Report to Scrutiny Committee: Performance

October 2008

Overview

This report to the Scrutiny Committee is spilt into two parts.

Part 1 based in part on the Performance Report as submitted to the PCT Board.

Part 2 is a report on the establishment of a new body, the Joint Performance Management Board, charged with overseeing strategic performance in partnership with the PCT's chief secondary care provider, Leeds Teaching Hospitals Trust.

This section of the report for the Scrutiny Committee also contains a set of example papers. The performance report, of a similar type to that used for the PCT Board, si not included here, to avoid repetition. The format of the report for the Performance Board, being consistent with the PCT report, will help to achieve consistency. The Joint Performance Management Board considers performance indicators that are 'shared' by the PCT and the Hospitals Trust, using a programme that divides them into manageable segments. All the shared indicators will considered by the Board at least three times each year, using this system.

Part 1: The PCT Board Performance Report

The performance objectives for the PCT include the six key priorities, our commitment to the Local Area Agreement, Healthy Ambitions and statutory targets toward the delivery of the Annual Health Check. A full list of these is attached at Annex A, shown by PCT directorate and including the indicator reference number.

As agreed by the PCT Board the process for performance monitoring and reporting is:

1. A report comprising summary progress updates, on the six key priorities (colour coded within Annex A). The specific 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 8 min standard
  - Ambulance response times: Cat B 19 min standard

2. A summary progress update on indicators where exceptions or non-delivery has occurred, or there is a risk of it doing so, i.e. where the status is red traffic lighted. For the current period these areas have been identified as:-

- Commissioning of early intention in psychosis services
- Data quality on ethnic group

3. There will also be a warning if an objective has moved from green to amber and a summary report will be produced to explain why there was a dip in performance. Presently, the indicator on childhood obesity is potentially identified as carrying some risk, though this is still being quantified.

4. The PCT Board agreed that there would be a focus on the Commuter Walk-in Centre, based at the Light for the current period. This is presented in a similar fashion to other indicators, though with added narrative.

Performance indicators supporting the PCT's priorities:

- 18 week standards
- Cancer wait times standards
- Health care associated infections standards
- Primary care access standards
- Sexual health programme standards
- Urgent care standards

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.

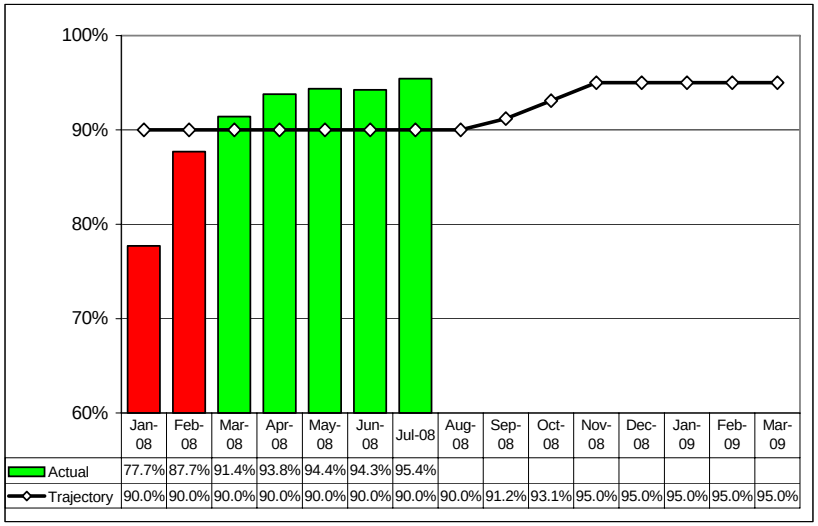
The target position for delivery of 18 weeks is now on track each month with work underway to deliver the higher level target by September 08. Early indications from LTHT are that they are more likely to achieve their elements of the target by October 08 but nevertheless there is a will and push for 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 has been commissioned as a result of this, notably for areas experiencing breaches of 13 and 26 weeks, 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

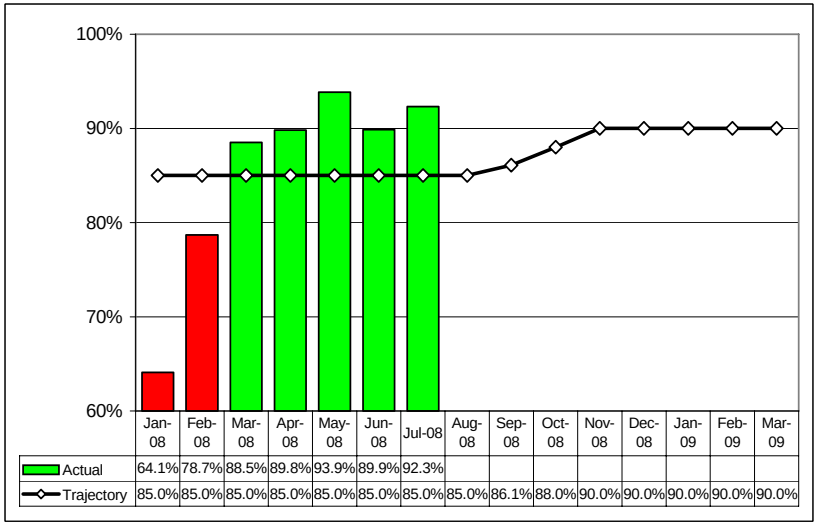
Percentage of patients seen within 18 weeks - non admitted



	Jan-08	Feb-08	Mar-08	Apr-08	May-08	Jun-08	Jul-08	Aug-08	Sep-08	Oct-08	Nov-08	Dec-08	Jan-09	Feb-09	Mar-09
Actual	77.7%	87.7%	91.4%	93.8%	94.4%	94.3%	95.4%								
Trajectory	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	91.2%	93.1%	95.0%	95.0%	95.0%	95.0%	95.0%

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

Percentage of patients seen within 18 weeks - admitted



	Jan-08	Feb-08	Mar-08	Apr-08	May-08	Jun-08	Jul-08	Aug-08	Sep-08	Oct-08	Nov-08	Dec-08	Jan-09	Feb-09	Mar-09
Actual	64.1%	78.7%	88.5%	89.8%	93.9%	89.9%	92.3%								
Trajectory	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	86.1%	88.0%	90.0%	90.0%	90.0%	90.0%	90.0%

18 weeks standards

18 week supporting indicators: GP referrals for outpatient (general & acute); Other referrals for outpatient (general & acute).

Target:

No specific target, the intention being to support decision making around the capacity needed to deliver and sustain a maximum 18 week wait time.

The first indicator here records the actual number of referrals made by a GP for an outpatient appointment, whilst the second indicator describes the total of referrals for an outpatient appointment from sources other than a GP.

Recent analysis has shown that there is likely to be a significant increase in referrals during 08/09. This trend has been seen nationally, within the SHA, PCT and by local providers. Referrals have, in fact, been on the rise for the last 12 months, but the increase was particularly marked in Q1 08/09.

There are some features that make the reported increase appear greater than the actual increase. These include the bank holiday falling in March rather than April and the PCT provider now reporting activity through national systems, whereas they were not 12 months ago. However, accounting for the above, the real increase in all referrals across the full year may be as high as 11%. For Leeds patients, the percentage increase may be greater to local hospitals other than LTHT.

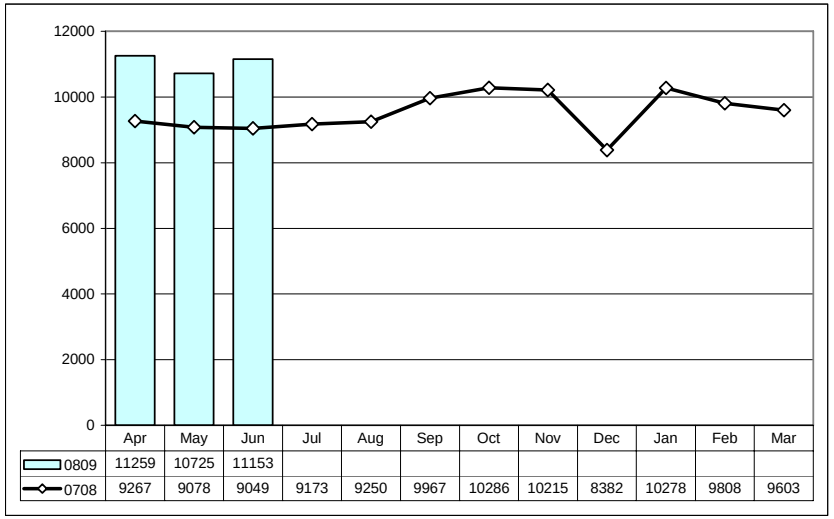
A number of tasks are being undertaken to further investigate all of the above, including work with PBC Consortia and GP Practices.

It should be noted that due to the way data is reported nationally, a month by month comparison with last year is not possible in all areas.

Lead Executive Director: Lynton Tremayne
Management Lead: Alastair Cartwright
Operational Lead: Alastair Cartwright

18 weeks

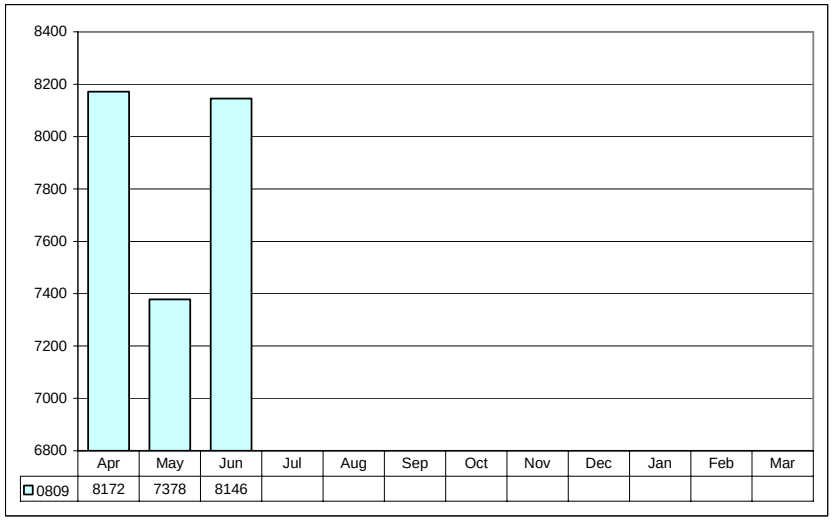
18 week supporting indicator: GP referrals for outpatient - G&A



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
0809	11259	10725	11153									
0708	9267	9078	9049	9173	9250	9967	10286	10215	8382	10278	9808	9603

18 weeks

18 week supporting indicator: Other referrals for outpatient -G&A



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
0809	8172	7378	8146									

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.

Paediatric Audiology
A number of June and July breaches of this specialty were seen in early August. Major efforts have been undertaken in August to ensure no breaches in August or thereafter.

Diagnostic waits at secondary care providers
The position is improving month on month. We anticipate 38 breaches in August. These are split down as:

25	Neurophysiology
5	Cystoscopy
8	Endoscopy

Analysis of the reasons for the breaches in August has shown:

- Lack of admin capacity which has impacted on contacting and scheduling of patients
- Cancellations due to lack of anaesthetic cover

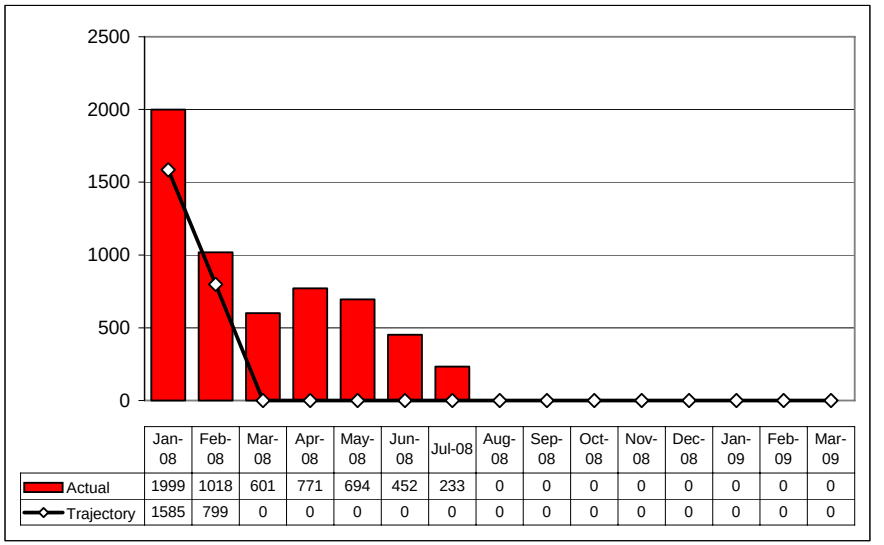
Steps have been taken to rectify these issues and we are working towards a zero breach position from September onwards.

