Whittington Health NHS

ITEM: 12
Doc 08

Trust Board Meeting

DATE: 23 May 2012

TITLE: Performance Dashboard

SPONSOR: Maria da Silva	**REPORT FROM:** Directors of Operations

PURPOSE OF REPORT:
This reports aims to inform the Board on Trust Performance for the month of March 2012 – National, SLA and Local Access Targets

EXECUTIVE SUMMARY:

Areas of performance where we have made significant progress

- Un-outcomed contacts within District Nursing Services have reduced to less that 0.5%
- DNA rates in adult community services have moved from red to amber
- ALOS reduction in Women, Children & Families Division
- Cancer and 18 week performance (incomplete and admitted continues to be above target level)
- Consultant to consultant referral rates achieving SLA indicator target
- Surgical Length of stay reduce from 4.2 to 3.5 including significant Length of Stay reduction in first three months of fractured neck of femur pathway from average 21 to 14 days

Areas of performance where we have concerns

- Waiting times for routine appointments for MSK / physiotherapy out-patients – action plan agreed with commissioners to bring waiting times for routine appointments in line with target (6-8 weeks) by June 2012. Lead: Beverleigh Senior, Service Manager
- Waiting times in out patient clinics – Steering Group across divisions in place overseeing an action plan to improve patient experience in Out-patient clinics including the achievement of this local targets. Trust Board deep dive into out-patients in July.
  Leads: Matthew Boazman, Director Operations and Jennie Williams, AD Patient Experience
- ED Total time for admitted patients - During March the Trust continued to experience several episodes of intense bed pressures which have impacted upon total time for admitted patients again this month despite a small improvement. Mental health escalation protocol due for

implementation in May 2012. In-patient bed reconfiguration workshop on the 16 May 2012 will enable WH to agree a firm plan on further bed closures. It is anticipated that this target will remain red within the next 3 months whilst the planned changes to the bed base (Cavell Ward closure and development of a dedicated T&O unit) settle.
Leads: Richard Jennings, Divisional Director and Carol Gillen, Director Operations

- Outpatient first to follow-up ratio Women, Children & Families Division – action plan in place to bring these within target
  Lead: Michelle Johnson/Sally Riley
- Community data outcomes not recorded - working with 2e2 to improve remote connectivity.
  Lead: Hester de Graag/2e2/IT Team
- Readmission rates for surgical patients (particularly the target of zero elective readmissions) – action plan in place. However, achieving this target is very challenging for WH due to the complex elective case mix at the Trust- including major colorectal and bariatric surgery, which has an associated complication factor and potential readmission risk
- DNA rates have improved to amber RAG rating but still above target KPI rate on local indicators- lean project being done with Unipart regarding the streamlining of administrative processes. OP steering group work program as stated above.
  Lead: Matthew Boazman, Director of Operations

PROPOSED ACTION: For discussion

APPENDICES: Performance Dashboard

DECLARATION
In completing this report, I confirm that the implications associated with the proposed action shown above have been considered – any exceptions are reported in the Supporting Information:

Implications for the NHS Constitution, CQC registration
Financial, regulatory and legal implications of proposed action
Risk management, Annual Plan/IBP
Moving Ahead – how does this report support any of the Trust's 5 Strategic Goals

PERFORMANCE DASHBOARD

MARCH 2012

Whittington Health NHS

Domain (target)	Trust Summary		IC & Acute Medicine		Surgery & Diagnostics		Women, Children & Families	
National Targets	Mar-12	YTD	Mar-12	YTD	Mar-12	YTD	Mar-12	YTD
Urgent Care: Total Time in ED (95th % Wait < 240 mins)	239 min ↑	239 min	239 min	239 min				
Urgent Care: Total Time in ED - Admitted (95th % Wait < 240 mins)	327 min	350 min	327 min	350 min				
Urgent Care: Total Time in ED - Non-Admitted (95th % Wait < 240 mins)	235 min	236 min	235 min	236 min				
Urgent Care: Wait for Assessment (95th % Wait < 15 mins)	10 min	8 min	10 min	8 min				
Urgent Care: Wait for Treatment (Median < 60 mins)	85 min	80 min	85 min	80 min				
Urgent Care: Left Without Being Seen Rate (<5%)	5.0%	4.3%	5.0%	4.3%				
Urgent Care: Re-attendance Rate (>1% and <5%)	3.2%	1.5%	3.2%	1.5%				
18 Weeks: Admitted (95th % Wait < 23 weeks)	19.67 wk	20.87 wk	22.25 wk	24.03 wk	20.33 wk	20.54 wk	15.48 wk	17.54 wk
18 Weeks: Non-Admitted (95th % Wait < 18.3 weeks)	14.15 wk	14.5 wk	13.28 wk	13.45 wk	15.57 wk	16.0 wk	12.85 wk	12.53 wk
18 Weeks: Incomplete Pathways (95th % Wait < 28 weeks)	19.65 wk	23.17 wk	22.16 wk	19.51 wk	16.53 wk	25.09 wk	13.38 wk	25.98 wk
Diagnostic Wait: % Seen within 6 weeks (>99%)	99.9%	99.6%	100%	98.9%	100%	99.7%	98.6%	99.7%
Cancer: 14 days from urgent GP/breast referral (93%) (Feb)	95.5%	95.5%	87.5%	92.2%	96.9%	96.1%	95.3%	95.1%
Cancer: 31 days from decision to treat to treatment (96%) (Feb)	100%	99.5%	100%	100%	100%	99.3%	100%	100%
Cancer: 62 days from referral/upgrade to treatment (86%) (Feb)	92.5%	87.8%	100.0%	94.8%	91.4%	88.4%	100.0%	59.3%
Cancelled Operations (<0.8% of elective admissions)	0.1%	0.3%	0.0%	0.1%	0.2%	0.3%	0.0%	0.6%
Single-Sex Accommodation (0 mixed sex breaches)	0	9	0	9	0	0	0	0
Delayed Transfers of Care (<3.5% of beddays)	1.9%	1.7%						
Diagnostics: Cervical Cytology Turnaround Times (98% within 14 days)	100%	99%			100%	99%		
Maternity Bookings within 12 weeks 6 days (90%)	87.8%	89.4%					87.8%	89.4%
Maternity: 1:1 care in established labour (100%) (Jan 2012)	100%	100%					100%	100%
Maternity: Smoking in pregnancy at delivery (<17%)	8.2%	8.0%					8.2%	8.0%
Maternity: Breastfeeding at birth (90%)	90.9%	89.4%					90.9%	89.4%
Health Visits: Prevalance of breastfeeding at 6-8wks (74%) (Q4)	78%	75%					78%	75%
Health Visits: New Birth Visits (Islington, 95% within 14 days)	50.8%	70.1%					50.8%	70.1%
Health Visits: New Birth Visits (Haringey, 95% within 28 days)	92.5%						92.5%	
Child Health: Immunisations - Islington (80%) (Q3)	87.1%	84.9%					87.1%	84.9%
Child Health: Immunisations (Haringey) (80%) (Q3)	81.7%						81.7%	
GUM: Patients offered appointment within 2 days (100%)	100%	100%					100%	100%
IAPT: Number entering psychological therapies (Q3)	921	3032	921	3032				
IAPT: Number moving off sick pay & benefits (Q3)	25	150	25	150				
Monitor Community Services Governance Indicators: Referrals	9340	108473	6591	78658			2749	29815
Monitor Community Services Governance Indicators: Contacts	55211	591503	37238	416133			17973	175370

Above standard | near miss/at risk | below standard | not applicable

Arrows indicate an improvement/deterioration in performance determined by a change in RAG rating compared with the previous month (Trust level)

PERFORMANCE DASHBOARD

MARCH 2012

Whittington Health NHS

Domain (target)	Trust Summary		IC & Acute Medicine		Surgery & Diagnostics		Women, Children & Families	
SLA Indicators	Mar-12	YTD	Mar-12	YTD	Mar-12	YTD	Mar-12	YTD
Outpatient Follow-Up Ratio (Median) - % excess follow-ups (<1%)	13%		25%		4%		17%	
Consultant to Consultant Activity (Median) - % excess firsts (<1%)	<1%		2.5%		<1%		0%	
Emergency Readmissions - from original elective admission (0 allowed)	15	174	5	49	5	99	5	26
Emergency Readmissions - from original emergency admission (25% reduction from 2010/11)	115	1107	82	816	17	196	16	95
Excess Beddays (against SLA plan)								
Local Targets								
Formal Complaints Response Times - % responded on time (85%) (Feb 2012 data)	67%		71%		73%		57%	
Consultant 7 Day Ward Rounds	N	N	N	N	N	N	N	N
Acute Medicine: Consultant presence 8am-8pm every day	N	N	N	N				
Surgery: Consultants with no elective work on call 7 days	N	N			N	N		
Discharge Before 11am (50% by Apr 12)	25.6%	22.6%	26.4%	24.3%	24.4%	19.7%	31.2%	22.8%
Average Length of Stay (1 day reduction by March 2013)	6.6	6.3	8.9	7.8	3.5	4.2		
Theatre Session Utilisation (95%)	79.1%	76.1%			79.1%	76.1%		
Outpatient DNA Rate - Acute (8%)	13.5%	14.4%	14.1%	14.9%	14.4%	15.0%	11.0%	11.8%
Outpatient DNA Rate - Community Adult Services (8%)	9.1%	9.1%	9.1%	9.1%				
Outpatient DNA Rate - Community Children's Services (8%)	12.5%	14.3%					12.5%	14.3%
Outpatient Clinics: % waiting less than 15 minutes (98%)	68.0%	65.7%	57.5%	60.9%	57.5%	57.6%	83.2%	76.4%
Outpatient Follow-Up Ratio (Upper Quartile) - % excess follow-ups (<1%)	29%		43%		18%		39%	
Consultant to Consultant Activity (Upper Quartile) - % excess firsts (<1%)	1.7%		4.1%		1.3%		<1%	
Community Average Waiting Times: Children (18 weeks)	13.4 wk	12.5 wk					13.4 wk	12.5 wk
Community Average Waiting Times: Adults (6 weeks)	5.3 wk	5.1wk	5.3 wk	5.1wk				
Drugs & Alcohol Service: 3 weeks waiting time (100%) (Q3)	100%	100%	100%	100%				
Drugs & Alcohol Service: % effective treatment (85%) (Q3)	84%	85%	84%	85%				
Drugs & Alcohol Service: planned discharges (85%) (Q3)	80%	84%	80%	84%				
Data Quality: NHS Number Completeness - Acute (YTD only to Jan 12)		97.2%						
Data Quality: NHS Number Completeness - Community	99.9%	99.9%						
Data Quality: Outcomes Not Recorded - Acute (<0.5%)	0.4%		0.2%		0.2%		0.4%	
Data Quality: Outcomes Not Recorded - Community (<0.5%)	3.0%		1.5%				6.7%	

