The North West London Hospitals NHS NHS Trust	Agenda Item	7
Trust Board	Paper	**TB/11/74**
Meeting on: Wednesday 27th April 2011	Board Assurance Framework Reference	**5**

Subject: Safety, Quality and Performance Report

Director Responsible:	**Author:**
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Summary:

The Trust Safety, Quality and Performance Report is made up of indicators reflecting the Annual Health Check new and existing targets and also local efficiency indicators set out by the Trust. The report also now covers a range of quality indicators on safety, effectiveness and the patient experience.

Financial Implications:
N/A

Risk Issues (including legal implications, reference to Assurance Framework and Risk Register):
Rating in the Annual Health Check (National targets component) and not realising the benefit of efficiency savings.

Communication & Consultation Issues (including PPI):
None

Workforce Issues (including training and education implications):
The report contains the monthly Workforce Board Report providing an overview of Trust performance against a number of Workforce related indicators.

How this Policy/Proposal Recognises Equality Legislation:
N/A

Has an Equality Impact Assessment been carried out on this issue or proposal?
N/A

What impact will this have on the wider health economy, patients and the public?
Contained within the report are details of how the Trust is performing against the various performance indicators appropriate to the organisation. Many of these targets are related to the wider Health Economy as well as the Trust.

What is required of the Trust Board?
The Trust Board is asked to note the Performance, Quality and Patient Safety Report

The North West London Hospitals NHS
NHS Trust

SAFETY, QUALITY AND PERFORMANCE REPORT

MARCH 2011

1. ABOUT THIS REPORT

This report is split into five sections, reflecting the integrated approach to performance within the Trust. Performance is detailed against the Care Quality Commission national priorities, core standards and clinical indicators.

1. Corporate Objectives
2. Safety Standards
3. Quality Standards
4. Performance Standards (Efficiency / Productivity)
5. Workforce Standards

Each section provides a table of the key indicators, with detailed commentary within each section on those indicators that have been RAG rated Red, or where there has been a significant change in performance in month. Also included in the commentary is any change in practice or guidance that has been issued in relation to the indicator in month.

When a new indicator is introduced, an explanation of the indicator will be provided on its first month of introduction. Thereafter, a comment will only be provided if the indicator has been RAG rated Red, if there has been a significant change in performance or if there is some additional guidance provided in relation to it.

2. EXECUTIVE SUMMARY

The Trust achieved both the MRSA and Ci-Diff Infection Control Targets for the year. The revised targets for next year have now been issued and show a significantly more challenging target for next year, with further improvements required over and above the 2010-11 out turn.

There has been a shift in the Trust performance against the internally set Hospital Standardised Mortality Ratio (HSMR) of less than 83, with the Trust achieving a year to date performance (for period April to January) of 81.4. The Medical Director continues to lead a piece of work to examine the target in more detail. The Trust has been highlighted as being one of the best performing Trust's in the country in relation to mortality rate, following the recent publication of the Dr Foster Patient Survey. They have confirmed that we are amongst the best 10 Trusts in London and the top 26 in the country.

Year end performance against the cancellations on the day of surgery target is 1% against a target of less than 0.8%. Performance for the month of March was also a further improvement from that of February, with 0.88% being achieved. 36 patients were cancelled on the day of surgery in March, with one Vascular Surgery patient not being readmitted within 28 Days. The year end position of the readmissions within 28 days still remains within tolerance.

Performance against the Four Hour Target has been a significant challenge to the Trust and Health Economy throughout the year, however a year end position of 97% and associated trajectory was agreed between the Trust, the local PCT's, the Commissioning Partnership and NHS London. This was achieved at the year end. A further improvement was seen in performance for the month of March; compared to February and the previous months. Year end performance stands at 97.00% (for Type 1 and 3), with performance for March at 97.99%. Performance against the A&E Department (Type 1) target is 94.33% year to date and 96.14% for March. For the 95% target, which has been in place since quarter 2, Health Economy performance stands at 96.54% and A&E Department (Type 1) at 93.35%.

Over performance against the planned levels of activity continues to be a consistent problem for the Trust, especially in relation to the emergency patient pathway. At the year end, the Trust has seen a 20% over performance against contract in terms of A&E Attendances and a 13% over performance in relation to non-elective admissions. In terms of activity comparisons to last year, A&E Attendances (Trust sites only) have seen a 2% decrease comparing 2010-11 to 2009-10. Non-elective admissions have seen a 6% increase comparing the same two periods.

The Daily Performance Meetings are continuing, which are chaired by the Chief Executive to review Four Hour Performance for the previous day, to understand trend and examine any lessons learned. The attendees for this meeting have now been broadened out even further to encompass all aspects of the emergency patient pathway.

The Urgent Care Centre opened on the Central Middlesex site on Monday 28th March 2011, hosted by Care UK. This has meant a significant change in the activity profile to the Central Middlesex site, with the majority of the activity on this site now being related to major work. As a result, the Trust has seen a 57% decrease in the volume of attendances presenting at Central Middlesex comparing the first two weeks the UCC was open to the previous two weeks. The service now appears to becoming more established with a good flow of patients between the two units. The Trust continues to have daily regular contact with the Care UK operational teams to facilitate a seamless patient pathway between the Trust and Care UK units.

The Trust continues to work to implement the new A&E Clinical Quality Indicators, focusing initially on the five main indicators. The Trust is now in a position to report performance on a site basis (for the Trust facilities only) on four of the five indicators. Performance for these is now being reported to the weekly Executive Directors meeting with the position from the beginning of April being presented. A full position for the month of April will be reported in next months report. The indicator that still remains a challenge is the time to first assessment for ambulance attendances; however the Trust has a plan for reporting the April position, with a longer term solution being implemented for the future. The Trust continues to work with the management teams from the co-located UCC's within the A&E Departments at Northwick Park and Central Middlesex Hospitals to report a joint position of the new indicators.

The Trust continues to perform well against the other Access Targets with both the original and revised Referral to Treatment Targets at a cross speciality position being achieved. Trauma and Orthopaedics remains a challenge in terms of the admitted and non-admitted speciality targets due to the long term sick leave of a single handed practice consultant, as well as a reduction in the volume of additional theatre lists that are completed. The Trust failed to achieve the 62 day screening target for the month of March, however this will have no effect on the quarterly or year end position. The Trust continues to achieve all the other Cancer Targets.

The Trust continues to report its performance against the mixed sex target and reported 140 incidents of breach in March 2011, which was a decrease from 184 reported in February. All breaches of the target were on the Trust's Surgical Admission Unit on the Northwick Park site; however this has now been relocated to prevent further breaches. Since the relocation of the unit, no further mixed sex breaches have occurred across the Trust.

The Trust continues to work through the implications of the signed Acute Contract for 2011-12. A major change will be the new readmissions target that has been established since the 1st April 2011 and we are working with the PCT's to develop a mechanism for measurement and how the diverted income from readmissions can be invested. Even considering this, the readmissions are likely to place a significant financial burden on the Trust. As part of the contract, a number of targets now have financial fines associated with them for breach. These include a fine for any ambulance waits, for mixed sex breaches and MRSA cases above the yearly target. The Trust is working to minimise breaches in all areas to improve the quality of the care it provides. A revised Safety, Quality and Performance Report will be produced from next month onwards which will document in full all these new targets and Trust performance against them where it is available.

Throughout the year, the Trust has seen a significant over performance against the contracted level of births. Plans were put in place to try and slow down this rate by diverting expecting mothers to other local maternity units; however a significant over performance was expected. A revised expected birth rate of 5,400 births was agreed. At the year end, the Trust had 5,268 births against the revised trajectory of 5,400. This is following a significant slow down of the birth rate for quarter 4 of 2010-11.

CORPORATE OBJECTIVES

Business Objectives 2010/11		Lead Director	Support Director	Board / Committee	RAG Status - May
1	A clear and deliverable strategy	Fiona Wise	David Cheesman	Trust Board	
2	Satisfaction and Engagement	Carole Flowers	David Cheesman/ Don Fairley	Governance, Compliance and Risk Committee, Trust Board	
3	Stronger Infection Control	Fiona Coogan	Philip Sutcliffe	Trust Infection Control Committee, Trust Board	
4	Improving Finances	Kishamer Sidhu		Finance Committee, Audit Committee, Trust Board	
5	Better Services, Meeting Targets (Access)	Dena Marshall	Rory Shaw, Philip Sutcliffe, Don Fairley	Governance, Compliance and Risk Committee, Trust Board	
6	Improving Patient Outcomes and Reducing Inequalities	Dena Marshall	Don Fairley	Governance, Compliance and Risk Committee, Trust Board	
7	Workforce Development	Don Fairley	Fiona Wise, Dena Marshall	HR, Education and Training Committee	

SAFETY STANDARDS

SAFETY STANDARDS SCORECARD

CQC National Priorities	Exec Lead	RAG Status	Actual Target	Proxy Target	YTD Actual	Apr-10	May-10	Jun-10	Jul-10	Aug-10	Sep-10	Oct-10	Nov-10	Dec-10	Jan-11	Feb-11	Mar-11
Hospital Acquired Infections																	
MRSA Bacteraemia- Trust- Post 48 Hours	FC	G	8	8	4	0	0	0	0	0	1	0	1	0	2	0	0
MRSA Bacteraemia- Health Economy	FC	N/A			10	3	0	1	2	0	0	2	0	1	0	0	1
Clostridium Difficile infection rate- Trust	FC	G	62	62	47	2	2	2	3	3	2	4	3	5	10	7	4
Clostridium Difficile infection rate- Health Economy	FC	N/A			59	1	5	6	9	5	5	6	5	2	4	5	6
Clinical Safety	**Exec Lead**	**RAG Status**	**Proxy target**	**YTD Target**	**YTD Actual**	**Apr-10**	**May-10**	**Jun-10**	**Jul-10**	**Aug-10**	**Sep-10**	**Oct-10**	**Nov-10**	**Dec-10**	**Jan-11**	**Feb-11**	**Mar-11**
Mortality Rate																	
Hospital Standardised Mortality Ratio Performance	RS	G	<83.0	<83.0	81.4	84.9	92.6	91.7	77.7	85.0	87.3	85.2	72.6	79.0	65.3		
Cleanliness- Environment Scores																	
Central Middx Hospital - Very high risk Area	DM	G	98.0%	98.0%	98.6%	98.4%	98.5%	98.6%	98.6%	98.6%	98.6%	98.6%	98.7%	98.6%	98.7%	98.6%	98.7%
Northwick Hospital - Very high risk Area	DM	G	98.0%	98.0%	98.8%	98.7%	98.7%	98.9%	99.0%	98.9%	98.8%	99.0%	98.9%	98.7%	98.3%	98.8%	98.7%
Central Middx Hospital - High risk Area	DM	G	95.0%	95.0%	97.7%	97.9%	97.6%	97.8%	97.7%	97.6%	97.6%	98.1%	97.7%	97.6%	97.7%	97.6%	97.6%
Northwick Hospital - High risk Area	DM	G	95.0%	95.0%	97.8%	97.6%	97.8%	98.1%	98.1%	97.8%	97.5%	97.9%	98.0%	97.9%	97.8%	98.1%	98.2%
Central Middx Hospital - Significant risk Area	DM	G	90.0%	90.0%	96.9%	95.1%	96.3%	98.4%	96.3%	98.1%	N/avail	97.0%	N/avail	N/avail	97.2%	97.2%	98.3%
Northwick Hospital - Significant risk Area	DM	G	90.0%	90.0%	97.1%	N/avail	97.8%	97.0%	97.4%	96.5%	97.1%	96.8%	95.7%	95.9%	96.5%	96.1%	N/avail
Central Middx Hospital - Low risk Area	DM	G	85.0%	85.0%	94.2%	93.2%	92.3%	92.3%	96.7%	96.9%	N/avail	N/avail	N/avail	N/avail	N/avail	N/avail	N/avail
Northwick Hospital - Low risk Area	DM	N/A	85.0%	85.0%		N/avail	N/avail	N/avail	N/avail	N/avail	N/avail	N/avail	N/avail	N/avail	N/avail	N/avail	N/avail

Hospital Acquired Infections- At year end the Trust achieved all of the Infection control Targets for 2011-12, with 4 cases of MRSA against a target of 8 or less and 47 cases of Ci-Diff against 62 or less. The targets for 2011-12 have now been confirmed for the Trust, with the MRSA target being set at 3 cases or less and the Ci-Diff target being set at 29 cases or less. Even in view of the Trust's excellent performance for 2010-11, these targets are going to be a challenge. The Commissioning Partnership has placed a fine on the Trust performance against the MRSA target of £20K per breach above the threshold of 3 cases in the year.

