



TRAFFORD
COUNCIL

**AGENDA PAPERS FOR
HEALTH SCRUTINY COMMITTEE MEETING**

Date: Wednesday, 3 December 2014

Time: 6.30 pm

**Place: Committee Room 2 and 3, Trafford Town Hall, Talbot Road, Stretford M32
0TH**

A G E N D A	PART I	Pages
1.	ATTENDANCES	
	To note attendances, including Officers, and any apologies for absence.	
2.	MINUTES	1 - 6
	To receive and, if so determined, to agree as a correct record the Minutes of the meeting held on 3 rd September 2014.	
3.	DECLARATIONS OF INTEREST	
	Members to give notice of any interest and the nature of that interest relating to any item on the agenda in accordance with the adopted Code of Conduct.	
4.	INTEGRATED CARE UPDATE	7 - 16
	To receive a presentation from the Joint Director for Adults (Social Care).	
5.	NORTH WEST AMBULANCE SERVICE RESPONSE PERFORMANCE	
	To receive an update from the Chair following a meeting with representatives from the North West Ambulance Service.	
6.	DISTRICT NURSING IN TRAFFORD	
	To receive an oral update from Councillor Chilton regarding the potential for the Health Scrutiny Committee to support and enhance the review of district nursing in Trafford currently being commissioned by Trafford Clinical Commissioning Group and Pennine Care NHS Foundation Trust.	

7. GREATER MANCHESTER HEALTH SCRUTINY COMMITTEE 17 - 22

To receive an update on the work of the Greater Manchester Health Scrutiny Committee from the Vice Chairman. The minutes of the meeting on the 8 October are attached

8. UPDATES ON HEALTH ISSUES

To receive an update from the Democratic and Performance Services Manager on current health scrutiny issues and the recent work of associated bodies.

(a) TRAFFORD COUNCIL RESPONSE TO HEALTHIER TOGETHER CONSULTATION 23 - 24

(b) GREATER MANCHESTER JOINT HEALTH SCRUTINY RESPONSE TO HEALTHIER TOGETHER CONSULTATION 25 - 32

(c) JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE MINUTES 2ND SEPTEMBER 2014 33 - 36

(d) TRAFFORD CCG PERFORMANCE REPORT 28TH OCTOBER 2014 37 - 70

9. URGENT BUSINESS (IF ANY)

Any other item or items (not likely to disclose "exempt information") which, by reason of special circumstances (to be specified), the Chairman of the meeting is of the opinion should be considered at this meeting as a matter of urgency.

10. EXCLUSION RESOLUTION (REMAINING ITEMS)

Motion (Which may be amended as Members think fit):

That the public be excluded from this meeting during consideration of the remaining items on the agenda, because of the likelihood of disclosure of "exempt information" which falls within one or more descriptive category or categories of the Local Government Act 1972, Schedule 12A, as amended by The Local Government (Access to Information) (Variation) Order 2006, and specified on the agenda item or report relating to each such item respectively.

THERESA GRANT

Chief Executive

Membership of the Committee

Councillors J. Lloyd (Chairman), Mrs. P. Young (Vice-Chairman), Mrs. J.E. Brophy, Mrs. A. Bruer-Morris, R. Chilton, J. Harding, D. Higgins, K. Procter, B. Shaw, S. Taylor, Mrs. V. Ward and A. Mitchell (ex-Officio)

Further Information

For help, advice and information about this meeting please contact:

Rhys Hughes, Democratic Services

Tel: 0161 912 2019

Email: rhys.hughes@trafford.gov.uk

This agenda was issued on **Tuesday, 25 November 2014** by the Legal and Democratic Services Section, Trafford Council, Trafford Town Hall, Talbot Road, Stretford M32 0TH.

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HEALTH SCRUTINY COMMITTEE

3 SEPTEMBER 2014

PRESENT

Councillor J. Lloyd (in the Chair).

Councillors P. Young (Vice-Chairman), J. Brophy, A. Bruer-Morris, R. Chilton, J. Harding, K. Procter, S. Taylor and V. Ward

In attendance

Diane Eaton	Joint Director for Adult Social Care
Jo Maloney	Senior Democratic Services Officer
Rhys Hughes	Democratic Services Officer

Also in attendance

Linda Devereux	Service Specialist, NHS England Cheshire, Wirral and Warrington Area Team
Claire Yarwood	Director of Finance, NHS England (Greater Manchester).
Madeline Edgar	Senior Communications Manager, North West Ambulance Service NHS Trust
Pat McFadden	Central Sector Manager, North West Ambulance Service NHS Trust
Dr John Crampton	Medical Director, University Hospital of South Manchester NHS Trust
Ann Day	Chair of Trafford Healthwatch

APOLOGIES

Apologies for absence were received from Councillors D. Higgins, B. Shaw and A. Mitchell

14. DECLARATIONS OF INTEREST

The following declarations of personal interests were reported to the meeting:

Councillor Brophy in relation to her employment by the Pennine Acute Hospitals NHS Trust.

Councillor Bruer-Morris in relation to her employment within the NHS.

Councillor Chilton in relation to his employment by General Medical Council.

Councillor Harding in relation to her role with the Save Trafford General campaign.

Councillor Lloyd in relation to the Stroke Association.

Councillor S. Taylor in relation to her employment within the NHS.

15. MINUTES

RESOLVED: That the Minutes of the meeting held on 23 July 2014 be agreed as a correct record and signed by the Chair.

16. SPECIALISED CANCER SERVICES

The Committee received a presentation on the proposed redesign of NHS specialised cancer services from Linda Devereux, the Service Specialist for NHS England's Cheshire, Wirral and Warrington Area Team who commission cancer services for the North-West region, and Claire Yarwood, the Director of Finance for NHS England (Greater Manchester). The presentation set out plans to improve outcomes of treatment and bring services in line with national standards by concentrating complex diagnostic and surgical expertise with a smaller number of specialist providers in centres of excellence.

It was explained that the existing arrangements were inefficient, with too many hospitals providing similar specialised services resulting in issues including inconsistent distribution of patients between providers, some providers not having adequate numbers of specialist staff and core quality standards not being met in some centres. The Committee was informed that the concentration of specialist cancer services under the plans would address these issues and improve clinical outcomes and patient experience.

It was emphasised that the changes related specifically to specialist surgery and that most cancer treatment would remain the same. It was anticipated that the changes to service delivery would affect less than 700 patients undergoing this type of surgery, so the scale of change was relatively minimal.

The Committee asked a series of questions on the impact that proposals might have on patients' travel requirements, the existing specialist teams and the hospitals affected. Linda Devereux stated that the effect on patients having to travel further would be revealed through the consultation but acknowledged that some patients will inevitably have to travel further when specialised services are reorganised. It was confirmed that specialists were expected to transfer to new sites and that providers would be required under the contracting framework to ensure that specialist expertise was retained. It was further stated that patient numbers handled by surgeons would comply with national guidelines following the adoption of the plans and that an emphasis was being placed on maintaining the stability of the service.

The Committee asked that comparative figures be provided to illustrate the impact on service delivery in areas where the model had already been implemented. It was also requested that the Committee were kept up to date with developments in the procurement process, particularly in relation to specialist urological cancer treatment.

The Chair thanked Linda Devereux and Claire Yarwood for their presentation and for addressing the Committee's concerns.

RESOLVED:

- 1) That the presentation be noted;
- 2) That the Committee's comments be fed in to the consultation;
- 3) That information be provided to the Committee to show how the implementation of the model for delivering specialised cancer services in other areas had affected clinical performance and patient experience; and

- 4) That the Committee be kept informed of the result of the procurement process.

17. NORTH WEST AMBULANCE TRUST - FIVE YEAR PLAN AND PERFORMANCE

Madeline Edgar, Senior Communications Manager, and Pat McFadden, Central Sector Manager, of the North West Ambulance Service NHS Trust (NWAS) delivered a brief summary of the Service's 5 Year Plan and gave an update on the performance of NWAS in the Trafford area.

Statistics had been submitted to the Committee which showed that ambulance response times in Trafford were significantly slower than those in the other council areas of Greater Manchester. The Committee expressed their concerns in respect of this, asking why performance was comparatively weak in Trafford and whether measures were being taken by NWAS to improve this.

The Central Sector Manager said that he shared the Committee's concerns and attributed the performance levels to NWAS experiencing resource challenges in respect of meeting increasing public demand. Greater demands on the Service had caused response time statistics to decline recently, and the quieter period anticipated over the summer months, which usually allowed statistics to level out, had not materialised. It was explained that the comparative statistics for Trafford may also be affected by the virtue of Trafford's large geographic area and the natural concentration of available ambulances picking up calls as they leave the acute hospitals in more central locations.

It was emphasised that it was necessary to be prudent in the use of the limited resources available to deliver ambulance services in the most effective way possible, and the success of a GP referral scheme in reducing the number of patients requiring ambulance attendance was cited. The development of integrated pathways had also been expected to ease the pressure on the Service, but increasing demands on resources had led to this mitigating the extent of Service pressure, rather than generating an improvement in performance statistics. Measures had also been taken to identify frequent callers and an information exercise had led to a reduction in calls from some addresses.

The Committee requested that NWAS provided a statistical breakdown of ambulance response times in Trafford in order to help identify potential differences in results between the North and South of the borough. It was also requested that statistical information be provided to quantify the impact of ambulances being delayed, if possible.

RESOLVED:

- 1) That the update be noted;
- 2) That a breakdown of ambulance response times in Trafford, categorised by postcode, be submitted to the Committee; and
- 3) That information be provided to the Committee showing the practical impact of increased ambulance response times.

18. UPDATE - UNIVERSITY HOSPITAL OF SOUTH MANCHESTER

Dr John Crampton, Medical Director of the University Hospital of South Manchester NHS Foundation Trust, attended the Committee meeting to give an update of the current issues facing the Trust and the proposals that the Trust had developed in response. The Medical Director informed the Committee that Nora Ann Heery, the Trust's Deputy Chief Executive, had been due to attend the meeting but had been called away at short notice and wished to pass on her apologies for being unable to attend.

It was explained that the Trust's main challenges were in securing the Trust's financial stability, and ensuring that the Trust was assigned the status as a centre of excellence for delivering specialist services following the changes to commissioning arrangements under the Healthier Together programme. The Medical Director specified the financial pressures that the Trust faced and set out a recovery plan that the Trust's leadership was confident would deliver financial stability, and which had been endorsed by Monitor, the sector regulator for health services in England.

The Healthier Together proposals (Minute 19 refers) to reduce the number of specialist providers and to concentrate expertise in a small number of centres of excellence were identified as a potential risk to the continuation of specialist services provided by the Trust. The Trust was said to have significant expertise in heart, lung and vascular treatments, and the importance of securing specialist status to enable the continuation of these services was emphasised to the Committee. The Medical Director expressed that the Trust's expertise in these areas and its strong portfolio of secondary and tertiary services meant that the Trust was well placed to bid for the commission of these services, and the Committee offered its full support to the Trust in securing specialist status.

In response to concerns raised by the Committee of delays in patient discharges, the Medical Director said that this was largely due to pressures on the availability of hospital beds, but confirmed that measures had been taken to address delays such as attention being given to the effective timing of ward rounds to promote timely discharges and avoid unnecessary delays. This was said to have halved the number of delayed discharges in the last 6 months.

The Committee identified an issue with low staffing levels for nurses, with concern that a freeze on recruitment would exacerbate the problem. The Medical Director stated that staffing levels complied with national guidelines and reiterated the importance of the Trust operating services as efficiently as possible.

Members also discussed with the Medical Director ongoing concerns regarding pressures on A+E services at University Hospital of South Manchester, Wythenshawe.

The Chair thanked the Medical Director for giving a very clear and helpful presentation and reiterated the Committee's support for the Trust's bid for specialist status, which would be reflected in the Committee's response to the ongoing Healthier Together consultation.