Above standard | near miss/at risk | below standard | not applicable

Arrows indicate an improvement/deterioration in performance determined by a change in RAG rating compared with the previous month (Trust level)

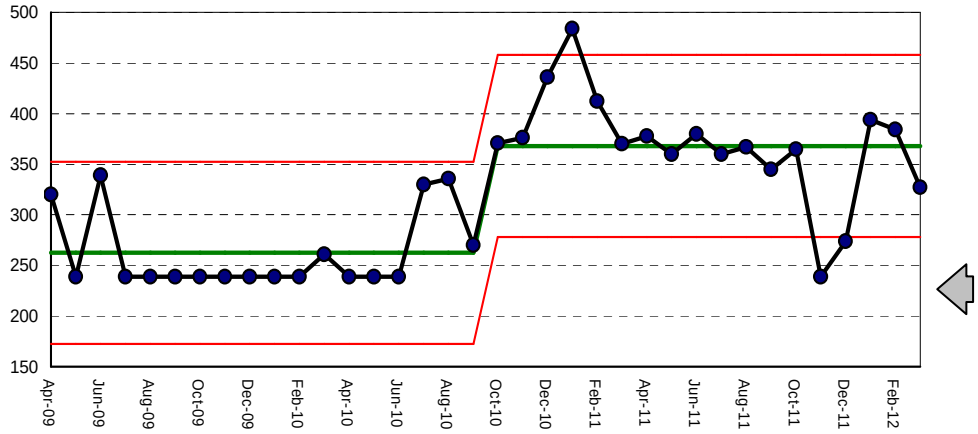
Whittington Health NHS

PERFORMANCE DASHBOARD
March 2012

ICAM Feedback

Indicator: Total Time in ED for admitted patients	**This Month**	
	Last Month	

Target: 95th percentile to be less than 240 minutes



Commentary & Action plan

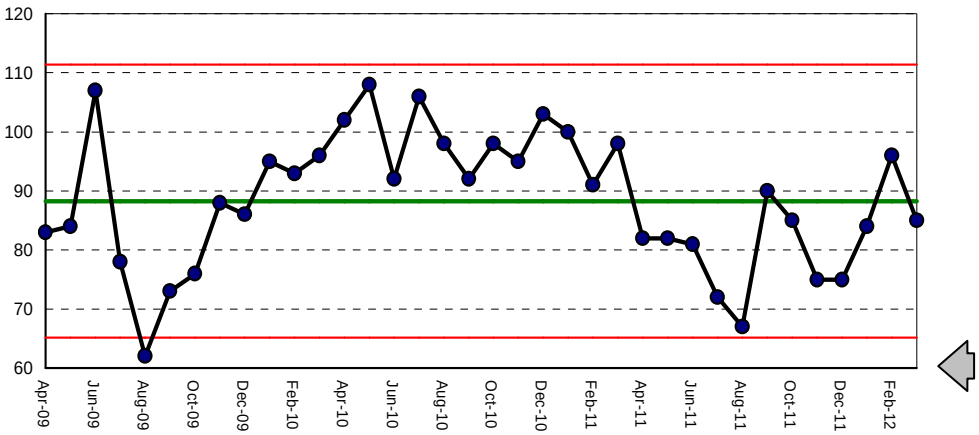
Bed capacity pressures impact on this target
The main causes for remaining breaches are due to Mental Health key reason is repatriating patients to their borough of residence.
Meeting held in Dec 11 with C&I MHFT who will now provide a response on breaches as part of the breach analysis.
Discussions taking place with Planning and Performance Team to renegotiate the Camden and Islington Foundation Trust SLA. The 12/13 SLA will include explicit targets that reflect Quality indicators.

Update on Progress:

During March the Trust continued to experience several episodes of intense bed pressures which have impacted upon total time for admitted patients again this month despite a small improvement.
Mental health escalation protocol due for implementation in May 2012 – PM leading on this.
Bed modelling workshop planned for May 2012.
It is not anticipated that this target will not be green rated within the next 3 months.
The planned changes to the bed base (Cavell Ward and development of a dedicated T&O unit) will take time to settle.

Indicator: Urgent Care – Wait for Treatment	This Month	
	Last Month	

Target: Median wait to be less than 60 minutes



Commentary & Action plan

- Development of "pit stop" assessment of major patients to speed up diagnosis and clinical decision – commenced Nov 11
- Establish a dedicated team who would in busy periods be solely responsible for the initial assessment and treatment of LAS patients when they arrive in ED (bid submitted to NCL as part of NHS London ED Performance bids
- Escalation plan in place and ratified at EC
- In process of developing inter-professional standards for the ED clarifying expectations for joint working between ED and speciality teams

Update on Progress March 2012:

- Changes now made to the IT system to capture nurse initiated treatment staff being instructed on this change and we expect to see impact over next few months (by May expect to hit 70 mins) - PM leading on this
- Agreement on sixth ED Consultant post will increase availability of senior decision makers

Indicator: Cancer Two Week Wait	This Month	
	Last Month	

Target: 93%

February 2012 Breaches: 1 Haematology, 3 Upper GI, 1 Lung

Commentary & Action plan

Trust target is 93% and the reason for breaches is down to patient choice booking outside the 14 day target. Trust is achieving overall 93% and as there is few cancer pathways in ICAM that other areas then the denominator is small therefore only 1 or two patients choosing appointments outside the target can skew the figures for out division.

Indicator: Follow-Up Ratio (Median & Upper Quartile) **This Month** **Last Month**

Target: to achieve median benchmark by March 2012 and upper quartile by March 2013

Exclusions: Respiratory Medicine and Gastroenterology

	Follow-Up Ratio			
Specialty	**Median**	**Upper Quartile**	**Mar 12**	**Q4**
Cardiology	1.43	0.92	2.06	2.12
Diabetic Medicine	5.96	3.48	10.76	12.92
Endocrinology	2.96	2.46	3.09	2.98
General Medicine	2.66	1.52	3.86	5.49
Geriatric Medicine	2.16	1.37	2.81	3.49
Haematology (Clinical)	6.46	4.84	7.76	8.27
Nephrology	5.82	3.92	3.14	4.03
Neurology	1.20	0.89	0.78	0.88
Pain Relief	1.82	1.42	2.03	1.98
Rheumatology	3.75	3.18	4.95	4.44

Commentary & Action plan

Cardiology
Cardiac Rehabilitation and Nurse Led Clinics are being moved and therefore should see an improvement in December report

Diabetes
A date is being set for a table top exercise. To include clinical lead, specialist nurse, within January.

Elderly Care
Incorrect procedure codes- including tissue viability sessions at Dorothy Warren Day Hospital. Action : data clean

Acute Medicine
JLM activity to be removed as agreed at ICAM board.

Update on Progress:
In the shadow report, it demonstrates that when we move all nurse led clinics from Cardiology and Diabetes to community intermediate care services as is clinically appropriate, then both of these specialities will have achieved Median range. As previously reported because of contractual negotiation it was advised that this activity should remain on PAS until end of financial year and in discussion with the planning team it is anticipated that this activity should be transferred to RIO by April.

General Medicine continues to be an major issue for the division as it includes James Malone Lee's activity and the performance of this speciality falls within the surgical division. This speciality needs to be divided in two for performance purposes.

Elderly Care are still seeing problems with data which has eventually been resolved and relates to outcomes for procedure codes but also the booking of ward discharges as follow ups rather than new patients into the services. This has now been addressed but will only be reflected in April activity. Further reduction to follow up slots will also help this service achieve better follow up within median working towards upper quartile target.

Rheumatology activity has seen an increase in follow up activity for the February/May which appears to be as a result of a number of issues, mainly due to a change in practice for methotrexate management which is not reflective on PAS and needs to be outcomed as a procedure code. This has now been addressed.

