

Performance Report

July 2008

Performance Report

Executive Summary

The report this month is presented in two parts:

- Part 1 – Process for performance reporting
- Part 2 – Performance against key priorities.

Part 1

The PCT Strategy 2008-2011 has been translated into an operating plan for 2008/09, with objectives set for the PCT towards achieving the Strategy.

These objectives include the six priorities, our commitment to the Local Area Agreement, Healthy Ambitions and statutory targets toward the delivery of the Annual Health Check. These are attached at Annex A.

It is proposed that the process for performance monitoring and reporting be as follows:

1. The performance team set up an internal process to monitor progress against all the objectives. This process is already advanced for the six priority areas (colour coded within Annex 1), but it will be extended to cover all objectives, many of which are different from previous targets.
2. The PCT Board receives summary progress updates, through the performance report, on all six priorities. The indicators associated with the six priority areas are:
 - **18 weeks standards**
 - 18 week referral to treatment waits; admitted and non-admitted
 - Diagnostic waits less than 6 weeks
 - Maximum wait time of 13 weeks for an outpatient appointment
 - Maximum wait time of 26 weeks for an inpatient appointment
 - Choose & Book rates
 - **Cancer wait times**
 - Maximum wait time of 14 days from urgent GP referral to first outpatient for suspected cancer
 - Maximum wait time of 31 days from diagnosis to treatment for all cancers
 - Maximum wait time of 62 days from urgent GP referral to treatment for all cancers
 - Breast cancer screening for women aged 53 to 70 years
 - **Health care associated infections standards**
 - MRSA levels sustained, with local stretch targets beyond the national targets

- C.Difficile reduction of 30% at national level, with local targets now agreed
- **Primary care access standards**
 - Guaranteed access to a primary care professional within 24 hrs
 - Guaranteed access to a GP within 48 hrs
 - Number of GP practices offering extended opening hours
- **Sexual health programme standards**
 - Chlamydia screening programme standard
 - Access to a GUM service within 48 hrs
- **Urgent care**
 - 4 hr A&E standard
 - Ambulance response times: Cat A 9 min standard
 - Ambulance response times: Cat B 19 min standard

The indicators are colour coded as follows –

18 weeks	Cancer	Primary care	Urgent Care	HCAI	Sexual Health
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3. The PCT Board receives summary progress updates on any objectives where exceptions or non-delivery has occurred, or there is a risk of it doing so, i.e. where the status is Red.
4. The PCT Board are warned if an objective has moved from Green to Amber and a summary report will be produced next time to explain why there was a dip in performance.
5. The PCT Board choose to receive more detail on a few of the other objectives for presentation at the next meeting.

The advantage of this approach is that whilst keeping the PCT Board abreast of performance on the six priorities, and any exceptions, there is a robust system in place to monitor performance on all the others, to allow the PCT Board to 'drill down' and secure assurance as required on other matters.

The PCT Board should consider requesting progress on objectives and targets that are performing well or where there is a local or national interest.

In addition to the motivational effect that this will have on service teams across the PCT, it would help to embed the performance regime across all PCT business.

6. As part of the Annual Health Check, we will also report on ratings given to the PCT and released during late October, to the November PCT Board meeting.

Part 2

Monthly Performance Report – July

Overview

The following charts use a traffic light system, with bars showing as green, amber or red, indicating whether performance is on track or not. Where possible, the traffic lights colours use the thresholds of the Healthcare Commission. This should provide a close guide on the likely performance outcome, as the year progresses.

18 weeks standards

18 week referral to treatment waits; admitted and non-admitted

Target:

Government operational targets of 90% of pathways where patients are admitted for hospital treatment; and 95% of pathways that do not end in an admission, should be completed within 18 weeks

Delivery of the referral to treatment (RTT) time standard is challenging for the PCT. The performance trajectory draws from the plan agreed with the SHA for delivery of the operational targets.

The PCT achieved the milestones that were set for March 2008 and continues to show performance exceeding trajectory. The charts show the latest validated data available.

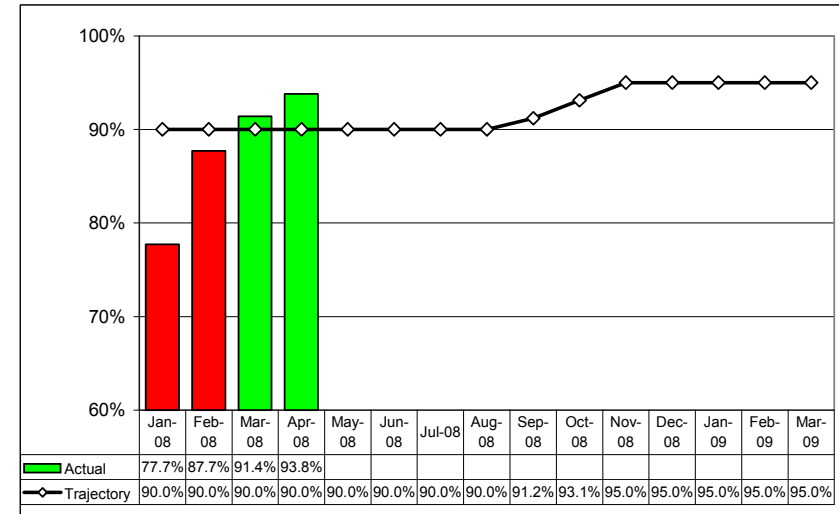
The target position for delivery of 18 weeks is now on track each month with work underway to deliver the higher level target by September 08. Early indications from LTHT are that they are more likely to achieve their elements of the target by October 08 but nevertheless there is a will and push for September.

A comprehensive capacity plan has been produced identifying which specialities have identified any risks and capacity gaps in the delivery of 18 weeks. Project leads have been identified to do further work at speciality level. Capacity required elsewhere in the system will be commissioned as a result of this with the aim of fully utilising IS capacity currently in the system.

Lead Executive Director: Matt Walsh
 Management Lead: Nigel Gray
 Operational Lead: Sue Hillyard

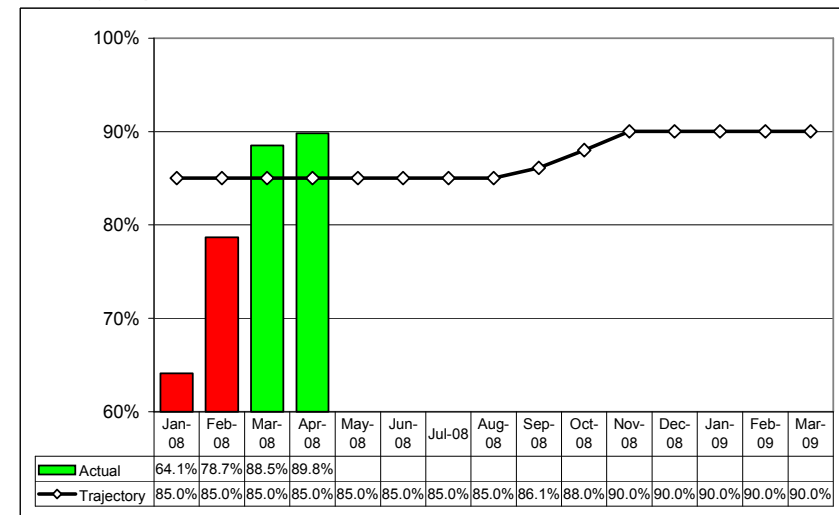
Ensure by March 08 most patients wait less than 18 weeks from referral to treatment

Percentage of patients seen within 18 weeks - non admitted



Ensure by March 08 most patients wait less than 18 weeks from referral to treatment

Percentage of patients seen within 18 weeks - admitted



18 weeks standards

Diagnostic waits less than 6 weeks

Target:

The number of patients waiting 6 weeks or more at the date of measurement for all diagnostic tests, should decrease to zero as rapidly as possible after March 2008.