19. HEALTHIER TOGETHER - CONSULTATION

Following the presentation of the Healthier Together consultation at the Committee's meeting on 23 July 2014, members had agreed to collate their views in advance of the September meeting to form a formal response on behalf of the Committee.

In relation to the consultation process, the Committee raised concerns in respect of complexity of the consultation and the rationality of the questioning. The Committee was also concerned that three hospitals had already been designated speciality status in advance of the consultation, pre-judging the outcome to a certain extent and limiting the range of options available. It was observed that the University Hospital of South Manchester was not one of the three hospitals that had been given speciality status, and given the clinical and geographical advantages of the hospital, sought assurances that due consideration would be given for these factors.

The Committee noted that the Healthier Together consultation was taking place at the same time as consultations in respect of the 'New Health Deal' and the South Sector Review, and submitted that an integrated approach to these consultations would have given a better opportunity for a more holistic view of the potentially very significant implications for local providers.

RESOLVED: The Committee agreed a number of key issues to be incorporated in to its final response to the consultation, and agreed that authority to finalise this be delegated to the officers in consultations with the Chair and Vice-Chair.

20. HEALTH SCRUTINY WORK PROGRAMME

The Committee had been asked in advance of the meeting to consider issues that they believed merited consideration for inclusion in the Committee's work programme. Three proposals were outlined by members of the Committee which concerned addressing childhood obesity, district nursing services and mental health provision in Trafford.

The officers emphasised the importance of developing a work programme which would maximise effective outcomes with close regard for the resources available to the Committee, and the Chair specified that any potential topics should be clearly focused and specify attainable outcomes. In consideration of this the Chair requested that the officers re-circulate the assessment form to members of the Committee, accompanied by enhanced guidance to help with the formulation of potential study areas, with forms to be returned to officers promptly.

RESOLVED:

- 1) That officers circulate an updated form accompanied by enhanced guidance on criteria for consideration in the proposal of potential work programme areas; and
- 2) That members wishing to propose a topic complete and return the form to the officers.

21. JOINT HEALTH SCRUTINY COMMITTEE

The Chair provided an update of the matters discussed at the meeting of the Joint Health Scrutiny Committee on 2 September 2014.

RESOLVED: That the update be noted.

The meeting commenced at 6.30 pm and finished at 9.12 pm

Integrated Care: Trafford's Journey

3rd December 2014

Diane Eaton



Timeline

February 2009

Trafford PCT approves strategy to develop integrated care

Autumn 2009

PCT invites expressions of interest around providers around delivering integrated care

2007

CYP integrated area model established

April 2009

Provider/commissioner separation between Trafford PCT and community health services

April 2010

£2million from PCT to fund "proof of concept year" around vertical integration of community health, acute services and "vanguard" GP practices

April 2011

Trafford community health services goes into Bridgewater

December 2010

Trafford Healthcare Trust announces it is seeking acquisition; community health services can no longer be integrated

Focus shifts to adult health and social care integration

October 2011

Unscheduled Care Business Case submitted, ultimately resulting in the commissioning of the Community Enhanced Care Service

March 2012

Health and Social Care Act receives royal assent

April 2012

Trafford Healthcare Trust subsumed into Central Manchester Foundation Trust

November 2013

Community Enhanced Care service launched - aim to reduce admission to acute services

April 2013

PCFT takes over operation of Trafford community health

April 2014

Adult Integrated Health and Social Care Model phase 1 initiated

Timeline

April 2014

Gantt chart and project objectives established

Sub Groups commence work

Regular updates to PMG

Staff Road shows July 2014

Project lead seconded

Project Steering Group and framework

- Business support
- HR & OD
- New Working Models

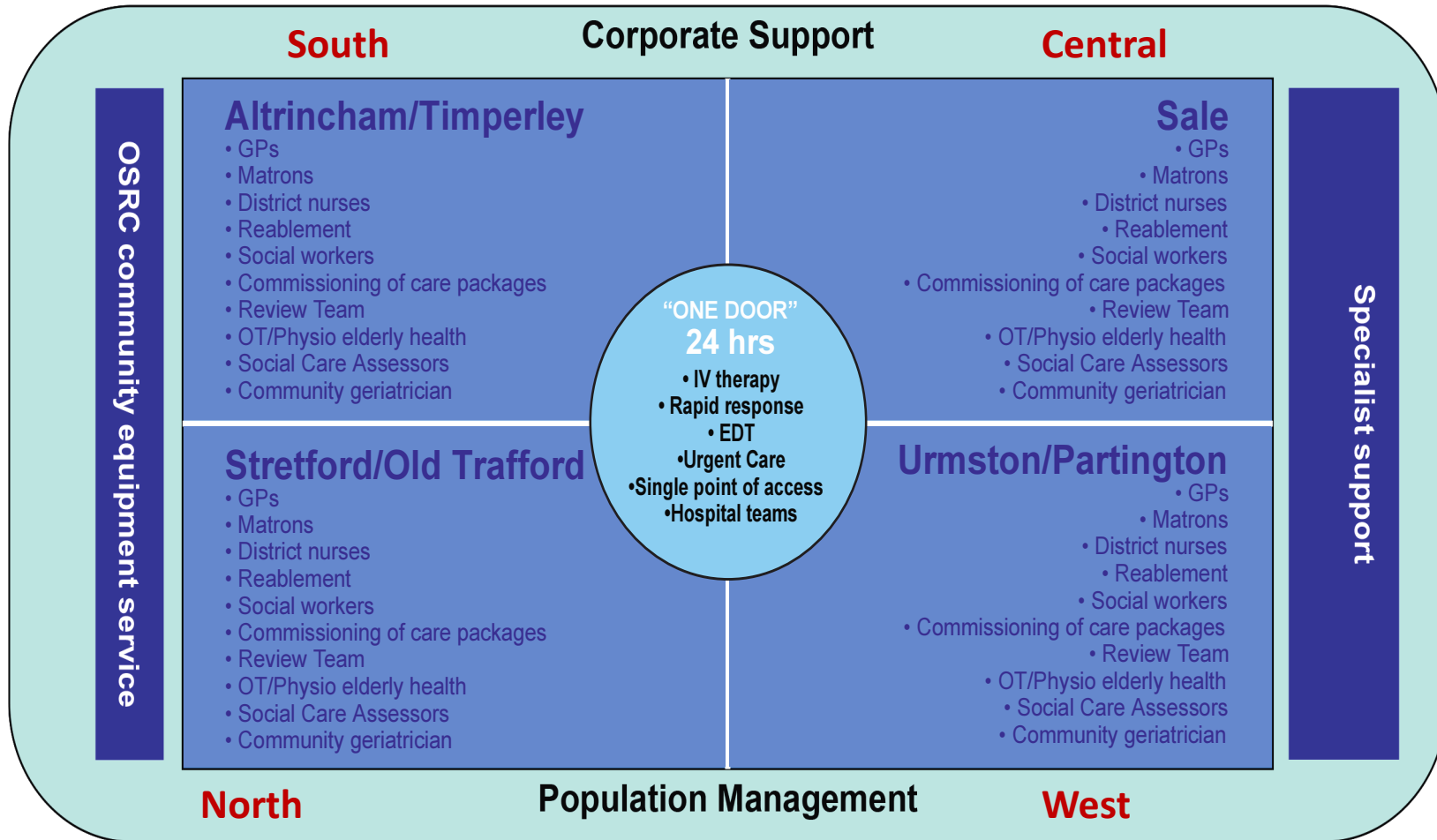
Phase 1 consultation on Management Structure – July 2014