The SHA have been kept informed of and involved in the developing situation.

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



	Jan-08	Feb-08	Mar-08	Apr-08	May-08	Jun-08	Jul-08	Aug-08	Sep-08	Oct-08	Nov-08	Dec-08	Jan-09	Feb-09	Mar-09
Actual	1999	1018	601	771	694	452	233	0	0	0	0	0	0	0	0
Trajectory	1585	799	0	0	0	0	0	0	0	0	0	0	0	0	0

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.

Breaches have continued to occur in each month since the last performance report. 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.

Neurosurgery and plastics 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 independent sector. The impact of referrals from outside of Leeds also is also a key issue in these specialties and LTHT is working on a piece of capacity and demand work, to try to remove the risks for the future.

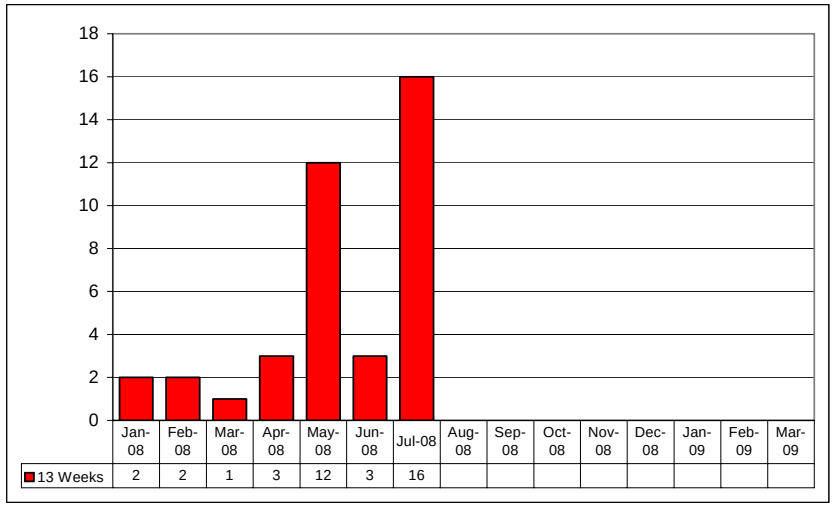
The threshold for achievement has been set at 99.97% of all patients to be seen within the standard time. The number of breaches so far this year means, based on activity levels from 2007/08, both standards have failed to be achieved for 2008/09. The number of outpatients seen last year was over 96,000, meaning that 30 and over breaches would lead to failure to achieve, whilst for inpatients over 63,000 were seen, meaning that 20 and over breaches would equate to failure. So far this year 39 outpatients and 36 inpatients have waited longer than the minimum standards

The PCT and LTHT have recently agreed an early warning process, which will be used to ensure that the maximum notice is given of likely breaches so that remedial action can be taken, where possible.

Lead Executive Director: Matt Walsh
Management Lead: Philip Grant
Operational Lead: Neil Hales & Richard Wall

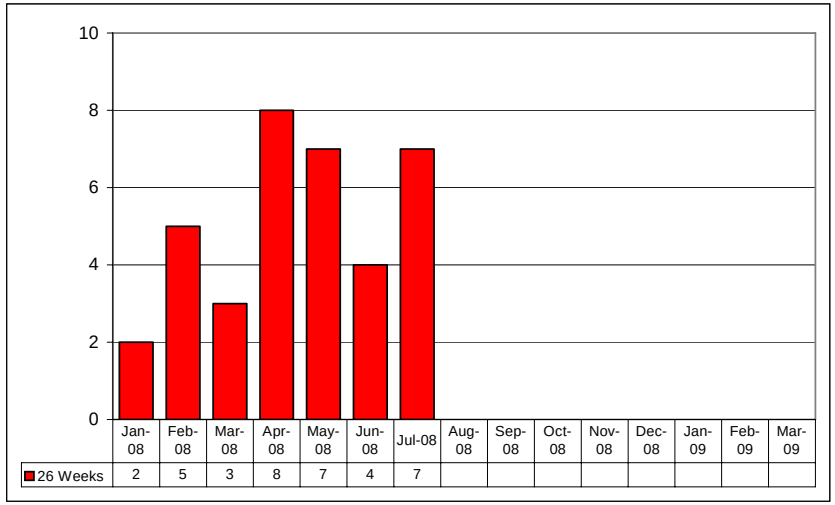
Ensure a maximum wait of 13 weeks for outpatients

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 secure 100% usage of Choose & Book system for onward referrals by Oct 2009.

June and July rates of referrals using Choose and Book were both 27%; an increase from the 25% achieved in May. This is set against a national average of 52%, which is also a static figure. June/July was affected by the increasing number of unavailable appointment slots. If slot issues were addressed, performance would have been 29% and 30% respectively.

A revised trajectory and the actions required for 100% utilisation of the Choose and Book system by October 2009 has been submitted for discussion to the 18 Week Programme Board.

Updated statistics show that the number of GP Practices utilising the Choose and Book system for more than 20% of their referrals has increased from 30 practices to 63 practices. Additionally, the Choose and Book team made 44 GP practice visits in July.

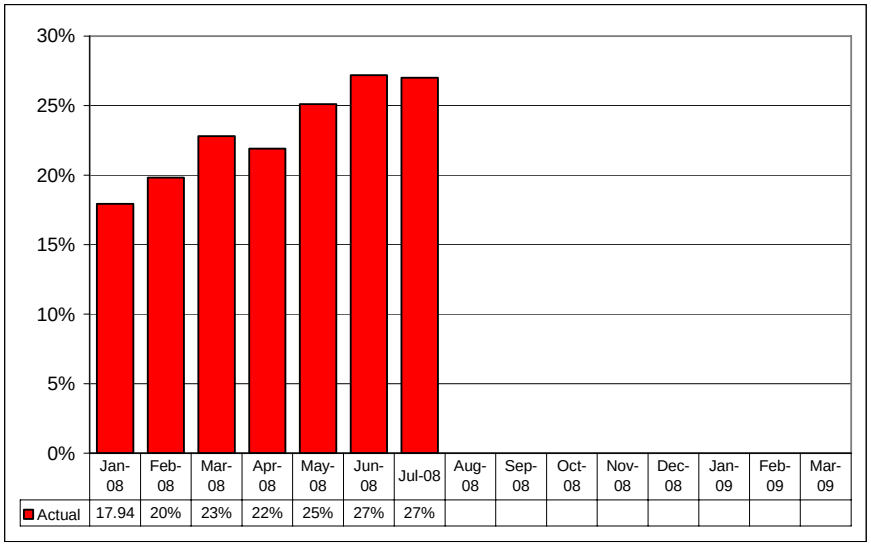
The PCT is working with the PBC consortium Leodis to train all of their GP practices in the use of the Choose and Book system, intending to make its use mandatory. Discussions are beginning for a similar approach with other PBC Consortia.

Atos Origin, who have developed and implemented Choose & Book nationally, have been approached to discuss how they can help contribute to achievement of 100% based on their experience of delivery elsewhere.

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 98% patients seen.

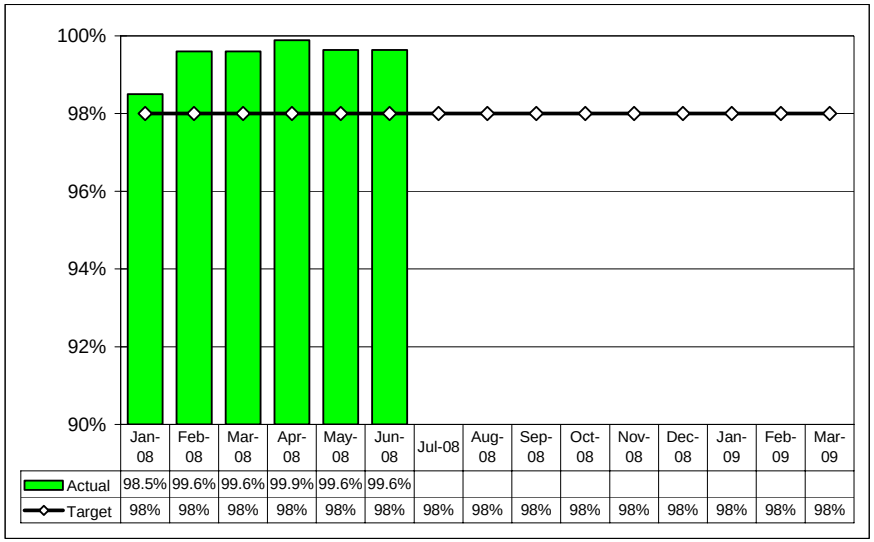
The unvalidated position is that the July target has been achieved. Preliminary information shows that August should also be achieved, though neither of these positions will be formally confirmed until around six weeks after each month-end.

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

It is expected to be able to maintain this target until March 09. From January 09 the clock start time will change to align with the 18 week clock state rules, ie: from date of referral to date received, which allows one additional day or more "leeway" in sustainability.

Access to Cancer Services

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



	Jan-08	Feb-08	Mar-08	Apr-08	May-08	Jun-08	Jul-08	Aug-08	Sep-08	Oct-08	Nov-08	Dec-08	Jan-09	Feb-09	Mar-09
Actual	98.5%	99.6%	99.6%	99.9%	99.6%	99.6%									
Target	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%

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:

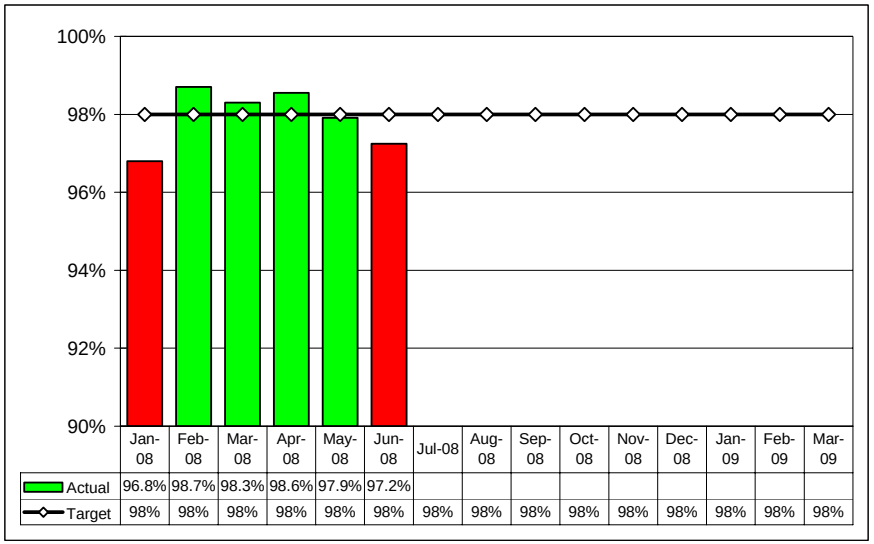
That there be a maximum wait time of 31 days from diagnosis of cancer to the beginning of treatment , with a target of 98% of patients seen.

The validated position for July 08 recorded 99.6% and was achieved.

The unvalidated position for August 08 is five breaches within LTHT – two of the patients being Leeds residents. With the denominator of 320 patients, a 98% and above target is expected to be achieved.