6 week for direct access Audiology

Direct access audiology diagnostics is currently showing significant numbers of waiters over 6 weeks. However following a comprehensive validation process, the position is now on track to deliver 6 weeks in June. The reason for this has been the recent implementation of a diagnostics patient tracking list (PTL) which when initially became operational, comprised of a broader range of patients than should have been featured. This has now been rectified.

Hearing Aid fittings

This service is not currently 18 week compliant but significant work has been done to address this and overall improvements have been made. It is anticipated that through this work and increased capacity identified, delivery of target will be achieved by August. In addition waiting times for paediatric audiology are between 5 and 6 weeks.

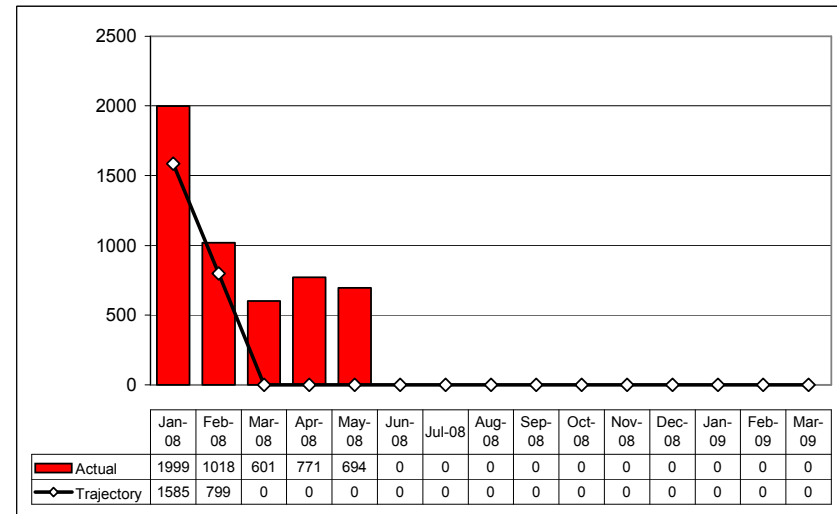
Diagnostic waits

There remains a significant number of diagnostic waits over 6 weeks, Critical areas are endoscopy, colonoscopy and gastroscopy and work is ongoing to manage weekly performance delivery reports utilising the IS for additional capacity. In addition a modelling exercise is underway within each relevant CMT to identify what capacity is needed to deliver less than 6 weeks waits and then a further piece of work will model that delivery down to 2 weeks if necessary to sustain 18 weeks.

Lead Executive Director: Matt Walsh
 Management Lead: Nigel Gray
 Operational Lead: Sue Hillyard

Waits for diagnostics to be reduced to 6 weeks maximum

Number of patients waiting 6+ weeks for 15 key diagnostics



18 weeks standards

**Number of inpatients waiting longer than standard;
Number of outpatients waiting longer than standard**

Target:

That the maximum wait for a first outpatient appointment be no more than 13 weeks from GP referral and for an inpatient no more than 26 weeks after a decision to admit.

There continues to be sub speciality breach risks for 13 and 26 weeks in part as a result of the backlog of patients untreated earlier in the year. It is anticipated that these patients will be cleared in July for gastroenterology and August for the hands speciality. In addition there is further work being managed weekly through the task force to look at dermatology capacity and the utilisation of both the independent sector and primary care providers to address the current increase in demand.

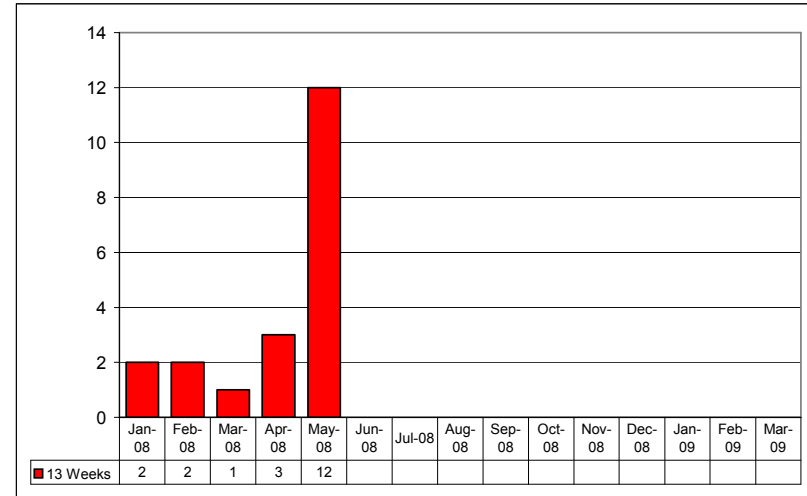
Neurosurgery and plastics also continue to be breach risks for 26 weeks due to the complex nature of a number of patients and therefore the reduced options for treatment in the IS. The impact of referrals from outside of Leeds also is also a key issue in these specialties therefore LTHT is particularly focussing a piece of capacity and demand work on these specialties with the greatest risk of breaching 13 and 26 weeks.

This will give a more comprehensive picture of capacity needed following the impact of free choice and the solutions needed to address these issues. This will report into the 18 week programme management arrangements for sign off.

Lead Executive Director: Matt Walsh
Management Lead: Nigel Gray
Operational Lead: Sue Hillyard

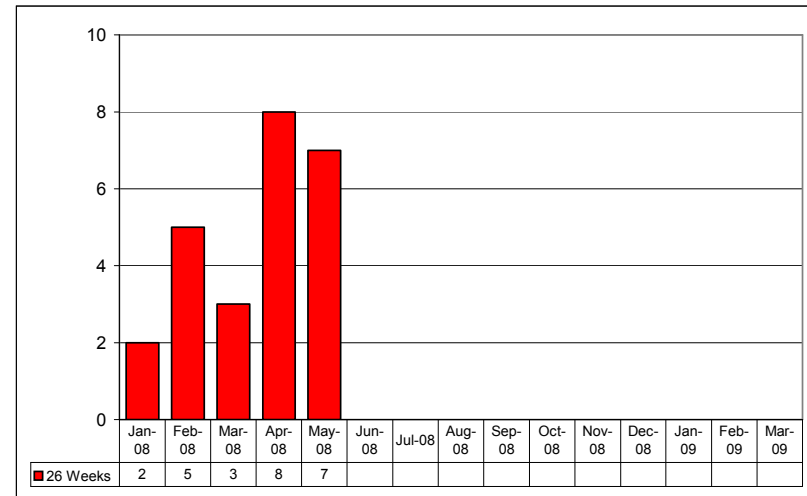
Ensure a maximum wait of 13 weeks for outpatients

Number of outpatients breaching 13+ weeks at each month-end



Ensure a maximum wait of 26 weeks for inpatients

Number of inpatients breaching 26+ weeks at each month-end



18 weeks standards

Maximise the use of the Choose & Book system

Target:

To be developed.

