Leeds PCT-level Performance Report

NHS Airedale, Bradford and Leeds

December 2011

1 Executive Summary

This edition of the performance report covers available data for the period up to November 2011. There are some performance changes to report. Significant changes are shown below, where performance has moved from one traffic light category to another.

a. Operating Framework/Performance Framework Indicators: A&E waiting times - after recent improvements, has now slipped back to below the level required. Action plans are in place, as described in the body of the report.

b. Operating Framework/Performance Framework Indicators: 62 day cancer waits. Despite achievement in Q1, this indicator is now below that required, after poor performance in Jul and Aug. Further details are set out in the body of the report.

c. Operating Framework/Performance Framework Indicators: Commissioning of early intervention services. This indicator shows performance is now back on track.

d. Operating Framework/Performance Framework Indicators: Breastfeeding. Both prevalence and coverage elements of this indicator now better performance than previously reported.

e. Workforce Metric Indicators: Staff with appraisals. This indicator is now showing as red, because of a drop in performance from 77.4% to 73.4%. Remedial actions are outlined in the body of the report.

f. Workforce Metric Indicators: Training compliance in infection prevention, information governance and slips trips and falls all now show as green, due to recent increases in compliance.

g. Urgent Care Provision Indicators: Emergency home visits within 1hr. This indicator has moved from red to amber, showing continuing improvement from that seen in the last report.

December 2011

2 Introduction

This performance report uses a dashboard-based system, covering a wide range of topics. It is intended that the report will include other topics as required, to ensure the Board is well informed, as we move through 2011/12.

3 External Performance Management of the PCT

The indicators shown here represent only a part of the total performance management systems for 2011/12, which are run by the SHA and DH. The two main mechanisms are –

- The Dept of Health Operating Framework for the NHS.
- The NHS Performance Framework.

The report also contains dashboards covering a range of other performance topics, including locally determined indicators. The national performance systems have been updated from that seen during 2010/11. This means that, whilst the format remains, some of the indicators have been changed in definition or form.

4 Risk

Top-level risks across the PCT, those that require to be drawn to the attention of the Board are shown using red highlights directly at each dashboard indicator line, as required.

5 Format

As mentioned earlier, the format remains as before. Traffic lights are used within each dashboard, and with few exceptions these contain a trend arrow. This arrow shows the general direction of travel in performance terms, compared to earlier reported performance. An upward pointing arrow indicates improving performance, downward equates to deteriorating performance and across means that performance is stable. The traffic light colour indicates performance that is either -

- Green: at or above planned levels or targets
- Amber: near to planned levels or targets (where there is a bandwidth between achievement and outright failure)
- Red: below planned levels or targets (or at a level below the threshold for amber, where one exists)

Each dashboard also contains a brief description of the indicators and where required, short supplementary information note.

A narrative describing remedial action, detailing the reasons for poor performance, the actions being taken to mitigate against it and the timescales, will be all be set out where performance is not at required levels. There is no narrative where performance is adequate or does not present a significant risk.

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NHS Operating & Performance Frameworks Indicators 2011/12