Hospital Standardised Mortality Ratio- Year to date performance has improved since last month and now stands at 81.4 against a target of less than 83 and therefore the target has now been RAG rated Green. The Trust has again been highlighted as being one of the best performing Trust's in the country in relation to mortality rate, following the recent publication of the Dr Foster Patient Survey. They have confirmed that we are amongst the best 10 Trusts in London and the top 26 in the country. The Medical Director continues to lead a piece of work to examine the target in more detail, focusing on areas where performance is worse than the Trust average. It is planned to target these areas specifically in order to improve the ratio even further and to contact Dr Foster to understand more detail around how the target is calculated. This together with the implementation of Care Bundles in specific areas should allow for further improvement.

CQUIN / CONTRACTING TARGETS

Clinical Quality- CQUINS	Exec Lead	RAG Status	Proxy target	YTD Target	YTD Actual	Apr-10	May-10	Jun-10	Jul-10	Aug-10	Sep-10	Oct-10	Nov-10	Dec-10	Jan-11	Feb-11	Mar-11
National- 20%																	
% of patients who had a VTE Assessment on admission	RS	R	TBC	90% by Q4				45.7%	57.4%	57.4%	57.4%	67.6%	65.0%	65.0%	66.0%	77.0%	
Quality Requirements- Contracting	**Exec Lead**	**RAG Status**	**Actual Target**	**Proxy Target**	**YTD Actual**	**Apr-10**	**May-10**	**Jun-10**	**Jul-10**	**Aug-10**	**Sep-10**	**Oct-10**	**Nov-10**	**Dec-10**	**Jan-11**	**Feb-11**	**Mar-11**
Infection Control																	
All applicable admissions to be screened for MRSA	FC	N/K	100%	100%													
Other																	
Safeguarding Children- To ensure data held on Trust systems is the most accurate and latest available. Child Protection Plans are in place	DM		TBC	TBC													

VTE Assessment- The monthly audit of the VTE Performance continues and is reported to the Department of Health. The latest performance available was for the month of February, where a significant improvement was seen from the previous month, to 77%, however this is below the quarter 4 target and therefore the indicator has been RAG rated red. Work is in place to improve performance further both in terms of performance and the reporting of the target. For 2011-12, the Trust will be required to report performance for near 100% of admissions; therefore it is planned that the Electronic Discharge Note (EDN) will be used for the collection and reporting of performance against this target. Roll out of this data capture mechanism is progressing well and it is planned that performance from April will be reported using this mechanism.

QUALITY STANDARDS

CLINICAL QUALITY – SCORECARD

CQC National Priorities	Exec Lead	RAG Status	Actual Target	Proxy Target	YTD Actual	Apr-10	May-10	Jun-10	Jul-10	Aug-10	Sep-10	Oct-10	Nov-10	Dec-10	Jan-11	Feb-11	Mar-11
Access to Healthcare for people with a Learning Disability																	
Mechanism in place to identify and flag patients with learning disabilities and protocols that ensure that pathways of care are reasonably adjusted	CF	N/A	N/A- Assessment of current Position only		3	Scoring System as spliulated two indicatoras below											
Does the trust provide readily available and comprehensible information regarding Treatment Options, Complaints Procedure and Appointments for patients with Learning Disabilities	CF	N/A	N/A- Assessment of current Position only		2	Indicator is scored against the following criteria: 1. Accessible information not provided, 2. Accessible information provided for one of the criteria, 3. Accessible information provided for two of the criteria, 4. Accessible information provided for all three of the criteria.											
Does the trust have protocols in place to provide suitable support for family carers who support patients with learning disabilities, including learning disabilities, relevant legislation and carers' rights?	CF	N/A	N/A- Assessment of current Position only		3	The Indicator is based on a scoring system of: (1) = Protocols/mechanisms are not in place, (2) = Protocols/mechanisms are in place but have not yet been implemented, (3) = Protocols/mechanisms are in place but are only partially implemented, (4) = Protocols/mechanisms are in place and are fully implemented.											
Protocols in place to routinely include training on learning disability awareness, relevant legislation, human rights, communication techniques for working with people with learning disabilities	CF	N/A	N/A- Assessment of current Position only		3												
Protocols in place to encourage representation of people with learning disabilities and their family carers within Trust Boards, local groups and other relevant forums	CF	N/A	N/A- Assessment of current Position only		3												
Does the trust have protocols in place to regularly audit its practices for patients with learning disabilities and to demonstrate the findings in routine public reports?	CF	N/A	N/A- Assessment of current Position only		3												
Engagement in clinical audits																	
Each clinical directorate to participate in a national clinical audit study	RS		Yes	Yes	Yes												
Has Trust got a clinical audit strategy that addresses national priorities	RS		Yes	Yes	Yes												
Has Trust arranged suitable training for clinical staff in audit	RS		Yes	Yes	Yes												
Has Trust given clinicians enough time to participate in audit	RS		Yes	Yes	Yes												
Has Trust reviewed its audit programme to ensure meets national audit stds	RS		Yes	Yes	Yes												
Has Trust governance leads received assurance on implementation progress	RS		Yes	Yes	Yes												
Patient Experience																	
This is detailed elsewhere within the report as well as the Nursing Report	CF																
Participation in heart disease audits																	
MINAP fields completed	DM	G	>=90%	n/a	95.0%												
Participation in MINAP data validation	DM	G	YES / NO	n/a	YES												
Monthly data upload to CCAD Percutaneous Coronary Intervention database	DM	G	YES / NO	n/a	YES												
Percutaneous Coronary Intervention data completeness on CCAD - demographics	DM	G	>=90%	n/a	100.0%												
Percutaneous Coronary Intervention data completeness on CCAD - treatment	DM	G	>=90%	n/a	90.1%												
Participation in cardiac rythmn national audit	RS	G	YES / NO	n/a	YES												
Participation in congenital heart disease national audit	RS	N/A	YES / NO	n/a	Not Applicable												
Quality of Stroke Care																	
% of patients who spend => 90% of their time on a Stroke Unit	RS/DM	G	70%	70%	96.4%	91.0%	96.6%	97.1%	97.6%	96.4%	94.9%	98.9%	100.0%	100.0%	97.1%	98.1%	90.8%
Infant health and inequalities																	
% of women who are smoking at the time of delivery (Quarterly Performance)	DM	R	<=0% as compared with 2009/10			3.8%	5.0%	4.5%	3.8%	5.1%	3.4%	4.9%	4.4%	4.8%	5.7%	5.0%	3.4%
% of women who are Breast Feeding at the time of discharge (Quarterly Performance)	DM	G	>=-5% compared with 2009/10			78.5%	75.9%	80.5%	77.1%	82.3%	83.1%	85.3%	85.7%	86.6%	85.3%	84.8%	86.0%

Stroke Indicators (Based on the Sentinel Audit)		Exec Lead	RAG Status	Actual Target	Proxy Target	YTD Actual	Apr-10	May-10	Jun-10	Jul-10	Aug-10	Sep-10	Oct-10	Nov-10	Dec-10	Jan-11	Feb-11	Mar-11
Stroke	**Stroke Unit Indicators**																	
	% patient having swallow screen with 24hrs	RS / DM	G	70%	70%	98%	100%	100%	97%	94%	95%	99%	100%	100%	100%	100%	95%	
	% patients having Physio Ax within 72hrs	RS / DM	G	75%	75%	99%	100%	98%	100%	100%	99%	100%	100%	100%	100%	98%	100%	
	% patient having OT assessment within 7 days	RS / DM	G	60%	60%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	
	% patient having CT within 24hrs admission from A&E	RS / DM	G	90%	90%	96%	97%	100%	96%	93%	96%	94%	99%	96%	99%	100%	96%	
	% appropriate patients on aspirin within 24hrs	RS / DM	G	80%	80%	95%	97%	95%	91%	98%	87%	93%	98%	98%	98%	100%	98%	
	% Patients weighed within 72 hours of SU admission	RS / DM	G	75%	75%	94%	88%	82%	91%	100%	94%	100%	99%	97%	94%	95%	92%	
	% Patients with mood assessment	RS / DM	G	70%	70%	94%	72%	90%	97%	90%	100%	100%	100%	100%	100%	100%	100%	
	% patients thrombolysed	RS / DM	G	5%	5%	13%	17%	16%	11%	9%	15%	10%	11%	11%	13%	15%	15%	
	% CVA patients admitted direct to SU from A&E	RS / DM	G	80%	80%	93%	88%	83%	90%	98%	95%	98%	94%	99%	96%	100%	100%	
	% of high risk TIA's within 24 Hours	RS / DM	N/K	N/K	N/K	90%	94%	81%	91%	91%	81%	89%	95%	96%	95%	91%	92%	

Clinical Quality- Patient Clinical Quality	Exec Lead	RAG Status	Actual Target	YTD Target	YTD Actual	Apr-10	May-10	Jun-10	Jul-10	Aug-10	Sep-10	Oct-10	Nov-10	Dec-10	Jan-11	Feb-11	Mar-11
Care																	
Pressure Ulcers	CF	G	<91	<91	27	1	3	2	2	1	2	2	2	3	2	4	3

% of women who are smoking at the time of delivery- Delivery of this target requires joint working with Brent and Harrow PCT's who run the smoking cessation services. NWLH Midwives proactively ask the questions in regard to smoking status in the antenatal clinics, and make the appropriate referral to the smoking cessation advisor in the relevant PCT. Performance for the month of March has improved significantly to a position of 3.4%, however given the performance over the rest of the year, this target continues to be RAG rated Red. In order to improve performance for Brent patients the follow actions have been jointly agreed:

- Recruitment of a Smoking Cessation Midwife for two days a week.
- Brent PCT to supply 25 CO2 machines to be use on smoking women at booking. To commence in May 2011.
- Smoking cessation out reach clinic to be set up in the antenatal clinic.
- Incentives to be offered to women to encourage them to stop smoking.