During May there was an increase in the rate of referrals using Choose & Book (C&B) from 18.57% to 19%. This is against a national average of 51%, a static figure for some time. The national average provides a realistic aim for achievement by March 2009. Further work on a more accurate “trajectory” to support this aim will confirm how this will be achieved.

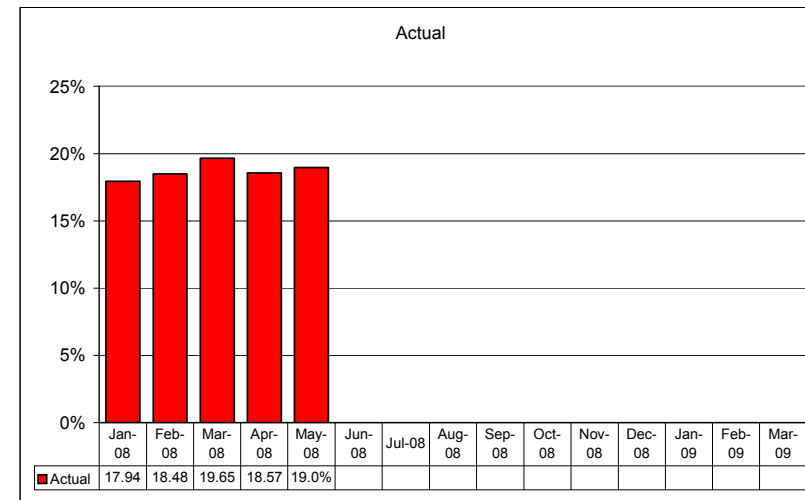
Statistics for the 4 months to December last year illustrate that only 17% of GPs use the C&B system to make more than 20% of their referrals. The main reason given for this is the lack of Directly Bookable Services that are live on the C&B system. Specialties that are not live account for up to 40% of all first referrals by GPs. The PCT is working to get these services available. The C&B team is also working with providers, including community services, to help facilitate their services going live on the system. The C&B system also now has further improved functionality and the ability to offer greater choice to the patient. GP engagement continues with visits being made to individual practices and GP consortia, following a sign up to use C&B by more than 95% of all GPs.

Additional actions being undertaken to improve the use of C&B include work being undertaken on helping practices with IT related queries; a review of the current PCT Referral Management System; and the improvement of governance and supporting systems underpinning C&B within the PCT.

Lead Executive Director: Lynton Tremayne
 Management Lead: Rob Goodyear
 Operational Lead: Rob Goodyear

Choose and Book

Percentage of outpatient bookings made using the Choose & Book system



Cancer wait times

Maximum wait time of 14 days from urgent GP referral to first outpatient appointment for suspected cancer

Target:

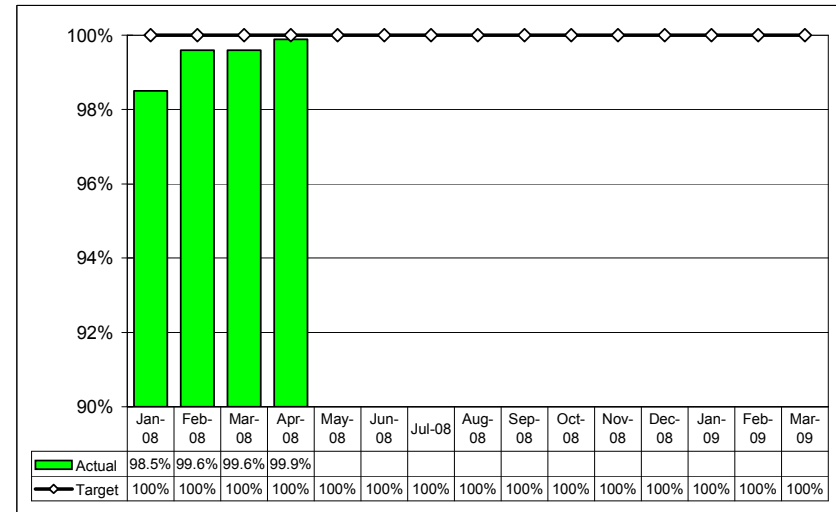
That there be a maximum wait time of 14 days from urgent GP referral to a first outpatient appointment for suspected cancer, with a target of 100% and an operational standard of greater than or equal to 97% patients seen.

The unvalidated position is that May and June targets appear to have been achieved, though this will not be formally confirmed until around six weeks after each month-end.

This wait time target has been consistently achieved within the operational standards.

Access to Cancer Services

Urgent GP Cancer Referrals received within 48 hours and seen within 14 days



Lead Executive Director: Matt Walsh
 Management Lead: Nigel Gray
 Operational Lead: Jayne Reeves

Cancer wait times

Maximum wait time of 31 days from diagnosis to treatment for all cancers

Target:

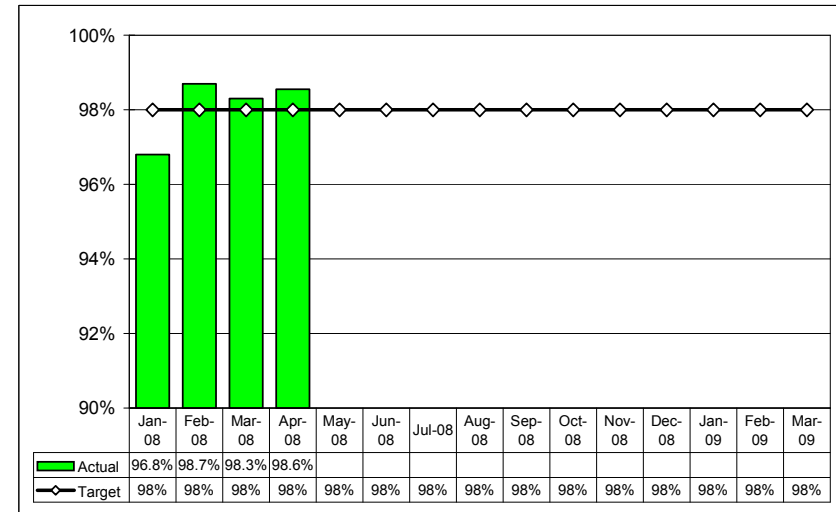
That there be a maximum wait time of 31 days from diagnosis of cancer to the beginning of treatment, with a target of 98% and an operational standard of greater than or equal to 96% of patients seen.

The unvalidated position is that May and June targets appear to have been achieved, though this will not be formally confirmed until around six weeks after each month-end.

This wait time target has been consistently achieved within the operational standards.

Access to Cancer Services

Percentage of patients receiving treatment within 31 days of diagnosis



Lead Executive Director: Matt Walsh
 Management Lead: Nigel Gray
 Operational Lead: Jayne Reeves

Cancer wait times

Maximum wait time of 62 days from urgent GP referral to treatment for all cancers

Target:

That there be a maximum wait time of 62 days from urgent GP referral for suspected cancer to the beginning of treatment, with a target of 95% and an operational standard of greater than or equal to 93% of patients seen.

The unvalidated position is that May and June targets appear to have been achieved, though this will not be formally confirmed until around six weeks after each month-end.