Access to Cancer Services

Percentage of patients receiving treatment within 31 days of diagnosis



	Jan-08	Feb-08	Mar-08	Apr-08	May-08	Jun-08	Jul-08	Aug-08	Sep-08	Oct-08	Nov-08	Dec-08	Jan-09	Feb-09	Mar-09
Actual	96.8%	98.7%	98.3%	98.6%	97.9%	97.2%									
Target	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%

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% of patients seen.

The validated position is that May and June targets have been achieved. July and August are presenting some risks of under achievement, though this will not be formally confirmed until around six weeks after each month-end.

The risks to achieving the standard are that there are continuing problems in lung cancer capacity which mean that early indications are continuing to show patients breaching.

There are several 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

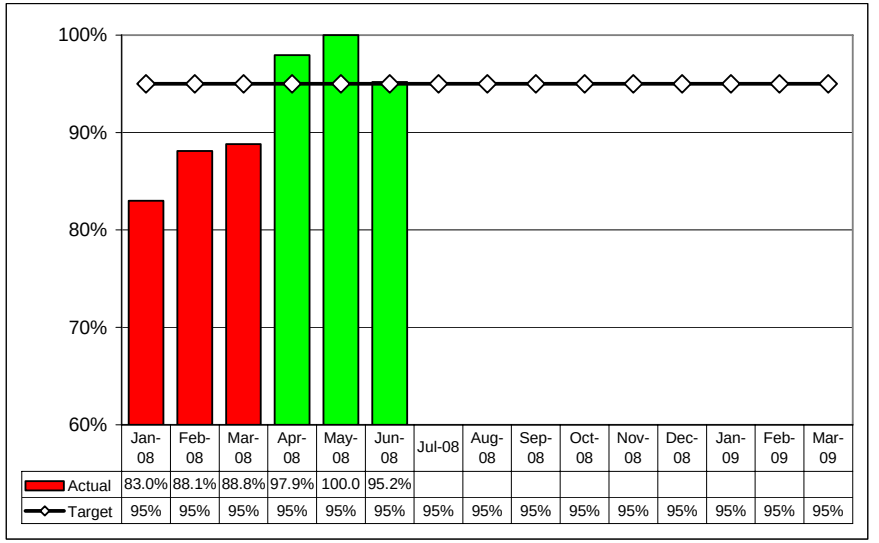
The immediate action now is to reach agreement on the recovery plan and for all parties to ensure it is delivered.

The previously applied operational standards have been tightened as a result of a decision of the Healthcare Commission and the minimum standard for achievement is now set at the target level of 98%

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



	Jan-08	Feb-08	Mar-08	Apr-08	May-08	Jun-08	Jul-08	Aug-08	Sep-08	Oct-08	Nov-08	Dec-08	Jan-09	Feb-09	Mar-09
Actual	83.0%	88.1%	88.8%	97.9%	100.0	95.2%									
Target	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%

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.

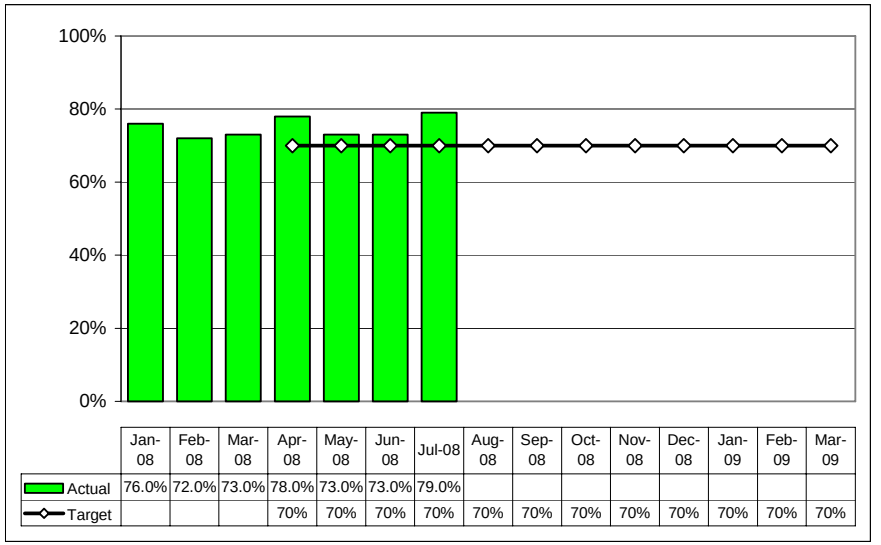
The data presented comes directly from the Breast Screening Unit and includes women eligible from 50-70 years of age.

Round length continues to meet target, presently at 98% for July and uptake has increased to 79%. Public Health and the Breast Screening Unit continue to work together to promote breast screening with intention to meet a gold standard of 80% uptake.

Leeds Breast Screening Unit, as with other units will be expected to implement an age extension programme of 47-73 (implementation date to be confirmed). Work is ongoing to model this planned age extension programme and ensure that the local population increase is 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.

Access to Cancer Services

Women offered breast screening



	Jan-08	Feb-08	Mar-08	Apr-08	May-08	Jun-08	Jul-08	Aug-08	Sep-08	Oct-08	Nov-08	Dec-08	Jan-09	Feb-09	Mar-09
Actual	76.0%	72.0%	73.0%	78.0%	73.0%	73.0%	79.0%								
Target				70%	70%	70%	70%	70%	70%	70%	70%	70%	70%	70%	70%

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

Health care associated infections standards

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

Target:

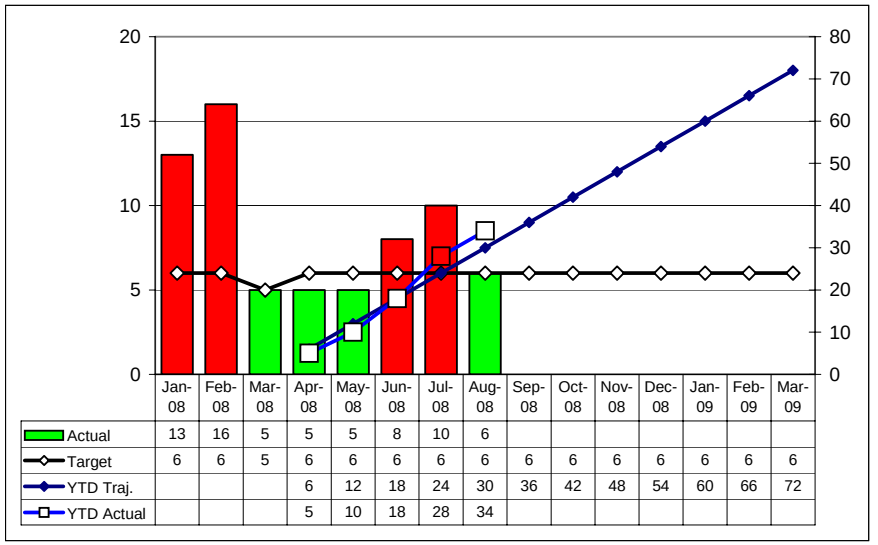
To maintain a maximum of not more than 6 cases per month.

After a good start to the year, things appeared to be slipping again with 10 cases reported for July. LTHT have had 2 cases successfully appealed 1 each for March and May. These cases however have to remain on the numbers and are classed as non trajectory cases. Data for August shows a total number of 6 cases for the month against a target of 6, this data will be confirmed in the first week of September. At present LTHT remain 4 cases over trajectory for the YTD. The weekly meetings with LTHT, SHA and DH are set to continue for the foreseeable future.

LTHT and the PCT are currently acting on the results of the relevant root-cause analysis processes to renew efforts in reducing the number of cases. In LTHT this is mainly focused on intravenous lines and in the PCT on Urinary Catheter Care in care homes. Further updates on this work will be given as available.

Health Care Associated Infections

Cumulative number of MRSA positive blood culture episodes



	Jan-08	Feb-08	Mar-08	Apr-08	May-08	Jun-08	Jul-08	Aug-08	Sep-08	Oct-08	Nov-08	Dec-08	Jan-09	Feb-09	Mar-09
Actual	13	16	5	5	5	8	10	6							
Target	6	6	5	6	6	6	6	6	6	6	6	6	6	6	6
YTD Traj.				6	12	18	24	30	36	42	48	54	60	66	72
YTD Actual				5	10	18	28	34							

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

Health care associated infections standards

Hospital admissions screened for MRSA

Target:

To screen all elective admissions for MRSA by the end of 2008/09.

LTHT have an agreement with the DH that they can start by screening acutely admitted high risk patients in 2008/09, as this will have a greater impact on local MRSA rates, with the proviso that they will start to screen all electively admitted patients from the end of March 2009. They are currently undertaking a recruitment drive for 30 extra laboratory staff and are planning for a laboratory refurbishment to provide the capacity for this level of work. The intention is to screen in the following order:

- Renal acute & elective admissions.
- Elderly medicine acute & elective admissions.
- Acute & Elective admissions for specialities currently undertaking decolonisation regimes e.g orthopaedics and urology.
- Other elective admissions.
- Other acute admissions.

Planned timetable is

- End Sept/early Oct- 50 tests per week on Renal admissions.
- Mid October onwards - 250 tests per day = 78,000 per year. Elderly medicine and some electives.
- From February 09 at full capacity undertaking 150,000 tests per year.

In addition to this screening pathways and decolonisation protocols will need to be developed and the PCT may need to assist in this with GP prescribing involvement.

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

Progress on the achievement of this target will be shown in graphical format in future reports

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.

The number of cases are reducing month on month but not at a significant enough rate to be effective in the long term. The number of community cases has dropped sharper than those from LTHT which will reflect a seasonal reduction in antibiotic use in the community. Campaigns are being developed to sustain this reduction in usage in the community as per NICE (July 2007) guidelines.

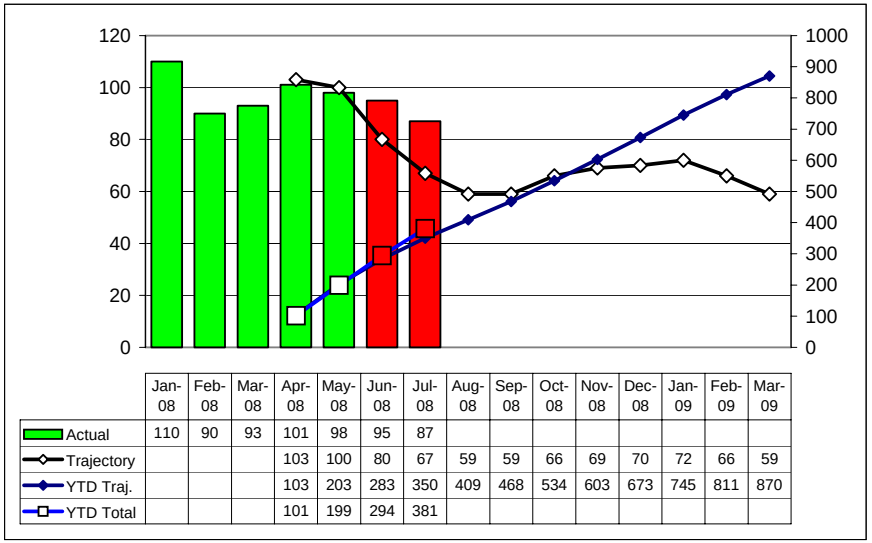
The PCT are working in partnership with LTHT, LPFT and St Gemma's Hospice to reduce the number of Cdiff cases in the Leeds population.

Ward 42 LGI will open on 15 Sep as a Cdiff isolation unit in an attempt to reduce cases through cross contamination. This will be followed by a similar ward at SJUH Beckett wing (opening early December at present but this may be brought forward).

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

Health Care Associated Infections

C.Diff infections



	Jan-08	Feb-08	Mar-08	Apr-08	May-08	Jun-08	Jul-08	Aug-08	Sep-08	Oct-08	Nov-08	Dec-08	Jan-09	Feb-09	Mar-09
Actual	110	90	93	101	98	95	87								
Trajectory				103	100	80	67	59	59	66	69	70	72	66	59
YTD Traj.				103	203	283	350	409	468	534	603	673	745	811	870
YTD Total				101	199	294	381								

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 more recent was undertaken in July 2008.