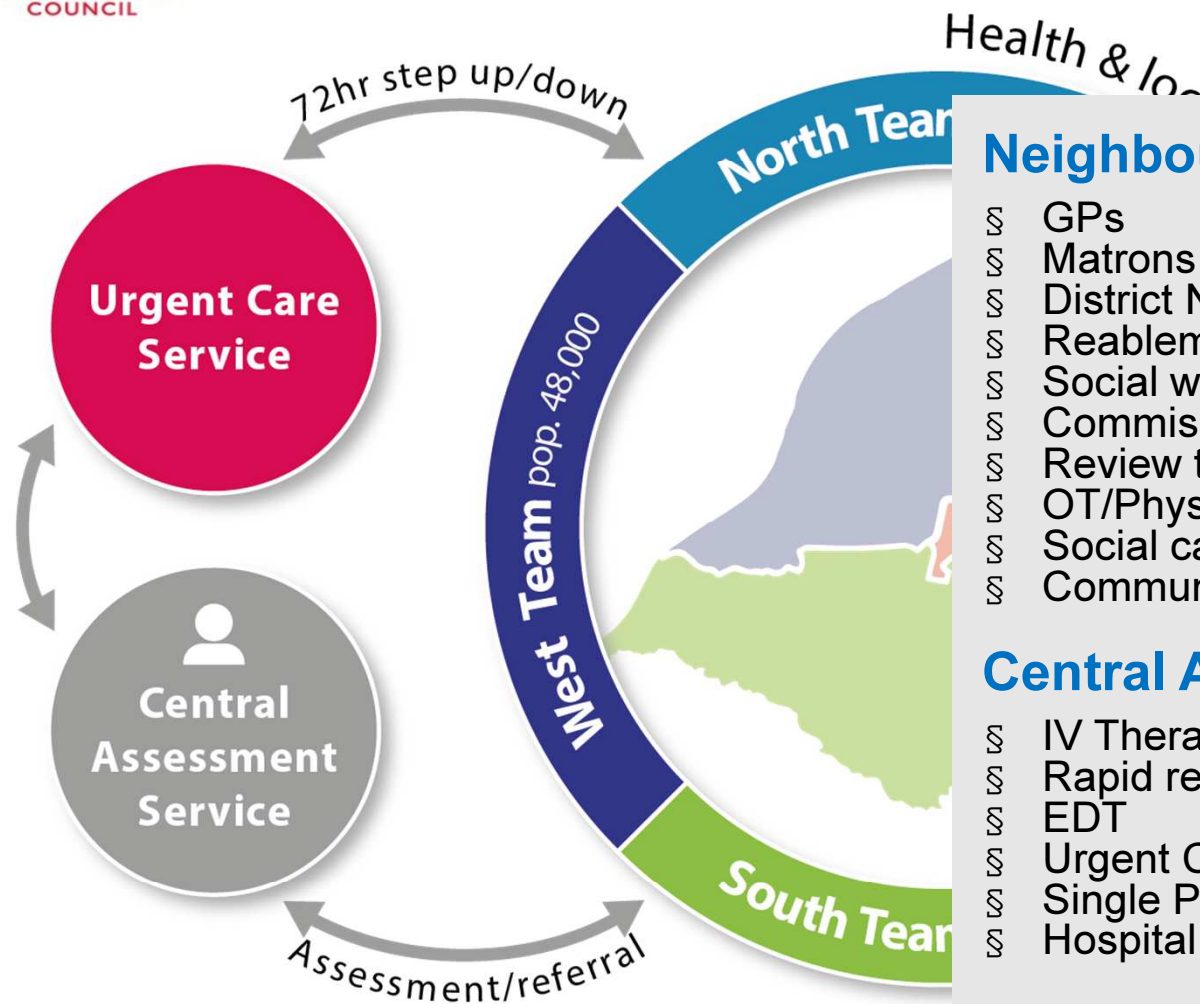
Consultation closes – end August

Sept HoS interviews
Oct – Operational Managers

OCTOBER 2014

The Service Delivery Model





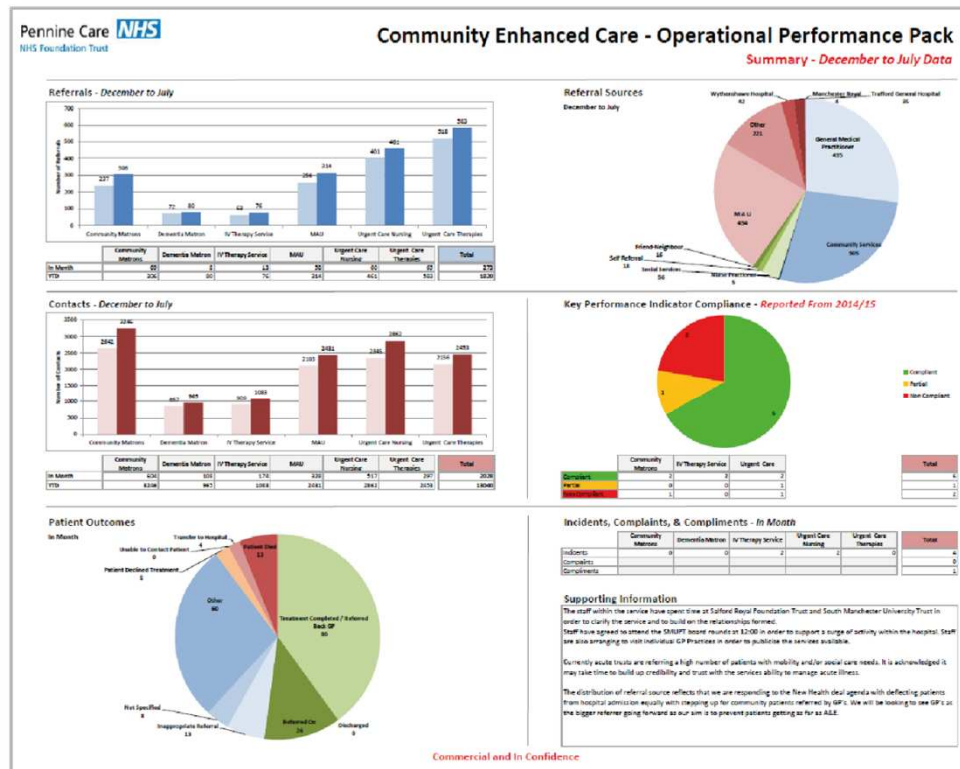
Neighbourhood Teams:

- ⌘ GPs
- ⌘ Matrons
- ⌘ District Nurses
- ⌘ Reablement
- ⌘ Social workers
- ⌘ Commissioning of care packages
- ⌘ Review team
- ⌘ OT/Physio elderly health
- ⌘ Social care assessors
- ⌘ Community geriatrician

Central Assessment Service:

- ⌘ IV Therapy
- ⌘ Rapid response
- ⌘ EDT
- ⌘ Urgent Care
- ⌘ Single Point of Access
- ⌘ Hospital teams

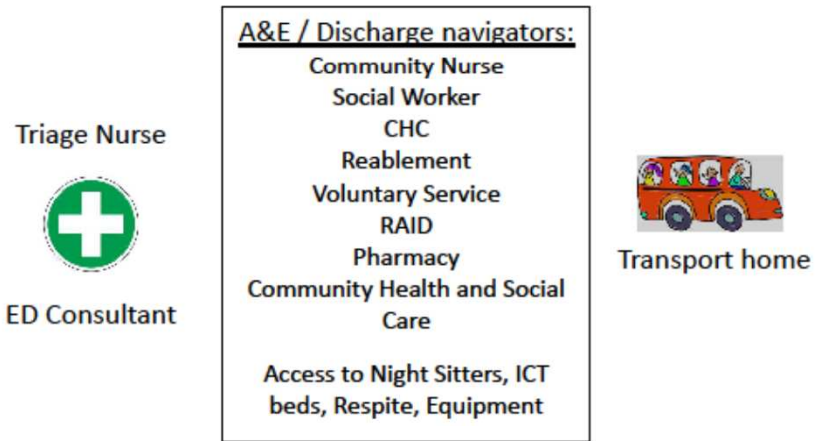
Community Enhanced Care



- § Launched November 2013, designed to prevent unnecessary admissions to acute
- § Critical to our integrated care offer
- § Collaboration with commissioners for market insight
- § Underpinned by shared data, designed around a seamless pathway
- § It takes time and effort to achieve change – but we are beginning to see the results

Hospital – “Not a day more”

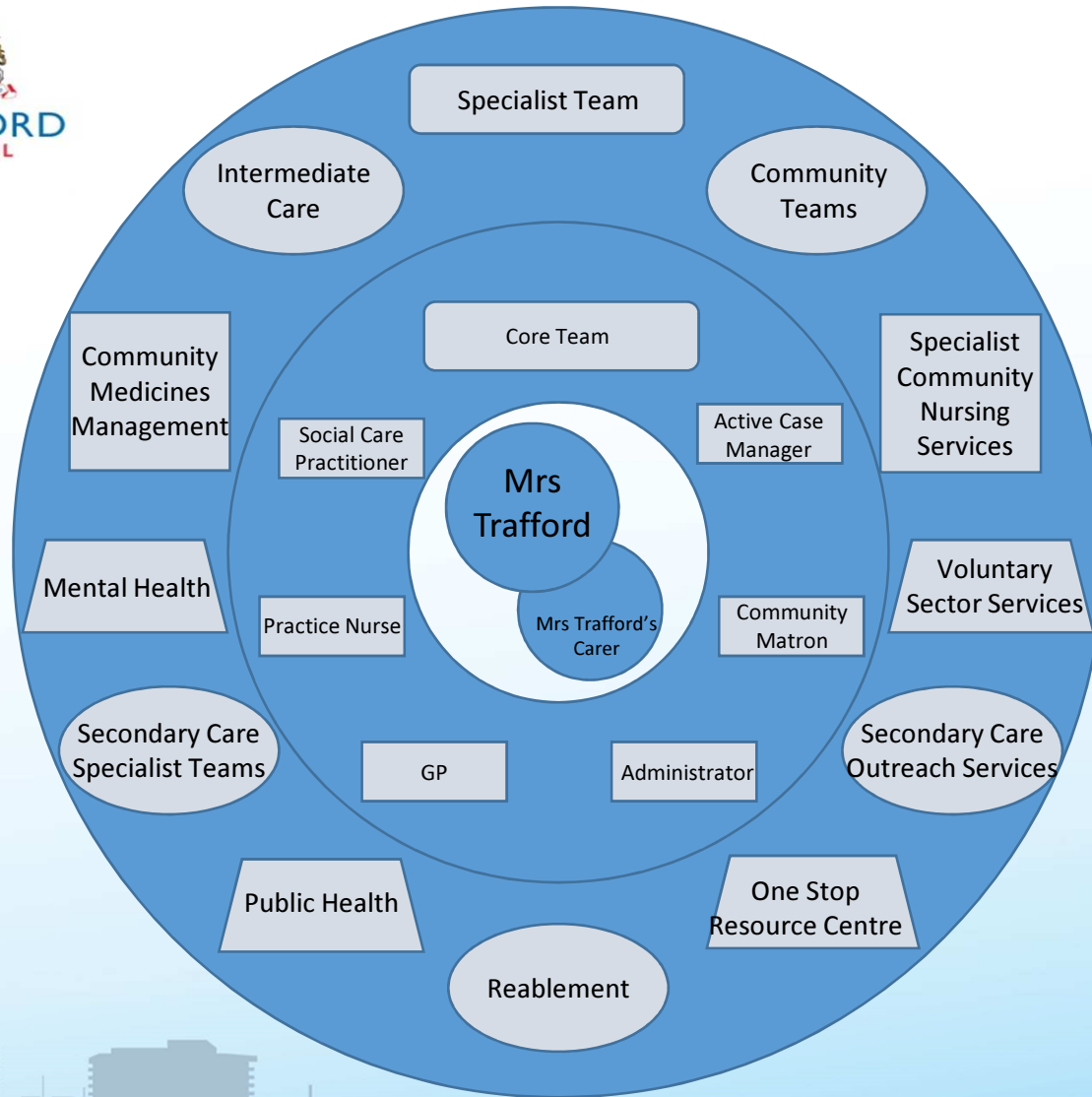
Front Door Team – Triage Team 8am - midnight

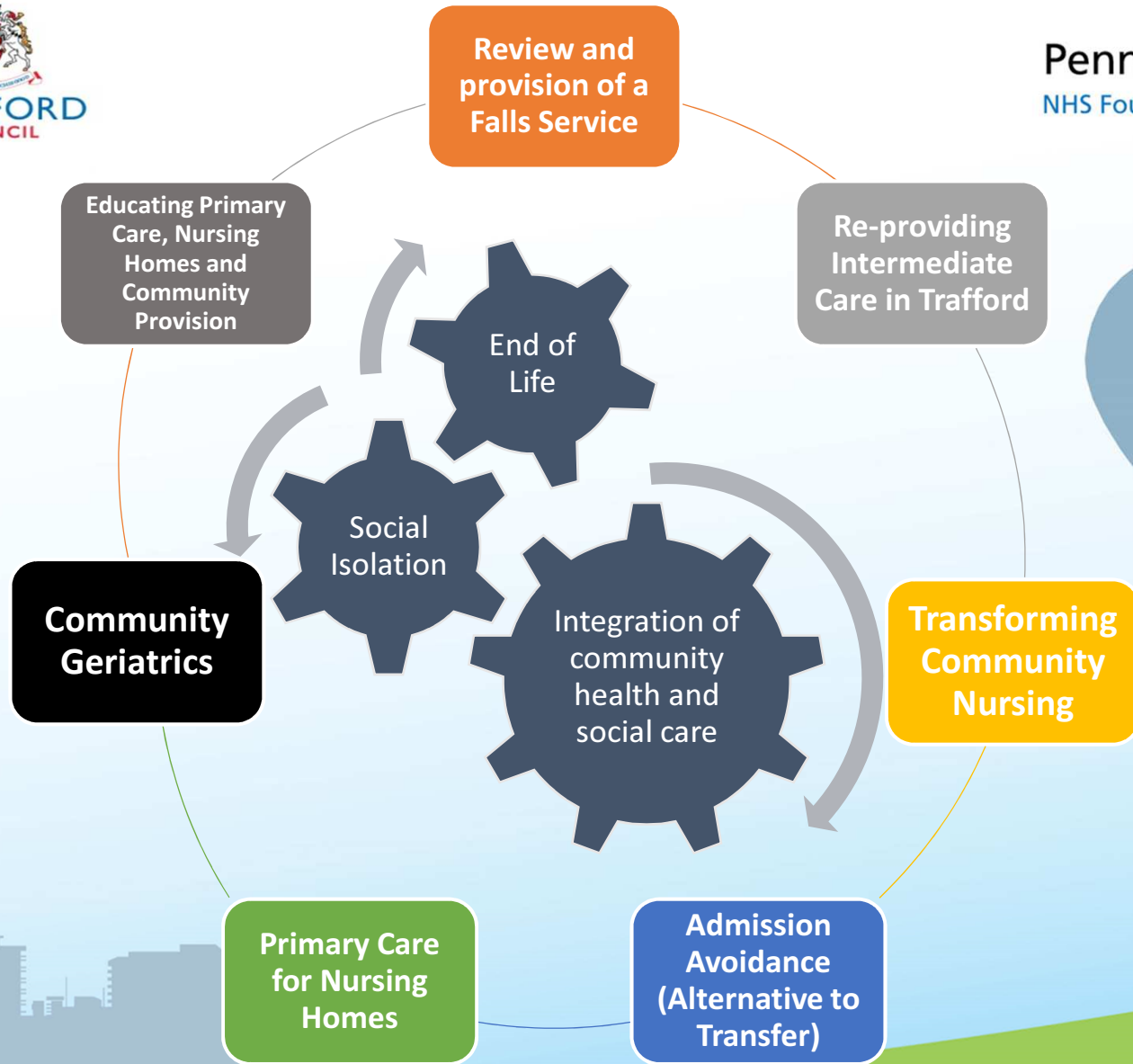


Triage Nurse 
ED Consultant

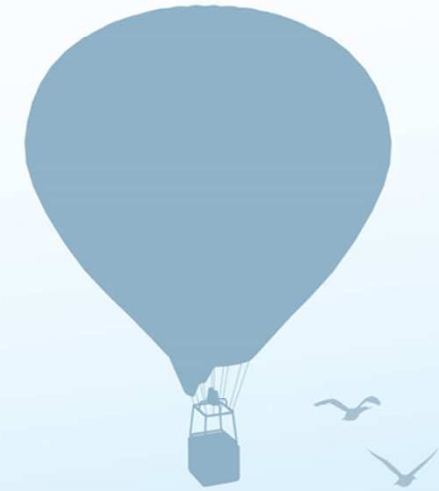
ONE RECORD – ONE PLAN







Any Questions?



