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The Whittington Hospital NHS Trust
Magdala Avenue
London N19 5NF

Whittington Health Trust Board

2 July 2014

Title:	Trust Board Performance Report July 2014 (May data)		
Agenda item:	**14/119**	**Paper**	**8**
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 Following the Electronic Patient Record (EPR) upgrade, quality issues were identified with referral to treatment (RTT) incomplete data. An action plan has been developed and reporting is expected to resume in July. A review of the Board performance dashboard is underway. This is expected to be completed by the end of August for implementation in September 2014. The review will be carried under the NHS Trust Development Authority guidance. Improvement plans and data quality audits will then be agreed **Areas improving** • First to follow up rates (slide 4) • District Nursing (slide 14) • MSK (slide 15) • New Birth Visits (slide 16) • HCP or Midwife visits within 12 weeks and 6 days (slide 17) • Mixed sex accommodation (slide 55) **Areas for focus** • Theatres (slide 5) stretch target • Hospital and Service Cancellations (slide 7 and 8) • Did not attend (DNA) rates (slide 9 and 10) • Community waiting times (slides 13) alignment of waiting time to service is underway • Referral to treatment (RTT) incomplete (slides 20) data validation underway • Cancer 2 week waits capacity (slide 26 and 27) • Serious Incident reporting (slide 41) increase reporting		

	encouragement
Summary of recommendations:	That the board notes the performance plan and provides feedback
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:	20 June 2014

Author name and title:				**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

July 2014
(May Data)

Success Highlights

Focus Areas

A review of the Board performance dashboard is underway. This is expected to be completed by the end of August for implementation in September 2014. The review will be carried under the NHS Trust Development Authority guidance. Improvement plans and data quality audits will then be agreed.

Areas improving

First to follow up rates (slide 4)
District nursing (slide 14)
Musculoskeletal (MSK) (slide 15)
New birth visits (slide 16)
HCP or midwife visits within 12 weeks and 6 days (Slide 17)
Mixed sex accommodation (slide 55)

Areas for focus

Theatres (slide 5)
Hospital and service cancelations (slide 7 and 8)
Did not attend (DNA) rates (slide 9 and 10)
Community waiting times (slides 13)
Referral to treatment incomplete pathway (slides 20) – data validation continuing
Cancer two week waits – capacity (slide 26 and 27)
Serious incident reporting (slide 41)

Board Aims

Focus Areas

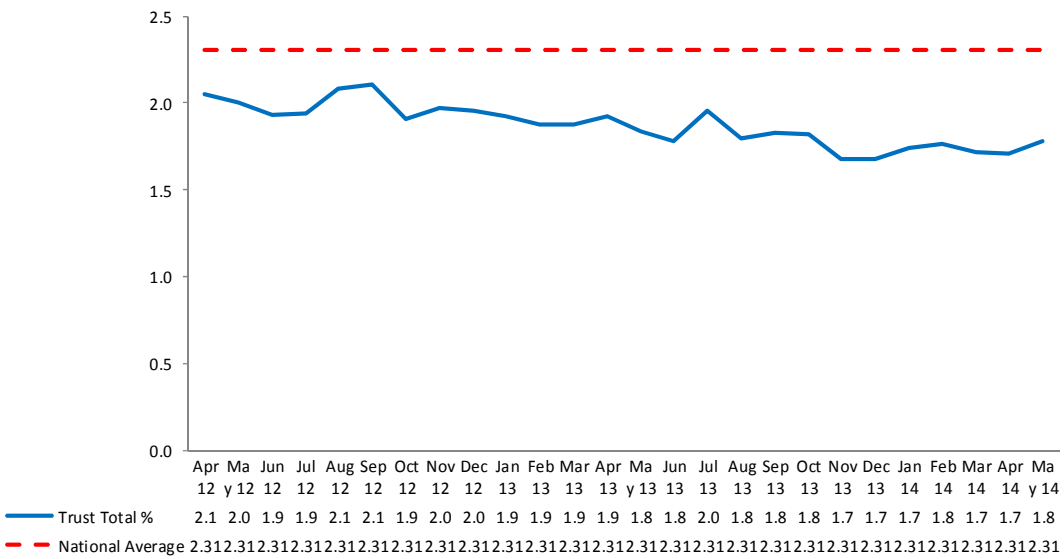
All indicators have been mapped to the Board Aims

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	May 14
Acute Trust Total	-	1.84	1.78	1.96	1.80	1.83	1.82	1.68	1.68	1.74	1.76	1.72	1.71	1.78



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

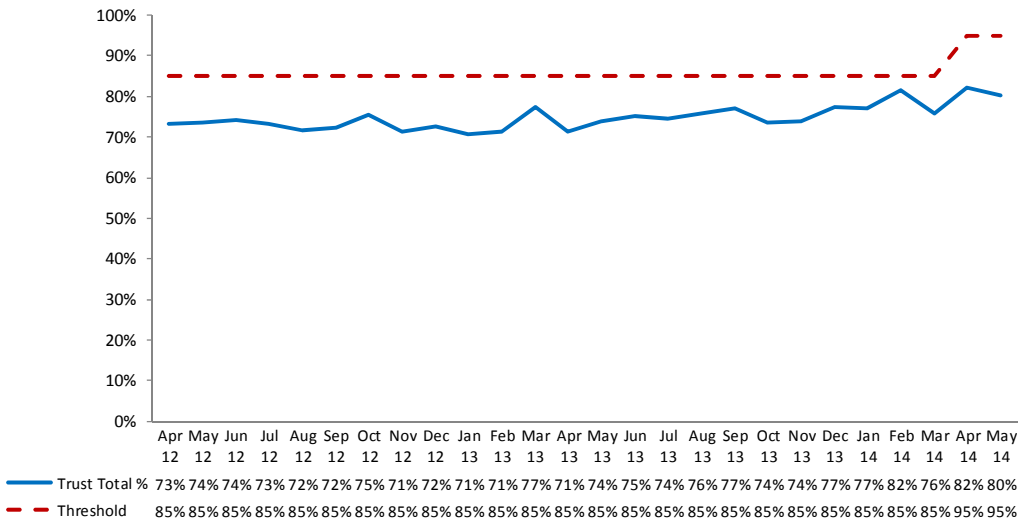
The first to follow up rate is continuing to improve over time and is well under the national benchmark of 2.31. The value improvement programme for the outpatients department will continue to monitor and improve first to follow up ratios by unit.

Theatre Utilisation

Deliver

Focus Areas

	Utilisation			Available Session Time (Minutes)			Time Utilised (Minutes)		
	Mar 14	Apr 14	May 14	Mar 14	Apr 14	May 14	Mar 14	Apr 14	May 14
Local Threshold	>85%								
Trust Total	76%	82%	80%	62,220	61,680	52,290	47,134	50,597	42,020



The target threshold currently set at 85% will be increasing to 95% by July 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 use remains below the trajectory of the 95 per cent stretch target by June 2014. A review is underway to check whether it will meet the stretch target. Among the improvements are patients being contacted to make them aware that they are first on the theatre list. This is reducing did not attends (DNAs) and late starts. Lists are also signed off and 'locked down' by surgeons a minimum of seven days in advance, encouraging lists to be booked more appropriately and admin staff are checking completion of notes the day before surgery, reducing delays if documentation is not fully completed.

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%	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"	99%	100%											Monthly

Dental	**Number of Contacts**	90%	Reporting Tools from software of excellence	91%	107%											Monthly
	Units of dental activity	90%	Reporting Tools from software of excellence	90.00%	93%											Monthly

Whittington Health dental services are meeting the agreed standards.

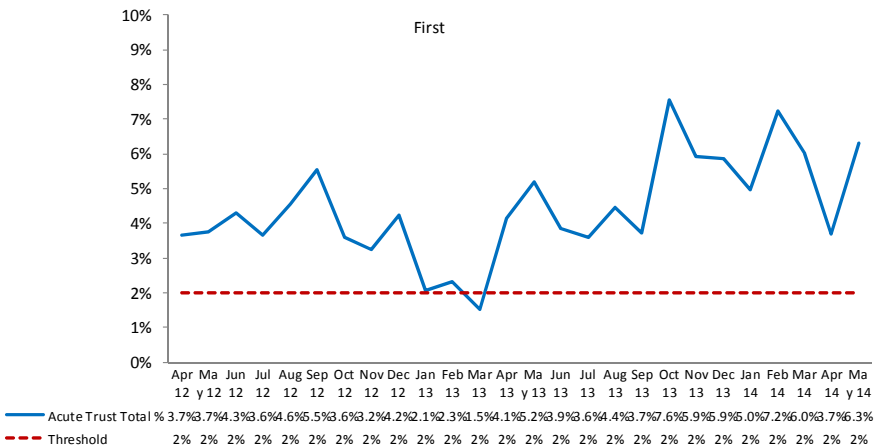
Hospital Cancellations - Acute

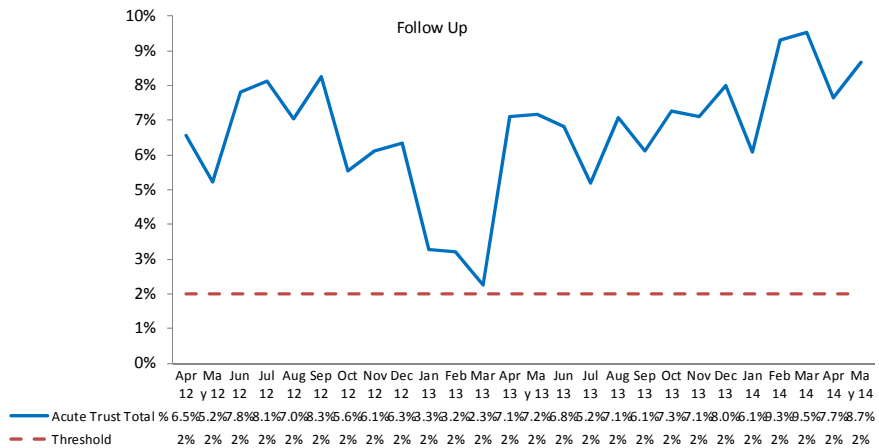
Deliver

Focus Areas

	First Appointments			Follow Up Appointments		
	Mar 14	Apr 14	May 14	Mar 14	Apr 14	May 14
Local Threshold	<2%			<2%		
Acute Trust Total	6.0%	3.7%	6.3%	9.5%	7.7%	8.7%

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





The positive reduction in hospital cancellations seen for April (3.7% for first, and 7.7% for follow-up appointments) was not sustained in in May (6.3% for first and 8.7% for follow-up appointments), so both remain above threshold. Bookings for new appointments are to be made no further than six weeks in advance, and follow-up appointments partially booked if over six weeks, commencing 23 June. This will reduce the cancellations and enable specialties to understand and address any capacity and demand issues.

Service Cancellations - Community

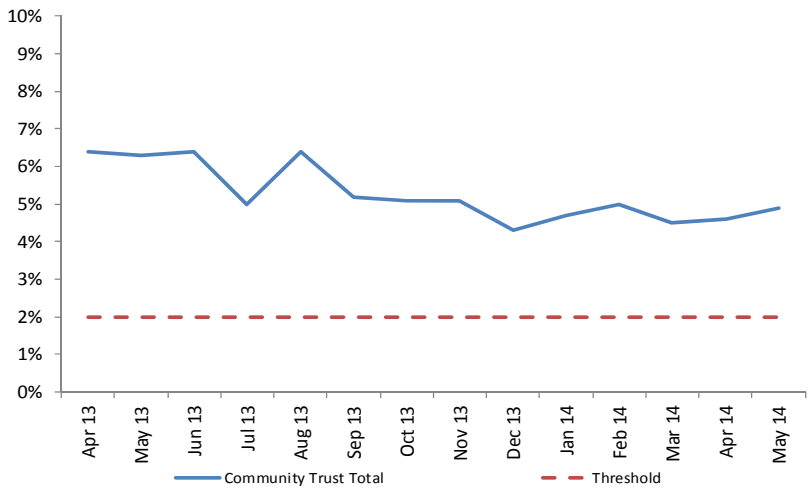
Integrate

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	May 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%	4.9%

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 almost 3% above the local threshold of 2%. Community activity is recorded on RIO and if an appointment is brought forward, it will be included in this cancellation rate. There is currently no way to extract these cancellations. The improvement plan for waiting list management in the community includes a review of all templates and an increase in filling unfilled late cancelations by patients.

DNA Rates - Acute

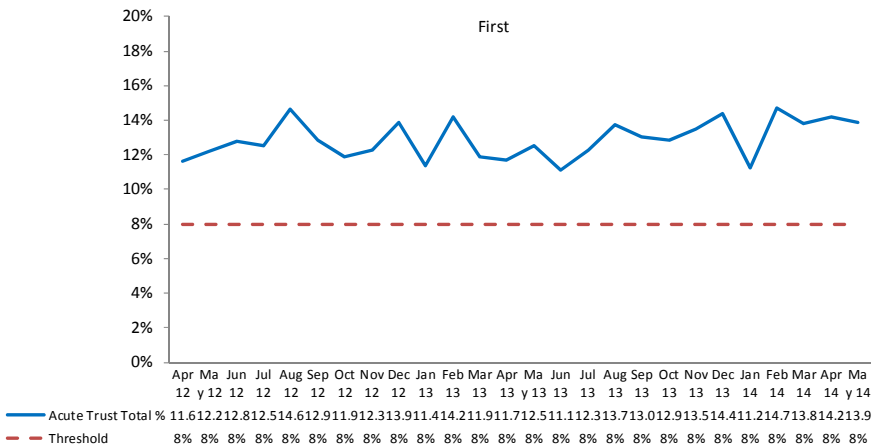
Deliver

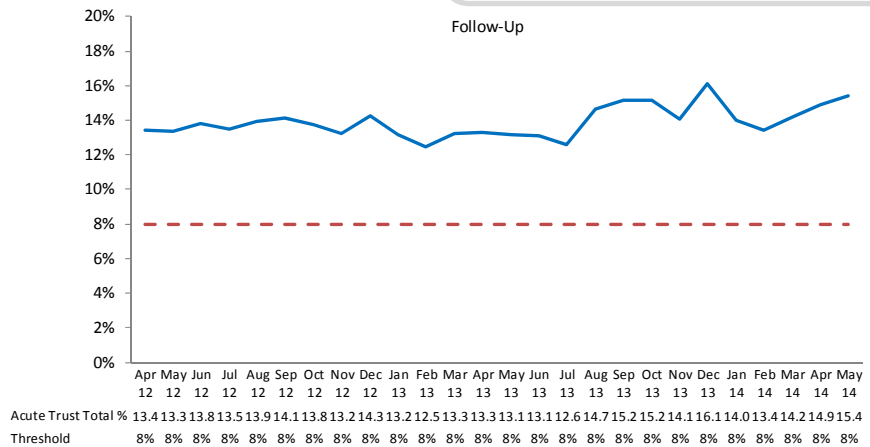
Focus Areas

	First Appointments			Follow Up Appointments		
	Mar 14	Apr 14	May 14	Mar 14	Apr 14	May 14
Local Threshold	8%			8%		
Acute Trust Total	13.8%	14.2%	13.9%	14.2%	14.9%	15.4%

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





Did Not Attend (DNA) rates for first appointments have very slightly improved in May from April. However, the rate still remains well above the local threshold for both new and follow up appointments. Targeted DNA reduction campaigns are being made within four specialities to test improvements. Training was implemented for access centre staff in April and for outpatient reception areas in May, which included the standard operating procedures agreed for the management of DNAs. 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.