There are continuing problems in lung cancer capacity which mean that early indications are that achievement of the target in July and possibly August look to be at risk.

There are several planned actions to address the problems in this area –

- A new locum has now started in post
- An extra all day list has been put in place

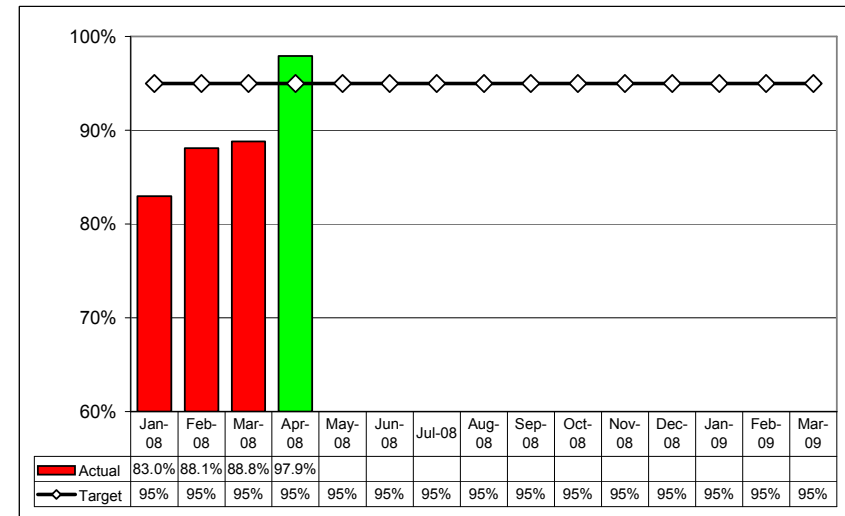
A plan is being developed to reduce backlog – early estimates suggest it may be up to September 08 before there is a return to steady state

The immediate action now is to reach agreement on the recovery plan and for all parties to ensure it is delivered.

Lead Executive Director: Matt Walsh
 Management Lead: Nigel Gray
 Operational Lead: Jayne Reeves

Access to Cancer Services

Percentage of patients receiving treatment within 62 days of referral



Cancer wait times

Breast cancer screening for women aged 53 to 70 years

Target:

That all women aged 53 to 70 years be invited for routine screening for breast cancer, based on a three-year screening cycle, with an operational target of 70% for uptake and 90% for round length cycle.

The data presented comes directly from the Breast Screening Unit and includes women eligible from 50-70 years of age. The minimum standard for uptake is set at 70%.

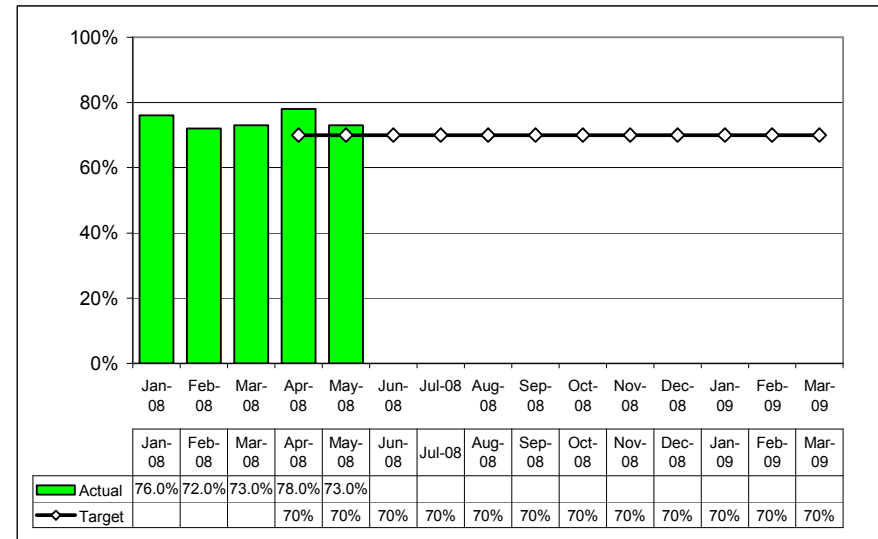
Uptake in Leeds has remained over the minimum standard of 70% since January 2008. The Leeds health economy previously struggled to meet the target for round length (> 90% of eligible women offered screen within 36 months of previous screen) and due to this it was felt that working to improve uptake could have a detrimental effect on round length. The Breast Screening Unit has now worked for 3 months within the round length target. Validated data for April 2008 shows 97% and yet to be validated data for May shows 98% achievement. Therefore, work has begun to promote breast screening in the target age groups and within the vulnerable groups across the city, working in partnership with the voluntary sector.

Leeds Breast Screening Unit, as with other units will be expected to implement an age extension programme of 47-73 (Date for this to be confirmed). Work is ongoing to model this planned age extension programme statistically and ensure that the local population increase is accounted for and built in to future business planning. This work is also mapping where uptake may be particularly low and work will be targeted in these geographical areas.

Lead Executive Director: Ian Cameron
 Management Lead: Simon Balmer
 Operational Lead: Kate Jacobs

Access to Cancer Services

Women offered breast screening



Health care associated infections standards

MRSA levels sustained, with local stretch targets beyond the national targets

Target:

To maintain a maximum of not more than 6 cases per month.

Unvalidated data for June is a total number of 8 cases for the month against a target of 6. The target has been breached for June by two cases, but over the 4 month period March, April, May & June, for which the SHA set a performance 'envelope', the target has been achieved overall to date.

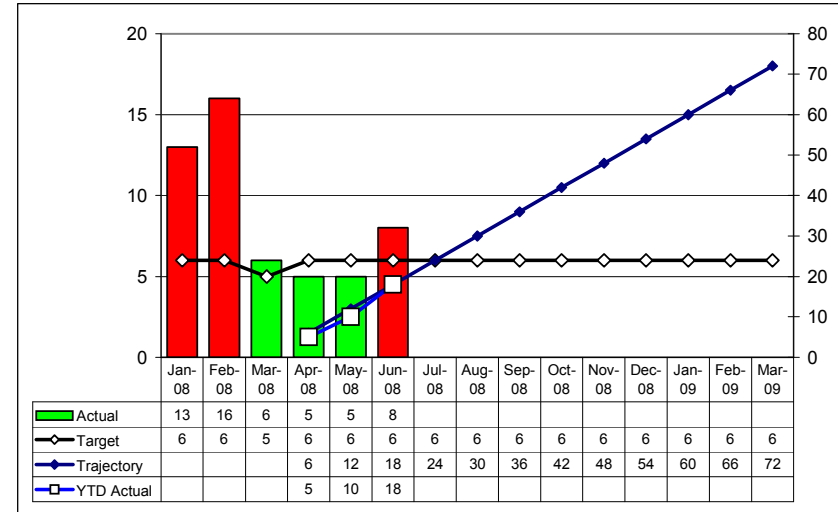
LTHT and the PCT are currently working to renew efforts in reducing the number of cases. Further updates on this work will be given in the next performance report.

The degree of progress that LTHT have made in reducing the number of cases from that seen in September 2007 should be acknowledged, especially in the process of the detailed analysis of all individual cases that takes place. This focus has helped achieve the present position.