Two indicators identified in the Risk Register as carrying a red risk rating			
Indicator	**Trend**	**Target/Threshold**	**Information**
A&E waiting times	↓	95%	Sep: 91.2%; Oct: 91.7% YTD: 94.04%
Access to GUM clinics (offered)	↔	98%	Q2: 100%
Delayed transfers of care	↓	Comparison with national average	Q2: 11.5
Category A calls responded to within 8 mins	↓	75%	Aug: 75.6%, Sepl: 75.0% YTD: 76.3%
Category A calls responded to within 19 mins	↔	95%	Aug: 97.9%; Sep: 98.1% YTD: 98.1%
Cancer urgent referral to first outpatient appointment waiting times	↔	93%	Sep: 96.3%/95.7% YTD: 95.9%/96%
Cancer diagnosis to treatment times	↔	All\Surg\Drug\Radio 96%\94%\98%\94%	Sep:95.7%\97%\100%\99.2% YTD: 97%\98.5%\99.9%\98.6%
Cancer urgent referral to treatment waiting times	↓	All\Screen\Upgr 85%\90%\85%	Sep:85%/100%/86.7% YTD:85.4%/96.9%/88.1%
Diabetic retinopathy screening	↔	95%	Q2: 99.0%
Commissioning of early intervention in psychosis services	↑	124 cases	Sep: 15, YTD: 70/62
Commissioning of crisis resolution/home treatment services	↔	Whole year: 1652 episodes	Aug: 173, YTD: 850
MRSA	↓	26 cases max	Trajectory 16, 16 cases to date
C.Diff	↓	270 cases max	Trajectory 152, 255 cases to date
Breast cancer screening	↑	Q2: 14%	Q2: 16.7%
Bowel screening	↑	Target only applies from Q4: 5%	Q2: 2.1%
Access to primary dental services	↑	419,000 min	Q2: 422,419
Quality of stroke care	↑	80.4%	Q2: 81.4%
Cervical cancer screening: 2wk result	↔	98%	Q2: 99%
Four week smoking quitters	↔	Q2: 1985	Q2: 1813
12 week maternity appointments	↑	90% min	Q2: 98.9%
Breastfeeding	↑	Q2 Prevalence: 50%; Coverage: 95%	Q2: 50.7%/97.9%
Health visitor numbers (WTEs)	↓	Sep: 125.8	Sep: 120.3
Choose & book rates	↑	Comparison with national average	Oct: 53%
18 week referral to treatment waiting times	↑	90% admitted; 95% non-admitted	Aug: 87.75% admitted/97.72% non-admitted
Improve access to psychological therapy: Number receiving treatment	↑	1.80%	Q2: 2.2%
Improve access to psychological therapy: Number referred	↔	51.30%	Q2: 53.7%

The indicators shown here are drawn from the NHS Operating and Performance Frameworks 2011/12.

Operating Framework & Performance Framework

6 A&E 4hr waits

This indicator is also identified as a Board level risk. Performance against 4hr target was particularly low in Sep, although at SJUH rather than LGI. There is no correlation between admission rates and 4hr wait performance. An average weekly breach peak of 589 occurred during Sep, although the levels were not in line with increases in activity. A whole health and social care economy summit meeting was held recently, to plan a way forward. An action plan was agreed with immediate activities around recruiting GPs into A&E, increasing out of hours capacity, improving referral rates through the primary care access line and communications campaigns. Significant extra commissioning relating to winter planning has also been agreed and the winter plan is now ion operation. LTHT are confident that performance will improve from Nov onwards.

7 Delayed transfers of care

Whilst this indicator is not showing as a red traffic light, there is an indicated significant rise from the rate seen previously, which ordinarily would give major cause for concern. It seems though that the reported rate is due in part to changes at LTHT, which caused a higher rate than should have been reported. This has now been addressed.

8 62 day cancer waits

This indicator is also identified as a Board level risk, due to poor performance on the 62 day waits following a GP/GDP referral element. Plans agreed between the SHA and YCN include increasing: the proportion of 2 week wait patients seen within 7 days; the number of 62 day patients with a decision to treat by day 38; and the number of 62 day patients treated by day 54, with the aim to shorten the pathway at each stage. LTHT aims to achieve the 62 day target (excluding referrals by day 38) from Oct 11. An urgent review of the Head and Neck, GI, Urology and lung MDT's and the pathways is underway.

9 C.difficile numbers

The trajectory for the second quarter has not been met, though the rising trend seems to have levelled. The number of cases in the community linked to hospital admission is declining. LTHT have carried out a considerable amount of work to reduce the number of cases. Contractual levers have been applied with LTHT, in efforts to help bring about an overall reduction in numbers. In the community, the focus continues to be giving support to GPs to improve prescribing of antibiotics, to reduce the probability of patients developing C.diff. Increasing infection prevention and control support has been given to Leeds care homes. Other initiatives include improving the provision of information for patients who have been affected by C.diff previously.

10 Four week smoking quitters

The service has performed significantly better than last year despite operating with reduced staffing as a result of sickness and maternity leave. At the same time point in 2010, 1584 people were quit at 4 weeks achieving 36.46% of the annual target, compared to 40.74% this year. The service is on track for achieving the annual target for 2011/12, but due to the front load of the projected figures appears to be below the threshold. Using a more realistic trajectory that takes into account the seasonal fluctuations the service would expect to have achieved 40% of the annual target by the end of September.