**MINUTES OF THE GREATER MANCHESTER JOINT HEALTH SCRUTINY
COMMITTEE HELD ON 8 OCTOBER 2014 AT GMFRS, TRAINING CENTRE,
CASSIDY CLOSE, MANCHESTER.**

Present:

Bury Council	Councillor Peter Bury
Derbyshire CC	Councillor Caitlin Bisknell
Manchester CC	Councillor Glyn Evans
Oldham Council	Councillor Brian Ames
Salford CC	Councillor Val Burgoyne
Stockport MBC	Councillor Tom McGee
Tameside MBC	Councillor Claire Reynolds
Trafford MBC	Councillor Patricia Young
Wigan Council	Councillor John O'Brien (in the Chair)

Advisors/Officers:

AGMA	Warren Heppolette
GM NHS	Sophie Hargreaves
GM NHS	Dr Martin Smith
JHOSC Pennine Acute	Alice Rea
Derbyshire CC	Jackie Wardle
GMIST	Andrew Burridge
GMIST	Julie Gaskell

HSC/14/57 APOLOGIES

Apologies were received from Councillor Linda Robinson, Councillor Asif Ibrahim and Steven Pleasant.

HSC/14/58 DECLARATIONS OF INTEREST

None were received.

HSC/14/59 MINUTES

RESOLVED/-

To approve the minutes of the meeting held on 3 September 2014 as a correct record.

HSC/14/60 HEALTHIER TOGETHER – RESPONSE TO QUESTIONS FROM THE PREVIOUS MEETING OF THE COMMITTEE

A report was submitted by GM NHS Healthier Together team giving further details to questions raised by the Committee at its previous meeting. This gave an update on peak period travel times.

RESOLVED/-

Report noted.

HSC/14/61 HEALTHIER TOGETHER - REPORT OF WIGAN COUNCIL HEALTH & SOCIAL CARE SCRUTINY COMMITTEE

A report was presented of the Wigan Council Health and Social Care Scrutiny Committee on its consideration of Healthier Together at its meeting on 11 August 2014.

RESOLVED\-

Response noted.

HSC/14/62 RESPONSES FROM HEATHWATCH BOLTON AND MANCHESTER CITY COUNCIL ON HEALTHIER TOGETHER

Responses received by the Committee from Healthwatch Bolton and Manchester City Council on Healthier Together were tabled at the meeting.

RESOLVED\-

1. That the responses be noted.
2. That further submissions from Healthwatch and local Scrutiny Committees would be circulated to the members. It was clarified that these bodies need to submit consultation responses to Healthier Together, and may provide these to the Joint Health Scrutiny for information.

HSC/14/63 HEALTHIER TOGETHER – COMMITTEE SUBMISSION TO THE CONSULTATION

A paper was presented by Andrew Burridge to the Committee which set out the GM Joint Health Scrutiny Committee's draft response to the NHS consultation on Healthier Together. Members were asked to consider and give comments to the response.

The meeting was informed that the draft response was captured from the minutes of the previous meetings of the Committee. The responses received by the Committee from Healthwatch Bolton, Manchester City Council along with any further submissions would be shared with members for information. The Committee may wish to consider all of these as evidence for its Final Report. .

A discussion followed during which Members highlighted their concern for public misconceptions surrounding the Healthier Together programme. It was felt that inaccurate messages had been received through incorrect language and confusing terminology used throughout the consultation. The Committee felt that this encouraged scepticism. The negative and incorrect perceptions surrounding the programme

could have been addressed by making basic and clear statements, and Healthier Together had not been successful in achieving this. Officers advised the meeting that “bitesize” documents explaining the programme, together with updated FAQs, had been produced to address this and had received good public feedback.

Members also believed that, in some cases, messages not giving the correct information had been issued by some Chief Executives of hospital trusts.

The Committee recognised its own role and responsibility for providing an accurate and balanced public statement on Healthier Together. Its own consultation response, and later Final Report, should be seen as important documents helping to ‘bust myths’ and increase public confidence.

A Member raised concern in relation to the wording in the draft response concerning transport. The Member felt that the emphasis in the Committee’s response was on patient rather than family/relative transport. The wording needed to reflect the Committee’s opinion on both aspects of the issues around transport. It was agreed that this would be taken on board in the final response.

Questions were raised regarding the understanding that hospitals within the conurbation had already begun to work collaboratively in respect of shared services, or that they may begin to do so as an inevitable consequence of the consultation. The Committee expressed concern on how this could impact negatively with the proposals for the Healthier Together initiative. The Committee felt that in principle this should be supported. However, the Committee stressed that Healthier Together was a statutory consultation on very specific hospital services. Collaboration between two or more hospital providers would also need consultation and public discussion or the public and partners would feel missed.

The Committee raised the following issues that were not being picked up in Healthier Together’s presentation of the proposals:

- 1) The strategic context of CCGs and Local Authorities planning for less activity in acute settings. There needs to be a clearer presentation of the challenges facing hospitals.
- 2) The primary and integrated care models that need to be impact prior to changes to the hospital network.
- 3) Healthier Together needs to make better sense of how 1) and 2) are specifically related to the proposed changes in the consultation document.
- 4) The impact on patients out of the Greater Manchester, in particular within High Peak.
- 5) There was not a clear enough description of what will happen in specialist hospitals and what remains in the non-specialist hospitals. The Committee felt that ‘specialist hospital’ had proved to be confusing terminology, given the existence of services across GM understood as ‘specialisms’. The Committee recognised that within its own meetings, and at public engagement events, Healthier Together had been able to make this clarification.

In conclusion, the Committee was of the opinion that its response to the NHS consultation required more robust statements around its anxiety of public understanding of the Healthier Together programme proposals. That clear statements should be made to give clarity around the case for change of standards within hospitals, the need for change in neighbourhood community services and better understanding of a shared single service.

RESOLVED\-

That a further draft response, to include observations raised as above, be circulated to Members for any additional comments.

HSC/14/64 UPDATE ON THE COMPLETION OF THE CONSULTATION

Sophie Hargreaves, GM NHS, gave a brief verbal overview to Members on details regarding the completion of the consultation.

Initial statistics included:

- Consultation completed on 30 September 2014 - online and paper responses would still be received until 24 October 2014.
- Over 200,000 consultation documents distributed.
- 400,000 leaflets distributed to households during the first two weeks of the consultation period.
- Over 183 public consultation events and 200-300 CCG held events.
- Over 40,000 unique uses of the Healthier Together website.
- A leaflet drop to every household undertaken within the last few weeks of the consultation.
- 12,700 (reported two weeks prior to the meeting) completed consultation documents and increasing. A final figure (broken down geographically) will be reported on 24 October 2014.

The Committee was informed that next steps included full analysis of the consultation results. That the Committees in Common (CiC) would meet to agree a staged decision making process based upon criteria, other models of care/options proposed, the number of specialised hospitals and identification of which sites would collaborate together.

In response to a query raised by a Member, it was advised that it was difficult to determine a timescale for implementation of the Healthier Together programme. This was mainly due to how long the evaluation procedure would take and whether or not a procurement process would be required. It was envisaged that a decision by the CiC would not be achieved until 2015 and that, if agreed, implementation of the programme would be incremental.

In respect of the reported household leaflet drop, Members from Manchester, Trafford, Bury and Stockport stated that they were not aware of their residents receiving this information. The Chair asked that this would be investigated and addressed by the Healthier Together team.

RESOLVED\-

1. To note the update.
2. That the Healthier Together team would investigate the household leaflet distribution in Manchester, Trafford, Bury and Stockport.
3. That a final report summarising the consultation be brought to the next meeting of the GM Joint Health Scrutiny Committee.

HSC/14/65 ACUTE HOSPITAL PROVIDERS

Item deferred to the meeting of the GM Joint Health Scrutiny Committee on 26 November 2014.

HSC/14/66 SINGLE SERVICE MODEL

Dr Martin Smith, GM NHS, verbally presented to the Committee key aspects of the proposed single service model recommended for some aspects of care (Accident and Emergency, Acute Medicine and General Surgery) to achieve improved hospital standards.

The Committee was reminded that at present hospitals work in different ways, some working in silos, and that the standard of care received can vary greatly. There are currently not enough trained specialist doctors and nurses to meet the quality standards at every GM hospital.

Dr Smith confirmed that a single service model helping staff to work better together and share senior staff would achieve an enhanced quality standard of care.

In summary, Dr Smith gave an outline of proposals stating:

- That all accident and emergency services will remain as present and be upgraded.
- That all outpatient departments will remain as present and be upgraded.
- That moderate to low risk surgery would be undertaken locally.
- Those only changes would be made with regard to acute general (not cardiac, plastic etc) and highly specialised/complex elective surgery.

The Committee thanked Dr Smith for his comments as this was felt to be the simplest and clearest descriptions of the proposals that it had received. There was a view that the need to describe the proposals in the context of overall public service reform, and the integrated and primary care dimensions, had unhelpfully complicated the narrative.

The Committee reiterated its concern regarding the lack of clear messages and terminology used when describing the single service model. The Chair felt that the simple explanation of patients being taken to where they would be best treated and achieve the best medical outcome with clinicians being placed where they were required, was not being delivered to the public. It was suggested that a basic low cost explanation leaflet be produced by the team on explaining the fundamental principles of Healthier Together would be useful. The Committee recognised that the decisions arising from Healthier Together could be taken after the General election, or potentially later if the work requires a procurement exercise. As a result, the Committee wished to see further communication to the public and partners following the consultation period. The Committee suggested a “You said : We did” approach.

RESOLVED\-

1. That the update be noted.
2. That the possibilities of producing a low cost leaflet explaining the basic principles of Healthier Together be investigated by the Healthier Together team.

HSC/14/67 DATES OF FUTURE MEETINGS

Wednesday, 26 November 2014, 10am, GMFRS, Stretford Fire Station

Wednesday, 21 January 2015, 10am, GMFRS, Stretford Fire Station

Chair.....



Healthier Together
Committees in Common
c/o G.M. Service
Transformation
4th floor, 3 Piccadilly Place,
Manchester, M1 3BN.

Trafford Town Hall
Talbot Road
Stretford
M32 0TH

Telephone: 0161 912 4298
Fax: 0161 912 1277
Email: Joseph.Maloney@trafford.gov.uk
Minicom: 0161 912 2012
When phoning ask for: J. Maloney

Our ref:
Your ref:
Date: 30 September 2014

To Whomsoever it may concern,

**“Healthier Together”: Consultation Response from Trafford Council’s
Health Scrutiny Committee**

As Chairman and Vice-Chairman of Trafford Council’s Health Scrutiny Committee, we are writing to you on behalf of that Committee to advise of its views in relation to the current “Healthier Together” consultation in respect of Healthcare in Greater Manchester.

As a Committee, we have considered the consultation in detail on two occasions, have received a presentation from Dr. Jonathan Berry and Gina Lawrence, and heard the views of a number of key stakeholders. Our comments are summarised below.

