Agenda Item No. 11

Part 1 X Part 2

NHS Trafford Clinical Commissioning Group

NHS TRAFFORD CLINICAL COMMISSIONING GROUP GOVERNING BODY 24th February 2015

Title of Report	Performance and Quality Report.
Purpose of the Report	This paper updates the Governing Body on Trafford CCG's performance against the 2014/15 statutory frameworks and the performance of the CCG's main providers, University Hospital South Manchester (UHSM), Central Manchester Foundation Trust (CMFT) and Pennine Care Foundation Trust (PCFT).

Actions Requested	**Decision**		**Discussion**	**x**	**Information**	

Strategic Objectives Supported by the Report		
	1. Consistently achieving local and national quality standards.	x
	2. Delivering an increasing proportion of services from primary care and community services in an integrated way.	x
	3. Reduce the gap in health outcomes between the most and least deprived communities in Trafford.	x
	4. To be a financial sustainable economy.	

Recommendations	The Governing Body is asked to: • Note the issues raised in relation to performance. • Endorse the actions being taken to improve performance and consider any further actions they would like the Performance and Quality Team to take.

Discussion history prior to the Governing Body	N/A
Financial Implications	Provider contractual targets may attract a financial penalty. Delivery of CQUINs will attract a financial reward. Failure to achieve Quality Premium indicators will result in non-payment.
Risk Implications	There is a risk some targets will not be delivered.
Equality Impact Assessment	N/A
Communications	N/A

Issues	
Public Engagement Summary	N/A

Prepared by	Deanne Yates Senior Performance Manager Zoe Mellon, Performance Lead. Kate Provan, Quality Lead.
Responsible Director	Michelle Irvine, Associate Director of Performance and Quality.

1.0 INTRODUCTION AND BACKGROUND

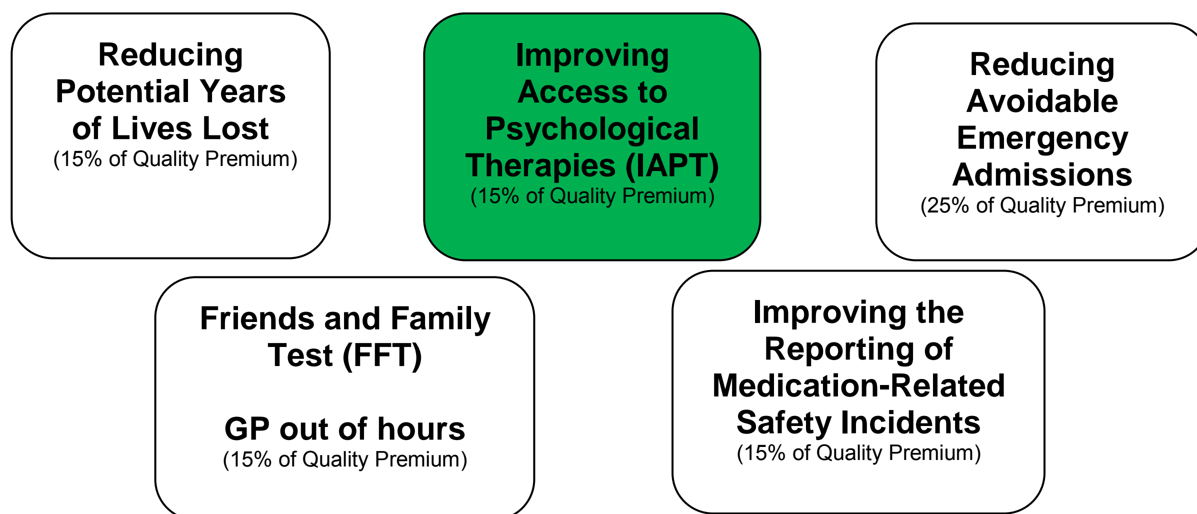
1.1 This paper updates the Governing Body on Trafford CCG's performance against the 2014/15 statutory frameworks and the performance of the CCG's main providers, University Hospital South Manchester (UHSM), Central Manchester Foundation Trust (CMFT) and Pennine Care Foundation Trust (PCFT). The following performance scorecards are attached:

- Quality Premium (Appendix A)
- Everyone Counts (Appendix B)
- UHSM Contract Key Performance Indicators (Appendix C)
- CMFT Contract Key Performance Indicators (Appendix D)
- PCFT Contract Key Performance Indicators (Appendix E)

2.0 QUALITY PREMIUM

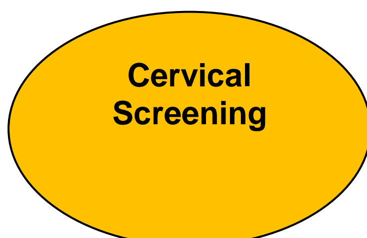
2.1 Below is an assessment of the CCG's performance against the 2014/15 Quality Premium indicators as at the end of November 2014. Data is available for six of the ten indicators.

2.2 For achieving all the performance targets the CCG will receive a payment of £1,126,000.



ONE LOCAL MEASURE

FOUR NHS CONSTITUTION REQUIREMENTS



(15% of Quality Premium)

(25% of Quality Premium is reduced for failure to achieve each of these)

3.0 PERFORMANCE HOT SPOTS

3.1 This section of the report sets out those performance areas causing concern and the actions being undertaken to address them.

3.2 Pages 6 to 13 relate CCG performance, the areas covered in this report are:

- Dementia diagnosis
- Healthcare acquired infections – C-Diff
- Ambulance response times
- Diagnostic waiting times
- Access to A&E
- Over 52 weeks

3.3 Pages 14 to 20 relate to performance at UHSM, the areas covered in this report are:

- Ambulance handover
- Access to A&E
- Access to diagnostic tests
- Cancelled ops – binding date within 28 days
- Complaints
- Stoke Care

3.4 Pages 21 to 28 relate to CMFT, the areas covered in this report are:

- Ambulance handover
- Access to A&E
- Access to diagnostic tests
- Cancer 62 day – from screening services
- Stroke services
- Pharmacy

3.4 The exception reports are followed by an update on the high risk areas relating to PCFT, these are:

- Contractual Compliance
- Ear Care
- Urgent and Intermediate Care Services
- Pulmonary Rehab

DOMAIN / STRATEGIC PRIORITY

Measures: **Dementia**
Indicator Name: **Estimated diagnosis rate for people with dementia - (ii)**
* Good performance is Higher than target *

2013/14 Value	2014/15 Target	Actual *Dec-14*	Actual *YTD*	Direction of travel	Forecast	Risk	Financial Consequences
51.2%	67.2%	**59.4%**	**56.4%**	**Improved**	Achieve	Medium	None Identified at CCG level

Issue
The NHS is committed to improving the ability of people living with dementia to cope with symptoms through improving access to services, treatment, care and support.

In order to achieve this, the CCG is working to ensure that by the end of 2014/15, 67% of people living with dementia are correctly diagnosed and recorded on GP registers.

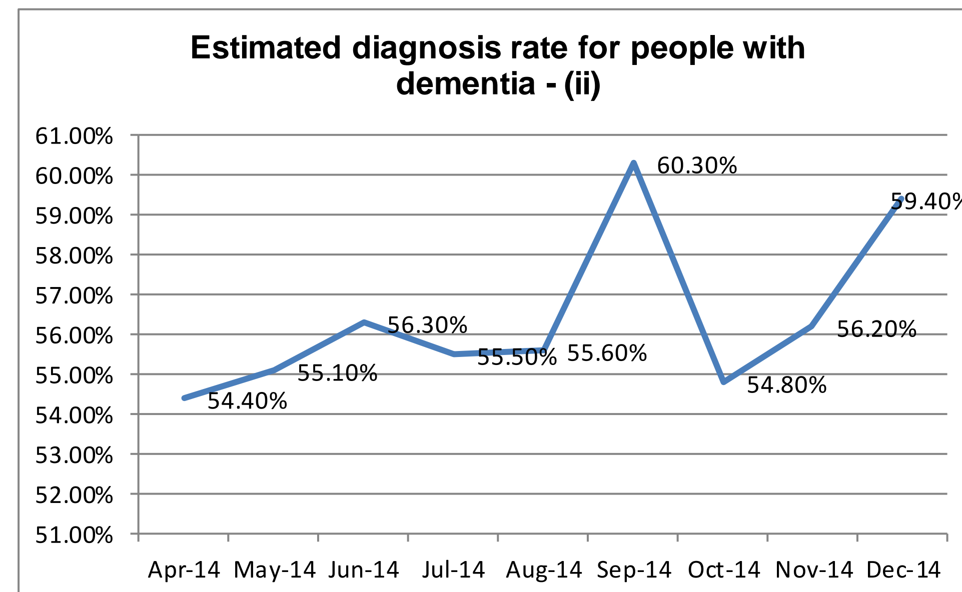
In December 2014, the CCG achieved 59.4% (YTD 56.4%).

Performance in this area is showing signs of improvement but is still short of the year-end target of 67%

Risks
No significant risks have been identified.

Action Plan
The CCG has:

- Encouraged GPs and other professionals to identify patients with dementia and refer through the Memory Team (GMW) in an appropriate and timely manner.
- Re-commissioned the Memory Service to have its emphasis on being a Memory Assessment Service.
- Undertaken a cleansing exercise of the GP practice dementia registers cleansing in line with best practice guidance.



- Undertaken a LEAN review of the service to resolve the continuing problem whereby the service continues to receive and accept more referrals each month than they manage to make a final diagnosis.

Back on Trajectory by:	Tuesday, 31 March 2015	**Commissioner Lead:**	Mental Health
Lead Organisation:	**TCCG**	**Performance & Quality Lead:**	Mike Carr

DOMAIN / STRATEGIC PRIORITY

Measures: **HCAI**
Indicator Name: **Healthcare acquired infection (HCAI) measure (clostridium difficile infections) - All Cases**
* Good performance is Lower than target *

2013/14 Value	2014/15 Target	Actual *Dec-14*	Actual *YTD*	Direction of travel	Forecast	Risk	Financial Consequences
56	59	**7**	**53**	**Worse**	Fail	High	None Identified at CCG level

Issue
The NHS has a national ceiling for C-Diff cases attributed to CCGs.

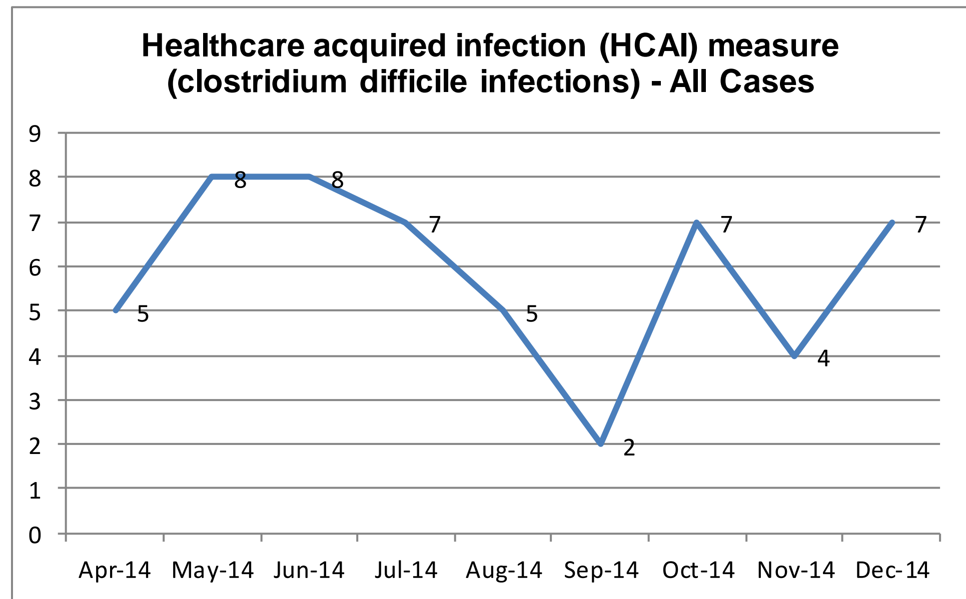
In December, 7 cases of C. Diff have been attributed to the CCG, this brings the year to date position to 53 cases against an annual maximum trajectory of 59.

Risks
At provider level, all cases are subject to a Post Infection Review (PIR) and only those cases resulting from a 'lapse of care' are monitored against the national maximum trajectory. At this time, there is no process at CCG level for determining those cases that are due to lapses of care.

Public Health England (PHE) is assured by the infection control practices in place at local providers.

Action Plan
The following actions will be put in place to respond to this issue:

- The Performance and Quality team will continue to monitor the number of cases.
- Further work to improve community reporting by PHE will hopefully enable the CCG lapses of care to be reported in the future.



Back on Trajectory by:	Tuesday, 31 March 2015	**Commissioner Lead:**	Public Health
Lead Organisation:	**TCCG**	**Performance & Quality Lead:**	Zoe Mellon

DOMAIN / STRATEGIC PRIORITY

Measures: **Ambulance Clinical Quality**
Indicator Name: **Ambulance clinical quality - Category A (Red 1) 8 minute response time**
* Good performance is Higher than target *

2013/14 Value	2014/15 Target	Actual *Dec-14*	Actual *YTD*	Direction of travel	Forecast	Risk	Financial Consequences
75.9%	75.0%	**59.0%**	**69.9%**	**Worse**	Fail	High	-25% of Quality Premium

I Issue

The North West Ambulance Service (NWAS) is required to respond to 75% of red 1calls within 8 minutes.

Response rates in December were 59.0%, with YTD of 69.9% which shows the pressures within the service over the winter period has impacted upon the service to Trafford CCG residents.

Risks

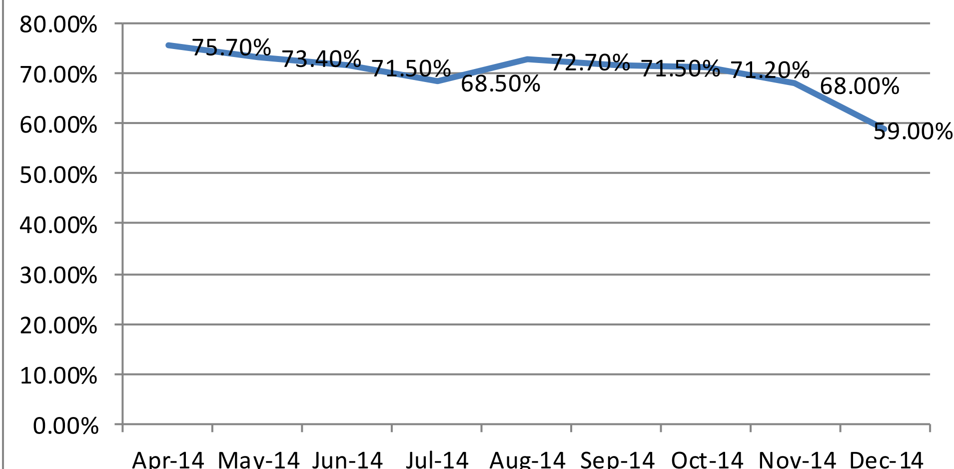
The CCG will lose 25% of their quality premium if NWAS response rates for red 1calls are below 75% in 2014/15.

During this year, NWAS has seen higher than planned activity levels. This has put increasing demand on the service and has compromised its ability to achieve performance.

There is a downward trend in performance.

Action Plan

- The recovery plan focusses on maximising the amount of capacity available, and deploying this in the most appropriate way. Service changes include - changing protocols for health care professional referrals, frequent caller schemes and GP navigation/deflection pilots.
- NWAS de-escalated from REAP 4 (where they've been since September) to REAP 3 in late January. This reflects a move in activity towards more seasonal norm levels.



- South West and London ambulance services are to undertake a pilot throughout February and March aimed at reducing the number of wasted ambulance journeys by allowing dispatchers an additional 120 seconds to better evaluate the caller's requirements. Research has shown that when dispatchers are given more time to assess calls, fewer ambulances are dispatched unnecessarily. Currently 20% of ambulances are cancelled before reaching the scene.

Back on Trajectory by:	Tuesday, 31 March 2015	**Commissioner Lead:**	Blackpool CCG
Lead Organisation:	**TCCG**	**Performance & Quality Lead:**	Jason Hughes

DOMAIN / STRATEGIC PRIORITY

Measures: **Ambulance Clinical Quality**
Indicator Name: **Ambulance clinical quality - Category A (Red 2) 8 minute response time**
* Good performance is Higher than target *

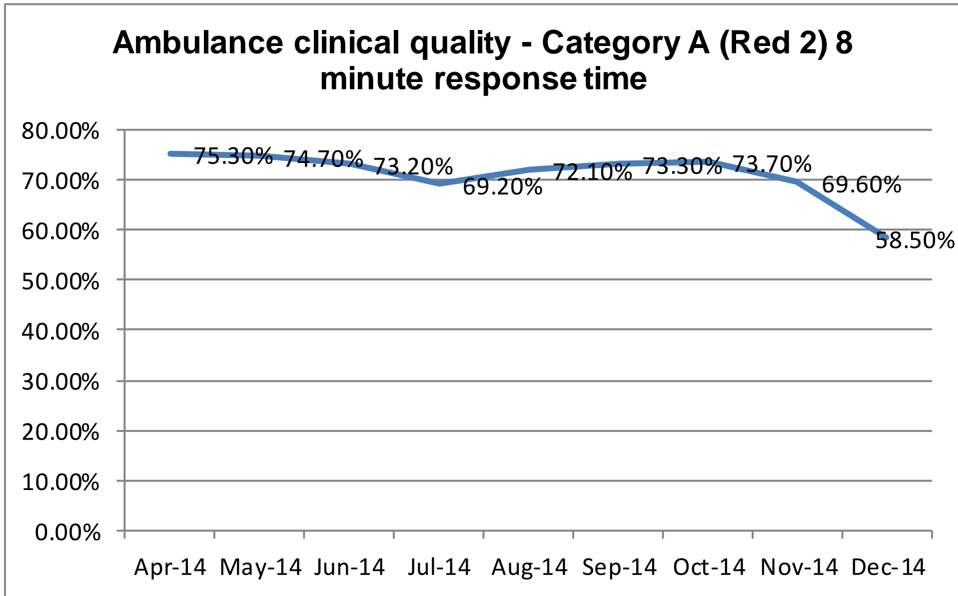
2013/14 Value	2014/15 Target	Actual *Dec-14*	Actual *YTD*	Direction of travel	Forecast	Risk	Financial Consequences
77.4%	75.0%	**58.5%**	**70.8%**	**Worse**	Fail	High	None Identified at CCG level

Issue
The North West Ambulance Service (NWAS) is required to respond to 75% of red 2 calls within 8 minutes.

Response rates in December deteriorated again to a year low of 58.5%, however the recovery plan is still a crucial step in improving the performance of this indicator.

Risk
During this year, NWAS has seen higher than planned activity levels. This has put increasing demand on the service and has compromised its ability to achieve performance.
The Trust has been unable to secure additional staff.

Action Plan
Described in previous exception report



Back on Trajectory by:	Tuesday, 31 March 2015	**Commissioner Lead:**	Blackpool CCG
Lead Organisation:	**TCCG**	**Performance & Quality Lead:**	Jason Hughes

DOMAIN / STRATEGIC PRIORITY

Measures: **Ambulance Clinical Quality**
Indicator Name: **Ambulance clinical quality - Category A 19 minute transportation time**
* Good performance is Higher than target *

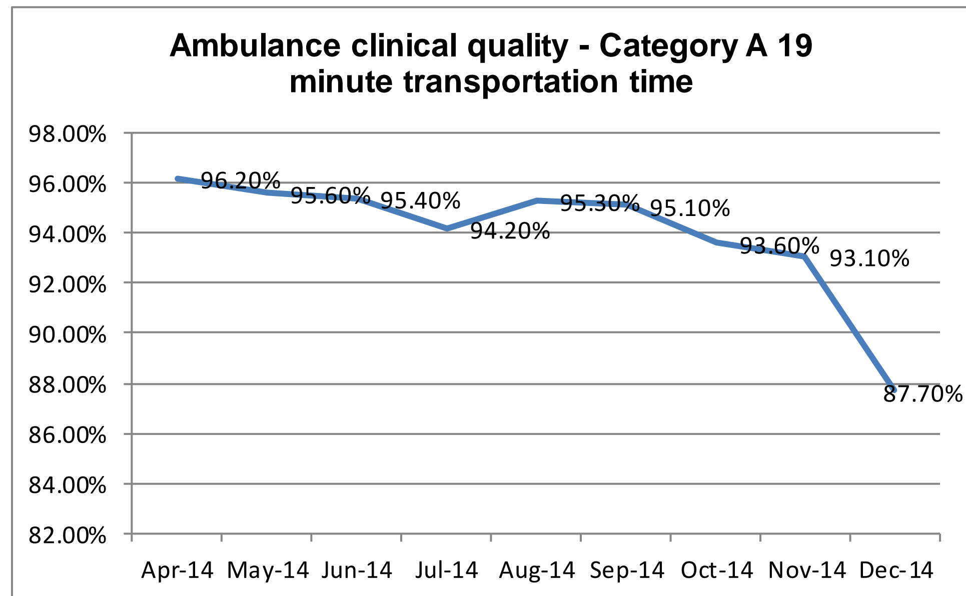
2013/14 Value	2014/15 Target	Actual *Dec-14*	Actual *YTD*	Direction of travel	Forecast	Risk	Choose an item.
96.3%	95.0%	**87.7%**	**93.8%**	**Worse**	Fail	High	None Identified at CCG level

Issue
NWAS are working to ensure that 95% of vehicles are available to convey at the scene of a Category A incident within 19 minutes.