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Quality, Innovation, Productivity and Prevention (Financial Plans)

No indicator set identified in the Risk Register as carrying a red risk rating				
ICT/Directorate	**Lead**	**Performance & Trend**	**CIP Plan £000's**	**CIP Forecast £000's**
Planned Care	Philomena Corrigan	↔	18,417	21,097
Unplanned Care	Philomena Corrigan	↑	10,485	11,428
Long Term Conditions	Philomena Corrigan	↔	4,929	4,929
Continuing Care	Philomena Corrigan	↓	545	515
Mental Health	Philomena Corrigan	↔	6,660	6,660
Safeguarding	Philomena Corrigan	↔	0	100
Learning Disabilities	Philomena Corrigan	↔	286	0
Non-Clinical Productivity	June Goodson Moore	↔	1,200	1,200
Other Workstreams	Kevin Howells	↔	11,232	11,382
Primary Care & Prescribing	Dr Damian Riley	↓	6,702	6,532
		TOTAL	**60,456**	**63,843**

In year planned recurrent QIPP targets of £60.5m have been set, of which £32.5m relates to the 4% national efficiency requirement built into provider contracts. In year QIPP achieved as at the end of September totals £36.3m. The PCT is on course to over deliver its QIPP target by £3.4m in 2011/12 thereby reducing QIPP targets in years 2-4.

QIPP Financial Plans

11 Learning Disabilities

As reported previously, the learning disabilities pooled budget is forecast to be overspent as a result of an increase in the number of learning disability patients being assessed for continuing care, putting at risk the achievement of the financial target. Discussions are continuing with Leeds City Council, to determine further potential risk within the pooled budget and to identify in-year funding for increased costs, though are not yet concluded. The latest point at which discussions can be brought to a close is December.

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Local Indicators

No indicator identified in the Risk Register as carrying a red risk rating			
Objective	**Indicator**	**Performance & Trend**	**Information**
Reducing the gap in infant mortality	Early booking rates for maternity services	↑	Q2: 98.86%
	Rates of smoking during pregnancy	↑	Q2: 10.8%
Maximise the number of children aged 2 completing MMR immunisation	Rate of children completing	↑	Q1 11/12: 93.8%
Reduce the gap in mortality between the most deprived areas and the rest of Leeds	Male rate	↔	2008: 295 actual gap vs 287 trajectory
	Female rate	↔	2008: 142 actual gap vs 148 trajectory
Reduce admissions for alcohol related harm	Number of admissions	↓	2009/10: 14% increase
Reduce health inequalities	Reduce CVD mortality	↔	2009/10: 76.2
Increasing life expectancy	AAACM rate male	↔	2009: 672 rate vs 697 trajectory
	AAACM rate female	↔	2009: 480 rate vs 481 trajectory

These indicators describe progress toward delivering agreed outcomes and fit within a locally determined process designed to stimulate the best commissioning practice. Performance is managed locally. The outcomes form part of the Strategic and Operational Plans of the PCT Cluster. Some of the indicators are also used in other systems. Please note that some indicators used here are only available annually and may also be up to 3 years behind, due to the complexity of the production of the data, a factor that is outside the control of NHS Leeds. Overall, performance has improved across these indicators as compared with that seen over the past 2-3 years

Local indicators

12 Reduce the gap in mortality – Males

This indicator is only updated annually; hence the commentary is as used previously - Life expectancy for all living in Leeds continues to increase year on year. However, life expectancy for the most affluent is generally increasing faster than for the most deprived. This based on current forecasts, looks likely to continue. To redress this, actions on the most significant causes of premature mortality are being pursued, covering CVD, cancer, respiratory disease and infant mortality. Examples include action to increase early detection of lung cancer in inner south and east Leeds, and increasing access to the NHS Health Check and stop smoking services for our most disadvantaged populations. Strategically, work with Leeds City Council and other partners to reduce the impact of social causes of poor health both at a City wide and locality levels is ongoing. One important factor is that a change in how this Indicator will be measured is anticipated once the Public Health outcomes framework is published later this year. Further details on the changes will be outlined once they are available

13 Admissions for alcohol related harm

This indicator is only updated annually; hence the commentary is as used previously - The availability of treatment will be increased by the recruitment of two workers, one in the Addiction and Dependency Service (ADS) and one in the Leeds Addiction Unit, to be in place by September at the latest. Initiatives to target high intensity users of hospital services are planned. The first of these is to target people who have had five or more hospital attendances linked to alcohol related issues. Work with their GP's and ADS to offer a case alcohol treatment and conference approach, is planned to be piloted with specific practices from September. The second initiative is to implement the 'Doncaster model' of targeting high intensity users via a multidisciplinary group to include A&E consultant, ambulance services, Community Matrons, and business management from the hospital, as a few examples. Dual diagnosis (drug and alcohol use) discussions are underway with service providers. The plan is to develop an approach within existing services to reduce the blockage in the drug treatment services, for people on methadone that have a alcohol problem. One part of the plan is to increase the treatment slots available.