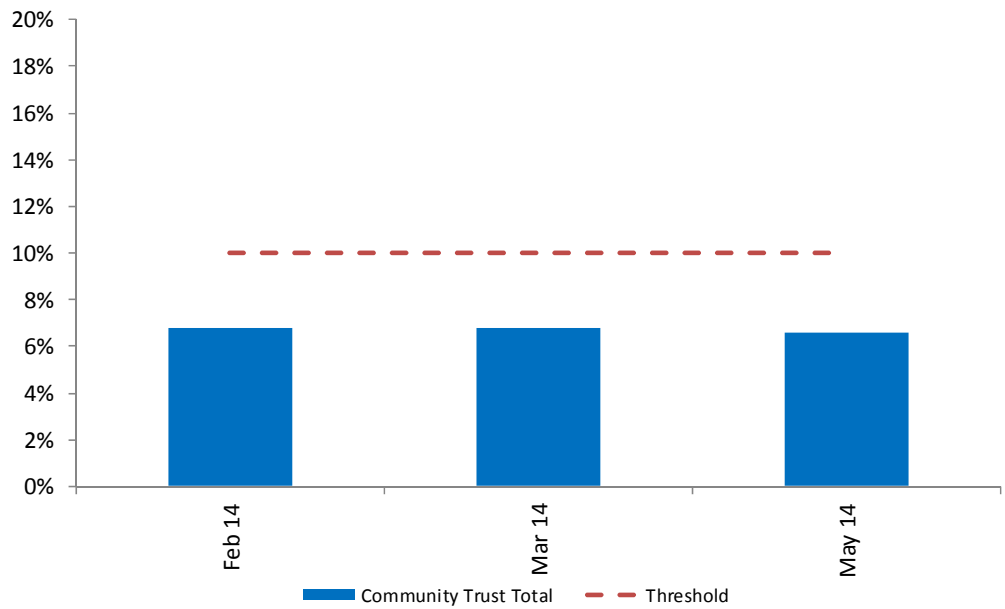
DNA Rates - Community

Integrate

Focus Areas

First + Follow-Up

	Mar 14	Apr 14	May 14
Local Threshold	10%		
Community Trust Total	6.8%	6.8%	6.6%



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.

A pilot to reduce the number of appointments where patients did not attend (DNA) is being carried out in community paediatrics to check whether the trust wide improvement is transferable to our community services. This includes patient feedback.

Community Face-to-Face Contacts

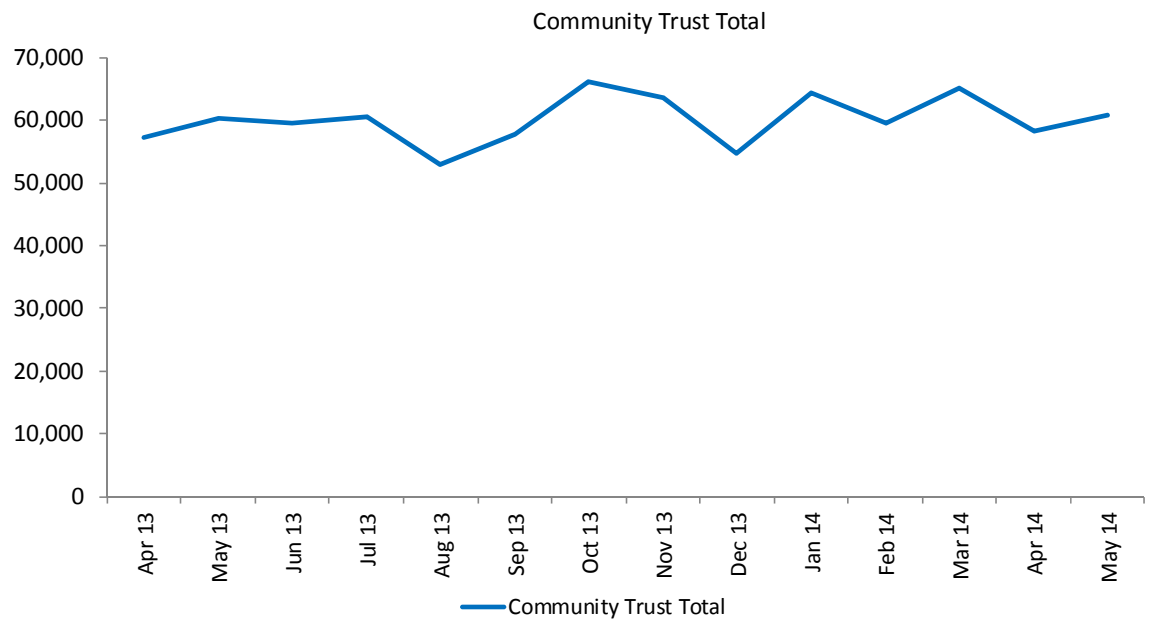
Integrate

Focus Areas

	Mar 14	Apr 14	May 14
Threshold	n/a		
Community Trust Total	65,046	58,311	63,129

2012/13 Apr - May	2013/14 Apr - May	2014/15 Apr - May	Variation between 2012/13 and 2014/15	Variation between 2013/14 and 2014/15
n/a				
100,331	117,671	121,440	21%	3%

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 3% for April and May 2014 compared to the same period in 2013, and an increase of 21% compared to two years ago.

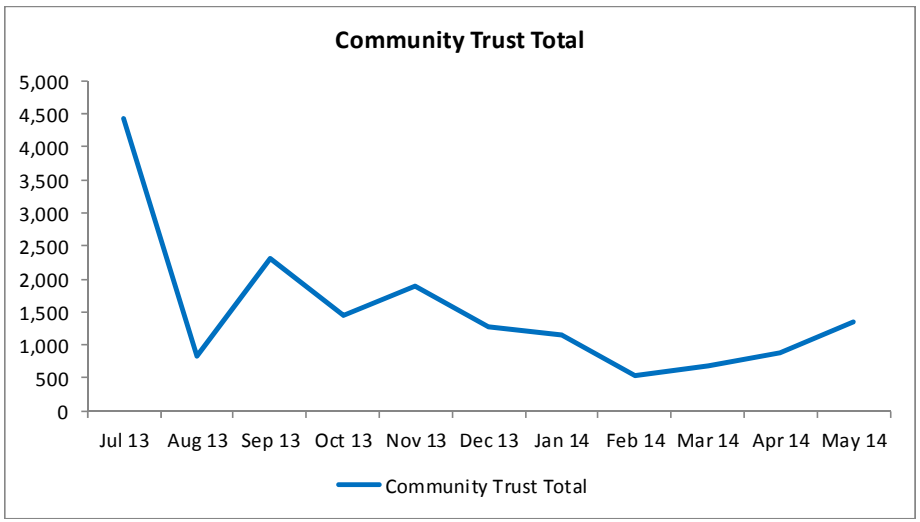
Community Appointment with no outcome

Integrate

Focus Areas

	Mar 14	Apr 14	May 14
Local Threshold	n/a		
Community Trust Total	693	891	1,359

% of Total Face-to-Face Contacts		
Mar 14	Apr 14	May 14
0.5%		
1.1%	1.5%	2.2%



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.

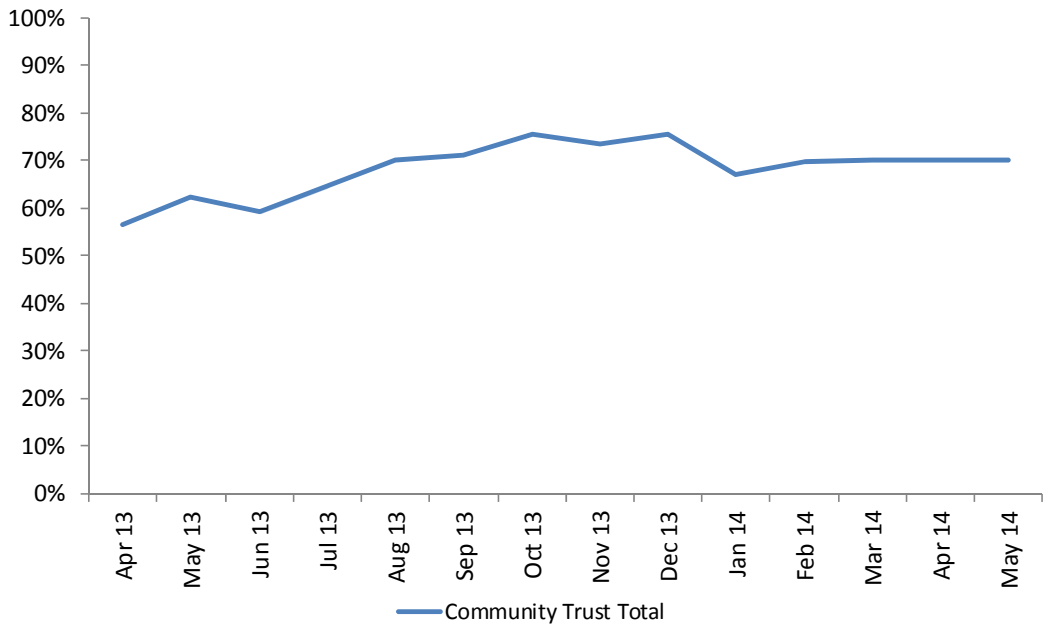
There has been a steep increase in community appointments with no outcome in May compared to April. The increase is mainly in one area and is part of the data validation process underway in the community. Individual managers are now using daily reports to cross check that appointments have an outcome entered.

Community Waiting Times
% waiting less than 6 weeks

Integrate

Focus Areas

	Mar 14	Apr 14	May 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.

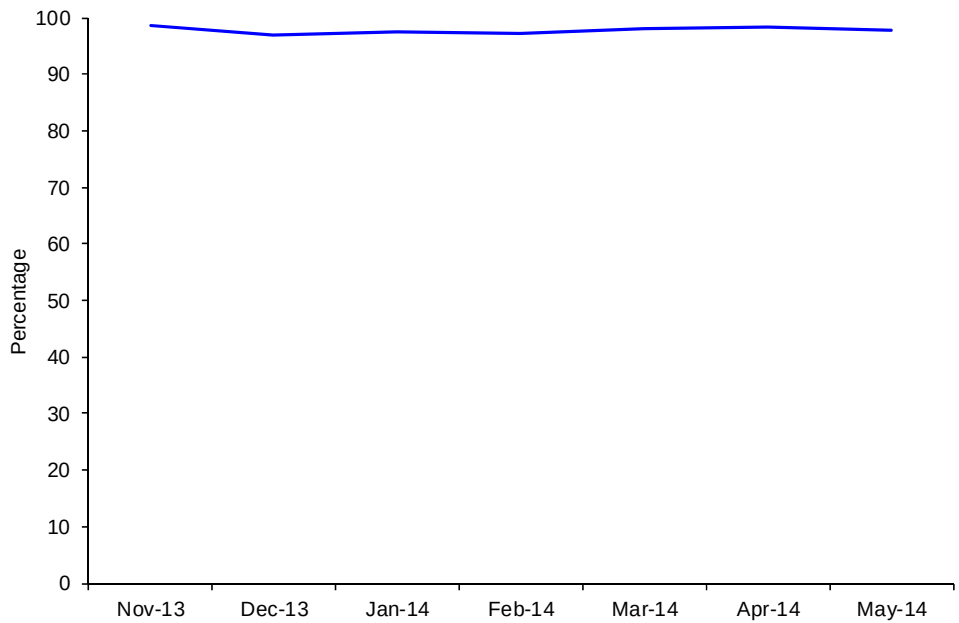
There continues to be a slight month-on-month increase in the percentage of patients waiting less than six weeks for a community appointment. A community Patient Tracking List (PTL) is now in use and regular meetings to review the PTL have been set up to assist with waiting list management. Data validation is underway with agreement that this will be completed by the end of July

District Nursing Waiting Times
% waiting less than 6 weeks

Integrate

Focus Areas

	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14
Threshold	n/a						
Community Trust Total	98.5	97.02	97.4	97.15	97.95	98.42	97.76



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. Improvements have been seen in the recruitment of nursing and support staff, alignment to locality based teams and coordination with local GPs.

MSK Waiting Times

Integrate

Focus Areas

Incomplete Pathways (29/05/2014)	Waiting Time	Total Under Waiting Time	Total Over Waiting Time	% Waiting
Routine MSK	6 Weeks	1773	120	93.7%
MSK Consultant Led	18 Weeks	200	7	96.6%

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.

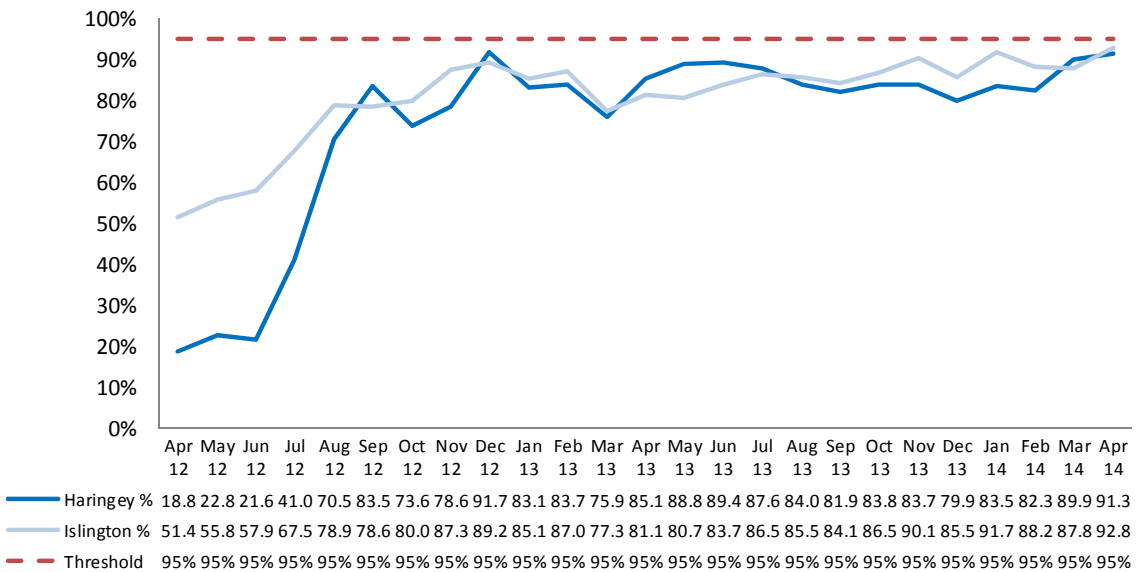
We have developed a value improvement programme (transformation) to embed our revised MSK model. The model includes information and education for patients and a single point of access into the three services. The services are physiotherapy and podiatry, consultant led enhanced physiotherapy, podiatry, medication management and specialist GPS, and specialist review and treatment. Communication will be improved with monthly updates to GPs and the development of a new website.

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	Apr 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%	91.3%
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%	92.8%



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

The improvement seen in March in Haringey (89.9%) has continued in May with the percentage of new birth visits within 10 to 14 days at 91.3%. Islington has also seen a good improvement in May, moving to 92.8% from 87.8% in April.

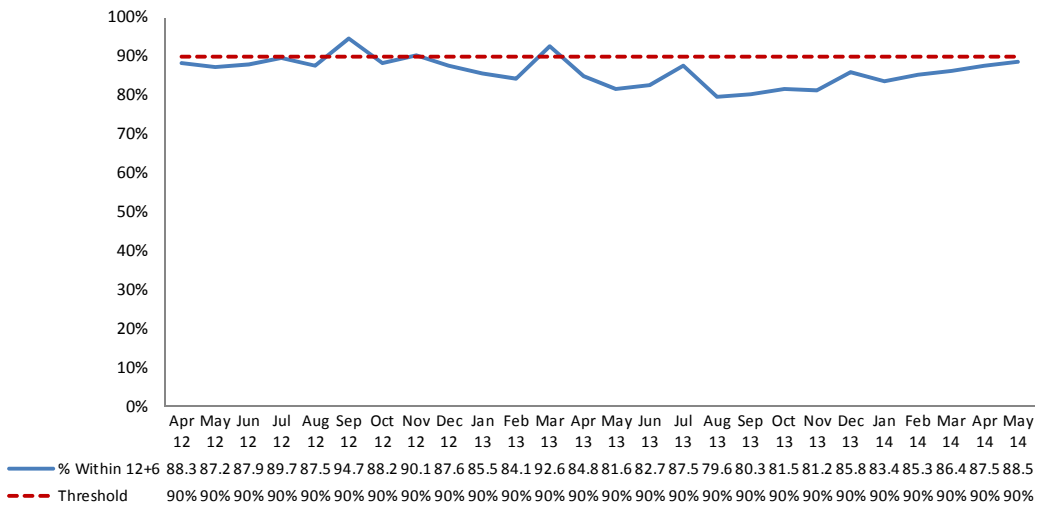
Women seen by HCP or Midwife within 12 weeks and 6 days

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	May 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%	88.5%
Total Number of Bookings	-	374	404	359	421	376	369	375	359	339	384	335	345	333	404
Referrals within 12 Weeks and 6 days	-	323	347	312	359	324	319	324	330	302	338	286	309	289	349

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, and is only 1.5% short of the 90% threshold. The designated Midwife Consultant focused on public health has attributed to this improvement. Maternity is working on one named Midwife throughout the pregnancy to enable continuity of carer.