Risk
During this year, NWAS has seen higher than planned activity levels. This has put increasing demand on the service and has compromised its ability to achieve performance.

The Trust has been unable to secure additional staff.

Action Plan
Described in previous exception report.



Back on Trajectory by:	Tuesday, 31 March 2015	**Commissioner Lead:**	Blackpool CCG
Lead Organisation:	**TCCG**	**Performance & Quality Lead:**	Jason Hughes

DOMAIN / STRATEGIC PRIORITY

Measures: **Diagnostic Test Waiting Times**
Indicator Name: **Diagnostic test waiting times**
* Good performance is Lower than target *

2013/14 Value	2014/15 Target	Actual *Dec-14*	Actual *YTD*	Direction of travel	Forecast	Risk	Financial Consequences
0.4%	1.0%	**2.1%**	**1.1%**	**Worse**	Fail	High	None Identified at CCG level

Issue
Providers are required to ensure that only 1% of patients referred for diagnostic tests wait in excess of 6 weeks. At the end of December performance had deteriorated to 2.1%, but there has been an action plan put in place by UHSM which should demonstrate an improvement over Q4.

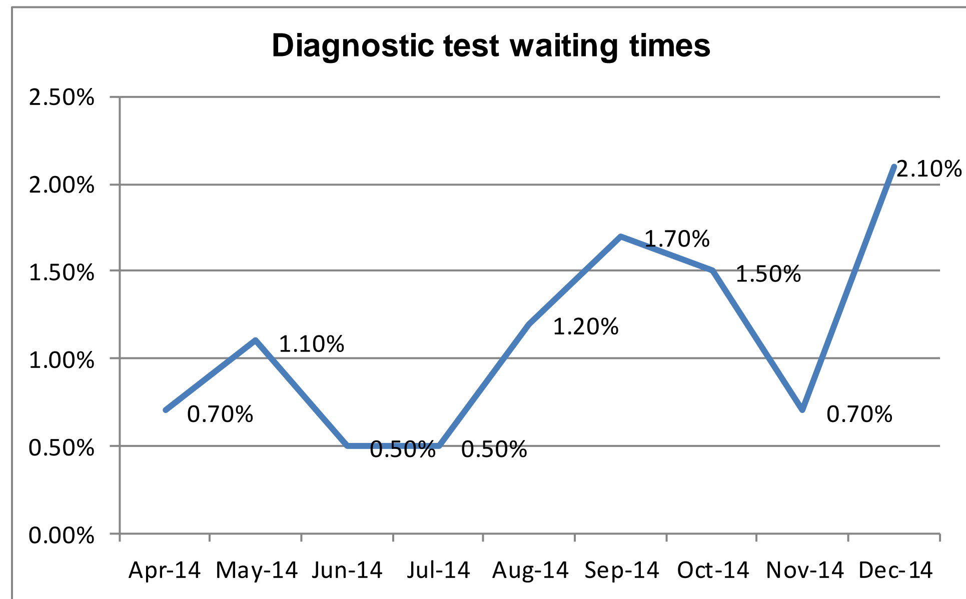
Risks
The number of patients waiting more than 6 weeks at the end of December are in total 95 the majority which were in the following tests:

Peripheral Neurophysiology – 48 (of which 13 are waiting more than 13 weeks
Gastroscopy – 8
Colonoscopy – 12
Flexi sigmoidoscopy – 15

The main area of concern is waiting times for neurophysiology testing, a service commissioned at UHSM from Salford Royal FT.

Action Plan

- Medinet are providing weekend endoscopy lists during January and February 2015 to assist with reducing backlogs
- a nurse consultant has been employed to run evening and weekend sessions. This will address capacity issues experience due to the running of single-sex sessions.
- The service is working to secure further nursing posts
- Due to IT complications, the Unisoft Scheduler will not be in place until late February 2015. Once fully implemented (in March/ April) this system will help improved scheduling
- Waiting list initiatives in Neurophysiology are continuing to be offered until the end of March 2015



Back on Trajectory by:	Tuesday, 31 March 2015	**Commissioner Lead:**	Tim Weedall
Lead Organisation:	**TCCG**	**Performance & Quality Lead:**	Zoe Mellon

DOMAIN / STRATEGIC PRIORITY

Measures: **A&E Waiting Times**

Indicator Name: **A&E waiting time - total time in the A&E department**

* Good performance is Higher than target *

2013/14 Value	2014/15 Target	Actual *Dec-14*	Actual *YTD*	Direction of travel	Forecast	Risk	Financial Consequences
94.9%	95.0%	**89.8%**	**93.6%**	**Worse**	Fail	High	-25% of the CCG Quality Premium

Issue

95% of patients in A&E should be seen and treated within 4 hours of arrival. By the end of December 2014, CCG year to date performance deteriorated to 93.6% against a target of 95%. The CCG A&E score is calculated using a mapping where a proportion of providers' activity is attributed to a CCG based on historical patient flow

CCG A&E performance has been adversely affected by under-performance at UHSM and CMFT. Both of these organisations failed to achieve the target in quarter 3.

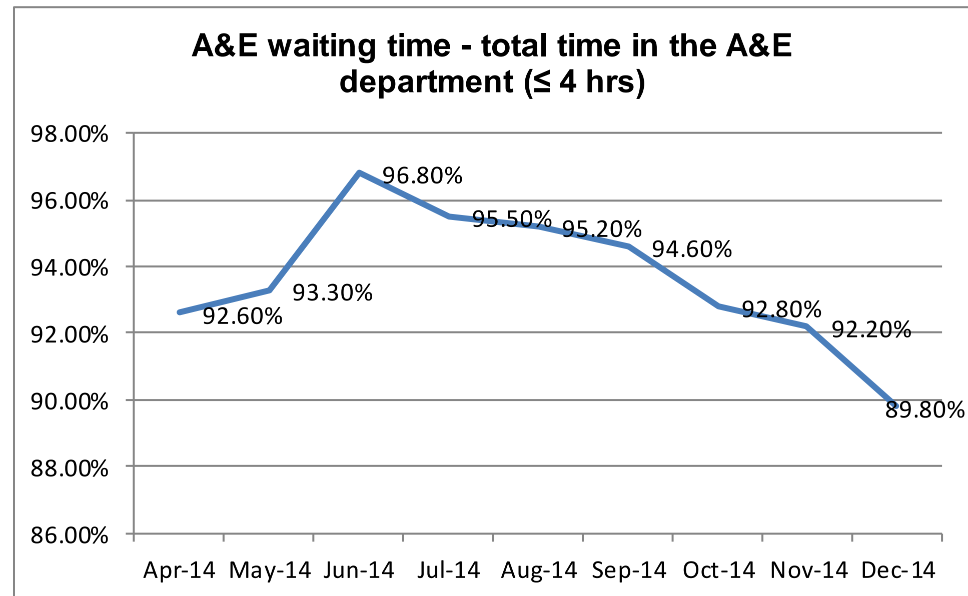
Risks

The CCG will lose 25% of their quality premium if the A&E target is not met (over the course of the year).

As at 16.2.15 Q4 performance was 94.47% at CMFT and 86.8% at UHSM.

Action Plan

Actions at UHSM and CMFT are described later in this report.



Back on Trajectory by:	Tuesday, 31 March 2015	**Commissioner Lead:**	Marion Ross
Lead Organisation:	**TCCG**	**Performance & Quality Lead:**	Jason Hughes

DOMAIN / STRATEGIC PRIORITY

Measures: **Referral to Treatment**

Indicator Name: **The number of incomplete pathways greater than 52 weeks for patients on incomplete pathways at the end of the period**

* Good performance is Lower than target *

2013/14 Value	2014/15 Target	Actual *Dec-14*	Actual *YTD*	Direction of travel	Forecast	Risk	Financial Consequences
3	0	**1**	**1**	**Worse**	Fail	High	None Identified at CCG level

Issue

There is a national Performance requirement to ensure no patient waits in excess of 52 weeks.

At the end of December 2015 there was waiting over 52 weeks on an incomplete pathway.

This patient was discovered during an RTT validation exercise that Tameside Hospital FT has undertaken following the migration of IT systems.

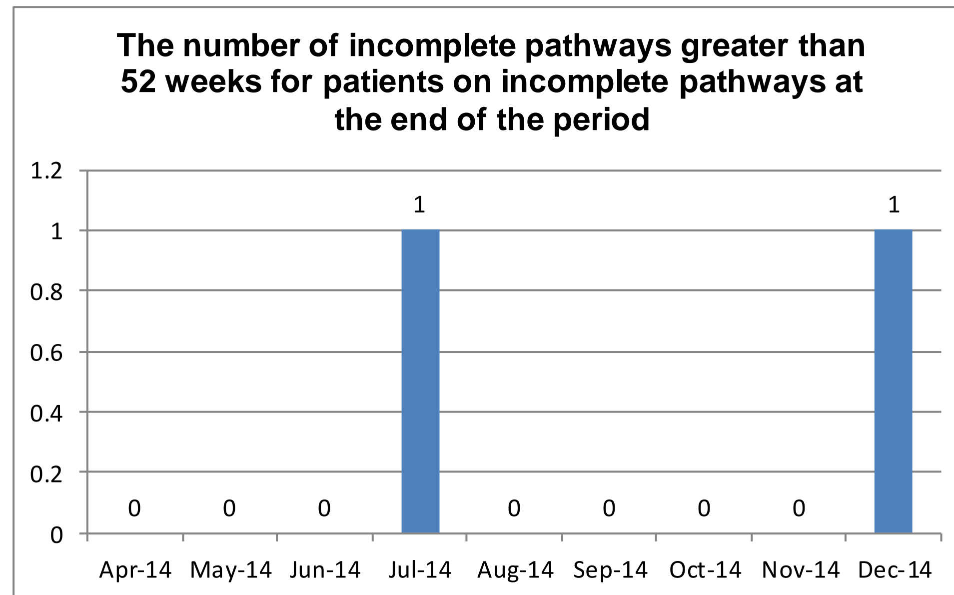
Risks

This patient was on a T&O pathway at Tameside Hospital Foundation Trust. Discussions with T&G CCG are on-going to identify when this patient was treated.

As the Trust undertake further validation it is possible that additinal long waiters will be identified.

Action Plan

- The Performance and Quality Improvement team are currently liaising with the Lead CCG for this Trust.



Back on Trajectory by:	Tuesday, 31 March 2015	**Commissioner Lead:**	Tim Weedall
Lead Organisation:	**TCCG**	**Performance & Quality Lead:**	Zoe Mellon

OMAIN / STRATEGIC PRIORITY

Measures: **Ambulance**

Indicator Name: **Compliance with Recording Patient Handover between Ambulance and A&E**

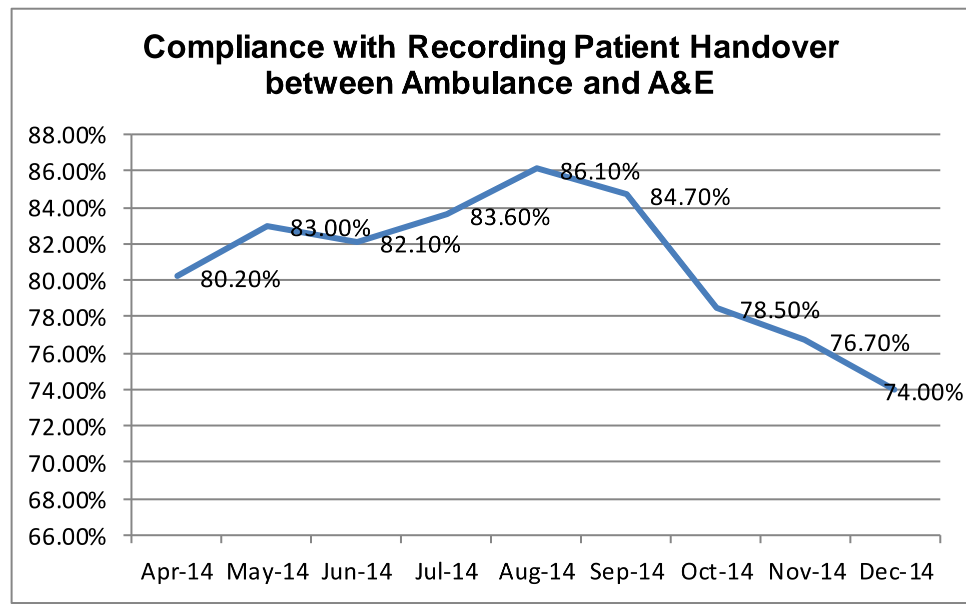
* Good performance is Higher than target *

2013/14 Value	2014/15 Target	Actual *Dec-14*	Actual *YTD*	Direction of travel	Forecast	Risk	Financial Consequences
	95.0%	**74.0%**	**81.0%**	**Worse**	Fail	High	None in 2014/15

Issue

Greater Manchester providers are working with NWAS, to ensure that ambulance handovers are recorded correctly in 95% of cases and the length of time taken to handover is kept to a minimum.

In December, the Trust recorded 74.0% of ambulance handovers correctly, this is against a target of 95% which is one of lowest in the Greater Manchester footprint. 40 handovers were reported as completed in excess of an hour.



Risks

NWAS de-escalated from REAP 4 (where they've been since September) to REAP 3 in late January. This reflects a move in activity towards more seasonal norm levels.

Action Plan

The following actions will be put in place to respond to this issue:

National (NHSE)

- 2 pilots: additional 1-120 seconds prior to clock start for all 999 calls except Red 1
- Developmental work re. R2 codes and response times; and A19 conveyance definitions

North West (Blackpool)

- Incentivising deflection schemes
- Review the inter facility/MH transfers
- Implement the 365 pilot (111 HCP referrals transport)
- Lead on the contract negotiations/CQUIN

GM (urgent care leads)

- GM ambulance commissioning group established
- More comprehensive data to be available - demographics, flows
- ATT / urgent care first response review
- PTS procurement & Acute impact

Back on Trajectory by:	Tuesday, 31 March 2015	Commissioner Lead:	Teresa Emery
Lead Organisation:	UHSM	Performance & Quality Lead:	Jason Hughes

DOMAIN / STRATEGIC PRIORITY

Measures: **A&E Waiting Times**

Indicator Name: **Percentage of Patients spending 4 hours or less in A&E**

* Good performance is Higher than target *

2013/14 Value	2014/15 Target	Actual *Dec-14*	Actual *YTD*	Direction of travel	Forecast	Risk	Financial Consequences
	95.0%	**85.4%**	**92.6%**	**Worse**	Fail	High	Penalties are in place for non-delivery each month

Issue

95% of patients in A&E should be seen and treated within 4 hours of arrival. In December the performance was 85.4% which is below the threshold and reflects the issues and pressures the Trust experienced during this month. The deteriorating performance of this indicator has impacted upon the Q3 performance.

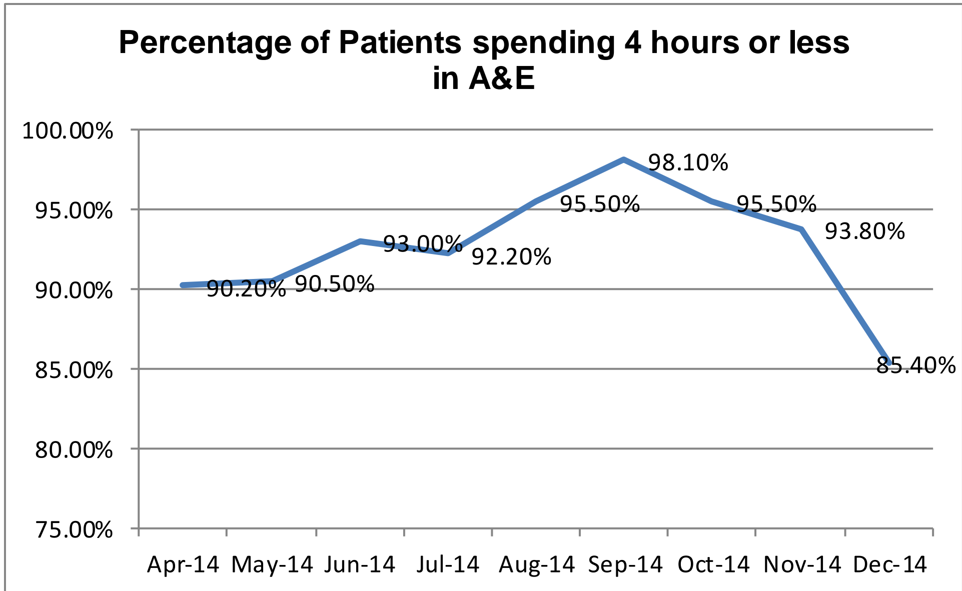
Risks

Where the number of breaches in the month exceeds the tolerance permitted by the threshold, £200 in respect of each excess breach above that threshold. To the extent that the number of breaches exceeds 8% of A&E attendances in the relevant month, no further consequence will be applied in respect of the month. This equates to £50,000 in December. (unvalidated)

The Trust reported a 12 hour trolley wait in January 2015. The CCG is awaiting the final route cause analysis from the Trust. Following receipt, the CCG will work with the Trust to implement any recommendations as a result of the findings.

Action Plan

- The Trust have put in place a number of actions which are detailed overleaf.



Back on Trajectory by:	Tuesday, 31 March 2015	**Commissioner Lead:**	Teresa Emery
Lead Organisation:	**UHSM**	**Performance & Quality Lead:**	Jason Hughes

Further Information
A&E Waiting Times at UHSM

The health economy experienced significant problems with demand and acute trusts at full capacity over this period. The impact was an increase in medical outliers, issues with ambulance handover, negative effect on length-of-stay and DTOC and severe pressure on front-door activity with high acuity and an increase in elderly patients.

Action Plan

- continued recruitment to medical, nursing and administrative posts to ensure full establishment to meet increased demand;
- an additional GP has been agreed to improve front-door capacity between 10:00 and 18:00 daily. Four GPs identified to support this initiative who have already or will be starting shortly;
- a medical bed manager is based in AMU to improve flow both in and out of the Unit;
- increasing numbers of patients are going through AMRU with patients being pulled through the ED process who are suitable for ambulatory care;
- introduced within CDU, the Mental Health Assessment Room is managed by MMHSCT to support improved flow for patients that would normally remain in ED;
- additional HCAs are funded through winter monies to support bed management, and in particular, night management;
- enhanced provision for night management has improved patient flow across the Trust in the evening with a positive impact;
- a Home Finder Co-ordinator has been recruited to support the Home Finder Nurse in identifying and supporting patients to move to their preferred home on discharge. This is funded through winter monies but is a role that has had a significant positive impact within the Team and in particular in relating to DTOCs;
- DTOCs have reduced considerably with the Trust achieving its target of 5 DTOCs per CCG consecutively for several days; there has been a slight rise recently but not in the range previously seen during Quarter 3;
- a single point-of-access has been introduced for ward discharges with additional escalation to the head of service. This has seen a rise in ‘blocked’ or needlessly-delayed discharges, which again has had a positive impact on the CCG DTOCs target for the Trust;
- focus has been directed on greater utilisation of the Discharge Lounge with a push to have greater throughput by 11am each day;
- additional social workers have been recruited to the Discharge Team through winter monies by both Manchester and Trafford CCGs. Split shifts have meant that social worker cover up to 9:30pm each night and weekends 10am to 2pm has seen deflection from ED and early start social-worker assessment;
- Trafford CCG’s community services (managed by Pennine Care) have now successfully recruited to their vacant nursing posts that are based within the discharge team; this should now support timely nursing needs assessments for Trafford patients and release UHSM staff from providing that additional support;
- winter monies have been used to purchase additional laptops for social workers to ensure timely report-writing and assessments; and
- small process changes have seen a reduction in duplication in report provision that has had a positive impact on referrals for assessment for Trafford patients.
- Performance and breach validation is undertaken and reported daily and will demonstrate the impact of improvements in these areas. Regular review of performance takes place at weekly UCOG with oversight by UCB fortnightly. Additionally, performance is monitored twice weekly for South and Central Manchester via tactical tele calls with additional monitoring through UCOG weekly and reported up through UCB.