The PCT achieved a 100% target in this Vital Sign for Quarter 2.

Focussed work continues to ensure the sustainability of the target through the autumn. This is a particular challenge for GP practices who are focussed on the flu campaign throughout October

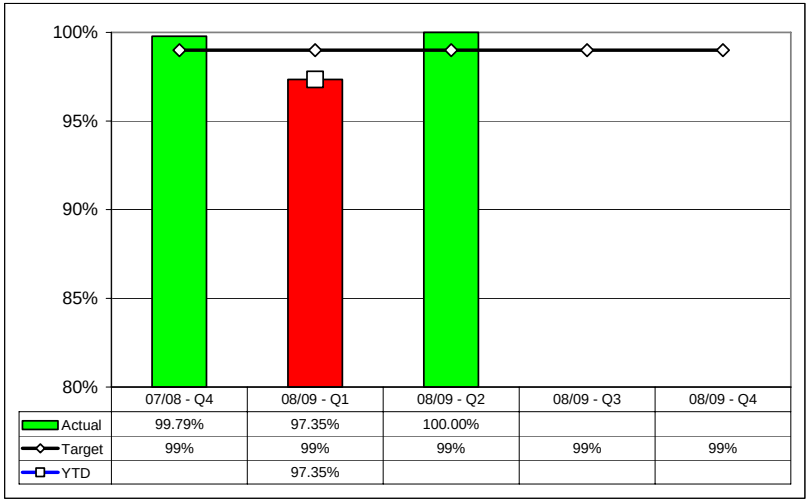
The other element of the indicators on the delivery of the access standards is that drawn from the Patient Experience survey, which is conducted independently of the PCT. Further action planning and support will be organised over the coming months in response to the results.

The Patient Experience Survey (PES) results are now available for 07/08. The PCT is required to submit action plans to the SHA which provide an understanding of how the results of the two surveys can be integrated and address areas where improvements have not been made.

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

Primary Care Access

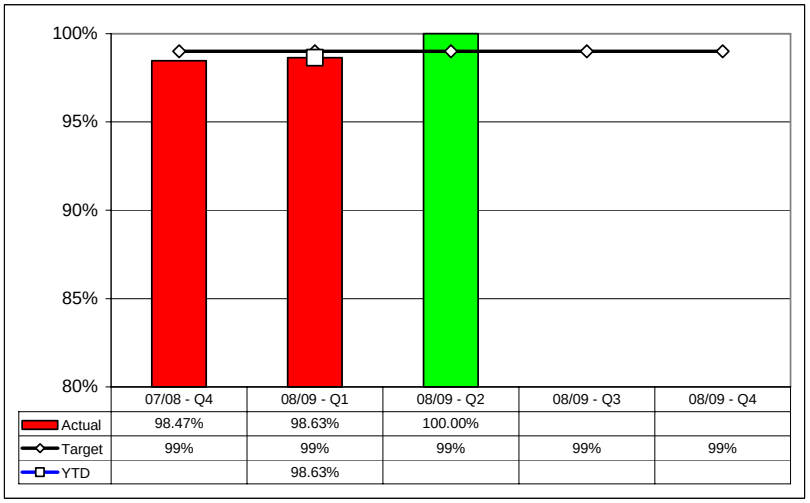
48 Hour Access to a GP



	07/08 - Q4	08/09 - Q1	08/09 - Q2	08/09 - Q3	08/09 - Q4
Actual	99.79%	97.35%	100.00%		
Target	99%	99%	99%	99%	99%
YTD		97.35%			

Primary Care Access

24 Hour Access to a PCP



	07/08 - Q4	08/09 - Q1	08/09 - Q2	08/09 - Q3	08/09 - Q4
Actual	98.47%	98.63%	100.00%		
Target	99%	99%	99%	99%	99%
YTD		98.63%			

Primary care access standards

Access to primary care

Target:

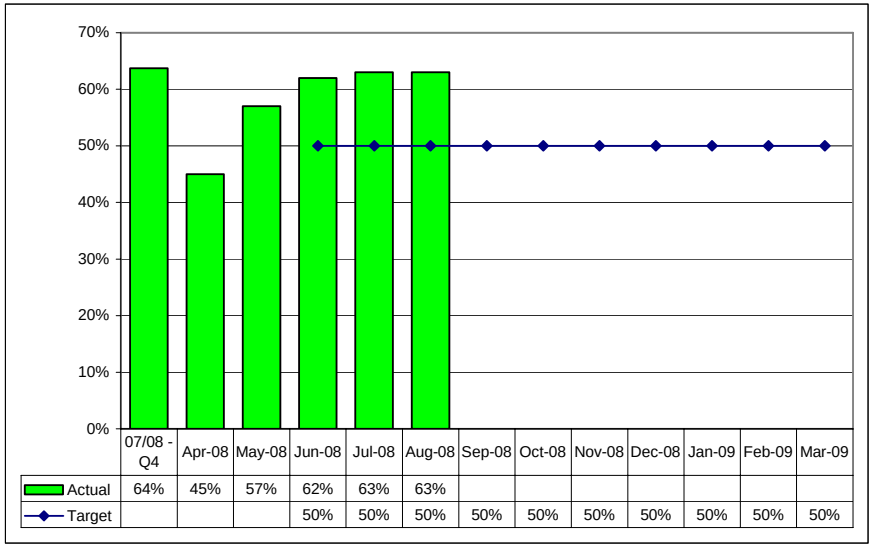
At least 50% of GP practices in the PCT offer extended opening hours by Dec 2008.

The PCT has exceeded its target of 50% of GP practices opening for longer hours. In the absence of the national Directed Enhanced Service (DES), this was achieved by issuing a Local Enhanced Service (LES) which offered an opportunity for flexibility in the type of service available to patients outside of core hours. Following the publication of the DES on 1st September, it is anticipated that a umber of practices will sign up to the national standard. Work continues to ensure that the components of the two contracting routes are integrated in order that consistency in service is not compromised.

Further work has been requested by the DOH regarding the accuracy of information available pertaining to GP practice opening hours, ie: on the NHS Choices website.

Primary Care Access

Family Friendly Hours



	07/08 - Q4	Apr-08	May-08	Jun-08	Jul-08	Aug-08	Sep-08	Oct-08	Nov-08	Dec-08	Jan-09	Feb-09	Mar-09
Actual	64%	45%	57%	62%	63%	63%							
Target				50%	50%	50%	50%	50%	50%	50%	50%	50%	50%

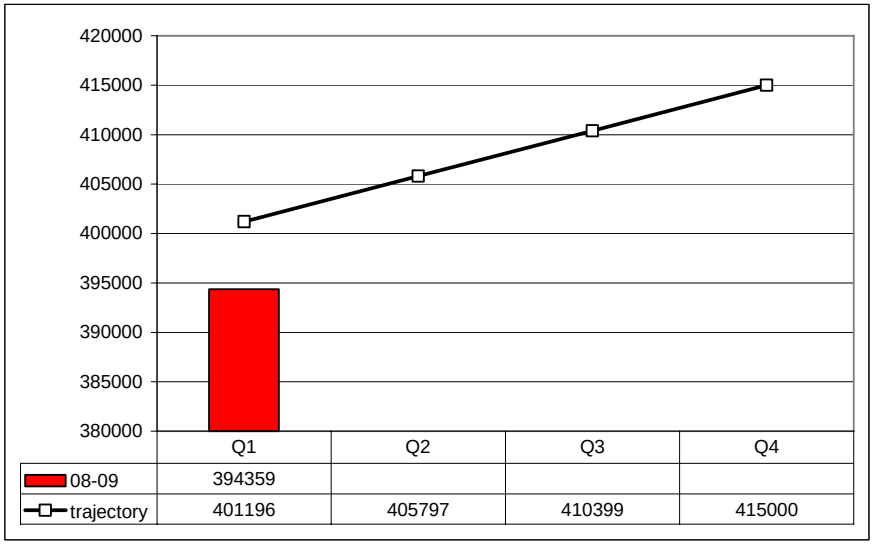
Lead Executive Director: Matt Walsh
Management Lead: Damian Riley
Operational Lead: Emma Wilson

Annual Health Check Standards

Access to primary dental services

Primary Care

Access to primary dental services



Target:

To increase the number of patients receiving primary dental services across the PCT to 415,000 during the year, from a baseline set in the 24 month period to March 2006 of 414,947.

The trajectory target does not reflect in full the events from April 2006, when a significant number of practices left the NHS. Most of that capacity was replaced, though not in full, and subsequently performance figures have dropped to around 395,000 in June 2008. The service is reasonably confident that the 2010 and 2011 targets can be achieved. The target for 2008/09 however is likely to be extremely challenging.

There are perverse incentives in meeting the target, in that there is less gain to be made from treating patients with the most need of sustained episodes of care. The service has also been measuring how long a patient seeking an NHS dentist has to wait to secure a dentist. Up until July this year, the objective of within 4-6 weeks has been met.

A three pronged approach to increasing capacity is in place:

- All our existing NHS contract holders who offer non restricted contracts and have achieved 85% or more of their activity targets have been offered up to £25,000 of additional activity on a non-recurrent basis, linked to accepting patients from the Leeds Dental Advice Line.
- The PCT have invited bids from all providers of dental services in Leeds (private & NHS) who are prepared to offer additional NHS sessions on a non recurrent NHS contract.
- A proposal to be submitted to the PCT Board to invest £2m in new dental services in locations across the city with particularly high access needs.

Lead Executive Director: Matt Walsh
Management Lead: Damian Riley
Operational Lead: Steve Laville

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

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.

Q1 target of 4460 screens exceeded, actual screens were 4804. This included non NCSP tests. Mechanisms now in place to collate this data for quarterly submission to HPA by agreed dates.

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.

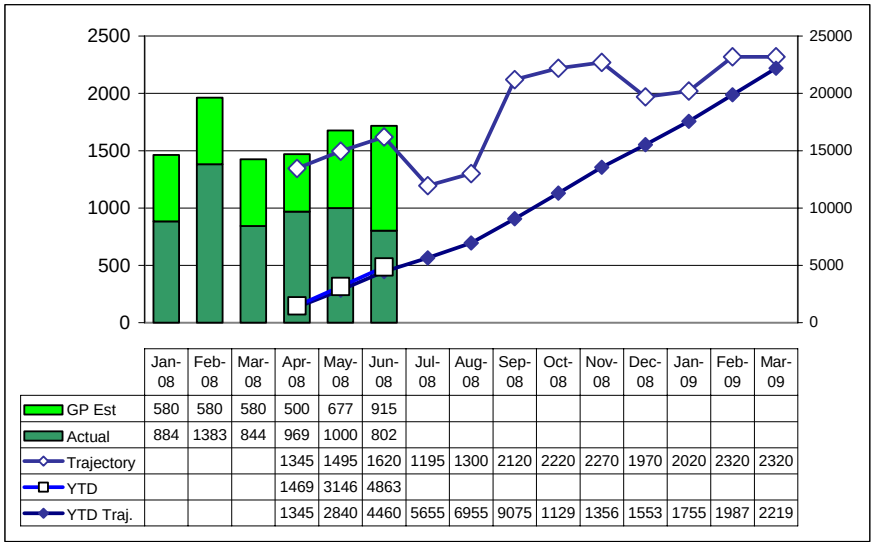
Actions in primary health care include – progress on introducing standardised request form, to be piloted in two practices. A meeting with H3 PBC Consortium has taken place.
In the prisons actions include - screening sessions re-established in HMP Armley and Wetherby YOI during August.
In pharmacies - launch of campaign making postal kits available from 19 pharmacies across Leeds

Other actions to ensure delivery include weekly meetings to monitor the agreed action plan and identify risks to achieving target.