Referral to Treatment 18 weeks - Admitted

Deliver

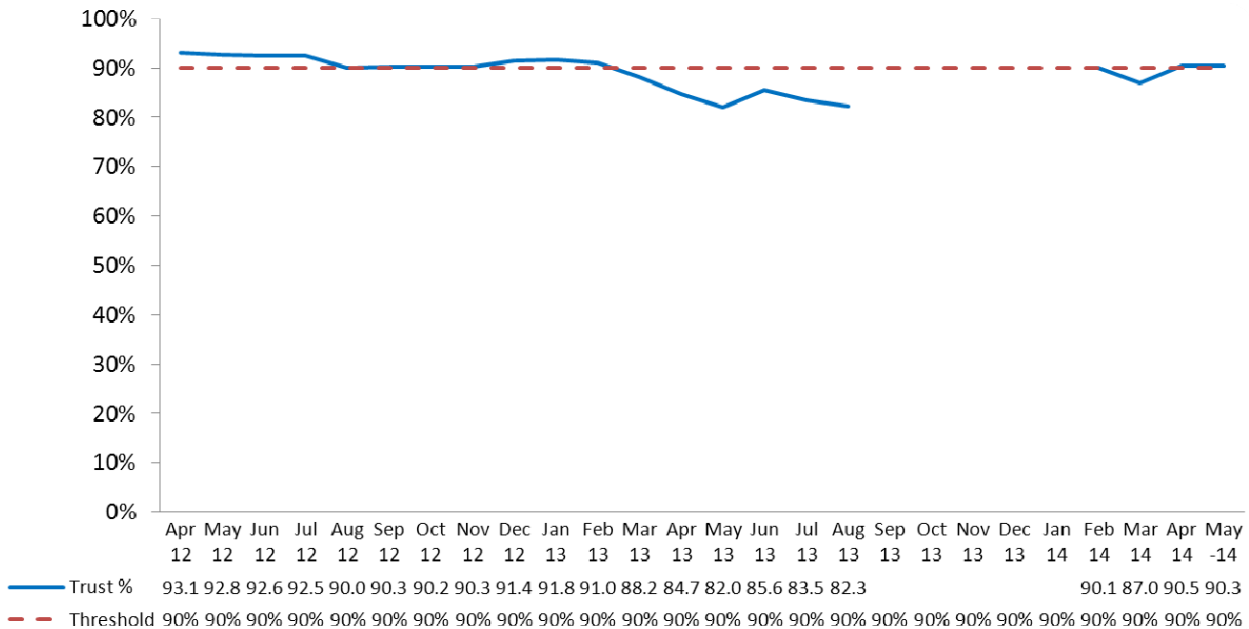
Access Metrics

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

RTT Admitted

	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	May 14
National Threshold	90%													
Trust Total	84.7%	82.0%	85.6%	83.5%	82.3%	-	-	-	-		90.1%	90.1%	90.5%	90.3%



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

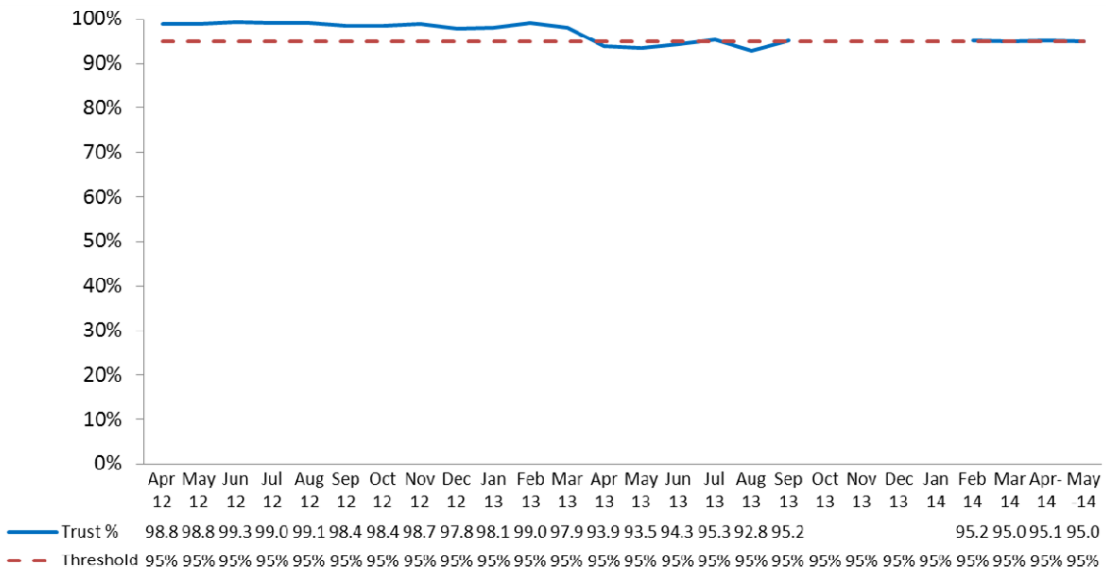
Referral to Treatment 18 weeks – Non Admitted

Deliver

Access Metrics

RTT Non-Admitted

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



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

na denotes, data not available

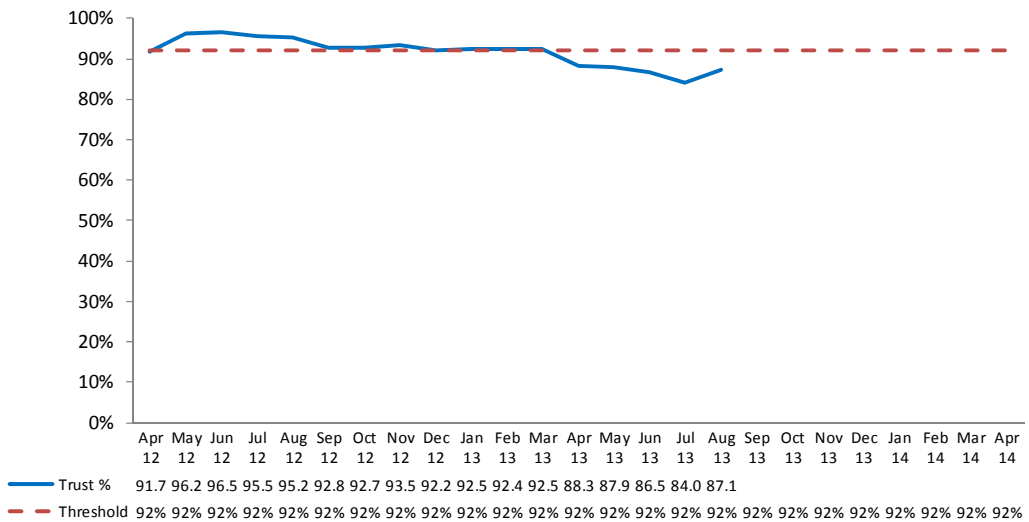
Non Admitted clock stops also achieved the target at 95.0%.

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 data quality issues

March 2014 data correct as at 8th April 2014

n/a denotes, data not available

Following the Electronic Patient Record (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 due to be submitted in July. The action plan is on track to achieve the validation tasks by the data return deadline.

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 data quality Issues

March 2014 data correct as at 8th April 2014

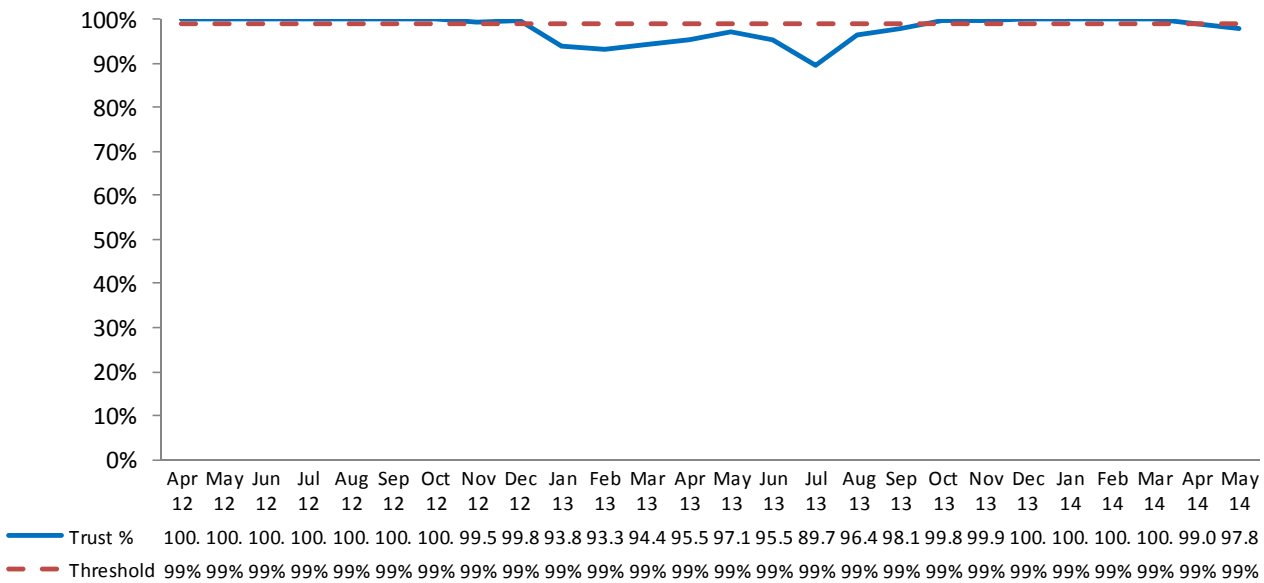
There have been no 52 week waits.

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	May 14
National Threshold	99%													
Trust Total	95.46%	97.07%	95.53%	89.72%	96.38%	98.06%	99.82%	99.86%	100.00%	100.00%	100.00%	100.00%	98.97%	97.80%



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).

May percentage includes audiology activity which as at 13/06/2014 is not signed-off

The 99 per cent standard was not met in May as a small number of patients were delayed in audiology because of capacity. Escalations have now been put in place to ensure the referral pathway is monitored.

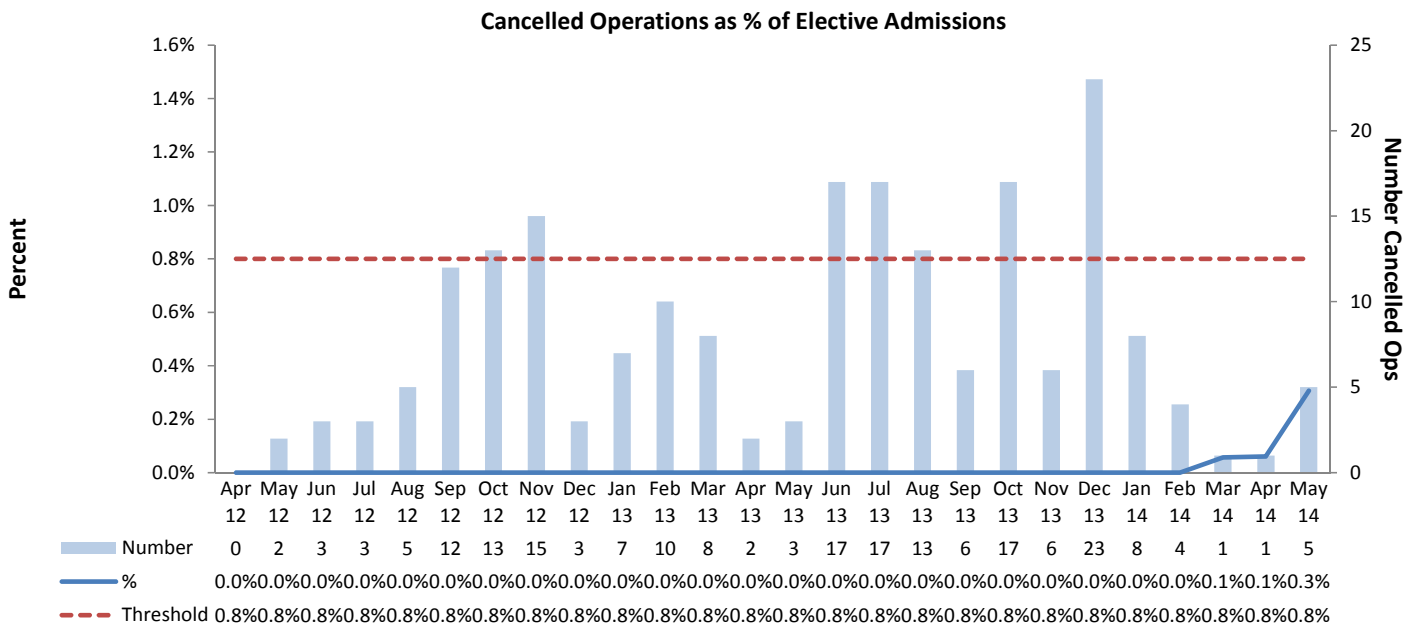
Hospital Cancelled Operations

Deliver

Access Metrics

	Number of Cancelled Operations			Cancelled Operations as % of Elective Admissions		
	Mar 14	Apr 14	May 14	Mar 14	Apr 14	May 14
National Threshold	n/a			< 0.8%		
Trust Total	1	1	5	0.1%	0.1%	0.3%

Hospital initiated cancellations on day of operation



There were five cancellations in May. One was due to a list overrun in gynaecology. A review of the cases has been completed. The areas for improvement have been escalated to the floor medical coordinator and general manager for surgery to assist with possible solutions before cancelations are decided.

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	May-14
National Threshold	95.0%	95.0%
4hr Waits	96.3%	96.3%
12hr Waits	0.0%	0.0%

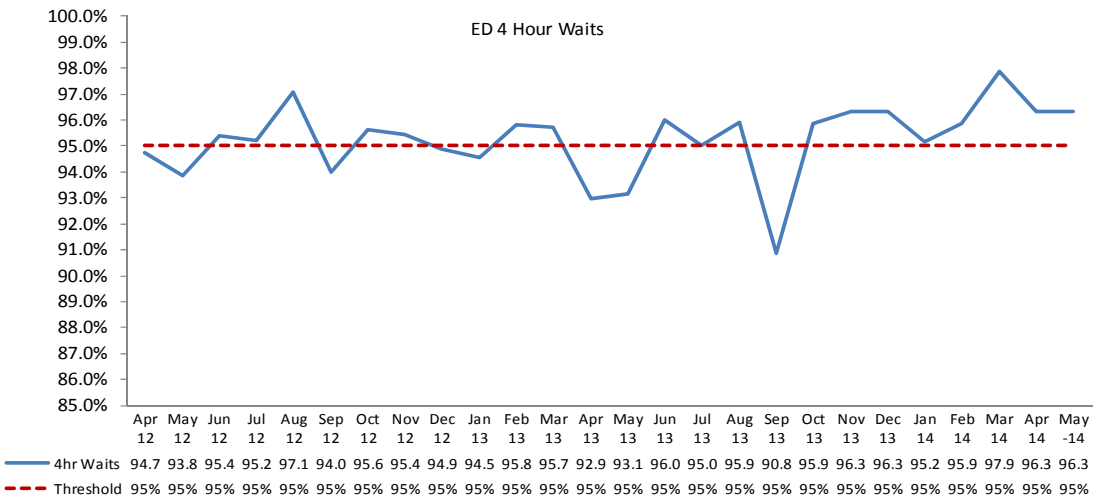
ED Waits (Adult)

	Apr 14	Apr 15
National Threshold	95.0%	95.0%
4hr Waits	96.2%	95.9%
12hr Waits	0.0%	0.0%

ED Waits (Paeds <=16)

	Apr 14	May-14
National Threshold	95.0%	95.0%
4hr Waits	96.5%	97.6%
12hr Waits	0.0%	0.0%

Re-attendance rate indicator not currently available



The Emergency Department continues to deliver the emergency access national care standards, seeing 96.3% of patients within four hours in both April and May. Demand for the service is high and a sustainable improvement plan is underway including reviewing the physical environment of the front entrance.