DOMAIN / STRATEGIC PRIORITY

Measures: **Diagnostic Test Waiting Times**

Indicator Name: **The Percentage of Patients waiting 6 weeks or more for a Diagnostic Test (15 Key Diagnostic Tests)**

* Good performance is Lower than target *

2013/14 Value	2014/15 Target	Actual *Dec-14*	Actual *YTD*	Direction of travel	Forecast	Risk	Choose an item.
	1.0%	**5.5%**	**3.7%**	**Improved**	Fail	High	Penalties are in place for non- delivery each month

Issue

Providers are required to ensure that only 1% of patients referred for diagnostic tests wait in excess of 6 weeks. In December performance was 5.5%, which is an improvement from the previous 3 months, but is still above the national standard.

At UHSM, Neurophysiology testing is the main area for concern.
The number of patients waiting move than 6 weeks at the end of Deacember were in total 259. The main diagnostics tests affected are:

Peripheral Neurophysiology – 173 – deteriorated since November
Gastroscopy – 25 - improved since November
Colonoscopy – 17- improved since November
Flexi sigmoidoscopy – 32– deteriorated since November

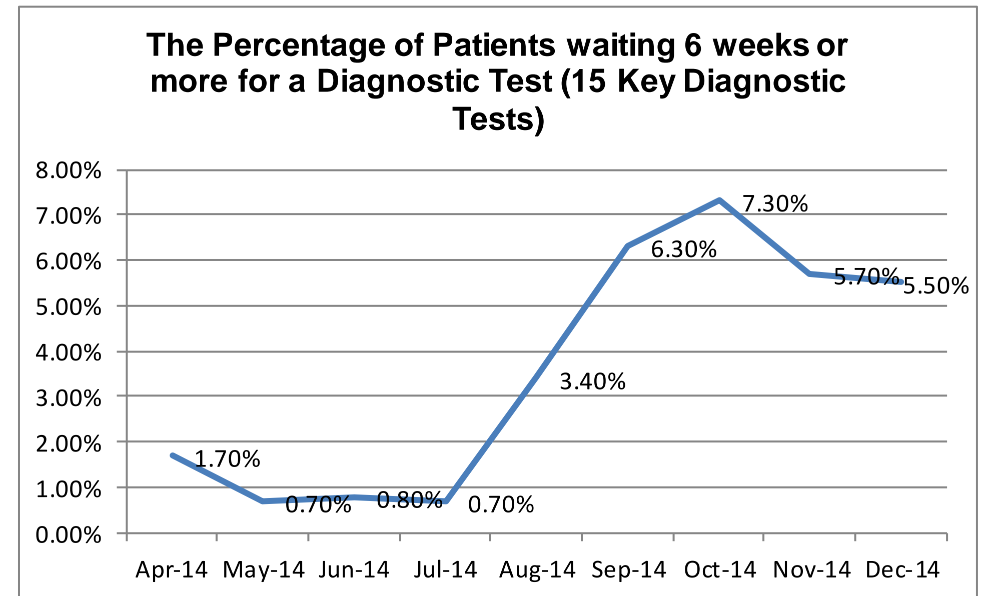
Risks

The potential impact of single sex endoscopy lists which are required as part of JAG accreditation on diagnostics waiting times is currently being assessed, although the Trust has reported that the impact so far has been minimal.

The December, the Penalty applied to the Trust was £43,000.

Action Plan

- A third part provider is running weekend endoscopy lists during January and February to assist with reducing backlogs
- A nurse consultant has been employed to run evening and weekend sessions. This will address capacity issues experienced due to the running of single-sex sessions
- The service is working to secure further nursing posts



Action Plan (cont)

- Due to IT complications, the Unisoft Scheduler will not be in place until late February 2015. Once fully implemented (in March/ April) this system will help improved scheduling
- Waiting list initiatives in Neurophysiology are continuing to be offered until the end of March 2015

Back on Trajectory by:	Tuesday, 31 March 2015	**Commissioner Lead:**	Jane Melvin
Lead Organisation:	**UHSM**	**Performance & Quality Lead:**	Zoe Mellon

DOMAIN / STRATEGIC PRIORITY

Measures: **Cancelled Operations**

Indicator Name: **Number of Patients not offered another Binding Date within 28 days of a Cancelled Operation**

* Good performance is Lower than target *

2013/14 Value	2014/15 Target	Actual *Dec-14*	Actual *YTD*	Direction of travel	Forecast	Risk	Financial Consequences
	0	**5**	**11**	**Unchanged**	Fail	Medium	Financial penalties are place for non-delivery on a quarterly basis

Issue

The trust endeavours to give all patients cancelled on the day of their surgery a further date within 28 days of the first cancellation.

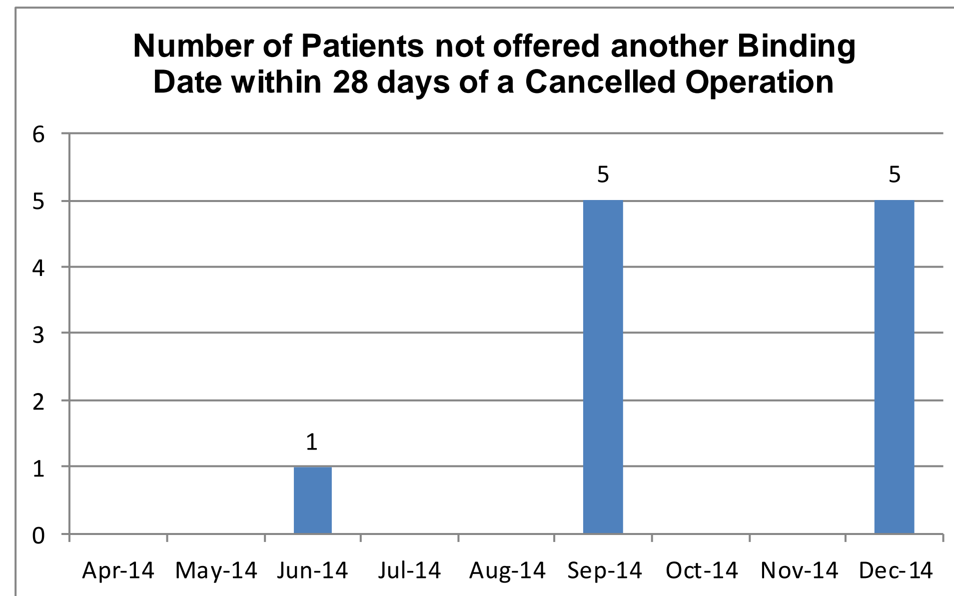
During December UHSM reported 5 cancelled operations for patients, who were not offered a binding date within 28 day. The Trust is investigating this to find the root cause and will share with the performance and quality team. The YTD figure is 11 so the significant increase for the month of December is of concern, and the resulting analysis will be reviewed and action plan requested from the Trust.

Risks

Financial penalties apply. Non-payment of costs associated with cancellation and non- payment or reimbursement (as applicable) of re-scheduled episode of care.

Action Plan

- The CCG is awaiting the findings of the Trusts internal investigation.
- Each cancelled operation under this indicator definition is recorded and discussed at the weekly operational group meeting and a review of the SOP and escalation procedures is currently under review.



Back on Trajectory by:	Tuesday, 31 March 2015	**Commissioner Lead:**	Jane Melvin
Lead Organisation:	**UHSM**	**Performance & Quality Lead:**	Zoe Mellon

DOMAIN / STRATEGIC PRIORITY

Measures: **Complaints**

Indicator Name: **% of complaints responded to within timescale agreed at the outset upon receipt of the complaint with the complainant ("the response period" SI 309, 2009 paragraph 13 (7)) where appropriate.**

* Good performance is Higher than target *

2013/14 Value	2014/15 Target	Actual *Dec-14*	Actual *YTD*	Direction of travel	Forecast	Risk	Financial Consequences
	90.0%	**76.3%**	**87.0%**	**Worse**	Fail	High	None

Issue

The CCG has in place a local KPI in relation to complaints, the Trust is required to ensure 90% of complaints are responded to within the timescale agreed with the complainant.

In December 2014, 76.3% of formal complaints were responded to within the time-frame that was agreed with the complainant. Of the fifty-nine complaints that were due to be completed in the month, forty-five were completed on time.

There have also been staffing issues within the Patient Experience Team which are now resolved.

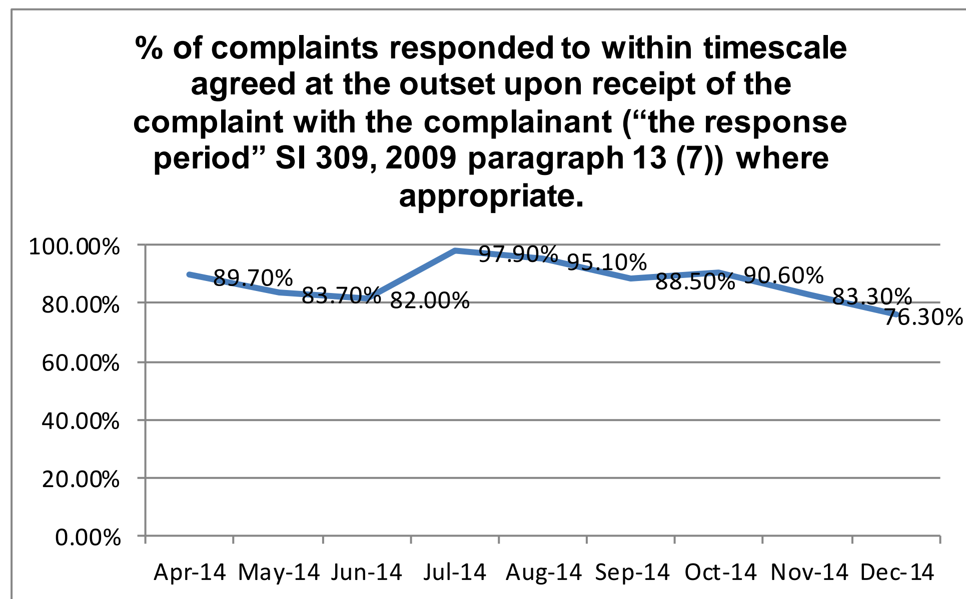
Risks

Performance had improved but in recent months has been on a downward trend which is affecting the YTD achievements.

Action Plan

The following actions will be put in place to respond to this issue:

- monthly divisional performance reviews are in place with the Executive Team monitoring performance
- the monthly complaints investigation training is continuing and will be re-advertised to ensure that all complaint responders attend
- the Patient Experience Matron is undertaking a LEAN project in respect of dissatisfied complainants with the aim of improving performance
- Patient Experience Team is up to full complement in January 2015



Back on Trajectory by:	Tuesday, 31 March 2015	**Commissioner Lead:**	Kate Provan
Lead Organisation:	**UHSM**	**Performance & Quality Lead:**	Kate Provan

DOMAIN / STRATEGIC PRIORITY

Measures: **Stroke**

Indicator Name: **Quality stroke care - patients who spend at least 90% of their inpatient stay on a stroke unit**

* Good performance is Higher than target *

2013/14 Value	2014/15 Target	Actual *Dec-14*	Actual *YTD*	Direction of travel	Forecast	Risk	Financial Consequences
	80.0%	**76.5%**	**73.3%**	**Worse**	Fail	Medium	£100 financial penalty per breach

Issue

In December, following a stroke 76.5% of patients spent 90% of their hospital stay on the Stroke Unit.

Risks

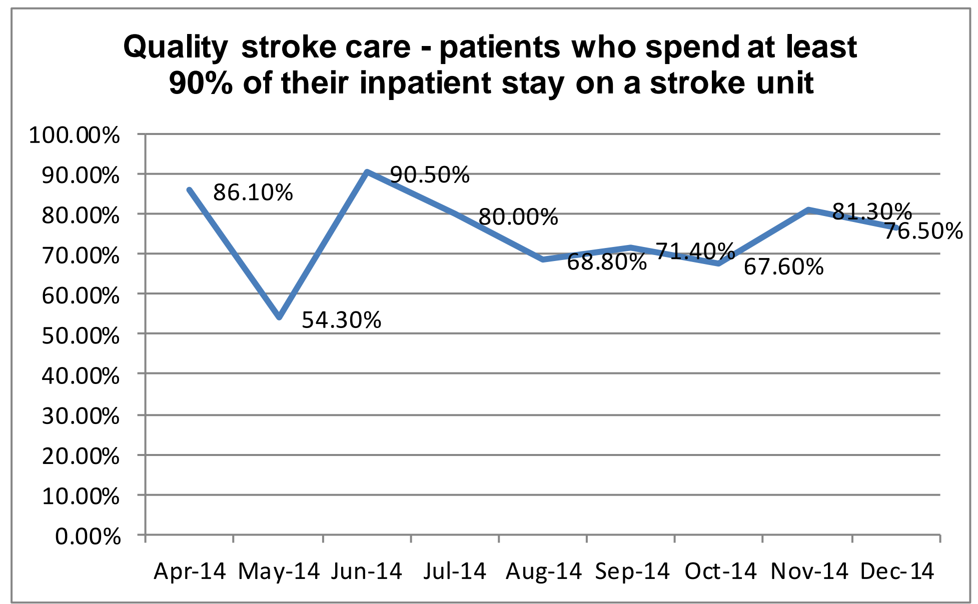
£100 financial penalty per breach below threshold.
During busy periods, the trust is unable to ring fence stroke beds for patients admitted following a stroke.

Delivery of the stroke performance standards often mirrors overall ED performance as patients wait longer to be seen in ED and bed availability is variable due to non-stroke patients being lodged onto the Stroke Unit.

Action Plan

The Trust has:

- re-issue the Stroke Bed Escalation Policy to reduce utilisation of stroke beds for non-stroke patients
- increased utilisation of the Wellington Unit to maximise use of ward F15 for new stroke admissions.
- The new GM stoke model is due to go live in April 2015.



Back on Trajectory by:	Tuesday, 31 March 2015	**Commissioner Lead:**	Jane Melvin
Lead Organisation:	**UHSM**	**Performance & Quality Lead:**	Sarah Griffiths

DOMAIN / STRATEGIC PRIORITY

Measures: **Ambulance**
Indicator Name: **Compliance with Recording Patient Handover between Ambulance and A&E**
* Good performance is Higher than target *

2013/14 Value	2014/15 Target	Actual *Dec-14*	Actual *YTD*	Direction of travel	Forecast	Risk	Financial Consequences
80.7%	95.0%	**78.0%**	**80.8%**	**Worse**	Fail	High	None in 2014/15

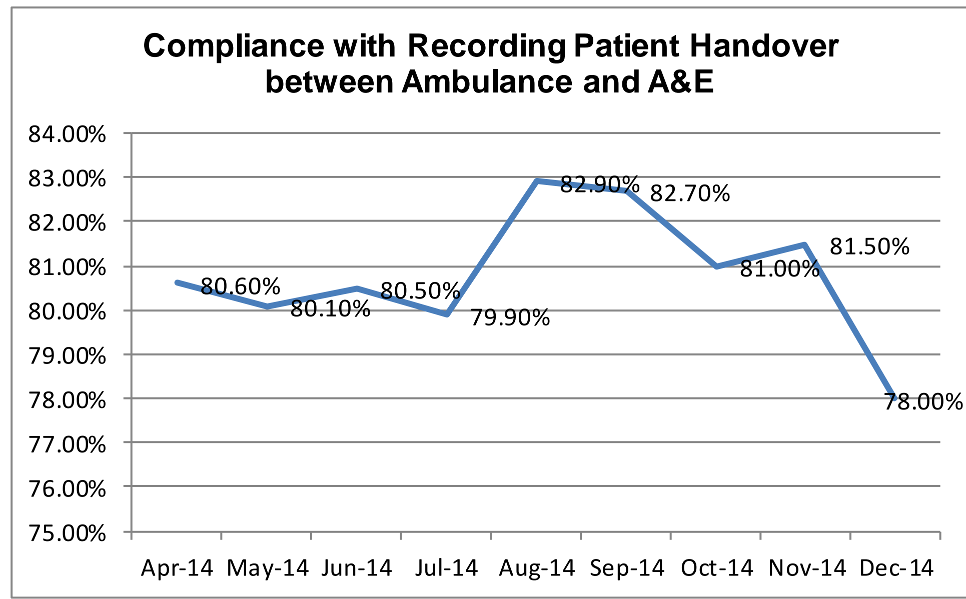
Issue
Greater Manchester providers are working with NWAS, to ensure that ambulance handovers are recorded correctly in 95% of cases and the length of time taken to handover is kept to a minimum.

In December, the Trust recorded 78.0% of ambulance handovers correctly; this is against a target of 95%. 197 handovers were completed in excess of an hour.

Risks
The Trust is working with the CCG and NWAS to understand whether the 95% target is realistic, Trusts across GM have plateaued in the area of 80%.

Action Plan
The following actions have been put in place to respond to this issue:

- The Trust has identified a lead manager to ensure the recording of ambulance handover times is accurate.
- The Trust has work directly with NWAS to identify those patients whose handovers are in excess of 60 minutes. A route cause analysis (RCA) is completed for this group of patients and key themes shared at the System resilience Group (SRG).
- The Performance and Quality Team has prioritised this as an area requiring performance improvement and will be working with the Trust.



Back on Trajectory by:	31st March 2015	**Commissioner Lead:**	Blackpool CCG
Lead Organisation:	**CMFT**	**Performance & Quality Lead:**	Jason Hughes

DOMAIN / STRATEGIC PRIORITY

Measures: **A&E Waiting Times**
Indicator Name: **Percentage of Patients spending 4 hours or less in A&E**
* Good performance is Higher than target *

2013/14 Value	2014/15 Target	Actual *Dec-14*	Actual *YTD*	Direction of travel	Forecast	Risk	Financial Consequences
95.1%	95.0%	**91.2%**	**93.9%**	**Worse**	Fail	High	Contractual penalties apply

Issue
Providers are to ensure that 95% of patients arriving at A&E are seen and treated within 4 hours.

The urgent care system at CMFT has been under extreme pressure. Analysis suggests that performance has been affected by a range of factors, including:

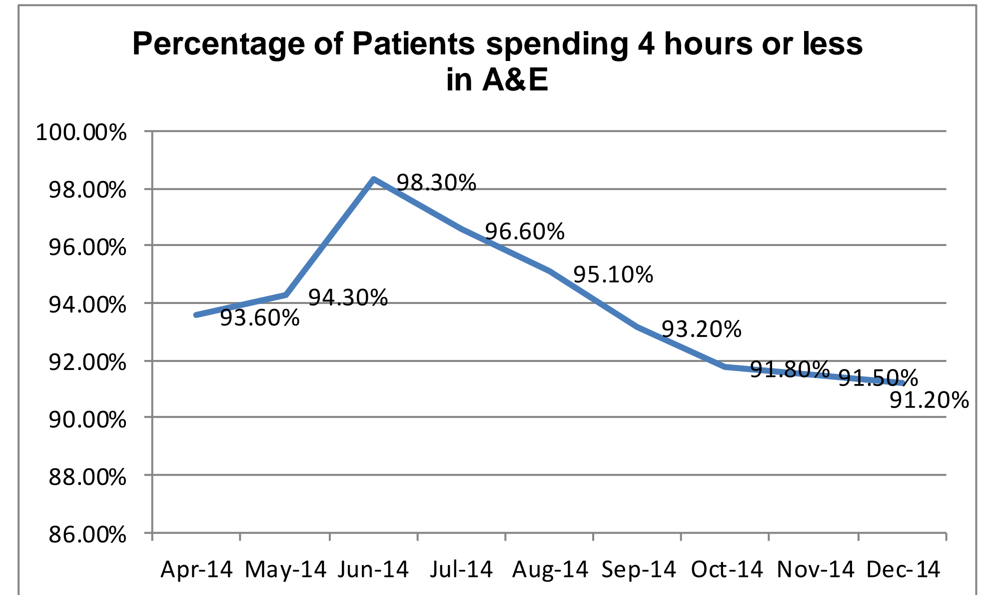
- High attendances. Trust-wide higher A&E attendances.
- High acuity of attendees. The MRI has seen a 9.7% rise in red and amber care groups, when compared to the same period in 2013.
- Rising ambulance presentations. Ambulance arrivals at the MRI increased by approximately 2.8%.
- Increasing emergency admissions. Trust wide (when adjusted for the Trafford new deal model), emergency admissions have been approximately 10.3% higher

CMFT Failed Quarter 3 with performance of 91.52%

Risks
Where the number of breaches in the month exceeds the tolerance permitted by the threshold, £200 in respect of each excess breach above that threshold. To the extent that the number of breaches exceeds 8% of A&E attendances in the relevant month, no further consequence will be applied in respect of the month.

Action Plan
The following actions have been put in place to respond to this issue:

- A trajectory for recovery during Q4 has been developed and shared as part of the tri-partite meeting held in December with the Trusts and CCG. It is heavily reliant on extra capacity which can be provided physically but clinical nurse recruitment will be the key challenge.