Pain continues to be an outlier for Q4 having achieved its median originally in M4. This is due to capacity management of displaced patients as a result of long term sickness

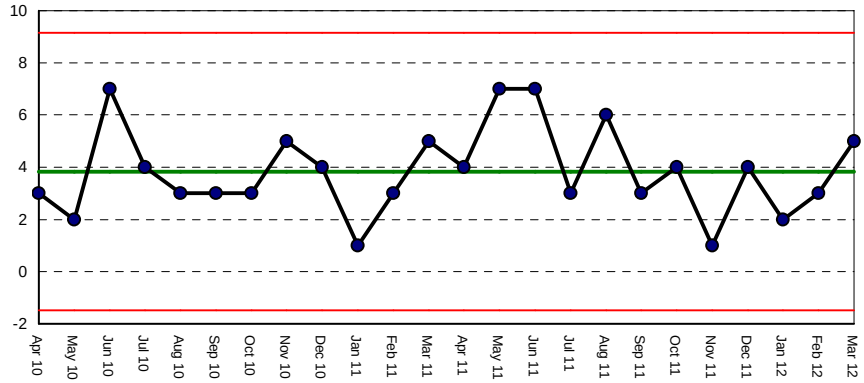
Haematology has been showing as an outlier however activity charts and analysis from the data shows the clinical haematology is in fact achieving its target.

Indicator: Emergency Readmissions	This Month	
	Last Month	

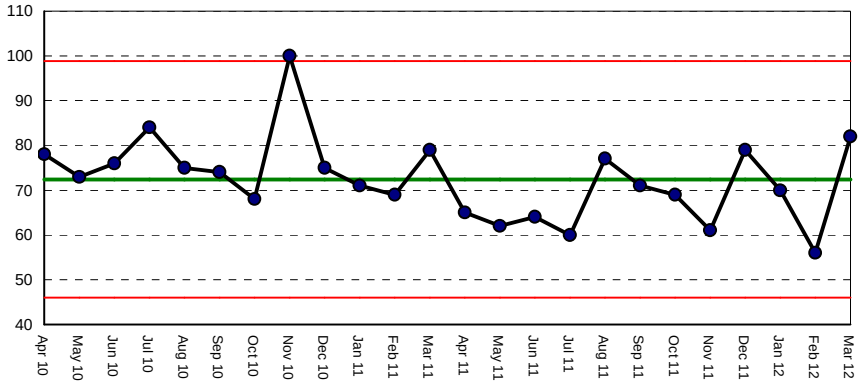
Target:
Following emergency admission: to achieve a 25% reduction on 2010/11 levels
Following elective admission: 0

Readmissions have been adjusted as per PbR guidance. Only readmissions relating to the same HRG chapter as the original admission are shown.

Following original elective admission:



Following original emergency admission:



Commentary & Action plan

The flagging system for patients arriving in ED has been changed alerting clinical staff to potential readmission.

Links to 30 day readmissions to ambulatory care service.

Looking into referring patients to shop floor c. Plan is for ED consultants on shop floor to see patients who present as readmissions.
Meeting set up with CM to firm up plans on how patients when flagged are seen by Consultant (ambulatory care)

Update on Progress:
Will expect some seasonal variation each month
Community Matrons attending post MAU ward round to ensure optimal community support for those at risk of readmission
Targeting top 10 clinical conditions that are readmitted to develop a set of patient information leaflets that will give information and advice for patients on discharge (PM and clinical teams) due to launch in July.
Planning audit of 100 set of records for re admitted patients to better understand causes of re admission (PM) this will inform future target setting and income. Pilot completed main audit due to take place in May.

Indicator: Consultant 7 day ward rounds	**This Month**	
	Last Month	

Commentary & Action plan
Action plan completed and expected delivery of model to be implemented by August 2012. See action plan attached. Recruitment for locum posts has begun for all divisions to fill gaps in the interim whilst substantive recruitment is undertaken.

Indicator: Consultant presence 8-8 every day	**This Month**	
	Last Month	

Commentary & Action plan
As above.

Update on Progress:

Business case was presented to EC on 14 March and approved. We are now currently drafting proposed timetables and job plans for the new appointments and intend to recruit to two of the posts as locums as quickly as possible for six months to ensure that we have cover arrangements in place whilst the substantive recruitment, which takes longer, are put in place. ED consultant will be recruited to substantively within the next few weeks.

Indicator: Discharge before 11am	This Month	
	Last Month	

Target: 50% by April 2012

CAVELL WARD	51%
MEYRICK WARD	40%
MERCERS	31%
CLOUDESLEY WARD	30%
MONTUSCHI WARD	27%
MARY SEACOLE SOUTH	24%
MARY SEACOLE WARD	17%
NIGHTINGALE	10%

Commentary & Action plan

At the end of the week to 1.4.2012 two wards had exceeded the target, Mercers (54.5%) and Meyrick (69.2%). Meyrick has very actively engaged in the daily discharge board rounds, and weekly point prevalence.

Nightingale had 0% discharges before 11am (w/e 1.4.12), but achieved 85% discharged before the EDD.

Advice from ENIST is to make the target achievable and it is recommended that, as this is no longer a CQUIN, the target is set at 40% which would allow for enough beds to be identified in the morning for patient flow to be maintained but would be more achievable.

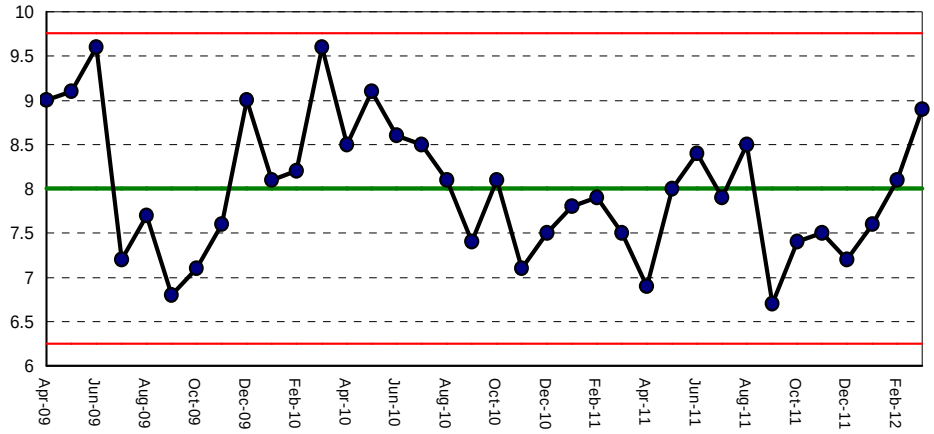
It is also recommended that the two Mary Seacole medical assessment wards be removed from the target report, as the pattern of work is different, and it might be entirely appropriate for people to be discharged later in the day once their assessment and treatment is completed.

Making the amendments to the target (which is no longer a CQUIN, but which is important for maintaining available beds and reducing waits for admission) would make it more possible to achieve. 40% matches what other high performing trusts are achieving.

DT leading on this target.

Indicator: Average Length of Stay reduction	This Month	
	Last Month	

Target: 1 day by March 2013



Commentary & Action plan

Reducing LOS multifactorial and will involve actions as reported last month: -
Setting EDD at point of admission and one that is clinically owned.
Continuing to push for and report discharges before 11am
Targeted work on lengths of stay over 14 days
Proactive targeting of readmissions with rapid progressed discharge.
Daily ward/board rounds and active use of whiteboards

Impact of successful ambulatory care (ICRAS) might be to increase average LOS if avoid very short stay admissions.

Suggest monthly ward based discharge performance reports produced – to include LOS, over 14 day stays, weekend discharges, pre 11 am discharges, EDD set, and reattendance/readmissions of discharges from that ward.

From overall report not clear why LOS has gone up - ? increased number of outliers.

Update on Progress:

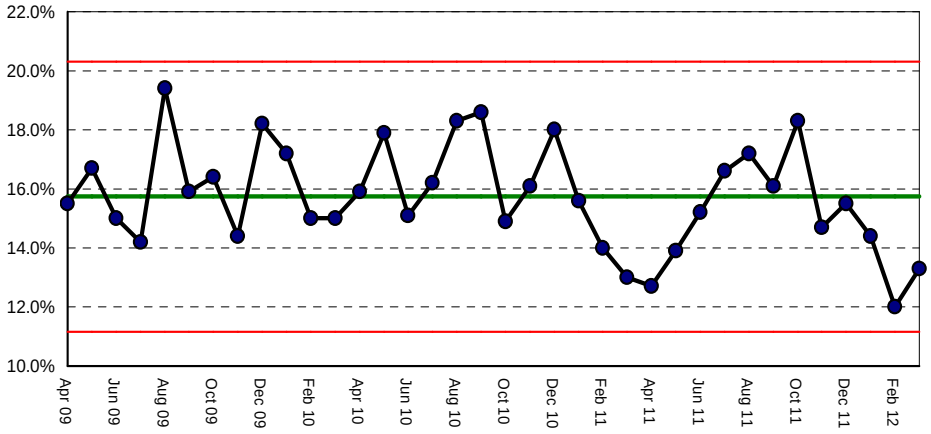
Setting criteria led EDD at point of admission – Dr. Murdoch leading on review of post-take forms to improve this.
Continued focus on pre 11am discharges – as above
Joined up discharge planning with hospital SW to create one complex discharge team (achieved April 2012)
Targeted work on lengths of stay over 14 days – number has reduced (85 to 76 in last two months). Discharge team to check reports monthly to ensure accurate.

Proactive targeting of readmissions with rapid progressed discharge.
Daily ward/board rounds and active use of white boards as part of Discharge Project (DT lead) – pilot of redesigned whiteboard layout and handover sheets on Meyrick and Cloudsley to be reviewed prior to NIST visit 30.5.12.