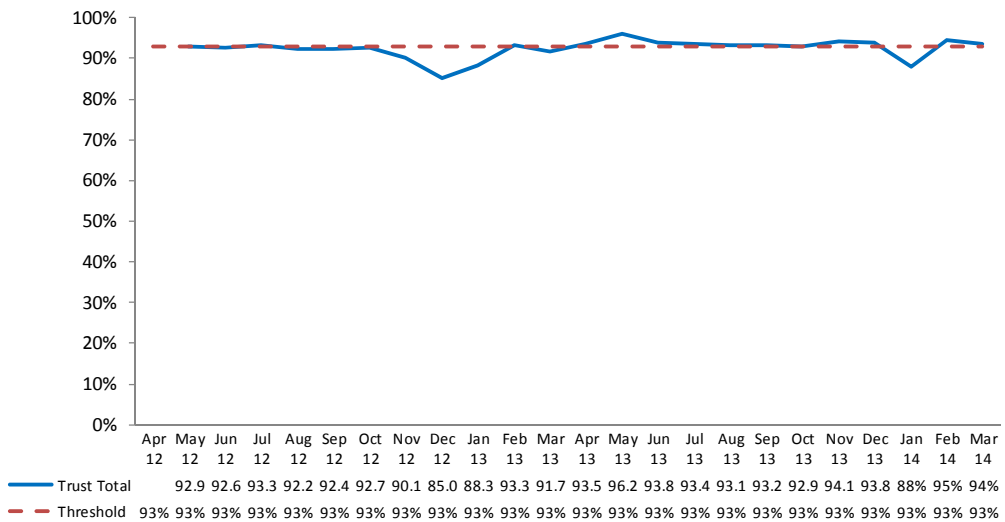
Cancer – 14 days to first seen

Deliver

Access Metrics

14 Days to First Seen

	Feb 14	Mar 14	Apr 14	Q1	Q2	Q3	Q4
National Threshold	93%			93%			
Trust Total	94.5%	93.6%	90.6%	94.6%	93.5%	93.4%	90.6%



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

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

The Trust did not achieve the target for April because of patient choice and capacity within the breast service following a 30 per cent increase in referrals across London. The capacity and demand plans, and escalation triggers have been reviewed and agreed with the Clinical Director. A review of education campaigns has been done with no new campaigns started. However, a national story re breast cancer has been in a high profile TV drama.

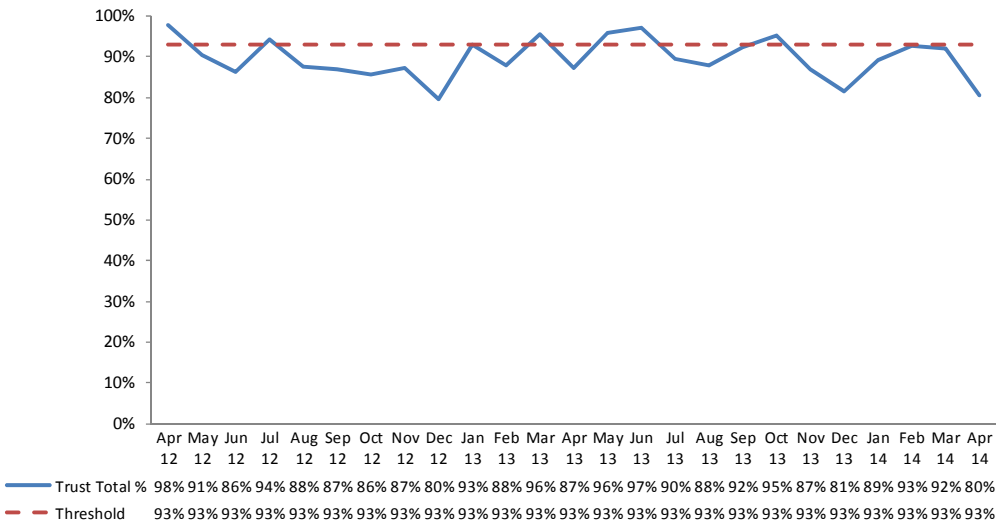
Cancer – 14 days to first seen – Breast symptomatic

Deliver

Access Metrics

14 Days to First Seen - Breast Symptomatic

	Feb 14	Mar 14	Apr 14	Q1	Q2	Q3 TD	Q4
National Threshold	93%			93%			
Trust Total	92.55%	92.0%	80.5%	88.2%	92.1%	91.6%	80.5%



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 is not being met because of patient choice and a 30% increase in breast referrals across London. Additional breast capacity will be available and the team are reorganising consultant sessions to ensure more appointments are available to provide as much choice as possible. The additional capacity is also aligned to a clear pathway for breast imaging.

Cancer – 31 Days to first treatment

Deliver

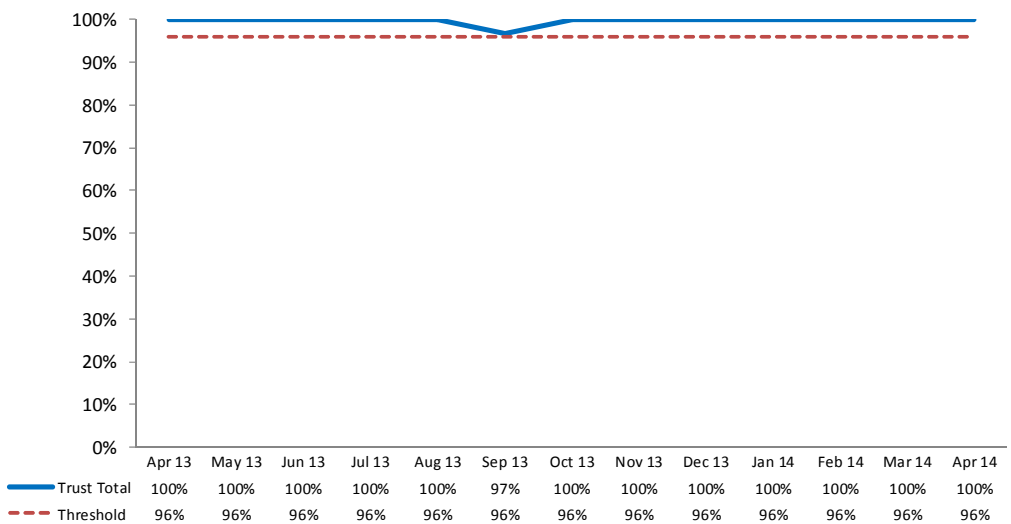
Access Metrics

31 Days to First Treatment

	Feb 14	Mar 14	Apr 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.



The Trust is consistently delivering this target with 100% compliance.

Cancer – 31 days to subsequent treatment - Surgery

Deliver

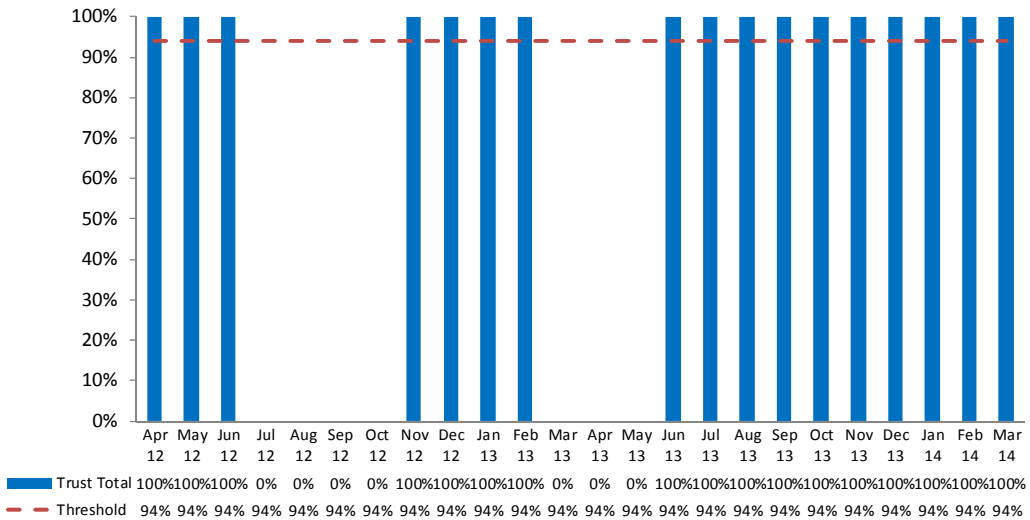
Access Metrics

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

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



The Trust is consistently delivering this target with 100% compliance.

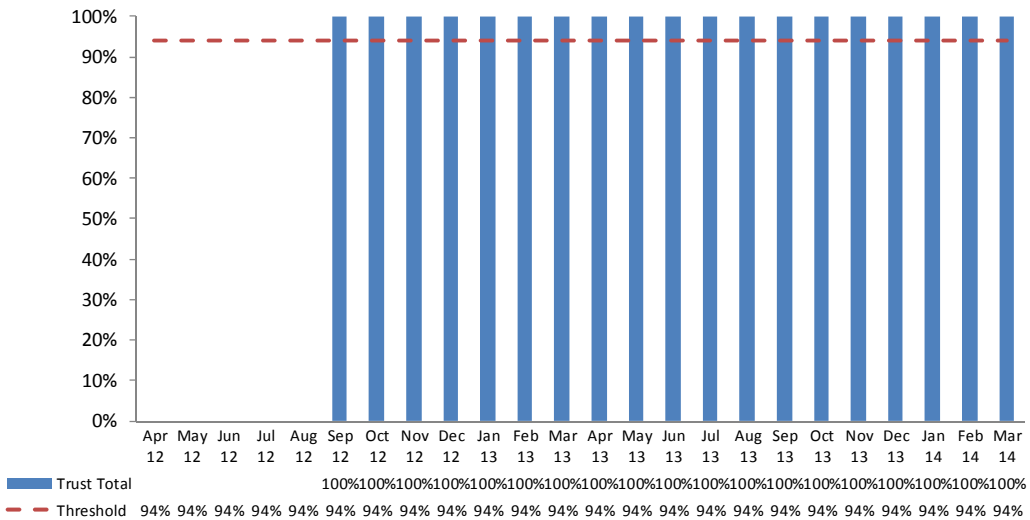
Cancer – 31 days to subsequent treatment - Drugs

Deliver

Access Metrics

31 Days to Subsequent Treatment - Drugs

	Feb 14	Mar 14	Apr 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

The Trust is consistently meeting this target with 100% compliance.

Cancer – 62 days from referral to treatment

Deliver

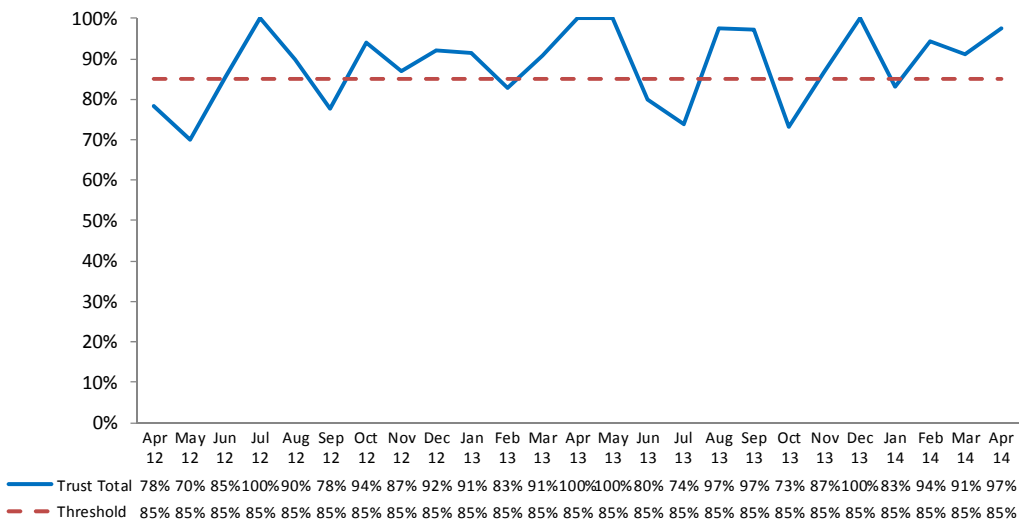
Access Metrics

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

	Feb 14	Mar 14	Apr 14	Q1	Q2	Q3	Q4
National Threshold	85%			85%			
Trust Total	94.4%	91.1%	97.4%	100.0%	83.1%	85.2%	97.4%



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

Cancer – 62 days from consultant upgrade

Deliver

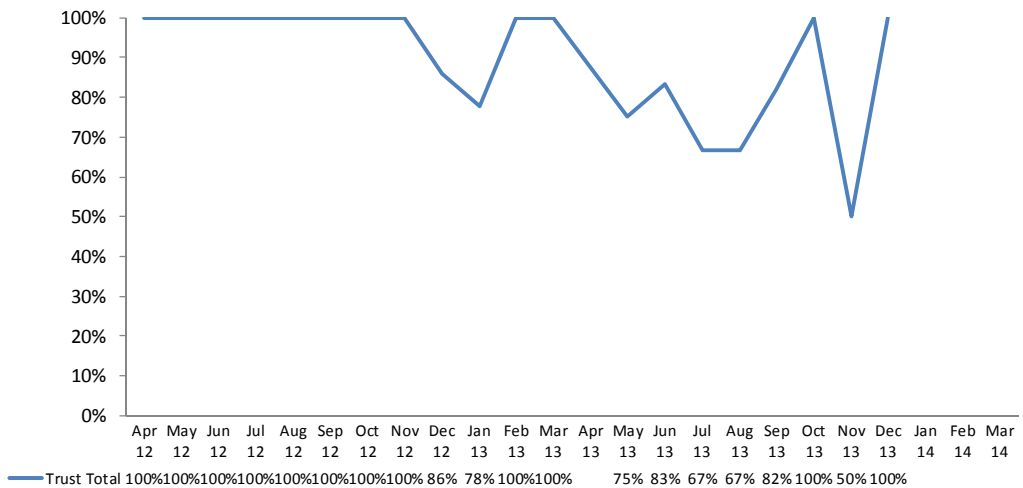
Access Metrics

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

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



No patients applicable under this measure for March or April. There is no national standard for this indicator.