Action Plan (continued)

- The CCG and Trust have agreed to step up the Urgent Care Operation Group Meeting (Health Economy Group) to weekly and the CCG has representation on MRI's Winter Group meeting.
- The Trust has recently undertaken a "perfect week" exercise (described in more detail overleaf. The key finding will be shared with the CCG.

Back on Trajectory by:	31st March 2015	**Commissioner Lead:**	Stef Cain
Lead Organisation:	**CMFT**	**Performance & Quality Lead:**	Jason Hughes

FOR INFORMATION

PERFECT WEEK – Thursday 5th February 2015 to Wednesday 11th February 2015

The trust is currently facing significant operational difficulties across the MRI caused by a significant increase in the demand for acute care. The increase in demand has resulted in high occupancy rates, high and sustained escalation, patients in the "wrong" beds not best placed to deal with their health issues, crowding in assessment units, longer lengths of stay and cancellations for elective surgery. All of these issues are detrimental to the excellent care and safety that we strive to provide for our patients; they also add further pressure on our staff, which if not contained will have a lasting and damaging effect on morale.

What is the Perfect Week?
It is aimed at addressing issues that prevent the Trust from providing excellent care and ensuring safety for our patients e.g. pressure on our staff. The Trust will implement an initiative ("Perfect Week) to generate energy for change by doing things differently to support "patient flow" and consequently improve patient experience, safety and staff engagement.

Why are they doing this?
The purpose of this is to extend senior medical review to ensure that each MRI ward has a daily consultant ward round and afternoon board round to ensure that:

- Patients are able to get to the next step in their journey more quickly
- Patients are more likely to be admitted to the appropriate ward
- Delays in transferring to an inpatient bed will be reduced
- Non-clinical inter-ward transfers will be reduced
- Systems will be less frustrating and confusing for patients, relatives and carers
- Less time in hospital means less risk of harm
- Increase in overall and timeliness of discharge

Why is improving patient flow important for staff?

- Lower bed occupancy is required to enable patient flow
- The aim is to have no (or significantly less) outliers (patients in the wrong specialty wards)
- Patients should benefit from improved care received in a timely manner in the right environment
- Patients should benefit from a well-planned, timely discharge
- Staff will benefit from being able to provide patients with the specialist care for their needs
- Staff will have all the information they need to ensure care is delivered appropriately
- Staff will be able to deliver real time, accurate information to the Command Centre
- The Trust will benefit from meaningful information enabling capacity to be effectively managed.

The main aims of the week are to:

- Allow clinical staff more time to focus on clinical duties
- Enable support services to provide a rapid response to clinical departments
- Recalibrate (or reset) the system
- Benefit from improved patient flow throughout the MRI
- Free up capacity earlier in the day (to prevent bottlenecks)
- Test some of the new measures introduced through the winter plan such as Ambulatory Emergency Care, discharge lounge, new escalation policy and command centre, 5 steps to discharge processes and transfer between the MRI and Trafford sites.

DOMAIN / STRATEGIC PRIORITY

Measures: **Diagnostic Test Waiting Times**

Indicator Name: **The Percentage of Patients waiting 6 weeks or more for a Diagnostic Test (15 Key Diagnostic Tests)**

* Good performance is Lower than target *

2013/14 Value	2014/15 Target	Actual *Dec-14*	Actual *YTD*	Direction of travel	Forecast	Risk	Financial Consequences
1.5%	1.0%	**1.5%**	**2.0%**	**Unchanged**	Achieve	Medium	£200 per breach above the tolerance

Issue

Providers are required to ensure that no more than 1% of patients are waiting in excess of 6 weeks for diagnostic tests when a snapshot of those waiting is taken at the end of every month.

In December, 1.5% of patients were waiting over 6 weeks for diagnostic tests. This was, in the main, due to excessive waits in children's services.

Tests that breached in the month are;

- MRI – 1.1%
- Urodynamics – 15.0%
- Colonoscopy – 11.5%
- Cystoscopy – 22.1%
- Gastroscopy – 5.9%

Risks

Where the number of breaches in the month exceeds the tolerance permitted by the threshold, a financial penalty of £200 per breach is Incurred by the Trust.

Action Plan

Recovery plans are in place the Trust is to confirm the date this will be back on track by the end of January 2015.

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The Percentage of Patients waiting 6 weeks or more for a Diagnostic Test (15 Key Diagnostic Tests)

Month	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14
Value	2.60%	3.10%	1.90%	2.10%	1.90%	2.20%	1.50%	1.50%	1.50%

Back on Trajectory by:	31st February 2015	Commissioner Lead:	Sarah Fletcher
Lead Organisation:	CMFT	Performance & Quality Lead:	Zoe Mellon

DOMAIN / STRATEGIC PRIORITY

Measures: **Cancer 62 day waits**

Indicator Name: **Percentage of Patients Receiving First Definitive Treatment for Cancer within 62 Days of Referral from an NHS Cancer Screening Service**

* Good performance is Higher than target *

2013/14 Value	2014/15 Target	Actual *Nov-14*	Actual *YTD*	Direction of travel	Forecast	Risk	Financial Consequences
90.4%	90.0%	**33.3%**	**77.5%**	**Worse**	Fail	Medium	£1000 per breach (quarterly)

Issue

The Trust is required to ensure that 90% of patients on a cancer pathway, referred from screening services receive their first definitive treatment within 62 days.

For November, the Trust performance was 33.3%; this was due to a single breach.

The reason for the breach was because the patient was referred out from CMFT to UHSM on day 34. The patient was deferred at one MDT at UHSM because they didn't have the histology; it was then found to be inconclusive at the next MDT. The patient then went into a redo scope but this histology was also not conclusive. Unfortunately UHSM could then not fit the patient in for surgery until after the breach date - the positive histology only came after surgery.

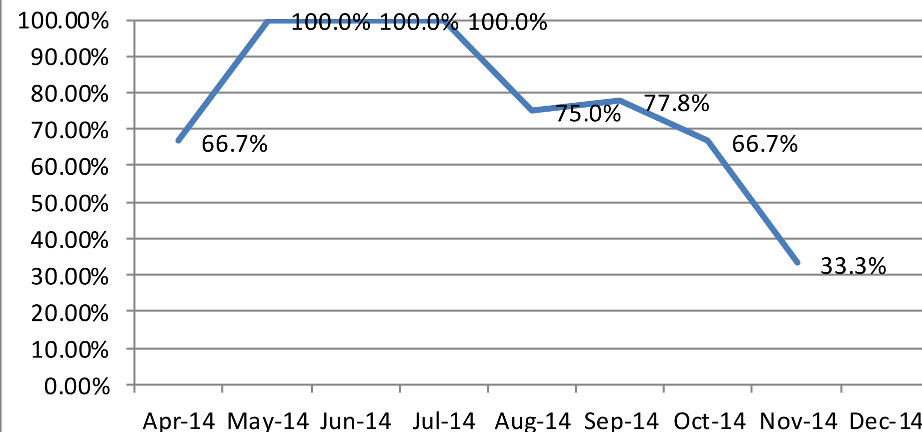
Risks

The Trust will be fined £1,000 for each breach above that threshold on a quarterly basis.

Action Plan

The following actions will be put in place to respond to this issue:

- A more in-depth performance monitoring tool is under development which will allow the CCG to have access to more comprehensive data relating to breaches. This will include the length of time patients wait for their treatment and the reasons for breaches.



Back on Trajectory by:	Tuesday, 31 March 2015	**Commissioner Lead:**	City Wide
Lead Organisation:	**CMFT**	**Performance & Quality Lead:**	Zoe Mellon

DOMAIN / STRATEGIC PRIORITY

Measures: **Stroke**

Indicator Name: **Quality stroke care - patients who spend at least 90% of their inpatient stay on a stroke unit**

* Good performance is Higher than target *

2013/14 Value	2014/15 Target	Actual *Nov-14*	Actual *YTD*	Direction of travel	Forecast	Risk	Financial Consequences
82.7%	80.0%	**61.3%**	**70.2%**	**Worse**	Fail	High	£100 financial penalty per breach.

Issue

Providers are required to ensure at least 80% of patients admitted to hospital following a stroke spend 90% of their stay on a stroke ward.

In November the Trust achieved 61.3% against the 80% target. Of a total of 31 patients 19 spent at least 90% of their inpatient stay on a stroke unit.

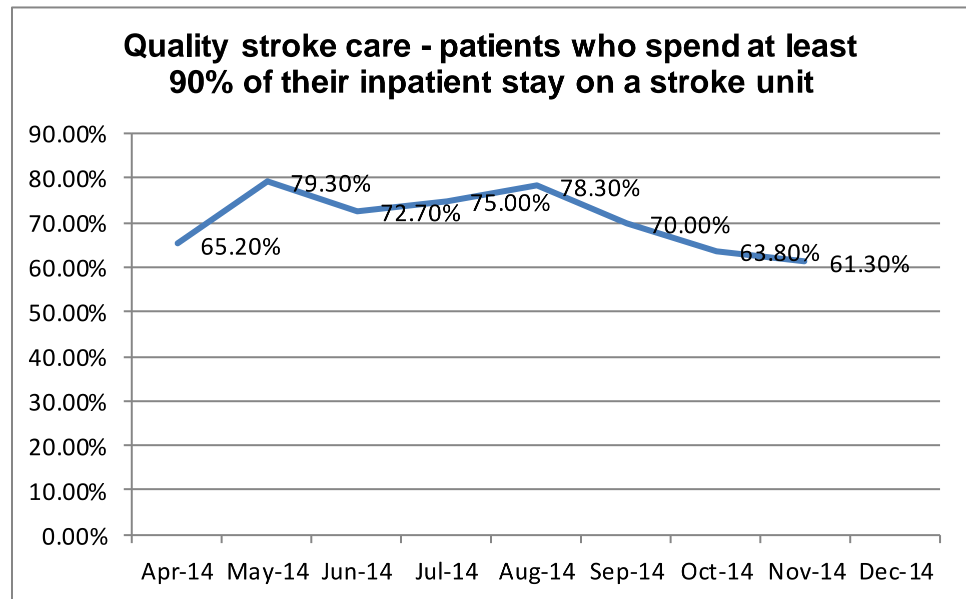
Risks

£100 financial penalty per breach below threshold.
During busy periods, the trust is unable to ring fence stroke beds for patients admitted following a stroke.

Action Plan

The following actions will be put in place to respond to this issue:

- CMFT is working with partner providers to understand the operational implications of the new Greater Manchester (GM) model, and to develop appropriate clinical protocols within the new model, for example for those who experience inpatient strokes.
- The new GM stroke model is due to go live in April 2015, and this will have a significant impact on the flow of patients across Greater Manchester. This has the potential to improve how and when patients access the stroke units at CMFT, and this will be kept under close review once the new model goes live.
- A CQUIN has been developed to incentivised improvements to the service.



Back on Trajectory by:	Tuesday, 31 March 2015	**Commissioner Lead:**	Sarah Fletcher
Lead Organisation:	**CMFT**	**Performance & Quality Lead:**	Sarah Griffiths

DOMAIN / STRATEGIC PRIORITY

Measures: **Stroke**

Indicator Name: **Quality stroke care - proportion of high risk TIA cases investigated and treated within 24 hours**

* Good performance is Higher than target *

2013/14 Value	2014/15 Target	Actual *Dec-14*	Actual *YTD*	Direction of travel	Forecast	Risk	Financial Consequences
55.9%	60.0%	**40.0%**	**50.0%**	**Worse**	Achieve	Medium	£100 financial penalty per breach.

Issue

Providers are to ensure all high risk TIA patients have access to the service within 24 hours of diagnosis.

In December there were 4 out of 10 reported cases, not seen within the standard.

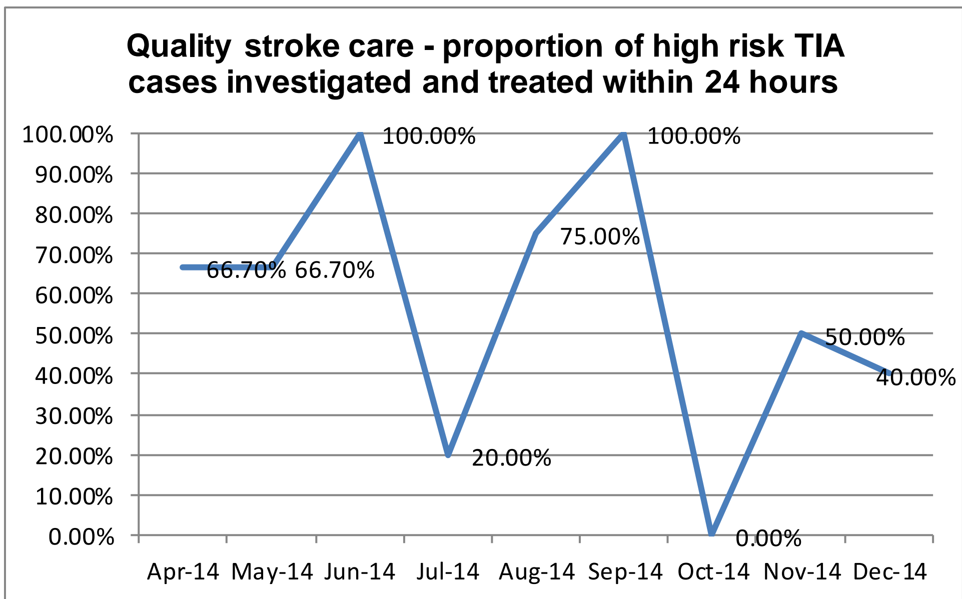
Risks

£100 financial penalty per breach below threshold.

Action Plan

The following actions will be put in place to respond to this issue:

- The CCG is working with CMFT to develop a discreet piece of work to improve the management of high risk TIAs at the Trust. The intention is to progress this work in Q4 of 2014/15, with a view to increasing the proportion of cases which are treated in an outpatient setting and within 24 hours.
- CMFT is working with partner providers to understand the operational implications of the new model, and to develop appropriate clinical protocols within the new model, for example for those who experience inpatient strokes.



Back on Trajectory by:	Tuesday, 31 March 2015	**Commissioner Lead:**	Sarah Fletcher
Lead Organisation:	**CMFT**	**Performance & Quality Lead:**	Sarah Griffiths

DOMAIN / STRATEGIC PRIORITY

Measures: **Pharmacy**

Indicator Name: **All patients on wards with daily pharmacy visit should have medicines reconciled by a pharmacist within 24 hours of admission and have the following data recorded on admission: (Where no 24 hour pharmacy, locally agree timeframe)**
- A list of all medicines currently prescribed inc OTC (if known)
- Dose, frequency, formulation and route of all medicines listed
- Known allergies and any recorded intolerances

* Good performance is Higher than target *

2013/14 Value	2014/15 Target	Actual *Dec-14*	Actual *YTD*	Direction of travel	Forecast	Risk	Financial Consequences
N/A	95.0%	**81.6%**	**71.6%**	**Improved**	Fail	High	No financial consequences

Issue

95 % of patients on wards with daily pharmacy visit should have medicines reconciled by a pharmacist within 24 hours of admission.

In December was 81.6% and year to date performance at 71.6%

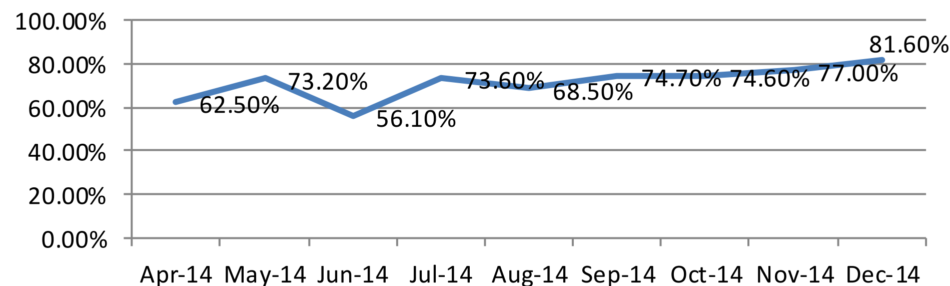
Risks

It is seen as highly unlikely that the trust will achieve this indicator as they have only achieved above 80% on one occasion this year.

Action Plan

The following actions will be put in place to respond to this issue:

- The trust is looking at developing a trajectory for 2015/16 that will help the work towards the 95% target in the coming year.



Back on Trajectory by:	TBC	**Commissioner Lead:**	TBC
Lead Organisation:	**CMFT**	**Performance & Quality Lead:**	Kate Provan

4.0 PENNINE CARE FOUNDATION TRUST (PCFT) – TRAFFORD COMMUNITY SERVICES

4.1 PCFT has reported a number of under-performing areas. The main areas of concerned are outlined below.

Mandatory Training

4.2 PCFT has put in place a robust actin plan to increase the number of staff undertaking mandatory training and ensure this is reported correctly. There has been a steady improvement.

4.3 The CCG has asked for a review of the action plan to ensure that full compliance is achieved by the end of quarter 4.

Ear Care

4.4 Patient appointment within 2 weeks of referral – 88% of patients referred to the ear care service was seen within 2 weeks against a target of 95%.

4.5 This represents a significant and reflects the additional investment made in this service.

Urgent and Intermediate Care Services

4.6 The service is undertaking a review of patients on their caseload who were admitted to hospital. This will be shared with the CCG when it is completed.

4.7 The service is reporting 74% of patients referred to District Nursing are contacted within 3 days against a target of 80%. Moving forward, the service has developed management reports to ensure backlogs do not build up in future. The service and the CCG are undertaking a review of this service. Good data quality is vital in facilitating capacity and demand analysis.

4.8 The service will also benefit from the roll-out of the single point of access central booking system. This service model will improve compliance with the Trust's access policy and triage protocols.

Pulmonary Rehabilitation

4.9 No patients are been seen within 8 weeks of referral and 59% of patients are completing the course against a target of 70%. There are currently:

- 122 Patients waiting over 18 weeks
- DNA rate of 9.3
- Service Cancellations 0.4%

4.10 The provider has been given additional funding to recruit additional staff on a

non-recurring basis to address the backlog. There should see a slow but steady rise in activity over the next month as patients go through assessment and into classes.

4.11 The CCG has asked for an evaluation of the success of the classes. This will be shared with the Board when it has been received.

4.12 A review of the respiratory pathway will be taking place in April.

5.0 QUALITY RISKS AND CONCERNS - UHSM AND CMFT

5.1 This section provides the governing body with an update on the main quality concerns at UHSM and CMFT.

UHSM - Care Quality Commission Intelligent Monitoring Report

Issue:

5.2 The publication of the CQC IMR in December 2014 (where UHSM remained at a Band 2) and other quality concerns (such as the two never events reported in quarter 3) led SMCCG and TCCG met with UHSM to discuss quality and seek further assurances in relation to the areas identified as risks both in the CQC IMR and by the CCG. Areas where UHSM is an outlier in relation to mortality were identified within this report and discussed.

Assurance:

5.3 Following on from this, a single item risk summit was called on the 19th of January 2015. At this meeting the CCG had the opportunity to comment on the action plan that UHSM had developed and request further assurances in relation to areas of concern.

5.4 It was agreed at this meeting that UHSM would update the CQC IMR action plan to ensure that it included all of the areas of risk as identified at this meeting.

5.5 UHSM engaged positively in this process and have produced a detailed action plan in relation to the CQC IMR and the other concerns identified.

Action:

5.6 As agreed at the single item risk summit the CCG is to attend UHSM's Quality Assurance Committee where the action plan will be updated on regular basis.

5.6 The first meeting of the UHSM Quality Assurance Committee that the CCG will attend is on the 20th of February 2015. The SMCCG Clinical Lead for Quality and Performance and SMCCG/ TCCG Associate Director of Performance and Quality are intending to attend this.

5.7 This will be reported on and updated on at the Quality and Performance Committee until all actions have been completed.

Serious incidents involving liaison at UHSM between UHSM and mental health providers

Issue:

5.8 In the last 2-3 months there have been a series of high profile inquests that have highlighted concerns in relation to the interface of UHSM with providers of mental health services within the hospital setting.

5.9 These inquests have been in relation to patients who died in 2009, 2012 and 2013.

5.10 UHSM and providers of mental health services within the provider have been issued with a prevention of future deaths report (PFD). These reports replaced what was known as the Rule 43s issued by the coroner that were issued following an inquest. Unlike the Rule 43s these PFDs can be issued at any stage of the inquest process.

5.11 This PFD was issued mainly in response to concerns in relation to the interface of UHSM with providers of mental health services within the hospital setting.

Assurance:

5.12 UHSM is facilitating a meeting between themselves, providers of mental health services and the CCG in response to this PFD with the aim of developing a joint action plan.