PATIENT EXPERIENCE SCORECARD

Clinical Quality- We Care	Exec Lead	RAG Status	Proxy target	YTD Target	YTD Actual	Apr-10	May-10	Jun-10	Jul-10	Aug-10	Sep-10	Oct-10	Nov-10	Dec-10	Jan-11	Feb-11	Mar-11
Patient Experience- Dr Foster Trackers																	
Staff looking after me had a caring and compassionate attitude	CF	G	80%	80%	85.8%	84.1%	86.6%	85.3%	88.8%	86.3%	91.7%						
Staff looking after me did things they said they would do	CF	G	80%	80%	82.3%	80.4%	85.4%	80.0%	82.5%	84.0%	91.7%						
I feel fully informed about what was happening with my treatment	CF	R	80%	80%	77.6%	77.2%	79.2%	76.1%	80.4%	74.8%	91.7%						
I was involved as much as I wanted to be in decisions about care	CF	R	80%	80%	76.9%	75.8%	78.5%	72.7%	77.7%	81.0%	66.7%						
Overall I was very satisfied with the care I received	CF	G	80%	80%	85.5%	84.2%	85.7%	84.0%	86.5%	88.7%	91.7%						
Clinical Quality- Patient Experience	**Exec Lead**	**RAG Status**	**Proxy target**	**YTD Target**	**YTD Actual**	**Apr-10**	**May-10**	**Jun-10**	**Jul-10**	**Aug-10**	**Sep-10**	**Oct-10**	**Nov-10**	**Dec-10**	**Jan-11**	**Feb-11**	**Mar-11**
Patient Experience Indicators																	
Emergency treatment	CF	A			7.1												
Waiting lists and planned admissions	CF	A			6.6												
Waiting to get a bed on a wards	CF	A			7.0												
The hospital and ward	CF	R			7.5												
Doctors	CF	R			7.9												
Nurses	CF	R			7.6												
Care & treatment	CF	R			6.9												
Operations and procedures	CF	R			7.7												
Leaving hospital	CF	A			6.4												
Overall experience	CF	R			5.8												
Clinical Quality- Complaints and Enviroment	**Exec Lead**	**RAG Status**	**Proxy target**	**YTD Target**	**YTD Actual**	**Apr-10**	**May-10**	**Jun-10**	**Jul-10**	**Aug-10**	**Sep-10**	**Oct-10**	**Nov-10**	**Dec-10**	**Jan-11**	**Feb-11**	**Mar-11**
Complaints																	
% of complaints acknowledged within 3 days of receipt	CF	G	90.0%	90.0%	90.2%	91.0%	87.0%	98.0%	97.0%	92.0%	93.0%	86.0%	96.0%	71.0%	90.0%		
% of complaints responded to within the agreed first target	CF	R	75.0%	75.0%	55.0%	62.0%	69.0%	67.0%	61.0%	45.0%	53.0%	51.0%	55.0%	48.0%	39.0%		
Enviroment																	
% of patients in mixed sex accommodation	CF	R	0%	0%		2.3%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.2%	0.2%	0.2%	0.2%

We Care Programme

The implementation of the Optimum product continues with the product being rolled out across the Trust in late March. The implementation continues for the Inpatient Survey in ward areas and it is envisaged that we will have data available to report to board from next month. After the Inpatient Survey has been implemented, it is planned that the product will be used to monitor patient experience within other areas within the hospitals, including Outpatients and A&E.

Complaints- Due to the nature of the 25 day target, performance for January performance is the latest available. Performance against the three day acknowledgment target for January was 90% against a target of 90% or more. Performance against the percentage responded to within the agreed first target continues to be a challenge, with year to date performance standing at 55% against the 75% target and performance for the month of January standing at 39%. Although this is a drop a further drop in performance, the Divisions are working with the Complaints team to improve performance especially in poor performing areas. The review meetings with the Complaint Divisional Leads (typically the Head of Nursing) the Director of Nursing and the patients Relations Manager are continuing in order to improve performance.

Mixed Sex- Further breaches were experienced in relation to this target in March, all of which were on the Surgical Admission Unit (SAU) on the Northwick Park site. 140 breaches were experienced for the month; however the unit has now moved to its alternative location and therefore should prevent any further breaches. To date, there have been no further breaches against this target, inline with the required performance for April 2011. From April 2011, the new Acute Contract has placed a £250 per person per night fine on any mixed sex breaches.

CQUIN / CONTRACTING TARGETS

Clinical Quality- CQUINS	Exec Lead	RAG Status	Actual target	YTD Target	YTD Actual	Apr-10	May-10	Jun-10	Jul-10	Aug-10	Sep-10	Oct-10	Nov-10	Dec-10	Jan-11	Feb-11	Mar-11
National- 20%																	
Adult IP survey (5 Qs). Positive scores req'd (part of CQC Programme)	CF	N/K	>73.2	>73.2		Available in 2011											
Regional- 40%																	
% of cases using the IHI Global Trigger Tool who meet the criteria	DM	N/K	TBC	TBC													
% of patients who undergo Enhanced Recovery from agreed Group	DM	N/K	TBC	TBC	5.81	4.75	6.66	5.42	5.38	6.20	7.28	6.66	5.68	5.30	5.80	5.48	5.10
% of patients discharged on their agreed date within the agreed Specs	DM/RS	N/K	Q1 Baseline	Q1 Baseline													
% of patients discharged before noon and at weekend in agreed Specialities	DM/RS	N/K	Q1 Baseline	Q1 Baseline	24.6%	30.6%	24.4%	20.5%	26.5%	25.9%	24.8%	18.9%	31.0%	27.3%	23.9%	15.2%	25.5%
Milestones achieved per HfL Dementia Services Guidance	CF	N/K	Yes	Yes													
% of readmissions within 28 Days for COPD, Heart Failure & Diabetes	DM/RS	R	10% reduction 0910	10% reduction 0910	19.82%	22.40%	22.95%	25.69%	18.87%	21.01%	14.29%	16.53%	15.00%	17.50%	18.85%	24.09%	20.83%
% of readmissions within 14 Days for COPD, Heart Failure & Diabetes	DM/RS	R	5% reduction 0910	5% reduction 0910	14.18%	16.13%	13.93%	19.27%	10.38%	13.45%	9.52%	11.57%	13.33%	15.00%	11.48%	18.25%	18.06%
Local- 40%																	
%of pts who receive Emerg Surgery within 24 hours of arrival	DM	R	Q4- 90%, 85%- Q3	85%	74.1%	75.0%	72.8%	74.7%	72.4%	71.4%	77.1%	73.2%	74.0%	74.9%	70.7%	74.2%	80.4%
% of Low Cost Statins Perscribed	DM	N/K	85% for Q3	85% for Q3													
Quality Requirements- Contracting	**Exec Lead**	**RAG Status**	**Actual Target**	**Proxy Target**	**YTD Actual**	**Apr-10**	**May-10**	**Jun-10**	**Jul-10**	**Aug-10**	**Sep-10**	**Oct-10**	**Nov-10**	**Dec-10**	**Jan-11**	**Feb-11**	**Mar-11**
Planned Care																	
Single Sex Plan in place and milestones achieved	CF	G	Yes	Yes	Yes												
Critical Care																	
% pts disc to ward from Level 3 CC between 22h00 and 08h00	DM	N/A	Monitor	Monitor	15.77%	18.44%	15.28%	15.48%	11.92%	18.90%	14.89%	15.25%	11.66%	16.67%	24.22%	12.08%	13.87%
Womens and Children																	
% of women who have seen a midwife or obstetrician by 12 weeks + 6 Days	DM	G	90%	90%	94.7%	91.4%	93.3%	91.7%	95.2%	96.2%	96.1%	95.4%	97.9%	95.7%	94.4%		
% of women receiving 1:1 midwifery care during established labour	CF/DM	N/K															
Proportion of caesarean Sections	DM	N/K	TBC	TBC													
Other																	
Medicine Management- % of Low Cost Statins perscribed	DM	N/K	80%	80%													
Medicine Management- % of Low Cost Ace inhibitors perscribed	DM	N/K	71%	71%													
% of clinically appropriate Myocardial Infarction patients discharged on Aspirin, B-Blockers and Statins	DM	N/K	Target set by Q2	Target set by Q2													

Enhanced Recovery- The Enhanced Recovery Programme encompasses Trauma and Orthopaedics and Colorectal Surgery with progress being made in relation to the length of stay of both as can be seen above. Monitoring of the length of stay will continue into 2011-12 to ensure that the excellent progress made to date is improved upon even further.

Discharge on agreed date / weekends- Performance against both of these indicators is being reported to the Commissioning Partnership on a monthly basis via Clinical Quality Group, with targets yet to be agreed. The Trust is continuing to work to ensure that the number of patients discharged at the weekend and before 10am are maximised across both sites. This includes the roll out of the Expected Date of Discharge work, as well as the utilisation of the Criteria Led Discharge Care Bundle for weekend discharge.

Readmissions Rates for COPD, Heart Failure and Diabetes- Performance against these targets are now being monitored as part of the contracting round for 2011-12, whereby the Trust will not be funded for readmissions from April onwards. The Trust has now calculated the potential risk to the organisation and is working the Commissioning Partnership to develop a plan reduce the volume of readmissions.

% of patients who receive Emergency Surgery within 24 Hours of Arrival- The year end performance against this target stands at 74.1% and therefore the indicator has been RAG rated Red. Work will continue throughout the new financial year to improve performance and ensure that patients receive surgery within an appropriate time frame.

PERFORMANCE STANDARDS (EFFICIENCY / PRODUCTIVITY)