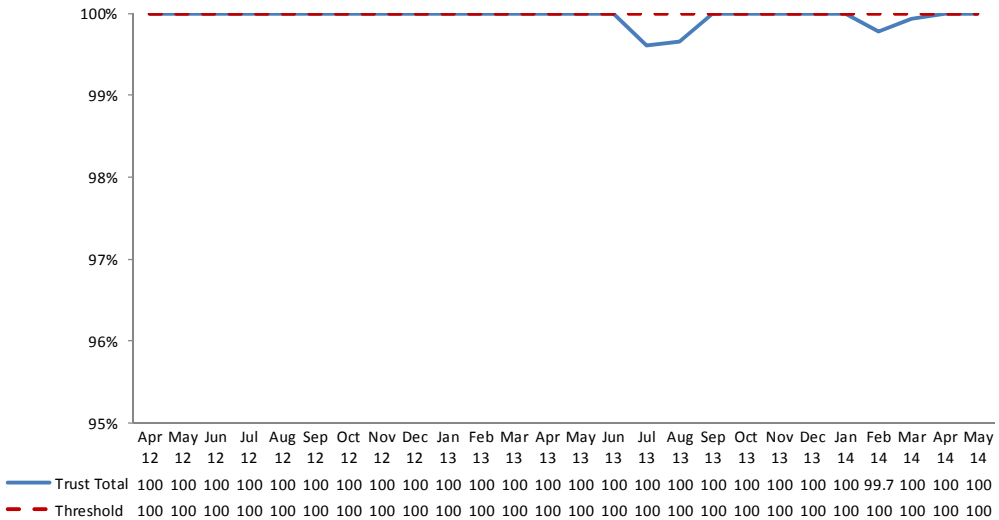
Genito-Urinary Medicine Appointment within 2 Days

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	May 14
Trust Total	100%	100%	100%	100%	99.6%	99.7%	100%	100%	100%	100%	100%	99.78%	99.93%	100.00%	100.00%

The percentage of patients offered an appointment within 2 days



Performance remains at 100% as expected following a process issue which occurred and was addressed in March.

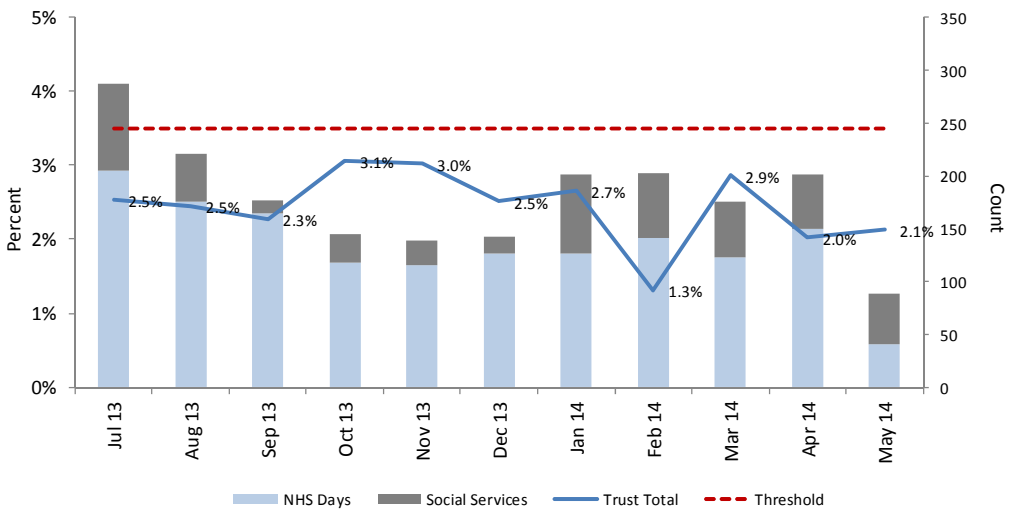
Delayed Transfers of Care

Integrate

Outcome Metrics

	Number of Days Delayed		
	May 14		
	NHS Days	Social Services	Both
Trust Total	90	60	0

	Mar 14	Apr 14	May 14
Local Threshold	3.5%		
Trust Total Delayed Transfers	2.9%	2.0%	2.1%



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.

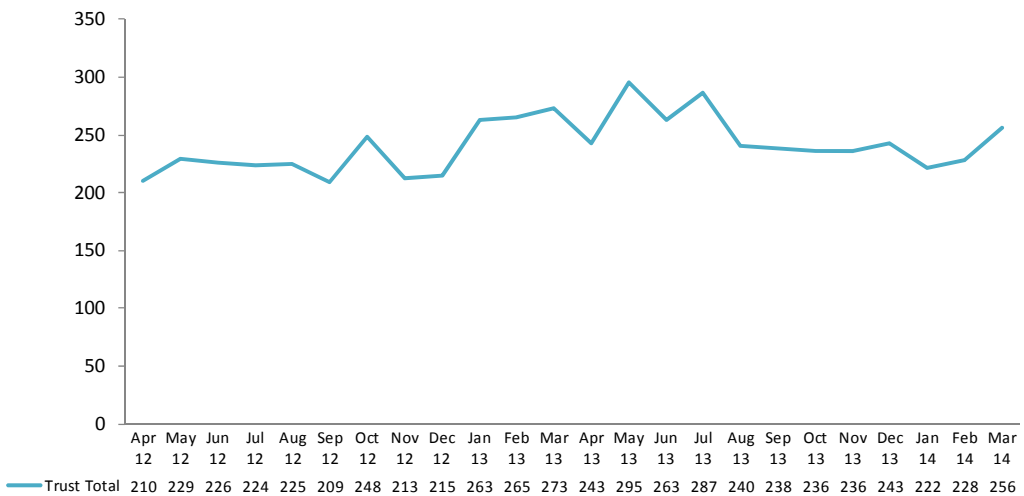
Performance at 2.1% is consistently achieving the local threshold. Delays are reviewed daily and escalated. There are good working practices with the Trust's local authority partners to progress any potential delays and resolve early where possible.

30 day Emergency Readmissions

Deliver

Outcome Metrics

	Apr 13	May 13	Jun 13	Jul 13	Aug 13	Sep 13	Oct 13	Nov 13	Dec 13	Jan 14	Feb 14	Mar 14
Trust Total	243	295	263	287	240	238	236	236	243	222	228	256



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.

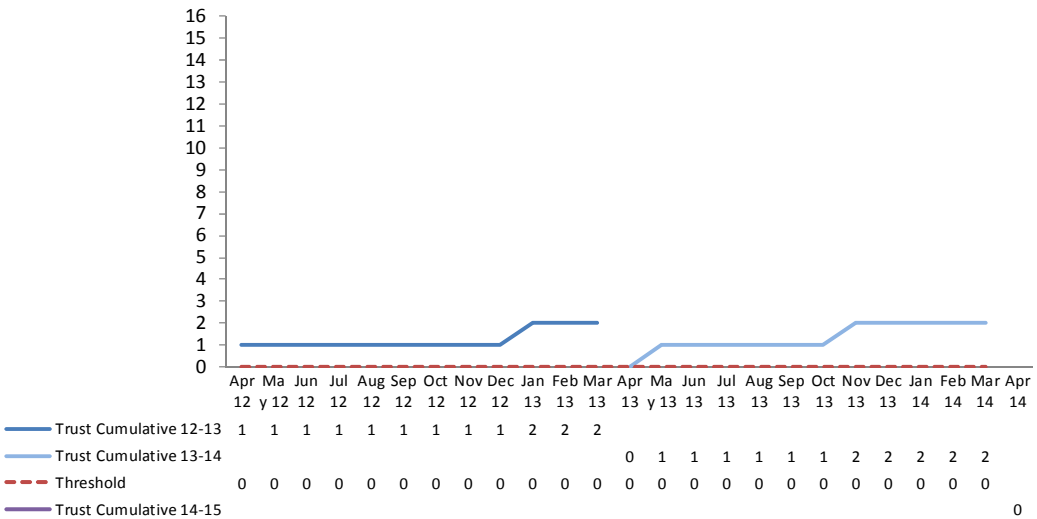
MRSA

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	May 14
National Threshold	0													
Trust Total	0	1	0	0	0	0	0	1	0	0	0	0	0	0

Number of MRSA bacteraemia (bacteria in the blood)



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

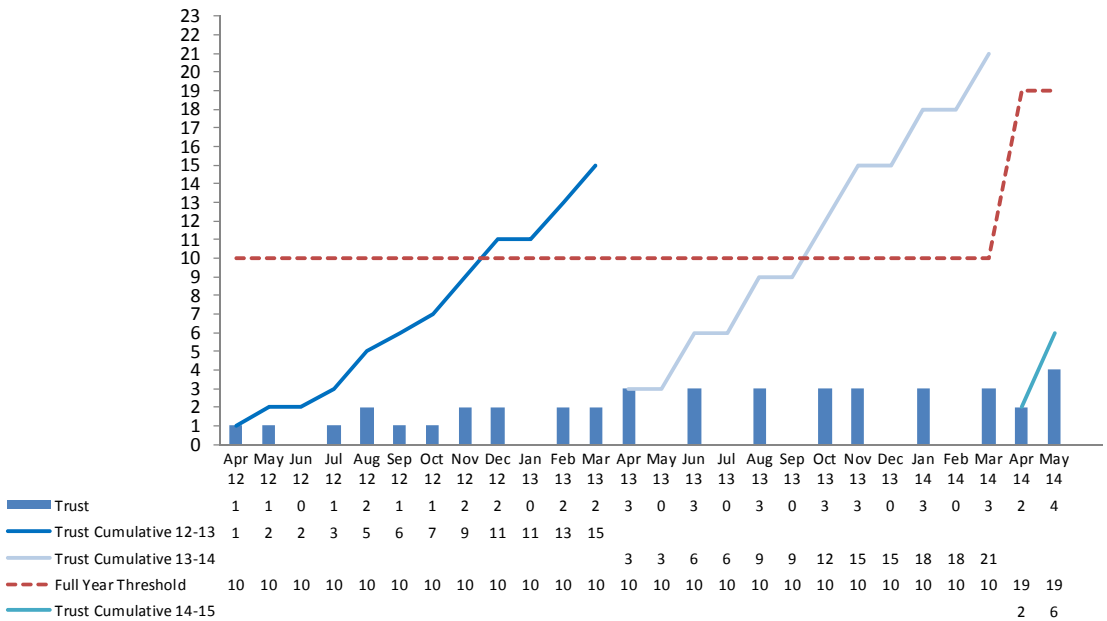
C Difficile Infections

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	May 14
Full Year National Threshold	<=10												<=19	
Trust Total	3	0	3	0	3	0	3	3	0	3	0	3	2	4

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



The Trust threshold standard is below 19 cases reported within the financial year 2014/15. Two cases were reported in May, bringing the total to six reported cases.

E.coli and MSSA

Deliver

Outcome Metrics

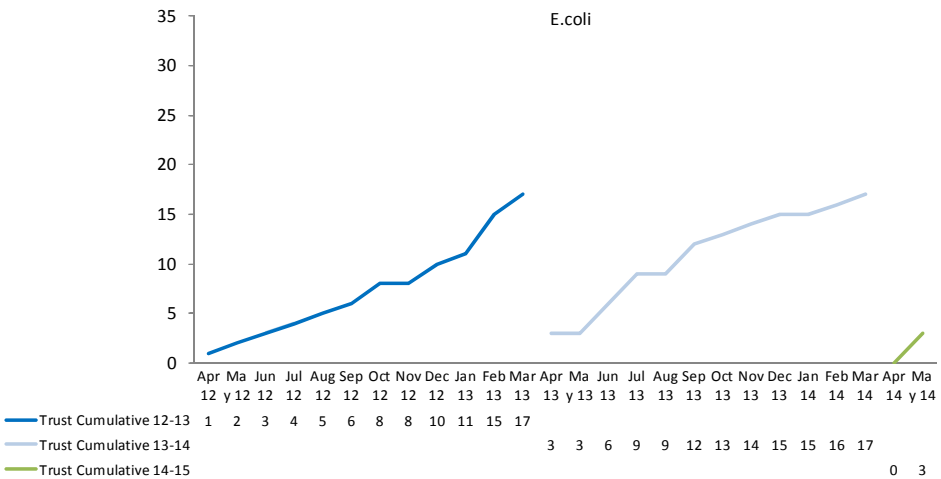
E.coli (Post 48 Hours)

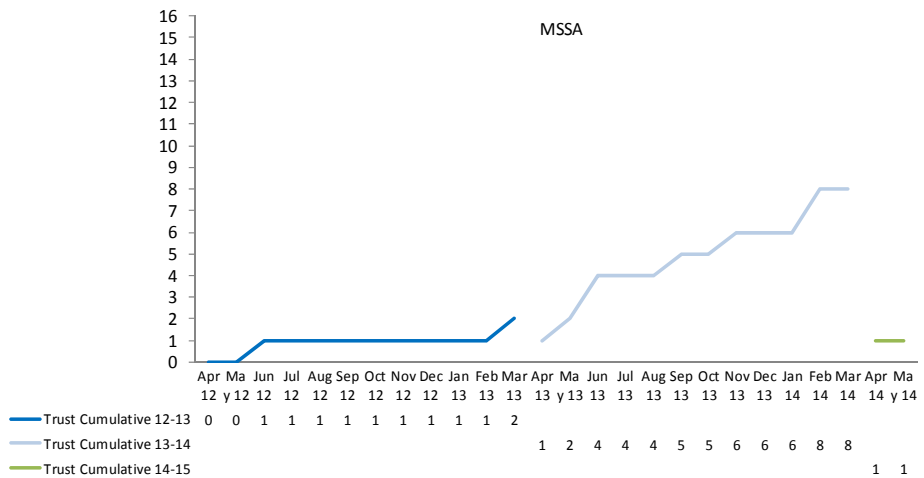
	Mar 14	Apr 14	May 14
Threshold	n/a		
Trust Total	1	0	3

MSSA (Post 48 Hours)

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

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





There was no cases of MSSA bacteraemia reported in May but three cases of E.coli reported. A review of when E.coli tests should be performed is underway.

There are currently no national thresholds for these indicators.

Harm Free Care

Deliver

Outcome Metrics

	Contractual Threshold	Mar 14	Apr 14	May 14
% of Harm Free Care	95%	93.60%	93.20%	93.2%
Completeness of Safety Thermometer (CQUIN)	100%	100%	100%	n/a
Pressure Ulcer (PU) Incidence	Q4 2013/14 - 40	12	27	

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

May14

	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	825	756	91.64%	60	7.27%	0	0.00%	9	1.09%	2	0.24%
SCD	64	63	98.44%	0	0.00%	0	-	1	-	0	0.00%
WCF	145	145	100%	0	-	0	-	0	-	0	-
Trust Total	**1034**	**964**	**93%**	**60**	**5.80%**	**0**	**0.00%**	**10**	**0.97%**	**2**	**0.19%**

Division	Team\Ward Name	Mar-14	Apr-14	May-14
ICAM	DN Islington Central	88%	N/A	80%
ICAM	DN Haringey Assessment	94%	N/A	82%
ICAM	Mercers	100%	N/A	85%
ICAM	Nightingale	86%	N/A	86%
ICAM	Cloudesley	87%	N/A	87%
ICAM	Islington Podiatry	100%	N/A	88%
ICAM	DN East Haringey	93%	N/A	89%
ICAM	Extra Ward (Bridges)	94%	N/A	91%
ICAM	DN Islington South West	96%	N/A	91%
ICAM	Meyrick	87%	N/A	92%
ICAM	Cavell Rehabilitation	100%	N/A	93%
ICAM	DN Islington South East	94%	N/A	94%
ICAM	DN West Haringey	95%	N/A	94%
SCD	Coyle	100%	N/A	94%
ICAM	DN Islington Assessment	95%	N/A	95%
ICAM	DN Islington North	91%	N/A	95%

May 2014

Pressure Ulcers	Cat 2-4	Cat 2	Cat 3	Cat 4
All	60	34	15	11
Old	33	18	7	8
New	27	16	8	3

List of wards that fail the 95% threshold. Ward level data not available for April.

