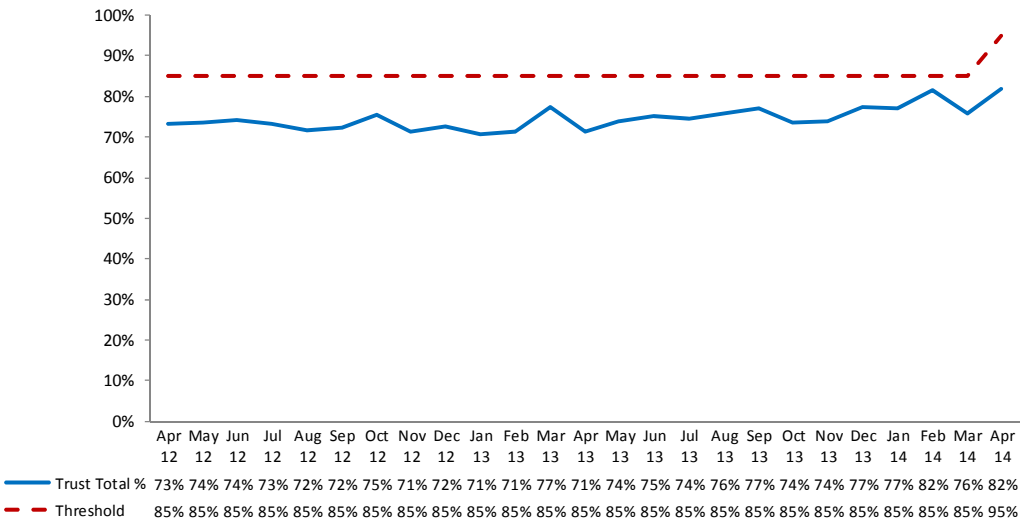
A review of the data within this indicator is underway to determine the reason for increased rates of follow up to the new ratio. Data has been requested from the information department for auditing and some specialties have developed training for junior doctors regarding pathway management and appropriate discharge. Policy for discharge and training is to be completed by the end of May.

Theatre Utilisation

Deliver

Focus Areas

	Utilisation			Available Session Time (Minutes)			Time Utilised (Minutes)		
	Feb 14	Mar 14	Apr 14	Feb 14	Mar 14	Apr 14	Feb 14	Mar 14	Apr 14
Local Threshold	>85%								
Trust Total	82%	76%	82%	60,840	62,220	61,680	49,676	47,134	50,424



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.

Theatre utilisation is steadily improving and an action plan is in place to achieve the projections by the end of June 2014. Patients are being contacted to make them aware they are first on the theatre list, this is reducing DNAs and late starts. Lists are signed off and 'locked down' by surgeons a minimum of seven days in advance, encouraging lists to be booked more appropriately. Admin staff are also checking completion of notes the day before surgery, reducing delays if documentation is not fully completed. Actions were introduced in April.

Community Dental

Deliver

Focus Areas

High Level Dental KPIs 2013/14

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%	97%	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%	99%	Monthly

Dental	**Number of Contacts**	90%	Reporting Tools from software of excellence	101%	103%	112%	120%	102%	92%	132%	129%	83%	107%	98%	101%	Monthly
	Units of dental activity	90%	Reporting Tools from software of excellence	98.00%	104%	108%	118%	87%	83%	124%	122%	89%	89%	60%	113%	Monthly

High Level Dental KPIs 2014/15

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"	96%												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"	99%												Monthly

Dental	**Number of Contacts**	90%	Reporting Tools from software of excellence	91%												Monthly
	Units of dental activity	90%	Reporting Tools from software of excellence	90.00%												Monthly

Community dental service are archiving the KPIs, further work is underway to provide information on the matrix and services that the Whittington Health dental service provide

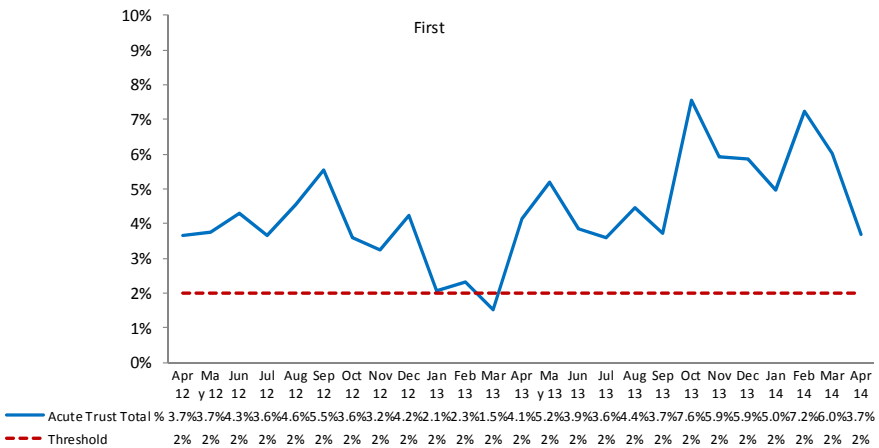
Hospital Cancellations - Acute

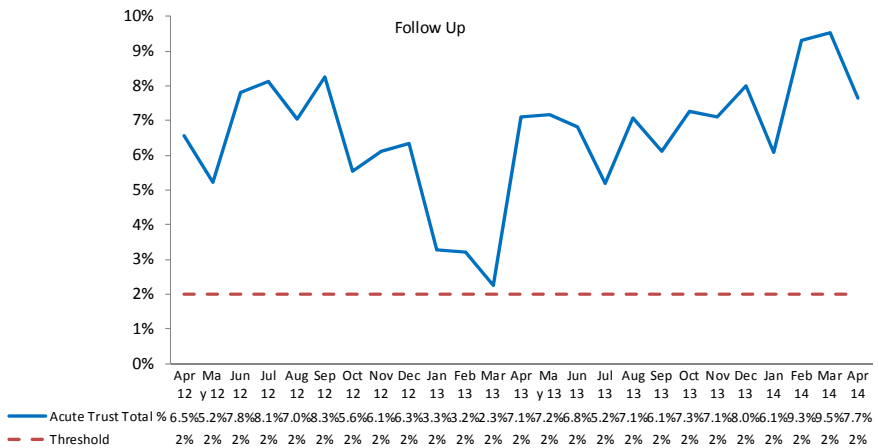
Deliver

Focus Areas

	First Appointments			Follow Up Appointments		
	Feb 14	Mar 14	Apr 14	Feb 14	Mar 14	Apr 14
Local Threshold	<2%			<2%		
Acute Trust Total	7.2%	6.0%	3.7%	9.3%	9.5%	7.7%

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





Hospital cancellations has seen a positive reduction for April to 3.7 per cent for first, and 7.7 per cent for follow-up appointments, however both remain above threshold. Cancellations due to clinician annual leave or study leave is a key issue. The Trust policy requires six week notification, this is being re-launched and reinforced with immediate effect. Out patient department booking office will book new appointments no further than six weeks in advance, and follow-up appointments are to be partially booked if over six weeks, commencing 23 June. This should reduce the cancellations and enable specialties to better understand and address any capacity and demand issues.

Service Cancellations - Community

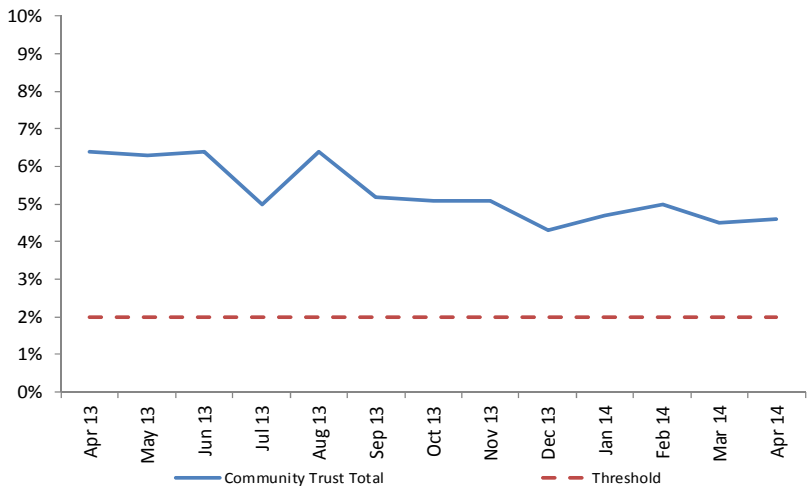
Integrate

Focus Areas

First + Follow-Up

	Apr 13	May 13	Jun 13	Jul 13	Aug 13	Sep 13	Oct 13	Nov 13	Dec 13	Jan 14	Feb 14	Mar 14	Apr 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%	4.5%	4.6%

The proportion of outpatient appointments that are cancelled by the Trust. Outpatient appointments are defined as all booked appointments including home visits in addition to those in a clinical setting.



Performance remains above the local threshold at 4.6 per cent. Community activity is recorded on RIO and if an appointment is brought forward, it will be included in this cancellation rate. There is no current way to extract these type of cancellations.

DNA Rates - Acute

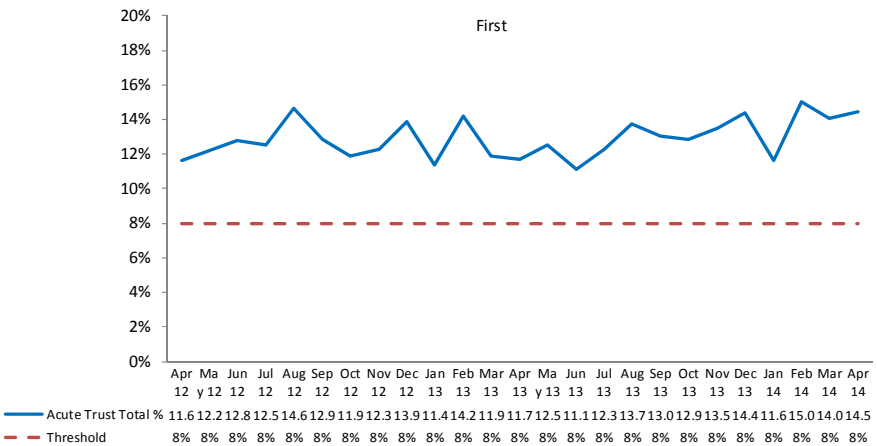
Deliver

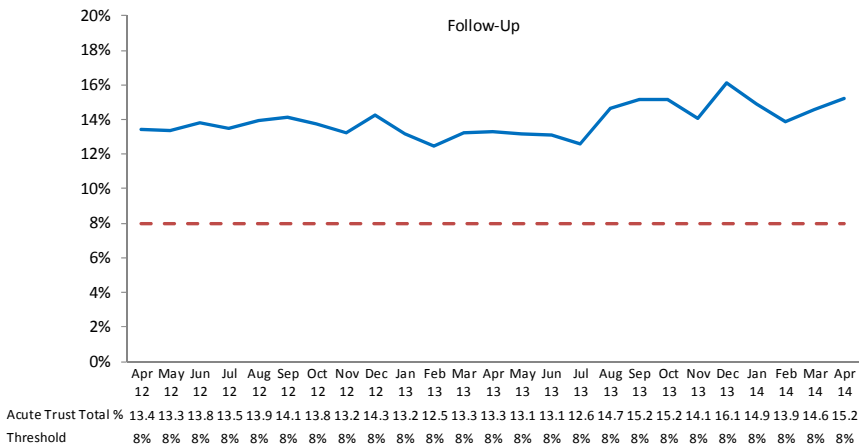
Focus Areas

	First Appointments			Follow Up Appointments		
	Feb 14	Mar 14	Apr 14	Feb 14	Mar 14	Apr 14
Local Threshold	8%			8%		
Acute Trust Total	15.0%	14.0%	14.4%	13.9%	14.6%	15.2%

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





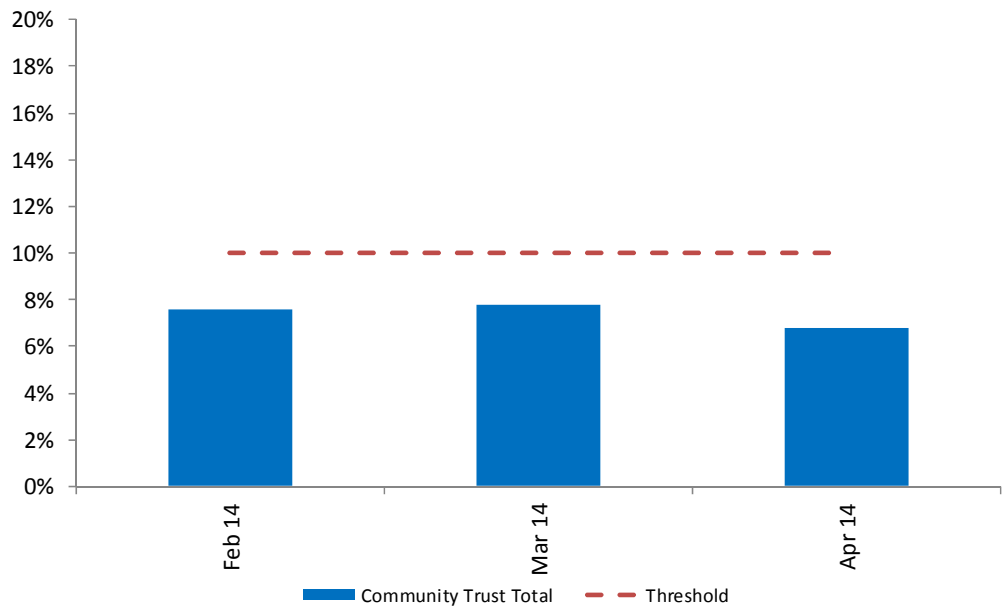
DNA rates have increased slightly in April, possibly due to the Easter bank holidays. Additionally SOPs (Standard Operating Procedures) agreed for management of DNAs are not being adhered to. Training has been implemented for access centre staff in April and outpatient reception areas will be trained when they transfer to access centre management in May. Continue to deal with phone calls via access centre and agree appointment dates with patients. SOP Training is on-going until the end of June. Full booking of appointments will start from 23 June and phone call performance continues to improve, helping patients who wish to rebook.

DNA Rates - Community

Integrate

Focus Areas

First + Follow-Up	Feb 14	Mar 14	Apr 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.

April delivered a reduction in DNA rates to 6.8 per cent and has been consistently below the local 10 per cent threshold.

Community Face-to-Face Contacts

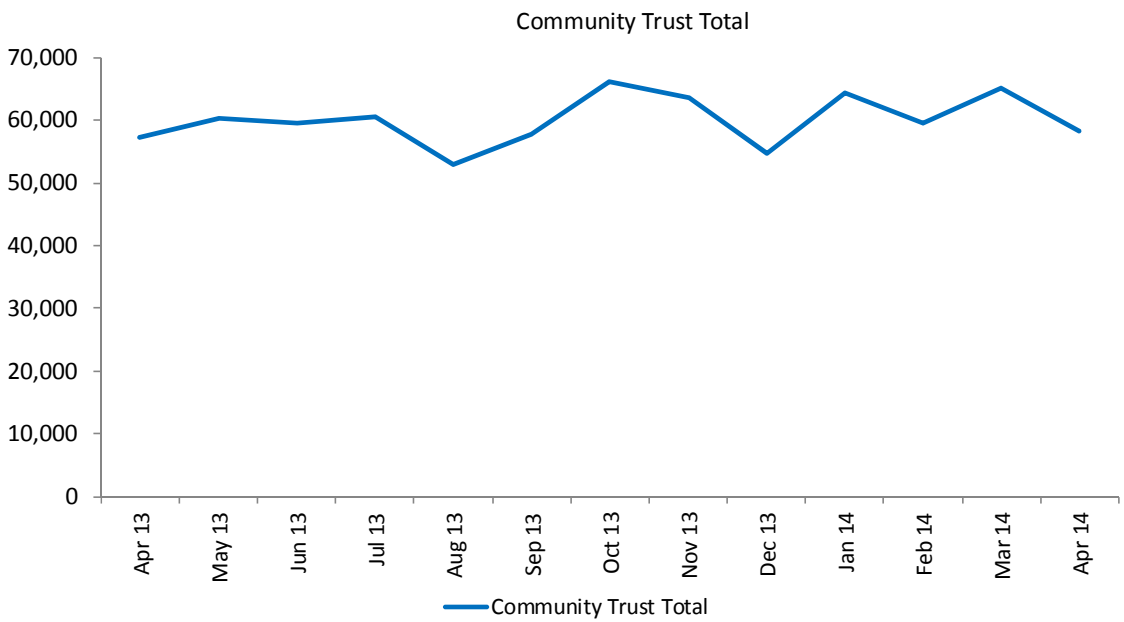
Integrate

Focus Areas

	Feb 14	Mar 14	Apr 14
Threshold	n/a		
Community Trust Total	59,447	65,046	58,311

2012/13 Apr - Apr	2013/14 Apr - Apr	2014/15 Apr - Apr	Variation between 2012/13 and 2014/15	Variation between 2013/14 and 2014/15
n/a				
44,668	57,306	58,311	31%	2%

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 of two per cent for April 2014, compared to April 2013.