Action:

5.13 The Performance and Quality Team are undertaking a review of the historic serious incidents to support this. A further update will be provided to board following the meeting at UHSM in respect of this issue

5.14 This section provides the governing body with an update on the main quality concerns at CMFT.

CMFT - Care Quality Commission Intelligent Monitoring Report

Issue:

5.15 CMFT remain at Band 4 in respect of the CQC IMR.

Assurance:

5.16 The CCG have received an action plan in relation to this.

Action:

5.17 This will be reported on and updated on at the Quality and Performance Committee until all actions have been completed.

6.0 RECOMMENDATION

6.1 The Governing Body is asked to note the issues raised in relation to performance and quality.

2014-15: Everyone Counts Scorecard - Trafford CCG

Appendix B

Performance Reporting Month: Feb-2015

Code	Measures	Indicator name	2013-14 Latest	Annual Target 2014-15	Year To Date Performance			2014-15	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Comments
					Target	Actual	Period Used				Q1 14-15			Q2 14-15			Q3 14-15			Q4 14-15	
EA1	Potential Years of Life Lost (PYLL)	Potential years of life lost (PYLL) from causes considered amenable to healthcare	2205.40	**2083.14**				Due Sep 15													
EA2	Long Term Conditions	Health-related quality of life for people with long-term conditions	53.2%	**75.1%**				Due Sep 15													
EA3	Mental Health Measures	IAPT Roll-Out	14.7%	**15.0%**	*9.0%*	9.6%	YTD				3.5%			3.0%			3.1%				YTD Fig is sum of quarters
EA4	Emergency Admissions	Composite measure on emergency admissions	2293.70	**1996.40**							Due Jan 15										
EA4(i)	Emergency Admissions	Composite measure on emergency admissions - (*LOCAL DATA*)	New	**1,996**																	
EA5	Patient Experience of Hospital Care	Patient experience of hospital care - 'Poor' patient experience of inpatient care	Not Avail.	**130.34**				See note >													National publication timetable is not yet available. No local in-year data is available.
EA6a	Friends and Family Test	Friends and Family Test Score: CMFT (Combined)	68			65	Latest Month		65	64	66	68	68	62	67	66	65				Publication date for national targets has not been released.
EA6b	Friends and Family Test	Friends and Family Test Score: UHSM (Combined)	64			71	Latest Month		69	72	71	72	75	77	77	75	71				Publication date for national targets has not been released.
EA6d	Friends and Family Test	Response Rate: CMFT (Combined)	23.6%			21.9%	Latest Month		19.2%	19.9%	27.5%	25.2%	26.2%	24.8%	24.4%	24.3%	21.9%				Publication date for national targets has not been released.
EA6e	Friends and Family Test	Response Rate: UHSM (Combined)	23.3%			28.6%	Latest Month		23.9%	26.8%	23.6%	25.9%	27.3%	27.4%	30.9%	28.6%	28.6%				Publication date for national targets has not been released.
EA6g	Friends and Family Test	Friends and Family Test Score: CMFT (A&E)	64			61	Latest Month		61	60	63	66	65	59	64	63	61				Publication date for national targets has not been released.
EA6h	Friends and Family Test	Friends and Family Test Score: CMFT (Inpatient)	80			73	Latest Month		75	76	71	69	73	71	72	71	73				Publication date for national targets has not been released.
EA6s	Friends and Family Test	Friends and Family Test Score: CMFT (Maternity)	New			68	Latest Month		80	74	77	78	71	80	75	81	68				Awaiting national guidance on roll-out and target methodology.
EA6i	Friends and Family Test	Friends and Family Test Score: UHSM (A&E)	47			58	Latest Month		53	58	56	50	58	66	64	63	58				Publication date for national targets has not been released.
EA6j	Friends and Family Test	Friends and Family Test Score: UHSM (Inpatient)	77			78	Latest Month		80	80	81	82	82	82	82	81	78				Publication date for national targets has not been released.
EA6t	Friends and Family Test	Friends and Family Test Score: UHSM (Maternity)	New			92	Latest Month		92	91	89	88	87	87	93	91	92				Awaiting national guidance on roll-out and target methodology.
EA6k	Friends and Family Test	Response Rate: CMFT (A&E)	21.7%	**20.0%**	*17.5%*	19.6%	Latest Month		19.2%	19.4%	23.3%	20.7%	23.3%	24.2%	23.0%	21.7%	19.6%				
EA6l	Friends and Family Test	Response Rate: CMFT (Inpatient)	30.5%	**30.0%**	*27.5%*	34.2%	Latest Month		20.2%	23.2%	48.1%	44.1%	39.5%	32.0%	35.0%	35.1%	34.2%				
EA6v	Friends and Family Test	Response Rate: CMFT (Maternity)	New			11.4%	Latest Month		15.5%	14.3%	10.7%	15.5%	18.9%	11.4%	7.4%	19.7%	11.4%				Awaiting national guidance on roll-out and target methodology.
EA6m	Friends and Family Test	Response Rate: UHSM (A&E)	17.2%	**20.0%**	*17.5%*	20.6%	Latest Month		17.6%	17.3%	16.1%	14.3%	13.4%	15.7%	18.6%	20.2%	20.6%				
EA6n	Friends and Family Test	Response Rate: UHSM (Inpatient)	32.4%	**30.0%**	*27.5%*	40.3%	Latest Month		33.2%	42.2%	36.5%	43.7%	47.2%	45.0%	48.3%	40.1%	40.3%				

2014-15: Everyone Counts Scorecard - Trafford CCG

Appendix B

Performance Reporting Month: Feb-2015

Code	Measures	Indicator name	2013-14 Latest	Annual Target 2014-15	Year To Date Performance			2014-15	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Comments
					Target	Actual	Period Used				Q1 14-15			Q2 14-15			Q3 14-15			Q4 14-15	
EA6w	Friends and Family Test	Response Rate: UHSM (Maternity)	New			20.9%	Latest Month		24.4%	22.5%	14.6%	20.1%	30.8%	16.8%	20.8%	26.9%	20.9%				Awaiting national guidance on roll-out and target methodology.
EA7i	Patient Experience of Primary Care	Poor patient experience of GP Services	3.5%	4.4%				Due Jul 15													National publication date is not yet available.
EA7ii	Patient Experience of Primary Care	Poor patient experience of GP Out of Hours	13.9%	4.4%				Due Jul 15													National publication date is not yet available.
EA7ii(L)	Patient Experience of Primary Care	Poor patient experience of GP Out of Hours - (*LOCAL DATA*)	New	4.4%					See note >												Data is only available annually. BI Team are exploring local data sources to provide more frequent performance information.
EA8	Patient Safety Measure	Hospital deaths attributable to problems in care	New					See note >													Indicator under development
EA9a	Patient Safety Measure	Improving the reporting of medication-related safety incidents (CMFT)	New	2.5%	*2.5%*						8.1%			4.5%							
EA9b	Patient Safety Measure	Improving the reporting of medication-related safety incidents (UHSM)	New	5.0%																	
EAS1(i)	Dementia	Estimated diagnosis rate for people with dementia - (i)	51.2%	67.2%	*67.2%*									60.0%	54.9%	56.2%	59.4%				HSCIC Data
EAS1(ii)	Dementia	Estimated diagnosis rate for people with dementia - (ii)	51.2%	67.2%	*67.2%*	56.4%	YTD		54.4%	55.1%	56.3%	55.5%	55.6%	60.3%	54.8%	56.2%	59.4%				Data sourced from Primary Care Web Tool Dementia Calculator
EAS2	Mental Health Measure	IAPT Recovery Rate	49.0%	50.0%	*50.0%*	59.0%	YTD				60.3%			57.6%			Data due 16 Feb				
EAS3	Re-ablement Measure	Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services	New	78.3%				Due Sep 15													
EAS4a	HCAI	Healthcare acquired infection (HCAI) measure (MRSA) - AVOIDABLE	0	0	*0*	0	YTD		0	0	0	0	0	0	0	0	0				Assigned cases only
EAS4b	HCAI	Healthcare acquired infection (HCAI) measure (MRSA) - UNAVOIDABLE	New	0	*0*	0	YTD		0	0	0	0	0	0	0	0	0				
EAS5	HCAI	Healthcare acquired infection (HCAI) measure (clostridium difficile infections) - All Cases	New	59	*46*	53	YTD		5	8	8	7	5	2	7	4	7				
EB6	Cancer 2 Week Waits	All cancer two week wait	97.4%	93.0%	*93.0%*	95.7%	YTD		96.3%	96.8%	94.4%	96.6%	94.0%	96.3%	96.1%	95.1%	95.5%				
EB7	Cancer 2 Week Waits	Two week wait for breast symptoms (where cancer was not initially suspected)	98.4%	93.0%	*93.0%*	97.7%	YTD		100.0%	95.4%	99.0%	97.5%	96.3%	97.5%	96.9%	98.0%	99.0%				
EB8	Cancer 31 Day Waits	Percentage of patients receiving first definitive treatment within one month of a cancer diagnosis (measured from 'date of decision to treat')	98.9%	96.0%	*96.0%*	99.0%	YTD		98.9%	98.5%	100.0%	100.0%	97.7%	97.6%	100.0%	99.0%	98.7%				
EB9	Cancer 31 Day Waits	31-day standard for subsequent cancer treatments-surgery	97.6%	94.0%	*94.0%*	98.5%	YTD		94.4%	100.0%	100.0%	100.0%	93.8%	100.0%	100.0%	100.0%	100.0%				
EB10	Cancer 31 Day Waits	31-day standard for subsequent cancer treatments-anti cancer drug regimens	100.0%	98.0%	*98.0%*	100.0%	YTD		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%				
EB11	Cancer 31 Day Waits	31-day standard for subsequent cancer treatments-radiotherapy	99.3%	94.0%	*94.0%*	99.5%	YTD		100.0%	100.0%	100.0%	100.0%	100.0%	94.7%	100.0%	100.0%	100.0%				
EB12	Cancer 62 Day Waits	Percentage of patients receiving first definitive treatment for cancer within two months (62 days) of an urgent GP referral for suspected cancer	87.5%	85.0%	*85.0%*	90.2%	YTD		91.7%	84.4%	86.8%	93.8%	95.5%	85.7%	85.7%	96.2%	87.1%				

2014-15: Everyone Counts Scorecard - Trafford CCG

Appendix B

Performance Reporting Month: Feb-2015

Code	Measures	Indicator name	2013-14 Latest	Annual Target 2014-15	Year To Date Performance			2014-15	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Comments
					Target	Actual	Period Used				Q1 14-15			Q2 14-15			Q3 14-15			Q4 14-15	
EB13	Cancer 62 Day Waits	Percentage of patients receiving first definitive treatment for cancer within 62-days of referral from an NHS Cancer Screening Service	95.9%	90.0%	90.0%	98.6%	YTD		91.7%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%				
EB14	Cancer 62 Day Waits	Percentage of patients receiving first definitive treatment for cancer within 62-days of a consultant decision to upgrade their priority status	89.9%	85.0%	85.0%	92.3%	YTD		100.0%	87.5%	88.9%	93.3%	84.6%	83.3%	100.0%	100.0%	93.8%				
EB15i	Ambulance Clinical Quality	Ambulance clinical quality - Category A (Red 1) 8 minute response time	75.9%	75.0%	75.0%	69.9%	YTD		75.7%	73.4%	71.5%	68.5%	72.7%	71.5%	71.2%	68.0%	59.0%				
EB15ii	Ambulance Clinical Quality	Ambulance clinical quality - Category A (Red 2) 8 minute response time	77.4%	75.0%	75.0%	70.8%	YTD		75.3%	74.7%	73.2%	69.2%	72.1%	73.3%	73.7%	69.6%	58.5%				
EB16	Ambulance Clinical Quality	Ambulance clinical quality - Category A 19 minute transportation time	96.3%	95.0%	95.0%	93.8%	YTD		96.2%	95.6%	95.4%	94.2%	95.3%	95.1%	93.6%	93.1%	87.7%				
EB1	Referral to Treatment	The percentage of admitted pathways within 18 weeks for admitted patients whose clocks stopped during the period on an adjusted basis	93.4%	90.0%	90.0%	92.5%	YTD		93.7%	93.3%	91.8%	91.8%	92.1%	92.7%	92.4%	90.9%	93.7%				
SPECIALTY LEVEL >>>	RTT - SPECIALTY LEVEL >>>	- Admitted Adjusted Pathways: SPECIALTY LEVEL - Neurology	New	90.0%	90.0%	50.0%	YTD									50.0%					
SPECIALTY LEVEL >>>	RTT - SPECIALTY LEVEL >>>	- Admitted Adjusted Pathways: SPECIALTY LEVEL - Trauma & Orthopaedics	New	90.0%	90.0%	88.4%	YTD		89.6%	91.0%	87.8%	86.5%	88.5%	89.1%	89.0%	85.2%	89.6%				
EB2	Referral to Treatment	The percentage of non-admitted pathways within 18 weeks for non-admitted patients whose clocks stopped during the period	97.6%	95.0%	95.0%	96.5%	YTD		96.8%	96.6%	97.6%	96.7%	97.1%	96.2%	95.7%	95.6%	97.1%				
SPECIALTY LEVEL >>>	RTT - SPECIALTY LEVEL >>>	- Non-admitted Pathways: SPECIALTY LEVEL - Thoracic Medicine	New	95.0%	95.0%	96.7%	YTD		99.1%	96.5%	98.6%	97.7%	100.0%	97.6%	96.6%	92.5%	93.4%				
EB3	Referral to Treatment	The percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the period	94.8%	92.0%	92.0%	94.7%	Latest Month		94.4%	94.9%	95.1%	94.9%	94.9%	94.7%	94.5%	94.9%	94.7%				
SPECIALTY LEVEL >>>	RTT - SPECIALTY LEVEL >>>	- Incomplete Pathways: SPECIALTY LEVEL - General Surgery	New	92.0%	92.0%	91.9%	Latest Month		92.9%	93.7%	94.0%	93.6%	93.8%	94.3%	93.3%	93.1%	91.9%				
EB4	Diagnostic Test Waiting Times	Diagnostic test waiting times	0.4%	1.0%	1.0%	1.1%	YTD		0.7%	1.1%	0.5%	0.5%	1.2%	1.7%	1.5%	0.7%	2.1%				
Diagnostic Test Name >>>	Diagnostic Test Name >>>	Diagnostic test waiting times - PERIPHERAL_NEUROPHYS	New	1.0%	1.0%	15.9%	YTD		8.0%	1.9%	No activity	2.0%	23.9%	23.2%	16.5%	0.0%	38.1%				
Diagnostic Test Name >>>	Diagnostic Test Name >>>	Diagnostic test waiting times - SLEEP_STUDIES	New	1.0%	1.0%	12.3%	YTD		5.0%	11.1%	0.0%	0.0%	25.0%	14.3%	16.7%	0.0%	40.0%				
Diagnostic Test Name >>>	Diagnostic Test Name >>>	Diagnostic test waiting times - URODYNAMICS	New	1.0%	1.0%	6.9%	YTD		4.3%	4.5%	0.0%	9.1%	0.0%	9.4%	18.5%	5.6%	4.0%				
Diagnostic Test Name >>>	Diagnostic Test Name >>>	Diagnostic test waiting times - COLONOSCOPY	New	1.0%	1.0%	8.8%	YTD		4.3%	5.7%	7.2%	5.4%	10.3%	15.3%	13.0%	6.1%	8.2%				
Diagnostic Test Name >>>	Diagnostic Test Name >>>	Diagnostic test waiting times - FLEXI_SIGMOIDOSCOPY	New	1.0%	1.0%	4.1%	YTD		0.0%	0.0%	0.0%	0.0%	2.6%	7.4%	6.2%	3.8%	10.2%				
Diagnostic Test Name >>>	Diagnostic Test Name >>>	Diagnostic test waiting times - CYSTOSCOPY	New	1.0%	1.0%	4.7%	YTD		5.1%	2.3%	3.7%	0.0%	7.4%	13.3%	7.3%	4.8%	3.0%				
Diagnostic Test Name >>>	Diagnostic Test Name >>>	Diagnostic test waiting times - GASTROSCOPY	New	1.0%	1.0%	6.7%	YTD		5.3%	3.8%	1.4%	2.6%	5.7%	14.9%	11.0%	7.3%	5.5%				
EB5	A&E Waiting Times	A&E waiting time - total time in the A&E department (≤ 4 hrs)	94.9%	95.0%	95.0%	93.4%	YTD		92.6%	93.3%	96.8%	95.5%	95.2%	94.6%	92.8%	92.2%	89.8%	91.1%			

2014-15: Everyone Counts Scorecard - Trafford CCG

Appendix B

Performance Reporting Month: Feb-2015

Code	Measures	Indicator name	2013-14 Latest	Annual Target 2014-15	Year To Date Performance			2014-15	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Comments
					Target	Actual	Period Used				Q1 14-15			Q2 14-15			Q3 14-15			Q4 14-15	
EBS1	Mixed Sex Accommodation	Mixed Sex Accommodation (MSA) Breaches	0.08	**0.00**	*0.00*	0.00	YTD		0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00				
EBS3	Mental Health Measures	Care Programme Approach (CPA): The proportion of people under adult mental illness specialities on CPA	98.3%	**95.0%**	*95.0%*	97.4%	YTD				96.7%			98.2%							
EBS4a	Referral to Treatment	The number of admitted pathways greater than 52 weeks for admitted patients whose clocks stopped during the period on an un-adjusted basis	11	**0**	*0*	3	YTD		1	1	0	1	0	0	0	0	0				
EBS4b	Referral to Treatment	The number of non-admitted pathways greater than 52 weeks for non-admitted patients whose clocks stopped during the period	2	**0**	*0*	1	YTD		0	0	0	1	0	0	0	0	0				
EBS4c	Referral to Treatment	The number of incomplete pathways greater than 52 weeks for patients on incomplete pathways at the end of the period	3	**0**	*0*	1	YTD		0	0	0	1	0	0	0	0	1				
EBS5	Trolley Waits in A&E	Trolley waits in A&E	New	**0**	*0*	0	YTD		0	0	0	0	0	0	0	0	0				
EBS6	Cancelled Operations	Urgent operations cancelled for a second time	New	**0**	*0*	0	YTD		0	0	0	0	0		0	0	0				