IMPROVING ACCESS SCORECARD

CQC Existing Commitments	Exec Lead	RAG Status	Actual Target	Proxy Target	YTD Actual	Apr-10	May-10	Jun-10	Jul-10	Aug-10	Sep-10	Oct-10	Nov-10	Dec-10	Jan-11	Feb-11	Mar-11
Maintain 4-hour maximum wait in A&E- Health Economy	DM	R	98.0%	98.0%	97.00%	98.92%	98.59%	97.63%	97.28%	97.06%	97.25%	96.57%	96.45%	93.79%	95.18%	97.91%	97.99%
Maintain 4-hour maximum wait in A&E- Trust	DM	R	98.0%	98.0%	94.33%	98.10%	97.53%	95.69%	94.97%	94.54%	94.90%	93.46%	93.13%	87.52%	90.36%	95.92%	96.14%
Maintain 4-hour maximum wait in A&E- Health Economy- 95% Q2 Target	DM	G	95.0%	95.00%	96.54%				97.28%	97.06%	97.25%	96.57%	96.45%	93.79%	95.18%	97.91%	97.99%
Maintain 4-hour maximum wait in A&E- Trust- 95% Q2 Target	DM	R	95.0%	95.00%	93.35%				94.97%	94.54%	94.90%	93.46%	93.13%	87.52%	90.36%	95.92%	96.14%
Access to genito-urinary medicine clinics	DM	G	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Cancelled operations: % of elective patients cancelled on the day of surgery	DM	R	<0.8% elective ops	n/a	1.00%	1.21%	1.14%	0.89%	0.88%	0.77%	1.02%	0.73%	0.97%	1.15%	1.36%	0.97%	0.88%
Cancelled operations: Patients not readmitted within 28 days	DM	G	<=5%	n/a	2.8%	2.4%	4.8%	5.7%	0.0%	2.7%	0.0%	3.7%	0.0%	2.6%	6.4%	2.6%	2.8%
Delayed transfers of care to reduce to a minimal level	DM	G	Not known	< 3%	0.7%	0.4%	0.8%	0.7%	0.5%	0.8%	0.6%	0.7%	0.5%	0.9%	0.5%	0.8%	0.8%
Data quality on ethnic group - % FCEs with ethnic coding	DM	G	>=85%	>=85%	87.1%	87.6%	86.9%	87.0%	87.1%	87.0%	86.8%	88.1%	86.3%	87.3%	87.1%	87.0%	87.4%
Number of inpatients waiting longer than the standard - 26 weeks	DM	G	<=0.03%	<=0.03%	0	0	0	0	0	0	0	0	0	0	0	0	0
Number of outpatients waiting longer than the standard - 13 weeks	DM	G	<=0.03%	<=0.03%	1	0	0	0	0	0	0	0	0	0	1	0	0
Waiting time for rapid access chest pain clinic within 2 weeks	DM	G	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
CQC National Priorities	**Exec Lead**	**RAG Status**	**Actual Target**	**Proxy Target**	**YTD Actual**	**Apr-10**	**May-10**	**Jun-10**	**Jul-10**	**Aug-10**	**Sep-10**	**Oct-10**	**Nov-10**	**Dec-10**	**Jan-11**	**Feb-11**	**Mar-11**
18 week referral to treatment times																	
% of Admitted patients completing their pathway within 18 weeks	DM	G	90.0%	90.0%		96.2%	96.5%	95.6%	96.1%	95.2%	95.7%	94.2%	94.3%	92.4%	92.2%	92.3%	
% of Non admitted patients completing their pathway within 18 weeks	DM	G	95.0%	95.0%		98.2%	98.5%	98.3%	98.5%	98.3%	98.3%	98.0%	98.2%	98.0%	97.6%	97.6%	
Admitted patients data completeness indicator	DM	G	80 - 120%	90 - 110%		107.0%	96.0%	95.0%	91.0%	104.0%	97.0%	97.0%	96.0%	97.0%	90.0%	109.0%	
Non admitted patients data completeness indicator	DM	G	80 - 120%	90 - 110%		92.0%	97.0%	100.0%	100.0%	104.0%	101.0%	102.0%	107.0%	92.0%	102.0%	87.0%	
% of Admitted patients finishing their pathway within 18 weeks- T&O	DM	R	90.0%	90.0%		90.3%	90.1%	90.2%	90.7%	89.0%	89.8%	81.9%	79.3%	71.5%	73.9%	73.2%	
% of Non admitted patients finishing their pathway within 18 weeks- T&O	DM	R	95.0%	95.0%		95.1%	95.5%	95.2%	95.7%	93.9%	96.2%	94.1%	94.2%	93.9%	93.3%	94.3%	
% of Admitted patients finishing their pathway within 18 weeks- Urology	DM	G	90.0%	90.0%		93.4%	90.1%	91.8%	90.6%	90.7%	93.8%	91.6%	90.9%	92.0%	95.1%	91.6%	
Referral to Treatment Target- Admitted- Median Wait (Weeks)	DM	G	< 11.1 Weeks	< 11.1 Weeks								6.0	6.3	5.3	7.0	5.0	
Referral to Treatment Target- Admitted- 95th Percentile (Weeks)	DM	G	< 27.7 Weeks	< 27.7 Weeks								19.0	25.4	21.3	23.4	22.1	
Referral to Treatment Target- Non-Admitted- Median Wait (Weeks)	DM	G	< 6.6 Weeks	< 6.6 Weeks								3.6	3.8	3.7	4.8	2.9	
Referral to Treatment Target- Non-Admitted- 95th Percentile Wait (Weeks)	DM	G	< 18.3 Weeks	< 18.3 Weeks								15.4	15.6	15.3	15.9	15.7	
Referral to Treatment Target-Incomplete Pathways- Median Wait (Weeks)	DM	G	< 7.2 Weeks	< 7.2 Weeks								5.9	6.6	6.8	7.7	5.9	6.9
Referral to Treatment Target-Incomplete Pathways- 95th Percentile (Weeks)	DM	G	< 36.0 Weeks	< 36.0 Weeks								23.9	25,5	24.9	28.3	29.2	31.4
Direct access audiology patients waiting less than 18 weeks	DM	G	100.0%	100.0%		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Diagnosis Waits >= 6 Weeks	DM	G	0	0		0	0	0	0	0	0	0	0	0	0	0	0
Direct Access Audiology patients Data Completeness Indicator	DM	G	80 - 120%	90 - 110%		95.0%	95.0%	92.09%	93.60%	92.00%	96.10%	93.90%	92.20%	91.90%	92.80%	100.00%	92.60%
Cancer Targets																	
2 week GP referral to 1st outpatient appointment	DM	G	93.0%	93.0%	95.71%	94.5%	94.9%	96.0%	94.1%	95.3%	97.1%	97.0%	95.8%	95.1%	95.0%	96.1%	96.0%
31 day second or subsequent treatment (surgery and drug)	DM	G	96.0%	96.0%	100.00%	100.0%	100.0%	95.8%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
31 day diagnosis to treatment for all cancers	DM	G	97.0%	97.0%	99.85%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	98.3%	98.5%	94.8%	97.1%	100.0%	97.7%
62 day referral to treatment from screening	DM	G	90.0%	90.0%	98.77%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	92.9%	94.1%	100.0%	88.9%
62 day referral to treatment from Consultant upgrade	DM	G	85.0%	85.0%	100.00%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
62 days urgent referral to treatment of all cancers	DM	G	85.0%	85.0%	96.05%	95.2%	95.2%	100.0%	95.7%	95.4%	96.1%	95.1%	95.0%	94.7%	97.1%	97.4%	93.3%
Breast symptom - Two week wait	DM	G	93.0%	93.0%	97.41%	93.2%	99.0%	92.6%	93.6%	99.5%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	99.5%
Maternity Hospital Episode statistics																	
% of mandatory fields not complete within all Maternity Finished Consultant Episodes	DM	N/K															
A&E Clinical Breach Profile	**Exec Lead**	**RAG Status**	**Actual Target**	**Proxy Target**	**YTD Actual**	**Apr-10**	**May-10**	**Jun-10**	**Jul-10**	**Aug-10**	**Sep-10**	**Oct-10**	**Nov-10**	**Dec-10**	**Jan-11**	**Feb-11**	**Mar-11**
A&E Breaches																	
Number of Clinical Breaches	DM	N/K	TBC	TBC	1237	67	83	77	112	109	124	104	106	206	166	83	
% of Clinical Breaches against all breaches	DM	N/K	TBC	TBC	13.59%	24.10%	22.13%	12.56%	15.47%	15.14%	17.69%	11.39%	11.36%	10.56%	12.22%	15.43%	

Maintain Four Hour Target (Health Economy and Type 1) – Following the challenges that the Trust has faced in relation to the Four Hour A&E Target over the last year, the Trust agreed a year end trajectory of 97% against the 98% Four Hour Health Economy Target with the Commissioning Partnership and NHS London. At year end, the Trust achieved its agreed trajectory to 97%, although it was a challenge over the last few days of March. In addition, a significant improvement was seen in relation to performance against the indicator in the month of March. For the month of March, the Trust achieved 97.99% for the Health Economy Target and 96.14% for the Trust Target (Type 1). Year end performance against the target is 97.00% for the Health

Economy Target and 94.33% for the Trust Target (Type 1), subsequently both these targets have been RAG rated Red. Performance against the 95% quarter 2 targets at year end stood at 96.54% for the Health Economy target and 93.35% for the Trust (Type 1) target. Therefore the Health Economy target has been RAG rated Green and the Trust target Red.

Significant increases in activity continue across all areas of the emergency pathway. The over performance against the non-elective admissions contract continues with the Trust over performing by 13% against contract to year end. Harrow PCT continues to be a significant part of this over performance at 19%. When comparing the year 2010-11 to 2009-10, there has been a 6% increase in non-elective admissions.

A&E Attendances are also over performing against the contract and the expected volume of attendances. Overall there is a 20% over performance against the A&E Attendances contract. Again Harrow PCT make up a significant part of this over performance with a 74% over performance against their contract alone. Comparing activity figures to this time last year, there has been a 2% reduction in the volume of A&E Attendances Trust wide, however Northwick Park has actually seen an increase in the volume of attendances.

The Daily Performance Meetings continue with the Chief Executive continue, which review the Four Hour Performance, along with trends in breaches and activity profiles to understand performance for the previous day. The meeting attendees continue to be broadened out to encompass all aspects of the emergency patient pathway.

The Urgent Care Centre (UCC) opened on the Central Middlesex site on Monday 28th March 2011, hosted by Care UK which has significantly changed the profile of activity to the Central Middlesex A&E Department. As the department now only generally received major's patients, there has been a 57% reduction in activity when comparing the first two weeks of the UCC being opened, with the previous two weeks. In addition the UCC had a number of breaches over the first week of opening which placed additional pressure on the 97% trajectory. The service now appears to becoming more established with a good flow of patients between the two units. The Trust continues to have daily regular contact with the Care UK operational teams to facilitate a seamless patient pathway between the NWLH and Care UK units.

The Trust continues to work to implement the new Clinical Quality Indicators, focusing initially on the five main indicators. The Trust is now in a position to report performance on a site basis (for the Trust facilities only) on four of the five indicators. Performance for these is now being reported to the weekly Executive Directors meeting with the position from the beginning of April being presented. A full month position for the month of April will be reported in next months report. The indicator that still remains a challenge is the time to first assessment for ambulance attendances; however the Trust has a plan for reporting the April position, with a longer term solution being implemented for the future. The Trust continues to work with the management teams from the co-located UCC's within the A&E Departments at Northwick Park and Central Middlesex Hospitals to report a joint position of the new indicators. The Trust has now received a dataset from the one of the providers and is working its way through the contents of this and is awaiting information from the second to allow the joint position to be reported. The first submission that will be required is in the month of May for April's performance.

Cancelled operations: % of elective patients cancelled on the day of surgery- Year end Trust performance against this target stands at 1% against a target of less than 0.8% and therefore the target has been RAG rated red, however a further improvement was made in the month of March with 0.88% being achieved, with 36 patients being cancelled in the month. One Vascular Surgery patient breached the readmission within 28 Days target in March; however year to date performance still remains within tolerance.

Referral to Treatment Target- National monitoring of the Referral to Treatment Targets are now completed using the median and 95th percentile wait at a cross speciality position for admitted, non-admitted and incomplete (patients who are still awaiting treatment) pathways, in addition to the traditional 90% for admitted patients and 95% for non-admitted patients.

February performance was the latest available at the time of writing this report, except for the incomplete pathways. The Trust continues to achieve both the traditional and revised targets at a cross speciality level. The Trust achieved 92.3% and 97.6% for the admitted and non-admitted targets respectively. In addition, all the median and 95th percentile indicators are well within tolerance. At a Speciality level, Trauma and Orthopaedics continues to be an area of challenge with the Trust achieving 73.2% and 94.3% respectively against the admitted and non-admitted targets. Performance remains a problem due to the long term sick leave of a single handed practice Consultant and due to a reduction in the number of additional theatre lists that are being completed.

Cancer- In line with Cancer Reporting mechanisms, the RAG Rating is based on the latest quarter performance or partial month's performance. Provided in the report is an unvalidated position that is yet to be submitted to Open Exeter. However, no significant change is expected from the published position. The Trust failed the 62 day screening target for the month of March due to the small volume of activity and one breach; however this will not cause a failure for the quarterly or yearly position. A recovery plan has been completed and submitted to the Cancer Network; however a reoccurrence is not expected. The Trust continues to achieve all the other Cancer targets both at a quarterly and year to date position.