Community Appointment with no outcome

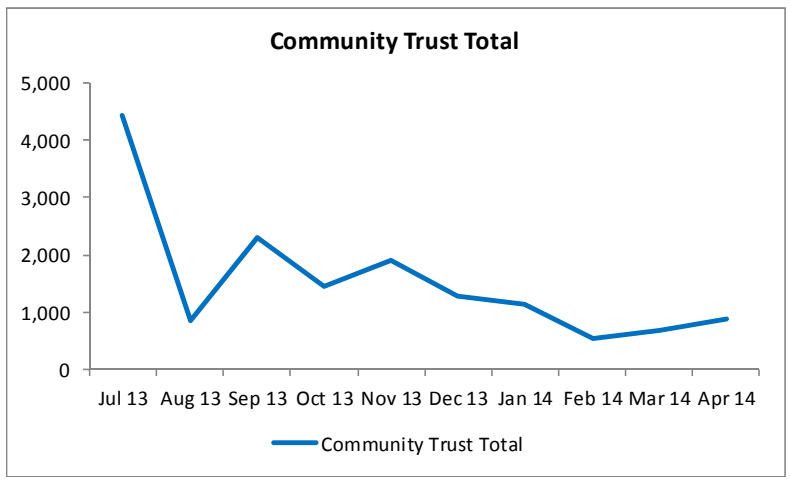
Integrate

Focus Areas

	Feb 14	Mar 14	Apr 14
Local Threshold	n/a		
Community Trust Total	544	693	891

% of Total Face-to-Face Contacts		
Feb 14	Mar 14	Apr 14
0.5%		
0.9%	1.1%	1.6%

Appointments that do not have an outcome entered by the data deadline of the 3rd working day of the following month. Clinicians are required to complete this action. Failure to complete this field correctly impacts on a number of measures where open caseloads are used as a denominator.



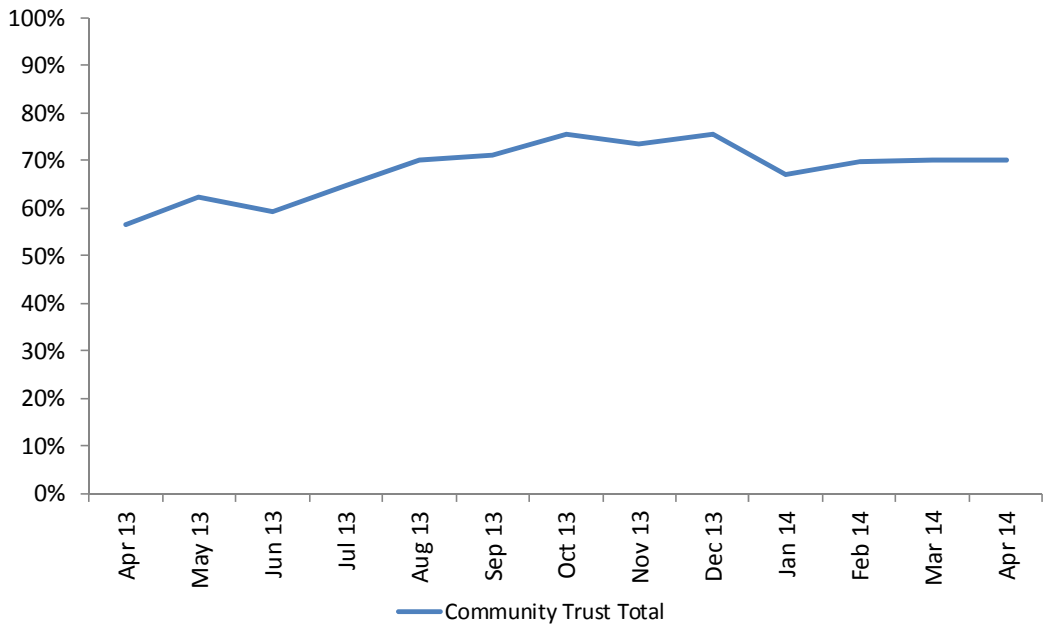
There has been an increase in community appointments with no outcome in April. Some services saw an increase of un-outcome appointments due to locum or new members of staff, who were not aware of the procedures

Community Waiting Times
% waiting less than 6 weeks

Integrate

Focus Areas

	Feb 14	Mar 14	Apr 14
Threshold	n/a		
Community Trust Total	69.8%	70.0%	70.1%



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.

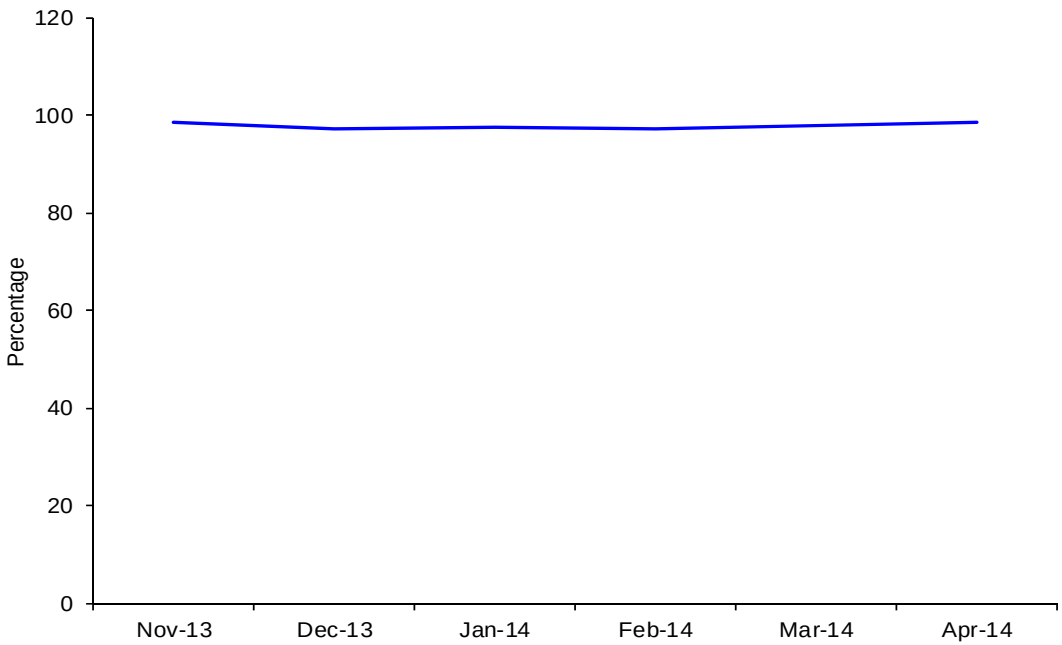
There was a slight increase in the percentage of patients waiting less than six weeks for a community appointment. A community Patient Tracking List (PTL) is now in use to assist with waiting list management.

District Nursing Waiting Times
% waiting less than 6 weeks

Integrate

Focus Areas

	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14
Threshold	n/a					
Community Trust Total	98.5	97.02	97.4	97.15	97.95	98.42



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 led by the chief operating officer. The improvement plan is well underway and a communication plan for the local population will be in place within the next two weeks.

MSK Waiting Times

Integrate

Focus Areas

Incomplete Pathways (09/05/2014)	Waiting Time	Total Under Waiting Time	Total Over Waiting Time	% Waiting
MSK Physiotherapy	6 Weeks	1916	143	93.10%
Consultant Led MSK	18 Weeks	224	1	99.60%

Clock stops is, for a given month, the time a person has waited from referral to first attended appointment.

Incomplete pathways is as at the snapshot date, the current waiting list for first appointment.

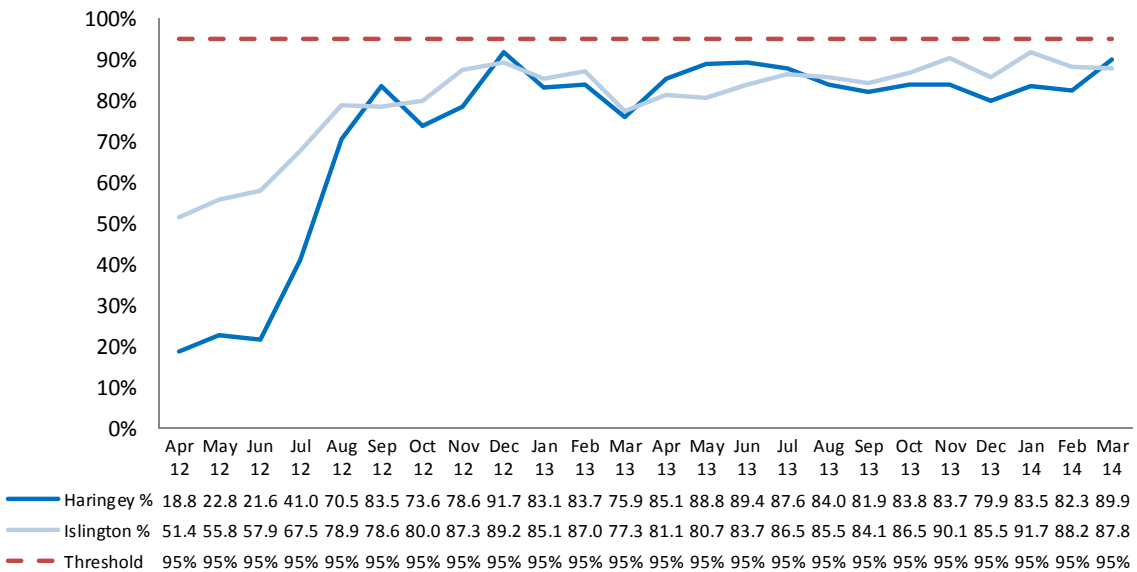
The MSK service have implemented an improvement plan which is based on delivering the performance standards for 6 weeks routine physio and patients referred on a 18 week pathway
Further improvements will be carried out over the next 3 months

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	Mar 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%	89.9%
Islington	81.1%	80.7%	83.7%	86.5%	85.5%	84.1%	86.5%	90.1%	85.5%	91.7%	88.2%	87.8%



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

March has seen an improvement in Haringey to 89.9 per cent but a slight decrease in Islington at 87.8 per cent. The division are investigating the reasons for this reduction and will take action as appropriate.

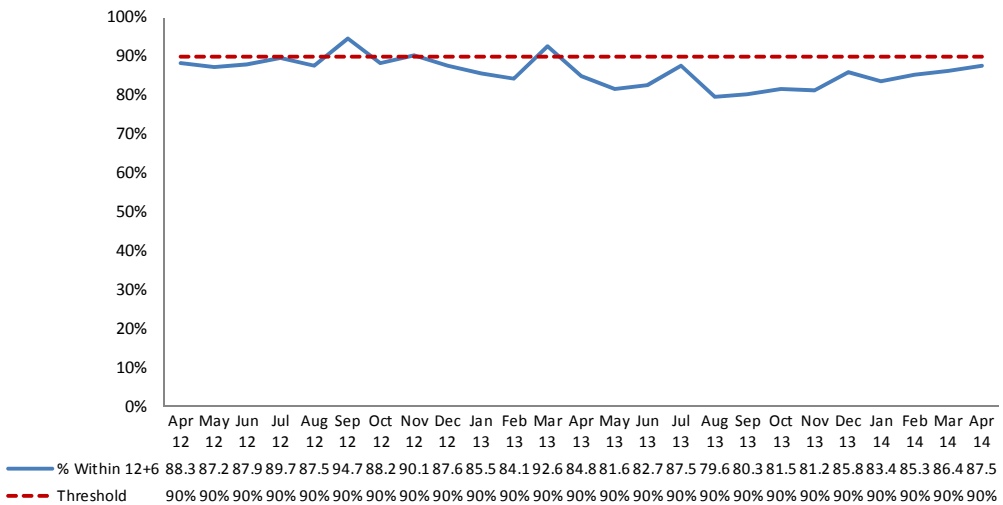
Women seen by HCP or Midwife within 12 weeks and 6 days

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	Apr 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%	87.5%
Total Number of Bookings	-	374	404	359	421	376	369	375	359	339	384	335	345	333
Referrals within 12 Weeks and 6 days	-	323	347	312	359	324	319	324	330	302	338	286	309	289

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 continues to show small improvements, now at 87.5 per cent against a 90 per cent threshold. The designated midwife consultant focused on public health is linked to this improvement. Maternity is working on one named midwife throughout the pregnancy to give continuity of carer.

Referral to Treatment 18 weeks - Admitted

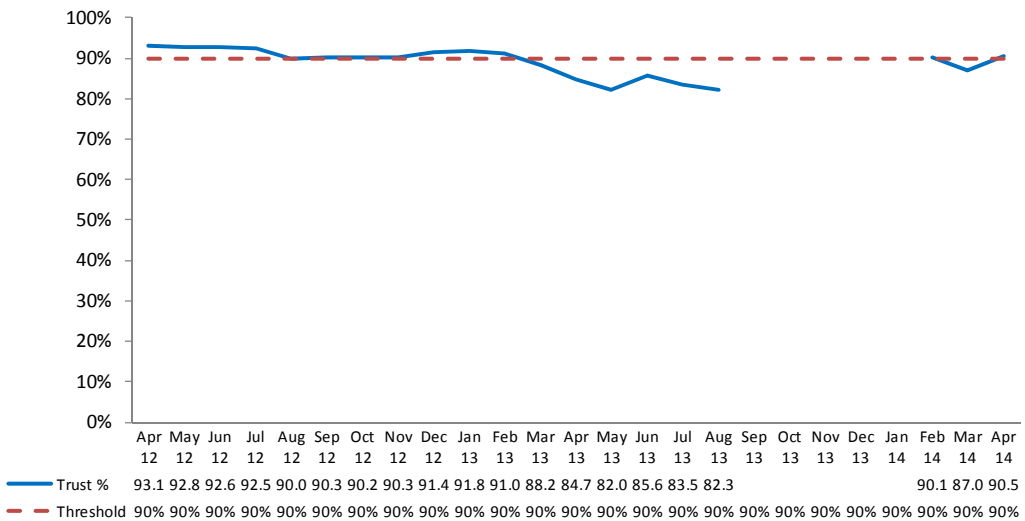
Deliver

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	Apr 14
National Threshold	90%												
Trust Total	84.7%	82.0%	85.6%	83.5%	82.3%	-	-	-	-		90.1%	90.1%	90.5%

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



Referral to treatment for admitted clock stops achieved the target for the third consecutive month since reporting resumed.