The Consultation Proposals

The Committee has a number of principal concerns. Firstly, during the 12 weeks available, only two public meetings were scheduled in Trafford, and neither of these in the south or west of the borough, such as in Partington and Altrincham, which would have represented better coverage of the population in Trafford as a whole. Accessibility issues are already well known, notably in respect of patients in Partington who will potentially be faced with significant challenges in getting to a hospital, whatever the conclusions of this consultation. Secondly, the consultation is inherently complex, and the potential implications do not emerge clearly from the consultation documentation. By contrast, the questionnaire questions appear as simplistic, and in some cases directed at securing particular responses. On occasion, responses are likely simply to be made on the basis of the respondent’s physical proximity to a healthcare provider unit, and this will not necessarily promote a rational basis for any assessment decision. Finally, the Committee was very concerned that three hospitals had already been designated as Specialist Hospital sites in advance of the consultation. This effectively pre-judges the outcome to a significant extent, and does not promote thorough consideration of the range of available options.

The Consultation Context

The Committee is aware that the outcome of the process has potentially significant implications for the services provided at, and thus for the sustainability of, local providers. In responding to the previous “New Health Deal” consultation in respect of Trafford General Hospital, the Committee argued for an integrated approach between this and “Healthier Together”, which had already been announced. The context is further complicated by the South Sector Review. Current developments confirm the Committee’s view that an integrated approach to these consultations should have been followed, to allow a holistic view to be taken in the implications in the round, bearing in mind the many co-dependencies within the local health economy.

Impact on Local Health Provision

As indicated above, the Committee is seriously concerned at the prior designation of three hospitals as Specialist Hospital Sites. If this was being done, it is unclear to the Committee why the same did not apply to the University Hospital of South Manchester. The Committee is aware of a broad range of major specialisms which are already provided at the hospital. The hospital has major advantages, in terms of accessibility, for patients in South Manchester, Stockport and Trafford, and more broadly, for example via air ambulance; and its non-selection would be likely to generate significant transport issues for local patients. The Committee notes that a very significant proportion of Trafford patients currently attend UHSM. The Committee is also aware of significant qualitative advantages in some specialisms at UHSM, as compared to other potential specialist hospitals within the conurbation; and would welcome reassurance that such qualitative aspects will be taken into full account in any eventual selection decision.

Yours faithfully,

Councillors Judith Lloyd and Mrs. Patricia Young

(Chair and Vice-Chairman of Trafford Council’s Health Scrutiny Committee)

Item No. 4

Greater Manchester Joint Health Scrutiny Committee submission to the NHS consultation on Healthier Together

31 October 2014

1. Key comments

In fulfilling its duty to scrutinise these proposals the Greater Manchester Joint Health Scrutiny Committee has developed an informed understanding. The Committee recognises its own role in contributing to a clear understanding of the proposals. The Committee therefore wishes to preface its response to the consultation with clear statements about how the proposals have been presented and understood:

1. The hospital element of Healthier Together is at the heart of the consultation but has not been well understood.
2. The Committee itself, and sections of the public, at first found it difficult to understand the consultation. At Committee meetings and public events clinicians supporting the programme often gave the clearest explanations. Following presentations by Martin Vernon (Consultant Physician) and Martin Smith (A&E Consultant), the Committee wishes to stress that:
 - The proposals will not lead to the closure of any hospitals or Accident and Emergency Departments.
 - The hospital element of the consultation is, at heart, about which operating theatre a small but significant number of patients have their specialist or more complex surgery in.
 - The hospital proposals only relate to specific services for accident and emergency, acute medicine and general surgery in emergency circumstances.
 - The proposals will create two types of hospitals for these services, 'Specialist' and 'General'. The proposals will create between 4 and 5 'Specialist' hospitals in Greater Manchester, but *only for the services* described above. In other words, the many different services provided in hospitals – urology, sexual health, cancer and others, are unaffected. For example, one hospital's website in the South of the city region lists 148 different services on its website. Hospitals' own *specialisms*, like neuro-rehab at Salford Royal Foundation Trust, or burns at University Hospital South Manchester, are unaffected. The Committee felt that use of 'specialist' and 'specialism' terminology had created unnecessary confusion.
 - In the future, complex and high risk surgery will take place in the Specialist hospitals, and moderate to low risk surgery will take place locally. Once someone has received 'specialist' care in the Specialist hospital, they will return to their local General hospital.
 - For most patients there will be little change. The Committee heard that for A&E 10% of all patients need specialist care which equates to 100,000 patients a year. Each local General A&E will still treat 90% of the patients they do currently, which means that 95% of A&E patients will continue to attend the same hospital. For general surgery 90% of patients will attend the same hospital they currently do.

- In the future, all the hospitals in Greater Manchester, Specialist and 'General', will work together within a single service model. Clinicians argued that achievement of the single service model is more important than the location of the specialist sites. Achieving the single service model, and ensuring that all hospitals meet the standards that have been agreed (currently no hospital meets all the standards) will save lives and improve patient care in Greater Manchester.
 - The proposals have not been created in order to make savings, in fact they will slightly increase expenditure, but are driven by the desire to improve patient care.
3. The Committee recognises that the NHS is complex organisation and its own attempt to provide clear messages about the hospital elements runs to over a page. Moreover, at times public understanding has been muddled by the contributions of some politicians, pressure groups, and individual hospital trust boards. However, ensuring public confidence in hospital changes should be seen as of the utmost importance, and indeed is essentially a requirement of the statutory framework for consultation. Although the Committee feels there has been a genuine attempt to describe these proposals, Healthier Together should recognise the need to improve communication. Healthier Together have already begun to address these criticisms with the creation of 'Bite Size' fact sheets, and a leaflet sent to every household in Greater Manchester.
 4. The Committee's understanding is that the final decision for Healthier Together will be made in the new year, and may well be made after the General Election. The Committee recommends ongoing communication by the Healthier Together team which seeks to address the comments made in this response.
 5. Finally, the consultation recognises how dependent these hospital changes are upon primary care, particularly access to GP services, and local integration between health and social care. As discussed below, the Committee supports the overall strategic vision for reform, and particularly the need to improve primary care. The Committee particularly welcomes the primary care standards. The Committee recognises the value and ambition in a consultation which seeks to engage the public on the whole reform agenda and the interdependencies between the three key strands. However, it should be recognised that many individuals first concerns will be about changes to their local hospitals, and the Committee suggests that more can be done to address these concerns.

2. Background

During June 2014 the Committees of Common (CiC) of the Association of GM Clinical Commissioning Groups launched a consultation upon Healthier Together.

Under the Health Scrutiny Regulations the affected local authorities are required to appoint a Joint Scrutiny Committee for the purposes of responding to the Healthier Together consultation.

The Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 set out the responsibilities upon local authorities with regard to consultations by the NHS:

- *In summary, where a responsible person has under consideration any proposal for a "substantial development of the health service in the area of a local authority", or for*

“a substantial variation in the provision of such service” the person must consult the authority.

- *The affected authority may report to the Secretary of State in writing where it is not satisfied that consultation on the proposal i) has been adequate, or ii) if it feels that the proposal would not be in the best interests of the health service in its area.*

GM local authorities agreed that the existing GM Health Scrutiny Panel be formally appointed as the Joint Scrutiny Committee for the purposes of the Healthier Together consultation. More recently, Derbyshire County Council were identified as an affected local authority and joined the Committee.

The Committee will continue to meet in order to produce a detailed Final Report once the CiC confirms the decision making timescale. The Committee was keen to provide initial comments at this stage in response to the consultation.

3. Evidence gathered

The existing GM Health Scrutiny Panel received updates on Healthier Together within regular briefings on issues of strategic importance to the NHS. Meetings of the GM Health Scrutiny Panel were held in April, May and June.

The revised Committee then held meetings in July, August, September and October to consider the following agenda items during the consultation period:

- The overall case for change and summary of the proposals.
- Finance.
- Workforce transformation.
- Patient and carer transport.
- Primary care.
- The single service model.

Colleagues representing NHS England, the CiC, Transport for Greater Manchester, the Patient Reference Group, ORS (the organisation supporting the consultation) and clinicians attended meetings.

Additionally, Committee members and supporting officers attended a number of the public consultation meetings, including patient engagement events, transport meetings, and the public engagement bus.

4. Comments on the overall programme

The Committee agrees with the underlying principles behind the Healthier Together consultation – that standards of care can be improved, that clinical expertise is sometimes spread thinly across Greater Manchester, and if possible care should take place in the community and not in hospital settings.

The Committee agrees that changes to services are needed, and recognises the joint principles agreed by AGMA and the CiC during 2013:

- At the local level integration between health and social care will help ensure that people who do not need to go to hospital can be seen in more appropriate settings, including their own home.

- The overwhelming majority of hospital treatment should be at a local General hospital. However, rare conditions and specialist treatments – ‘once in a lifetime’ instances – might be more appropriately addressed at specialist centres.

The Committee supports the main aim of Healthier Together to provide ‘best care’ for everyone in Greater Manchester. Healthier Together has made clear that there are too many variations in the quality of care in Greater Manchester – particularly within hospital emergency care but also within primary care. The Committee recognised that currently not one hospital in Greater Manchester meets all the national quality standards.

5. How primary care is changing

The Committee agrees that improvements to hospital services, and broader improvements to care and support rest upon the quality and accessibility of our primary care services. More patients need to be supported independently, avoiding hospital attendance and admissions. Members of the Committee highlighted the need to improve standards in primary care, and in particular to improve seven day access.

The Committee heard how Greater Manchester’s primary care demonstrator sites are making progress, with 6 sites now covering a population of 377,000 citizens. Four of the six sites include a specific focus on extended GP access over 7 days.

The Committee agrees with the standards set out in the consultation document. The Committee suggests that the Primary Care Strategy focuses upon:

- Mental Health.
- Patients with established conditions and the large number of patients receiving optimal treatment.
- Patients with conditions that they are unaware they have and attending accident and emergency services too late.
- Patients on the “cusp” of developing conditions and although accessible via data bases there is currently an inability to focus on these individuals.
- Individuals who do not take up free analysis i.e. bowel cancer screening.
- The current disjointed services provided to vulnerable people i.e. the elderly.

6. Joining up healthcare

The Committee agrees with the proposals for joining up the health and care system. The Committee had agreed to focus its work plan upon the in-hospital elements and accordingly gathered less information on this aspect of Healthier Together.

In exploring improvements to primary care and integrated care, the Committee identified risks. If partners plan to re-invest strategically into primary care this has the potential to destabilise hospitals. The Committee thought that it was essential that funding and staff flows are handled in a correct manner.

The Committee recognised the interdependencies of primary care, integrated care and hospital reform. It was felt that the partners are not used to governing as a whole system in partnership, but there is increasing appetite to work in this way.

The Committee felt that the parts of the system that back up hospital improvements had not been presented clearly enough (although recognised the difficulties in achieving this whilst ensuring the appropriate focus on the in-hospital element). Without the

commitment to get the primary and community elements in place, the public will not believe that there is the will to make these changes. The Committee felt that some quick moves into community settings need to be described visibly as success stories.

7. How hospital services could change

The Committee received a presentation on finance and agrees that the hospital proposals are based upon improvements in quality and patient safety, not about making savings.

In its introduction to this response the Committee describes its understanding of the in-hospital proposals. The Committee agrees that the shared service model is at the heart of the proposals, but this has been lost in the consultation. The Committee agrees that we cannot make improvements to meet the standards without the single service model.

In principle, the Committee supported hospitals co-operating to meet the standards. Committee members were aware of initial proposals to collaborate advocated by the NW and southern sectors. The Committee agreed that these collaborations have the potential to provide clinical excellence and service provision that is sustainable and affordable. However, the Committee felt the need to stress that if collaboration leads to sharing of services beyond the scope of Healthier Together, it is extremely important that these developments are also consulted upon. Failure to do so will be damaging to public trust.