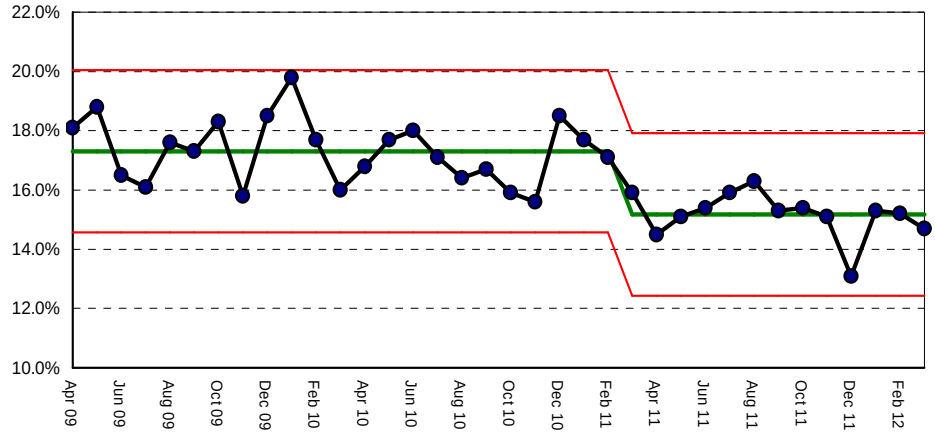
Indicator: DNA Rates – Acute	**This Month**	
	Last Month	

Target: <8%

First Appointments:



Follow-Up Appointments:



Commentary & Action plan

Pan divisional approach

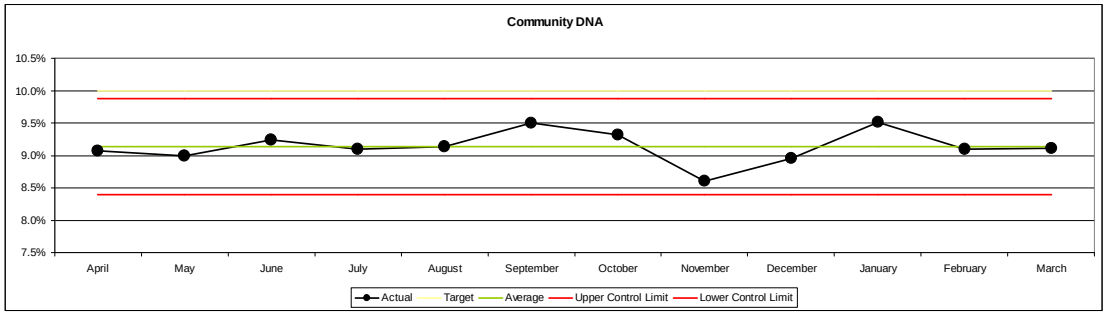
Further discussion on how this can be managed collaboratively - as with other outpatient kpis

Update on Progress:

It is clear that the trajectory is heading in the right direction as current rag rating has improved. This has been as a result of more proactive approach to discharging patients after 1st DNA where appropriate and better slot utilisation within the clinics. However, there is still further work to be done is some of the specialities. The organisation how now set up an operational group across divisions to work collaboratively in order to address the pan-division issues that will address further improvement in this target, such as partial booking for follow ups, full booking for new appointments.

Indicator: DNA Rates – Community	**This Month**	
	Last Month	

Target: <8%



Commentary & Action
N&D haringey -highest DNA were in GP surgeries. Now centralised into health centres and bookings managed centrally (as opposed to booking made by surgery staff)
MSK ,starting opt in pilot and if successful will roll to podiatry.
Respiratory service- working on integrated approach now under single mgt

Update on Progress:

Text messaging is proving successful and is now becoming imbedded within the services. The area that the is skewing the community data is the podiatry service which is currently running circa 14% and it should be noted that nationally the DNA rate for this service is on average 18-23%. However, we are continuing to ensuring that clinicians do not bring patients back inappropriately and therefore reducing the risk of DNAs.
Physio DNA rates are currently running at 17% in Islington and are initiating telephone reminders for all appointments.
In MSK DNA rates appear to have increased as waiting times have increased and

therefore linked. With an improvement plan in place for improving waiting times in MSK we would anticipate a reduction.

Indicator: Waiting times in outpatient clinics	This Month	
	Last Month	

Target: 90% of patients seen within 15 mins (TBC)

Specialty	Atts	% with valid times entered	% seen within 15 mins (apts with valid times)
Nephrology	91	2.2 %	100.0 %
General Medicine	341	16.1 %	92.7 %
Diabetics	437	48.7 %	84.0 %
Thoracic Medicine	624	99.0 %	66.3 %
Pain Relief/Anaesthetic	121	95.9 %	65.5 %
Cardiology	535	91.2 %	65.4 %
Haematology (Clinical)	251	26.3 %	65.2 %
Neurology	182	14.3 %	61.5 %
Elderly Care	164	8.5 %	50.0 %
Rheumatology	577	23.7 %	38.7 %
Gastroenterology	682	86.2 %	30.4 %
	4,005	**58.0** %	**57.5** %

Commentary & Action plan
An action plan will be put into place on how this can be managed corporately.

Update on Progress:

An action plan will be put into place on how this can be managed corporately

Indicator: Drug & Alcohol Service	This Month	
	Last Month	

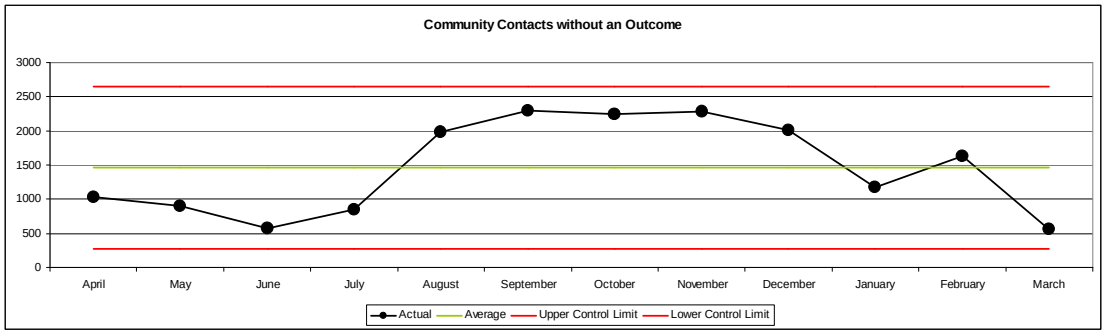
Target: 90% of patients seen within 15 mins (TBC)

Drugs & Alcohol Service: % effective treatment (85%) (Q3)
Drugs & Alcohol Service: planned discharges (85%) (Q3)

Commentary & Action plan
Only reported on each quarter and Q4 data not available (TO)

Indicator: Outcomes Not Recorded (Community)	This Month	
	Last Month	

Target: TBC



Commentary & Action plan

There has been a huge drive on community recorded outcomes with new standards set.

Update on Progress:

Bladder and Bowel outcomes are being monitored through performance review with the practitioners to ensure increased completion rates. Problems with RIO system have meant delays in outcoming in an appropriate time period. This is being monitored and managed by the service managers and we would anticipate a continued improvement in this target.

Significant improvement in District Nursing continues with both Haringey and Islington having less than 0.5% of un outcomed appointments (SH). Anticipate maintaining this level of performance within the service with regular ongoing audit and performance management in place.

Whittington Health NHS

PERFORMANCE DASHBOARD
March 2012

Surgery, Cancer, & Diagnostics Feedback

Indicator: Follow-Up Ratio (Median & Upper Quartile)	This Month	
	Last Month	

Target: to achieve median benchmark by March 2012 and upper quartile by March 2013

Exclusions: Oncology

	Follow-Up Ratio			
Specialty	**Median**	**Upper Quartile**	**Mar 12**	**Q4**
Dermatology	1.89	1.41	1.92	1.82
Ent	1.23	1.08	0.95	0.99
General Surgery	1.63	1.12	1.47	1.56
Ophthalmology	2.61	1.96	2.97	3.15
Plastic Surgery	1.36	1.05	0.40	0.48
Trauma & Orthopaedics	1.68	1.55	1.78	1.88
Urology	2.09	1.74	1.75	1.78

Commentary & Action plan

Ophthalmology and Trauma and Orthopaedics continue to be the main areas of focus for the division with regards to this metric. Ophthalmology and orthopaedic clinics to be reviewed in conjunction with Performance and Planning as both include support staff run clinics (orthotics, optometrist).

In addition to reviewing the information and coding a clinical notes review will be undertaken by consultants in each of the service with aim of discharging patients with non-essential follow-up ratios.

Update on Progress

Work still ongoing with ophthalmology and orthopaedic teams as part of the notes review and service configuration- this is being led by the General Manager for Surgery in conjunction with the Service Manager and the Clinical Lead for orthopaedics- to be completed May 2012. Decreases continue to be seen in month with a reduction in these specialty follow-up ratios in March compared to Q4.

Following on from the notes audit the clinical team are working on the development of specific clinical profiles linked to the target follow-up ratio in order to standardise pathway follow-up and imaging.

Additional work in orthopaedics is also taking place to centralise the Image Exchange Portal (IEP) pulling and clinic preparation and to alongside this enable linked appointments for all modalities of imaging (including MRI) to try and optimise one stop initial appointments and reduce unnecessary follow review- completion May 2012

The Divisional Team are awaiting the current list of included /excluded clinics linked to the agreed contract measures from the finance team in order to review and ensure correct exclusions/inclusions within the data- this is particularly relevant as some acute (low follow up ratio activity) is now being delivered in the community but excluded from the above measures- which is adversely impacting on acute delivered activity despite it being the same specialty.