Lead Executive Director: Ian Cameron
 Management Lead: Simon Balmer
 Operational Lead: Bob Darby

Health Care Associated Infections

Cumulative number of MRSA positive blood culture episodes



Health care associated infections standards

Incidence of Clostridium Difficile

Target:

That the PCT work to contribute to a reduction of 30% in the number of cases at the national level, with a local target of 4.1 cases per 1000 admissions by 2010/11.

This target has been the subject of detailed discussions between the PCT and the SHA, which has resulted in an ambitious plan and trajectory, as part of the delivery of the national plan.

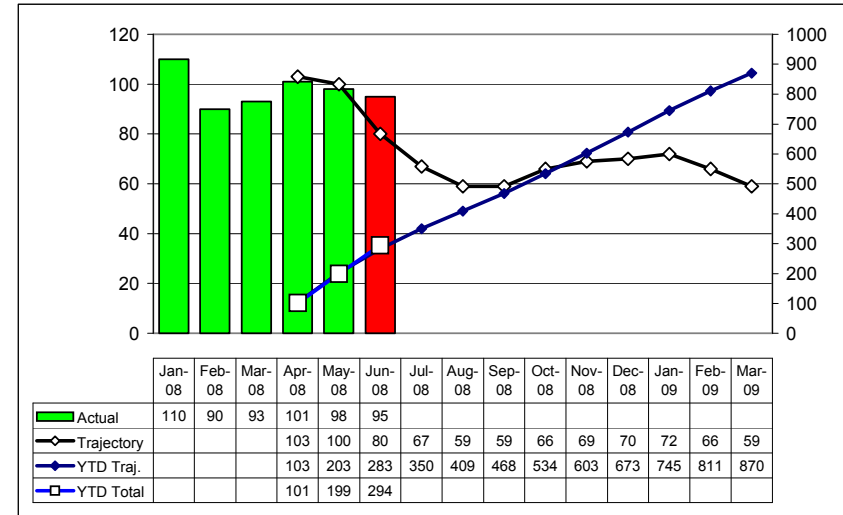
The new 3-year trajectory, a part of which can be seen on the chart opposite, now shows seasonal changes that are anticipated to affect the rate of cases through the year, though the overall projected trend is downwards. The chart has two scales, showing the monthly totals from the left hand side and the year to date information from the right.

Performance so far this year from April, has been reasonable, though slightly higher than planned. June data shows that the number of cases was higher than planned for, although the actual number is reduced from that seen in May. This higher figure for June pushed the total for the year to date over that anticipated and this represents an increased challenge for the remainder of the year.

Lead Executive Director: Ian Cameron
 Management Lead: Simon Balmer
 Operational Lead: Bob Darby

Health Care Associated Infections

C.Diff infections



Primary care access standards

Access to primary care

Target:

Patients are able to access a primary care professional within 24 hrs and a GP within 48 hrs and the PCT.

The Primary Care Access Survey, the data for which is presented in the charts opposite describes the results of the GP practice responses to questions on the availability of appointments. This survey is conducted quarterly and the next one is due to take place shortly.

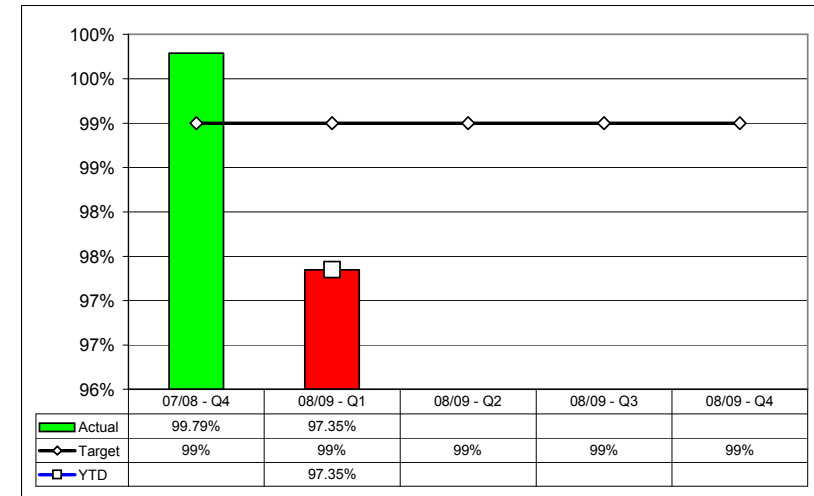
The latest data available is shown, which was also presented to the Board meeting in June.

The other element of the indicators on the delivery of the access standards is that drawn from the GP Patient Survey, which is conducted independently of the PCT. The Patient Survey is carried out annually and therefore cannot be represented in the chart data until results are released to the PCT. It is understood that this will be later this year.

Lead Executive Director: Matt Walsh
 Management Lead: Damian Riley
 Operational Lead: Emma Wilson

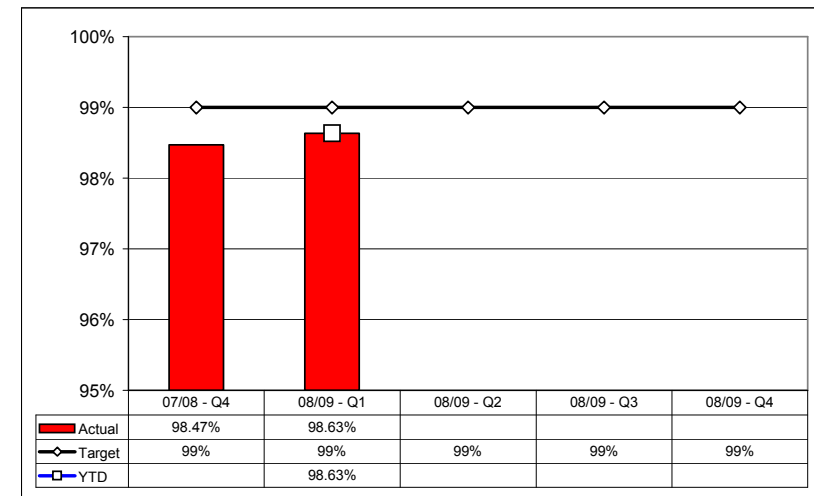
Primary Care Access

48 Hour Access to a GP



Primary Care Access

24 Hour Access to a PCP



Primary care access standards

Access to primary care

Target:

At least 50% of GP practices in the PCT offer extended opening hours by Dec 2008.

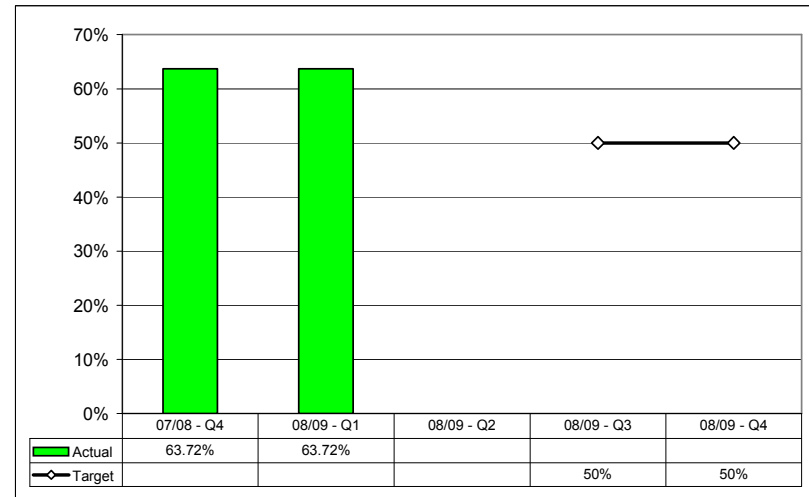
The target of 50% of practices offering extended opening hours in line with DH guidelines, by Dec this year has already been met. In June, the PCT was reporting that almost 64% of practices were meeting the requirements. This is planned to increase further during the year.