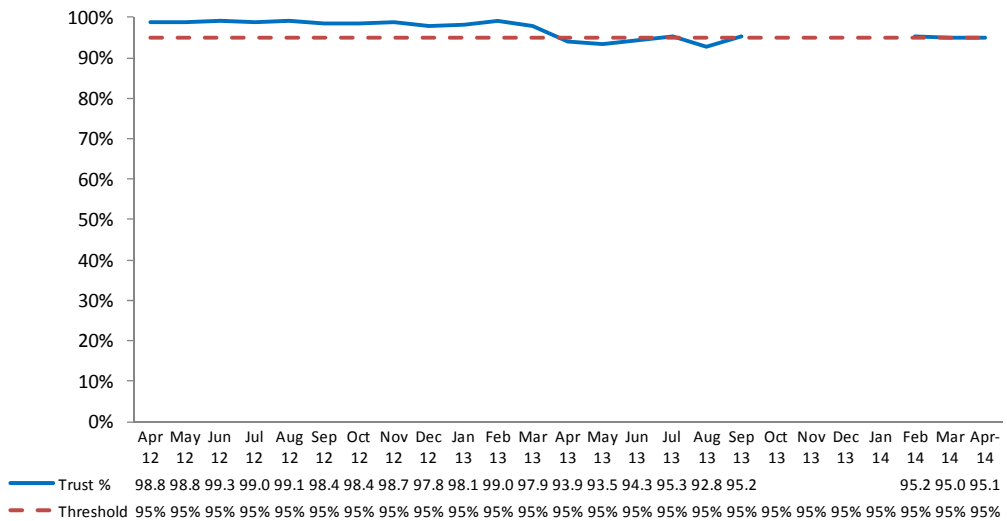
Referral to Treatment 18 weeks – Non Admitted

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	Apr 14
National Threshold	>95%												
Trust Total	93.9%	93.5%	94.3%	95.3%	92.8%	95.2%	-	-	-	-	95.2%	95.0%	95.1%

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



na denotes, data not available

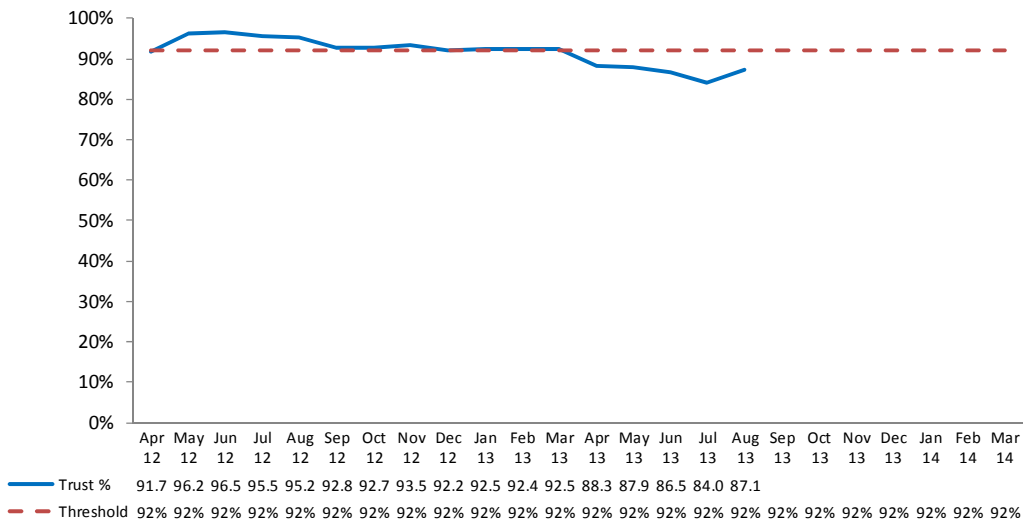
Non admitted clock stops also achieved the target at 95.1 per cent.

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	Apr 14
National Threshold	92%												
Trust Total	88.3%	87.9%	86.5%	84.0%	87.1%	-	-	-	-	-	-	-	na



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

March 2014 data correct as at 8th April 2014

na denotes, data not available

Following the EPR upgrade, internal reporting resumed which identified data quality issues. An action plan has been put into place to address the data quality and reporting is expected to resume with June's data which is submitted in July.

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	Apr 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

March 2014 data correct as at 8th April 2014

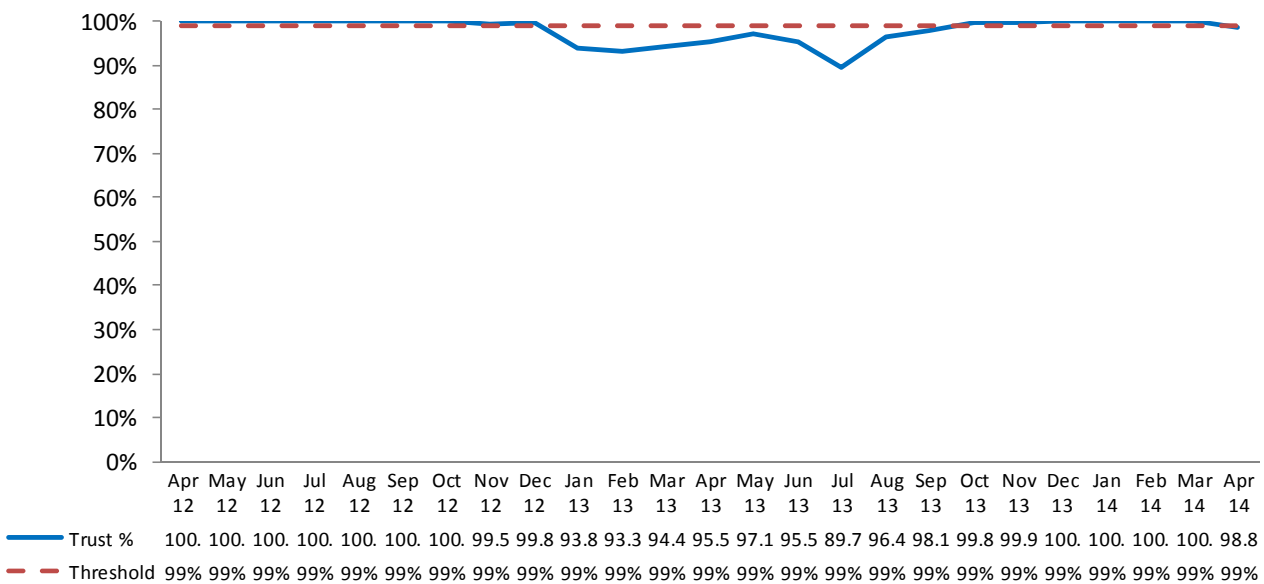
There have been no 52 week waits.

Diagnostic 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	Apr 14
National Threshold	99%												
Trust Total	95.5%	97.1%	95.5%	89.7%	96.4%	98.1%	99.8%	99.9%	100.0%	100.0%	100.0%	100.0%	98.8%



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).

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).

There was one breach in neurology due to an administrative error, this is under investigation. The remaining breaches were in audiology. An issue has been identified regarding delays in the logging of referrals in the access centre and the process is now under review.

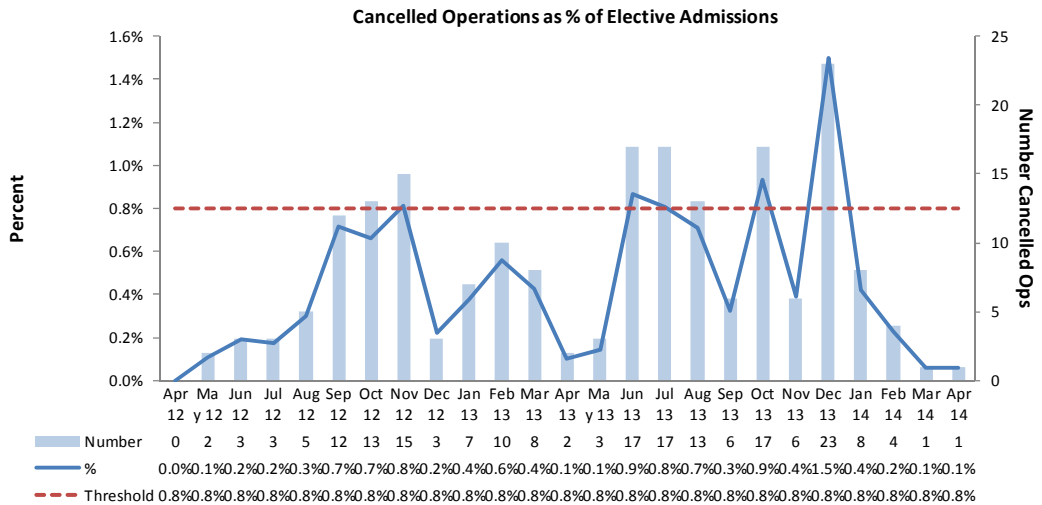
Hospital Cancelled Operations

Deliver

Access Metrics

Hospital initiated cancellations on day of operation

	Number of Cancelled Operations			Cancelled Operations as % of Elective Admissions		
	Feb 14	Mar 14	Apr 14	Feb 14	Mar 14	Apr 14
National Threshold	n/a			< 0.8%		
Trust Total	4	1	1	0.2%	0.1%	0.1%



There was one cancellation in April due to the previous case taking longer due to clinical complications and the last patient was cancelled. Action has been taken to ensure theatre lists are signed off in advance by the surgeon to ensure the scheduling is appropriate. Actions described for theatre utilisation to ensure lists start on time will also contribute to reducing cancellations for this reason.

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 (Total)

	Apr 14
National Threshold	95.0%
4hr Waits	96.3%
12hr Waits	0.0%

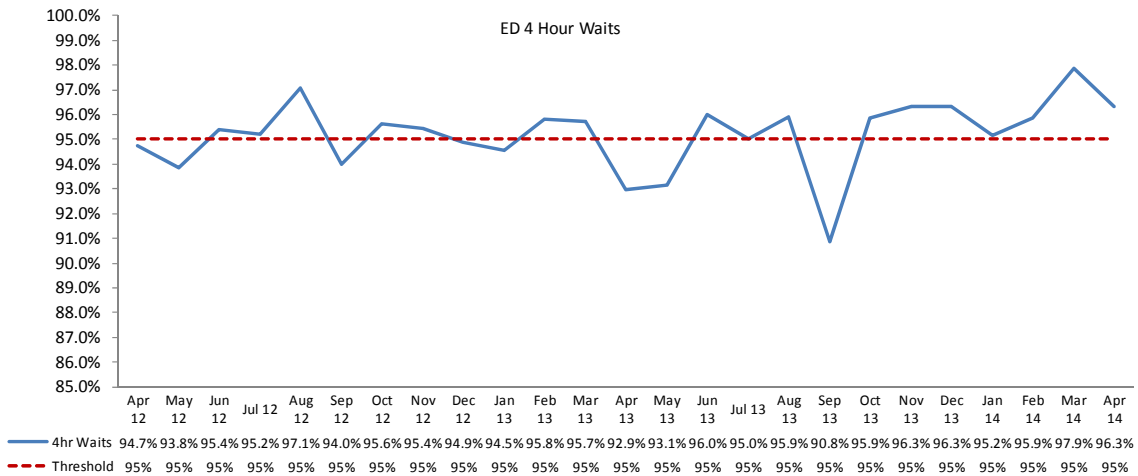
ED Waits (Adult)

	Apr 14
National Threshold	95.0%
4hr Waits	96.2%
12hr Waits	0.0%

ED Waits (Paeds <=16)

	Apr 14
National Threshold	95.0%
4hr Waits	96.5%
12hr Waits	0.0%

Re-attendance rate indicator 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%)	-	-	-

The emergency department continues to deliver the four hour target, achieving 96.3 per cent in April.

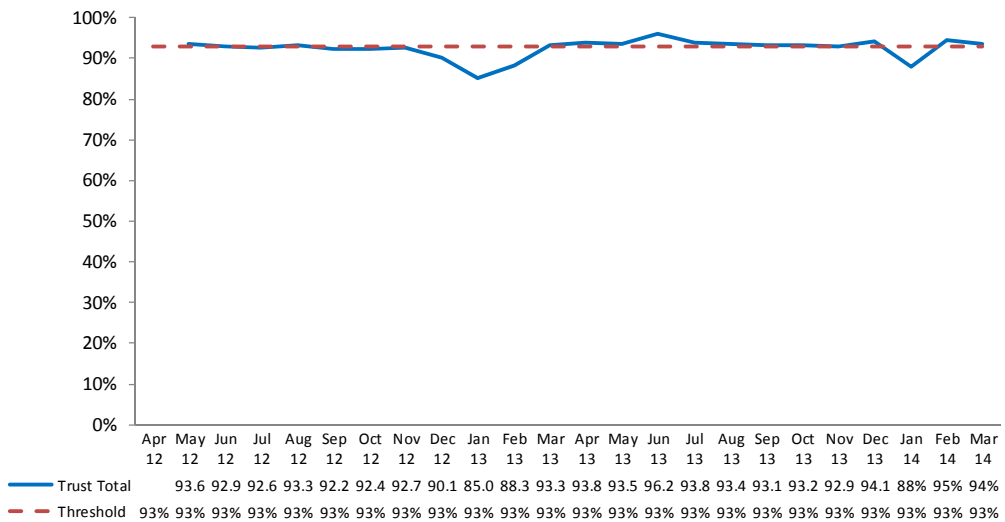
Cancer – 14 days to first seen

Deliver

Access Metrics

14 Days to First Seen

	Jan 14	Feb 14	Mar 14	Q1	Q2	Q3	Q4
National Threshold	93%			93%			
Trust Total	87.9%	94.5%	93.6%	94.6%	93.5%	93.4%	92.0%



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

WH achieved the target for March, however due to poor performance in January as previously reported, the quarterly target was not achieved.

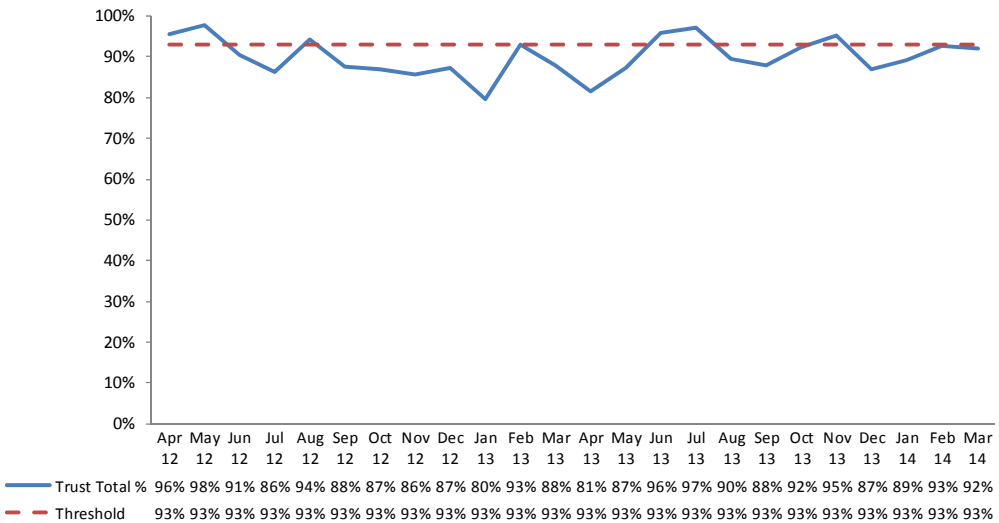
Cancer – 14 days to first seen – Breast symptomatic

Deliver

Access Metrics

14 Days to First Seen - Breast Symptomatic

	Jan 14	Feb 14	Mar 14	Q1	Q2	Q3 TD	Q4
National Threshold	93%			93%			
Trust Total	89.26%	92.5%	92.0%	88.2%	92.1%	91.6%	91.4%



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

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

This target remains non compliant due to patient choice, although patients are offered two alternative dates, and the 30% increase in breast referrals seen across London. Additional breast capacity will be available in June and the team are reorganising consultant sessions to ensure more slots are available, this will provide as much choice for the patient as possible.

Cancer – 31 Days to first treatment

Deliver

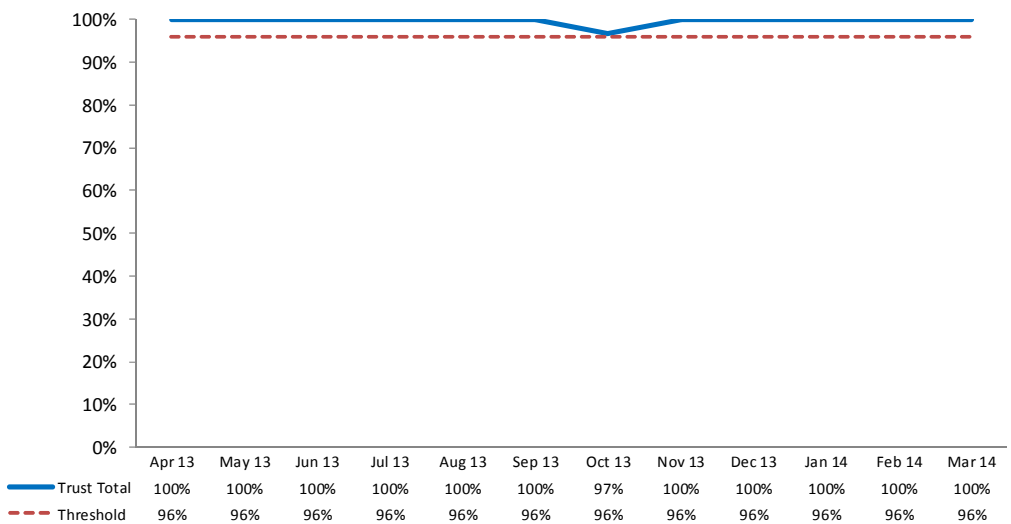
Access Metrics

31 Days to First Treatment

	Jan 14	Feb 14	Mar 14	Q1	Q2	Q3	Q4
National Threshold	96%			96%			
Trust Total	100%	100%	100%	100%	100%	99%	100%

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

31 day target is timed from diagnosis to treatment.



Sustainably delivering 100 per cent compliance.