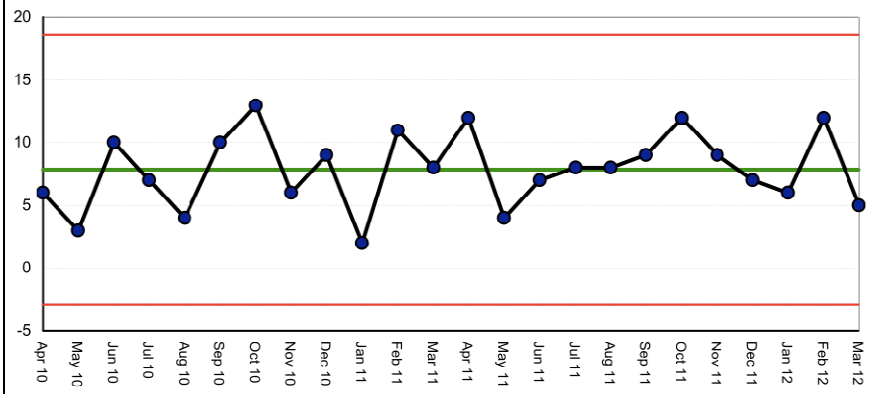
All other specialities in division have met median performance and a number of specialities are at the upper quartile target.

Indicator: Emergency Readmissions	This Month	
	Last Month	

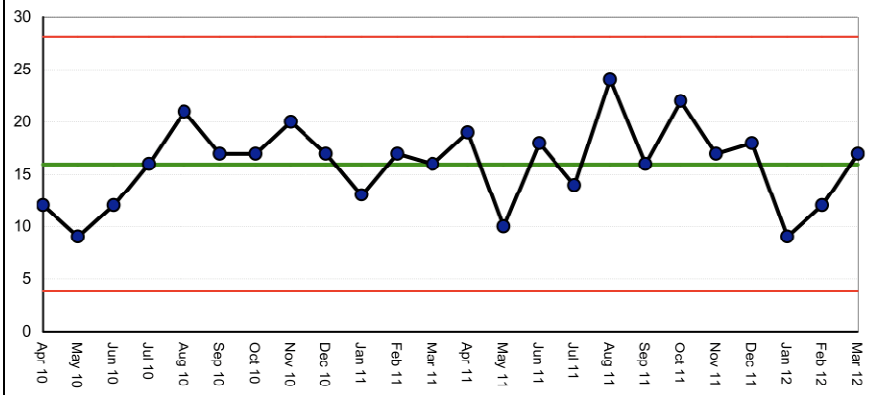
Target: 0 readmissions following elective discharge

Target: to achieve a 25% reduction on 2010/11 levels for readmissions following an emergency admission

Following original elective admission:



Following original emergency admission:



Only readmissions related to the original admission have been included (same HRG chapter). Exclusions as per PbR guidance.

Key updates since the last performance report:

New general surgery consultant rota starts in July 2012, which will ensure 12/7 consultant presence and input enabling more senior decision making both in the discharge and admission process. This has been led and agreed by the General Manager for Surgery and Clinical Director for Surgery.

Protocols have now been developed and are in place for urology conditions to reduce admissions and support ambulatory care model. In addition, a pilot will commence on May 15th which involves a nominated Urology CNS being available in-hours to triage any queries from Urology outpatients. This action was identified following an avoidable admission post op and subsequent complaint. This is supported by a named consultant Urologist. If it is proven to be successful, this will be rolled out to cover out-of hours.

The top ten surgical procedure patient information leaflets are in the process of being reviewed to ensure they are current and readily available for patients. Additional emphasis is being placed on discharge advice and who to contact with any concerns once discharged.

Coyle and Thorogood ward are now ring fenced from May 2012 onwards, linked to the fractured neck of femur project, this will support earlier intervention and compliancy with the fractured neck of femur pathway and will support earlier discharge. Significant progress has already been seen on the project work to date with average length of stay reducing from 21 days to an average 14 days in the first three months of the project. to be ring fenced for orthopaedic patients only from May 2012 to support fractured neck of femur work.

As stated previously the target for zero elective readmissions continues to be extremely challenging given the complex elective case mix at the Trust- including major colorectal and bariatric surgery, which has an associated complication factor and potential readmission risk

Indicator: Consultant 7 day ward rounds

Commentary & Action plan

Business case taken to EC in December 2011. Approval gained for two additional general surgeons to support the split of emergency and elective work in general surgery. This recruitment will enable the general surgery consultant on-call to be free of elective commitments and undertake twice daily ward rounds.

Indicator: Consultants on call with no elective commitment

Commentary & Action plan

See above commentary as links to appointments – additional two general surgery consultant posts are currently out to advert. On-call and elective commitment rota being drafted to be implemented from April to enable twice daily consultant-led 7 day ward rounds.

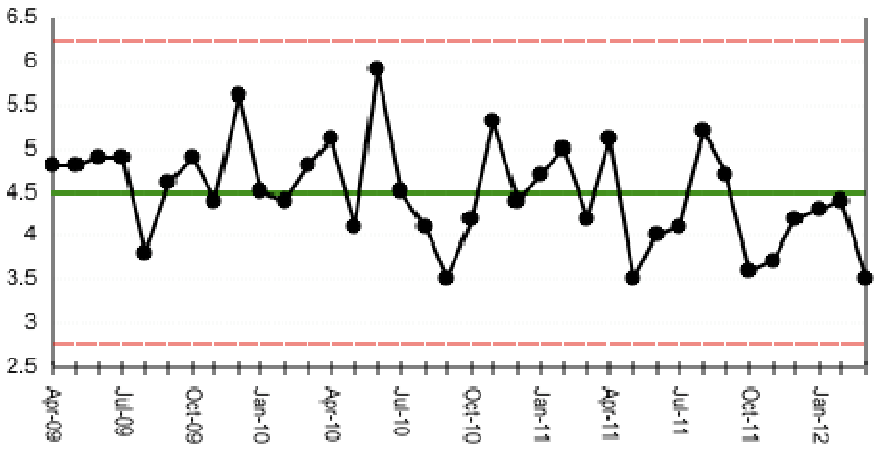
Update on Progress

Two general surgery consultant posts being interviewed on 8 May 2012.

New rota will start in July 2012 enabling split of elective and emergency work for general surgeons to allow consultant 7 day ward rounds and consultant on-call with no elective commitments. 7 Day ward rounds and separated elective commitments will be in place from July 2012

Indicator: Average Length of Stay reduction	**This Month**	
	Last Month	

Target: Reduce by 1 day by March 2013



Commentary & Action plan

Update on Progress:

Several key projects underway across the division to support the reduction in LOS by one day by March 2013:

- Improvement of emergency surgical pathway – supported by the division of elective and emergency work for general surgery consultants.
- Roll-out of enhanced recovery programme to all surgical patients, which has demonstrated a reduction in LOS in colorectal and orthopaedic patients.
- Fractured Neck of Femur project being led by Deputy Director of Operations, with KPI of reduction in LOS to upper quartile.
- Estimated Date of Discharge plan led by Divisional Head of Nursing.

These projects are all underway to contribute to the achievement of reducing LOS for surgical patients by one day by March 2013.

The average LOS for March 2012 is 3.5 days compared to the average LOS year to date of 4.2 days (0.7 day reduction) and the division has maintained length of stay below previous average since October 2011. This will be further supported by the general surgery elective and on-call split.

The Fractured neck of femur programme has made some significant progress in terms of average length of stay since the project commenced. Before the project started the average LOS for Jan-Oct 2011 was 21 days. Between November 2011-Feb 2012 average length of stay reduced to 14 days- overall 7 day reduction and is profiled to reduce further as the next phases of the project are embedded.

Work on-going by the breast team to ensure 24 hour stay for mastectomy patients in line with cancer commissioning metric. Whittington breast service currently has the lowest average length of stay for mastectomy patients in NCL based on latest NCL figures but will be reduced further in line with the increase shift to 24 hour stay work.

Indicator: Discharges before 11am	**This Month**	
	Last Month	

Target: 50% by April 2012

March 2012 Surgical Wards:

BRIDGES WARD	20%
COYLE WARD	19%
THOROGOOD WARD	31%
VICTORIA WARD	25%

Commentary & Action plan

Weekly monitoring of target.

Ward managers and Matrons have identified a list of issues that inhibit the discharge of patients by 11am and include:

- Delay in TTA prescribing by FY1. Generally due to workload.
- Delays from pharmacy supplying TTA
- Patients who require results from investigations before being discharged
- Patients admitted to the ward post op from recovery who make a quicker than expected recovery and are discharged late in the evening. This is also applicable for the elective joint patients
- Patients requiring trial without catheter – i.e. cannot be discharged until they have passed urine post removal of catheter. Patients need to void satisfactorily on a number of occasions and have a bladder scan. These are usually post op patients.
- Patients with high care needs at home requiring discharge after care package is activated. In many cases this can be after 4pm.
- Residential of nursing home request.

Update on Progress:

Focus being maintained on improving figures by Divisional Head of Nursing and Acting Matron for Surgery. This work also links to the Estimated Date of Discharge action plan that has been developed by the Divisional Head of Nursing. This incorporate a number of key elements.