2014-15: Full Set of KPIs Scorecard - UHSM

Appendix C

Reporting Month: Feb-2015

Code	Measures	Indicators	Target 2014-15	Year to Date Performance			2014-15	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Comments
				Target	Actual	Period Used				Q1 14-15			Q2 14-15			Q3 14-15			Q4 14-15	
CB_A15a	HCAI	Overall Number of Cases of MRSA Bacteraemia - AVOIDABLE	0	*0*	0	YTD		0	0	0	0	0	0	0	0	0				
CB_A15b	HCAI	Overall Number of Cases of MRSA Bacteraemia - UNAVOIDABLE	0	*0*	1	YTD		0	0	0	0	1	0	0	0	0				
CB_A16a	HCAI	Number of Cases of C. Difficile Caused by Lapse in Care - NHS Patients	39	*26*	7	YTD		1	0	0	1	0	1	4	0					Dec 14 awaiting verification
CB_A16b	HCAI	Overall Number of Cases of C. Difficile - NHS Patients	See Note		35	YTD		3	2	4	4	3	3	8	3	5				Targets not applicable
CB_A16c	HCAI	Number of Cases of C. Difficile Caused by Lapse in Care - in Intermediate Care	4	*3*	0	YTD		0	0	0	0	0	0	0	0	0				
CB_A16d	HCAI	Number of Cases of C. Difficile - in Intermediate Care (UNAVOIDABLE)	TBC	*0*	3	YTD		0	0	1	0	2	0	0	0	0				
CB_B1	Referral to Treatment	The Percentage within 18 weeks for Completed Admitted RTT Pathways	90.0%	*90.0%*	91.5%	YTD		91.9%	91.7%	90.0%	91.3%	91.0%	90.1%	92.3%	93.4%	92.0%				
SPECIALTY LEVEL >>>	**RTT - SPECIALTY LEVEL >>>**	- Admitted Adjusted Pathways: SPECIALTY LEVEL - Cardiology	90.0%	*90.0%*	81.2%	YTD		80.7%	81.0%	87.9%	80.9%	77.7%	74.9%	79.4%	88.7%	80.8%				
SPECIALTY LEVEL >>>	**RTT - SPECIALTY LEVEL >>>**	- Admitted Adjusted Pathways: SPECIALTY LEVEL - General Surgery	90.0%	*90.0%*	84.4%	YTD		83.3%	84.4%	80.5%	83.1%	87.7%	83.5%	88.2%	86.0%	84.1%				
SPECIALTY LEVEL >>>	**RTT - SPECIALTY LEVEL >>>**	- Admitted Adjusted Pathways: SPECIALTY LEVEL - Trauma & Orthopaedics	90.0%	*90.0%*	82.5%	YTD		84.6%	79.6%	74.7%	81.3%	83.4%	82.4%	85.6%	83.9%	86.4%				
CB_B2	Referral to Treatment	The Percentage within 18 weeks for Completed Non-Admitted RTT Pathways	95.0%	*95.0%*	96.2%	YTD		97.2%	97.0%	97.5%	96.8%	96.9%	95.5%	95.9%	95.0%	95.4%				
SPECIALTY LEVEL >>>	**RTT - SPECIALTY LEVEL >>>**	- Non-admitted Pathways: SPECIALTY LEVEL - Gastroenterology	95.0%	*95.0%*	92.7%	YTD		86.6%	95.2%	95.2%	92.7%	97.2%	93.4%	93.4%	86.8%	94.0%				
SPECIALTY LEVEL >>>	**RTT - SPECIALTY LEVEL >>>**	- Non-admitted Pathways: SPECIALTY LEVEL - Thoracic Medicine	95.0%	*95.0%*	91.4%	YTD		92.9%	94.7%	94.6%	92.4%	94.0%	89.3%	93.2%	86.9%	88.7%				
SPECIALTY LEVEL >>>	**RTT - SPECIALTY LEVEL >>>**	- Non-admitted Pathways: SPECIALTY LEVEL - Trauma & Orthopaedics	95.0%	*95.0%*	91.8%	YTD		89.9%	90.8%	95.1%	93.2%	95.7%	89.0%	88.0%	91.1%	94.6%				
CB_B3	Referral to Treatment	The Percentage within 18 weeks for Incomplete RTT Pathways	92.0%	*92.0%*	94.6%	YTD		95.3%	95.1%	95.4%	95.0%	95.2%	95.6%	95.0%	94.9%	94.6%				
SPECIALTY LEVEL >>>	**RTT - SPECIALTY LEVEL >>>**	- Incomplete Pathways: SPECIALTY LEVEL - General Surgery	92.0%	*92.0%*	91.1%	YTD		91.0%	90.9%	92.9%	93.1%	93.3%	92.6%	92.1%	91.5%	91.1%				
CB_S6c	Referral to Treatment	The Number of RTT Pathways > 52 weeks for Incomplete Pathways	0	*0*	0	YTD		0	0	0	0	0	0	0	0	0				
CB_S7a	Ambulance Handover Time	Ambulance Handover Delays of over 30 minutes - Wythenshawe Hosp	0	*0*	828	YTD		131	92	72	79	53	40	93	65	203				Change of Historic Performance due to a review of our methodology
CB_S7b	Ambulance Handover Time	Ambulance Handover Delays of over 1 hour - Wythenshawe Hosp	0	*0*	142	YTD		32	23	17	7	5	1	13	4	40				Change of Historic Performance due to a review of our methodology
NWA1	Ambulance	Compliance with Recording Patient Handover between Ambulance and A&E	95.0%	*95.0%*	81.0%	YTD		80.2%	83.0%	82.1%	83.6%	86.1%	84.7%	78.5%	76.7%	74.0%				Change of Historic Performance due to a review of our methodology
CB_B5	A&E Waiting Times	Percentage of Patients spending 4 hours or less in A&E	95.0%	*95.0%*	92.6%	YTD		90.2%	90.5%	93.0%	92.2%	95.5%	98.1%	95.5%	93.8%	85.4%				Monthly reported figure has reverted to in-month (used to be YTD)
CB_B5Q	A&E Waiting Times	Percentage of Patients spending 4 hours or less in A&E	95.0%	*95.0%*	93.2%	YTD				91.3%			95.2%			91.5%				
CB_S9	Trolley Waits in A&E	Number of Patients who have waited over 12 hours in A&E from Decision to Admit to Admission	0	*0*	0	YTD		0	0	0	0	0	0	0	0	0				
CB_S10	Cancelled Operations	Number of Urgent Operations Cancelled for a Second Time	0	*0*	0	YTD		0	0	0	0	0	0	0	0	0				
CB_B4	Diagnostic Test Waiting Times	The Percentage of Patients waiting 6 weeks or more for a Diagnostic Test (15 Key Diagnostic Tests)	1.0%	*1.0%*	3.7%	YTD		1.7%	0.7%	0.8%	0.7%	3.4%	6.3%	7.3%	5.7%	5.5%				
Diagnostic Test Name >>>	**Diagnostic Test Name >>>**	Diagnostic test waiting times - DEXA_SCAN	1.0%	*1.0%*	1.1%	YTD		1.0%	0.6%	7.1%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%				
Diagnostic Test Name >>>	**Diagnostic Test Name >>>**	Diagnostic test waiting times - PERIPHERAL_NEUROPHYS	1.0%	*1.0%*	33.8%	YTD		24.0%	6.0%	2.5%	8.6%	42.1%	43.2%	36.1%	47.9%	53.2%				
Diagnostic Test Name >>>	**Diagnostic Test Name >>>**	Diagnostic test waiting times - SLEEP_STUDIES	1.0%	*1.0%*	3.8%	YTD		9.5%	5.9%	0.0%	0.0%	6.3%	0.0%	0.0%	0.0%	0.0%				
Diagnostic Test Name >>>	**Diagnostic Test Name >>>**	Diagnostic test waiting times - URODYNAMICS	1.0%	*1.0%*	3.5%	YTD		6.7%	3.1%	3.3%	0.0%	0.0%	4.2%	6.4%	0.0%	6.7%				

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2014-15: Full Set of KPIs Scorecard - UHSM

Appendix C

Reporting Month: Feb-2015

Code	Measures	Indicators	Target 2014-15	Year to Date Performance: Target	Year to Date Performance: Actual	Year to Date Performance: Period Used	2014-15	Apr-14	May-14	Jun-14 (Q1 14-15)	Jul-14	Aug-14	Sep-14 (Q2 14-15)	Oct-14	Nov-14	Dec-14 (Q3 14-15)	Jan-15	Feb-15	Mar-15 (Q4 14-15)	Comments
Diagnostic Test Name	Diagnostic Test Name >>>	Diagnostic test waiting times - COLONOSCOPY	1.0%	*1.0%*	13.5%	YTD		4.8%	3.7%	0.0%	2.4%	12.7%	25.9%	32.0%	14.5%	8.0%				
Diagnostic Test Name	Diagnostic Test Name >>>	Diagnostic test waiting times - FLEXI_SIGMOIDOSCOPY	1.0%	*1.0%*	12.3%	YTD		0.0%	0.0%	1.0%	2.0%	10.9%	17.1%	23.9%	14.8%	22.3%				
Diagnostic Test Name	Diagnostic Test Name >>>	Diagnostic test waiting times - CYSTOSCOPY	1.0%	*1.0%*	13.5%	YTD		12.9%	4.7%	10.7%	0.0%	16.7%	19.1%	20.9%	14.8%	16.0%				
Diagnostic Test Name	Diagnostic Test Name >>>	Diagnostic test waiting times - GASTROSCOPY	1.0%	*1.0%*	13.4%	YTD		3.1%	2.4%	0.9%	2.3%	3.7%	30.1%	34.5%	21.7%	10.8%				
CB_B17a	Mixed Sex Accommodation	MSA Breach Number	0	*0*	0	YTD		0	0	0	0	0	0	0	0	0				
CB_B6	Cancer 2 Week Waits	Percentage of Patients seen within two weeks of an urgent GP Referral for Suspected Cancer	93.0%	*93.0%*	96.9%	YTD		97.1%	97.1%	96.2%	96.2%	96.9%	96.6%	98.2%	97.1%					
CB_B6Q	Cancer 2 Week Waits	Percentage of Patients seen within two weeks of an urgent GP Referral for Suspected Cancer	93.0%	*93.0%*	96.8%	YTD				96.8%										
CB_B7	Cancer 2 Week Waits	Percentage of Patients urgently referred for Evaluation/Investigation of “Breast Symptoms” seen within 14 days	93.0%	*93.0%*	97.2%	YTD		99.4%	97.6%	96.9%	96.2%	97.3%	95.5%	97.5%	97.0%					
CB_B7Q	Cancer 2 Week Waits	Percentage of Patients urgently referred for Evaluation/Investigation of “Breast Symptoms” seen within 14 days	93.0%	*93.0%*	98.0%	YTD				98.0%										
CB_B8	Cancer 31 Day Waits	Percentage of Patients Receiving First Definitive Treatment for Cancer within 31 days of a Cancer Diagnosis	96.0%	*96.0%*	98.5%	YTD		99.5%	98.6%	98.0%	97.7%	98.4%	98.5%	99.0%	98.1%					
CB_B8Q	Cancer 31 Day Waits	Percentage of Patients Receiving First Definitive Treatment for Cancer within 31 days of a Cancer Diagnosis	96.0%	*96.0%*	98.7%	YTD				98.7%										
CB_B9	Cancer 31 Day Waits	Percentage of Patients Receiving Subsequent Surgery within a maximum Waiting Time of 31 Days	94.0%	*94.0%*	98.0%	YTD		98.0%	100.0%	100.0%	93.3%	97.3%	100.0%	97.6%						
CB_B9Q	Cancer 31 Day Waits	Percentage of Patients Receiving Subsequent Surgery within a maximum Waiting Time of 31 Days	94.0%	*94.0%*	99.1%	YTD				99.1%										
CB_B10	Cancer 31 Day Waits	Percentage of Patients Receiving a Subsequent/Adjuvant Anti-Cancer Drug Regimen within a maximum Waiting Time of 31 Days	98.0%	*98.0%*	100.0%	YTD		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%					
CB_B10Q	Cancer 31 Day Waits	Percentage of Patients Receiving a Subsequent/Adjuvant Anti-Cancer Drug Regimen within a maximum Waiting Time of 31 Days	98.0%	*98.0%*	100.0%	YTD				100.0%										
CB_B11	Cancer 31 Day Waits	Percentage of Patients Receiving a Subsequent/Adjuvant Radiotherapy Treatment within a maximum Waiting Time of 31	94.0%		n/a	YTD		n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a					
CB_B11Q	Cancer 31 Day Waits	Percentage of Patients Receiving a Subsequent/Adjuvant Radiotherapy Treatment within a maximum Waiting Time of 31	94.0%		n/a	YTD				n/a			n/a							
CB_B12	Cancer 62 day waits	Percentage of Patients Receiving First Definitive Treatment for Cancer within 62 Days of an Urgent GP Referral for Suspected	85.0%	*85.0%*	86.4%	YTD		90.8%	91.1%	82.9%	85.2%	92.3%	80.0%	79.2%	91.1%					Data taken from 62 day Cancer Waiting Time Standard Performance Report
CB_B12Q	Cancer 62 day waits	Percentage of Patients Receiving First Definitive Treatment for Cancer within 62 Days of an Urgent GP Referral for Suspected	85.0%	*85.0%*	86.1%	YTD				88.2%			85.6%							
CB_B13	Cancer 62 day waits	Percentage of Patients Receiving First Definitive Treatment for Cancer within 62 Days of Referral from an NHS Cancer Screening	90.0%	*90.0%*	99.3%	YTD		98.5%	100.0%	100.0%	100.0%	100.0%	97.9%	97.6%	100.0%					
CB_B13Q	Cancer 62 day waits	Percentage of Patients Receiving First Definitive Treatment for Cancer within 62 Days of Referral from an NHS Cancer Screening Service	90.0%	*90.0%*	99.5%	YTD				99.5%			99.5%							
CB_B14	Cancer 62 day waits	Percentage of Patients Receiving First Definitive Treatment for Cancer within 62 Days of a Consultant Decision to Upgrade	85.0%	*85.0%*	86.0%	YTD		90.5%	86.0%	84.4%	73.7%	83.3%	84.6%	93.3%	93.4%					
CB_B14Q	Cancer 62 day waits	Percentage of Patients Receiving First Definitive Treatment for Cancer within 62 Days of a Consultant Decision to Upgrade	85.0%	*85.0%*	83.1%	YTD				86.5%			80.1%							
CB_B18	Cancelled Operations	Number of Patients not offered another Binding Date within 28 days of a Cancelled Operation	0	*0*	11	YTD				1			5			5				
D05	Complaints	% of complaints responded to within timescale agreed at the outset upon receipt of the complaint with the complainant (“the response period” SI 309, 2009 paragraph 13 (7)) where	90.0%	*90.0%*	87.0%	YTD		89.7%	83.7%	82.0%	97.9%	95.1%	88.5%	90.6%	83.3%	76.3%				
No Ref01	VTE	VTE risk assessment: all inpatient Service Users undergoing risk assessment for VTE	95.0%	*95.0%*	95.4%	YTD		95.1%	95.2%	95.2%	95.2%	95.2%	95.1%	96.3%	95.7%	95.8%				
LTC2	LTCs	Screening of patients with LTCs for anxiety/depression - COPD patients	B/Line Yr		49.6%	YTD		44.4%	40.3%	50.0%	36.1%	78.6%	57.9%	46.9%	59.5%	69.2%				
LTC3	LTCs	Self Care for Patients with LTCs - COPD patients	B/Line Yr		100.0%	YTD		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%				
RHB1	Readmissions	Readmissions within 28 days - COPD patients	B/Line Yr		9.9%	YTD		9.1%	15.0%	12.5%	11.1%	10.3%	11.1%	11.8%	7.7%	4.8%				Issue discussed re significant time-lag before these figures can be considered "final" for any given month.

2014-15: Full Set of KPIs Scorecard - UHSM

Appendix C

Reporting Month: Feb-2015

Code	Measures	Indicators	Target 2014-15	Year to Date Performance			2014-15	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Comments
				Target	Actual	Period Used				Q1 14-15			Q2 14-15			Q3 14-15			Q4 14-15	
RHB3	Readmissions	No Admissions to hospital within 91 days of Referral - COPD patients	B/Line Yr		1.5%	YTD		0.0%	0.0%	12.5%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%				UHSM raised and discussed issues with Zoe Mellon
EXP2	Community Appointments	Wait from Referral to First community Assessment - 2 patient cohorts	B/Line Yr		3.20	YTD		3.10	3.10	3.50	See comme									Physio Clinic has ceased. As a result we are identifying a new specialty to include in its
STP1	Community: DNA	% Did not attend (DNA) rate for all clinic based appointments - 2 patient cohorts	B/Line Yr		28.5%	YTD		25.4%	25.0%	33.6%	See comme									Physio Clinic has ceased. As a result we are identifying a new specialty to include in it's
STP2	Community: CNA	% Could not access (CNA) rate for all home based visits - 2 patient cohorts	B/Line Yr		2.8%	YTD		2.6%	3.0%	2.8%	See comme									Physio Clinic has ceased. As a result we are identifying a new specialty to include in it's
GM05	Discharge Summaries	Discharge Letters are to be received by the patients GP within 24 hours of discharge (via GM ECC)	100.0%																	
GM06	Stroke	Quality stroke care - patients who spend at least 90% of their inpatient stay on a stroke unit	80.0%	*80.0%*	73.3%	YTD		86.1%	54.3%	90.5%	80.0%	68.8%	71.4%	67.6%	81.3%	76.5%				
GM07	Stroke	Quality stroke care - proportion of patients arriving in a designated stroke bed within 4 hours of arrival	60.0%	*60.0%*	67.4%	YTD		75.0%	44.4%	90.9%	88.2%	67.9%	80.0%	65.0%	53.3%	75.0%				
GM08	Stroke	Quality stroke care - proportion of high risk TIA cases investigated and treated within 24 hours	60.0%	*60.0%*	71.5%	YTD		100.0%	90.0%	60.7%	71.4%	57.9%	80.0%	88.2%	54.5%	61.1%				
GM09a	Maternity	% Women who have seen a midwife or a maternity healthcare professional by 12 weeks and 6 days of pregnancy	90.0%	*90.0%*	94.9%	YTD		94.5%	95.6%	93.4%	90.2%	93.5%	97.0%	99.8%	93.8%	96.5%				
GM13	Pharmacy	All patients on wards with daily pharmacy visit should have medicines reconciled by a pharmacist within 24 hours of admission	70.0%	*70.0%*	73.8%	YTD				74.9%			74.6%			71.9%				
GM14	Pharmacy	All patients on wards with daily pharmacy visit should have medicines reconciled by a pharmacist within 48 hours of admission	75.0%	*75.0%*	81.1%	YTD				96.5%			81.0%			78.3%				
D06	Complaints	% of complaints acknowledged in 3 working days of the day following receipt of the complaint	90.0%	*90.0%*	96.2%	YTD				90.2%			97.9%			96.2%				
D07	Complaints	% of complaints where, following investigation, an action plan has been put in place, acted upon, completed within an agreed timescale and reported back to the complainant	90.0%		None to report	YTD				None to			None to			None to				
D09	Delayed Transfers	Delayed transfers of care (lost bed days/nights) to be kept to a minimum level - NHS Only	TBC		3,799	YTD		334	343	381	530	460	369	341	334	707				NB - Report: Number of Days; NHS Only; Acute+Non-Acute
D02	Pharmacy	Evidence of a strategy to bring arrangements for homecare medicines in line with nationally agreed best practice	Yes	*Yes*	Yes	YTD							Yes			Yes				Awaiting further clarification from the CCG/CSU
D03	Pharmacy	Continue to improve compliance with provision of shared care protocols for amber drugs (amber drugs as defined in the GMMMG RAG list)	Yes	*Yes*												Yes				Awaiting further clarification from the CCG/CSU
No Ref02	Formulary	Formulary published	Yes	*Yes*		YTD														
No Ref03	Duty of Candour	Duty of Candour	0	*0*	0	YTD		0	0	0	0	0	0	0	0	0				
No Ref04	NHS Number	Completion of a valid NHS Number field in mental health and acute commissioning data sets submitted via SUS	99.0%	*99.0%*	99.7%	YTD		99.8%	99.8%	99.8%	99.8%	99.8%	99.8%	99.8%	99.8%	99.3%				
No Ref05	NHS Number	Completion of a valid NHS Number field in A&E commissioning data sets submitted via SUS	95.0%	*95.0%*	98.2%	YTD		98.1%	98.2%	98.0%	98.0%	97.9%	98.2%	98.3%	98.4%	98.2%				
E02	Choose & Book	Slot Issues	B/Line Yr																	Available via the Choose & Book website. CCGs to retrieve themselves.
E09	UM Review	Perfect Week																		Review complete. Awaiting final report.
E10	UM Review	Ward Based Point Prevalence																		Review complete. Awaiting final report.
QA5.1	Friends and Family Test	FFT Score - A&E			58	Latest Month		53	58	56	50	58	66	64	63	58				
QA5.2	Friends and Family Test	FFT Score - Inpatient			78	Latest Month		80	80	81	82	82	82	82	81	78				
QA5.3	Friends and Family Test	FFT Score - Outpatient																		
QA5.4	Friends and Family Test	FFT Score - Daycase																		
QA5.5	Friends and Family Test	FFT Score - Maternity - Birth (Qu.2)			92	Latest Month		92	91	89	88	87	87	93	91	92				
QA5.6	Friends and Family Test	FFT Response Rate - A&E	20.0%	*17.5%*	20.6%	Latest Month		17.6%	17.3%	16.1%	14.3%	13.4%	15.7%	18.6%	20.2%	20.6%				

2014-15: Full Set of KPIs Scorecard - UHSM

Appendix C

Reporting Month: Feb-2015

Code	Measures	Indicators	Target 2014-15	Year to Date Performance			2014-15	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Comments
				Target	Actual	Period Used				Q1 14-15			Q2 14-15			Q3 14-15			Q4 14-15	
QA5.7	Friends and Family Test	FFT Response Rate - Inpatient	30.0%	*27.5%*	40.3%	Latest Month		33.2%	42.2%	36.5%	43.7%	47.2%	45.0%	48.3%	40.1%	40.3%				
QA5.8	Friends and Family Test	FFT Response Rate - Outpatient																		
QA5.9	Friends and Family Test	FFT Response Rate - Daycase																		
QA5.10	Friends and Family Test	FFT Response Rate - Maternity - Birth (Qu.2)			20.9%	Latest Month		24.4%	22.5%	14.6%	20.1%	30.8%	16.8%	20.8%	26.9%	20.9%				