Cancer – 31 days to subsequent treatment - Surgery

Deliver

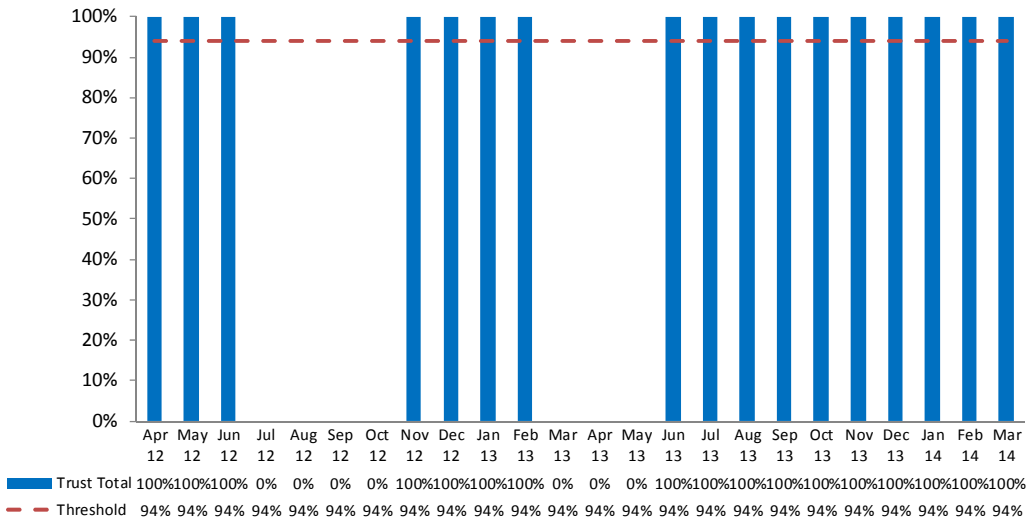
Access Metrics

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

	Jan 14	Feb 14	Mar 14	Q1	Q2	Q3	Q4
National Threshold	94%			94%			
Trust Total	100%	100%	100%	100%	100%	99%	100%



Sustainably delivering 100 per cent compliance.

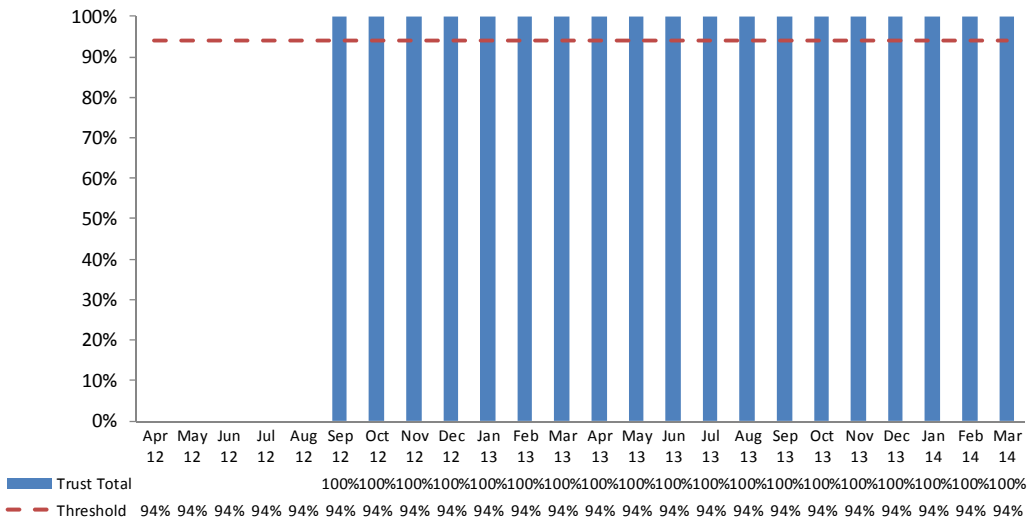
Cancer – 31 days to subsequent treatment - Drugs

Deliver

Access Metrics

31 Days to Subsequent Treatment - Drugs

	Jan 14	Feb 14	Mar 14	Q1	Q2	Q3	Q4
National Threshold	94%			94%			
Trust Total	100%	100%	100%	100%	100%	100%	-



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

31 day target is timed from diagnosis to treatment.

Division broken down by Tumour Type

Sustainably delivering 100 per cent compliance.

Cancer – 62 days from referral to treatment

Deliver

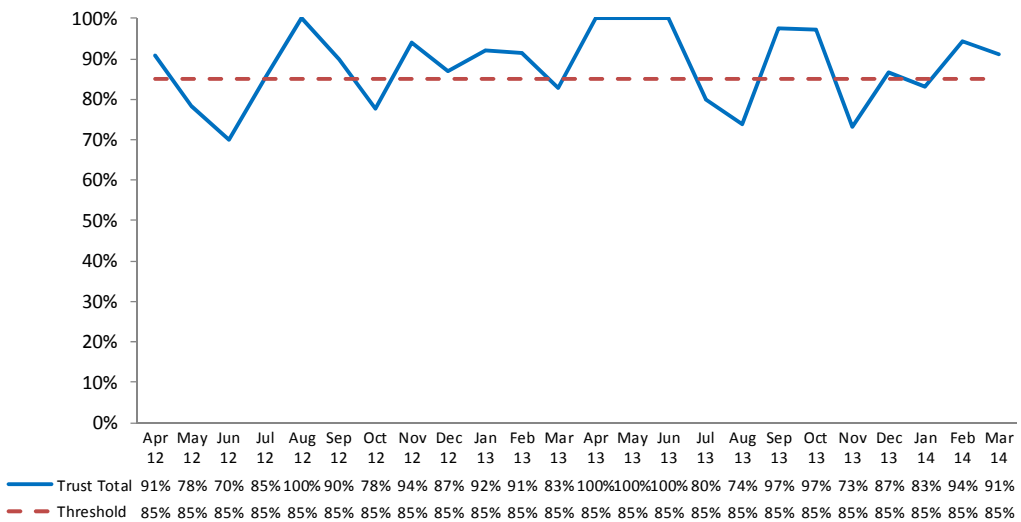
Access Metrics

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

	Jan 14	Feb 14	Mar 14	Q1	Q2	Q3	Q4
National Threshold	85%			85%			
Trust Total	83.0%	94.4%	91.1%	100.0%	83.1%	85.2%	89.0%



Compliant against the national threshold. The new prostate pathway commenced in March and is working well; this was a major contributor to previous 62 day breaches.

Cancer – 62 days from consultant upgrade

Deliver

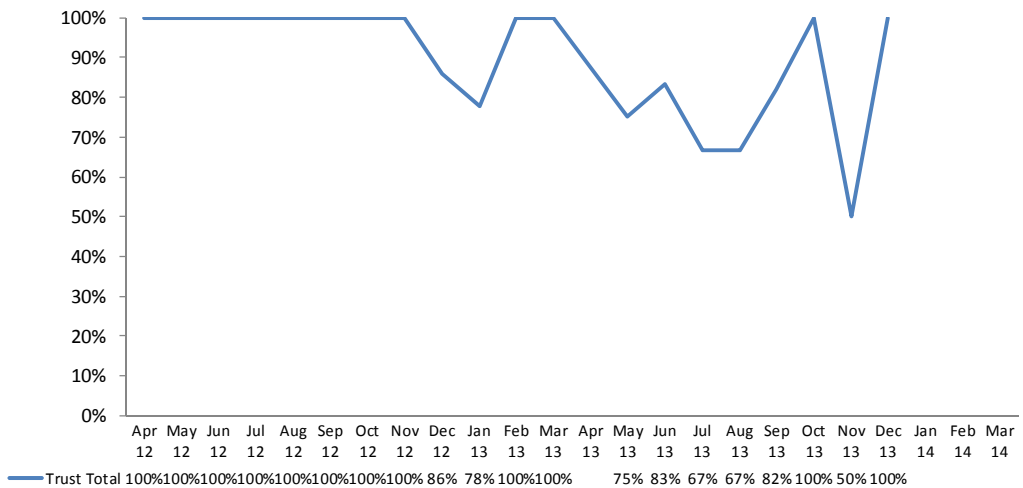
Access Metrics

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

	Jan 14	Feb 14	Mar 14	Q1	Q2	Q3	Q4
Trust Total	-	-	-	80%	72.4%	95.0%	-



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

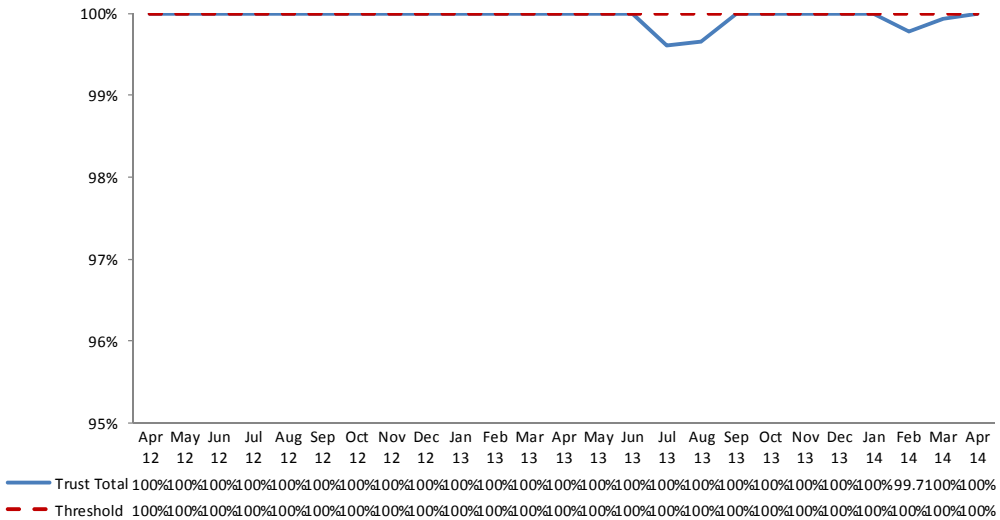
Genito-Urinary Medicine Appointment within 2 Days

Improving

Access Metrics

	Threshold	Apr 13	May 13	Jun 13	Jul 13	Aug 13	Sep 13	Oct 13	Nov 13	Dec 13	Jan 14	Feb 14	Mar 14	Apr 14
Trust Total	100%	100%	100%	100%	99.6%	99.7%	100%	100%	100%	100%	100%	99.78%	99.93%	100.00%

The percentage of patients offered an appointment within 2 days



Performance returns to 100 per cent as expected following a process issue which occurred and was addressed in March.

Delayed Transfers of Care

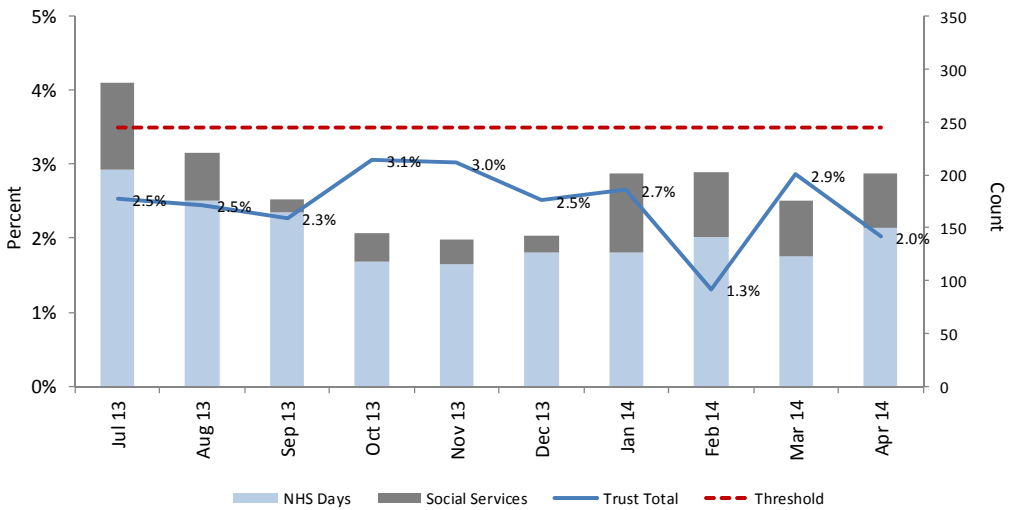
Integrate

Outcome Metrics

Number of Days Delayed

	Apr 14		
	NHS Days	Social Services	Both
Trust Total	102	32	0

	Feb 14	Mar 14	Apr 14
Local Threshold	3.5%		
Trust Total Delayed Transfers	1.3%	2.9%	2.0%



Patients with a delayed transfer of care to an intermediate setting as defined by discharge planning team. Shown as % of all inpatients at midnight snapshot.

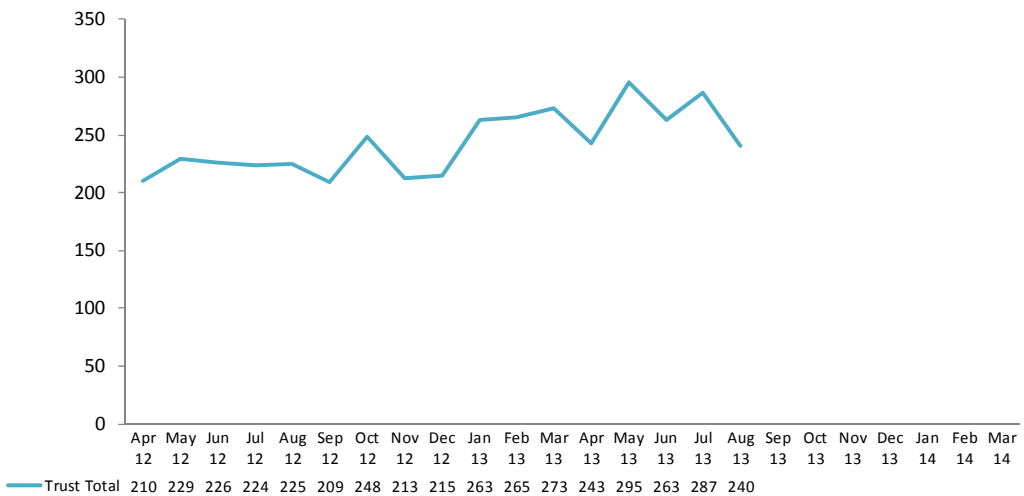
Performance at 2 per cent means we are sustainably achieving the local threshold. Delays are reviewed daily and escalated. Good working practices with local authority partners progress any potential delays and are resolved early where possible.

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

Reporting for this indicator will resume in the July report as we are working through validation.

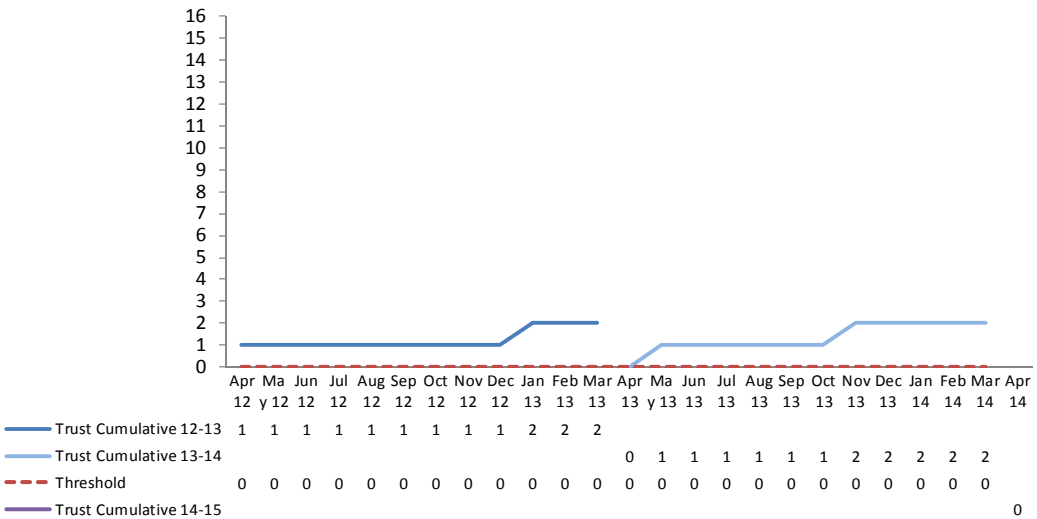
MRSA

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	Apr 14
National Threshold							0						
Trust Total	0	1	0	0	0	0	0	1	0	0	0	0	0

Number of MRSA bacteraemia (bacteria in the blood)



There were no cases reported in April, the fifth consecutive month with zero cases. Hand hygiene compliance and cleanliness is still being closely monitored and the standard remains high.