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Primary Care Commissioning

No indicators identified in the Risk Register as carrying a red risk rating				
Indicator	**Current performance**	**NHS Leeds**	**SHA**	**Comment**
% patients satisfied with dentistry received	↑	95.2%	95.2%	Q2 data
% patients satisfied with the time they had to wait for an appointment	↑	86.7%	89.7%	
Number of FTE GPs per 100,000 population	↔	59.8	60.9	Close to national average
Average total GP Practice Quality and Outcome Framework points	↓	947.96	n/a	2010/11 data: yet to be formally validated
Clinical QOF domain points	↑	675.39	n/a	
Organisational QOF points	↑	164.73	n/a	
Patient experience QOF points	↑	64.88	n/a	
% Patients treated as QOF exceptions	↓	5.5.%	n/a	Further guidance developed
% patients with BP recorded	↔	95.0%	94.9%	2008/09 data, 2010/11 not available at present
% patients with BP controlled within recommended limits	↔	80.8%	80.6%	
% patients with cholesterol recorded (all LTC's)	↔	94.3%	94.4%	
% patients with cholesterol within recommended limits (all LTC's)	↔	81.1%	81.7%	
% diabetic patients with HbA1c recorded	↔	97.4%	97.7%	
% patients with HbA1c in recommended limits (diabetes)	↔	63.7%	66.3%	
GP access: % able to see a doctor fairly urgently (24/48hr target)	↑	77.4%	78.2%	
GP access: % able to book ahead for appointments	↑	70.0%	69.9%	
Prescribing: weighted per capita prescribing costs	↑	£11.38	£11.07	NHSL cost growth lower than SHA & national
Generic Prescribing	↔	86.0%	85.9%	
%low cost lipid modifying prescribing	↑	69.1%	70.6%	
Total % uptake sight tests	↑	20.2%	23.0%	Uptake is below national and SHA average.
Sight tests: children 0-15yr % uptake	↓	19.9%	19.3%	Above SHA average
Sight tests: adults over 60years uptake	↑	53.9%	50.3%	Above national average

Primary Care indicators are locally compiled, using centrally prescribed data systems and which describe the quality and performance of first line health care providers. The indicators help to benchmark these services internally and against others in the region, although data at the regional level is not completely robust. Some of the indicators help to show the infrastructure for the delivery of key national targets, for example in areas relating to access or for screening. Indicators shown here are total of the Primary Care indicators that are not used in other dashboards.

Primary Care indicators

14 Percentage of patients with HbA1c in limits:

The data is yet to be refreshed, as reported previously. The management of HbA1c forms part of the diabetes clinical QOF indicator. Practices who are significant outliers against this indicator would be picked up as part of the QOF formal review process with clinical assessors. Practices are visited as part of QOF on a three yearly basis.

15 Sight test uptake:

As described previously, the total level of uptake is below national and SHA average, even though more positively, both 0-15 yrs and over 60 years old uptake numbers are above the SHA rates. Work to understand reasons, including actions for improving uptake, involving ophthalmology leads is underway. An action plan will be established where appropriate.

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NHS Leeds Commissioner - Workforce Metrics