The chart shows quarterly data, which represents the reporting frequency.

Note: This indicator is also sometimes described using the term 'Family friendly hours'.

Primary Care Access

Family Friendly Hours



Lead Executive Director: Matt Walsh
 Management Lead: Damian Riley
 Operational Lead: Emma Wilson

Sexual health programme standards

Chlamydia screening programme standard

Target:

That 17% of the population aged 15-24 accept screening or testing for chlamydia in 2008/09

Narrative:

This indicator now includes screens carried out in primary care, a revision to previous practice. The number of these screens is presently being validated and is shown as a 'top-up' to the known validated number conducted within the national screening programme.

Complete data for Q1 (08/09) is not yet available, as the primary care screens outside the project can only be estimated at this stage based on last year's activity, therefore best estimates of activity have been included.

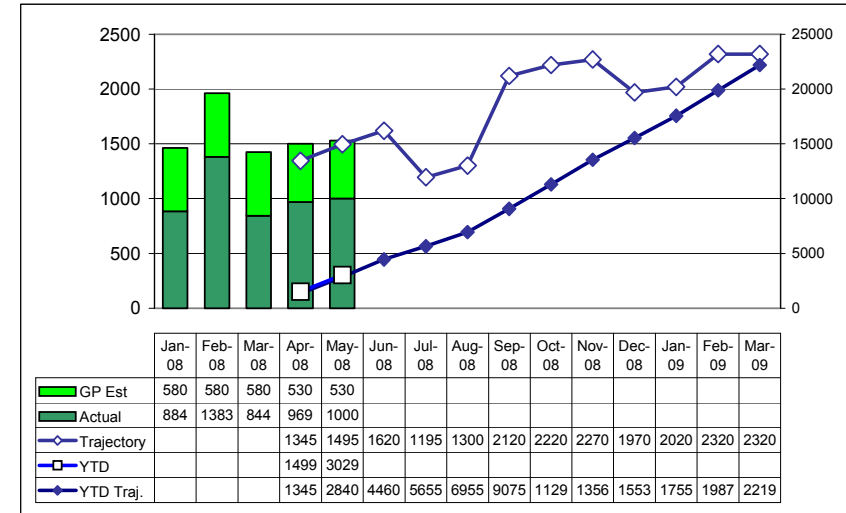
The chart shows the target trajectory will have been achieved up to June, with the inclusion of estimated data. In order to achieve the target rate of 17% of sexually active 15-24 year olds on 2008/09, screening activity will need to continue to increase.

Actions to ensure delivery include weekly meetings to monitor the agreed action plan and identify risks to achieving target. Key current risks are identified as within CaSH service and Prisons. Activity within both areas has fallen. This is being managed through discussion at senior level with PCT care services. Capacity has also been increased to manage key components of the project through matrix working. Capacity has been increased within the chlamydia screening team. A pharmacy campaign is planned for July/August, with Bond St Boots promoting postal testing kits. Workplace screening is also in progress and the PCT is working with FE colleges to implement registration screening.

Lead Executive Director: Ian Cameron
 Management Lead: Jon Fear
 Operational Lead: Victoria Eaton

Sexual Health

Chlamydia Screening



Sexual health programme standards

Access to GUM services

Target:

All patients should receive an offer of an appointment to be seen within 48 hrs of contacting the GUM service (not an offer made within 48hrs to be seen at a later date).

Narrative:

GUM have maintained the Healthcare Commission's 100% 'offered' target since March 2008 and continue to offer access to the service within 48 hours. Currently LTHT, as the main provider, have the capacity to continue to sustain this performance throughout the year.

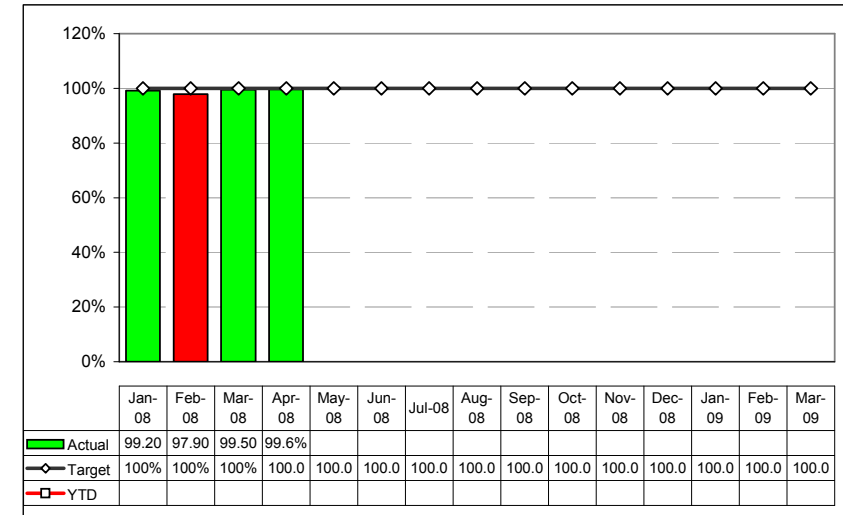
Other positive news is that the new patient DNA rate has fallen since March from 14.77% to 10.4% in June.

The other indicator previously used, that of the rate of patients actually seen within 48 hours is the subject of debate and there is a strong national view within the service that patient choice is preventing achievement of the 95% threshold. An extension to the time period for the 'seen' indicator is being considered to take account of this. Further news on this will follow as it becomes available.

Lead Executive Director: Ian Cameron
 Management Lead: Jon Fear
 Operational Lead: Victoria Eaton

Improve access to genito-urinary medicine

Percentage of patients offered an appt for within 48 hrs of contacting GUM



Urgent care standards

4 hr A&E standard

Target:

That at least 98% of patients spend 4hrs or less in A&E, from arrival to admission, transfer or discharge.

Year to date performance of 99.6% as at 2 July has been achieved. All sites at LTHT continue to achieve the target 98% daily, with rare exceptions.

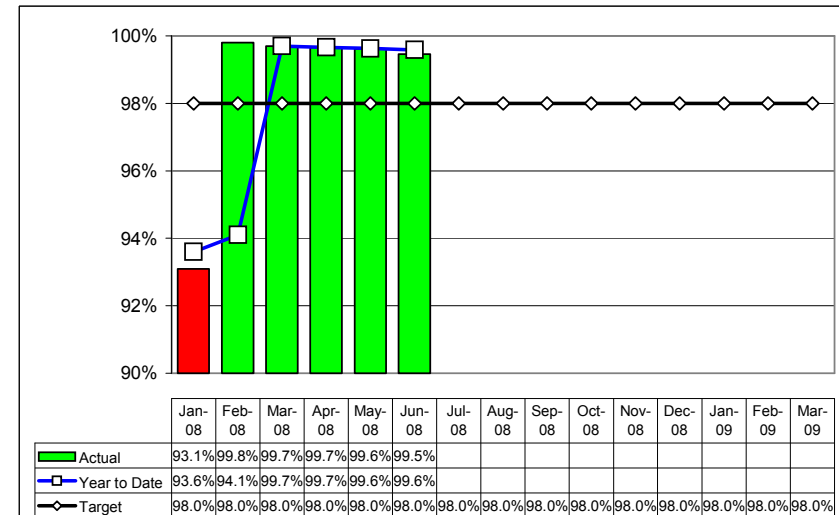
This significant turnround is clearly due to successful implementation during March of a system of ward assessment and receiving areas, which is having a positive impact on patient flow through the A&E department. The culture shift required within LTHT, both within A&E and the inpatient teams, has now been shown to have the desired effect. The PCT and LTHT continue to meet with the SHA to be clear about the position going forward.