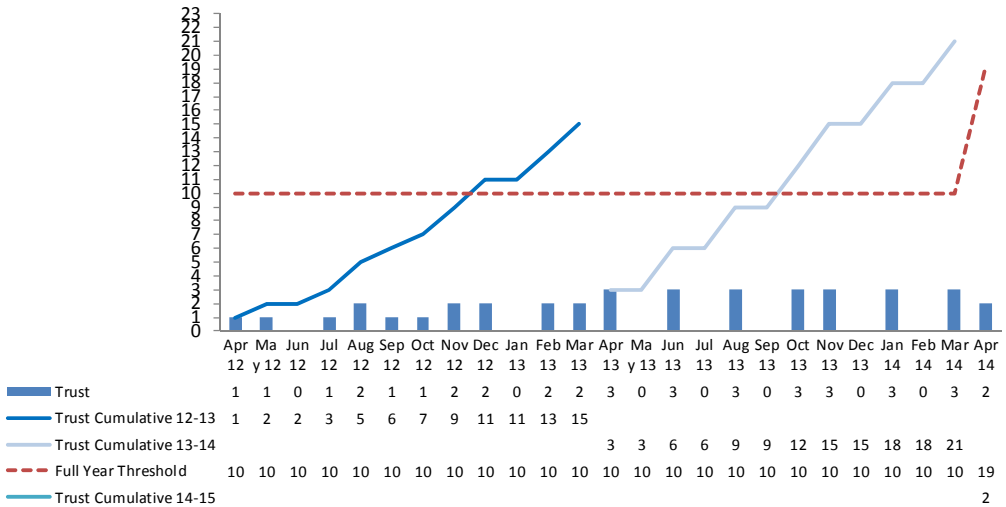
C Difficile Infections

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	Apr 14
Full Year National Threshold	<=10												
Trust Total	3	0	3	0	3	0	3	3	0	3	0	3	2

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



Two cases were reported in April against a full year 2014/15 threshold of 19.

E.coli and MSSA

Deliver

Outcome Metrics

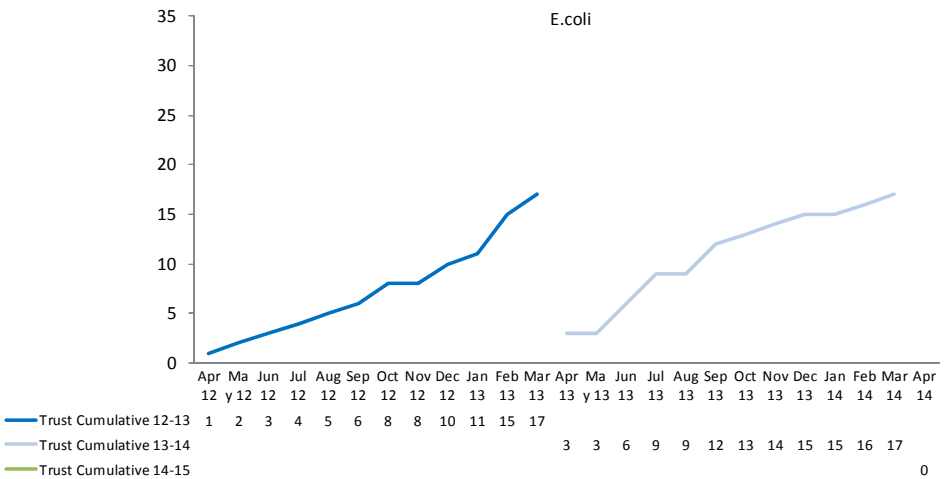
E.coli (Post 48 Hours)

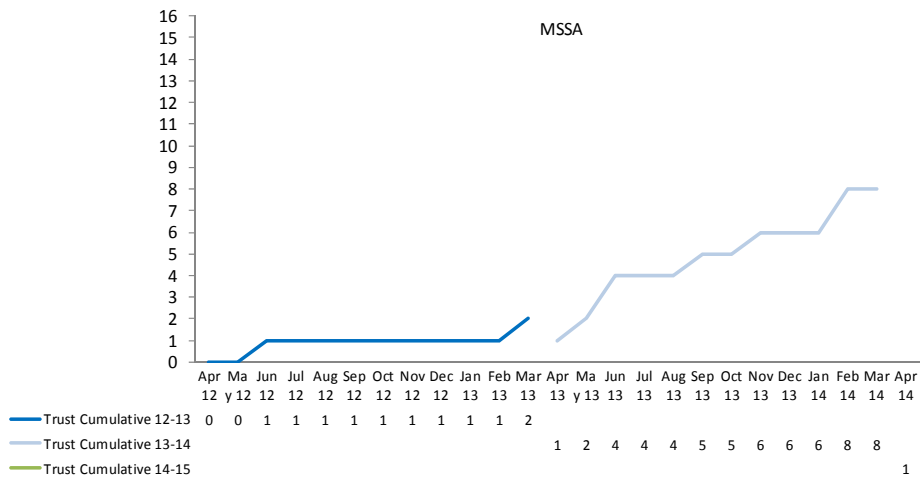
	Feb 14	Mar 14	Apr 14
Threshold	n/a		
Trust Total	1	1	0

MSSA (Post 48 Hours)

	Feb 14	Mar 14	Apr 14
Threshold	n/a		
Trust Total	2	0	1

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





There was no cases of E.coli and one case of MSSA bacteraemia reported in April. There are currently no national thresholds for these indicators.

Harm Free Care

Deliver

Outcome Metrics

	Contractual Threshold	Feb 14	Mar 14	Apr 14
% of Harm Free Care	95%	89.80%	93.60%	93.20%
Completeness of Safety Thermometer (CQUIN)	100%	100%	100%	100%
Pressure Ulcer (PU) Incidence	50% Reduction	21	12	

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

Apr14

	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	857	790	92.18%	58	6.77%	1	0.12%	6	0.70%	2	0.23%
SCD	60	59	98.33%	1	1.67%	0	-	0	-	0	0.00%
WCF	90	90	100%	0	-	0	-	0	-	0	-
Trust Total	**1007**	**939**	**93%**	**59**	**5.86%**	**1**	**0.10%**	**6**	**0.60%**	**2**	**0.20%**

April 2014

Pressure Ulcers	Cat 2-4	Cat 2	Cat 3	Cat 4
All	59	34	18	7
Old	36	16	13	7
New	23	18	5	0

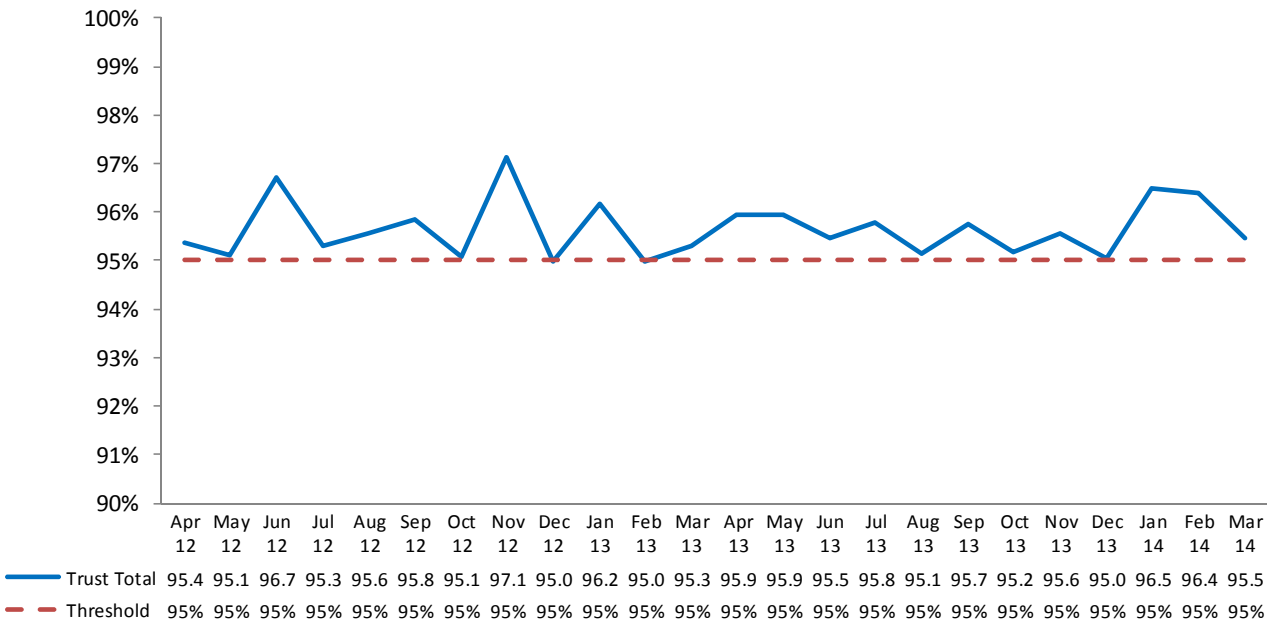
Performance has slightly reduced for April with 93.2 per cent of patients on a particular day of the month, receiving no harm for the three areas of Harm Free Care. Pressure ulcers remain the largest challenge and all are referred to the Quality Standards Committee.
Staff have also been reminding regarding the technique and removal of catheters when they are no longer required.

VTE Risk Assessment

Deliver

Outcome Metrics

	VTE Risk Assessed (CQUIN)			RCA for Hospital Acquired		
	Jan 14	Feb 14	Mar 14	Jan 14	Feb 14	Mar 14
CQUIN Threshold	95%			Target to be decided		
Trust Total	96.5%	96.4%	95.5%	0	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

WH continue to achieve the threshold. Divisions are ensuring escalation processes are in place where deep vein thrombosis (DVT) is diagnosed, and root cause analysis (RCA) are carried out.

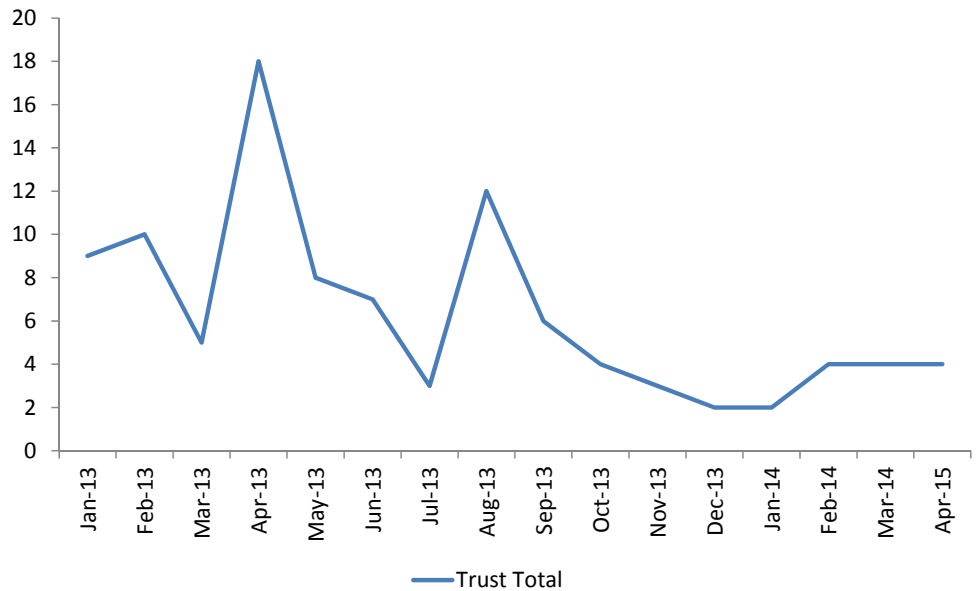
Serious Incidents

Change

Outcome Metrics

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

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



Month incidents are reported and not necessarily the month that the incident took place.

April saw four serious incidents reported, the same number reported for February and March. The April incidents are being reviewed through root cause analysis.

Never Events

Change

Outcome Metrics

Zero never events since December 2013

CAS Alerts (Central Alerting System)

Change

Outcome Metrics

Month	MDA alerts issued	Number not relevant	Action completed	Action required/ongoing	Acknowledged/Still assessing relevance
October 2013	6	3	3	0	0
November 2013	3	2	1	0	0
December 2013	6	5	1	0	0
January2013	4	2	2	0	0
February 2013	3	3	0	0	0
March 2013	4	3	1	0	0
April 2013	3	3	0	0	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 NHS England Safety Alerts Process, and the Department of Health

Open NHS England Alerts

Reference	Title	Date issued	Deadline
NHS/PSA/W/2014/008	Residual anaesthetic drugs in cannulae and intravenous lines	14/04/2014	13/05/2014
NHS/PSA/Re/2014/004	Addressing trends and outbreaks in carbapenemase-producing Enterobacteriaceae	06/03/2014	30/06/2014
NHS/PSA/D/2014/006	Improving medical device incident reporting and learning	20/03/2014	19/09/2014
NHS/PSA/D/2014/005	Improving medication error incident reporting and learning	20/03/2014	19/09/2014

Status of MDA Alerts

Reference	Title	Issue Date	Response	Deadline
MDA/2013/074	BD NeoflonTM IV cannula Manufactured by Becton Dickinson	10/10/2013	Not Used By Trust	07/11/2013
MDA/2013/073	Pressure relieving air mattresses and overlays.All models and manufacturers	10/10/2013	Completed	10/12/2013
14000-28 & 38	Hospira - some 15 Micron filter Plumset IV administration sets manufactured with an incorrect fluid filter.	16/10/2013	Not Used By Trust	27/11/2013
MDA/2013/075	Vacutainer® multiple sample Luer adaptor for blood sample collection.	17/10/2013	Not Used By Trust	13/11/2013
MDA/2013/076	Ultrasound Probe Cover: Burr Hole Probe Cover With Gel.	25/10/2013	Information Only	21/11/2013

A list of outstanding CAS Alerts has been provided to divisions and women, children and families head of quality is developing a Standard Operating Procedure (SOP) to improve the process.

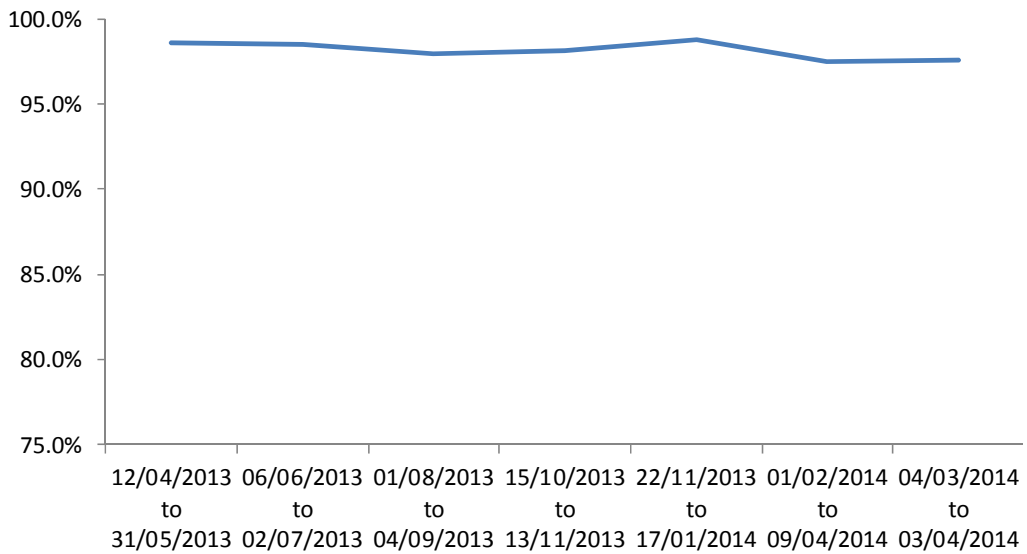
Ward Cleanliness

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	04/03/2014 to 03/04/2014
Trust Percentage	98.6%	98.5%	98.0%	98.13%	98.8%	97.5%	97.6%



Ward Cleanliness calculated as actual score against possible score

Latest Audit completed by Facilities

This data demonstrates good cleanliness compliance, however there are concerns regarding the data accuracy. Heads of nursing, matrons and infection control leads are undertaking their own environmental audits from the end of May to ensure quality control.