The Committee recognised that even following the completion of Healthier Together all GM Trusts will remain in financial deficit, and that the savings resulting from Healthier Together are relatively small in the context of overall financial challenge. The Committee acknowledged that Healthier Together had set out very clearly its aim to address quality and improve standards in in-hospital care, and not to primarily address financial challenge. The Committee noted that separate plans were in place to meet the financial challenge.

The Committee recognised that patient transport has been consistently raised at public engagement events. Healthier Together had assured the Committee that all the proposed options meet the standards. The Committee acknowledges that once patients have received care in a Specialist hospital they will be repatriated back to their local hospital.

Despite the presentation, the Committee had ongoing grave concerns about this area, particularly emphasising the impact upon relatives and carers. Some members of the Committee were left with little confidence as to the travel times and robustness of the information provided. The Committee suggested that further analysis was required, and in particular to consider information on peak period travel times, rather than an analysis between the hours of 10am and 4pm. As discussed below, the Committee requested further information upon the impact on residents in High Peak.

The Committee discussed the workforce aspects of the hospital proposals and recognised that these issues would be explored in more detail closer to implementation. However, the Committee recommends that the following areas are addressed in workforce planning:

- Lack of emergency consultants.
- Issues around GP recruitment

- Shortfalls in nursing.
- The need to understand what future models of care look like, upskilling existing workforce and identifying new ways of working/new roles.

At its last meeting members discussed the impact of the proposals upon High Peak, as an additional member from Derbyshire County Council had joined the Committee. There was felt to be a history of disappointing NHS consultation in the area. Derbyshire had not been involved early in this consultation and presentations subsequently given had been to be 'Manchester-centric'. The Committee heard that between 70-80,000 Derbyshire residents look out to Stockport and Wythenshawe for their hospital services. There was concern that these patients would not be able to access urgent care within the 45 minute standard. The Committee agreed that these patients should be taken into account within patient modelling and requested further information at a future meeting.

8. Initial comments on the consultation process

The Committee's Final Report will make detailed comments on the consultation process itself.

The Committee is broadly supportive of the consultation that has been carried out, recognising the complexities of consultations of this sort, and Healthier Together's wish to engage the public in a more positive 'conversation'.

The Committee, at its own meetings and public events, identified some misunderstandings on the nature of the consultation. The consultation document presents the overall health and social care public service reform programme, incorporating in-hospital reform, integrated health and social care, and primary care. The Committee felt that while it has been important to describe the wider narrative, the statutory consultation focused more specifically on the in-hospital changes, in particular the single service model and the development of General and Specialist Hospital sites for A&E, acute medicine and general surgery.

Although the Joint Health Scrutiny Panel had supported the consultation document, it was noted that at public meetings there had been confusion about the scope of the proposals. This may have been due to unhelpful misreporting of the proposals which inaccurately introduced the threat of hospital closure. The Committee acknowledges that Healthier Together, and the consultation document, stress very clearly that no hospitals will close as a result of these proposals.

The Committee felt that the CiC and NHS hospital trusts had been discussing Healthier Together for two years and therefore there should be no misunderstanding about what these proposals are trying to achieve. The Committee was concerned at the possibility that hospital Trust Boards and by extension hospital staff may have contributed to misunderstanding about the proposals.

The Committee has yet to discuss the proposals in detail with hospital Chief Executives, which has been scheduled for its November meeting. The Committee's concern about these issues rested upon members' participation in public consultation events and how Healthier Together has been reported in the media.

The Committee discussed the consultation process with representatives of the External Reference Group and the research organisation supporting the consultation process.

The Committee identified the following issues that were arising at public meetings:

- Although support was given for joined up health and social care plus GP 7/7 access, concern was being raised regarding the feasibility of recruitment and access to patient records
- That proposals were driven by financial necessity as opposed to clinical needs
- Concerns about travel and access to specialist hospitals in relation to visitor access.
- Clarification of terminology was required in respect of General and Specialist hospital/"Specialisms". People think that if a hospital is not designated as specialist, it is going to lose its specialism.
- Training and support for GPs and hospitals involved in order to meet the needs of patients with hearing, learning disabilities etc
- The practicalities and costs of staff working and moving across multiple sites.

The Committee agrees that indication of support for a particular option should not be seen as a 'numbers game'. Although the CiC should note the outcome, one hospital receiving the most responses would not necessarily mean that it was the best option.

As suggested above, the Committee discussed issues around public perception and negative assumptions/press coverage. It was believed that it was important to ensure that clear messages were made on the gains to be achieved, in particular, that standards in GM hospitals would be raised and no A&E service would close. Building public confidence remains a key task and the Committee recommends that following the consultation process Healthier Together publish a "You said.... We did..." document.

Contact details

Andrew BurrIDGE, Policy Manager, GM Integrated Support Team

a.burridge@agma.gov.uk

0161 234 3284

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JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE 2ND SEPTEMBER 2014 (DRAFT MINUTES)

6. NEW HEALTH DEAL FOR TRAFFORD

The Committee welcomed Dr Mike Burrows, Director (North West) NHS England, Dr Nigel Guest, Chief Clinical Officer of Trafford Clinical Commissioning Group (CCG), Gina Lawrence, Director of Commissioning and Operations of Trafford CCG and Jessica Williams, Head of Transformation, Primary Care, NHS England Greater Manchester Area Team.

Dr Guest and Ms Lawrence gave a presentation to the Committee which provided an update on the New Health deal for Trafford. The key points were:

- The number of Trafford registered patient attendance at the three local Trusts, including Walk In Centres are 1.9% over plan;
- A&E admissions of Trafford registered patient admissions at the three local Trusts are 540 below plan,
- The A&E performance indicator for UHSM is not achieving the 95% target for the 4 hour wait however figures for August indicate that they will meet this target.
- A number of initiatives and investment have been introduced at UHSM to identify need and address blockages in the systems.
- Patient satisfaction with the Urgent Care Centre in Trafford is high and promotion of this service continues to influence the flow of patients to UHSM.

The Chair welcomed the presentation and the information provided however stated that he regretted that there was no representation or direct input from the Senior Management Team of UHSM. He requested that they be represented at future meetings to contribute to the discussions and allow questioning from the Committee. Dr Guest noted the Chairs comments and request for future meetings.

Members discussed the performance at UHSM. Ms Lawrence advised the Committee that a Performance Team was established to identify issues in patient flow at the hospital and as a result a number of services have been commissioned and processes redesigned. The example was given of changes to the patient discharge process to ensure this is more efficient, especially complex cases where this process can begin sooner to avoid any unnecessary and avoidable delays. Assurances were given to the Committee following a question from a member that discharge decisions are always made by a clinician as part of a multi disciplinary team.

A member commented that whilst it was reassuring to learn that a number of measures have been implemented at UHSM to ensure the system is resilient he asked what would happen, if for example we experience a severe winter that would place additional pressures on the hospital. Ms Lawrence advised that these measures are reviewed fortnightly by the Urgent Care Board to ensure they are appropriate to meet demand on services. She stated that when necessary additional

services can be commissioned to address any need identified. She advised that this will help ensure that performance continues to improve at UHSM.

Dr Guest reiterated that a systematic approach is being taken to achieve targets across all services at the hospital. He stated that services are commissioned irrespective if patients are Trafford or South Manchester residents to ensure a consistency and improvement of service. He stated that further reports will reflect the improvements in target achievement.

A member commented that whilst he welcomed the resilience systems introduced at UHSM as described in the presentation and the capital investment at UHSM to expand the A&E department, pressures on the hospital continue to remain an issue. He stated this continues to be a concern for both Councillors and local residents. He further recommended that the performance of the hospital continues to be monitored by the Committee to ensure the best health outcomes are achieved for those residents served by UHSM.

In response to a question asked by a member regarding the increasing population and the resulting demand on the NHS, Dr Guest advised the Committee that NHS funding is linked to population size. Dr Guest further commented that it recognised that between 25 and 30% of all attendees at A&E can obtain suitable help elsewhere and that the NHS are looking into this at a national level to reduce this figure. He said that increased community based provisions and increased access to primary care will help reduce the pressures experienced by A&E.

The Chair commented that he welcomed the £12 million investment for UHSM to reconfigure their A&E Department and welcomed the contribution that this will have on the capacity and efficiency of the hospital. He stated that the Committee wish to see UHSM remain and continue to develop as a quality provider following the Healthier Together consultation. He encouraged all members and people they are in contact with to engage with the consultation exercise currently being undertaken.

Members then discussed the Urgent Care Centre (UCC) in Trafford. The Chair made reference to a promotional leaflet that he had seen which informed the public of the services that the UCC provide and the types of injuries they treat. He asked if a patient presented with an injury that the UCC advertised they can deal with, but then following assessment it was discovered that further specialist treatment was required, what would happen to them. The response was given that the patient, once assessed as requiring care other than that the UCC is equipped to deal with, would be transferred immediately to an appropriate hospital.

A member requested that the promotional leaflet referred to by the Chair be circulated to all the members so that they can promote this service to their constituents. It was agreed that this would be done. In response to a follow up question from a member Ms Lawrence advised that the UCC is currently operating below capacity and work is ongoing to promote this facility with the local population via libraries, GPs surgeries and staff awareness events. Ms Lawrence commented that by increasing patient awareness of the UCC and the service this offers this will reduce the demand on UHSM. A member commented that she had recently had to use the UCC and had found the service to be extremely efficient and quick.

The Chair asked for clarification, now that the UCC is established, at what point the UCC might be downgraded to a Minor Injuries Unit. He informed the Committee that it was understood that this was always the final intention following the decision by the Secretary of State to confirm the downgrading of Trafford General Hospital A&E Department – but not until the £12m capital investment hospital at UHSM is completed. Dr Guest reassured the Committee that this is not being discussed at this time and they are not actively planning for this in the near future.

Decision

The Committee;

1. Note the presentation.
2. Acknowledges that there has been increased activity at A&E at UHSM as a result of the downgrading of Trafford General Hospital.
3. Welcomes the measures taken to tackle the increased pressures on UHSM.
4. Expresses its concern as UHSM embarks on the winter period and the resulting pressures and increase in demand for services. The Committee calls for all appropriate measures to be taken to prepare for this.
5. Request that a progress report from the Senior Management Team of UHSM be considered for consideration at the next meeting of the Committee.
6. Request that updated information, including publicity be circulated to members of the Committee on a regular basis.
7. Continues to monitor the impact of the New Health Deal for residents of Manchester and Trafford.
8. Welcomed the statement given to the Committee confirming that there are currently no plans to downgrade the UCC in Trafford to a Minor Injuries Clinic. The Committee further reconfirmed its position that they do not endorse any decision to downgrade the UCC.
9. Welcomes the £12M capital investment in the A&E Department at UHSM.