CQUIN / CONTRACTING TARGETS

Clinical Quality- CQUINS	Exec Lead	RAG Status	Proxy target	YTD Target	YTD Actual	Apr-10	May-10	Jun-10	Jul-10	Aug-10	Sep-10	Oct-10	Nov-10	Dec-10	Jan-11	Feb-11	Mar-11
Regional- 40%																	
% of Inpatient Discharge Summeries that included the enhanced content	RC/DM	N/K	TBC	TBC													
% of Inpatient Discharge Summeries sent Electronically	RC/DM	N/K	TBC	TBC													
% of Outpatient Summaries rec'd within 5 days of attendance	RC/DM	N/A	Q1 Baseline	Q1 Baseline	48.1%	48.8%	49.8%	49.6%	47.7%	47.9%	44.7%						
Local- 40%																	
% of A&E Discharge Summaries rec' by pt GP	RC/DM	G	Q1 Baseline	>75%		85.3%	90.6%	83.4%	90.4%	84.9%	81.9%	84.7%	98.1%	68.0%	82.0%	78.0%	86.0%
% of A&E Discharge Summaries Transferred Electronically	RC/DM	N/A	Q1 Baseline	Q1 Baseline		3.2%	3.0%	2.6%	2.8%	3.6%	6.0%	52.3%	64.0%	65.0%	79.0%	76.0%	84.0%
Quality Requirements- Contracting	**Exec Lead**	**RAG Status**	**Actual Target**	**Proxy Target**	**YTD Actual**	**Apr-10**	**May-10**	**Jun-10**	**Jul-10**	**Aug-10**	**Sep-10**	**Oct-10**	**Nov-10**	**Dec-10**	**Jan-11**	**Feb-11**	**Mar-11**
Planned Care																	
Choose and Book- Slot Issues compared to the national Average	DM	A	0.04	0.04		0.06	0.10	0.12	0.12	0.16	0.08	0.06	0.10	0.04	0.04	0.04	0.05
Outpatient to Inpatient Conversion Rate	DM	N/A	Monitor	Monitor													
Consultant to Consultant Referrals	RS/DM	N/K	<17.5%	<17.5%													
18 Week Backlog- Admitted	DM	R	<100% of 1 weeks work	<100% of 1 weeks work		130%	115%	143%	150%	160%	138%	161%	203%	226%	233%	226%	239%
18 Week Backlog- Non Admitted	DM	G	< 200% of 1 weeks work	< 200% of 1 weeks work		110%	121%	115%	87%	71%	79%	89%	89%	86%	114%	128%	125%
18 Weeks- Number of Unknown Clock Starts	DM	G	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
First to Follow Up Ratio- Bottomline for selected Specialities	DM	R	1.60	1.60	1.92	1.84	1.91	1.85	2.00	1.93	1.94	1.90	2.02	1.97	2.09	2.12	2.05
% of admitted elective patients exceeding the trim point	DM	N/K	5% Improve 0910	5% Improve 0910	0.92%	0.95%	0.83%	0.95%	0.96%	0.89%	0.95%	1.14%	0.90%	0.90%	0.85%	0.83%	
% DNA Rate- Outpatient New Attendances	DM	G	<11%	<11%	10.9%	10.4%	10.0%	11.3%	10.8%	11.4%	11.4%	10.8%	10.2%	11.7%	11.1%	10.6%	10.6%
% DNA Rate- Outpatient Follow Up Attendances	DM	R	<11%	<11%	14.7%	14.8%	15.5%	14.8%	14.5%	15.0%	14.7%	14.4%	14.0%	16.0%	15.3%	14.0%	14.3%
% DNA Rate- Inpatient Elective Procedures	DM	G	<11%	<11%	2.2%	2.4%	2.1%	2.2%	1.4%	2.1%	2.9%	1.6%	2.0%	2.2%	3.1%	2.2%	2.6%
Unplanned Care																	
Number of A&E Admissions with less than 4 hours LOS	DM	N/A	Monitor	Monitor	6295	588	566	545	516	457	527	491	565	495	447	505	593
% of NELpatients stays exeeding the trim point	DM	N/K	TBC	TBC	3.6%	4.0%	3.8%	3.7%	3.2%	4.3%	3.0%	3.2%	3.8%	4.0%	3.5%	3.3%	
Critical Care																	
Average Length of Stay in ITU	DM	N/A	Monitor	Monitor	2.30	1.48	3.71	1.97	1.92	3.14	3.16	2.32	1.92	2.56	1.63	2.58	2.04
Average Length of Stay in HDU	DM	N/A	Monitor	Monitor	3.05	2.96	2.76	2.65	2.96	3.29	3.43	2.70	3.01	3.63	3.18	3.94	3.89
A&E Performance																	
% of patients waiting under 4 hours from DTA to Admission	DM	G	TBC	98%	3.16%	0.78%	0.64%	1.62%	3.08%	2.61%	3.38%	4.66%	4.05%	6.05%	6.80%	1.85%	2.49%
% of patients admitted more than 3.5hours after arrival in A&E	DM	N/A	Monitor	Monitor	13.29%	11.68%	11.98%	12.67%	11.88%	13.75%	13.56%	14.10%	14.29%	13.90%	14.26%	13.43%	14.18%
Satisfaction of Obligations under A&E/Ambulance Handover Plan	DM	G	Yes	Yes		Yes											
LAS Handover- % of patients handover in less than 15 minutes	DM	R	85%	85%	81.48%	86.17%	88.59%	87.38%	87.70%	84.58%	82.30%	79.46%	77.94%	68.77%	73.08%	81.50%	80.30%
LAS Handover- % of patients handover in less than 30 minutes	DM	G	95%	95%	95.31%	98.26%	98.65%	97.96%	97.56%	96.50%	96.22%	94.90%	93.94%	87.55%	90.85%	95.95%	95.35%
LAS Handover- % of patients handover in less than 60 minutes	DM	R	0%	100%	99.19%	100.00%	99.94%	100.00%	99.66%	99.61%	99.66%	99.21%	99.16%	96.94%	97.58%	99.41%	99.16%
Womens and Children																	
Ratio of non birth related attendances (NZ04)	DM		<0.7	<0.7													
Other																	
SUS- % of alterations- 5 days after month end and reconcilation date	KS/DM		<3%	<3%													

Choose and Book- The proportion of referrals received via Choose and Book is increasing which is in part due to greater use by local GPs of the 2 week wait services we have made available.

18 Week Backlog- Performance against the Admitted Backlog target remains outside tolerance at 239% against a target of less than 100%.The Non-admitted backlog performance remains within target, although has increased over the last few of months. Divisions are going to be tasked as part of the Waiting Times Meeting to fully validate their open RTT pathways and close those that require so, to give a better indication of the true backlog.

First to Follow Up Ratio- The second best performing Trust within the North West London Sector for each specialty has been chosen as the baseline. A bottom line position is now reported in this report on a monthly basis. Year end position shows a ratio of 1.92 against a target of 1.60 and therefore the

indicator has been Rag rated Red. However an improvement was seen in the month of March compared to February with a ratio of 2.05. Targets for next year have now been agreed as part of the recent contracting round, with the 2010-11 clinical exceptions accepted for 2011-12 ratios, however netting of performance is no longer allowed. The full implications of these will be available for next months report.

DNA Rates- Trust DNA Rates have now been included in the contracting indicators. The year end DNA rate for follow-up appointments stands at 14.7% against a target of less than 11% for the year to date position and this has been RAG rated Red. A consistent improvement has been seen in relation to this DNA rate over the past couple of months.

LAS Handover- The first part of the target states that we need to have a plan in place regarding LAS Handover and meet the necessary objectives. The second part of the LAS indicators relate to a specific percentage of patients who arrive by ambulance receiving their handover within set tolerances. The Trust failed to achieve the less than 15 minute target for the year with a performance of 81.45% against a target of greater than 85%. The Trust also failed to achieve for the year with performance of 99.19% against a target of 100%. However the performance for the month of March was a significant improvement from performance seen over a number of the previous months. The vast majority of these breaches are on the Northwick Park site due to the continued pressure as a result volumes of emergency workload that are presenting at the site.

PRODUCTIVITY & EFFICIENCY SCORECARD

Clinical Efficiency	Exec Lead	RAG Status	Proxy target	YTD Target	YTD Actual	Apr-10	May-10	Jun-10	Jul-10	Aug-10	Sep-10	Oct-10	Nov-10	Dec-10	Jan-11	Feb-11	Mar-11
Theatres																	
Theatre Utilisation	DM	R	80.0%	80.0%	71.1%	69.1%	70.2%	70.2%	71.6%	69.6%	71.5%	69.6%	69.9%	70.3%	70.8%	75.0%	76.0%
Day of Surgery Admission Rate	DM	G	80.0%	80.0%	90.7%	89.7%	90.2%	90.2%	90.1%	89.0%	90.8%	90.6%	91.4%	89.2%	92.1%	92.0%	92.9%
Daycase Rates																	
Trust Daycase Rate	DM	G	75.0%	75.0%	80.2%	79.6%	79.3%	78.6%	80.9%	79.2%	79.7%	79.8%	81.3%	82.3%	80.6%	81.0%	80.1%
Trust Daycase Rate for the HCC Basket of 25 Procedures	DM	R	80.0%	80.0%	71.5%	71.2%	71.2%	72.8%	74.2%	68.8%	69.1%	72.2%	72.0%	72.9%	71.5%	72.2%	70.2%
Length of Stay																	
LOS- Trust LOS	DM	R	2.27	2.27	3.37	3.25	3.09	3.49	3.26	3.36	3.18	3.38	3.48	3.53	3.69	3.47	3.34
LOS- Elective LOS	DM	G	1.20	1.20	1.20	1.29	1.18	1.25	1.21	1.28	1.18	1.17	1.17	1.19	1.05	1.30	1.17
LOS- Emergency LOS	DM	R	2.92	2.92	3.37	3.25	3.09	3.49	3.26	3.36	3.18	3.38	3.48	3.53	3.69	3.47	3.34
Choice																	
Choice Target- Outpatient Bookings %	DM	G	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Choice Target- Inpatient Bookings %	DM	G	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Clinical Quality	**Exec Lead**	**RAG Status**	**Proxy target**	**YTD Target**	**YTD Actual**	**Apr-10**	**May-10**	**Jun-10**	**Jul-10**	**Aug-10**	**Sep-10**	**Oct-10**	**Nov-10**	**Dec-10**	**Jan-11**	**Feb-11**	**Mar-11**
% Bed Occupancy Rate	DM	R	90-95%	90-95%	96.9%	92.6%	96.5%	98.0%	97.1%	95.9%	97.6%	97.3%	96.4%	95.3%	98.8%	98.9%	99.1%

Theatre Utilisation- Further sustained improvement in the Trust's Theatre Utilisation performance has been seen in March, with the in month performance reaching a year high of 76.0%. However the year end performance is 71.1% against a target of over 80%. The project continues to progress and work is being completed into the late starts and early finishes occur to ensure these are kept to a minimum. This includes the Consultant sign off of theatre lists to ensure that they are booked appropriately. Clinicians with consistently poor theatre utilisation are now being investigated to understand the reasons why and to facilitate an improved position. Work still continues to work with the PAS supplier to facilitate a real time data feed into the Newton System, which is aimed to further improve the utilisation of the system at a scheduling level. Clinician engagement and ownership of the data has improved, which has also assisted with the shift in performance.

Trust Daycase Rates for the HCC Basket of 25 Procedures- Performance against this indicator is below target at 70.2% for March against a target of greater than 80%. This report has been distributed to the Divisions to allow areas of poor performance to be targeted and improved. This is also being reviewed as part of the Trust's Cost Improvement Programme.

Length of Stay and Bed Occupancy- Targets have been set and are being monitored using the Trust's Length of Stay Improvement project, with an individual target set for the Trust, as well as elective and emergency length of stay. The targets have been updated to reflect the Trust length of stay programme and the RAG rating is based on the latest monthly performance rather than the year to date position to ensure that changes in performance can be monitored. At year end, the elective target was achieved for both the month of March and the year end position; however the targets for the emergency and Trust length of stay were not achieved, although significant improvements in the length of stay were made as part of the programme. A bed modelling exercise has now been completed for 2011-12 with each speciality again set a target (split by elective and emergency patients) based on the year end length of stay to make efficiency savings in terms of the Trust's bed base. In addition, the PCT's Demand Management initiatives have been profiled in terms of potential bed savings and these will be implemented should these initiatives deliver the proposed savings. For the month of March, the Trust saw a monthly year high bed occupancy rate, of 99.1%