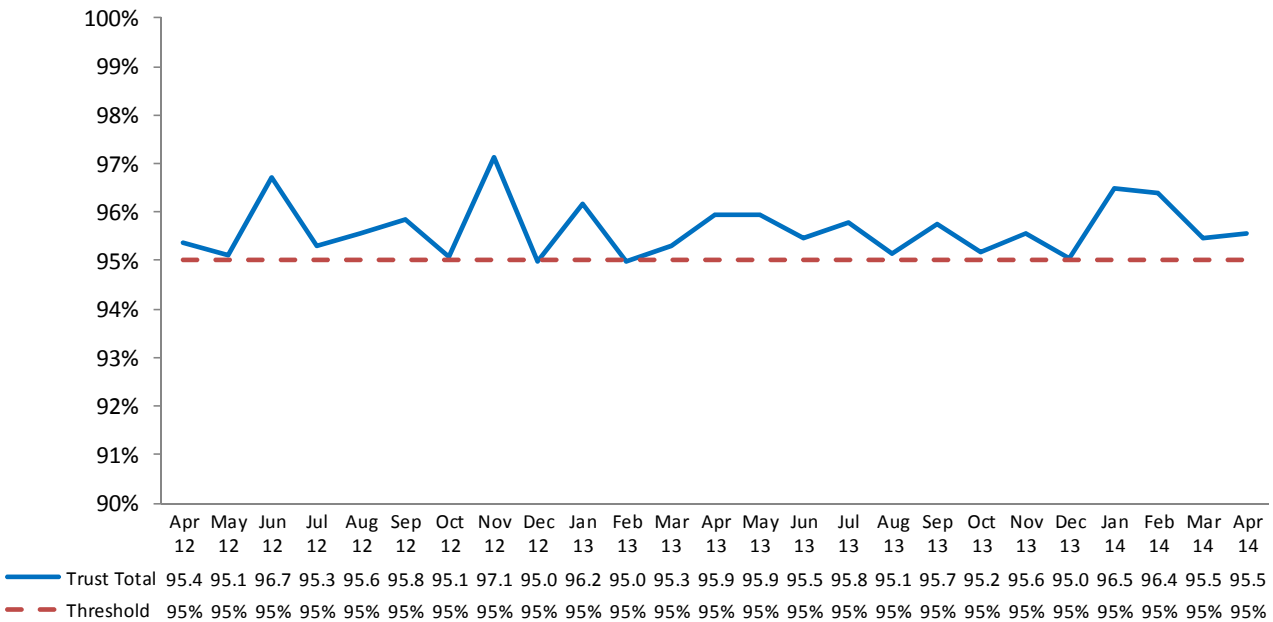
Performance has remained at the same rate for May as for April with 93.2% of patients on a particular day of the month, receiving no harm for the three areas of Harm Free Care. Pressure Ulcers remain the largest challenge and all are referred to the Quality Committee. Staff have also been reminded on 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		
	Feb 14	Mar 14	Apr 14	Feb 14	Mar 14	Apr 14
CQUIN Threshold	95%			Target to be decided		
Trust Total	96.4%	95.5%	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

We 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) is carried out.

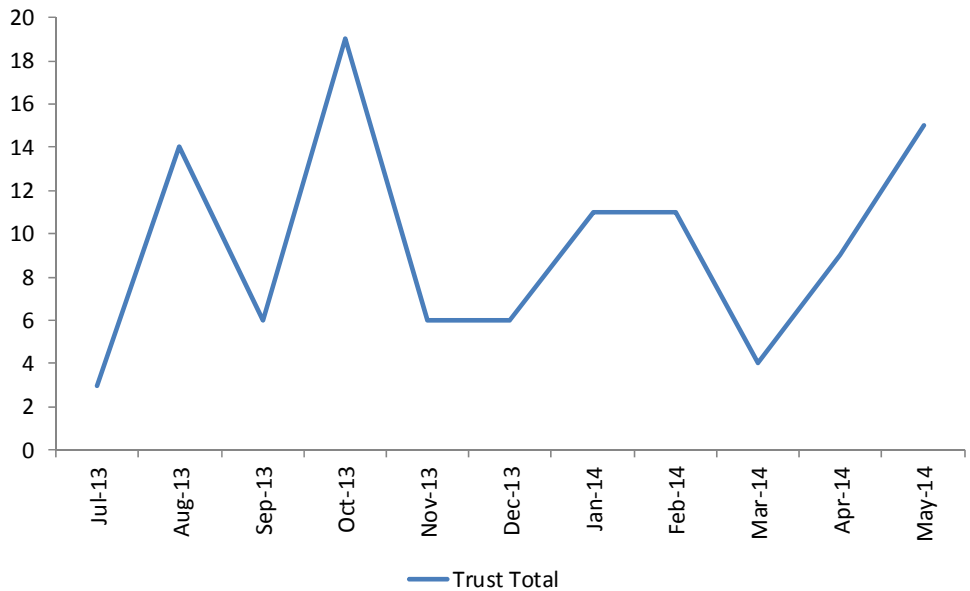
Serious Incidents

Change

Outcome Metrics

	Jul 2013	Aug 2013	Sep 2013	Oct 2013	Nov 2013	Dec 13	Jan 14	Feb 14	Mar 14	Apr 14	May 14
Integrated Care & Acute Medicine	2	13	5	17	1	2	8	7	2	5	8
Surgery, Cancer & Diagnostics	1	0	0	0	2	4	0	1	0	2	2
Women, Children & Families	0	1	1	2	3	0	3	3	2	2	5
Trust Total	3	14	6	19	6	6	11	11	4	9	15

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.

May saw 15 serious incidents (SI) reported, an increase on both March and April. All incidents are being reviewed through root cause analysis. Increased SIs may be part of the new improved governance processes implemented in the divisions who are championing increased reporting and improvement through lessons learnt.

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
January2014	4	2	2	0	0
February 2014	3	3	0	0	0
March 2014	4	3	1	0	0
April 2014	3	3	0	0	0
May 2014	5	1	0	4	0

Issued alerts include safety alerts, and Medical Device Alerts issued on behalf of the Medicines and Healthcare products Regulatory Agency, the NHS England, and the Department of Health

NHS England Patient Safety Alerts- 3 stage approach

Key
W= Warning
Re=Requires Resources
D= Directive

Reference	Title	Date issued	Deadline
NHS/PSA/W/2014/001	Risk of hypothermia in patients receiving continuous renal replacement therapy- action plan complete	06/02/2014	06/03/2014
NHS/PSA/D/2014/002	Non-Luer spinal (intrathecal) devices for chemotherapy- not used by this trust	20/02/2014	20/08/2014
NHS/PSA/W/2014/003	Risk of associating ECG records with wrong patients. - action complete	04/032014	04/04/2014
NHS/PSA/Re/2014/004	Addressing trends and outbreaks in carbapenemase-producing Enterobacteriaceae- action plan in place	06/03/2014	30/06/2014
NHS/PSA/D/2014/005	Improving medication error incident reporting and learning- action plan in place	20/03/2014	19/09/2014
NHS/PSA/D/2014/006	Improving medical device incident reporting and learning- action plan in place	20/03/2014	19/09/2014
NHS/PSA/W/2014/007	Minimising risks of omitted and delayed medicines for patients receiving homecare services- action complete	10/04/2014	09/05/2014
NHS/PSA/W/2014/008	Residual anaesthetic drugs in cannulae and intravenous lines- action complete	14/04/2014	13/05/2014

A list of outstanding Central Alerting System (CAS) Alerts has been provided to divisions and the Women Children and Families Head of Quality is developing a Standard Operating Procedure (SOP) to improve the process.

Ward Cleanliness

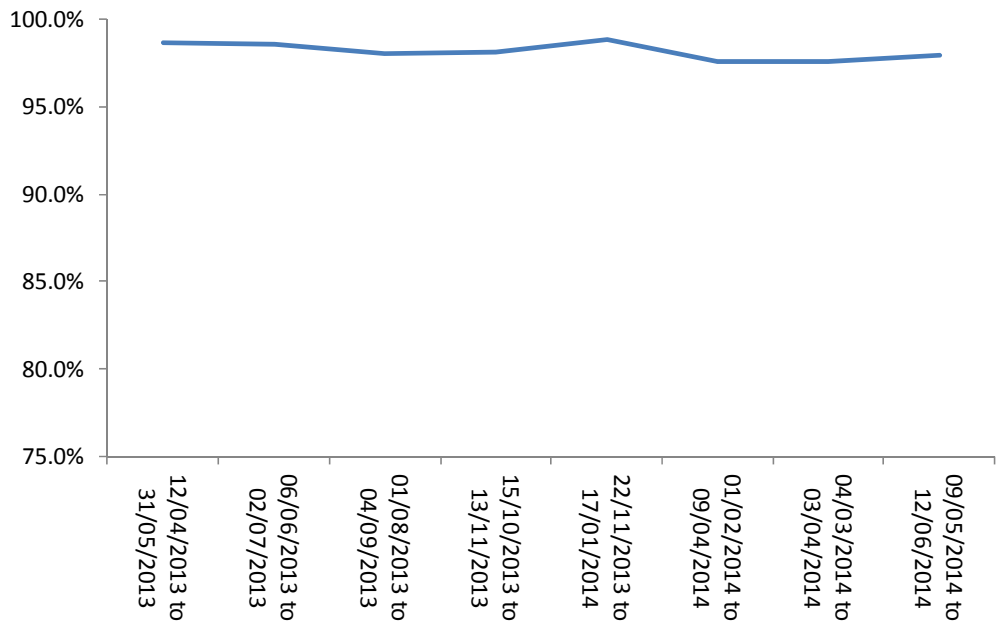
Change

Outcome Metrics

	12/04/2013 to 31/05/2013	06/06/2013 to 02/07/2013	01/08/2013 to 04/09/2013	15/10/2013 to 13/11/2013	22/11/2013 to 17/01/2014	01/02/2014 to 09/04/2014	04/03/2014 to 03/04/2014	09/05/2014 to 12/06/2014
Trust Percentage	98.6%	98.5%	98.0%	98.13%	98.8%	97.5%	97.6%	97.9%

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 and the results have been favourable so far. A marked increase in positive feedback via the Friends and Family Test has been noted for cleanliness.

Maternal Deaths

Deliver

Outcome Metrics

Zero maternal deaths reported across the Trust

Any death of a woman which occurs during or within one year of pregnancy, childbirth, miscarriage or termination, from any cause related to or aggravated by the pregnancy or its management

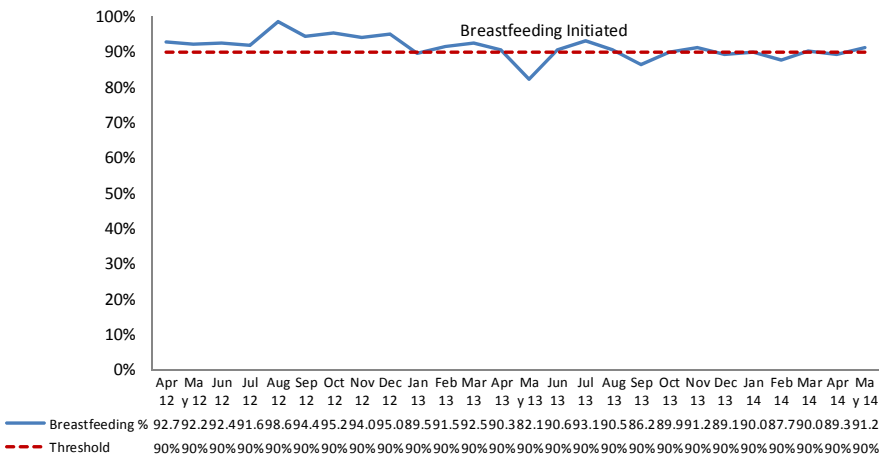
Breastfeeding and Smoking

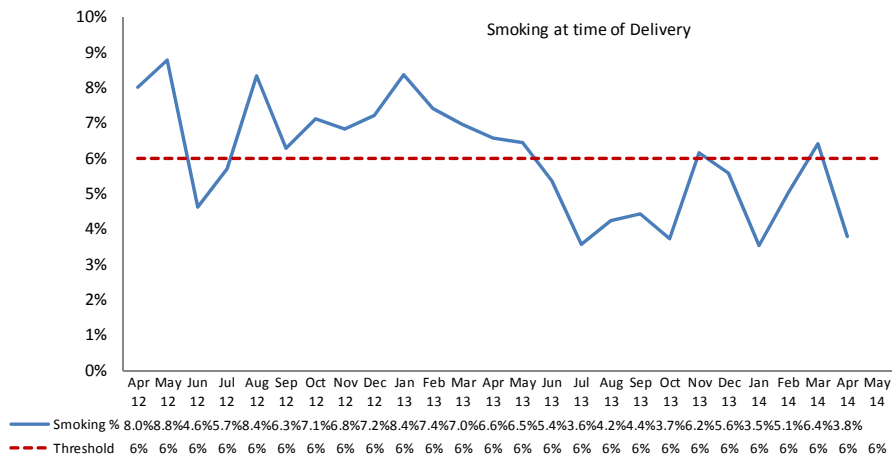
Improving

Outcome Metrics

	Threshold	Mar 14	Apr 14	May 14
Breastfeeding Initiated	90%	90.0%	89.3%	91.2%
Smoking at Delivery	<6%	6.4%	3.8%	5.4%

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.





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

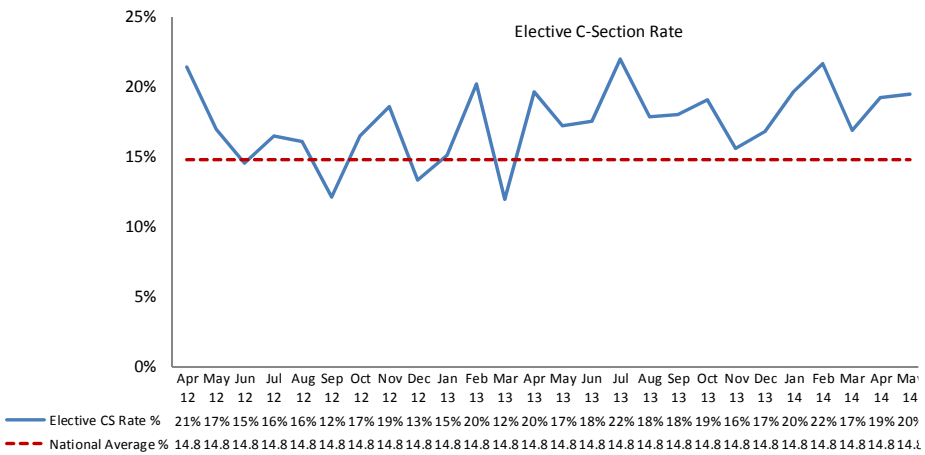
Caesarean Section Rates

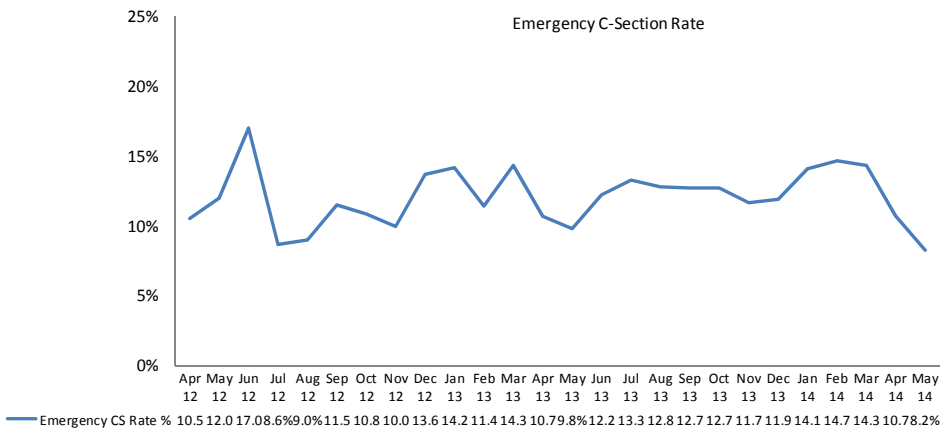
Deliver

Outcome Metrics

	National Average	Mar 14	Apr 14	May 14
Elective C-Section Rate	14.8%	16.9%	19.3%	19.5%
Emergency C-Section Rate	-	14.3%	10.7%	8.2%
All Deliveries	-	301	280	328

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





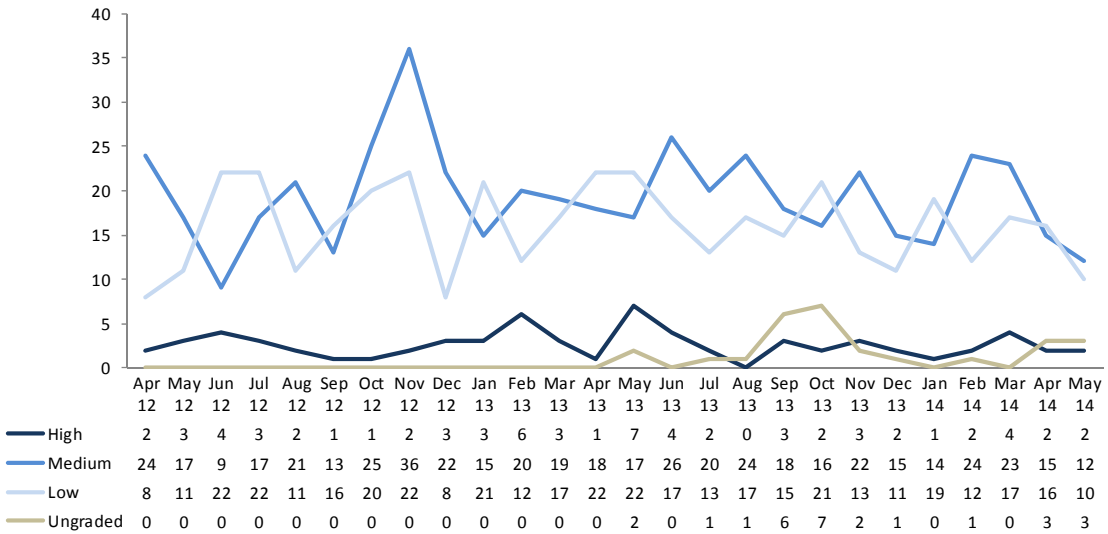
The emergency caesarean section rate saw a further reduction in May to 8.2%, down from 10.7% in April and 14.3% in March. The elective caesarean section rate continues to be above the national average. Multiple workstreams are in place to help reduce rates including improved education for women.