- Setting EDD at point of admission and one that is clinically owned and recorded on Bed Web
- Reviewing TTA process with Pharmacy team and ward managers
- Nurse-led protocol based discharge for weekends.
- Implementing revised transport requisition process to support effective discharge planning
- Ensure patients are informed of pre-11 discharge process at pre-assessment stage for elective patients
- Patient admission information booklets to include information for families and relatives on pre-11 process

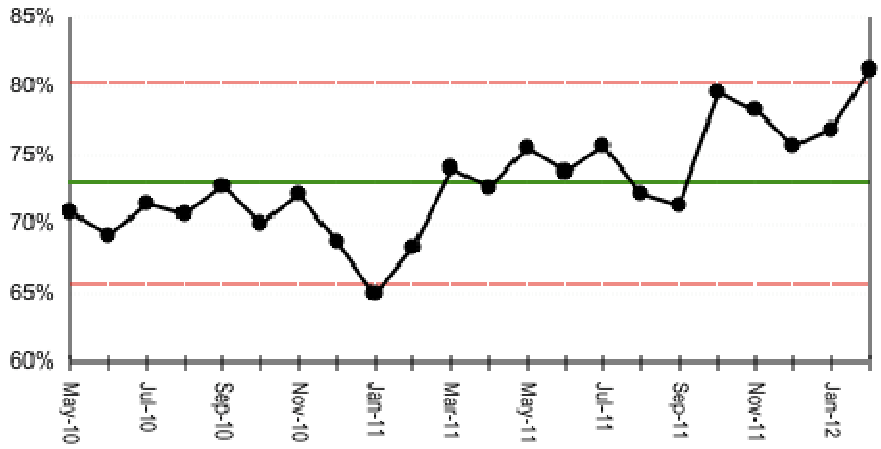
There continues to be a weekly review by the Head of Nursing with the Ward Managers. The detailed list of exceptions is reviewed each week at these meetings. As part of this the ward managers have also undertaken patient reviews of all discharges and an audit of discharges.

During the sample period this identified that approximately 20% of surgical discharges classed as after 11 am were either patients discharge before their Estimate Date of Discharge (the night before) and so had a reduced length of stay or where transferred to another ward. In both cases it was counting as post 11 discharge on the reports as the data is based on an automated PAS report of time of discharge and cannot capture such issues without manual validation.

During April 2012 the pre-11 figures have continued to improve with surgical wards achieving 35% and Victoria Ward showing significant improvement with (unvalidated figures) 60% of patients discharged pre-11 week ending 29 April 2012

Indicator: Theatre Utilisation	**This Month**	
	Last Month	

Target: TBC



Commentary & Action plan

The target for the first phase of the theatre utilisation project is 85% - this includes elective and emergency theatre utilisation. Importantly this is against funded sessional time.

Update on Progress

One inpatient theatre has now been closed since January 2012- supporting obstetric work- with no impact or current reduction in total operating workload carried out per work. The same volume of activity is running through one less inpatient theatre, which is supporting the efficiency programme and links to the CIP scheme on theatre utilisation for 2012/13.

A significant amount of work has been undertaken by the transformation team supporting the theatre programme to validate ORMIS theatre data and ensure accurate data capture of correct theatre utilisation times and down times.

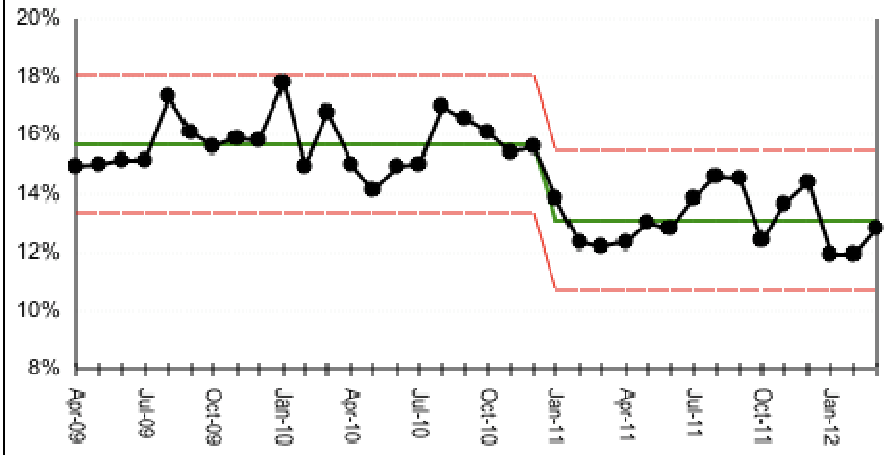
A new theatre timetable has been agreed with the surgical specialties and will be implemented in July 2012, being led by the Clinical Director for Anaesthetics and General Manager for Theatres. This will enable dedicated separate trauma and emergency theatres lists to be provided through reconfiguring the orthopaedic day case list, which will support both quicker times to theatre and improve efficiency of theatre lists in terms of utilised session time. As part of this the anaesthetic rotas are being reconfigured to move named anaesthetic cover from half to full day cover for a number of specialties which will also support additional support theatre productivity. Completion July and go live July 2nd 2012

The urology team are undertaking a pilot in May to consent a cohort of their patients in clinic to support reduced patient choice cancellations on the day through improved consenting and reduce time taken before a patient is ready for theatre on the day of surgery, which will increase the urology theatre utilisation rates. Further work with the Theatre group has also identified that there needs to be a change to the way the Urology service utilise their theatre sessions and the data is being captured. The clinicians attend clinical MDT sessions during the lunchtime period and the theatre day has been amended to a 2 ½ day sessions to reflect this. ORMIS currently monitors their attendance at a meeting as a delay / inactivity as it is rostering it based on 2 session day.

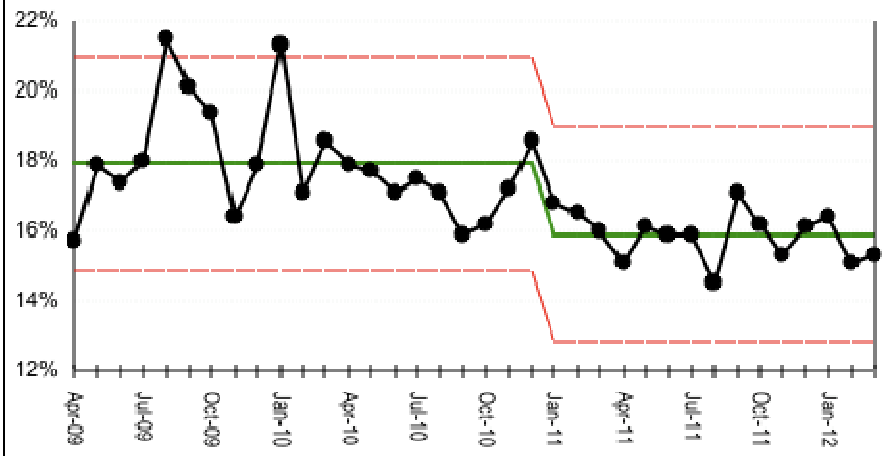
Indicator: DNA Rates – Acute	This Month	
	Last Month	

Target: <8%

First Appointments:



Follow-Up Appointments:



Commentary & Action plan

Roll out of partial bookings is commencing within surgery.

Improvement in the call handling of our hospital booking system also means that patients calling to cancel or change appointments are answered or now able to leave a message.

Update on Progress

Outpatient management team and team leaders are continuing to work directly with clinic staff to ensure that all staff are fully compliant with the current DNA policy. All previous DNA patients that needed rebooking (clinically requested and not suitable for discharge at appt no 1) are being telephone a week in advance to provide to a direct phone reminder of their forthcoming appointments and also informing them of the policy should they DNA for a second time. This is in addition to the Remind + text message system. This is supported by weekly meetings with clinic staff to review DNA patients and monitor compliancy with applying the DNA policy.

Partial booking is now in place in ophthalmology and orthopaedics, with ENT and urology being implemented in May. Patients with a follow-up more than 3 months are now being asked to contact the hospital one month before their appointment to ensure suitable time and date can be arranged. This aims to reduce the number of hospital cancelled appointments due to leave and also reduce the patient DNA rate.

Review of templates to maximise use of Choose and Book system also on-going.

The roll out of the e-communications project, being led by the Director of Operations for WCF, is supporting the patient administration of clinics and will be implementing e-comms for clinic letters when the PAS system upgrade is completed in June 2012.

Indicator: Waiting times in outpatient clinics	**This Month**	
	Last Month	

Target: 90% of patients seen within 15 mins (TBC)

March 2012:

Specialty	Atts	% with valid times entered	% seen within 15 mins (apts with valid times)
Ophthalmology	911	99.8 %	93.9 %
Dermatology	879	45.5 %	77.3 %
Plastic Surgery	21	95.2 %	70.0 %
Trauma & Orthopaedic	2,250	100.0 %	68.0 %
Urology	827	85.6 %	41.0 %
General Surgery	1,320	97.0 %	26.3 %
Ear, Nose & Throat	432	87.7 %	22.2 %
	6,640	**89.5** %	**57.5** %

Commentary & Action plan

Outpatient teams are now working towards ensuring that 100% of patients have valid times seen entered. This will include agreeing methodologies for entering and capturing data across divisions - for example outpatient support is run by the IC&M division for dermatology.

Update on Progress

Overall data capture rates have improved since previous report and waiting times are now being captured for 91% of surgical outpatient appointments during the month. (Dermatology data recording unfortunately remains poor – these clinics are supported administratively by ICAM division and the divisions are currently reviewing their outpatient managements structure in line with the Outpatient Improvement Programme).