CODING AND DATA QUALITY SCORECARD

Coding Standards	Exec Lead	RAG Status	Actual Target	Proxy Target	YTD Actual	Apr-10	May-10	Jun-10	Jul-10	Aug-10	Sep-10	Oct-10	Nov-10	Dec-10	Jan-11	Feb-11	Mar-11
Schedule																	
Clinical Coding- Inpatient Activity coded by the 20th working day in the month	DM / KS	G	>99%	100.0%		100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	99.97%	99.9%	
Clinical Coding- A&E Coding levels by final reconcilation date	DM	R	>99%	100.0%		92.4%	97.3%	98.9%	97.7%	98.8%	99.5%	96.8%	74.4%	75.9%	80.5%	79.5%	
Data Quality	**Exec Lead**	**RAG Status**	**Actual Target**	**Proxy Target**	**YTD Actual**	**Apr-10**	**May-10**	**Jun-10**	**Jul-10**	**Aug-10**	**Sep-10**	**Oct-10**	**Nov-10**	**Dec-10**	**Jan-11**	**Feb-11**	**Mar-11**
18 Weeks																	
Incomplete Pathways (DQI)	DM	N/A			837	6	7	16	32	23	46	38	55	76	54	89	395
Unfinished Outpatient Appointments	DM	N/A			1043	22	16	14	27	2	11	25	13	14	34	91	774
Non-Actioned Outpatient Appointments	DM	N/A			334	0	0	0	0	0	0	1	1	0	27	12	293
Overdue TCI's	DM	N/A			75	0	0	0	0	0	0	0	0	0	2	10	63
NHS Number																	
NHS Number Completeness- A&E	DM/KS	R	95.0%	95.0%	83.8%	85.3%	85.5%	85.2%	83.3%	84.0%	85.7%	84.5%	85.0%	84.0%	83.7%	82.2%	72.4%
NHS Number Completeness- Admitted Patient Care	DM/KS	G	95.0%	95.0%	95.0%	96.7%	97.0%	96.1%	94.2%	94.5%	95.5%	95.2%	95.4%	94.4%	94.4%	93.0%	90.4%
NHS Number Completeness- Outpatients	DM/KS	G	95.0%	95.0%	96.6%	96.6%	96.6%	96.4%	96.6%	96.7%	97.3%	97.3%	97.3%	96.3%	96.4%	96.2%	95.0%
NHS Number Completeness- EAL - Inpatient Waiting List	DM/KS	R	95.0%	95.0%	94.4%	91.8%	92.0%	92.2%	93.0%	93.2%	93.8%	94.9%	96.0%	96.4%	96.6%	97.1%	97.0%
NHS Number Completeness- Outpatient Waiting List	DM/KS	N/A	95.0%	95.0%													
Ethnicity																	
Ethnicity Completeness- A&E	DM/KS	R	95.0%	95.0%	90.5%	90.4%	90.2%	90.3%	90.2%	90.2%	90.3%	91.5%	91.2%	90.7%	89.8%	90.4%	91.8%
Ethnicity Completeness- Admitted Patient Care	DM/KS	R	95.0%	95.0%	87.2%	87.6%	86.9%	87.0%	87.1%	87.0%	86.7%	88.1%	86.3%	87.3%	87.1%	87.0%	87.4%
Ethnicity Completeness- Outpatients	DM/KS	N/K	95.0%	95.0%	77.5%	78.0%	78.1%	77.3%	77.1%	77.5%	77.8%	77.6%	77.4%	77.7%	78.2%	78.2%	79.4%
Ethnicity Completeness- Outpatient Waiting List	DM/KS	N/A	95.0%	95.0%													
GP Practitioner																	
Reg GP Completeness- A&E	DM/KS	R	95.0%	95.0%	89.1%	87.8%	88.4%	88.5%	88.2%	88.6%	89.5%	88.8%	90.5%	89.3%	89.8%	89.8%	89.4%
Reg GP Completeness- Admitted Patient Care	DM/KS	G	95.0%	95.0%	96.5%	96.2%	96.2%	96.0%	95.6%	96.4%	96.1%	96.7%	96.8%	96.5%	96.9%	96.7%	97.0%
Reg GP Completeness- Outpatients	DM/KS	G	95.0%	95.0%	97.9%	96.7%	97.6%	97.4%	97.6%	97.8%	97.8%	97.9%	98.1%	97.7%	97.9%	97.9%	98.0%
Reg GP Completeness- Outpatient Waiting List	DM/KS	N/A	95.0%	95.0%													
Postcode																	
Postcode Completeness- A&E	DM/KS	G	95.0%	95.0%	99.0%	99.1%	99.0%	99.1%	99.0%	99.0%	99.0%	99.0%	99.1%	99.1%	99.1%	99.2%	99.1%
Postcode Completeness- Admitted Patient Care	DM/KS	G	95.0%	95.0%	99.6%	99.6%	99.6%	99.6%	99.6%	99.5%	99.6%	99.5%	99.6%	99.5%	99.6%	99.5%	99.5%
Postcode Completeness- Outpatients	DM/KS	G	95.0%	95.0%	99.8%	98.8%	98.8%	98.8%	98.8%	99.8%	99.8%	98.8%	98.8%	98.8%	98.8%	98.8%	98.8%
Postcode Completeness- Outpatient Waiting List	DM/KS	N/A	95.0%	95.0%													

Clinical Coding- Due to the coding deadlines and timetable, February is the latest available data for the coding targets. The target for both inpatient and A&E attendances has been set at 99%. The Inpatient coding is within tolerance for the latest month available and therefore has been RAG rated Green. A&E Coding for the last five months remains a problem and therefore has been RAG rated Red. This is due to the backlog of uncoded activity that exists due to staff shortages within the A&E Department who are able to code the activity. Plans are in place to improve the position on an ongoing basis over the coming months.

WORKFORCE

WORKFORCE KEY PERFORMANCE INDICATORS

20010/11 Workforce Indicators		March 2009 Position (reported to Board)	Current Month Position	2010/11 Target	Mar-10	Apr-10	May-10	Jun-10	Jul-10	Aug-10	Sep-10	Oct-10	Nov-10	Dec-10	Jan-11	Feb-11	Mar-11	Data range across Trust	End of year position (annual figure)
Average Earnings	Total average earnings per directly contracted employee excluding bank, overtime and unsocial hours supplements etc but including London w eighting	Not Available	£40,500	<low er quartile in London	£40,000	£40,600	£41,000	£41,100	£40,800	£40,700	£40,700	£40,500	£40,600	£40,200	£40,500			Range: £23,300 for the Additional Clinical Services Staff Group to £78,800 for the Medical Staff Group (Jan 2011)	Not Available
Vacancies (gross)	Total number of budgeted posts not filled by a substantive employee as a percentage of total budgeted establishment	12.1%	6.9%	12%	10.7%	11.5%	11.5%	9.7%	9.3%	8.7%	7.1%	5.9%	5.6%	5.9%	6.7%	6.9%		Range: 1.1% in St Marks to 15.0% in Emergency Medicine (Feb 2011)	Not Available
Vacancies (net of bank usage)	Total number of budgeted vacancies not filled by a substantive or bank employee as a percentage of total budgeted establishment	Not Reported	-2.2%	6%	2.1%	2.1%	3.0%	0.7%	0.6%	-0.2%	-1.5%	-2.4%	-2.7%	-2.0%	-1.3%	-2.2%		Ranges: -14.2% in Elderly to 4.8% in Cancer (Feb 2011)	Not Available
Temporary staffing expenditure	Total temporary staffing expenditure as a percentage of total expenditure	12.6%	11.4%	9%	12.8%	12.8%	13.6%	12.0%	12.8%	12.7%	11.7%	12.3%	11.5%	10.5%	10.0%	11.4%		Data at disaggregated level not available	Not Available
Turnover (gross)	Total substantive leavers over a rolling 12 month period as a percentage of average number of staff in post in period	15.0%	9.2%	12%	10.6%	10.8%	10.6%	10.6%	10.9%	11.1%	10.6%	10.4%	9.8%	9.9%	9.4%	9.7%	9.2%	Range: 4.0% in Critical Care to 20.5% in Therapies & Rehabilatation (March 2011)	9.2%
Turnover (Voluntary)	Total substantive leavers that have left the Trust voluntarily over a rolling 12 month period as a percentage of average number of staff in post in period	Not Reported	6.8%		6.8%	6.5%	6.9%	6.9%	7.3%	7.7%	7.4%	7.3%	6.9%	7.3%	7.0%	7.3%	6.8%	Range: 2.2% in Critical Care to 16.6% in Therapies & Rehabilatation (March 2011)	6.8%
Turnover (Involuntary)	Total substantive leavers that have left the Trust involuntarily over a rolling 12 month period as a percentage of average number of staff in post in period	Not Reported	2.4%		3.9%	4.2%	3.8%	3.7%	3.6%	3.4%	3.3%	3.1%	2.9%	2.6%	2.4%	2.5%	2.4%	Range: 1.1% in St Marks to 6.0% in Pharmacy (March 2011)	2.4%
Sickness Absence (all staff groups)	Total number of FTE days lost through sickness as a percentage of total FTE days available	2.6%	2.5%	<= London Average	2.6%	2.4%	2.3%	2.3%	2.6%	2.4%	2.8%	3.2%	2.9%	3.3%	2.6%	2.5%		Range: 1.3% in Surgery to 4.6% in Womens (Feb 2011	2.7%
Sickness Absence (Nursing)	Total number of nursing & midw ifery FTE days lost through sickness as a percentage of total FTE days available	Not Reported	2.4%	<= London Average	2.9%	2.6%	2.0%	2.2%	2.7%	2.7%	2.9%	3.3%	2.8%	3.3%	2.4%	2.4%		Range: 0.9% in Nursing to 3.9% in Cancer & Clinical Haematology (Feb 2011)	2.8%
Sickness Absence (Medical)	Total number of medical FTE days lost through sickness as a percentage of total FTE days available	Not Reported	0.9%	<= London Average	0.8%	0.5%	0.6%	0.7%	0.8%	0.7%	1.1%	0.7%	1.2%	1.0%	0.9%	0.9%		Range: 0.2% in Head & Neck Surgery to 3.0% in Cardiology (Feb 2011)	0.9%
Appraisal		68.5%	60%*		73%													* Figure from staff attitude survey	60%*
EWTD Compliance	Total number of rotas that are EWTD compliant	77.0%	92.5%	100%	100.0%	100.0%	100.0%	90.6%	92.5%	92.5%	92.5%	92.5%	92.5%	92.5%	92.5%	92.5%	92.5%	Data at disaggregated level not available	Not Available
Ethnicity	Total number of employees from a BME background as a percentage of all employees	55.5%	56.2%	+/- 12% of local population	54.7%	53.8%	55.5%	54.2%	54.4%	55.0%	55.6%	55.7%	55.8%	55.8%	55.9%	55.0%	56.20%	Range: 35.9% in Nursing to 74.1% in Elderly Care (March 2011)	55.25%
Statutory & Mandatory Training	Total number of people that have attended statutory and mandatory training that should have undertaken the training	60.0%	73.0%	>75%	72.0%	57.9%	67.5%	72.6%	75.8%	68.2%	74.3%	58.0%	68.0%	73.0%	61.0%	64.0%	73.0%	Range: 33% in Safeguarding Children Level 2 to 100% in Health & Safety	73.0%

Vacancies

The vacancy rate has not yet been released for March; however it is expected to be below the vacancy rate of March 2010. Although the vacancy rate increased to 6.9% in February the overall trend for vacancies was downwards during the last financial year. The Director of Nursing has carried out a 'bottom-up' review of nursing vacancies within the Trust, which found that there are no longer vacancy hotspots within nursing. This provides further evidence that the Trust's strategy to recruit to large numbers of nursing vacancies, principally through overseas recruitment campaigns, was successful.

Temporary Staff Expenditure

Again the temporary staff expenditure figure for March is not yet available; however is it possible to say that overall our bank and agency spend this year is likely to be little different from 2009/10. The lead time for the international recruitment campaign means that tranches of the 150 qualified nurses will have completed the overseas nursing programme will be qualifying between now and June this year, which should impact positively on nursing agency spend into the next financial year.

Turnover

The downward trend for turnover continued in March with an annual low figure of 9.2%. This can be compared to 10.6% in March 2010 and 15.0% in March 2009. Both voluntary and involuntary turnover fell in March 2011. These decreasing turnover rates are likely to be in part due to the slow-down in the economy in general as well as improvements in staff satisfaction.

Sickness Absence

Sickness absence has decreased slightly between January and February from 2.6% to 2.5%, the sickness absence rates within nursing and the medical staff groups stayed the same between January and February. Over the last two years Trust wide sickness absence has changed very little with the March 2010 and March 2009 figures being 2.6%. Sickness absence has fallen within the nursing staff group from 2.9% in March 2010 to 2.4% in February 2011, however there does not appear to be a downward trend with significant fluctuations throughout the year; medical sickness absence rates continues to appear to be under-reported with little variation across the last 12 months.

EWTD Compliance

Work continues to ensure all rotas are compliant within the Trust. Problems are still being experienced in ensuring accurate monitoring of rotas and work has been undertaken to remind Consultants and their junior doctors of the need to complete monitoring forms accurately and in a timely fashion. Where monitoring falls below certain thresholds, the monitoring is deemed to be invalid and this does not assist in the small number of cases where rotas do not apparently comply with the working regulations or are banded at an inappropriate level. HR teams continue to work with medical staff groups to address these issues.

Ethnicity

The Equality, Diversity and Social Inclusion (EDSI) sub-committee have now agreed on 5 KPIs. The one on ethnicity continues to be reported through this report and shows that at present 56.2% of staff are from a black or ethnic minority background. All the EDSI KPIs will be monitored through the EDSI sub-committee at each of the meetings and reported to this board on an annual basis as part of the single equality scheme annual report.