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Agenda Item No. 11

Part 1 Part 2

**NHS TRAFFORD CLINICAL COMMISSIONING GROUP
GOVERNING BODY
28th October 2014**

Title of Report	Performance and Quality Report.
Purpose of the Report	<p>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 – CMFT, UHSM and Pennine Care (community services).</p> <p>In addition, there is a round-up of the main quality issues arising at the Trust.</p>

Actions Requested	Decision	Discussion	Information
		x	x
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 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.		x

Recommendations	<p>The Governing Body is asked to:</p> <ul style="list-style-type: none"> Note the issues raised in relation to performance and quality. Endorse the actions being taken to improve performance and quality and consider any further actions they would like the Performance and Quality Team to take.
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Discussion history prior to the Governing Body	N/A
Financial Implications	Provider underperformance may attract a financial penalty.
Risk Implications	There is a risk of non-delivery against a number of performance targets.
Equality Impact	N/A

Assessment	
Communications Issues	N/A
Public Engagement Summary	N/A

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

PERFORMANCE AND QUALITY REPORT

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 – Central Manchester Foundation Trust (CMFT), University Hospital South Manchester (UHSM) and Pennine Care (PCFT). The following performance scorecards with data covering April to August 2014 are attached in Appendix A:

- Quality Premium
- Everyone Counts
- CCG Outcome Indicator Set
- UHSM
- CMFT
- PCFT - Trafford Community Services

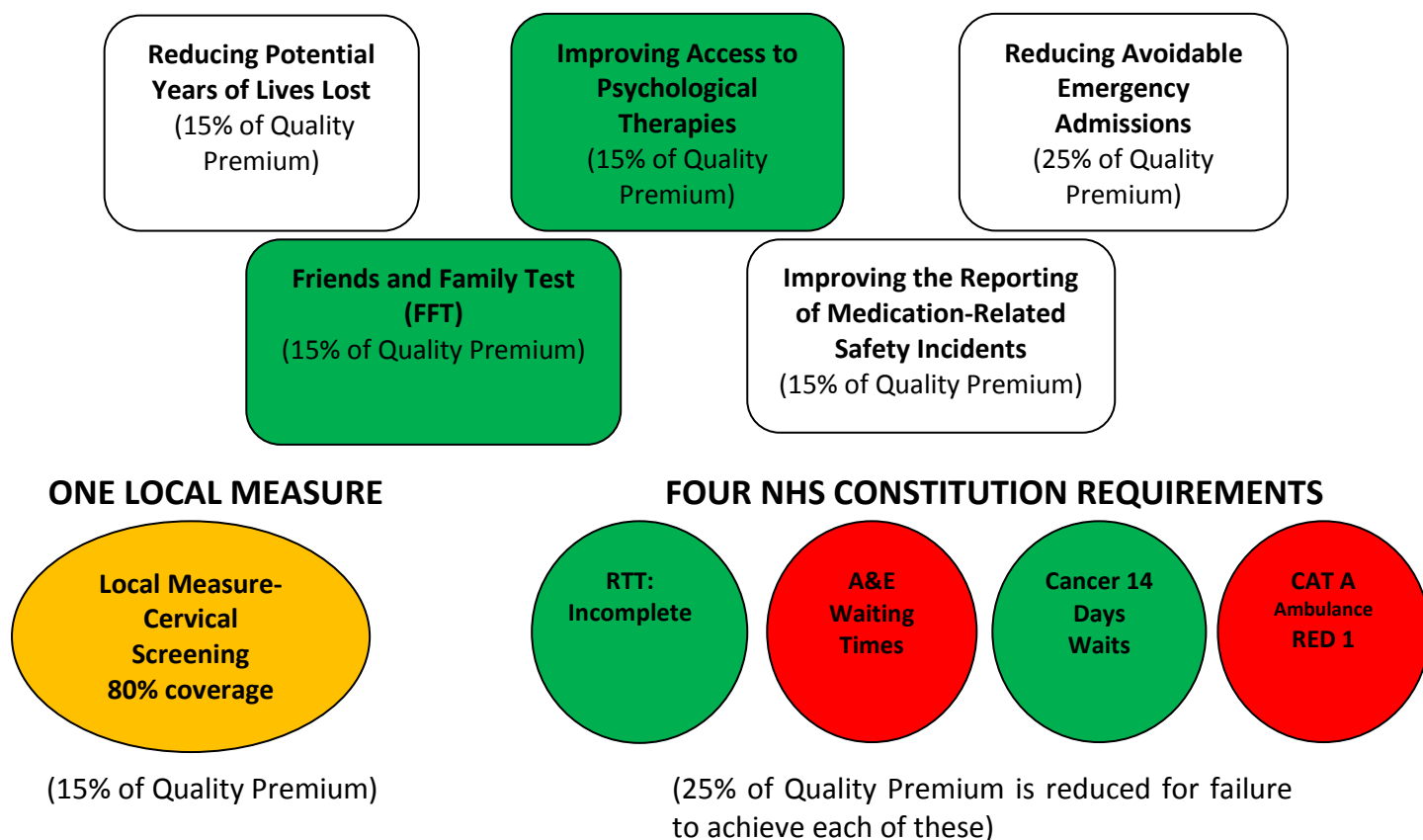
1.2 In addition, in section 4 there is a round-up of the main quality issues arising at CMFT and UHSM.

2.0 CCG PERFORMANCE 2014/15

2.1 Throughout 2014/15, the Performance and Quality Team are committed to providing a comprehensive round-up against national statutory frameworks. These include the Quality Premium, Everyone Counts and the CCG Outcome Indicator Set. The main challenges are described in this section of the report.

2014/15 Quality Premium

2.2 As at the end of August, performance information against the Quality Premium indicators is incomplete due to data availability; however, overleaf is an assessment of performance to date.



2.3 There are three areas underperforming, these are:

- Cervical screening: 80% of the appropriate cohort receives screening.
- A&E: 95% of patients are seen and treated within 4 hours
- Ambulance response times: 75% of red 1 ambulance calls to be responded to within 8 minutes

Cervical Screening

2.4 As at the end of August 2014, 78.1% of eligible women have been screened as part of the cervical screening programme against a local target of 80%. To address this under-performance the commissioning leads have established an integrated task and finish group with the responsibility for delivering the Integrated Cervical Screening Improvement Plan.

2.5 The plan has 3 key elements; Quality Improvement, Engagement and Implementation and Sustainability. Key actions include:

- Benchmarking practices in order to understand the degree of variation in screening rates and prioritising practices with the lowest uptake for additional support where appropriate, including reviewing practice systems and developing a best practice cervical screening protocol.
- Reviewing local training provision for cervical smear takers, with the longer term aim of providing e-training.

- Implementing a communications plan developed including a local Cervical Screening Poster Campaign titled 'Only takes a minute' is to be launched at multiple venues including Bars, clubs and hairdressers.

A&E waiting times

2.6 CCG performance is largely affected by under-performance at UHSM during quarter 1. Work to improve performance at the Trust was described in detail at the last Governing Board. UHSM were successful in achieving quarter 2 performance in excess on the 95% target - 95.1%. As at 17 October (the most up to date data at the time of producing this report), quarter 3 performance at UHSM was at 95.55%.

Ambulance response times

2.7 Between April and August 2014, NWAS responded to 72.3% of red 1 calls within 8 minutes, against a target of 75%. In the North West, the target has only been achieved in Merseyside (76.6%). Greater Manchester has the second best performance (72.5%), however responses across Trafford CCG are the lowest (62.3%).

2.8 The Performance and Quality Team are now representing Trafford at the Ambulance Strategic Partnership Board.

2.9 At this stage, the Ambulance Strategic Partnership Board has identified the following themes across the contract:

- Rurality and numbers of incidents.
- Availability of community fast responders and static defibrillators.
- Increase and timing of Health Care Professional referrals.
- Incidence of falls and falls management services.
- Centralisation and specialisation of health services – leading to further (cross-boundary) travel distances and impact on local cover.

2.10 NWAS is developing a recovery plan in response to the current levels of activity and performance. This will be cascaded to CCGs in due course.

Everyone Counts and CCG Outcome Indicator Set

2.11 There is one further area to be highlighted to the Governing Body – Diagnostic waiting times. This indicator is part of the Everyone Counts Framework but not included in the Quality Premium.

Diagnostic Waiting Times

2.12 In August 2014, 1.2% of patients waited over 6 weeks for a diagnostic test. This equates to 54 patients, 2 at Care UK, 2 at Salford Royal Foundation Trust, 14 at CMFT and 38 at UHSM. The main concern is waiting times for Neurophysiology tests where there were 20 breaches in August. This is discussed in more detail in section 3.

3.0 2014/15 PROVIDER PERFORMANCE – CMFT, UHSM and PCFT.

3.1 This section of the report highlights to the Governing Body the main areas of concern at the three providers. These areas are:

CMFT

- Referral To Treatment (RTT) specialty level
- Diagnostic waiting times
- Cancer
- Stroke care

UHSM

- RTT specialty level
- Diagnostic waiting times
- Cancer 62 day
- Friends and Family A&E response rate

PENNINE CARE (Trafford Community Services)

- Training

CMFT

RTT Specialty Level

3.2 The Trust continues to achieve aggregate level performance and is making good progress in addressing concerns in children's services.

3.3 In September, the longest waiting elective paediatric patient was treated at 49 weeks with the majority of patients treated before 46 weeks. In October, paediatric patients currently planned for surgery have a maximum waiting time of 44 weeks. For children's services the average waiting time in September was 29.5 weeks, this has reduced to 26.5 weeks in October.

3.4 The Trust successfully secured national resilience monies to undertake additional activity across a number of specialties to a financial value of £1.4 million. This will put the Trust in a good position to continue achieving RTT performance in 2015/16.

Diagnostic Waiting Times

3.5 In August, 2.1% of patients waited in excess of 6 weeks for diagnostic tests. This is, in the main, due to excessive waits in children's services. Recovery plans are in place however, the CCG has sought further assurance around these plans as performance fails to improve.

Cancer – 62 Day Referral to Treatment

3.6 In quarter 1, 77% of patients were seen within 62 days against a target of 85%. The breaches were due to an unusually large number of referrals into Gynecology. This is not expected to be an ongoing issue, performance in July recovered at 89.1%.

Stroke Care

- 3.7 There are ongoing concerns regarding stroke performance. At the end of this report is a specific performance brief outlining performance to date against headline contract and SSNAP indicators.
- 3.8 A Stroke Consultant and Divisional Manager have recently joined the Trust. The Performance and Quality Team are meeting these individuals over the coming week to review the stroke action plan currently in place and the function and attendance for joint performance improvement meetings.

UHSM

Referral to Treatment Times

- 3.9 The Trust continues to achieve all aggregate RTT targets however, there are ongoing issues in General Surgery and Trauma and Orthopaedics.
- 3.10 The Trust has successfully secured £1.8 million of national RTT monies to create additional capacity to address specialty level underperformance.

Diagnostic Waiting Times

- 3.11 UHSM did not achieve the 1% diagnostic wait target in August with 3.4% of patients waiting more than 6 weeks for tests. The main areas of concern are the Peripheral Neurophysiology, Colonoscopy and Gastroscopy services.
- 3.12 There are ongoing issues with neurophysiology capacity, a service UHSM commissions from Salford Royal Foundation Trust (SRFT). This service is unable to maintain adequate capacity levels when staff are absent due to annual leave. UHSM is working with SRFT to establish what can be done to consistently deliver performance standards.

Cancer – 62 Day Referral to Treatment

- 3.13 In quarter 1 the Trust treated 86.3% of patients within 62 days against a target of 85%. However, the Trust has underperformance in the last two months seeing 82.3% of patients within 62 days.
- 3.14 At this stage there are no common themes identified but further analysis is underway. The Trust is still expected to deliver quarter 2 performance.

Friends and Family – A&E Response Rate

- 3.15 The response rate of 13.4% for the Friends and Family Test in A&E is below the CQUIN target of 15%. It is the second consecutive month that this target has not been met. A response rate of at least 20% in A&E is required by the end of quarter 4 2014/15.
- 3.16 Actions taken by the Trust include:

- The matron for A&E will ensure that paper questionnaires are handed to every patient on discharge from the Department.
- Additional frontline volunteers will support staff with the paper questionnaires.
- Completed questionnaires will be reviewed by the patient experience team on a daily basis.
- An option to switch from SMS messaging to a 'home call' option, which has been shown to increase response rates, will be considered at the end of October 2014.

3.17 The Trust expects to be back on track by quarter 3.

PENNINE CARE (Trafford Community)

Training

- 3.18 Performance is monitored through the contract monitoring governance structure. This structure is currently under review to ensure efficient and robust performance management continues to be in place.
- 3.19 Implementing of training programmes continues to be the primary area of concern with only 3 of the 6 training related KPIs (health promotion, infection control and adult protection training) fully compliant.
- 3.20 Heads of Service are aware of the compliance issues and an action plan and improvement trajectory is being developed and will be forwarded to the October provider and CCG contract Finance and Performance Meeting.