Lead Executive Director: Ian Cameron
Management Lead: Victoria Eaton
Operational Lead: Sharon Foster

Sexual Health

Chlamydia Screening



	Jan-08	Feb-08	Mar-08	Apr-08	May-08	Jun-08	Jul-08	Aug-08	Sep-08	Oct-08	Nov-08	Dec-08	Jan-09	Feb-09	Mar-09
GP Est	580	580	580	500	677	915									
Actual	884	1383	844	969	1000	802									
Trajectory				1345	1495	1620	1195	1300	2120	2220	2270	1970	2020	2320	2320
YTD				1469	3146	4863									
YTD Traj.				1345	2840	4460	5655	6955	9075	1129	1356	1553	1755	1987	2219

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).

The GUM service has maintained the 100% 'offered' target since March 2008. The new patient DNA rate has increased since June from 11.82% to 13.04% in July. The GUM access group have met and identified accountability for performance against the access target within LTHT. This was confirmed by LTHT colleagues as being with the managers. The accountable people are the Business Manager, Acute Medicine at GUM service level, reporting to the Directorate Manager, reporting to Divisional General Manager who in turn reports to the Chief Nurse. The clinical lead for GUM will provide any clinical leadership required.

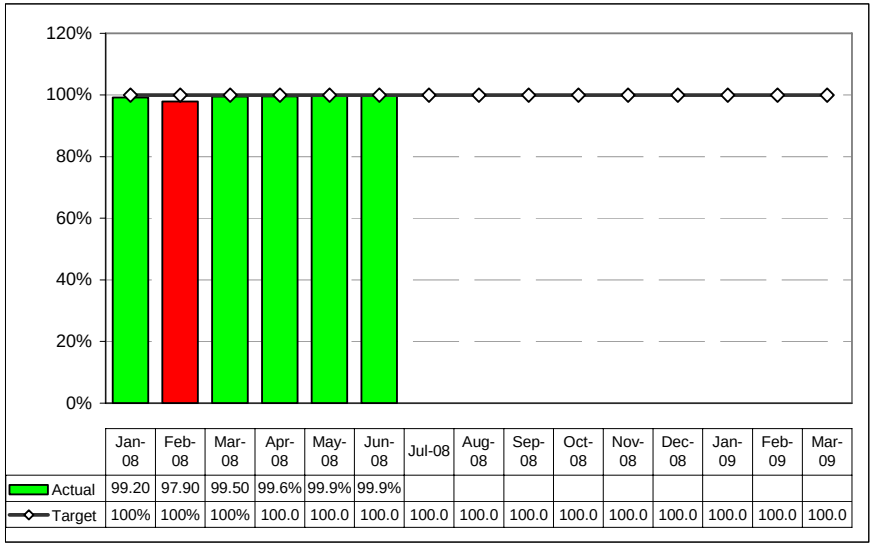
Currently LTHT, as the main provider, have the capacity to continue to sustain this performance throughout the year.

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: Victoria Eaton
Operational Lead: Sharon Foster

Improve access to genito-urinary medicine

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



	Jan-08	Feb-08	Mar-08	Apr-08	May-08	Jun-08	Jul-08	Aug-08	Sep-08	Oct-08	Nov-08	Dec-08	Jan-09	Feb-09	Mar-09
Actual	99.20	97.90	99.50	99.6%	99.9%	99.9%									
Target	100%	100%	100%	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

Sexual health programme standards

Teenage pregnancy rates

Target:

The rate of under-18 conception rates should reduce by at least half by 2010, set against the 1998 baseline, locally by 55%.

Following the Local Area Agreement negotiation, a more realistic approach for the next two years was devised. The focus is on reduction in wards (Harehills, Middleton, City & Holbeck, Seacroft, Hunslet and Richmond Hill) with the highest rates, increasing the impact on the whole Leeds rate.

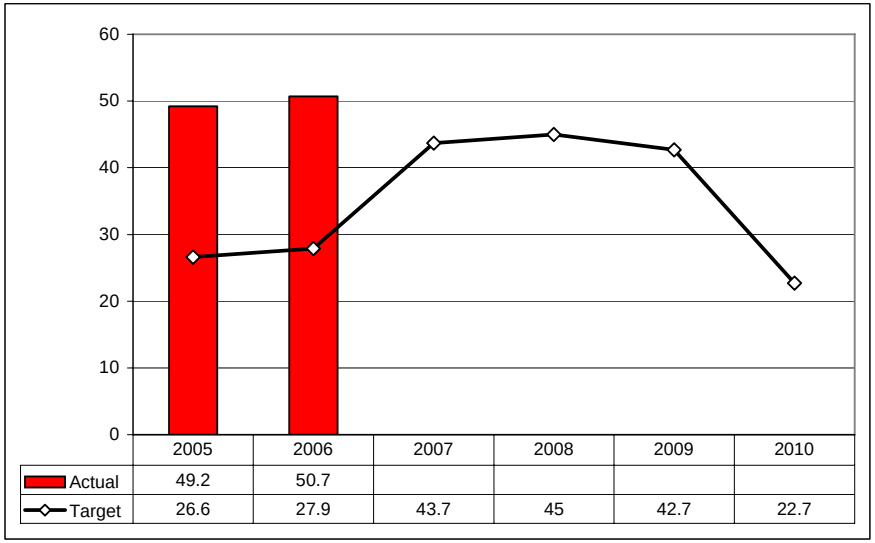
The appointment of a champion and a new chair of the Teenage Pregnancy and Parenthood Partnership (TPPP) have significantly raised awareness and profile. There has been a review of all aspects of the TPPP Board. This has led to a clearer vision with a revised strategy and work plan. This includes:

- Development of a joint commissioning framework.
- Establishing a clear performance management framework.
- Developing a communications strategy.
- Develop locality working enabling local service provision, within a clear governance framework
- Workforce training and development

The Commissioning Executive of the TPPP Board has developed a service map and identified funding for services that impact on teenage conception and sexual health. This is having a positive effect on commissioning arrangements, including the freeing up of resources for priority services in target wards and other priority actions.

Sexual Health

Teenage pregnancy rates per 1000 females aged 15-17 (NI 112 Under 18 conception rate)



	2005	2006	2007	2008	2009	2010
Actual	49.2	50.7				
Target	26.6	27.9	43.7	45	42.7	22.7

Lead Executive Director: Jill Copeland
Management Lead: Sarah Sinclair
Operational Lead: Martin Ford

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.

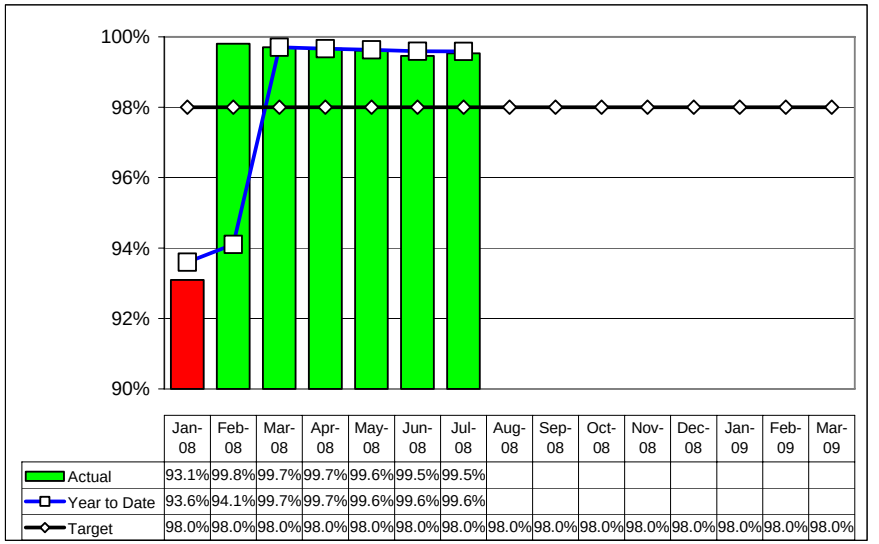
Year to date performance of 99.5% as at the end of July has been achieved. Performance during August has been similarly above the target rate. All individual sites at LTHT continue to achieve the target 98% on a daily basis, with rare exceptions.

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 is now being fed into the overall year-end return.

Sustainability of the target going into autumn and winter is a key priority for the recently re-launched whole system Capacity Planning Group, which will now report to a new Urgent Care Board led by Nigel Gray.

Maximum 4hr wait in A&E

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



	Jan-08	Feb-08	Mar-08	Apr-08	May-08	Jun-08	Jul-08	Aug-08	Sep-08	Oct-08	Nov-08	Dec-08	Jan-09	Feb-09	Mar-09
Actual	93.1%	99.8%	99.7%	99.7%	99.6%	99.5%	99.5%								
Year to Date	93.6%	94.1%	99.7%	99.7%	99.6%	99.6%	99.6%								
Target	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%

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

Urgent care standards

Ambulance response times: Cat A 8 min & Cat A 19 min standards; Cat A defined as immediately life-threatening

Target:

A minimum of 75% of Cat A calls should receive an emergency response at the scene within 8 mins and 95% of Cat A calls should be met within 19 mins of a request for a vehicle capable of transporting the patient.

Performance on these indicators is based on the whole ambulance service returns. On the Cat A 75% target, at 10th August 2008 the Yorkshire Ambulance Service (YAS) performance year to date stood at 64.3%. Performance required to achieve 75% for 2008/09 needs to be 81.2% for the rest of the year. This is a key risk for the region in terms of Healthcare Commission ratings. The efforts are focused on achieving the target level in-year, from September onwards, as per agreed trajectory, which is anticipated to deliver a year-end cumulative position of 71%.

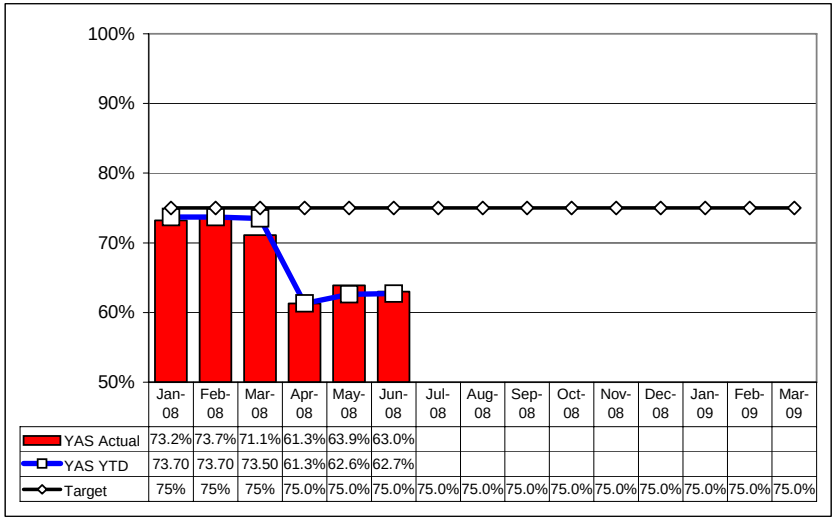
The recent marked decline in performance is acknowledged to be due to the impact of Call Connect. The performance management framework implemented by the SHA from April 08 with key actions for PCTs and NHS organisations is ongoing and includes trajectories to achieve the target. Going forward, the contract 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.

We are playing an active part in the YAS Consortium Board, chairmanship of which recently moved from Wakefield to Bradford, and have a Board to Board meeting with YAS in October.