Statutory and mandatory training

An overall figure of 73% has been reported for statutory and mandatory training, narrowly missing the target of 75%. Of the nine strands of statutory and mandatory training three missed the 75% target; Fire Safety with 73%, Infection control including hand hygiene – Clinical with 72% and Safeguarding Children Level 2 with 33%. The remaining six strands succeeded in training between 78% and 100% of staff who needed to be trained.

APPENDICES

Appendix 1- Performance Matrix Care Quality Commission Indicators 2009/10

CQC Existing Commitments	Exec Lead	RAG Status	Actual Target	Proxy Target	YTD Actual	Apr-10	May-10	Jun-10	Jul-10	Aug-10	Sep-10	Oct-10	Nov-10	Dec-10	Jan-11	Feb-11	Mar-11
Maintain 4-hour maximum wait in A&E	DM	R	98.0%	98.0%	97.0%	98.9%	98.6%	97.6%	97.3%	97.1%	97.2%	96.6%	96.5%	93.8%	95.2%	97.9%	98.0%
Maintain 4-hour maximum wait in A&E- Trust	DM	R	98.0%	98.0%	94.3%	98.1%	97.5%	95.7%	95.0%	94.5%	94.9%	93.5%	93.1%	87.5%	90.4%	95.9%	96.1%
Maintain 4-hour maximum wait in A&E- Health Economy- 95% Q2 Target	DM	G	95.0%	95.0%	96.5%				97.3%	97.1%	97.2%	96.6%	96.5%	93.8%	95.2%	97.9%	98.0%
Maintain 4-hour maximum wait in A&E- Trust- 95% Q2 Target	DM	R	95.0%	95.0%	93.4%				95.0%	94.5%	94.9%	93.5%	93.1%	87.5%	90.4%	95.9%	96.1%
Access to genito-urinary medicine clinics	DM	G	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Cancelled operations: % of elective patients cancelled on the day of surgery	DM	R	<0.8% elective ops	n/a	1.0%	1.2%	1.1%	0.9%	0.9%	0.8%	1.0%	0.7%	1.0%	1.2%	1.4%	1.0%	0.9%
Cancelled operations: Patients not readmitted within 28 days	DM	G	<=5%	n/a	2.8%	2.4%	4.8%	5.7%	0.0%	2.7%	0.0%	3.7%	0.0%	2.6%	6.4%	2.6%	2.8%
Delayed transfers of care to reduce to a minimal level	DM	G	Not known	< 3%	0.7%	0.4%	0.8%	0.7%	0.5%	0.8%	0.6%	0.7%	0.5%	0.9%	0.5%	0.8%	0.8%
Data quality on ethnic group - % FCEs with ethnic coding	DM	G	>=85%	>=85%	87.1%	87.6%	86.9%	87.0%	87.1%	87.0%	86.8%	88.1%	86.3%	87.3%	87.1%	87.0%	87.4%
Number of inpatients waiting longer than the standard - 26 weeks	DM	G	<=0.03%	<=0.03%	0	0	0	0	0	0	0	0	0	0	0	0	0
Number of outpatients waiting longer than the standard - 13 weeks	DM	G	<=0.03%	<=0.03%	1	0	0	0	0	0	0	0	0	0	1	0	0
Waiting time for rapid access chest pain clinic within 2 weeks	DM	G	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

CQC National Priorities	Exec Lead	RAG Status	Actual Target	Proxy Target	YTD Actual	Apr-10	May-10	Jun-10	Jul-10	Aug-10	Sep-10	Oct-10	Nov-10	Dec-10	Jan-11	Feb-11	Mar-11
18 week referral to treatment times																	
% of Admitted patients completing their pathway within 18 weeks	DM	G	90.0%	90.0%		96.2%	96.5%	95.6%	96.1%	95.2%	95.7%	94.2%	94.3%	92.4%	92.2%	92.3%	
% of Non admitted patients completing their pathway within 18 weeks	DM	G	95.0%	95.0%		98.2%	98.5%	98.3%	98.5%	98.3%	98.3%	98.0%	98.2%	98.0%	97.6%	97.6%	
Admitted patients data completeness indicator	DM	G	80 - 120%	90 - 110%		107.0%	96.0%	95.0%	91.0%	104.0%	97.0%	97.0%	96.0%	97.0%	90.0%	109.0%	
Non admitted patients data completeness indicator	DM	G	80 - 120%	90 - 110%		92.0%	97.0%	100.0%	100.0%	104.0%	101.0%	102.0%	107.0%	92.0%	102.0%	87.0%	
% of Admitted patients finishing their pathway within 18 weeks- Trauma & Orthopaedics	DM	R	90.0%	90.0%		90.3%	90.1%	90.2%	90.7%	89.0%	89.8%	81.9%	79.3%	71.5%	73.9%	73.2%	
% of Non admitted patients finishing their pathway within 18 weeks- Trauma & Orthopaedics	DM	R	95.0%	95.0%		95.1%	95.5%	95.2%	95.7%	93.9%	96.2%	94.1%	94.2%	93.9%	93.3%	94.3%	
% of Admitted patients finishing their pathway within 18 weeks- Urology	DM	G	90.0%	90.0%		93.4%	90.1%	91.8%	90.6%	90.7%	93.8%	91.6%	90.9%	92.0%	95.1%	91.6%	
Referral to Treatment Target- Admitted- Median Wait (Weeks)	DM	G	< 11.1 Weeks	< 11.1 Weeks								6.0	6.3	5.3	7.0	5.0	
Referral to Treatment Target- Admitted- 95th Percentile (Weeks)	DM	G	< 27.7 Weeks	< 27.7 Weeks								19.0	25.4	21.3	23.4	22.1	
Referral to Treatment Target- Non-Admitted- Median Wait (Weeks)	DM	G	< 6.6 Weeks	< 6.6 Weeks								3.6	3.8	3.7	4.8	2.9	
Referral to Treatment Target- Non-Admitted- 95th Percentile Wait (Weeks)	DM	G	< 18.3 Weeks	< 18.3 Weeks								15.4	15.6	15.3	15.9	15.7	
Referral to Treatment Target-Incomplete Pathways- Median Wait (Weeks)	DM	G	< 7.2 Weeks	< 7.2 Weeks								5.9	6.6	6.8	7.7	5.9	6.9
Referral to Treatment Target-Incomplete Pathways- 95th Percentile (Weeks)	DM	G	< 36.0 Weeks	< 36.0 Weeks								23.9	25,5	24.9	28.3	29.2	31.4
Direct access audiology patients waiting less than 18 weeks	DM	G	100.0%	100.0%		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Diagnosis Waits >= 6 Weeks	DM	G	0	0		0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Direct Access Audiology patients Data Completeness Indicator	DM	G	80 - 120%	90 - 110%		95.0%	95.0%	92.1%	93.6%	92.0%	96.1%	93.9%	92.2%	91.9%	92.8%	100.0%	92.6%
Access to Healthcare for people with a Learning Disability																	
Mechanism in place to identify and flag patients with learning disabilities and protocols that ensure that pathways of care are reasonably adjusted	CF	N/A	N/A- Assessment of current Position only		3	Scoring System as spliulated two indicators below											
Does the trust provide readily available and comprehensible information regarding Treatment Options, Complaints Procedure and Appointments for patients with Learning Disabilities	CF	N/A	N/A- Assessment of current Position only		2	Indicator is scored against the following criteria: 1. Accessible information not provided, 2. Accessible information provided for one of the criteria, 3. Accessible information provided for two of the criteria, 4. Accessible information provided for all three of the criteria.											
Does the trust have protocols in place to provide suitable support for family carers who support patients with learning disabilities, including learning disabilities, relevant legislation and carers' rights?	CF	N/A	N/A- Assessment of current Position only		3	The Indicator is based on a scoring system of: (1) = Protocols/mechanisms are not in place, (2) = Protocols/mechanisms are in place but have not yet been implemented, (3) = Protocols/mechanisms are in place but are only partially implemented, (4) = Protocols/mechanisms are in place and are fully implemented.										
Protocols in place to routinely include training on learning disability awareness, relevant legislation, human rights, communication techniques for working with people with learning disabilities	CF	N/A	N/A- Assessment of current Position only		3												
Protocols in place to encourage representation of people with learning disabilities and their family carers within Trust Boards, local groups and other relevant forums	CF	N/A	N/A- Assessment of current Position only		3												
Does the trust have protocols in place to regularly audit its practices for patients with learning disabilities and to demonstrate the findings in routine public reports?	CF	N/A	N/A- Assessment of current Position only		3												
Cancer Targets																	
2 week GP referral to 1st outpatient appointment	DM	G	93.0%	93.0%	95.7%	94.5%	94.9%	96.0%	94.1%	95.3%	97.1%	97.0%	95.8%	95.1%	95.0%	96.1%	96.0%
31 day second or subsequent treatment (surgery and drug)	DM	G	96.0%	96.0%	100.0%	100.0%	100.0%	95.8%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
31 day diagnosis to treatment for all cancers	DM	G	97.0%	97.0%	99.9%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	98.3%	98.5%	94.8%	97.1%	100.0%	97.7%
62 day referral to treatment from screening	DM	G	90.0%	90.0%	98.8%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	92.9%	94.1%	90.0%	88.9%
62 day referral to treatment from Consultant upgrade	DM	G	85.0%	85.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
62 days urgent referral to treatment of all cancers	DM	G	85.0%	85.0%	96.1%	95.2%	95.2%	100.0%	95.7%	95.4%	96.1%	95.1%	95.0%	94.7%	97.1%	97.4%	93.3%
Breast symptom - Two week wait	DM	G	93.0%	93.0%	97.4%	93.2%	99.0%	92.6%	93.6%	99.5%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	99.5%
Hospital Acquired Infections																	
MRSA Bacteraemia- Trust- Post 48 Hours	FC	G	8	8	4	0	0	0	0	0	1	0	1	0	2	0	0
MRSA Bacteraemia- Health Economy	FC	N/A			10	3	0	1	2	0	0	2	0	1	0	0	1
Clostridium Difficile infection rate- Trust	FC	G	62	62	47	2	2	2	3	3	2	4	3	5	10	7	4
Clostridium Difficile infection rate- Health Economy	FC	N/A			59	1	5	6	9	5	5	6	5	2	4	5	6
Engagement in clinical audits																	
Each clinical directorate to participate in a national clinical audit study	RS		Yes	Yes	Yes												
Has Trust got a clinical audit strategy that addresses national priorities	RS		Yes	Yes	Yes												
Has Trust arranged suitable training for clinical staff in audit	RS		Yes	Yes	Yes												
Has Trust given clinicians enough time to participate in audit	RS		Yes	Yes	Yes												
Has Trust reviewed its audit programme to ensure meets national audit stds	RS		Yes	Yes	Yes												
Has Trust governance leads received assurance on implementation progress	RS		Yes	Yes	Yes												
Maternity Hospital Episode statistics																	
% of mandatory fields not complete within all Maternity Finished Consultant Episodes	DM																
Patient Experience																	
This is detailed elsewhere within the report as well as the Nursing Report	CF																
Participation in heart disease audits																	
MINAP fields completed	DM	G	>=90%	n/a	95.0%												
Participation in MINAP data validation	DM	G	YES / NO	n/a	YES												
Monthly data upload to CCAD Percutaneous Coronary Intervention database	DM	G	YES / NO	n/a	YES												
Percutaneous Coronary Intervention data completeness on CCAD - demographics	DM	G	>=90%	n/a	100.0%												
Percutaneous Coronary Intervention data completeness on CCAD - treatment	DM	G	>=90%	n/a	90.1%												
Participation in cardiac rythmn national audit	RS	G	YES / NO	n/a	YES												
Participation in congenital heart disease national audit	RS	N/A	YES / NO	n/a	Not Applicable												
Quality of Stroke Care																	
% of patients who spend => 90% of their time on a Stroke Unit	RS/DM	G	70.0%	70.0%	96.4%	91.0%	96.6%	97.1%	97.6%	96.4%	94.9%	98.9%	100.0%	100.0%	97.1%	98.1%	90.8%
Infant health and inequalities																	
% of women who are smoking at the time of delivery (Quarterly Performance)	DM	R	<=0% as compared with 2009/10			3.8%	5.0%	4.5%	3.8%	5.1%	3.4%	4.9%	4.4%	4.8%	5.7%	2.6%	2.6%
% of women who are Breast Feeding at the time of discharge (Quarterly Performance)	DL	G	>=-5% compared with 2009/10			78.5%	75.9%	80.5%	77.1%	82.3%	83.1%	85.3%	85.7%	86.6%	85.3%	84.8%	86.0%
Experience of staff																	
Experience of staff - analysis of selected questions from staff survey	DF	N/K	Please see the Workforce part of this report														

Appendix 2- CQUIN's

CQUINS- These indicators have been agreed with the PCT's as they focus on specific areas, so as improvements in performance can be made. Poor performance can result in the commissioning PCT's withholding up to 1.5% of the commissioner's actual outturn value, a total of £3.5 million.