2014-15: Full Set of KPIs Scorecard - CMFT

Appendix D

Reporting Month: Feb-2015

Code	Measures	Indicators	Target 2014-15	Year to Date Performance			2014-15	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Comments
				Target	Actual	Period Used				Q1 14-15			Q2 14-15			Q3 14-15			Q4 14-15	
CB_A15a	HCAI	Overall Number of Cases of MRSA Bacteraemia - AVOIDABLE	0	0	3	YTD		1	0	1	0	0	1	0	0	0				
CB_A15b	HCAI	Overall Number of Cases of MRSA Bacteraemia - UNAVOIDABLE	0	0	2	YTD		0	1	0	0	0	0	0	1	0				
CB_A16a	HCAI	Number of Cases of C. Difficile Caused by Lapse in Care - NHS Patients	66	50	4	YTD		0	0	1	2	0	1	0	0	0				
CB_A16b	HCAI	Overall Number of Cases of C. Difficile - NHS Patients	See Note		55	YTD		6	8	4	7	13	6	2	4	5				Targets not applicable
CB_B1	Referral to Treatment	The Percentage within 18 weeks for Completed Admitted RTT Pathways	90.0%	90.0%	90.4%	YTD		91.0%	90.7%	90.9%	90.2%	90.0%	90.1%	91.1%	87.6%	92.4%				
SPECIALTY LEVEL >>>	RTT - SPECIALTY LEVEL >>>	- Admitted Adjusted Pathways: SPECIALTY LEVEL - Other	90.0%	90.0%	85.2%	YTD		86.7%	86.3%	84.1%	84.4%	81.8%	85.1%	87.4%	80.8%	90.1%				
SPECIALTY LEVEL >>>	RTT - SPECIALTY LEVEL >>>	- Admitted Adjusted Pathways: SPECIALTY LEVEL - Trauma & Orthopaedics	90.0%	90.0%	89.6%	YTD		90.9%	91.0%	91.6%	91.9%	92.5%	88.0%	90.4%	80.4%	93.7%				
CB_B2	Referral to Treatment	The Percentage within 18 weeks for Completed Non-Admitted RTT Pathways	95.0%	95.0%	95.4%	YTD		95.3%	95.8%	96.4%	95.9%	95.9%	95.3%	95.1%	93.6%	95.6%				
SPECIALTY LEVEL >>>	RTT - SPECIALTY LEVEL >>>	- Non-admitted Pathways: SPECIALTY LEVEL - Other	95.0%	95.0%	92.1%	YTD		91.0%	92.9%	93.8%	93.5%	93.0%	91.7%	92.2%	88.7%	92.0%				
SPECIALTY LEVEL >>>	RTT - SPECIALTY LEVEL >>>	- Non-admitted Pathways: SPECIALTY LEVEL - Plastic Surgery	95.0%	95.0%	91.5%	YTD		100.0%	80.0%	100.0%	100.0%	100.0%	100.0%	100.0%	70.6%	100.0%				
CB_B3	Referral to Treatment	The Percentage within 18 weeks for Incomplete RTT Pathways	92.0%	92.0%	92.0%	YTD		92.5%	93.1%	92.8%	92.1%	92.0%	92.1%	92.0%	92.1%	92.0%				
SPECIALTY LEVEL >>>	RTT - SPECIALTY LEVEL >>>	- Incomplete Pathways: SPECIALTY LEVEL - Gynaecology	92.0%	92.0%	91.1%	YTD		94.3%	94.7%	94.0%	93.2%	92.7%	92.8%	92.2%	91.5%	91.1%				
SPECIALTY LEVEL >>>	RTT - SPECIALTY LEVEL >>>	- Incomplete Pathways: SPECIALTY LEVEL - Other	92.0%	92.0%	88.8%	YTD		90.0%	90.7%	90.3%	89.2%	88.8%	88.9%	88.8%	89.5%	88.8%				
CB_S6c	Referral to Treatment	The Number of RTT Pathways > 52 weeks for Incomplete Pathways	0	0	0	YTD		0	0	0	0	0	0	0	0	0				
RTT7	Referral to Treatment	The Number of RTT Pathways > 46 weeks for Incomplete Pathways	0	0	401	YTD		82	82	54	44	49	33	30	27					
CB_S7a	Ambulance Handover Time	Ambulance Handover Delays of over 30 minutes - MRI	0	0	1,855	YTD		152	159	45	94	134	217	299	307	448				
CB_S7b	Ambulance Handover Time	Ambulance Handover Delays of over 1 hour - MRI	0	0	590	YTD		47	37	3	14	17	70	94	111	197				
CB_S7a	Ambulance Handover Time	Ambulance Handover Delays of over 30 minutes - TGH	0	0	1	YTD		0	1	0	0	0	0	0	0	0				
CB_S7b	Ambulance Handover Time	Ambulance Handover Delays of over 1 hour - TGH	0	0	0	YTD		0	0	0	0	0	0	0	0	0				
NWA1	Ambulance	Compliance with Recording Patient Handover between Ambulance and A&E	95.0%	95.0%	80.8%	YTD		80.6%	80.1%	80.5%	79.9%	82.9%	82.7%	81.0%	81.5%	78.0%				
CB_B5	A&E Waiting Times	Percentage of Patients spending 4 hours or less in A&E	95.0%	95.0%	93.9%	YTD		93.6%	94.3%	98.3%	96.6%	95.1%	93.2%	91.8%	91.5%	91.2%				Monthly reported figure has reverted to in-month (used to be YTD)
CB_B5Q	A&E Waiting Times	Percentage of Patients spending 4 hours or less in A&E	95.0%	95.0%	93.9%	YTD				95.3%			95.1%			91.5%				
CB_S9	Trolley Waits in A&E	Number of Patients who have waited over 12 hours in A&E from Decision to Admit to Admission	0	0	0	YTD		0	0	0	0	0	0	0	0	0				
CB_S10	Cancelled Operations	Number of Urgent Operations Cancelled for a Second Time	0	0	0	YTD		0	0	0	0	0	0	0	0	0				
CB_B4	Diagnostic Test Waiting Times	The Percentage of Patients waiting 6 weeks or more for a Diagnostic Test (15 Key Diagnostic Tests)	1.0%	1.0%	2.0%	YTD		2.6%	3.1%	1.9%	2.1%	1.9%	2.2%	1.5%	1.5%	1.5%				
Diagnostic Test Name >>>	Diagnostic Test Name >>>	Diagnostic test waiting times - MRI	1.0%	1.0%	2.3%	YTD		4.8%	5.1%	2.6%	2.7%	1.0%	1.0%	1.1%	0.7%	1.1%				Published data
Diagnostic Test Name >>>	Diagnostic Test Name >>>	Diagnostic test waiting times - ELECTROPHYSIOLOGY	1.0%	1.0%	41.7%	YTD		100.0%	50.0%	100.0%	50.0%	n/a	0.0%	n/a	0.0%	0.0%				Published data
Diagnostic Test Name >>>	Diagnostic Test Name >>>	Diagnostic test waiting times - SLEEP_STUDIES	1.0%	1.0%	1.1%	YTD		1.6%	1.1%	1.5%	2.7%	2.2%	0.0%	0.0%	0.0%	0.0%				Published data
Diagnostic Test Name >>>	Diagnostic Test Name >>>	Diagnostic test waiting times - URODYNAMICS	1.0%	1.0%	16.7%	YTD		0.0%	6.7%	6.7%	14.3%	29.4%	24.2%	29.2%	14.3%	15.0%				Published data

2014-15: Full Set of KPIs Scorecard - CMFT

Reporting Month: Feb-2015

Code	Measures	Indicators	Target 2014-15	Year to Date Performance			2014-15	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Comments
				Target	Actual	Period Used				Q1 14-15			Q2 14-15			Q3 14-15			Q4 14-15	
Diagnostic Test Name	Diagnostic Test Name >>>	Diagnostic test waiting times - COLONOSCOPY	1.0%	*1.0%*	16.6%	YTD		8.9%	16.0%	26.5%	19.7%	34.4%	22.1%	9.2%	11.3%	11.5%				Published data
Diagnostic Test Name	Diagnostic Test Name >>>	Diagnostic test waiting times - FLEXI_SIGMOIDOSCOPY	1.0%	*1.0%*	1.5%	YTD		0.7%	0.0%	1.7%	0.7%	2.8%	3.2%	2.0%	2.3%	0.5%				Published data
Diagnostic Test Name	Diagnostic Test Name >>>	Diagnostic test waiting times - CYSTOSCOPY	1.0%	*1.0%*	18.4%	YTD		16.7%	15.0%	7.3%	12.5%	13.8%	29.6%	27.0%	21.5%	22.1%				Published data
Diagnostic Test Name	Diagnostic Test Name >>>	Diagnostic test waiting times - GASTROSCOPY	1.0%	*1.0%*	11.3%	YTD		15.3%	17.0%	11.9%	10.1%	15.3%	12.9%	6.7%	8.9%	5.9%				Published data
CB_B17a	Mixed Sex Accommodation	MSA Breach Number	0	*0*	0	YTD		0	0	0	0	0	0	0	0	0				
CB_B6	Cancer 2 Week Waits	Percentage of Patients seen within two weeks of an urgent GP Referral for Suspected Cancer	93.0%	*93.0%*	94.6%	YTD		94.3%	95.0%	94.5%	96.3%	95.7%	94.0%	93.6%	93.0%					
CB_B6Q	Cancer 2 Week Waits	Percentage of Patients seen within two weeks of an urgent GP Referral for Suspected Cancer	93.0%	*93.0%*	95.0%	YTD				94.6%			95.3%							
CB_B8	Cancer 31 Day Waits	Percentage of Patients Receiving First Definitive Treatment for Cancer within 31 days of a Cancer Diagnosis	96.0%	*96.0%*	97.6%	YTD		97.5%	97.5%	97.5%	96.8%	98.0%	97.1%	97.2%	99.0%					
CB_B8Q	Cancer 31 Day Waits	Percentage of Patients Receiving First Definitive Treatment for Cancer within 31 days of a Cancer Diagnosis	96.0%	*96.0%*	97.4%	YTD				97.5%			97.4%							
CB_B9	Cancer 31 Day Waits	Percentage of Patients Receiving Subsequent Surgery within a maximum Waiting Time of 31 Days	94.0%	*94.0%*	98.2%	YTD		94.1%	100.0%	100.0%	100.0%	95.2%	100.0%	100.0%	100.0%					
CB_B9Q	Cancer 31 Day Waits	Percentage of Patients Receiving Subsequent Surgery within a maximum Waiting Time of 31 Days	94.0%	*94.0%*	97.6%	YTD				97.8%			97.4%							
CB_B10	Cancer 31 Day Waits	Percentage of Patients Receiving a Subsequent/Adjuvant Anti-Cancer Drug Regimen within a maximum Waiting Time of 31 Days	98.0%	*98.0%*	100.0%	YTD		100.0%	n/a	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%					No activity reported for May14
CB_B10Q	Cancer 31 Day Waits	Percentage of Patients Receiving a Subsequent/Adjuvant Anti-Cancer Drug Regimen within a maximum Waiting Time of 31 Days	98.0%	*98.0%*	100.0%	YTD				100.0%			100.0%							
CB_B11	Cancer 31 Day Waits	Percentage of Patients Receiving a Subsequent/Adjuvant Radiotherapy Treatment within a maximum Waiting Time of 31	94.0%		n/a	YTD		n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a					No activity reported to date
CB_B11Q	Cancer 31 Day Waits	Percentage of Patients Receiving a Subsequent/Adjuvant Radiotherapy Treatment within a maximum Waiting Time of 31	94.0%		n/a	YTD				n/a			n/a							
CB_B12	Cancer 62 day waits	Percentage of Patients Receiving First Definitive Treatment for Cancer within 62 Days of an Urgent GP Referral for Suspected	85.0%	*85.0%*	83.8%	YTD		85.9%	69.3%	77.3%	89.1%	86.3%	89.4%	87.9%						Data taken from 62 day Cancer Waiting Time Standard Performance Report
CB_B12Q	Cancer 62 day waits	Percentage of Patients Receiving First Definitive Treatment for Cancer within 62 Days of an Urgent GP Referral for Suspected	85.0%	*85.0%*	85.1%	YTD				80.5%			89.2%							
CB_B13	Cancer 62 day waits	Percentage of Patients Receiving First Definitive Treatment for Cancer within 62 Days of Referral from an NHS Cancer Screening	90.0%	*90.0%*	77.5%	YTD		66.7%	100.0%	100.0%	100.0%	75.0%	77.8%	66.7%	33.3%					
CB_B13Q	Cancer 62 day waits	Percentage of Patients Receiving First Definitive Treatment for Cancer within 62 Days of Referral from an NHS Cancer Screening Service	90.0%	*90.0%*	83.9%	YTD				85.7%			82.4%							
CB_B14	Cancer 62 day waits	Percentage of Patients Receiving First Definitive Treatment for Cancer within 62 Days of a Consultant Decision to Upgrade	85.0%	*85.0%*	92.4%	YTD		100.0%	95.8%	94.3%	84.2%	92.0%	85.4%	93.3%	97.4%					
CB_B14Q	Cancer 62 day waits	Percentage of Patients Receiving First Definitive Treatment for Cancer within 62 Days of a Consultant Decision to Upgrade	85.0%	*85.0%*	91.3%	YTD				96.7%			86.5%							
CB_B18	Cancelled Operations	Number of Patients not offered another Binding Date within 28 days of a Cancelled Operation	0	*0*	1	YTD		0	1	0	0	0	0	0	0					May14 = 1 Breach
D05	Complaints	% of complaints responded to within timescale agreed at the outset upon receipt of the complaint with the complainant ("the response period" SI 309, 2009 paragraph 13 (7)) where	90.0%																	
No Ref01	VTE	VTE risk assessment: all inpatient Service Users undergoing risk assessment for VTE	95.0%	*95.0%*	96.0%	YTD		95.8%	96.0%	96.2%	95.8%	95.9%	96.5%	95.9%	95.8%	95.5%				
RHB1	Readmissions	Readmissions within 28 days - Stroke patients	B/Line Yr																	
RHB3	Readmissions	No Admissions to hospital within 91 days of Referral - COPD patients	B/Line Yr																	
EXP2	Community Appointments	Wait from Referral to First community Assessment - COPD & Physiotherapy Patients	B/Line Yr																	
STP1	Community: DNA	% Did not attend (DNA) rate for all clinic based appointments - COPD & Physiotherapy Patients	B/Line Yr																	COPD patients seen in Gen Med clinic- unable to split out for this measure
STP2	Community: CNA	% Could not access (CNA) rate for all home based visits - COPD & Physiotherapy Patients	B/Line Yr																	COPD patients seen in Gen Med clinic- unable to split out for this measure

2014-15: Full Set of KPIs Scorecard - CMFT

Appendix D

Reporting Month: Feb-2015

Code	Measures	Indicators	Target 2014-15	Year to Date Performance			2014-15	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Comments
				Target	Actual	Period Used				Q1 14-15			Q2 14-15			Q3 14-15			Q4 14-15	
GM05	Discharge Summaries	Discharge Letters are to be received by the patients GP within 24 hours of discharge (via GM ECC)	100.0%																	
GM06	Stroke	Quality stroke care - patients who spend at least 90% of their inpatient stay on a stroke unit	80.0%	*80.0%*	70.2%	YTD		65.2%	79.3%	72.7%	75.0%	78.3%	70.0%	63.8%	61.3%					Central Stroke Team's Dec. figs not yet available
GM07	Stroke	Quality stroke care - proportion of patients arriving in a designated stroke bed within 4 hours of arrival	60.0%	*60.0%*	43.4%	YTD		28.6%	37.5%	35.7%	28.6%	83.3%	50.0%	44.4%	80.0%					Central Stroke Team's Dec. figs not yet available
GM08	Stroke	Quality stroke care - proportion of high risk TIA cases investigated and treated within 24 hours	60.0%	*60.0%*	50.0%	YTD		66.7%	66.7%	100.0%	20.0%	75.0%	100.0%	0.0%	50.0%	40.0%				
GM09a	Maternity	% Women who have seen a midwife or a maternity healthcare professional by 12 weeks and 6 days of pregnancy	90.0%	*90.0%*	76.4%	YTD		76.5%	77.7%	77.3%	79.1%	79.1%	72.6%	75.2%	75.0%	75.1%				
GM09b	Maternity	% Women (who present within 12 weeks) who have seen a midwife or a maternity healthcare professional by 12 weeks and 6 days of pregnancy	90.0%	*90.0%*	95.8%	YTD		95.2%	95.5%	97.3%	97.3%	96.2%	93.9%	96.7%	95.4%	94.5%				
GM13	Pharmacy	All patients on wards with daily pharmacy visit should have medicines reconciled by a pharmacist within 24 hours of admission and have the following data recorded on admission: (Where no 24	95.0%	*95.0%*	71.6%	YTD		62.5%	73.2%	56.1%	73.6%	68.5%	74.7%	74.6%	77.0%	81.6%				
D06	Complaints	% of complaints acknowledged in 3 working days of the day following receipt of the complaint	90.0%																	
D07	Complaints	% of complaints where, following investigation, an action plan has been put in place, acted upon, completed within an agreed timescale and reported back to the complainant	90.0%																	
D09	Delayed Transfers	Delayed transfers of care (lost bed days/nights) to be kept to a minimum level - NHS Only	TBC		1,739	YTD		122	113	179	131	308	496	390						
No Ref02	Formulary	Formulary published	Yes	*Yes*		YTD														
No Ref03	Duty of Candour	Duty of Candour	0	*0*	0	YTD		0	0	0	0	0	0	0	0					
No Ref04	NHS Number	Completion of a valid NHS Number field in mental health and acute commissioning data sets submitted via SUS	99.0%																	
No Ref05	NHS Number	Completion of a valid NHS Number field in A&E commissioning data sets submitted via SUS	95.0%																	
E02	Choose & Book	Slot Issues	B/Line Yr		21.6%	YTD		16.8%	16.6%	19.4%	25.7%	23.4%	23.6%	25.5%						
E09	UM Review	Zero Day Length of Stay Review: Adults																		Review complete. Awaiting final report.
E10	UM Review	Zero Day Length of Stay Review: Children																		Review complete. Awaiting final report.
QA5.1	Friends and Family Test	FFT Score - A&E			61	Latest Month		61	60	63	66	65	59	64	63	61				
QA5.2	Friends and Family Test	FFT Score - Inpatient			73	Latest Month		75	76	71	69	73	71	72	71	73				
QA5.3	Friends and Family Test	FFT Score - Outpatient																		
QA5.4	Friends and Family Test	FFT Score - Daycase																		
QA5.5	Friends and Family Test	FFT Score - Maternity - Birth (Qu.2)			68	Latest Month		80	74	77	78	71	80	75	81	68				
QA5.6	Friends and Family Test	FFT Response Rate - A&E	20.0%	*17.5%*	19.6%	Latest Month		19.2%	19.4%	23.3%	20.7%	23.3%	24.2%	23.0%	21.7%	19.6%				
QA5.7	Friends and Family Test	FFT Response Rate - Inpatient	30.0%	*27.5%*	34.2%	Latest Month		20.2%	23.2%	48.1%	44.1%	39.5%	32.0%	35.0%	35.1%	34.2%				
QA5.8	Friends and Family Test	FFT Response Rate - Outpatient																		
QA5.9	Friends and Family Test	FFT Response Rate - Daycase																		
QA5.10	Friends and Family Test	FFT Response Rate - Maternity - Birth (Qu.2)			11.4%	Latest Month		15.5%	14.3%	10.7%	15.5%	18.9%	11.4%	7.4%	19.7%	11.4%				