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

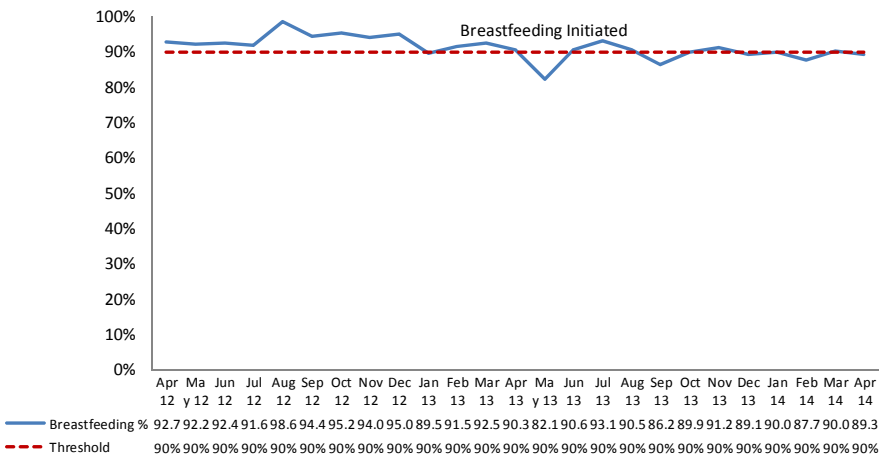
Breastfeeding and Smoking

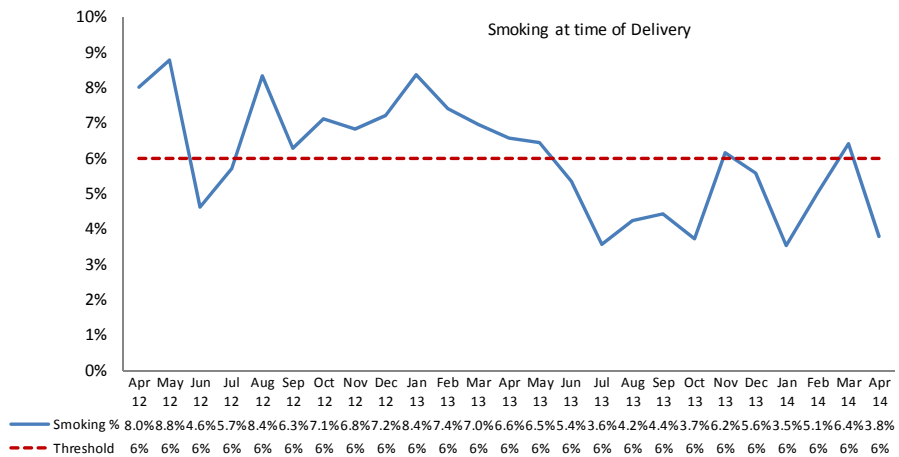
Improving

Outcome Metrics

	Threshold	Feb 14	Mar 14	Apr 14
Breastfeeding Initiated	90%	87.7%	90.0%	89.3%
Smoking at Delivery	<6%	5.1%	6.4%	3.8%

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.





Work continues on the Level 2 Unicef breastfeeding initiative and is due for completion in October.
Smoking at time of delivery has returned to a compliant position and the public health midwife is investigating how to introduce smoking cessation services for pregnant women.

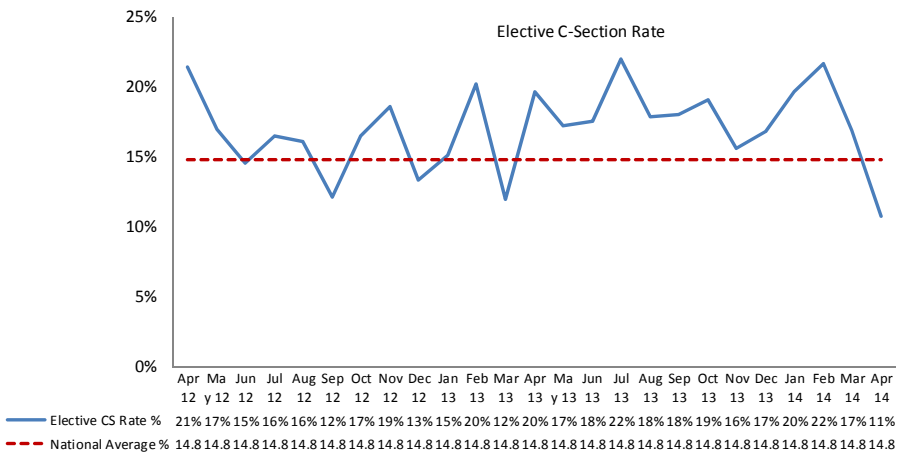
Caesarean Section Rates

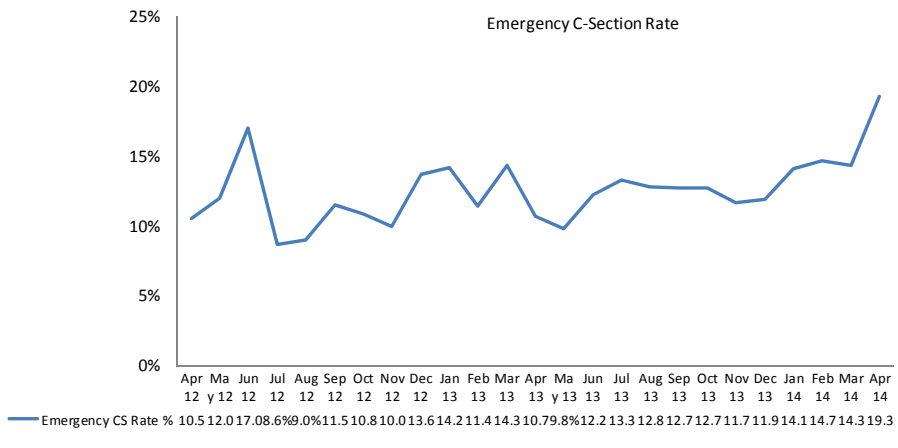
Deliver

Outcome Metrics

	National Average	Feb 14	Mar 14	Apr 14
Elective C-Section Rate	14.8%	21.7%	16.9%	10.7%
Emergency C-Section Rate	-	14.7%	14.3%	19.3%
All Deliveries	-	300	301	280

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





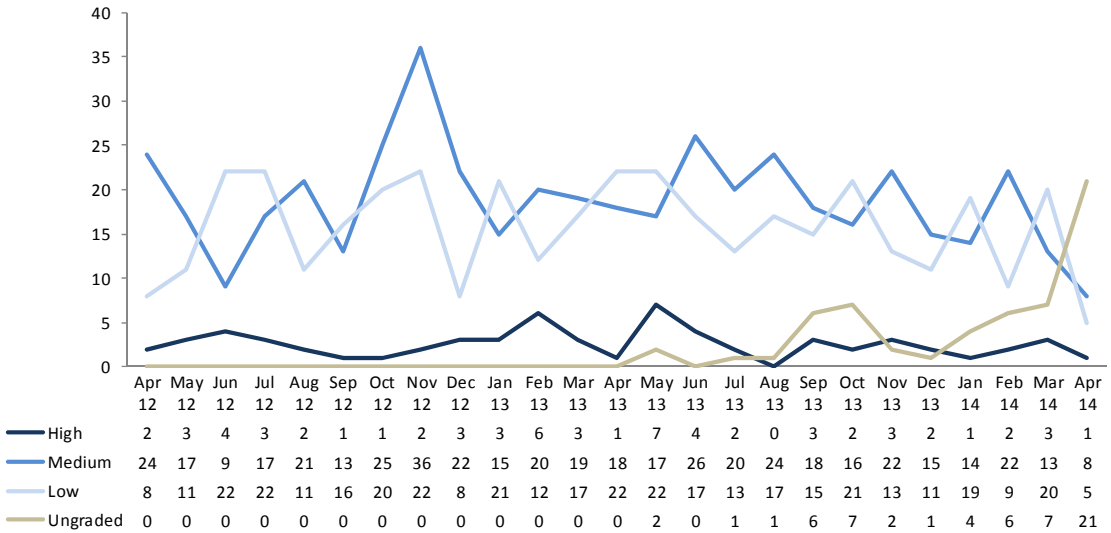
The elective c-section rate saw a reduction in April to 10.7 per cent. This is the first time since March 2013 that WH have a rate below the national average. Multiple workstreams are in place to help reduce rates including educating women better.

Medication Errors Causing Harm

Change

Outcome Metrics

		Apr 13	May 13	Jun 13	Jul 13	Aug 13	Sep 13	Oct 13	Nov 13	Dec 13	Jan 14	Feb 14	Mar 14	Apr 14
Risk	High	1	7	4	2	0	3	2	3	2	1	2	3	1
	Medium	18	17	26	20	24	18	16	22	15	14	22	13	8
	Low	22	22	17	13	17	15	21	13	11	19	9	20	5
	Ungraded	0	2	0	1	1	6	7	2	1	4	6	7	21
	Total	41	48	47	36	42	42	46	40	29	38	39	43	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 high risk incident was reported at HMP Pentonville. A doctor had intentionally suspended a drug (weekly oral methotrexate) but staff gave a further dose. This resulted in no harm to the patient. From 1 May 2014 medication incidents at HMP Pentonville will no longer be reported to Whittington ICO via Datix as the service transfers to another provider. The remaining incidents were reported by : Women, children and families (7), integrated care and acute medicine (10), surgery, cancer and diagnostics (6) and district nusrsing services (13).

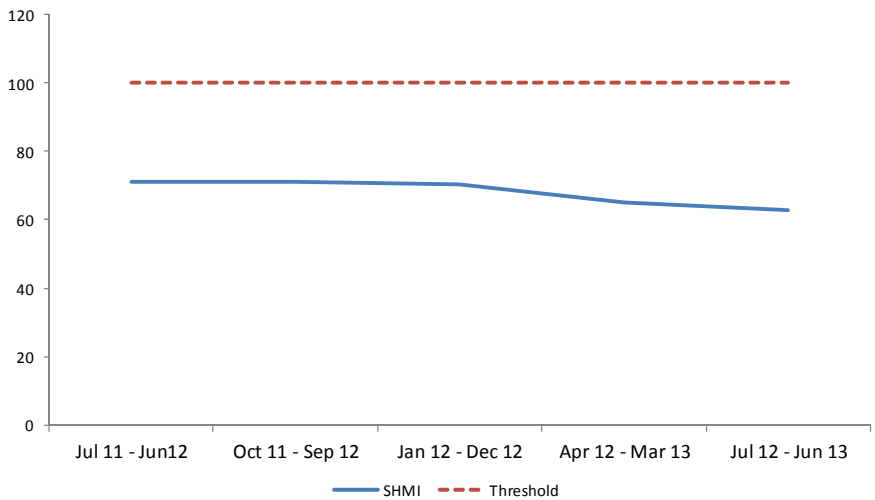
SHMI

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.



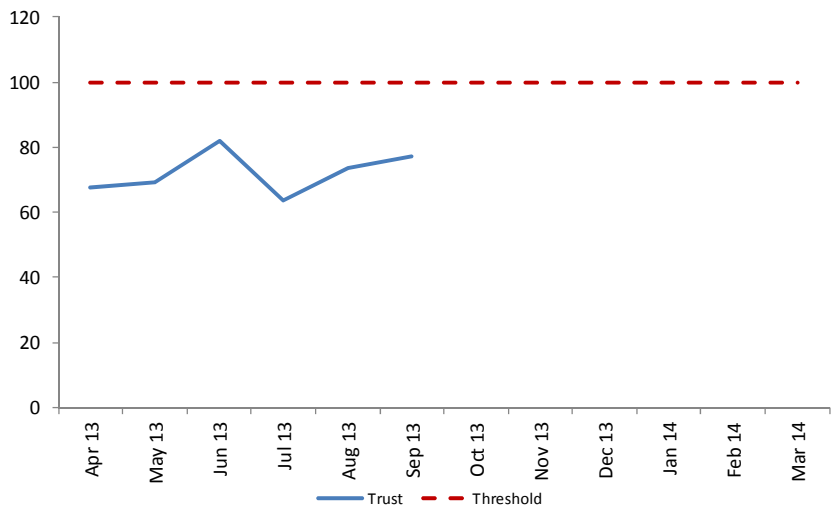
No further update on SHMI data, however continue to achieve excellent SHMI score.

HSMR

Change

Outcome Metrics

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



Hospital Standardized Mortality Ratio measures whether hospital deaths are higher or lower than expected. There is a significant time delay in data publication. Methodology varies from SHMI.

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

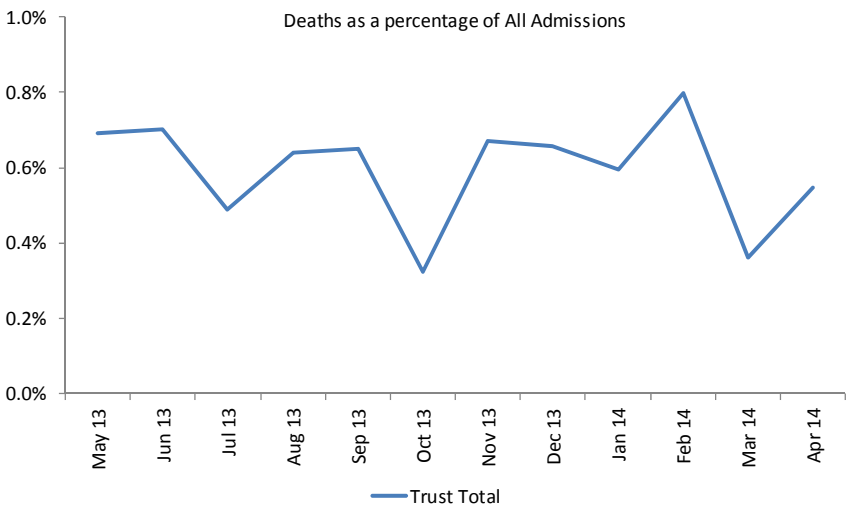
No data submitted after September 2013 due to EPR reporting issues.
Data is derived from standard reports which are expected to resume at the end of May 2014, and will take approximately three months to feed through to HSMR reporting.

Number of Inpatient Deaths

Outcome Metrics

	Deaths			Percentage of Admissions		
	Feb 14	Mar 14	Apr 14	Feb 14	Mar 14	Apr 14
Trust Total	35	17	24	0.8%	0.4%	0.5%

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



All inpatient deaths are processed through the mortality and morbidity audit tools, which reflect national improvements.

Patient Satisfaction (Friends & Family)

Ensure

Quality Indicators

	Feb 14	Mar 14	Apr 14
Inpatient Coverage	42.2%	39.4%	35.0%
Emergency Department Coverage	16.7%	17.9%	12.5%
Total Coverage (IP/ED)	20.6%	21.6%	16.1%
Inpatient Net Promoter Score	70	65	65
Emergency Department Net Promoter Score	54	53	56
Total Net Promoter Score (IP/ED)	59	57	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 and emergency department coverage has declined in April, contributing to the reduction in total coverage. The Net Promoter Score (NPS) for inpatients remains at the same level, and the emergency department NPS saw an increase to 56.

Mixed Sex Accommodation

Integrate

Quality Indicators

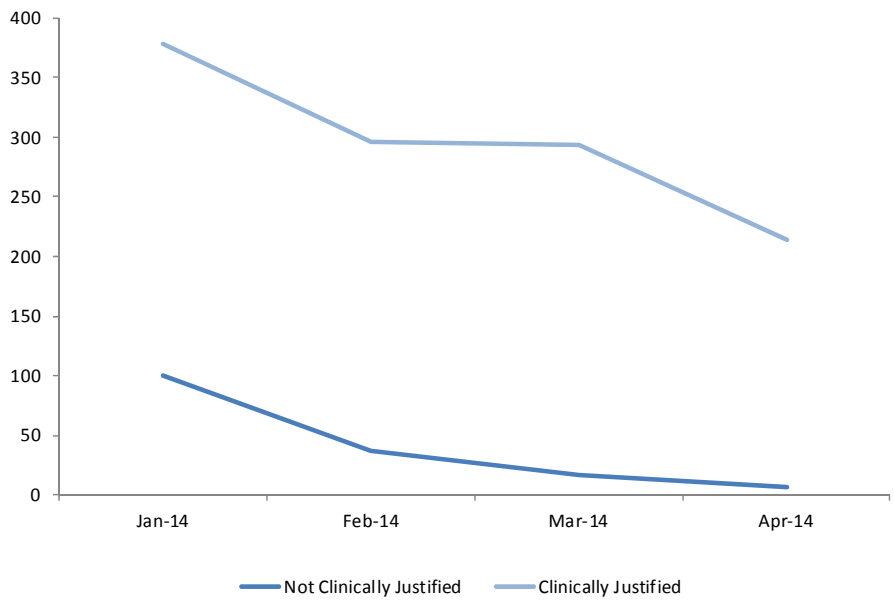
Not Clinically justified occurence

	Jan-14	Feb-14	Mar-14	Apr-14
ICAM	49	13	2	6
Cavell Rehabilitation Ward	0	0	0	0
Edward Drive	0	0	0	0
ISIS Ward	0	0	0	0
Mary Seacole South	49	13	0	0
Mercers	0	0	0	0
Meyrick Ward	0	0	0	6
Bridges Ward	0	0	0	0
Montuschi Ward	0	0	2	6
SCD	51	24	14	1
Coyle Ward	5	0	0	0
Intensive Care Unit	46	24	14	1
Thorogood Ward	0	0	0	0
Victoria Ward	0	0	0	0
Grand Total	100	37	16	7

Clinically justified occurence

	Jan-14	Feb-14	Mar-14	Apr-14
ICAM	111	39	35	22
Cavell Rehabilitation Ward	0	0	0	0
Edward Drive	0	0	0	0
ISIS Ward	0	0	0	0
Mary Seacole South	111	39	0	0
Mercers	0	0	0	0
Meyrick Ward	0	0	0	0
Bridges Ward	0	0	0	0
Montuschi Ward	0	0	35	22
SCD	267	257	259	192
Coyle Ward	0	0	0	0
Intensive Care Unit	267	257	259	192
Thorogood Ward	0	0	0	0
Victoria Ward	0	0	0	0
Grand Total	378	296	294	214

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



Breaches of mixed sex accommodation continue to reduce with April seeing seven not clinically justified occurrences and 214 clinically justified occurrences.