No indicators identified in the Risk Register as carrying a red risk rating					
Key Indicator	**Target**	**Performance**			**Comments**
Sickness Absence Rate	Max 2.5%	2.95% (year to Sep 11)		↑	YTD: 2.37%
Labour Turnover	10% - 15%	15.5% (year to Sep 11)		↑	Turnover higher than target may help in achieving management cost savings.
Organisation Size	461.83 FTE max	469.13 FTE (as at 30/9/11)		↑	Target based on submission to SHA
Projected full-year paybill (Managers)	£5119k (to Mar 11)	£4888k (10/11 whole year)		↔	Shows impact of voluntary redundancy and retirement.
Total paybill per FTE	£41842k (to Mar 11)	£41,546 (10/11 whole year)		↔	
% Agency spend	<= £332k end Sep 11	£374.3k (Apr-Sep 11)		↓	
Staff with appraisals	over 90%	73.4% (at 30/9/11)		↓	
% BME Staff	9.66%	10.2% (at 30/9/11)		↑	Working age population in Leeds from ethnic minority is 11.4%
Staff Satisfaction	3.58	3.52 (year to Mar 11)		↑	National average 3.6. Indicator changes annually.
Training Compliance Indicator	**Target**	**Performance**			**Comments**
Fire	At least 90%	88.2%	Data in each case is at 30/9/11. Amber performance within a range of 75% up to 90%	↑	
Moving & Handling		84.8%		↓	
Infection Prevention & Control		93.4%		↑	
Information Governance		93.4%		↑	Data should be interpreted with caution due to delays in registration
Induction		100%		↔	Based on new starters 1/6/10 to 31/3/11
Slips, Trips & Falls		93.8%		↑	Data should be interpreted with caution due to delays in registration

Workforce indicators are locally compiled, using PCT Cluster level data systems. They are used here to give a high level understanding of facts about the workforce, broken down into two categories, covering top level key indicators, as well as the main statutory/mandatory training course compliance. Some of the indicators help to show the relative 'health' of the Cluster organisation as an employer, for example in staff turnover and training compliance. Indicators shown here are total of the workforce indicators that are not used in other dashboards.

Workforce indicators

16 Sickness absence rates:

This figure has decreased to 2.95% from 3.07% in the September board report, though is still defined as red. Work continues to support effective absence management and following a scoping exercise to understand skill requirements, development sessions for managers are taking place in October. The rate for the period from April to September stands at 2.37%, below the threshold of 2.5%.

17 Staff with appraisals:

The decrease in percentage of employees with an appraisal has been reviewed and a series of measures are being taken to increase the numbers, including reminders to line managers to ensure that they are aware that appraisals are due; logging of appraisal data by LCHT under an SLA (this process is currently being reviewed to ensure that all data is recorded immediately); appraisal training sessions scheduled in December and January to update manager's skills, and finally the Protected Learning Time and Personal Development policy has been reviewed and improved and is currently going through the ratification process, with the aim of improving the levels of appraisal.

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Complaints, Incidents, Communications and FOI

No indicators identified in the Risk Register as carrying a red risk rating						
Indicator	**NHSL**			**Primary Care Providers**		
	Current	Traffic light	Target/ Max	Current	Traffic light	Target/ Max
Complaints: Number	16	Not applicable		44	Not applicable	
Complaints: % acknowledged within 3 working days	100%	↔	100%	100%	↔	100%
Complaints: % responded to within agreed timescales	100%	↔	100%	100%	↔	100%
Number clinical incidents (YTD)	110	Not applicable		234	Not applicable	
Number non-clinical incidents (YTD)	21			72		
Number level 4/5 incidents	0	↔	0	2	↑	0
PALS: Number of calls received	709	↑	Not applicable	383	↑	Not applicable
PALS: Main reason - Immunisation	314	↑		-	-	
PALS: Main reason - Waits for appointments	60	↑		136	↑	
PALS: Main reason - General queries	209	↑		152	↑	
PALS: Main reason - Handling complaints	-	-		46	↑	
No of patient opinion postings about services	13	↓		Not applicable		
No of people in NHSL Patient, Carer & Public Involvement	476	↑	25% increase			
Positive media coverage	92%	↑	85%			
Timely media response rate	100%	↔	100%			
Unique visitors to NHSL website	10,016	↑	-			
Number FOI's	Q2: 98	↔	Not applicable			
FOIs - % responded to within legal deadline	Q2: 100%	↔	100%			
FOIs - % where information was provided	Q2 data: 85%	↔	Not applicable			

Complaints and incidents indicators are locally compiled, using PCT level data systems. Note that the targets for Clinical and Non-Clinical Incidents are minimum levels of achievement. Indicators shown here are total of the complaints, incidents and media indicators that are not used in other dashboards. Previously, this dashboard also showed Leeds Community Healthcare's data. This is however not now appropriate, given that they are now a stand-alone NHS Trust.