Urology, ENT and General surgery remain the three most challenging specialties for waiting times by performance.

The Divisional Clinical and Management team are meeting with UCLH during May 2012 to review the ENT contract and discuss concerns regarding visiting clinician delays and start times with the few of negotiating financial penalties within the contract. The Clinical Director is also meeting with the UCLH Consultant ENT surgeons after their arrival times to clinic sessions were diarised over March 2012 by clinic staff to resolve concerns.

Capacity problems are being flagged and capacity shortfall being reviewed by speciality. Breast clinics have now been extended and are running on three days of the week resulting in extra capacity.

Indicator: Consultant to consultant activity	**This Month**	
	Last Month	

Target: Upper quartile by March 2013

Specialty	Upper Quartile	Mar-12
Dermatology	4%	7%
Ent	12%	12%
General Surgery	14%	18%
Ophthalmology	16%	18%
Trauma & Orthopaedics	42%	15%
Urology	20%	20%

Exclusions: Plastic Surgery

Commentary & Action plan Surgical General Manager and Service Manager have worked with the information department to mandate entry of referrer on PAS system to enable targeting of source of consultant to consultant referrals. Review of PAS data planned to ensure that high rates are not due to incorrect entering of data. Ophthalmology and urology are target areas; consultants have been reminded to reject inappropriate referrals and raise to service manager to ensure that these are prevented. Reduction in consultant to consultant referrals across surgery has reached median and majority of specialities have also reached upper quartile.
Update on Progress Problem with PAS identified and review completed which meant that source of referrer was not being recorded accurately. PAS team alerted and this has now been amended to enable the target referral source to be identified as this is often outside of the clinical specialty where the referral is received. All clinicians reminded of rules of accepting internal referrals. All SCD specialities have met median target for 2011/12 with three specialties already achieving upper quartile performance. Specialties are on trajectory to achieve this March 2013 upper quartile target. SLA target of achievement of median target has been met.

Whittington Health NHS

PERFORMANCE DASHBOARD
February 2012

Women, Children & Families Feedback

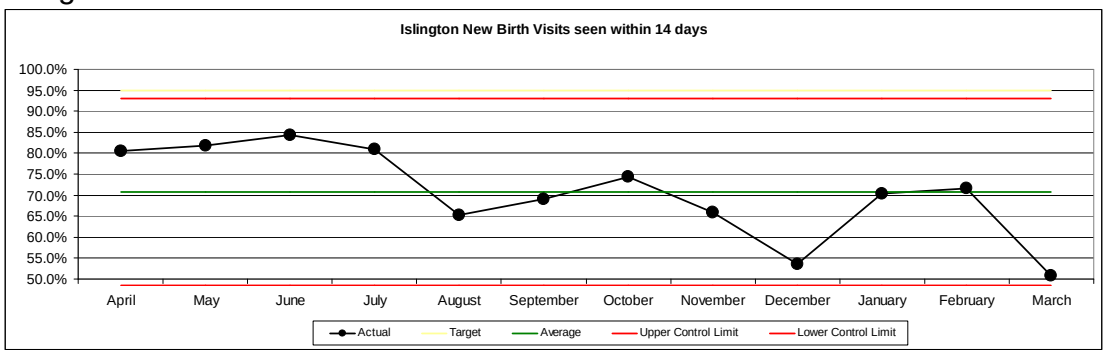
Indicator: Diagnostic Waits	**This Month**	
	Last Month	
2 Audiology breaches (145 total waiters)		
Commentary & Action plan **Target: 100%** **Actual: March 98.6%** **The 2 patients that breached had not been appointed because of the following:** **The PAS template had to be altered with subsequent reduction incapacity due to one member of staff leaving,** **The appointments offered to these patients could not be forward due to capacity issues.** **Action plan:** **We now have the PAS system changed to reflect the staffing levels and patients appointed in to the appropriate clinics** **We also have a locum audiologist in place(3 day cover) as of March 2012 to help prevent breaches and therefore support for the service.** **The audio logy service is undergoing a restructure which is in its final stages, and therefore we aim to advertise the vacant band 5 audiology post very soon.**		

Indicator: Maternity bookings within 12wks 6 days	**This Month**	
	Last Month	
Target: 90% Actual: March 87.8%		
Commentary & Action plan Weekly monitoring in place additional clinics to meet spikes in demand when staffing permits		
Update on Progress Review of patient level data has indicated that target was missed by 1 patient. Increased pressure on service as high number of referrals still coming in to the department. Matron is monitoring on a weekly basis and putting additional slots in place where possible.		

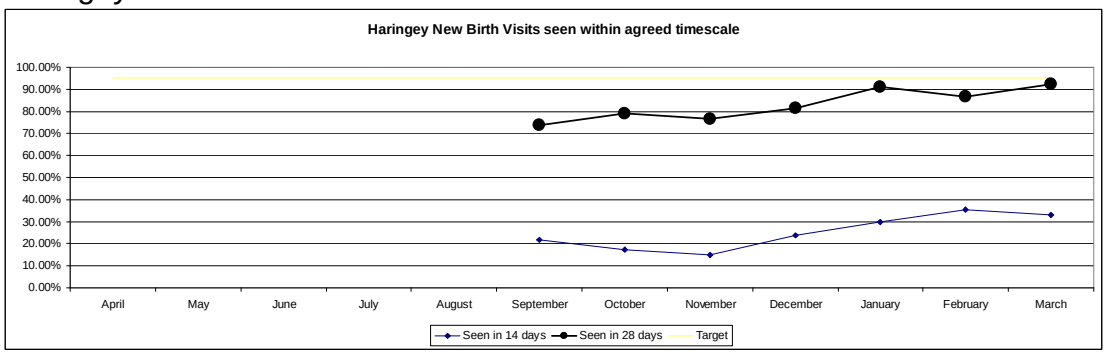
Indicator: New Birth Visits	**This Month**	
	Last Month	

Target: 95% within 14 days (Islington); 95% within 28 days (Haringey)

Islington:



Haringey:



Commentary & Action plan

High levels of Health visitor vacancies across both Haringey and Islington, action plan in place to aid recruitment

Update on Progress

Staffing problems continue as outlined below.

Current vacancies:
Haringey: 4.86 (4 just recruited) against 11/12 budget
Islington: 7.55 against 11/12 budget

Current sickness:
3 wte in Haringey
1 wte in Islington plus 1 phased return

Expansion in 12/13:
Haringey: 5 wte with promise of increase
Islington: 8 wte

Students qualifying in September:
Haringey 3
Islington 4

NBVs can be done at 3 per day.

Shortly Haringey will start to report within 14 days, which will increase the pressure. The issues are being discussed at the Board on the 23rd May 2012.

Indicator: Follow-Up Ratio (Median / Upper Quartile)	This Month	
	Last Month	

Target: to achieve median benchmark by March 2012 and upper quartile by March 2013

Exclusions: Obstetrics

	Follow-Up Ratio			
Specialty	**Median**	**Upper Quartile**	**Mar 12**	**Q4**
Gynaecology	1.17	0.95	1.55	1.62
Paediatrics	1.34	0.93	1.53	1.48

Commentary & Action plan

There is potential for Colposcopy and Fertility figures to be removed from the overall numbers as these are coded as separate specialties in other Trusts, including UCLH. However Colposcopy regular follow up appointments have also been altered to annually instead of 6 monthly to reduce follow ups and increase clinic capacity.

An additional telephone clinic has been set up to support the Women's Diagnostic Unit to prevent women returning for a face to face appointment if their results are normal or can be managed outside of the hospital setting.

Outpatient hysteroscopy has started at Hornsey Central. This clinic runs as a one-stop clinic and therefore reduces patient attendances by up to two appointments. . There are plans to convert the hospital based outpatient hysteroscopy service to the same model.

Neonatal follow up appointments and neurodevelopmental appointments in the new financial year be excluded from the overall figures and measured as a separate specialty.

Some previously hospital based community paediatrician clinics have been moved to the Northern Health Centre to reduce hospital recorded follow up.

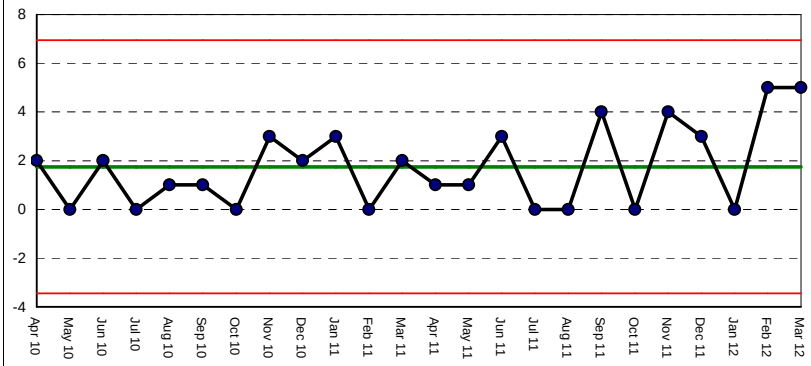
An audit of general paediatric clinic appointments has been undertaken to show appointments/conditions that could have been managed in a different setting eg. Community clinic or GP surgery and feeding this back to the GP's should assist with managing inappropriate referrals.