Clinical Quality- CQUINS	Exec Lead	RAG Status	Proxy target	YTD Target	YTD Actual	Apr-10	May-10	Jun-10	Jul-10	Aug-10	Sep-10	Oct-10	Nov-10	Dec-10	Jan-11	Feb-11	Mar-11
National- 20%																	
% of patients who had a VTE Assessment on admission	RS	N/K	TBC	90% by Q4				45.7%	57.4%	57.4%	57.4%	67.6%	65.0%	65.0%	66.0%	77.0%	
Adult IP survey (5 Qs). Positive scores req'd (part of CQC Programme)	CF	N/K	>73.2	>73.2													
Regional- 40%																	
% of cases using the IHI Global Trigger Tool who meet the criteria	DM	N/K	TBC	TBC	0												
% of patients who undergo Enhanced Recovery from agreed Group	DM	N/K	TBC	TBC	5.81	4.75	6.66	5.42	5.38	6.20	7.28	6.66	5.68	5.30	5.80	5.48	5.10
% of Inpatient Discharge Summeries that included the enhanced content	RJ/DM	N/K	TBC	TBC	0												
% of Inpatient Discharge Summeries sent Electronically	RJ/DM	N/K	TBC	TBC	0												
% of patients discharged on their agreed date within the agreed Specs	DM/CF	N/K	Q1 Baseline	Q1 Baseline	0												
% of patients discharged before noon and at weekend	DM/CF	N/K	Q1 Baseline	Q1 Baseline	24.6%	30.6%	24.4%	20.5%	26.5%	25.9%	24.8%	18.9%	31.0%	27.3%	23.9%	15.2%	25.5%
% of Outpatient Summaries rec'd within 5 days of attendance	RJ/DM	R	Q1 Baseline	Q1 Baseline	48.1%	48.8%	49.8%	49.6%	47.7%	47.9%	44.7%						
Milestones achieved per HfL Dementia Services Guidance	CF	N/K	Yes	Yes													
% of readmissions within 28 Days for COPD, Heart Failure & Diabetes	DM/CF	R	10% reduction 0910	10% reduction 0910	19.82%	22.40%	22.95%	25.69%	18.87%	21.01%	14.29%	16.53%	15.00%	17.50%	18.85%	24.09%	20.83%
% of readmissions within 14 Days for COPD, Heart Failure & Diabetes	DM/CF	R	5% reduction 0910	5% reduction 0910	14.2%	16.1%	13.9%	19.3%	10.4%	13.4%	9.5%	11.6%	13.3%	15.0%	11.5%	18.2%	18.1%
Local- 40%																	
% of A&E Discharge Summaries rec' by pt GP	RJ/DM	G	Q1 Baseline	>75%		85.3%	90.6%	83.4%	90.4%	84.9%	81.9%	84.7%	98.1%	68.0%	82.0%	78.0%	86.0%
% of A&E Dischare Summeries Transferred Electronically	RJ/DM	N/A	Q1 Baseline	Q1 Baseline		3.2%	3.0%	2.6%	2.8%	3.6%	6.0%	52.3%	64.0%	65.0%	79.0%	76.0%	84.0%
%of pts who receive Emerg Surgery within 24 hours of arrival	DM	R	Q4- 90%, 85%- Q3	85.0%	74.1%	75.0%	72.8%	74.7%	72.4%	71.4%	77.1%	73.2%	74.0%	74.9%	70.7%	74.2%	80.4%
% of Low Cost Statins Perscribed	DM	N/K	85% for Q3	85% for Q3													

Appendix 3- Quality Requirements – Contracting

Clause 32 Targets- Failure to achieve one of these targets could result in the North West London Commissioning Partnership invoking a formal performance review where a trajectory would be set to bring performance in line with the target. Repeated failure could lead to payment being withheld.

Monitor Only Targets- Indicators set by NWLCP to monitor performance. At present no targets or associated penalties have been set.

Quality Requirements- Contracting	Exec Lead	RAG Status	Actual Target	Proxy Target	YTD Actual	Apr-10	May-10	Jun-10	Jul-10	Aug-10	Sep-10	Oct-10	Nov-10	Dec-10	Jan-11	Feb-11	Mar-11
Infection Control																	
All applicable admissions to be screened for MRSA	FC	N/K	100%	100%													
Planned Care																	
Choose and Book- Slot Issues compared to the national Average	DM	A	0.04	0.04	0	0.06	0.1	0.12	0.12	0.16	0.08	0.06	0.1	0.04	0.04	0.04	0.05
Single Sex Plan in place and milestones achieved	CF	G	Yes	Yes	Yes												
Outpatient to Inpatient Conversion Rate	DM	N/A	Monitor	Monitor													
Consultant to Consultant Referrals	RS/DM	N/K	<17.5%	<17.5%													
18 Week Backlog- Admitted	DM	R	<100% of 1 weeks work	<100% of 1 weeks work		130%	115%	143%	150%	160%	138%	161%	203%	226%	233%	226%	239%
18 Week Backlog- Non Admitted	DM	G	< 200% of 1 weeks work	< 200% of 1 weeks work		110%	121%	115%	87%	71%	79%	89%	89%	86%	114%	128%	125%
18 Weeks- Number of Unknown Clock Starts	DM	G	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
First to Follow Up Ratio- Bottomline for selected Specialities	DM	R	1.60	1.60	1.92	1.84	1.91	1.85	2.00								
% of admitted elective patients exceeding the trim point	DM	N/K	5% Improve 0910	5% Improve 0910	0.92%	0.95%	0.83%	0.95%	0.96%	0.89%	0.95%	1.14%	0.90%	0.90%	0.85%	0.83%	
% DNA Rate- Outpatient New Attendances	DM	G	<11%	<11%	10.9%	10.4%	10.0%	11.3%	10.8%	11.4%	11.4%	10.8%	10.2%	11.7%	11.1%	10.6%	10.6%
% DNA Rate- Outpatient Follow Up Attendances	DM	R	<11%	<11%	14.7%	14.8%	15.5%	14.8%	14.5%	15.0%	14.7%	14.4%	14.0%	16.0%	15.3%	14.0%	14.3%
% DNA Rate- Inpatient Elective Procedures	DM	G	<11%	<11%	2.2%	2.4%	2.1%	2.2%	1.4%	2.1%	2.9%	1.6%	2.0%	2.2%	3.1%	2.2%	2.6%
Unplanned Care																	
Number of A&E Admissions with less than 4 hours LOS	DM	N/A	Monitor	Monitor	6295	588	566	545	516	457	527	491	565	495	447	505	593
% of NELpatients stays exeeding the trim point	DM	N/K	TBC	TBC	3.6%	4.0%	3.8%	3.7%	3.2%	4.3%	3.0%	3.2%	3.8%	4.0%	3.5%	3.3%	
Critical Care																	
% pts disc to ward from Level 3 CC between 22h00 and 08h00	DM	N/A	Monitor	Monitor	15.8%	18.4%	15.3%	15.5%	11.9%	18.9%	14.9%	15.3%	11.7%	16.7%	24.2%	12.1%	13.9%
Average Length of Stay in ITU	DM	N/A	Monitor	Monitor	2.30	1.48	3.71	1.97	1.92	3.14	3.16	2.32	1.92	2.56	1.63	2.58	2.58
Average Length of Stay in HDU	DM	N/A	Monitor	Monitor	3.05	2.96	2.76	2.65	2.96	3.29	3.43	2.70	3.01	3.63	3.18	3.94	3.94
A&E Performance																	
% of patients waiting over 4 hours from DTA to Admission	DM	G	TBC	98.0%	3.2%	0.8%	0.6%	1.6%	3.1%	2.6%	3.4%	4.7%	4.1%	6.1%	6.8%	1.9%	2.5%
% of patients admitted more than 3.5hours after arrival in A&E	DM	N/A	Monitor	Monitor	13.3%	11.7%	12.0%	12.7%	11.9%	13.8%	13.6%	14.1%	14.3%	13.9%	14.3%	13.4%	14.2%
Satisifaction of Obligations under A&E/Ambulance Handover Plan	DM	G	Yes	Yes		Yes											
LAS Handover- % of patients handover in less than 15 minutes	DM	R	85%	85%	81.5%	86.2%	88.6%	87.4%	87.7%	84.6%	82.3%	79.5%	77.9%	68.8%	73.1%	81.5%	80.3%
LAS Handover- % of patients handover in less than 30 minutes	DM	G	95%	95%	95.3%	98.3%	98.7%	98.0%	97.6%	96.5%	96.2%	94.9%	93.9%	87.6%	90.9%	96.0%	95.4%
LAS Handover- % of patients handover in more than 60 minutes	DM	R	0%	100%	99.19%	100.00%	99.94%	100.00%	99.66%	99.61%	99.66%	99.21%	99.16%	96.94%	97.58%	99.41%	99.16%
Womens and Children																	
% of women who have seen a midwife or obstetrician by 12 weeks + 6 D	DM	G	90%	90%	94.7%	91.4%	93.3%	91.7%	95.2%	96.2%	96.1%	95.4%	97.9%	95.7%	94.4%	59.5%	59.5%
% of women receiving 1:1 midwifery care during established labour	CF/DM	N/K	0%	0%													
Proportion of caesarean Sections	DM	N/K	TBC	TBC													
Ratio of non birth related attendances (NZ04)	DM	N/K	<0.7	<0.7													
Other																	
SUS- % of alterations- 5 days after month end and reconcilation date	KS/DM	N/K	<3%	<3%													
Medicine Management- % of Low Cost Statins perscribed	DM	N/K	80%	80%													
Medicine Management- % of Low Cost Ace inhibitors perscribed	DM	N/K	71%	71%													
% of clinically appropriate Myocardial Infarction patients discharged on Aspirin, B-Blockers and Statins	DM	N/K	Target set by Q2	Target set by Q2													
Safeguarding Children- To ensure data held on Trust systems is most accurate and latest available. Child Protection Plans are in place	DM		TBC	TBC													

Appendix 4 - Activity Levels

An Activity versus Plan report is now included in the Finance report, therefore it has been removed from this report, however Outpatient Referrals and Births will be monitored in this section of the report as these are not covered elsewhere.

Activity Levels	Exec Lead	RAG Status	Actual Target	Proxy Target	YTD Actual	Apr-10	May-10	Jun-10	Jul-10	Aug-10	Sep-10	Oct-10	Nov-10	Dec-10	Jan-11	Feb-11	Mar-11
Outpatient Referrals																	
Outpatient Referrals- GP	KS/DM	N/K			81,686	7,063	5,385	6,996	7,278	6,590	6,717	6,646	7,183	6,271	6,870	7,135	7,552
Outpatient Referrals- Other	KS/DM	N/K			35,422	2,983	2,588	3,390	3,578	3,031	3,308	3,480	3,225	2,487	2,549	2,158	2,645
Maternity																	
Number of Births	KS/DM	N/K			5,268	396	453	428	479	471	470	477	436	419	443	385	411