2014-15: Full Set of KPIs Scorecard - PCFT

Appendix E

Reporting Month: Feb-2015

Code	Measures	Indicators	Target 2014-15	Year to Date Performance			2014-15	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Comments
				Target	Actual	Period Used				Q1 14-15			Q2 14-15			Q3 14-15			Q4 14-15	
CB_B2	Referral to Treatment	The Percentage within 18 weeks for Completed Non-Admitted RTT Pathways	95.0%	95.0%	100.0%	YTD		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%				
CB_B3	Referral to Treatment	The Percentage within 18 weeks for Incomplete RTT Pathways	92.0%	92.0%	100.0%	YTD		100.0%	N/A	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%				
CB_S6c	Referral to Treatment	The Number of RTT Pathways > 52 weeks for Incomplete Pathways	0	0				0	0	0	0	0	0	0	0	0				
H03	Complaints	% of complaints responded to within timescale agreed at the outset upon receipt of the complaint with the complainant ("the	90.0%	90.0%	100.0%	YTD		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%				
H04	Complaints	% of complaints acknowledged in 3 working days of the day following receipt of the complaint	90.0%	90.0%	100.0%	YTD				100.0%			100.0%			100.0%				
H05	Complaints	% of complaints where, following investigation, an action plan has been put in place, acted upon, completed within an agreed	90.0%	90.0%	100.0%	YTD				100.0%			42.9%							
No Ref02	Formulary	Formulary published	Yes																	
No Ref03	Duty of Candour	Duty of Candour	0	0	0	YTD		0	0	0	0	0	0	0	0	0				
AS49	Overarching	KPI Compliance	80.0%	80.0%	85.3%	YTD		88.9%	88.9%	100.0%	81.8%	81.8%	81.8%	81.8%	72.7%	90.9%				
UE15	Overarching KPI (Funded Urgent, IV & Enhanced	Quality - Proportion of patients on an active Urgent, IV and Enhanced Care Service caseload whose non-elective admission is	90.0%	90.0%	100.0%	YTD				100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%				
RHB4	Venous Leg ulcers Healing	The percentage of venous leg ulcer wounds that have healed at 24 weeks from the start of treatment.	70.0%	70.0%	92.5%	YTD		90.9%	95.0%	93.8%	78.6%	N/A	93.8%	100.0%	100.0%	87.0%				
GM03	Children & Families	% Breastfeeding status recorded	95.0%	95.0%	97.0%	YTD				96.7%			96.0%			98.3%				
GM04	Children & Families	% Fully or partially breastfed	54.0%	54.0%	54.2%	YTD				54.4%			54.6%			53.6%				
GM08	Health Visitors	Number HVs (WTE)	51	51				52	51	50	51	50	50	53	53	53				
GM09	Harm free Care	Number of Grade 2> pressure ulcer	TBC		0	YTD		0	0	0	0	0	0	0	0	0				(Rate per 1000)
GM15	Dementia	% Dementia case notes with carer views	93.0%	93.0%	100.0%	YTD		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%				
GM16	Children & Families	% Given advice re Healthy vitamin supplementation	80.0%	80.0%	82.0%	YTD				82.0%			79.9%			84.3%				
GM30	Children & Families	% New mothers with an assessment postnatal depression	95.0%	95.0%	94.0%	YTD		89.8%	95.6%	92.5%	91.4%	92.8%	94.1%	97.7%	94.8%	97.5%				
GM32	Children & Families	% Looked after children 0-5 yr with twice yearly assessments	90.0%	90.0%	87.5%	YTD				92.9%			94.4%			77.5%				
GM33	Children & Families	% Looked after children 5 yr+ with annual assessments	90.0%	90.0%	97.1%	YTD				97.5%			95.7%			98.0%				
GM11 - T	Training	% eligible staff completing mandatory adult protection training	95.0%	90.0%	93.6%	YTD				91.7%			95.7%			93.4%				
GM12-T	Training	% eligible staff completing domestic abuse training	90.0%	90.0%	83.4%	YTD				86.4%			75.8%			91.0%				
GM13-T	Training	% eligible staff completing mandatory infection control training	90.0%	90.0%	84.2%	YTD				56.4%			93.4%			96.1%				
GM14-T	Training	% eligible staff completing basic level dementia awareness training	90.0%	90.0%	72.5%	YTD				67.7%			60.8%			88.6%				
GM29-T	Training	% eligible staff receiving health promotion training	90.0%	90.0%	90.5%	YTD				91.5%			90.3%			89.8%				
GM34-T	Training	% eligible staff completing mandatory child protection training	90.0%	90.0%	85.2%	YTD				89.3%			84.2%			82.2%				
GM27	Making every contact count	% Adults / children assessed for nutritional requirements	65.0%		66.4%	YTD	66.4%													
AS01	CNRT	Patients whose first treatment appointment is within 6 weeks for routine patients from referrals	90.0%	90.0%	86.5%	YTD		73.0%	86.1%	90.0%	87.5%	86.7%	88.6%	92.1%	93.1%	79.2%				
AS02	CNRT	Urgent referrals whose first treatment appointment is within 2 weeks for from receipt of referral	90.0%	90.0%	93.3%	YTD		100.0%	78.6%	94.4%	100.0%	83.3%	95.0%	100.0%	100.0%	80.0%				

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Appendix E

Reporting Month: Feb-2015

Code	Measures	Indicators	Target 2014-15	Year to Date Performance			2014-15	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Comments
				Target	Actual	Period Used				Q1 14-15			Q2 14-15			Q3 14-15			Q4 14-15	
AS03	CNRT	Patients for whom reason for referral is captured	80.0%	80.0%	95.3%	YTD		97.3%	94.3%	90.6%	96.6%	83.8%	98.3%	96.4%	100.0%	98.4%				
AS04	Community Rehabilitation	Patients whose first contact with a therapist is within 1 working day for urgent referrals	80.0%	80.0%	96.5%	YTD		96.8%	96.5%	98.4%	98.3%	100.0%	95.9%	97.6%	94.3%	90.4%				
AS05	Community Rehabilitation	Patients whose first contact with a therapist is within 10 working day for routine referrals	80.0%	80.0%	80.2%	YTD		68.4%	79.8%	73.2%	79.4%	81.8%	83.0%	84.4%	88.1%	89.1%				
AS06	Community Rehabilitation	Patients for whom the reason for referral is captured	80.0%	80.0%	97.0%	YTD		98.6%	98.6%	95.8%	98.4%	97.0%	95.0%	98.9%	98.8%	92.4%				
AS07	Continence	Urgent patients whose first attendance is within 10 working days from receipt of referral	80.0%	80.0%	97.8%	YTD		91.7%	100.0%	100.0%	100.0%	N/A	100.0%	100.0%	100.0%	100.0%				
AS08	Continence	Reason for referral including main diagnosis is capture	80.0%	80.0%	96.5%	YTD		97.2%	94.2%	96.1%	96.4%	96.9%	95.5%	96.0%	100.0%	97.8%				
AS10	District Nurse	Patients whose first contact is within 5 working days for routine and non-urgent patients from referral excluding those with a specified intervention time e.g. sutures	80.0%	80.0%	77.2%	YTD		80.4%	81.5%	77.6%	78.4%	78.6%	73.8%	72.0%	78.5%	74.2%				
AS11	District Nurse	Reason for referral including main diagnosis is captured	80.0%	80.0%	95.9%	YTD		94.1%	96.2%	95.9%	97.1%	95.2%	96.8%	95.5%	97.1%	95.2%				
AS12	Ear Care	Patients whose first appointment is within 2 weeks of referral	95.0%	95.0%	61.6%	YTD		68.1%	70.7%	48.1%	46.9%	68.5%	51.5%	57.6%	57.9%	88.3%				
AS13	Ear Care	Percentage of patients for whom the intervention is captured	90.0%	90.0%	89.3%	YTD		81.2%	94.0%	91.4%	89.2%	93.4%	91.7%	88.4%	88.6%	86.2%				
AS14	Ear Care	Percentage of GP practices that access the service	80.0%	80.0%	96.9%	YTD		94.4%	97.2%	97.2%	97.2%	97.2%	97.2%	97.2%	97.2%	97.2%				
AS15	MSK	Patients whose first attendance is within 18 weeks from referral	100.0%	100.0%	99.5%	YTD		98.4%	99.2%	100.0%	99.7%	99.4%	99.8%	99.6%	100.0%	100.0%				
AS16	MSK	Patients for whom the reason for referral is captured- body part	80.0%	80.0%	95.7%	YTD		95.5%	96.0%	96.2%	95.8%	95.9%	94.7%	96.3%	94.9%	95.6%				
AS17	Nutrition & Dietetics	Patients whose first attendance is within 6 weeks from receipt of referral	80.0%	80.0%	76.5%	YTD		82.1%	77.5%	83.9%	73.2%	68.1%	66.4%	73.7%	81.7%	84.5%				
AS18	Nutrition & Dietetics	Patients for whom the reason for referral is captured	80.0%	80.0%	95.6%	YTD		97.0%	91.8%	93.5%	96.9%	98.1%	92.4%	95.3%	99.3%	97.9%				
AS19	Nutrition & Dietetics	Percentage of GP practices that access the service	80.0%	80.0%	96.9%	YTD		94.4%	97.2%	97.2%	97.2%	97.2%	97.2%	97.2%	97.2%	97.2%				
AS20	OSRC	Assessment is within 7 days for urgent appointments	80.0%	80.0%	100.0%	YTD		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%				
AS21	OSRC	Assessment is within 56 days for routine appointments	80.0%	80.0%	100.0%	YTD		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%				
AS24	OSRC	Patients who receive their equipment within 7 days for community referrals	90.0%	90.0%	98.1%	YTD		98.1%	97.9%	99.3%	98.1%	98.6%	97.7%	97.4%	97.5%	98.1%				
AS25	Phlebotomy	Patients for whom category is allocated (HV, anti-coag, primary care) including clinic contacts	90.0%	90.0%	97.4%	YTD		99.1%	99.3%	98.1%	97.8%	97.3%	93.5%	97.3%	97.6%	97.2%				
AS26	Pulmonary Rehabilitation	Patients whose first attendance at a course is within 8 weeks from referral	90.0%	90.0%	1.8%	YTD		0.0%	0.0%	0.0%	3.8%	7.7%	0.0%	0.0%	8.3%	0.0%				
AS27	Pulmonary Rehabilitation	Patients for whom the type of attendance (group vs. 1:1 vs. telephone) contact is captured	90.0%	90.0%	100.0%	YTD		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%				
AS28	Pulmonary Rehabilitation	Patients who complete 80% of the course	70.0%	70.0%	59.1%	YTD		53.3%	100.0%	62.1%	28.6%	53.3%	42.9%	63.6%	60.0%	58.8%				
AS29	SPC Services	Patients whose first contact is within 3 days for specialist palliative care nurses from receipt of referral	80.0%	80.0%	55.7%	YTD		40.0%	52.1%	76.6%	43.9%	55.6%	53.1%	67.3%	63.2%	76.0%				
AS30	SPC Services	Patients for whom the reason for referral is captured	90.0%	90.0%	98.5%	YTD		98.1%	100.0%	98.1%	100.0%	100.0%	100.0%	98.1%	94.6%	96.7%				
AS31	SWMS	Referrals acknowledged and processed within 3 working days of referral receipt	95.0%	95.0%	100.0%	YTD		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%				
AS32	SWMS	Individuals to be offered a programme of intervention within 4 weeks of referral.	90.0%	90.0%	97.8%	YTD		100.0%	95.7%	100.0%	100.0%	92.9%	94.4%	100.0%	94.4%	100.0%				
AS35	SWMS	Clients have an initial weight, blood pressure and BMI recorded	100.0%	100.0%	100.0%	YTD		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%				
AS36	SWMS	Clients completing the programme having weight, blood pressure and BMI recorded	100.0%	100.0%	100.0%	YTD		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%				

2014-15: Full Set of KPIs Scorecard - PCFT

Appendix E

Reporting Month: Feb-2015

Code	Measures	Indicators	Target 2014-15	Year to Date Performance: Target	Year to Date Performance: Actual	Year to Date Performance: Period Used	2014-15	Apr-14	May-14	Jun-14 (Q1 14-15)	Jul-14	Aug-14	Sep-14 (Q2 14-15)	Oct-14	Nov-14	Dec-14 (Q3 14-15)	Jan-15	Feb-15	Mar-15 (Q4 14-15)	Comments
AS37	SWMS	Clients that have co-morbidity & drug therapy status (where appropriate) recorded pre & post treatment	100.0%	100.0%	100.0%	YTD		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%				
AS41	SWMS	Patients who drop out of the service following the start of the lifestyle programme	60.0%	60.0%	11.3%	YTD		20.0%	20.0%	16.7%	0.0%	0.0%	20.0%	0.0%	0.0%	14.3%				
AS42	Tissue Viability	% patients assessed within 25 working days from receipt of referral	90.0%	90.0%	90.1%	YTD		83.3%	100.0%	100.0%	72.2%	80.0%	87.0%	90.3%	95.5%	97.0%				
AS43	Tissue Viability	% GP practices that access the service	80.0%	60.0%	86.1%	Latest Month		25.0%	50.0%	58.3%	66.7%	75.0%	77.8%	80.6%	80.6%	86.1%				
AS44	SALT Adults	Patients for whom the reason for referral is captured	90.0%	90.0%	96.9%	YTD		92.5%	96.0%	100.0%	96.0%	95.0%	98.1%	98.3%	100.0%	96.0%				
AS46	SALT Adults	First assessment is completed within 1 week for routine dysphagia	90.0%	90.0%	97.4%	YTD		N/A	N/A	N/A	N/A	N/A	100.0%	100.0%	85.7%	100.0%				Change to KPI, now measures URGENT only referrals
UE16	Heart Failure	Routine patients whose first attendance is within 28 days from referral	80.0%	80.0%	85.0%	YTD		100.0%	68.8%	97.2%	89.5%	70.6%	55.6%	94.1%	84.6%	84.6%				
UE17	Heart Failure	Urgent patients whose first attendance is within 7 days from referral	80.0%	80.0%	66.7%	YTD		N/A	N/A	100.0%	N/A	100.0%	0.0%	N/A	N/A	N/A				
UE18	Heart Failure	Patients for whom the intervention is captured (titration of drugs, education, care planning)	90.0%	90.0%	94.8%	YTD		100.0%	94.0%	100.0%	93.9%	81.0%	95.4%	97.3%	95.7%	95.8%				
UE19	Heart Failure	Percentage of GP practices that access the service	80.0%	80.0%	72.8%	YTD		36.1%	55.6%	72.2%	72.2%	77.8%	83.3%	83.3%	86.1%	88.9%				
CY01	CAHMS	First contact with CAMHS worker is within the same working day for emergency self harm referrals	90.0%	90.0%	100.0%	YTD		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	N/A				
CY02	CAHMS	Contact with CAMHS worker is within 9 days for urgent referrals/self harm follow ups	90.0%	90.0%	100.0%	YTD		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%				
CY03	CAHMS	All referrals of looked after children scoring 18 pts or more on SDQ are dealt with appropriately by a CAMHS worker.	100.0%	100.0%	100.0%	YTD				100.0%			100.0%			100.0%				
CY04	CCNT	% referrals to CCNT during operational hours responded to and action taken within 2 hrs by CCNT via telephone or home visit	85.0%	85.0%	89.5%	YTD		88.8%	93.3%	81.8%	96.1%	88.3%	99.2%	100.0%	90.4%	72.9%				
CY05	Community Paediatric Medical	Timely medical assessments for SEN within 42 days of receipt of referral	90.0%	90.0%	95.9%	YTD		50.0%	100.0%	100.0%	92.9%	100.0%	100.0%	100.0%	91.7%	100.0%				
CY06	Community Paediatric Medical	Timely medical assessments within 1 working day of receipt of referral of children assessed as Section 47	90.0%	90.0%	96.0%	YTD		100.0%	83.3%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	N/A				
CY07	Community Paediatric Medical	Timely medical assessments of looked after children within 28 days of receipt of referral	90.0%	90.0%	100.0%	YTD		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%				
CY08	Health Management	% data records inputted to relevant systems within 7 days of receipt	90.0%	90.0%	89.5%	YTD		88.6%	91.1%	92.2%	94.2%	93.1%	88.3%	80.6%	83.1%	92.4%				
CY09	Health Management	% records that are accurate on relevant systems	90.0%	90.0%	98.8%	YTD		99.2%	99.2%	99.0%	98.9%	99.1%	98.5%	98.4%	98.3%	98.3%				
CY10	Health Management	% child health system returns completed and submitted within required timescales.	100.0%	100.0%	93.3%	YTD		n/a	100.0%	100.0%	n/a	100.0%	100.0%	100.0%	75.0%	100.0%				
CY11	Health Visiting	Children receiving primary birth visit within 14 days of birth	100.0%	100.0%	95.7%	YTD				95.5%			96.2%			95.4%				
CY12	Health Visiting	Children who by 32 months have been offered a 2 yr check as in HCP	100.0%	100.0%	95.4%	YTD				93.0%			96.8%			96.8%				
CY26	Safeguarding Health	% young offenders receiving an offer of a health assessment NB Deleted but will provide	80.0%	80.0%	54.2%	YTD		100.0%	77.8%	100.0%	100.0%	53.8%	81.3%	0.0%	0.0%	0.0%				
CY27	School Nursing	% new contacts for self harm acknowledged within 2 working days	80.0%	80.0%	100.0%	YTD		100.0%	100.0%	100.0%	100.0%	N/A	100.0%	100.0%	100.0%	100.0%				
CY28	School Nursing	Activity profile relating to children starting special school with complex /additional needs	B/Line Yr					Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes				
CY30	SALT Children	% referrals for children <6 months old with dysphagia whose initial assessment by a qualified therapist and management plan has commenced within 14 days of referral	80.0%	80.0%	0.0%	YTD		N/A	0.0%	N/A	N/A	N/A	N/A	0.0%	N/A	N/A				
CY14	Occupational Therapy	Patients for whom reason for referral is captured	80.0%	80.0%	95.4%	YTD		90.6%	97.7%	92.7%	92.7%	98.0%	95.7%	95.5%	98.2%	100.0%				
CY16	Occupational Therapy	Allocated equipment for 0-5 year olds is reviewed at 4 monthly intervals	95.0%	95.0%	92.9%	YTD		100.0%	N/A	100.0%	100.0%	N/A	100.0%	100.0%	100.0%	66.7%				
CY17	Occupational Therapy	Allocated equipment for 5-11 yr olds is reviewed at 8 monthly intervals	95.0%	95.0%	89.5%	YTD		71.4%	100.0%	100.0%	100.0%	100.0%	100.0%	66.7%	83.3%	100.0%				

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2014-15: Full Set of KPIs Scorecard - PCFT

Appendix E

Reporting Month: Feb-2015

Code	Measures	Indicators	Target 2014-15	Year to Date Performance			2014-15	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Comments
				Target	Actual	Period Used				Q1 14-15			Q2 14-15			Q3 14-15			Q4 14-15	
CY18	Occupational Therapy	Allocated equipment for 11-16 yr olds is reviewed at annual intervals	95.0%	95.0%	100.0%	YTD		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%				
CY20	Orthoptics	% children offered an assessment /test in an orthoptic led visual screening programme by end of reception year	95.0%	95.0%	50.6%	YTD		40.8%	53.1%	65.6%	78.2%	86.1%	90.8%	2.0%	11.2%	19.0%				
CY21	Physiotherapy	Patients for whom the reason for referral is captured	80.0%	80.0%	95.4%	YTD		90.6%	97.7%	92.7%	92.7%	98.0%	95.7%	95.5%	98.2%	100.0%				
UE01	Urgent Care	Access - % of urgent patients whose referral is triaged and first contact is within 6 hours of the referral being received	90.0%	90.0%	83.8%	YTD		91.1%	90.1%	92.3%	71.0%	77.5%	84.4%	81.7%	88.2%	83.1%				
UE02	Urgent Care	Access - % of referrals of patients for cellulities related IV Therapy whose referral is triaged within 4 hours and first contact is within 1 working day of referral	90.0%	90.0%	88.9%	YTD		N/A	100.0%	100.0%	100.0%	N/A	100.0%	0.0%	100.0%	N/A				
UE03	Urgent Care	Data - % of patients for whom the reason for referral is captured	90.0%	90.0%	99.9%	YTD		100.0%	100.0%	99.4%	100.0%	100.0%	100.0%	100.0%	99.4%	100.0%				
UE04	Urgent Care	Quality - % of patients for whom completion of full care regime and discharge plan from the service has occurred	80.0%	80.0%	100.0%	YTD		100.0%	100.0%	N/A	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%				
UE05	Urgent Care	Quality - % of GPs informed about the outcome of patients discharge from urgent care team and given case summary	90.0%	90.0%	100.0%	YTD		100.0%	100.0%	N/A	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%				
UE06	Enhanced Care (medically stable patients cared for by	Access - % of non-urgent patients whose referral is triaged within 3 working days and first attendance is commenced within 10 working days following triage	90.0%	90.0%	86.0%	YTD		87.8%	93.9%	93.5%	81.4%	76.9%	74.2%	84.7%	92.0%	96.2%				
UE07	Enhanced Care (medically stable patients cared for by	Data - %patients for whom the reason for referral is captured	90.0%	90.0%	99.4%	YTD		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	98.2%	95.9%				
UE08	Enhanced Care (medically stable patients cared for by	Quality - % of appropriate non-urgent patients on the enhanced care caseload who have an advanced care plan that identifies their preferred place of care	B/Line Yr					No data												
UE09	Enhanced Care (medically stable patients cared for by	Quality - %of patients on Enhanced Care Team caseload who die in their preferred place of care.	B/Line Yr					No data												
UE10	Enhanced Care (medically stable patients cared for by	Additional - % GPs informed about the outcome of inactive patients on the enhanced caseload and provided with a care summary	90.0%	90.0%	100.0%	YTD		100.0%	100.0%	N/A	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%				
UE11	IV Therapy	Access - % of patients with long term IV needs whose first contact with the IV team in home setting is within 1 working day of hospital discharge	B/Line Yr		86.1%	YTD		100.0%	100.0%	100.0%	75.0%	83.3%	100.0%	75.0%	N/A	33.3%				
UE12	IV Therapy	Data - % of patients for whom the reason for IV Therapy is captured	B/Line Yr		98.6%	YTD		100.0%	100.0%	92.3%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%				
UE13	IV Therapy	Data - % of patients for whom completion of a patient satisfaction survey is completed and reviewed.	90.0%	90.0%	100.0%	YTD		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%				
UE14	IV Therapy	Audit - % of patients whose outcome of care has been evaluated at 72 hours using a tool that identifies achievement against predicted 72 hours care outcomes and reasons for any variance (this applies	90.0%					No data												
IND-C1	Health Visitors	Number of mothers who received a first face to face antenatal contact with a Health Visitor.	B/Line Yr					No data												
D04	New to Follow up Ratio	In Development	B/Line Yr					No data												