The activity from the Commuter Walk-in Centre in The Light is now contributing towards the 4hr target, and historical data since April 07 is being fed into the overall year-end return.

Lead Executive Director: Matt Walsh
 Management Lead: Nigel Gray
 Operational Lead: Laura Sherburn

Maximum 4hr wait in A&E

Percentage of patients spending less than 4hrs in A&E



Urgent care standards

Ambulance response times: Cat A 9 min & Cat B 19 min standards

Target:

A minimum of 75% of Cat A calls should receive an emergency response at the scene within 8 mins and 95% of Cat B calls should receive an emergency response at the scene within 19 mins.

Performance on these indicators is based on the whole ambulance service returns. On the Cat A 75% target, at 15th June 2008 the Yorkshire Ambulance Service (YAS) performance year to date stood at 62.6%. This is a key risk for the region in terms of Healthcare Commission ratings.

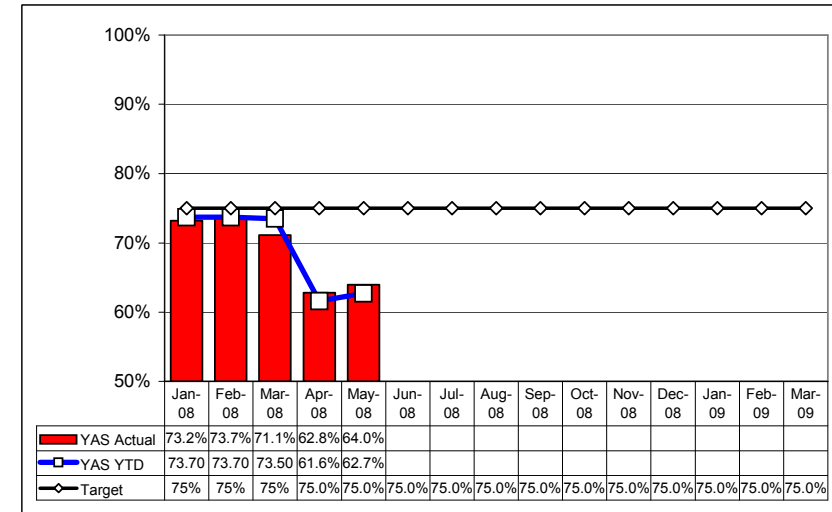
The recent marked decline in performance is acknowledged to be due to the impact of Call Connect. The performance management framework implemented by the SHA from April 08 with key actions for PCTs and NHS organisations is ongoing and includes trajectories to achieve the target. Going forward, the contract for 08-09 is currently being negotiated, and will look to move towards an activity-based contract funded through locally agreed tariff, with appropriate controls in place. The PCT is arranging to meet YAS at a future Board meeting to discuss performance trajectories and turnaround plans and we have offered to lead a workshop at the Directors of Performance network of Yorkshire and Humber to provide support and assistance to YAS in achievement of their plans.

On the Cat B target, YAS performance as a whole is 89.5% year to date. Ongoing contract negotiations for 08-09 and the SHA performance management action plan will address this going forward.

Lead Executive Director: Matt Walsh
 Management Lead: Nigel Gray
 Operational Lead: Laura Sherburn

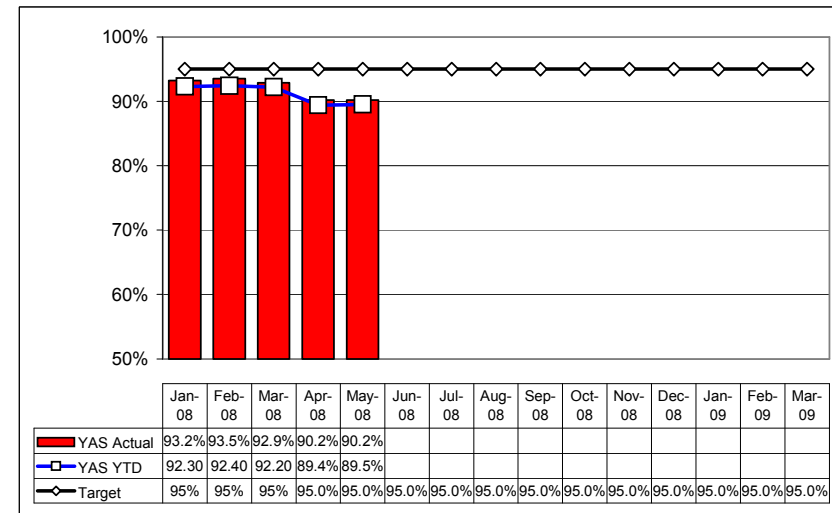
Ambulance Response Times

Category A calls receiving a first response within 8 minutes



Ambulance Response Times

Category B calls receiving a first response within 19 minutes



Annex A – Full list of 2008/09 indicators, by PCT Directorate

Directorate	ED lead	PCT Top 6 Priority	Description of Objective / Initiative	Mngmt lead	Ops lead
Commissioning	MW	18 weeks	18 weeks maximum wait from referral to the start of treatment by Dec 2008	NG	SH
			Diagnostic Waits > 6 Weeks	NG	SH
			Maximum wait time of 13 weeks for an outpatient appointment	NG	SH
			Maximum wait time of 26 weeks for an inpatient appointment	NG	SH
			Patient reported measure of choice of hospital	NG	SH
			Percentage of Patients seen within 18 weeks for direct access audiology services	NG	SH
		Cancer	A maximum waiting time of one month from diagnosis to treatment for all cancers	NG	JR
			A maximum waiting time of two months from urgent referral to treatment for all cancers	NG	JR
			A two week maximum wait from urgent GP referral to first outpatient appointment for all urgent suspected cancer referrals	NG	JR
			Improving cancer services - Implementation of IOGs	NG	JR
			Proportion of patients waiting no more than 31 days for second or subsequent cancer treatment (radiotherapy treatments)	NG	JR
			Proportion of patients waiting no more than 31 days for second or subsequent cancer treatment (surgery and drug treatments)	NG	JR
			Proportion of patients with breast symptoms referred to a specialist who are seen within two weeks of referral	NG	JR
		Primary care	Proportion of patients with suspected cancer detected through national screening programmes or by hospital specialists who wait less than 62 days from referral to treatment	NG	JR
			Guaranteed access to a primary care doctor within 48 hours	DR	EW
			Guaranteed access to a primary care professional within 24 hours	DR	EW
			Improvement in Family Friendly GP Hours (50% in PCT to offer extended opening)	DR	EW
			Patient reported measure of access to a GP	DR	EW
		Urgent Care	Primary dental services, based on assessment of local needs with the objective of ensuring year on year improvements in the numbers of patients accessing NHS dental services	DR	SL
			All ambulance Trusts to respond to 75% of Category A calls within 8 minutes	NG	LS
			All ambulance Trusts to respond to 95% of Category B calls within 19 minutes	NG	LS
			Four hour maximum wait in A&E from arrival to admission, transfer or discharge	NG	LS
			A maximum two week wait for Rapid Access Chest Pain Clinic	NG	PD
			All patients who have operations cancelled for non clinical reasons to be offered another binding date within 28 days, or the patients treatment to be funded at the time and hospital of the patient's choice	MW	NH
			Data quality on ethnic group (previously derived from SUS and MHMDS)	MW	NH/RW
			Number of people provided care closer to home	NG	
			Implementation of Stroke Strategy / Time to Treatment	NG	PD
			Emergency bed days (also used as proxy for VSC11: People with long-term conditions feeling independent and in control of their condition)	NG	PD
			Thrombolysis "call to needle" of at least 68% within 60 minutes, (where preferred local treatment for heart attack)/Primary angioplasty 'call to balloon' time	NG	PD
			Time to reperfusion for patients who have had a heart attack	NG	PD
			People with long-term conditions feeling independent and in control of their condition	CC	MiW
			A three month maximum wait for revascularisation	NG	PD