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Provider Indicators: Leeds Teaching Hospitals Trust

No indicators identified in the Risk Register as carrying a red risk rating			
Indicator	**Performance & Trend**	**Target**	**Information**
Fractured neck of femur operated on within 48hrs	↓	80%	Q2 to date: 68.2%
Cancelled operations	↓	0.8% max	YTD: 0.84%
Cancelled operations - patients not readmitted within 28 days	↑	5% max	YTD: 2.86%
Emergency Readmissions (within 30 days) - following elective discharge	↑	Peer average: 2.8%	Year to Aug 11: 4.6%
Elective inpatient length of episode	↑	3.06 max	YTD: 3.78

The indicators here are distinct from those that apply to commissioners. The elective inpatient length of episode is new, replacing the reducing length of stay indicator, to bring it into line with the Managing for Success programme. The information is taken from LTHT's latest published Integrated Performance Report, published during Nov 11.

Provider Indicators: Leeds Partnerships Foundation Trust - Mental Health

No indicators identified in the Risk Register as carrying a red risk rating			
Indicator	**Trend**	**Target**	**Information**
Admissions had access to crisis resolution teams	↑	90%	Aug data: 95.9%
100% enhanced CPA patients follow up contact within 7 days of discharge	↔	95%	Q2 data to date: 96.9%
Care programme approach patients having a formal review within 12 months	↔	95%	Aug data: 96.6%
Data completeness identifiers	↔	99%	Q2 data to date: 99.9%
Data completeness outcome: HoNOS Score	↔	50%	Q2 data to date: 79%
Assertive outreach caseload	↔	711 per q'tr	Q2 data to Aug: 651

The indicators here are drawn from the Monitor performance management systems in the main, via the LPFT performance report. Indicators shown here are those outside of the Vital Signs system, and are not used in other dashboards. The data is the latest available, as published in Sep 2011.

Provider Indicators: Leeds Teaching Hospitals

18 Patients admitted with a Fractured Neck of Femur operated on within 48hrs:
The LTHT trajectory for this indicator is that performance will improve throughout the year, from 70% to 80% for Q4 (Q1 performance was 71%). Data is a month in arrears. In August, 61.0% of patients were operated on within 48 hours of admission, which means that LTHT failed its internal trajectory. For the period July to August performance was 68.2%. Further improvements are necessary to ensure that the standard is met and sustained. The Trust is forecasting that it will achieve at the level required.

(text includes extracted information from LTHT performance report dated 10 November 2011)

19 30 day readmission rates, following elective discharge:
LTHT have carried out work to understand the reasons why different types of patients are readmitted. This categorised patients into five different groups. The aim of this is to help distinguish avoidable from unavoidable readmissions. The five groups cover those patients admitted from – the Assessment Unit, where an agreed change has been to eliminate counting these; Payment by Result (PbR) exclusions, according to the DH definitions, including maternity, cancer, and children under 4 years old; Leeds Local Pathways, recognising that there is a cohort of readmissions which are the result of how the current pathways are delivered in Leeds; Unrelated admissions, acknowledging that the current readmission indicators do not link the readmission with the original hospital spell; and finally Avoidable admissions. LTHT Divisions are currently focusing on this last element by analysing patient level data to understand why particular readmissions have occurred.

(text includes extracted information from LTHT performance report dated 10 November 2011)

Urgent Care Provision (primary care out of hours)

No indicators identified in the Risk Register as carrying a red risk rating			
Indicator	**Performance & Trend**	**Target**	**Information**
Appointments started within 30mins of appointed time	↑	95%	Q2: 97.9%
Face to face emergency consultations started within 1hr	↔	98%	Q2: 100%
Face to face urgent consultations started within 2hr	↔	98%	Q2: 100%
Face to face less urgent consultations started within 6hr	↔	98%	Q2: 100%
Emergency home visits started within 1hr	↑	98%	Q2: 92.4%
Urgent home visits started within 2hrs	↑	98%	Q2: 94.7%
Less urgent home visits started within 6hrs	↔	98%	Q2: 99.9%
Treatment within 2hrs	↔	98%	Q2: 100%
Walk in urgent patients assessed within 20mins of arrival	↔	98%	Q2: 99.5%
Consultations sent to GP/GDP by 8am next working day	↑	95%	Q2: 99.5%
Number of MIU walk in patients seen within 4hrs	↔	98%	Q2 :100%

The indicators used here with the provider (Local Care Direct) are locally agreed and sit within the contractual framework. The data shown here is Q2 2011/12 data.