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	Apr 14	May 14
Risk	High	1	7	4	2	0	3	2	3	2	1	2	4	2	2
	Medium	18	17	26	20	24	18	16	22	15	14	22	23	15	12
	Low	22	22	17	13	17	15	21	13	11	19	9	17	16	10
	Ungraded	0	2	0	1	1	6	7	2	1	4	6	0	3	3
	Total	41	48	47	36	42	42	46	40	29	38	39	44	36	27



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 number of medication errors reported in May was lower than at any other point in the last year, which is an improvement. The two high risk incidents were reported in Integrated Care and Acute Medicine (ICAM) and relate to a patient who was not given morphine sulphate when they should have been, and a patient was discharged home with a controlled drug for use in the community, the control drug stock chart did not reflect the ampoule size.

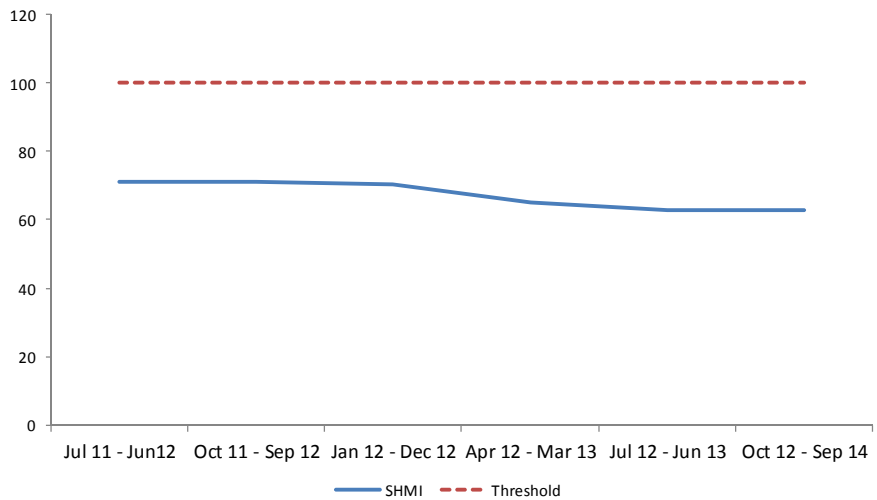
SHMI

Change

Outcome Metrics

	Threshold	Jul 11 - Jun12	Oct 11 - Sep 12	Jan 12 - Dec 12	Apr 12 - Mar 13	Jul 12 - Jun 13	Oct 12 - Sep 13
SHMI	100	71.08	71.28	70.31	65.00	63.00	63.00

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



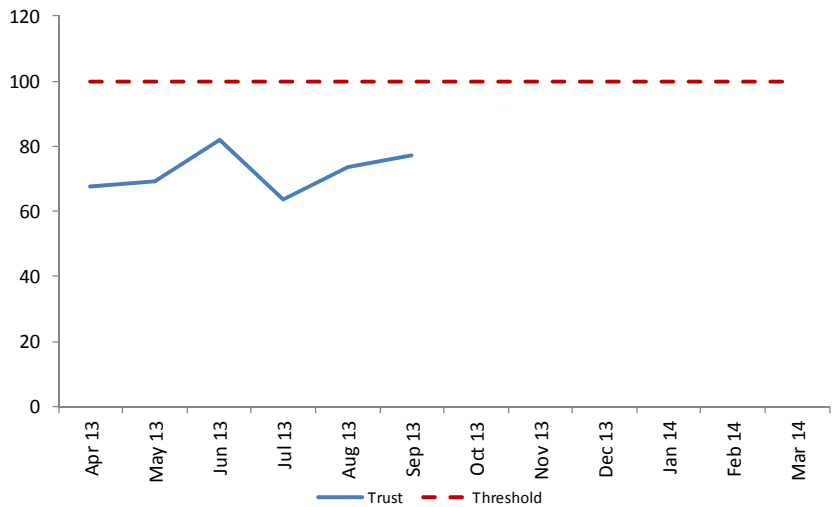
No further update on Summary Hospital-level Mortality Indicator (SHMI) data, however, we continue to achieve an excellent SHMI score.

HSMR

Change

Outcome Metrics

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



Hospital Standardised 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 Electronic Patient Record (EPR) reporting issues.
Data is derived from secondary user service (SUS) submissions (activity data) which are expected to resume at the end of May 2014, and will take approximately three months to feed through to Hospital Standardised Mortality Ratio (HSMR) reporting.

Number of Inpatient Deaths

Outcome Metrics

	Deaths			Percentage of Admissions		
	Mar 14	Apr 14	May 14	Mar 14	Apr 14	May 14
Trust Total	17	33	22	0.4%	0.7%	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

	Mar 14	Apr 14	May 14
Inpatient Coverage	39.4%	34.5%	46.0%
Emergency Department Coverage	17.9%	12.5%	
Total Coverage (IP/ED)	21.6%	16.0%	
Inpatient Net Promoter Score	65	65	59
Emergency Department Net Promoter Score	53	56	
Total Net Promoter Score (IP/ED)	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

Most data for the Friends and Family Test (FFT) had not been signed off at time of reporting. Inpatient coverage has increased compared to March and April and the net promoter score for inpatients has remained high.

Mixed Sex Accommodation

Integrate

Quality Indicators

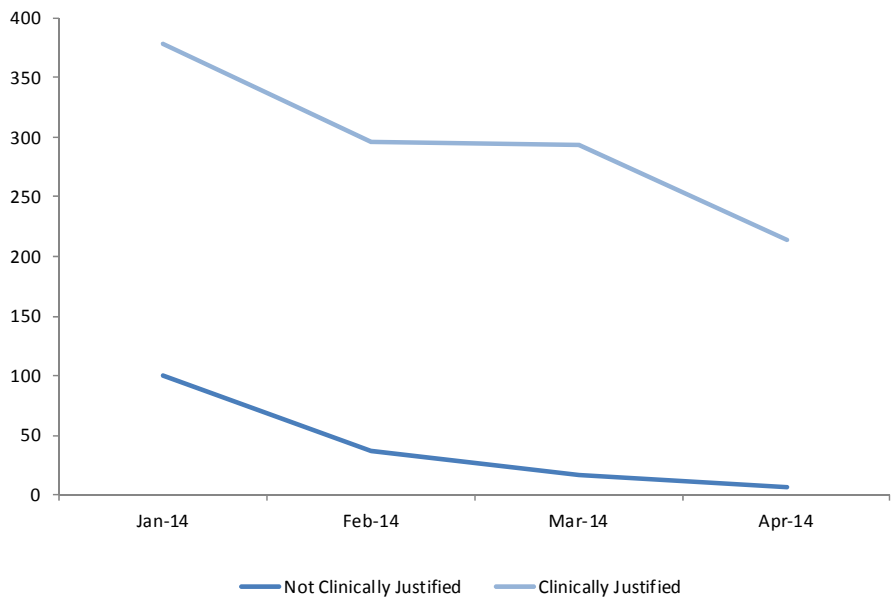
Not Clinically justified occurence

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

Clinically justified occurence

	Jan-14	Feb-14	Mar-14	Apr-14	May-14
ICAM	111	39	35	22	24
Cavell Rehabilitation Ward	0	0	0	0	0
Edward Drive	0	0	0	0	0
ISIS Ward	0	0	0	0	0
Mary Seacole South	111	39	0	0	0
Mercers	0	0	0	0	0
Meyrick Ward	0	0	0	0	0
Bridges Ward	0	0	0	0	0
Montuschi Ward	0	0	35	22	24
SCD	267	257	259	192	224
Coyle Ward	0	0	0	0	0
Intensive Care Unit	267	257	259	192	224
Thorogood Ward	0	0	0	0	0
Victoria Ward	0	0	0	0	0
Grand Total	378	296	294	214	248

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



Non-clinically justified breaches of mixed sex accommodation continue to reduce, in May there were seven recorded.

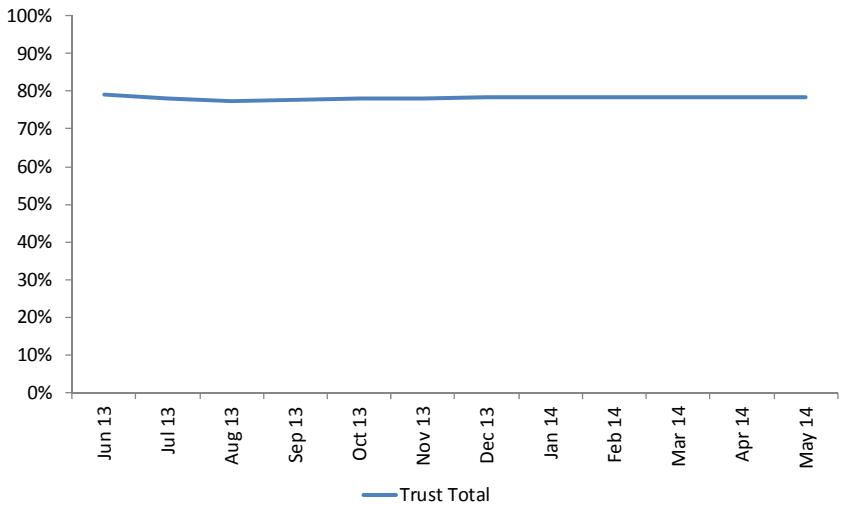
Percentage of Registered Nurses

Change

Quality Indicators

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

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



A review of the nursing staffing levels has been completed and recruitment to the increased staffing ratios is underway.

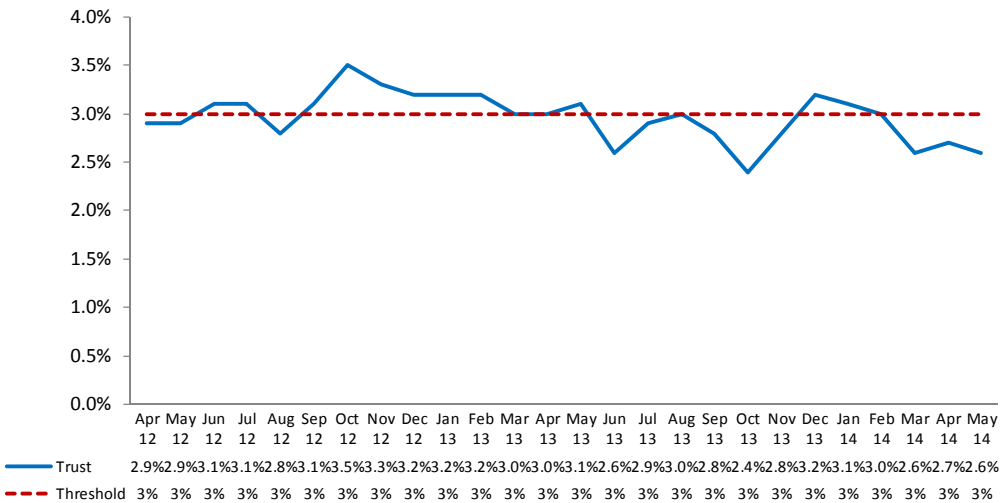
Sickness Rate

Change

Quality Indicators

	Sickness				High Bradford Scores		
	Local Threshold	Mar 14	Apr 14	May 14	Mar 14	Apr 14	May 14
Trust Total	<3%	2.6%	2.7%	2.6%	596	595	597

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, dropping below the threshold for the third month running. The workforce statistics have been reported to the Trust Operational Board on a monthly basis enabling senior managers to work with their departmental managers to address high sickness rates. Further, the recent Trust wide guidance to managers and staff has enabled a better understanding of the procedure and management of sickness.

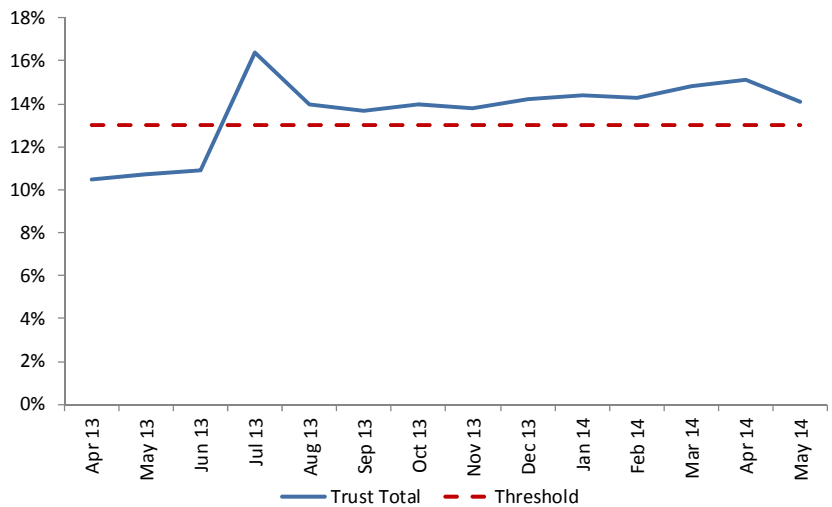
Staff Turnover

Change

Quality Indicators

	Local Threshold	Mar 14	Apr 14	May 14
Trust Total	<13%	14.8%	15.1%	14.1%

Proportion of workforce leaving in a given period.



This month's staff turnover rate shows a reduction from April but remains 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.