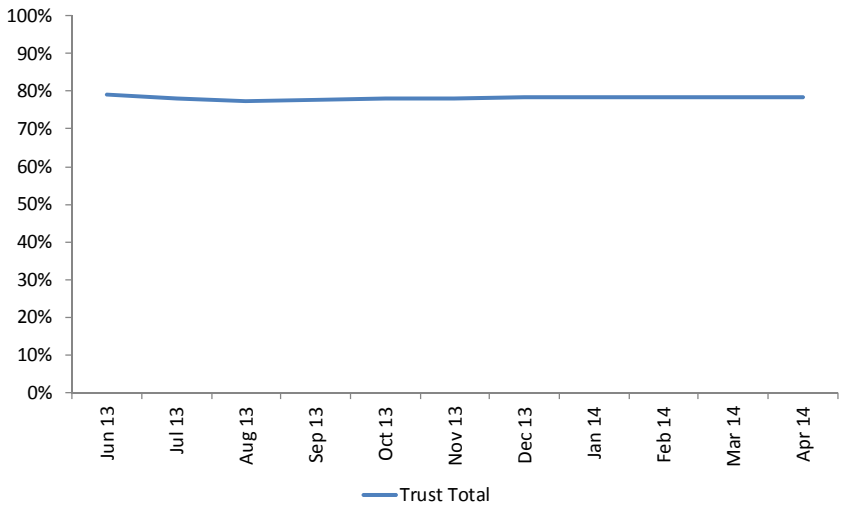
Percentage of Registered Nurses

Change

Quality Indicators

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

	Threshold	Feb 14	Mar 14	Apr 14
Trust Total	n/a	78.3%	78.3%	78.30%



Matrons on wards are reviewing staffing levels and have developed recruitment plans.

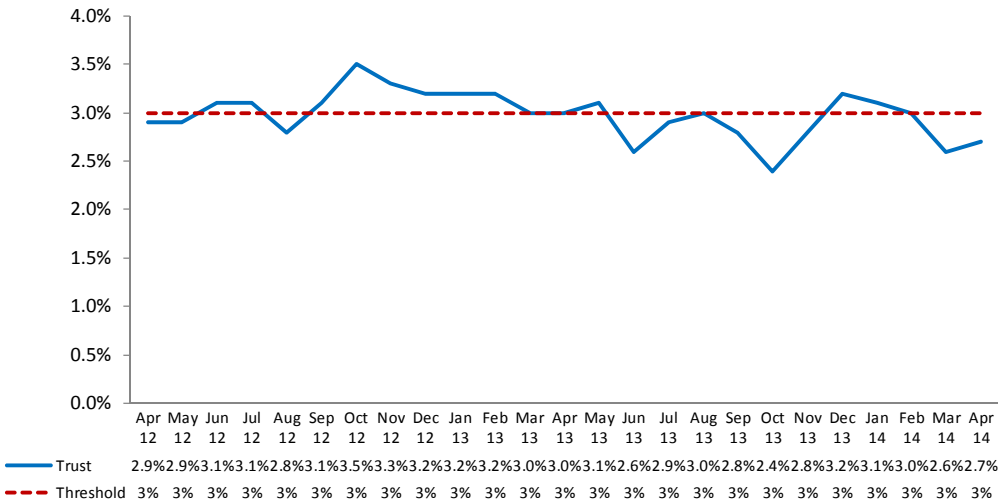
Sickness Rate

Change

Quality Indicators

	Sickness				High Bradford Scores		
	Local Threshold	Feb 14	Mar 14	Apr 14	Feb 14	Mar 14	Apr 14
Trust Total	<3%	3.0%	2.6%	2.7%	664	596	595

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



This month's report on the overall sickness rate for the trust is very encouraging, it shows rates below threshold compliance. The workforce statistics are reported to the Trust Operational Board on a monthly basis, which has enabled senior managers to work with their departmental managers to address high sickness rates. The recent Trust wide guidance provided to managers and staff has further enabled a better understanding of the procedure and management of sickness.

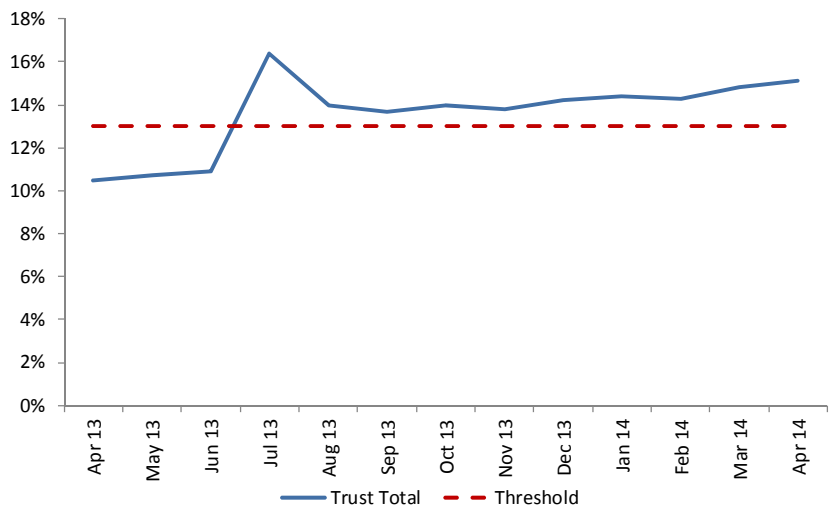
Staff Turnover

Change

Quality Indicators

	Local Threshold	Feb 14	Mar 14	Apr 14
Trust Total	<13%	14.3%	14.8%	15.1%

Proportion of workforce leaving in a given period.



This month's staff turnover rate is showing an increase above the threshold. Exit interviews are in place although adherence to recording leavers is not consistent across the Trust, despite raising this with divisional and departmental management teams. The recruitment plans are focussed on the highest turnover rates ie nursing recruitment both within the wards and in the community. The key factor is increasing retention rates, although this is a pan London challenge as evidenced by recent reports where there is nursing shortage.

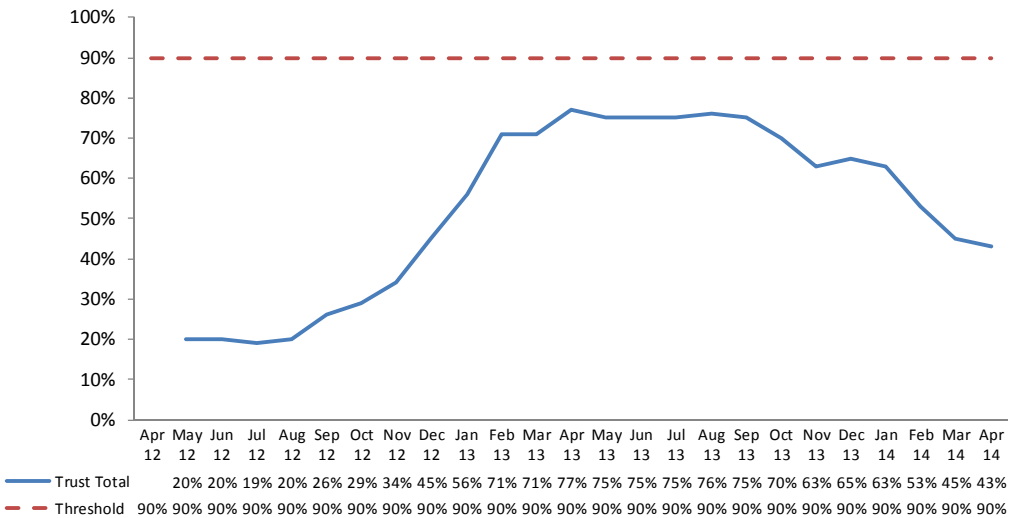
Staff Appraisal

Change

Quality Indicators

	Local Threshold	Feb 14	Mar 14	Apr 14
Trust Total	90%	53.0%	45.0%	43.0%

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



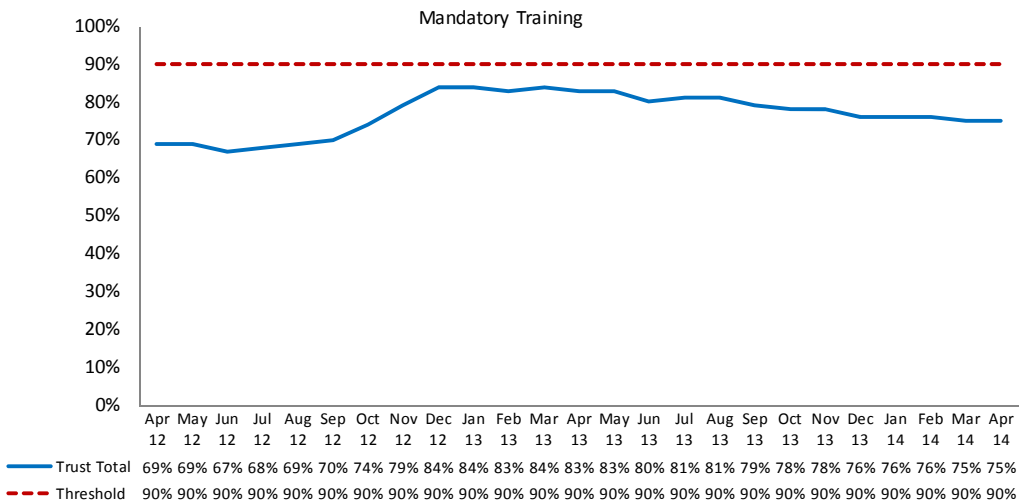
This month's appraisal rate is showing an increase below the threshold. The Trust Board and Executive team are performing managing low compliant divisions by requesting turnaround action plans and a zero tolerance message that appraisals must be conducted across the Trust. The approval and adoption of the new appraisal framework is trajected to create an improved approach and culture to ensure compliance.

Mandatory Training Compliance

Change

Focus Areas

	Mandatory Training			Information Governance			Child Protection Level 2			Child Protection Level 3		
	Feb 14	Mar 14	Apr 14	Feb 14	Mar 14	Apr 14	Feb 14	Mar 14	Apr 14	Feb 14	Mar 14	Apr 14
Local Threshold	90%			95%			90%			90%		
Trust Total	76%	75%	75%	70%	69%	70%	59%	69%	71%	69%	74%	73%



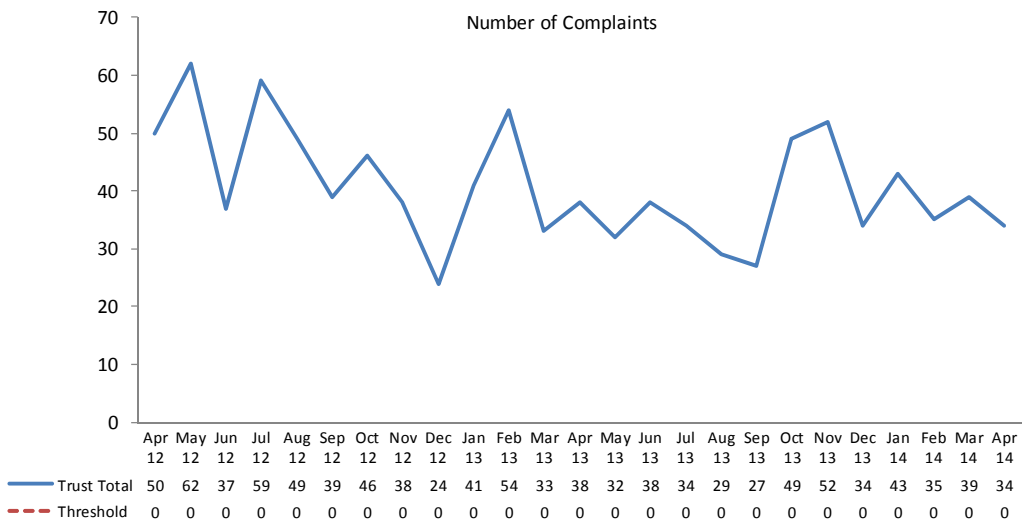
Data snapshot date 30/04/2014

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

This month's report on the overall mandatory training rate has maintained at an average of 75 per cent. The mandatory training statistics report to the executive team, trust operational board and divisional management teams, on a monthly basis which is enabling senior managers to work with their departmental managers to address low performance. Furthermore, the implementation of the mandatory training action plan has ensured targeted troubleshooting for those with low compliance and identified service teams offered bespoke support in access to training.

Complaints

	Complaints			Responded to in 25 days		
	Threshold	Feb 14	Mar 14	Apr 14	Jan 14	Feb 14	Mar 14
Trust Total	0	35	39	34	49%	71%	62%



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 decreased in March to 62 per cent within 25 days. An action plan is in place to manage complaints for each division.

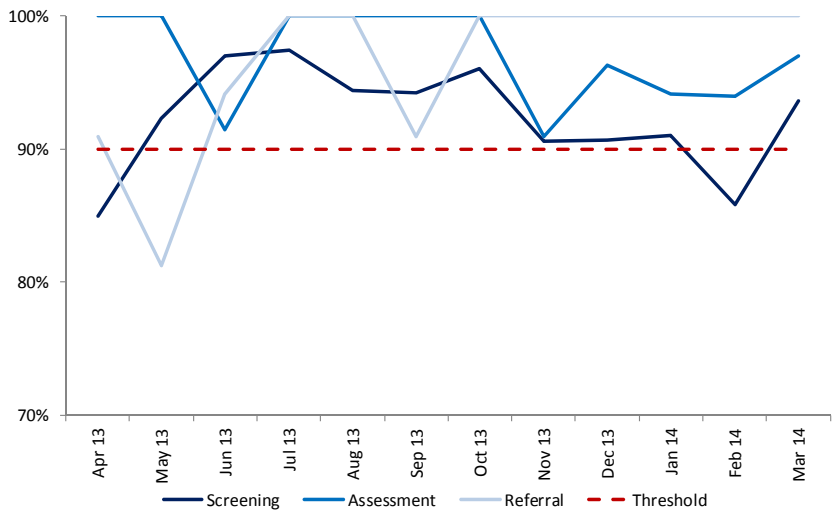
National CQUINs

Integrate

Quality Indicators

Dementia

	Contractual Threshold	Jan 14	Feb 14	Mar 14
Screening	90%	91%	86%	94%
Assessment	90%	94%	94%	97%
Referral	90%	100%	100%	100%



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

Data is one month in arrears

Performance improved in March with all elements of the Dementia CQUIN achieving the threshold. Improvements have been delivered by increased clinician time to educating staff and encourage them to remember that they must screen and record the actions. Sustainability is under discussion at CQUIN board.

Specialist Commissioning CQUINs

Deliver

Quality Indicators

NICU	Year End Target	Apr	May	Jun	Q1	Jul	Aug	Sep	Q2	Oct	Nov	Dec	Q3	Jan	Feb	Mar	Q3
Improve Access to Breast Milk in Preterm Infants	62%	100%	0%	57%	60.0%	50.0%	67.0%	33.0%	61%	50%	43%	88%	57%	100%	100%	83%	91%
Timely Administration of Total Parenteral Nutrition in Preterm Infants	95%	100%	-	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 (TPN): 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 recorded 83 per cent for March and 91 per cent for Q4 against a year end target of 62 per cent. TPN data is not yet available for the end of year position although previous performance has achieved the target. Child and adolescent mental health services (CAMHS) data is not yet available for Q4.

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%	89.4%	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%	94.6%	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%	29.5%	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%	18.1%
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%	77.6%
Crime Reduction Partnerships	Report by public health of anonymised dataset on alcohol related																
Audit	Plan for audit submitted and agreed Q1																

Smoking status did not achieve the year end target at 86.1 per cent.
Inpatient advice was 95.7 per cent and inpatient referral at 26.2 per cent, both exceeded the year end target.

Alcohol screening saw an increase in March however the Q4 position at 18.1 per cent did not achieve the target.
Intervention achieved the year end target at 100 per cent, however GP Communication at 77.6 per cent did not meet the year end target.