Directorate	ED lead	PCT Top 6 Priority	Description of Objective / Initiative	Mngmt lead	Ops lead
Public Health	IC	Cancer	Breast cancer screening for women aged 53 to 70 years	SB	KJ
		HCAI	All elective admissions screened for MRSA from 2008/09;	SB	BD
			All emergency admissions screened for MRSA as soon as possible in next three years	SB	BD
			C Diff reduction by 30% by 2011, SHA differential envelopes to deliver a 30% reduction nationally by 2011	SB	BD
			MRSA levels sustained, locally determined stretch targets taking us beyond the national target.	SB	BD
		Sexual Health	Chlamydia screening programme to be rolled out nationally (Year 1 (08/09) data to be used for prevalence indicator)	VE	SF
			Guaranteed access to a genito urinary clinic within 48 hours of contacting a service	VE	SF
			Prevalence of chlamydia (Year 1 will use existing AHC screening measure to set baseline)	VE	SF
			100% of people with diabetes to be offered screening for the early detection (and treatment if needed) of diabetic retinopathy	SB	KJ
			All Age All Cause Mortality Rate per 100,000	JF	JF
			All-age all cause mortality rate (target disaggregated to focus on narrowing the gap between most deprived 10% and the Leeds average)	JF	JF
			Children and young people's participation in high-quality PE and sport (NI 57)	DB	JB
			Healthy life expectancy at age 65	JF	JF
			Proportion of children who complete immunisation by recommended ages	SB	BB
			Reduce <75 Cancer Mortality Rate (20% by 2010)	JF	JF
			Reduce <75 CVD Mortality Rate (40% by 2010) (NI 121 Mortality rate from circularly diseases at ages under 75)	JF	LJ
			Reduction in gap between best and worst SOAs (CVD Mortality)	LJ	LJ
			Robust and up-to-date emergency planning	SB	BA
			Smoking prevalence (Quit Rates as presently reported)	HT	KH
			Stopping smoking - disaggregated to narrow the gap between 10% most deprived SOAs and rest of Leeds	HT	KH
			Tackling fuel poverty – People receiving income based benefits living in homes with a low energy efficiency rating (NI 187)	DB	DA
			COPD Prevalence	JF	HT
	Vascular risk	LJ	LJ		

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Strategic Development	JC	Sexual Health	Teenage pregnancy rates per 1000 females aged 15-17 (NI 112 Under 18 conception rate)	SS	MF
		Urgent Care	Delayed transfers of care per 100,000 population	CC	MiW
			Delayed transfers of care to be maintained at a minimum level	CC	MiW
			Number of drug users recorded as being in effective treatment (NI 40)	CC	TA
			Number of drug users successfully completing treatment	CC	TA
			% of women who have seen a midwife, or an appropriate healthcare professional, for health and social care assessment of needs and risk by 12 weeks of pregnancy	SS	MF
			Adults and Older people receiving direct payments and/or individual budgets per 100,000 population	CC	MiW
			All patients who need them to have access to crisis services, with delivery of 100,000 new crisis resolution home treatment episodes each year	CC	TA
			Breastfeeding continuation (prevalence 6-8 weeks)	SS	MF
			Carers receiving a 'carer's break' or a specific carers' service	CC	MiW
			Childhood obesity rate among primary school age	SS	MF
			Reduction in suicide and Undetermined injury mortality rate (20% by 2010) (Indicator to be used is AHC CPA 7 day follow up)	CC	TA
			Deliver 7,500 new cases (nationally) of psychosis served by early intervention teams per year;	CC	TA
			Effectiveness of CAMHS. % of PCTs providing a comprehensive service. (NI 51, Indicator under development; existing AHC Access to CAMHS indicator to be used as proxy for yr 1)	SS	MF
			Emotional and behavioural health of children in care (NI 58)	SS	MF
			Environment for a thriving third sector (NI 7)		LCC
			Number of vulnerable and socially excluded with mental health problems helped into settled into employment	CC	TA
			People supported to live independently	CC	MiW
			Percentage of vulnerable people achieving independent living (NI 141)	CC	LCC
			Rate of hospital admissions per 100,000 for alcohol related harm	CC	TA
			Stability of placements of looked after children: length of placement (NI 63)	SS	MF
			The extent to which older people receive the support they need to live independently at home (NI 139)	CC	MiW
			Timeliness of social care assessment (all adults) (NI 112)	CC	LCC
	Timeliness of social care packages following assessment (all adults) (NI 133)	CC	LCC		

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Information	LT	18 weeks	18 week supporting indicator: Activity for 15 key diagnostic tests	AC		VSA05:10
			18 week supporting indicator: All first OP attendances (consultant led) - G&A	AC		VSA05:4
			18 week supporting indicator: First OP attendances following GP referral - G&A	AC		VSA05:3
			18 week supporting indicator: GP referrals for outpatient - G&A	AC		VSA05:1
			18 week supporting indicator: Non elective G&A FFCEs (excluding well babies)	AC		VSA05:9
			18 week supporting indicator: Other referrals for outpatient -G&A	AC		VSA05:2
			18 week supporting indicator: Planned elective daycase FFCEs	AC		VSA05:6
			18 week supporting indicator: Total elective G&A admitted FFCEs	AC		VSA05:7
			18 week supporting indicator: Total elective G&A daycase FFCEs	AC		VSA05:5
			18 week supporting indicator: Total planned G&A admitted FFCEs	AC		VSA05:8
			Choose & Book rates	RG		Local

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Workforce & Corporate	JGM		Compliance with Core Healthcare Commission standards	JL		AHC
			NHS Survey: Staff Satisfaction	JW		VSB17
			Patient and user reported measure of respect and dignity in their treatment	JW		VSC32 & AHC
			Percentage of people who believe people from different backgrounds get on well together in their area (NI 1)	JW		LAA
			Percentage of people who feel they can influence decisions in their locality (NI 4)	JW		LAA
			Self reported experience of patients/users/public	JW		VSB15 & AHC