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

Ambulance Response Times

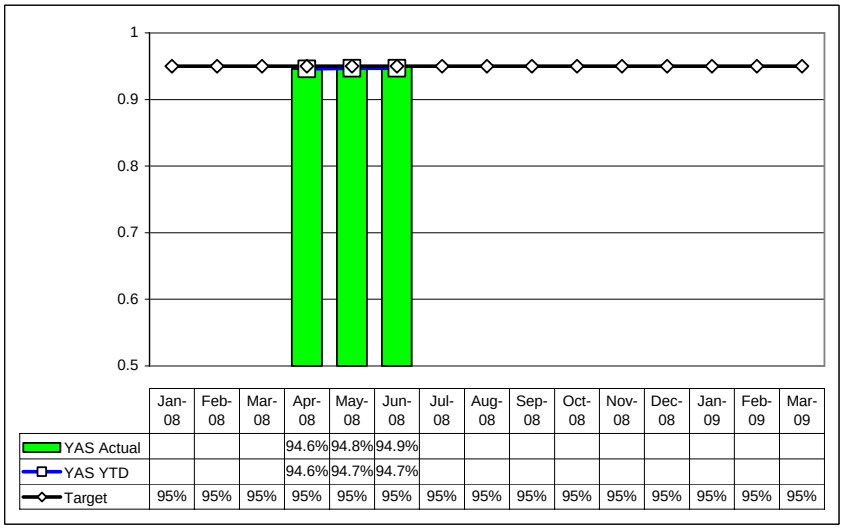
Category A calls receiving a first response within 8 minutes



	Jan-08	Feb-08	Mar-08	Apr-08	May-08	Jun-08	Jul-08	Aug-08	Sep-08	Oct-08	Nov-08	Dec-08	Jan-09	Feb-09	Mar-09
YAS Actual	73.2%	73.7%	71.1%	61.3%	63.9%	63.0%									
YAS YTD	73.70	73.70	73.50	61.3%	62.6%	62.7%									
Target	75%	75%	75%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%

Ambulance Response Times

Category A calls receiving a first response within 19 minutes



	Jan-08	Feb-08	Mar-08	Apr-08	May-08	Jun-08	Jul-08	Aug-08	Sep-08	Oct-08	Nov-08	Dec-08	Jan-09	Feb-09	Mar-09
YAS Actual				94.6%	94.8%	94.9%									
YAS YTD				94.6%	94.7%	94.7%									
Target	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%

Urgent care standards

Ambulance response times: Cat B 19 min standards; Cat B defined as serious, but not immediately life-threatening

Target:

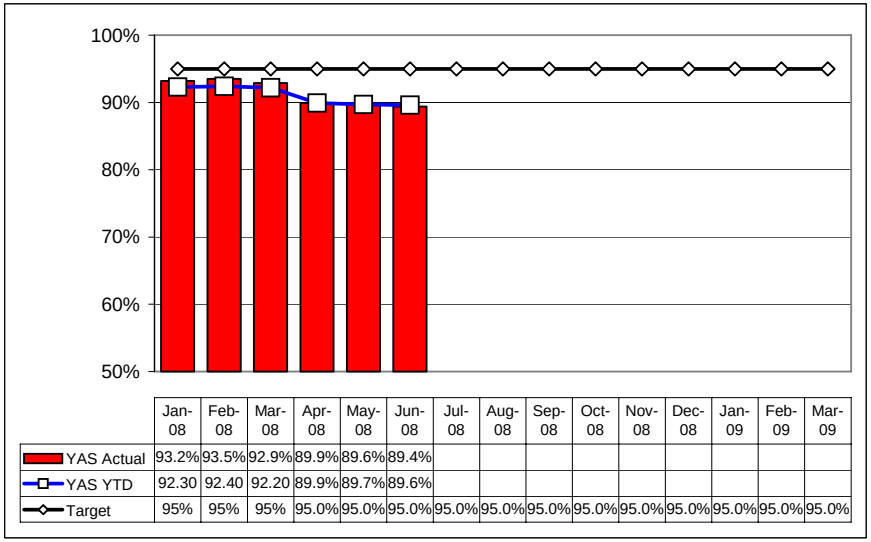
A minimum of 95% of Cat B calls should be met within 19 mins of a request for a vehicle capable of transporting the patient.

Performance on these indicators is based on the whole ambulance service returns.

On the Cat B target, YAS performance as a whole is 89.9% year to date. Ongoing contract negotiations for 08-09 and the SHA performance management action plan will address this going forward.

Ambulance Response Times

Category B calls receiving a first response within 19 minutes



	Jan-08	Feb-08	Mar-08	Apr-08	May-08	Jun-08	Jul-08	Aug-08	Sep-08	Oct-08	Nov-08	Dec-08	Jan-09	Feb-09	Mar-09
YAS Actual	93.2%	93.5%	92.9%	89.9%	89.6%	89.4%									
YAS YTD	92.30	92.40	92.20	89.9%	89.7%	89.6%									
Target	95%	95%	95%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%

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

Urgent care standards

Delayed transfers of care: Rate per 100,000 population

Target:

No identified target at this time, with 2007/08 to be used to set a baseline in a method yet to be defined.

The indicator on delayed transfers of care (often known as delayed discharges) is under development. The plan is to move toward a system that measures the rate per 100,000 of the general population, as opposed to the rate per occupied acute bed day. The Healthcare Commission have not defined the indicator at the time of writing, but the direction of travel seems clear.

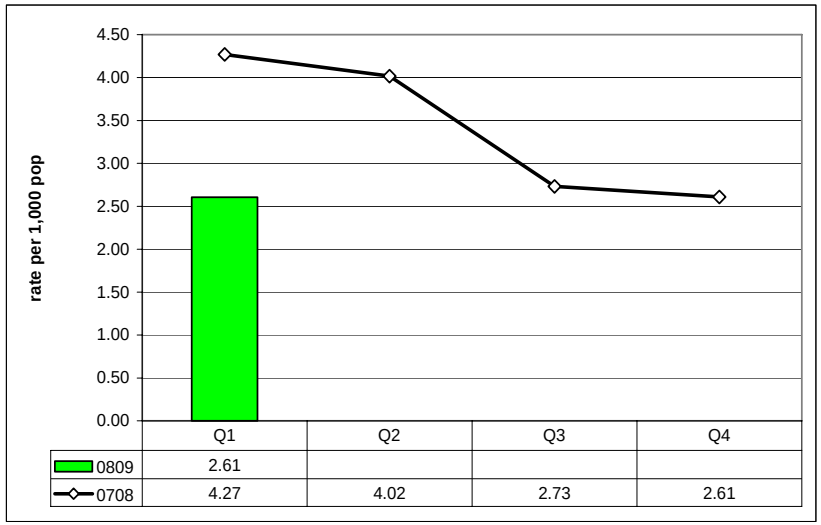
With this in mind, the report on this occasion also uses the old method of computing the rate, for information on this occasion (the bottom chart). Once the precise nature of the measure is confirmed, the report will be confined to that.

Numbers of reportable delays remain well under the national maximum of 3.5% of all admissions, with Leeds figures averaging at 1.9%. The Capacity Planning Group and Urgent Care Board are about to scope out the work required to reduce delays further, and review the Joint Protocol for Delayed Transfers of Care.

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

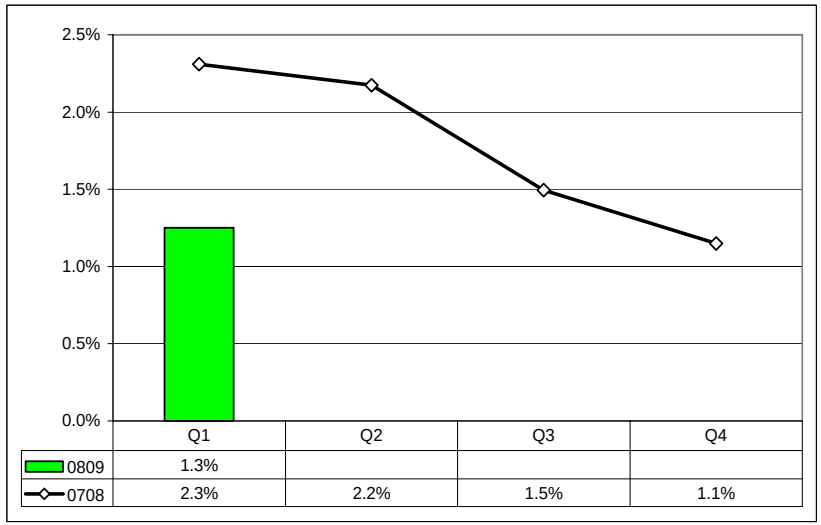
Urgent Care

Delayed transfers of care per 100,000 population



Urgent Care

Delayed transfers of care to be maintained at a minimum level



Annual Health Check indicators reported by exception:

- **Commissioning of early intervention in psychosis services**

- **Data quality on ethnic group**

Annual Health Check Standards

Commissioning of early intervention in psychosis services

Target:

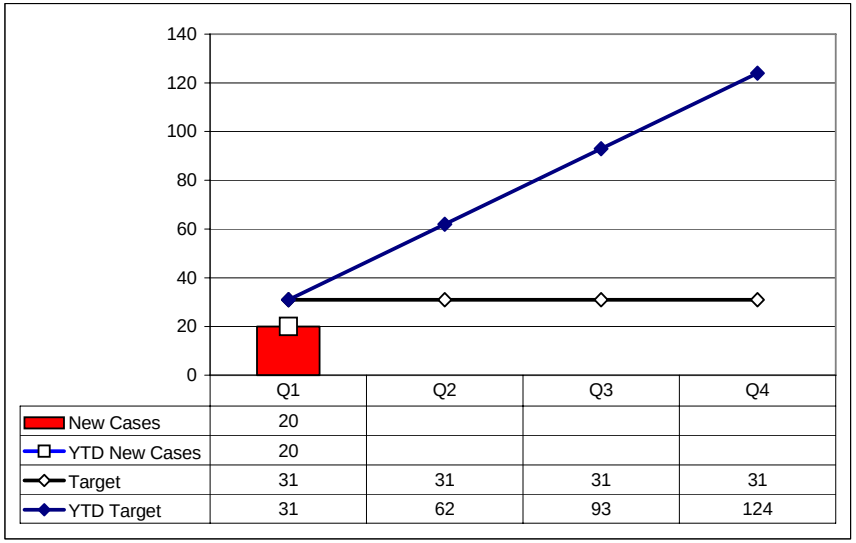
To deliver the locally agreed share of the national target of 7,500 new cases of psychosis served by early intervention teams, 124 new cases as applied to Leeds PCT.

Delivery of Early Intervention In Psychosis (EIP) is an initiative that has been developed to intervene early when someone is experiencing first signs of psychosis. Evidence shows that early intervention can prevent some people developing full-blown psychosis which is a debilitating long term mental health problem. The SHA expects the target to be met by March 2009.

Service delivery over the last three years is showing that the expected annual cases of psychosis predicted by the DH in 2005 for Leeds do not seem to be in evidence. With extra funding from the PCT this financial year the service is expected to increase new cases from 74 to 111. This will bring the number closer to the target. On this basis Leeds should be reporting an amber position by the end of the financial year. Negotiations are underway with the SHA about this situation, with the aim of agreeing a more realistic target number for Leeds.

Annual Health Check Standards

Commissioning of early intervention in psychosis services



	Q1	Q2	Q3	Q4
New Cases	20			
YTD New Cases	20			
Target	31	31	31	31
YTD Target	31	62	93	124

Lead Executive Director: Jill Copeland
Management Lead: Carol Cochrane
Operational Lead: Tabitha Arulampalam

Annual Health Check Standards

Data quality on ethnic group

Target:

To improve the levels of coding of patient data in secondary care, with a minimum threshold of 80%, as defined by SUS and MHMDS.

The delivery of this target, defined as underachieved in 2006/07, also the likely performance in 2007/08, is based on the ethnic coding of patient records as shown in the secondary uses service (SUS) for acute care and the mental health minimum data set (MHMDS) for mental health providers. The acute records account for around 88% of hospital episodes.

The first three months data does show an improvement over previous periods, though still at the level of an underachievement.