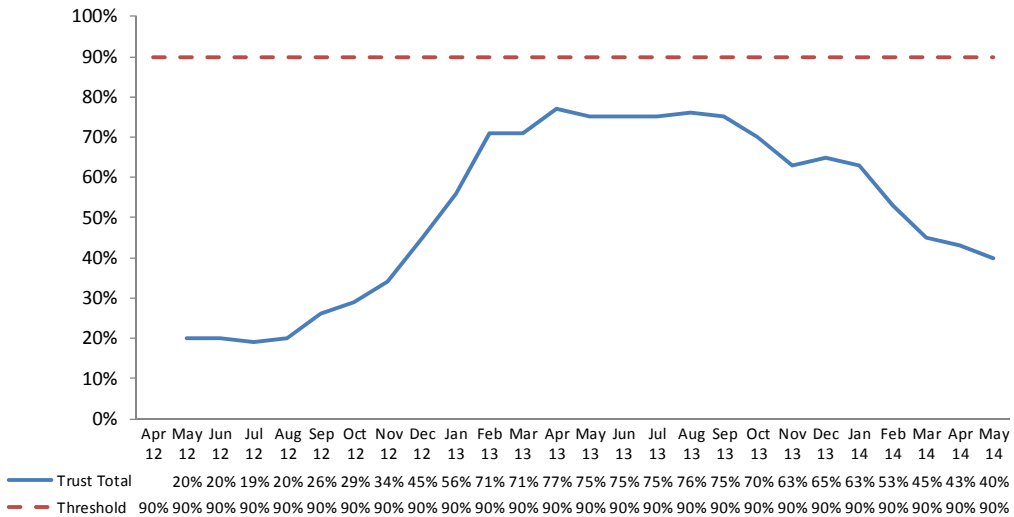
Staff Appraisal

Change

Quality Indicators

	Local Threshold	Mar 14	Apr 14	May 14
Trust Total	90%	45.0%	43.0%	40.0%

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



Appraisal compliance has shown a decrease in compliance by another 3%, at 40%.
Divisional meetings have been arranged with the COO to look at the data compliance issues and action plans. Divisional HR leads have been requested to produce action plans to rapidly improve the appraisal reporting.
Current appraisal training has also been increased.

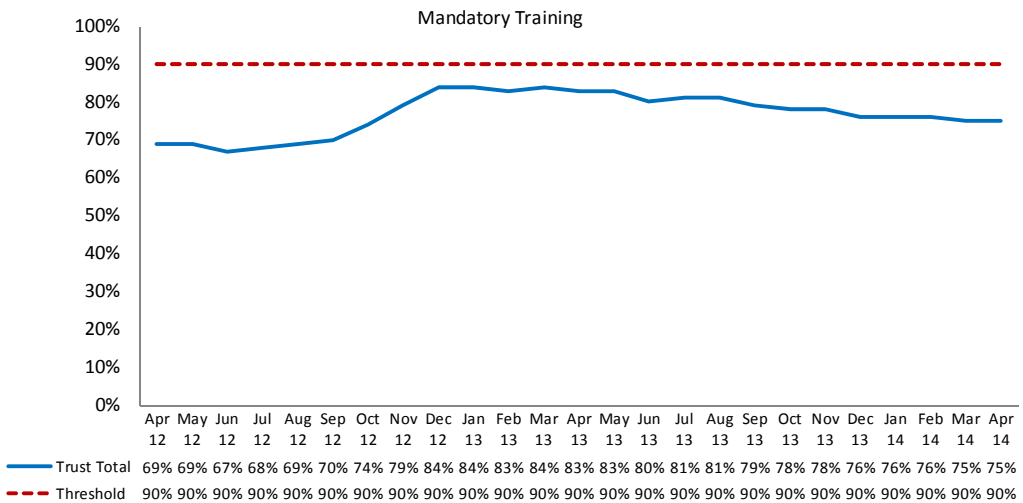
The new appraisal framework's guidance, templates and 'coaching conversation' training is being attended by all managers to ensure an improved appraisal approach and compliance going forward. June's compliance rate will show a swift increase due to this new improved approach being adopted across the Trust

Mandatory Training Compliance

Change

Focus Areas

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



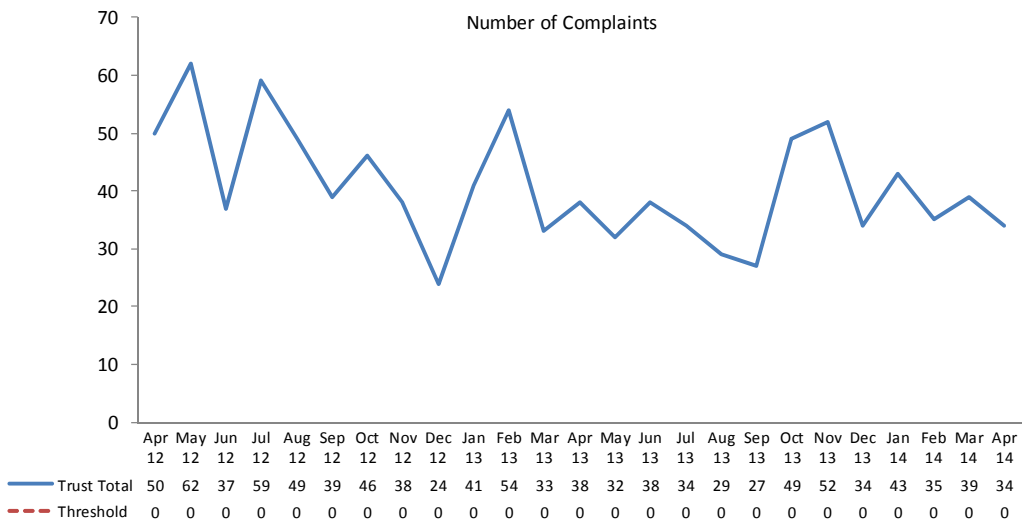
Data snapshot date 30/04/2014

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

The compliance rate for May has shown an increase by 2%, at 77%. This has been assisted by Child Protection L3 training not requiring renewal for 3 years. Operational & corporate divisions have received presentations at their DMT meetings to ensure performance management of lower performing departments.
The Organisational Development Action Plan for MT has a number of actions to assist in improving compliance rates, including a full review of all MT courses. It is to be noted that the Trust is still in the top 10% of London Trusts for completion of E-Learning mandatory training.

Complaints

	Complaints				Responded to in 25 days		
	Threshold	Mar 14	Apr 14	May 14	Mar 14	Apr 14	May 14
Trust Total	0	39	33	30	62%	64%	



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 slightly increased in April to 64% within 25 days compared to 62% in March, and the overall number of complaints received in May has continued to reduce from the beginning of the year. An action plan is in place to manage complaints for each division.

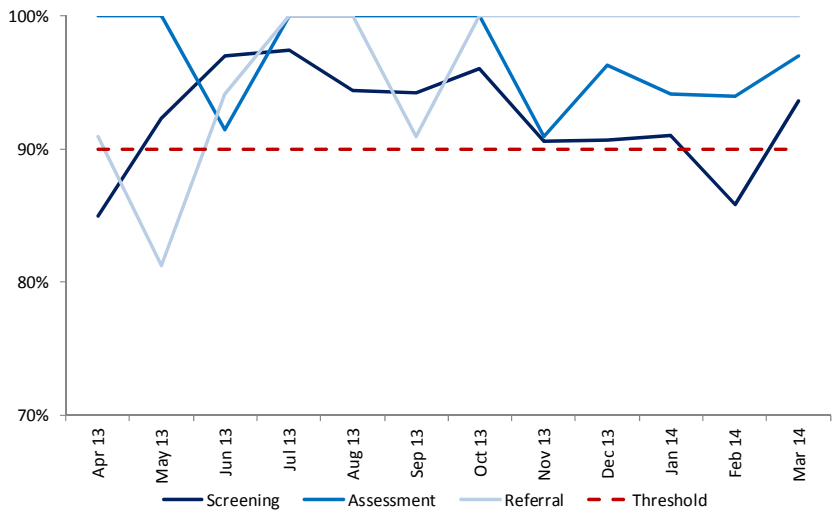
National CQUINs

Integrate

Quality Indicators

Dementia

	Contractual Threshold	Feb 14	Mar 14	Apr 14
Screening	90%	86%	94%	95%
Assessment	90%	94%	97%	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 continues to improve in April with all elements of the dementia Commissioning for Quality and Innovation (CQUIN) achieving the threshold. Improvements have been delivered by increased clinician time educating and chasing staff to remember to both 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: 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 delivered 83% for March and 91% for Q4 against a year end target of 62%. Total Parenteral Nutrition (TPN) data is not yet available for the end of year position although previous performance has achieved the target. Child and Adolescent Mental Health Service (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	Apr	May
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%	93.1%	
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%	95.8%	
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	Apr	May
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%	33.8%	36.3%
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%	99.1%	98.3%
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%	76.8%	82.6%
Crime Reduction Partnerships	Report by public health of anonymised dataset on alcohol related																		
Audit	Plan for audit submitted and agreed Q1																		

Smoking status has achieved above the target of 90% in the first month of the year (93.1%), and inpatient advice continues to stay above target.
Alcohol screening saw an increase in both April and May, however, it is still well below target at 33.8% and 36.3% respectively. An action plan has been developed and is being lead by the Clinical Lead for Emergency Care. Brief intervention has achieved target in the first two months of the year and GP Communication at 82.6% in May remains below 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 – Multi-Disciplinary Team (MDT) actions for Islington have improved although year end data is not currently available.

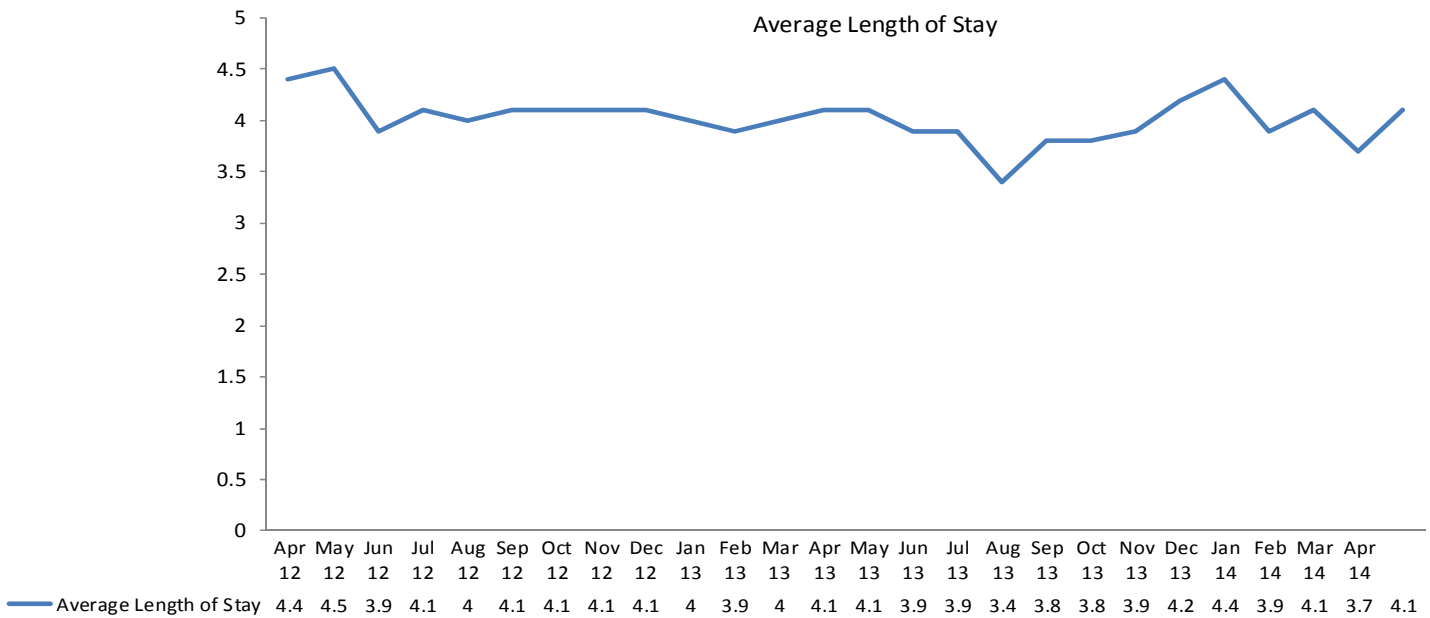
Average Length of Stay (days)

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	May 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	4.1
Longest LOS (Days) (Trust)	N/A										113	74	162	163	164

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



May saw an increase in length of stay back to the 4.1 days reported in March. The longest length of stay across the Trust was 164 days. As reported last month, the Patient Flow Lead Nurse was due to commence permanently in May, which is expected to deliver an improvement, However, a delay of one month has occurred due to sickness.

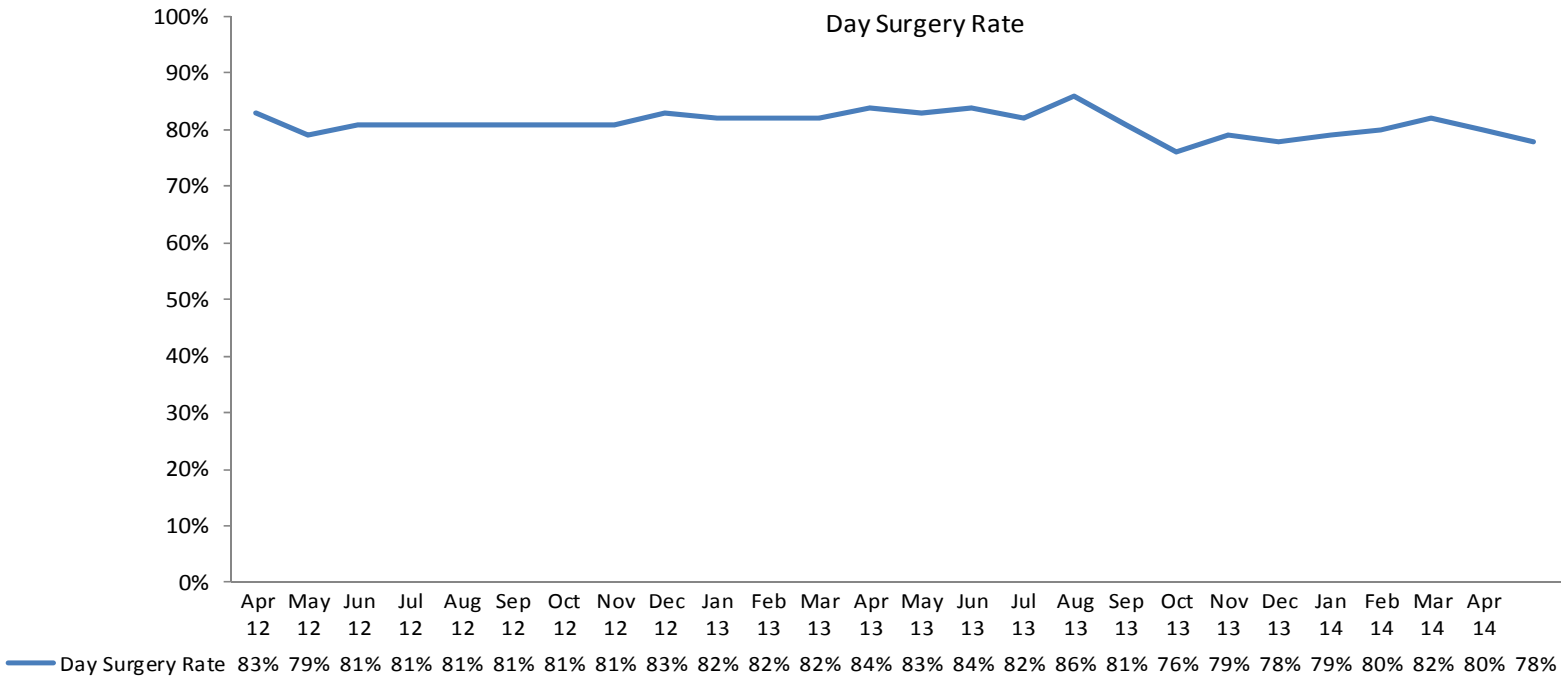
Day Surgery Rate

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

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 is being derived from submitting our Commissioning Data Set (CDS) which enables commissioners to see our contracted activity. This will restart at the end of May 2014.