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%	100%	97.2%
ACUTE CAP Bundle	80%	100%	0%	77.8%	83%	63.6%	100%	100%	86%	100%	100%	100%	100%	100%	100%	100%	100%
Community COPD Bundle	75%	100%	100%	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
Multidisciplinary Working - Haringey	4 MDT Case conferences a month MDT case conference membership	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			
Multidisciplinary Actions - Haringey	90% of actions completed	n/a	n/a	n/a	100%	-			96%
Multidisciplinary Actions - Islington	90% of actions completed	n/a	n/a	n/a	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			
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%	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 3 fig LTC6 received.			19%

All Chronic obstructive pulmonary disease (COPD) elements exceeded the year end target.
Integrated Care – multidisciplinary team (MDT) actions for Islington has improved although year end data is not currently available.

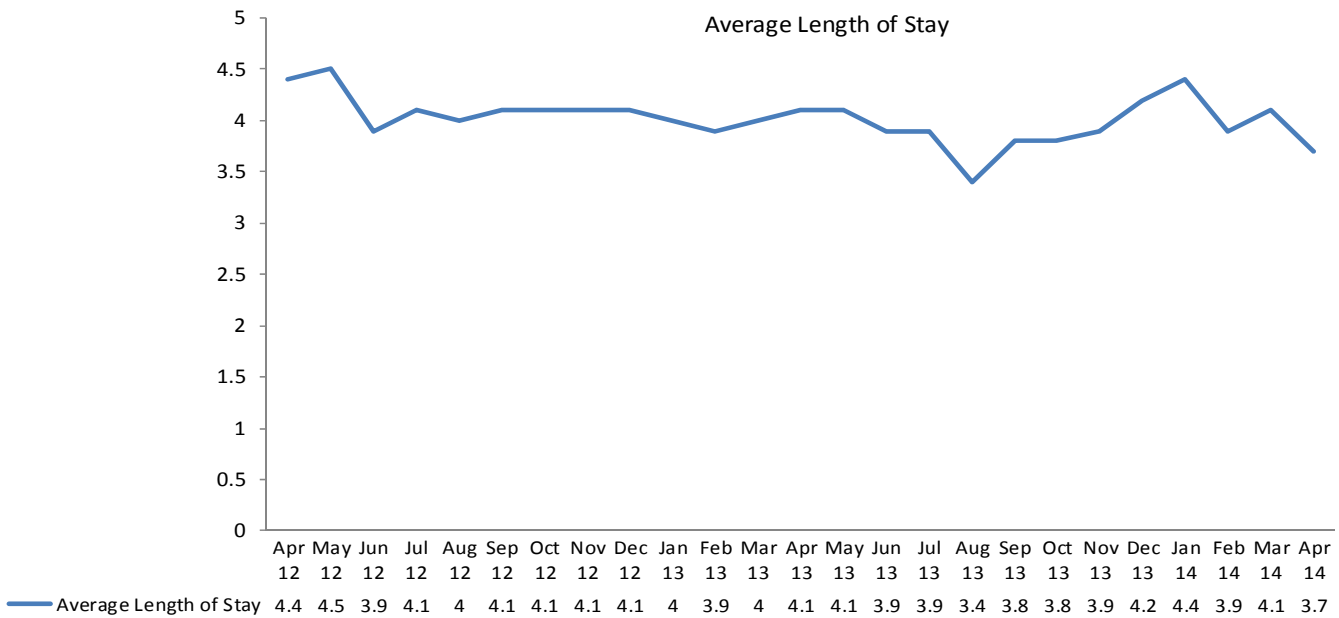
Average Length of Stay (days)

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	Apr 14
Average LOS (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	3.7
Longest LOS (Days) (Trust)	N/A										113	74	162	163

Average length of stay for patients within a given month. Excludes Day cases



April saw a reduction in length of stay to 3.7 days and the longest length of stay across the Trust was 163 days. As reported last month, the patient flow lead nurse will commence permanently in May, which is expected to deliver an improvement.

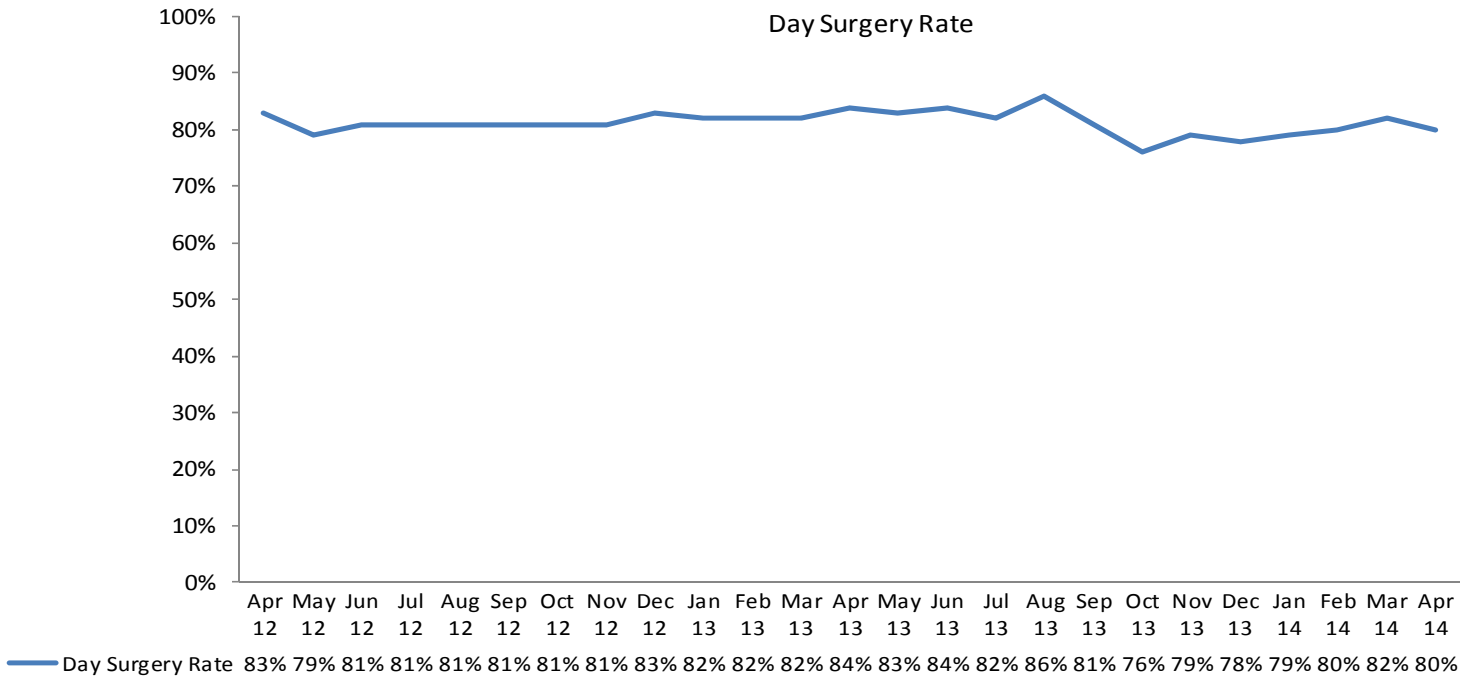
Day Surgery Rate

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

Proportion of total elective surgeries carried out as a day case



Day surgery rates saw a slight reduction, within the usual range of variation seen over the last two years.

Activity

Data derived for SLAM submissions which will re-start at the end of May 2014

Divisional Financial Performance

Deliver

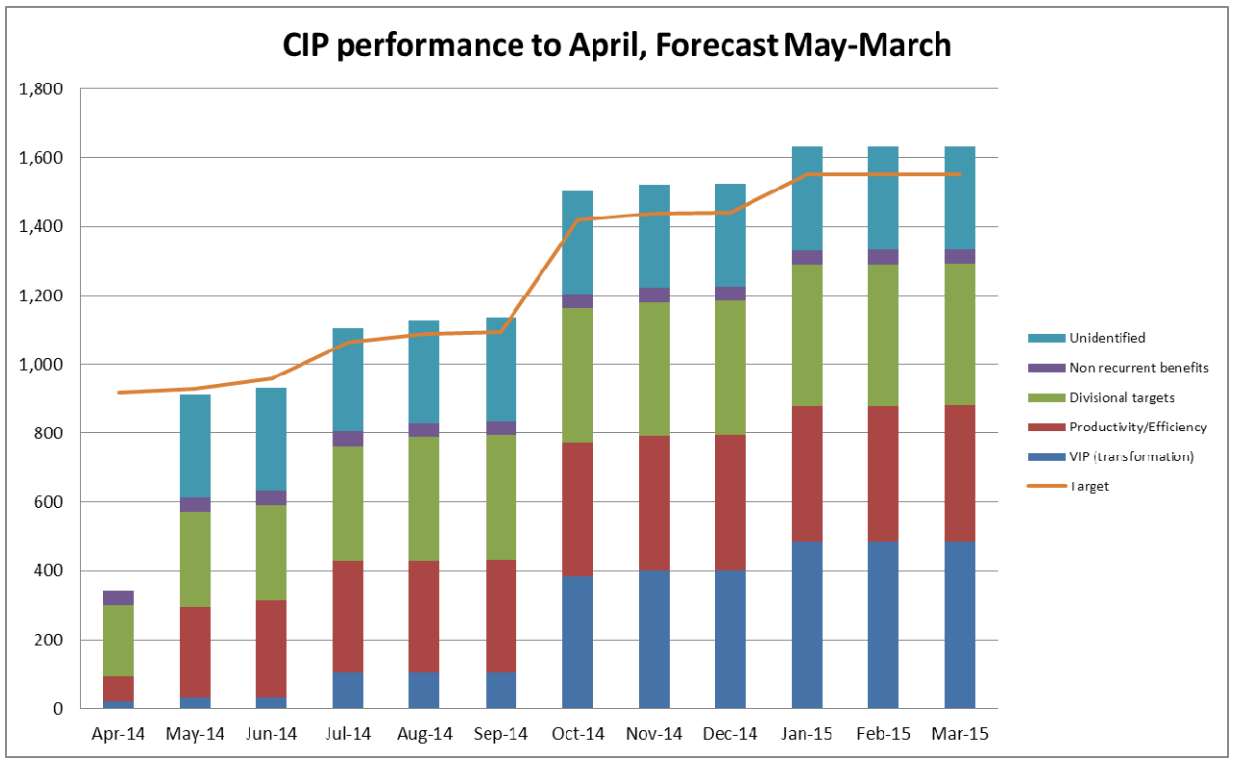
Finance & Activity

Operational Income and Expenditure– Month 01

Division	Income/Exp	In Mth Bud £'000	In Mth Act £'000	In Mth Var £'000	YTD Bud £'000	YTD Act £'000	YTD Var £'000
Integrated Care & Acute Medici	Income	(714)	(1,283)	569	(714)	(1,283)	569
	Operating Expenditure	6,884	7,809	(925)	6,884	7,809	(925)
Integrated Care & Acute Medici Total		**6,170**	**6,526**	**(356)**	**6,170**	**6,526**	**(356)**
Surgery, Cancer & Diagnostics	Income	(226)	(230)	4	(226)	(230)	4
	Operating Expenditure	5,019	5,080	(60)	5,019	5,080	(60)
Surgery, Cancer & Diagnostics Total		**4,793**	**4,849**	**(56)**	**4,793**	**4,849**	**(56)**
Women, Children & Families	Income	(713)	(726)	13	(713)	(726)	13
	Operating Expenditure	5,462	5,583	(122)	5,462	5,583	(122)
Women, Children & Families Total		**4,749**	**4,858**	**(109)**	**4,749**	**4,858**	**(109)**
Corporate	Income	(22,391)	(21,881)	(510)	(22,391)	(21,881)	(510)
	Operating Expenditure	6,440	5,651	788	6,440	5,651	788
Corporate Total		**(15,951)**	**(16,229)**	**278**	**(15,951)**	**(16,229)**	**278**
Grand Total		**(239)**	**4**	**(243)**	**(239)**	**4**	**(243)**

Divisional finance performance shows all clinical areas to be below plan in month one. Key drivers of the adverse position are under-delivery against CIP targets across the board combined with cost pressures relating to key areas such as district nursing, imaging, midwifery, theatres and medical specialties.

CIP Performance



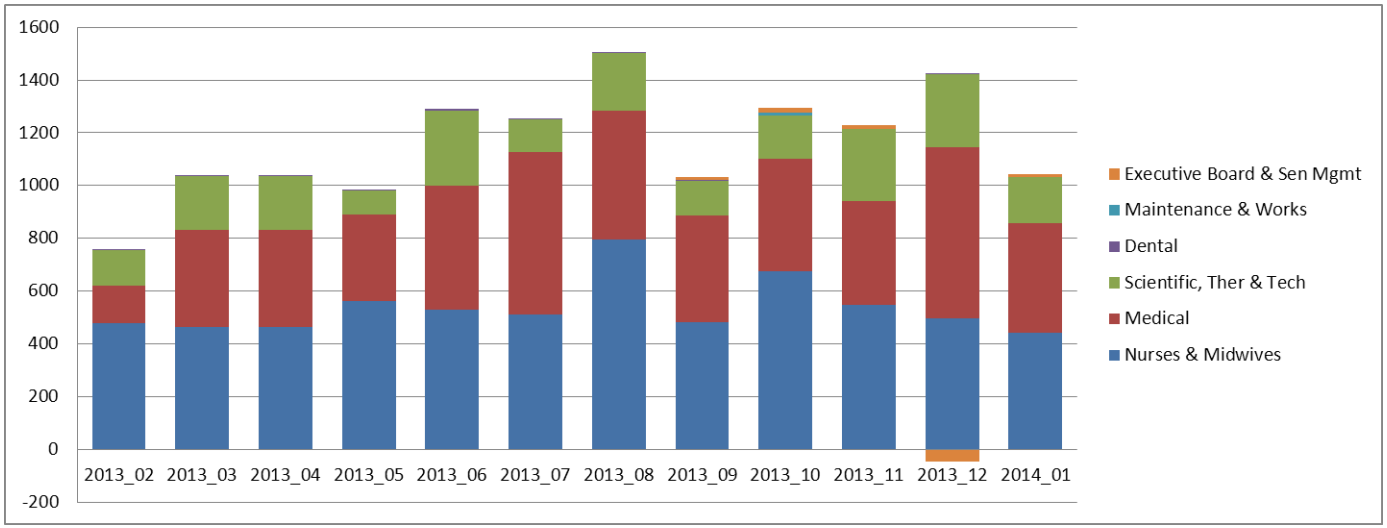
Trust wide CIP delivery in month one was £342k against a target of £919k (37 per cent)
Divisional 2 per cent CIP delivery in month one was £207k against a target of £426k (49 per cent)
The Trust CIP plan is phased to deliver greater savings in the second half of the year when VIP schemes are due to commence and the focus must remain on delivering all CIP targets in full.
Performance monitoring of CIP target is monthly through the Finance team. Performance is monitored by the CIP Steering Group, led by chief finance officer and chief operating officer.

Agency Expenditure – Trust-Wide

Deliver

Finance & Activity

Trust Agency Usage – 12 months to April 14



Staff Type	May-13 £'000	Jun-13 £'000	Jul-13 £'000	Aug-13 £'000	Sep-13 £'000	Oct-13 £'000	Nov-13 £'000	Dec-13 £'000	Jan-14 £'000	Feb-14 £'000	Mar-14 £'000	Apr-14 £'000	Grand Total £'000
Dental	2	2	2	4	5	3	5	3	1	1	1	1	30
Executive Board & Sen Mgmt	0	0	0	0	0	0	0	11	18	16	-45	9	9
Maintenance & Works	0	0	0	0	0	0	0	0	11	0	0	0	11
Medical	141	369	369	328	468	616	491	404	427	394	647	452	5,107
Nurses & Midwives	480	462	462	563	530	510	794	483	675	547	497	603	6,607
Scientific, Ther & Tech	134	202	202	89	286	126	216	130	163	272	277	185	2,282
Grand Total	**757**	**1,035**	**1,035**	**984**	**1,290**	**1,254**	**1,506**	**1,032**	**1,295**	**1,230**	**1,378**	**1,249**	**14,046**

A weekly steering group has been established to challenge the project leads of various agency reduction work streams to ensure that expenditure is being controlled and that action plans are firmly in place to rationalise agency usage wherever possible. Financial data is presented monthly. Key areas to address are consultant agency within medical specialties, middle grade medical agency within emergency department (ED) and nursing in midwifery and district nursing. Agency should reduce in coming months with the transfer of prison health, plans to recruit ED middle grades and the closing of ward escalation beds.