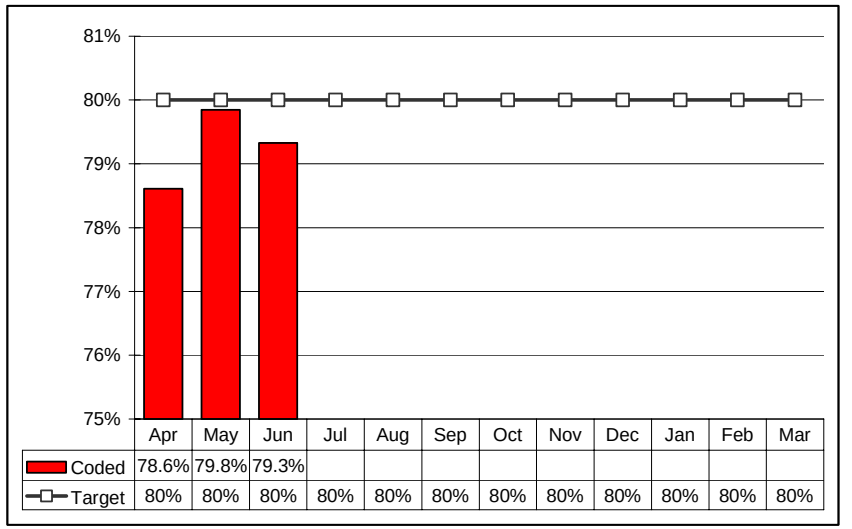
Actions include formally raising the issue with LTHT (currently 79.4%) and Bradford Hospitals Trust (72.4%) with a request to provide an action plan to realise a trajectory of 80% as a minimum.

There is also an option of contractually flagging this as a 'default' on information requirements, though the preferred step at this point is to request remedial action and focus from LTHT and Bradford before serving a performance notice.

The other two main providers, Mid Yorks (84.6%) and Harrogate (98.3%) are performing well. There may be some best practice learning from Harrogate that they could share with fellow providers.

Annual Health Check Standards

Ethnic Coding (% of FCE coding)



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Coded	78.6%	79.8%	79.3%									
Target	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%

Lead Executive Director: Matt Walsh
Management Lead: Philip Grant
Operational Lead: Neil Hales/Richard Wall

Performance focus:

- **The Light Community Walk-in Centre**

Performance Focus

The Light Community Walk-in Centre

Targets:

- *That at least 98% of patients spend 4hrs or less in A&E, from arrival to admission, transfer or discharge.*
- *That the contracted levels of activity be delivered.*

During 2004/2005 the Department of Health procured 6 Commuter Walk-in-Centres nationally (4 in London, 1 in Manchester and 1 in Leeds). The Leeds CWiC opened in February 2007.

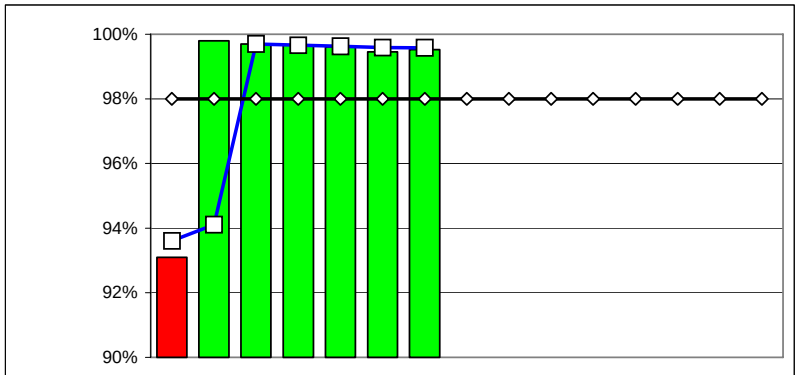
The centres were intended to provide primary care services to commuters as well as the local population and deliver improved access to NHS services and widen patient choice

The Leeds CWiC contributes to the delivery of the key urgent care target, the A&E 4hour maximum wait time.

Performance
To date the CWiC has treated 100% of its patients within 4 hours. Following discussions between the Department of Health and the SHA during the winter of 2007/2008 it was agreed that this activity would be counted towards the achievement of the 4-hour target in Leeds. This means that whilst a small percentage of overall A&E activity, the CWiC is nevertheless an important positive force in sustaining the delivery of the target. The chart below shows the delivery performance on A&E 4 hour waits, for ease of understanding.

Maximum 4hr wait in A&E

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



	Jan-08	Feb-08	Mar-08	Apr-08	May-08	Jun-08	Jul-08	Aug-08	Sep-08	Oct-08	Nov-08	Dec-08	Jan-09	Feb-09	Mar-09
Actual	93.1%	99.8%	99.7%	99.7%	99.6%	99.5%	99.5%								
Year to Date	93.6%	94.1%	99.7%	99.7%	99.6%	99.6%	99.6%								
Target	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%

Activity
The DH contract with the providers, Netcare UK, is at a year one cost of £1.63m. Contracted activity is 38,500 patients annually, at a cost of around £42 per patient. The centre is currently operating at just below these activity levels. It is understood though that activity levels at the Leeds CWiC compare favourably with the other centres. The chart below shows activity levels for each month since the beginning of the financial year.

The centre operates between the hours of 7am and 7pm, Monday to Friday (except Xmas and Boxing Day and New Years Day).

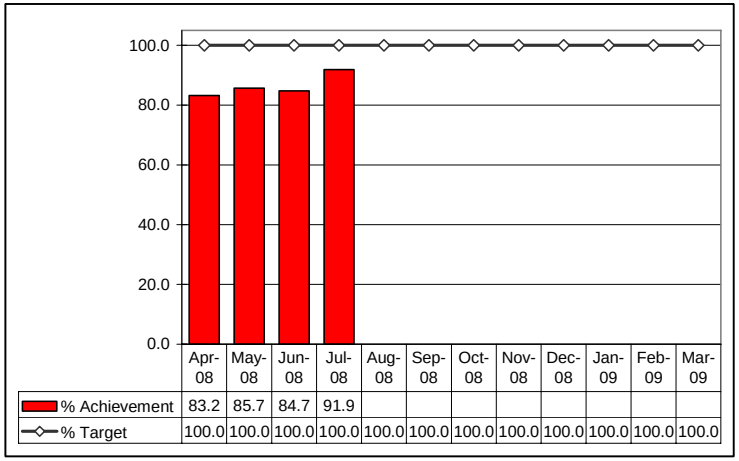
Performance topic identified by PCT Board

The Light Community Walk-in Centre

Continued from previous page /

Performance topic indentified by Board

Light CWiC: Activity levels



	Apr-08	May-08	Jun-08	Jul-08	Aug-08	Sep-08	Oct-08	Nov-08	Dec-08	Jan-09	Feb-09	Mar-09
% Achievement	83.2	85.7	84.7	91.9								
% Target	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

Premises
The CWiC is located within the Light shopping centre in Leeds City Centre. Leeds PCT are the head lease-holders and the unit is jointly sublet to Netcare UK (8 year sub-lease with a 5 year break clause) and One Medicare who provide a GP practice on the same site, on the floor above.

Contract Management
Contract management of Netcare UK is presently carried out by the Department of Health. The PCT carry out property management as head lease-holders and the urgent care commissioning team attend quarterly Joint Service Review meetings in order to ensure that the CWiC is joined up with the wider health economy. Netcare UK also meet regularly with the A&E department of LTHT to review the appropriateness of onward referrals from the centre to A&E at LTHT. To date the vast majority of these have been appropriate. There are also instances of patients from the A&E dept at LTHT being referred to the CWiC, where appropriate on occasions when A&E are under particular pressure.

Future developments
The Department of Health is currently having discussions with the SHA regarding the migration of the Independent Sector contracts to local NHS organisations. It is intended that these will devolve to the PCT, via the SHA. This is however subject to ongoing contract negotiations involving the PCT, the SHA and the DH.

Issues
- The co-location of the CWiC and GP Practice within the same premises can be problematic. Additionally, the premises are not ideal, being primarily designed for retail purposes.
- A shortage of skilled “Estates” staff within the PCT has meant the property management responsibilities have become protracted and required the ongoing costly input of solicitors to resolve the various issues.
- As the PCT do not currently contract manage the CWiC, potential service improvements and redesign of urgent care pathways have been difficult. However the relationship between the urgent care commissioning team and the DH contract manager is excellent.
- The quality of data received by the PCT regarding the CWiC is poor and therefore the opportunity to use this to inform current commissioning is not available at the appropriate levels of quality at present.

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

Annex A –

Full list of 2008/09 indicators, by PCT Directorate

PCT Directorate – Commissioning

Executive Lead – Matt Walsh

PCT Top 6 Priority	Description of Objective / Initiative	Mngmt lead	Ops lead	Code
18 weeks	**18 weeks maximum wait from referral to the start of treatment by Dec 2008**	**NG**	**SH**	**VSA04 & AHC**
	Diagnostic Waits > 6 Weeks	**NG**	**SH**	**VSA04**
	Maximum wait time of 13 weeks for an outpatient appointment	**PG**	**NH/RW**	**AHC**
	Maximum wait time of 26 weeks for an inpatient appointment	**PG**	**NH/RW**	**AHC**
	Patient reported measure of choice of hospital	**NG**	**SH**	**VSC16 & Local**
	Percentage of Patients seen within 18 weeks for direct access audiology services	**NG**	**SH**	**VSA04**
Cancer	**A maximum waiting time of one month from diagnosis to treatment for all cancers**	**NG**	**JR**	**AHC**
	A maximum waiting time of two months from urgent referral to treatment for all cancers	**NG**	**JR**	**AHC**
	A two week maximum wait from urgent GP referral to first outpatient appointment for all urgent suspected cancer referrals	**NG**	**JR**	**AHC**
	Proportion of patients waiting no more than 31 days for second or subsequent cancer treatment (radiotherapy treatments)	**NG**	**JR**	**VSA12**
	Proportion of patients waiting no more than 31 days for second or subsequent cancer treatment (surgery and drug treatments)	**NG**	**JR**	**VSA11**
	Proportion of patients with breast symptoms referred to a specialist who are seen within two weeks of referral	**NG**	**JR**	**VSA08**
	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**	**VSA13**
Primary care	**Guaranteed access to a primary care doctor within 48 hours**	**DR**	**EW**	**VSA & AHC**
	Guaranteed access to a primary care professional within 24 hours	**DR**	**EW**	**VSA & AHC**
	Improvement in Family Friendly GP Hours (50% in PCT to offer extended opening)	**DR**	**EW**	**VSA07**
	Patient reported measure of access to a GP	**DR**	**EW**	**VSA06 & AHC**
	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**	**VSB18 & AHC**
Urgent Care	**All ambulance Trusts to respond to 75% of Category A calls within 8 minutes**	**NG**	**LS**	**AHC**
	All ambulance Trusts to respond to 95% of Category A calls within 19 minutes	**NG**	**LS**	**AHC**
	All ambulance Trusts to respond to 95% of Category B calls within 19 minutes	**NG**	**LS**	**AHC**
	Four hour maximum wait in A&E from arrival to admission, transfer or discharge	**NG**	**LS**	**AHC**
	Delayed transfers of care per 100,000 population	**NG**	**LS**	**VSC10**
	Delayed transfers of care to be maintained at a minimum level	**NG**	**LS**	**AHC**
	A maximum two week wait for Rapid Access Chest Pain Clinic	NG	PD	AHC
	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	PG	NH/RW	AHC
	Data quality on ethnic group (previously derived from SUS and MHMDS)	NH	RW	AHC
	Number of people provided care closer to home	NG		Local
	Emergency bed days (also used as proxy for VSC11: People with long-term conditions feeling independent and in control of their condition)	NG	PD	VSC20 & Local
	Implementation of Stroke Strategy / Time to Treatment	NG	PD	VSA14 & AHC
	People with long-term conditions feeling independent and in control of their condition	NG	PD	VSC11
	A three month maximum wait for revascularisation	NG	PD	AHC
	Time to reperfusion for patients who have had a heart attack	NG	PD	AHC