Update on Progress

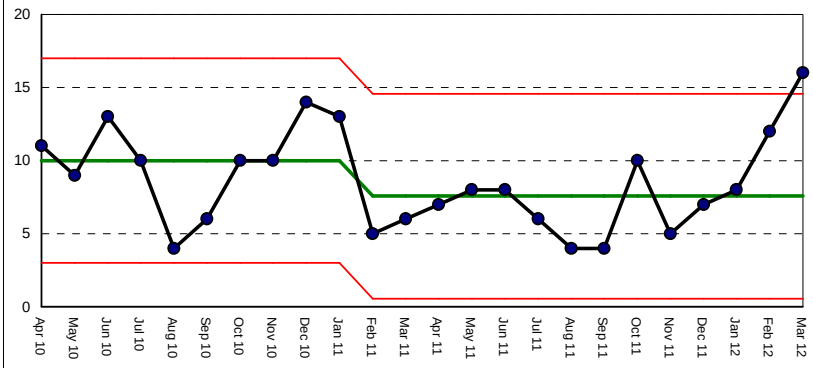
Improved position from last month, albeit a small one. Consultants are continuing to discharge back to GPs in all specialities and reviews of data are happening at patient level.

Indicator: Readmissions	This Month	
	Last Month	

Readmission following original elective admission:



Readmission following original emergency admission:



Commentary & Action plan

Readmission data still needs to be validated as patient level detail is not always available for review. Some readmissions appear to be close to 30 days after the original admission date. Paediatrics is particularly difficult to measure here as differentiation between admission reason cannot be instantly determined from PAS ie. all Paediatric admissions are coded as 'Paediatrics' but admission could be for a different diagnosis.

Indicator: Complaint response times	This Month	
	Last Month	

December 2011: 3 out of 5 responded to on time (60%)

January 2012: 4 out of 5 responded to on time (80%)

February 4 out of 5 responded to on time, late by 1 day (80%)

Awaiting March figures

Commentary & Action plan

Particular area of concern is Maternity complaints, some of which are very complex and therefore take considerable time to complete.

Overall numbers of complaints have been decreasing and therefore performance figures are based on small numbers. The maximum delay in response times is 5 days late.

In addition the complaints team have been under pressure recently and therefore when complaints are given to them close to the deadline it is not always possible for them to be immediately turned around.

Indicator: Consultant 7 day ward rounds	

Commentary & Action plan

Should be amber as consultant ward round rotas are in place for all specialties. Paediatrics, neonatology and labour ward rounds occur every day. Gynaecology and maternity ward rounds currently occur 50-60% of the time. Job plans are being reviewed in line with a change in Labour Ward cover at which point this figure should return to green.

Indicator: Discharges before 11am	**This Month**	
	Last Month	

Target: 50% by April 2012

February 2012: Betty Mansell ward: 31.2% before 11am (37.4% in February)

Commentary & Action plan

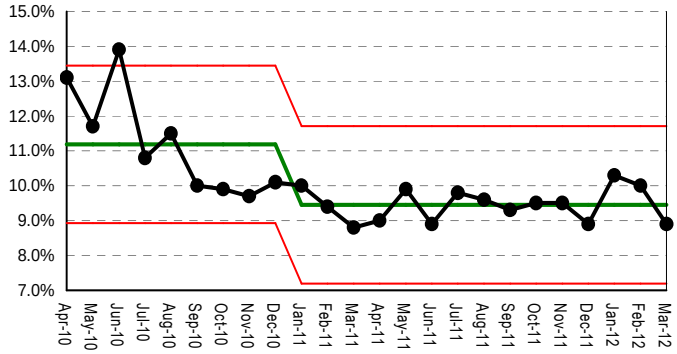
Missing EDD data significantly reduced. Raised profile of this target with Matron and ward manager.

Exclusions not exempt from this report despite valid clinical reason not to be counted, e.g TWOC patients.
Majority of patients on Betty Mansell ward remain Medical not Gynae which increases the difficulty of achieving this target, improvement since last month, however the target does not report patients who where discharge the day before EDD but after 11am.

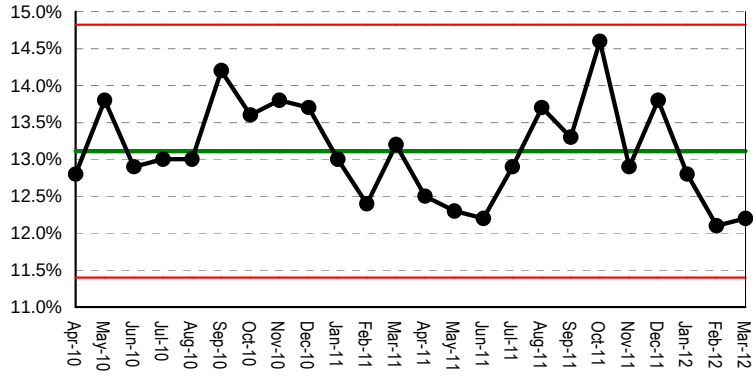
Indicator: DNA Rate – Acute	This Month	
	Last Month	

Target: <8%

First Attendances



Follow-Up Attendances



Commentary & Action plan

Much work has been undertaken within Colposcopy to reduce DNA rates including patients being texted, telephoned and sent reminder letters and this has remained fairly low as a result.

The Trust DNA policy has been adhered to strongly in Gynaecology and this is reflected in their low DNA rate. Maternity and Paediatric have a local policy due to safe guarding issues and therefore those who DNA are offered alternative

appointments.

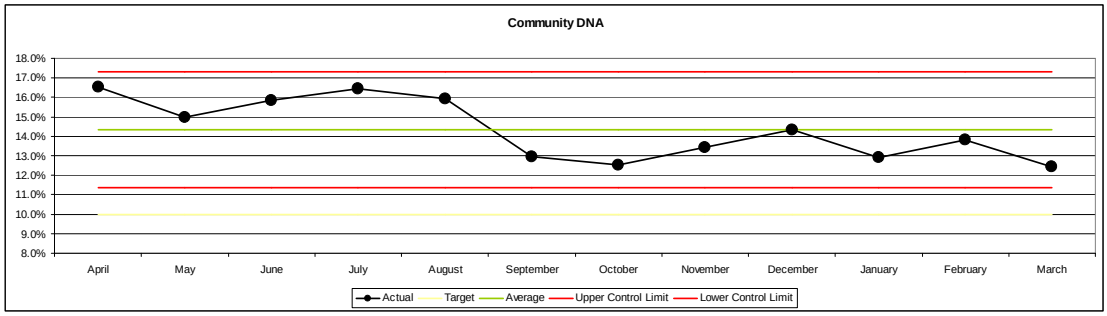
Both Maternity and Paediatric DNAs are reviewed by the relevant clinician and attempts are made to discover why the patient did not turn up and to re-book an appropriate appointment. This information is recorded in the notes.

Open appointments and annual follow ups have been reduced for all specialties, preventing appointments being missed due to patients no longer feeling unwell or forgetting the appointment had been booked.

Update on Progress

As above, there has been a small improvement in performance this month.

Indicator: DNA Rates – Community	**This Month**	
	Last Month	



Commentary & Action plan
DNA rates have significantly reduced in child development services, due to new texting system. In physiotherapy MSK services this still remains high and we are carrying out a telephone survey to look at reasons for this. SLT introducing texting in Nov so hope to see an improvement following this.

Update on Progress

Work continuing but children's services and in particular paediatric services are hard to engage, reviewing systems in audiology and spreading best practice.

Improved figures from last month.

Indicator: Waiting times in outpatient clinics	**This Month**	
	Last Month	

Target: 90% of patients seen within 15 mins (TBC)

Division	Specialty	Atts	% with valid times entered	% seen within 15 mins (apts with valid times)
Women &Children	Maternity Ante-Natal Op	4,151	94.4 %	88.5 %
	Paediatrics	1,198	22.0 %	82.9 %
	Colposcopy	276	100.0 %	82.2 %
	Gynaecology	1,575	80.4 %	67.1 %
Women & Children		**7,200**	**79.5 %**	**83.2 %**

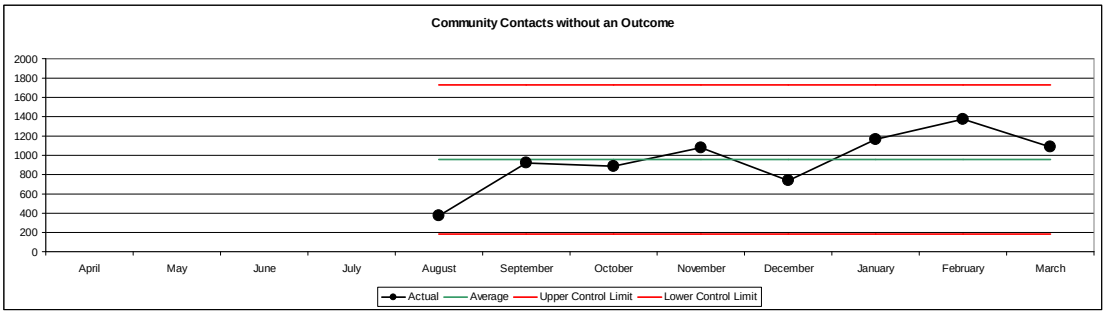
Commentary & Action plan

This target will be monitored at the monthly WCF Performance Meetings

Update on Progress

Continued Medical staff sickness in Obstetrics and Gynae impacting on waiting times
High sickness in junior Paediatric staff
Staff across the division will be reminded to input missing data.

Indicator: Outcomes Not Recorded (Community) **This Month** **Last Month**



Commentary & Action plan

Ongoing issues with connectivity in community and staff vacancies.

Update on Progress

Focussed piece of work to be undertaken to look at specific clinical staff groups and develop action plan.