PCT Directorate – Public Health

Executive Lead – Ian Cameron

PCT Top 6 Priority	Description of Objective / Initiative	Mngmt lead	Ops lead	Code
Cancer	**Breast cancer screening for women aged 53 to 70 years**	**SB**	**KJ**	**VSA09 & AHC**
HCAI	**All elective admissions screened for MRSA from 2008/09;**	**SB**	**BD**	**VSA02**
	All emergency admissions screened for MRSA as soon as possible in next three years	**SB**	**BD**	**VSA02**
	C Diff reduction by 30% by 2011, SHA differential envelopes to deliver a 30% reduction nationally by 2011	**SB**	**BD**	**VSA03 & AHC**
	MRSA levels sustained, locally determined stretch targets taking us beyond the national target.	**SB**	**BD**	**VSA01**
Sexual Health	**Chlamydia screening programme to be rolled out nationally (Year 1 (08/09) data to be used for prevalence indicator)**	**VE**	**SF**	**AHC**
	Guaranteed access to a genito urinary clinic within 48 hours of contacting a service	**VE**	**SF**	**AHC**
	Prevalence of chlamydia (Year 1 will use existing AHC screening measure to set baseline)	**VE**	**SF**	**VSB13**
	100% of people with diabetes to be offered screening for the early detection (and treatment if needed) of diabetic retinopathy	SB	KJ	AHC
	All Age All Cause Mortality Rate per 100,000	JF	JF	VSB01, AHC & LAA
	All-age all cause mortality rate (target disaggregated to focus on narrowing the gap between most deprived 10% and the Leeds average)	JF	JF	Local
	Children and young people's participation in high-quality PE and sport (NI 57)	DB	JB	NI 57
	Healthy life expectancy at age 65	JF	JF	VSC25
	Proportion of children who complete immunisation by recommended ages	SB	BB	VSB10 & AHC
	Reduce <75 Cancer Mortality Rate (20% by 2010)	JF	LJ	VSB03
	Reduce <75 CVD Mortality Rate (40% by 2010) (NI 121 Mortality rate from circularly diseases at ages under 75)	LJ	LJ	VSB02, AHC & LAA
	Reduction in gap between best and worst SOAs	LJ	LJ	Local
	Reduction in suicide and Undetermined injury mortality rate (20% by 2010)	JF	JF	VSB04
	Robust and up-to-date emergency planning	SB	BA	OF
	Smoking prevalence (Quit Rates as presently reported)	HT	KH	VSB05, AHC & LAA
	Stopping smoking - disaggregated to narrow the gap between 10% most deprived SOAs and rest of Leeds	HT	HT	Local
	Tackling fuel poverty – People receiving income based benefits living in homes with a low energy efficiency rating (NI 187)	DB	DA	NI 187
	COPD prevalence percentage from GP registers	JF	HT	WCC
	Vascular risk	LJ	LJ	VSC23

PCT Directorate – Strategic Development

Executive Lead – Jill Copeland

PCT Top 6 Priority	Description of Objective / Initiative	Mngmt lead	Ops lead	Code
Sexual Health	**Teenage pregnancy rates per 1000 females aged 15-17 (NI 112 Under 18 conception rate)**	**SS**	**MF**	**VSB08, AHC & LAA**
	Number of drug users recorded as being in effective treatment (NI 40)	CC	TA	VSB14, AHC & LAA
	% 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	VSB06 & AHC
	Adults and Older people receiving direct payments and/or individual budgets per 100,000 population	CC	MiW	VSC17 & LAA
	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	AHC
	Breastfeeding continuation (prevalence 6-8 weeks)	SS	MF	VSB11 & AHC
	Carers receiving a 'carer's break' or a specific carers' service	CC	MiW	VSC18
	Childhood obesity rate among primary school age	SS	MF	VSB09 & AHC
	Deliver 7,500 new cases of psychosis served by early intervention teams per year;	CC	TA	AHC
	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	VSB12 & AHC
	Emotional and behavioural health of children in care (NI 58)	SS	MF	NI 58
	Environment for a thriving third sector (NI 7)	CC	TA	LAA
	Number of vulnerable and socially excluded with mental health problems helped into settled into employment	CC	TA	VSC08 & LAA
	People supported to live independently (NI 136 defined as 'all ages'; VSC03 defined as 'adults (18+)'	CC	MiW	VSC03 & LAA
	Percentage of vulnerable people achieving independent living (NI 141)	CC	TA	LAA
	Rate of hospital admissions per 100,000 for alcohol related harm	CC	TA	VSC26 & Local
	Stability of placements of looked after children: length of placement (NI 63)	SS	MF	NI 63
	The extent to which older people receive the support they need to live independently at home (NI 139)	CC	MiW	NI 139
	Timeliness of social care assessment (all adults) (NI 132)	CC	MiW	LAA
	Timeliness of social care packages following assessment (all adults) (NI 133)	CC	MiW	LAA

PCT Directorate – Information

Executive Lead – Lynton Tremayne

PCT Top 6 Priority	Description of Objective / Initiative	Mngmt lead	Ops lead	Code
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

PCT Directorate – Workforce

Executive Lead – June Goodson-Moore

PCT Top 6 Priority	Description of Objective / Initiative	Mngmt lead	Ops lead	Code
	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

Part 2: Joint Performance Management between Leeds PCT and Leeds Teaching Hospitals Trust

INTRODUCTION

Leeds PCT relies heavily on Leeds Teaching Hospitals Trust for delivery of its key access targets as its primary provider of acute care.

Whilst both organisations have performance management arrangements in place to measure and monitor performance, there have been a number of issues which have, in the past six months, affected our ability to pull together to achieve improvements in those areas where we have a common interest.

These issues broadly relate to:

- Partnership working
- Formal reporting and accountability
- Data and Information Flows

A number of mechanisms have been developed which aim to address these issues and consequently improve our performance towards our joint priorities.

PARTNERSHIP WORKING

There has been a historical culture within Leeds that our issues are too difficult to resolve. The past year has seen a considerable strengthening of relationships and mutual confidence between the PCT and the Hospital Trust at the most senior levels. It has also seen us make good progress in improving standards of engagement around the contract and in service delivery and confirming our belief that Leeds can potentially rise to the challenge of being one of the top NHS performers. We need to continue to develop our partnership and strong working relationships so that, for example, delivery issues in either organisation are discussed in a climate of honesty and joint ownership, and also that changes in commissioning plans or delivery plans are openly and jointly discussed at the earliest stage.

To help us move towards achievement of the vision, a “Code of Conduct” should be adopted by the PCT and Hospital senior managers. The Code is:

- Shared responsibility
- Private not public disputes
- Openness and transparency
- Loose discussions, tight decisions

There is evidence that our organisations are already beginning to adopt and live by the proposed Code of Conduct. Our collective response on recent 13 and 26 week issues, reporting of diagnostic issues and our way forward on Urology, are all examples of working together to resolve common issues. It will take time to embed the code across all corners of the organisation.
To help establish this code, informal arrangements are in place to keep each other informed as issues arise.

We have developed a list of key contacts across both organisations, starting primarily from a basis of existing trust and relationships. These contacts will work together to:

a. Promote and live the code of conduct in relation to the priority targets
b. Ensure the new model of information flows is implemented
c. Keep each other informed as issues arise

FORMAL REPORTING AND ACCOUNTABILITY

We need to develop a greater consistency of approach to our performance monitoring across the two organisations, in terms of meeting regularity, fielded personnel, agenda and "Action follow through".

We need to be clearer about where the decision-making and accountabilities lie.

A Joint Performance Management Board will be established which meets monthly. The meeting will provide an opportunity for senior personnel in both organisations to discuss and resolve issues related to the contract, including financial issues, activity, performance indicators, associate PCT issues and commissioning intentions.

The agenda will be published in advance to allow diaries of the relevant DGM and Commissioner to be secured, but there will be flexibility to allow an opportunity to discuss any issues.

A detailed agenda for the first meeting is attached at Annex 1.

Minutes of meetings will be formally recorded and distributed to all attendees.

We will monitor the ongoing usefulness of the meeting and adapt its content and frequency as required.

DATA AND INFORMATION FLOWS

In relation to our performance on key targets, we still do not always have sufficient joint control of the data and information flows across and out of our organisations. The 'story' of where we are on a specific target can therefore differ across and within our organisations. This can give the impression to external stakeholders that we have no grip on reality and undermine others confidence that we understand what is going on in our business.

A new information flow model has been developed with the aim of providing rapid response on issues. This is outlined at Appendix 2.

We have already implemented this model for 13 and 26 week breaches in July and reversed our collective reputation from being viewed by the DH and SHA as not in control of our issues, to being on top of the issues and managing them to a successful outcome.

CONCLUSION

Through our formal and informal communications, our control of performance information out of the organisation and an improved culture of openness and shared responsibility , our joint strategic partnership will be strengthened and performance improved across Leeds.

Beverley Bryant
Executive Director
Performance, Improvement and Delivery
Leeds Primary Care Trust

September 2008

ANNEX 1

The Leeds Teaching Hospitals NHS
NHS Trust

Leeds NHS
Primary Care Trust

JOINT PERFORMANCE MANAGEMENT ARRANGEMENTS

MEETING TO BE HELD ON 24TH SEPTEMBER 2008 AT 12 NOON – 2PM

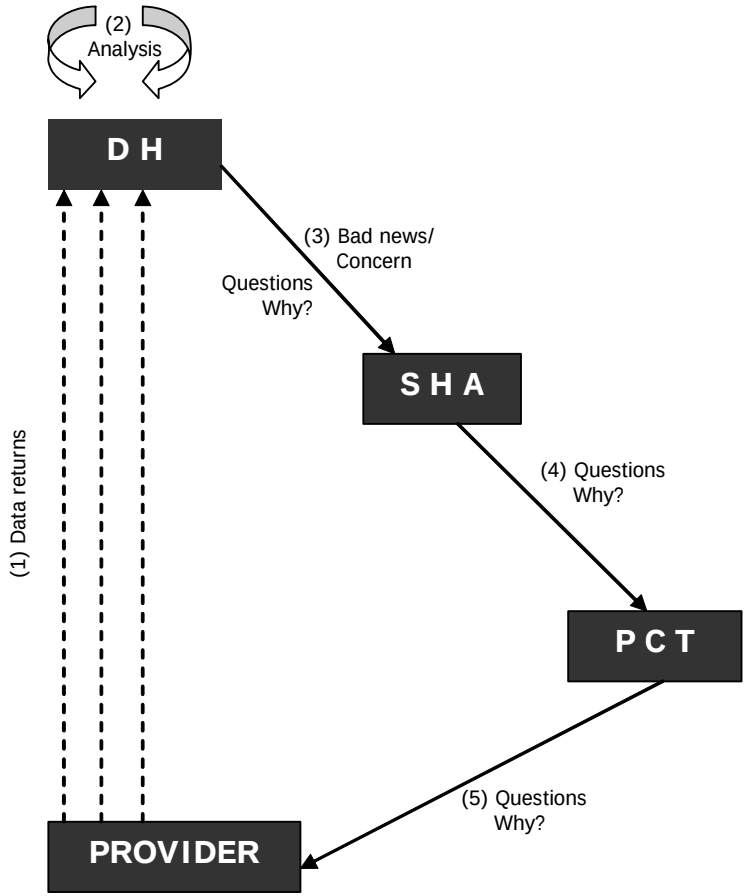
BOARD ROOM B, NORTH WEST HOUSE, LEEDS

A G E N D A

12:00	1.	Apologies	
	2.	Action Log – Last month	CO
12:05	3.	Strategic Context: a. Healthy Ambitions b. Wharfedale c. Children's Services Reconfiguration	CO & MB
12:30	4.	Finance and Activity – Overall Contractual Issues: a. Shared Financial Position b. Activity Statement and Analysis c. Contract Change Issues	
12:50	5.	Targets and Indicators: a. 18 Week RTT b. 16 Weeks Diagnostic Waits c. 13 Weeks d. 26 Weeks e. Choose & Book f. A & E 4 Hours g. Delayed Transfer of Care	Relevant DGM & Relevant Commissioner
13:30	6.	Medium Term Commissioning Intentions: a. PBC Plans b. Any Willing Provider Process and Plans c. 2009/10 Planning Process	
13:45	7.	Any Other Business	
	8.	Date and time of Next Meeting (22.10.08 @ 12 noon)	
13:55	9.	Next Months Indicators: a. C.Diff b. MRSA Numbers c. MRSA Screening of Admissions d. Cancer – 2 Week Wait e. Cancer – 31 Day Wait f. Cancer – 62 Day Wait g. 31 Day Radio (Second/Subsequent) h. 31 Day Surgery/Drugs (Second/Subsequent) i. Breast Screening	

OLD MODEL

INFORMATION FLOWS



NEW MODEL

INFORMATION FLOWS