4.0 QUALITY UPDATE

4.1 There are a number of quality issues to highlight to the Governing Body.

Sign up to Safety

- 4.2 On 6th October 2014, members of the CCG Quality team attended the launch of the national campaign 'Sign up to Safety' which aims to reduce harm to patients and save lives.
- 4.3 The Quality team are working together to prepare recommendations for the CCG in relation to Sign up to Safety and the launch of the Patient Safety Collaborative. Any actions resulting from this will be incorporated into the refresh of the CCG Quality Strategy.

UHSM Quarter 1 2014/15

Safer Staffing

- 4.4 All providers are now publishing staffing levels in the public domain. The national guidance in relation to how this should be presented to the public is open to interpretation and is leading to variances in reporting between providers making it difficult to benchmark one provider against another. Work

is on-going to address these variances both at a GM level and a national level.

4.5 UHSM began its implementation of long days in September 2014, which is anticipated to improve the number of staff on the wards and reduce the vacancy levels in line with the Trusts target for safe staffing.

4.6 UHSM is achieving the target it has set in relation to staffing levels.

Serious Incidents

4.7 Monitoring of the serious incidents reported by UHSM shows that the three re-occurring themes of Delayed Diagnosis, Sub-optimal Care of the Deteriorating Patient and Slips Trips and Falls. There are specific programmes of work which UHSM are undertaking to address these.

CMFT Q1 2014/15

Safer Staffing

4.8 CMFT is publishing staffing levels and detailed narratives through their Board papers.

4.9 There has been an increase in the number of occasions when actual staffing has not met the planned numbers. The reasons for this are noted as an increase in the number of nursing and midwifery vacancies and increased sickness or absence levels.

4.10 Work continues to address both these issues and there are a significant number of appointments due to take up posts in September (Newly Qualified Nurses). However staff retention and managing sickness absence and maternity leave remains challenging.

4.11 There have been no incidents raised in regards to unsafe staffing levels.

Serious Incidents

4.12 Monitoring serious incidents reported by CMFT shows two recurring themes - Sub-optimal Care of the Deteriorating Patient and Slips Trips and Falls. There are specific programmes of work which CMFT are undertaking to address these.

Never Events

4.13 There has been one never event reported in quarter 2 at CMFT. This was in relation to the insertion of a central line into the wrong patient. Technically under the guidance this is a wrong site surgery never event.

5.0 RECOMMENDATIONS

5.1 The Governing Body is asked to:

- Note the issues raised in relation to performance and quality.
- Endorse the approach which is being taken to manage performance and quality and consider any further actions they would like the Performance and Quality Team to take.

CMFT STROKE UPDATE OCTOBER 2014

Summary

The quality of stroke services is measured in two main ways:

- Three headline performance measures, which are reported on monthly. The latest information is set out in this note
- A broader collection of outcomes which are measured via the national stroke audit (SSNAP). Nationally validated data is released by quarter. Data for quarter 1 2014/15 is due to be released by the end of October 2014, and an update on performance against these measures will be brought following the data release

In very general terms, the most challenging areas of performance tend to relate to outcomes linked to the beginning of the stroke pathway. This is affected by a range of factors, including the nature of individual patient conditions, which can have an impact on where they are most appropriately treated (i.e. the stroke ward may not initially be the most appropriate place in the event that a patient has multiple acute conditions); the availability of designated stroke beds; and access to diagnostics such as scanning.

However, performance is generally better against those measures which relate to a patient's experience following admission to the stroke unit. SSNAP data which has previously been released has shown that, in the wider pathway, CMFT shows particular strength in multi-disciplinary team working and discharge arrangements.

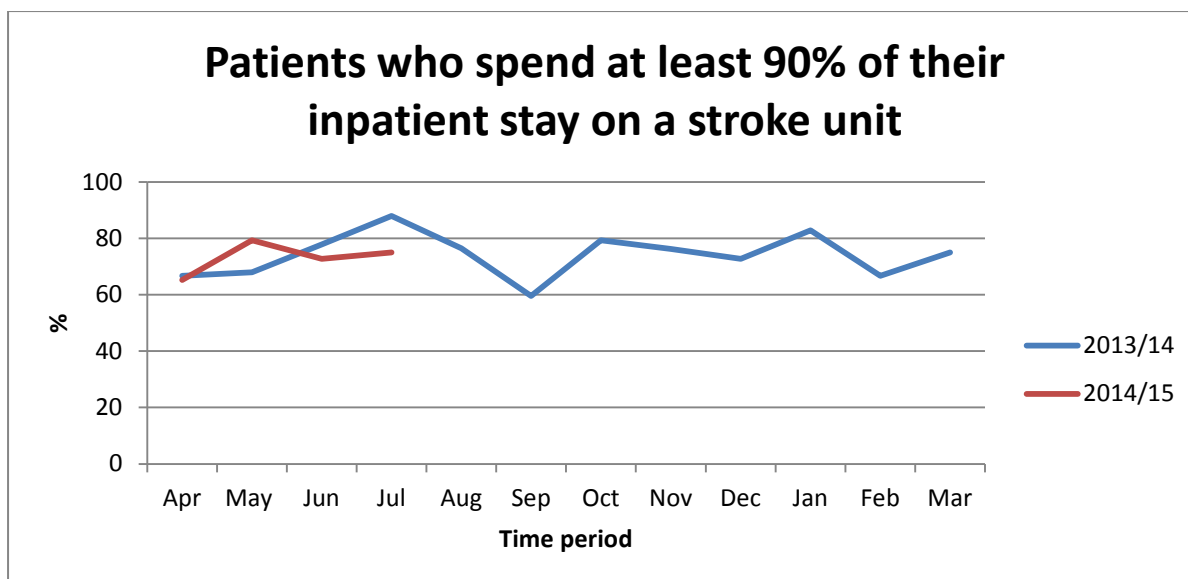
Central CCG is working closely with CMFT to understand the challenges and opportunities relating to stroke performance, and the action which the Trust is taking to respond to these. In particular, it is recognised that the implementation of the Greater Manchester stroke model, which will further centralise hyperacute stroke care across Greater Manchester, should have a positive impact on outcomes linked to the early part of the stroke pathway. The model is scheduled to go live in the latter part of 2014/15.

Headline stroke performance measures

CMFT performance against the three headline stroke measures continues to be challenging, with achievement generally at a lower level than for the same period in 2013/14. This reflects the ongoing challenges relating to the early part of the stroke pathway which are described above.

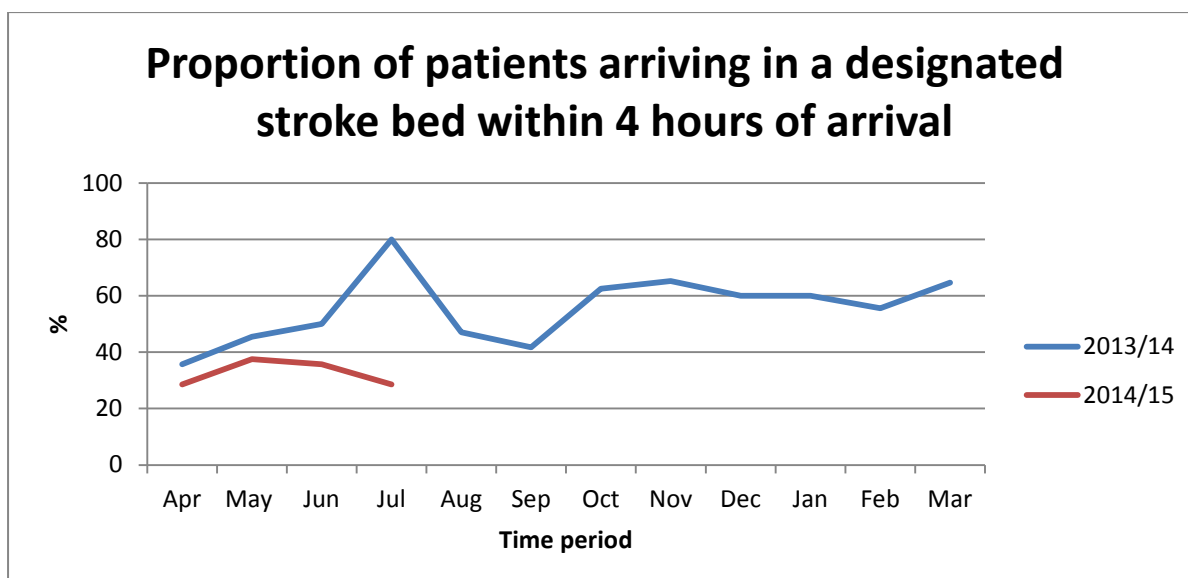
Patients who spend at least 90% of their inpatient stay on a stroke unit:

- Performance has improved during 2014/15 from a starting position of 65.2%, to 75% (July 2014)
- However, performance during the year to date has generally been lower than for the same period in 2013/14



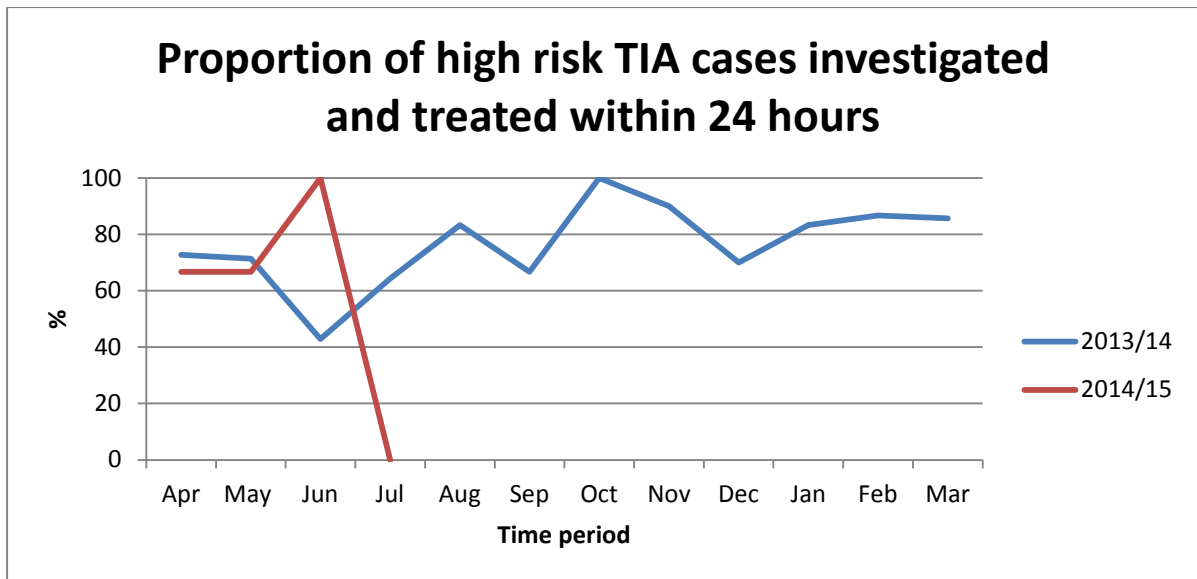
Proportion of patients arriving in a designated stroke bed within 4 hours of arrival:

- Around one third of patients arrive in a designated stroke bed within 4 hours of arrival
- However, performance continues to be below the levels achieved during 2013/14



Proportion of high risk TIA cases investigated and treated within 24 hours:

- Following some improvement during the first quarter of 2014/15, performance against this measure reduced significantly in July 2014
- However, it should be noted that this measure is based on very small numbers, and individual patient outcomes can therefore have a significant impact on overall performance



SSNAP audit

Data relating to Q1 of 2014/15 is due to be released by the end of October 2014. An update will be provided following the release of this data.

2014-15: Quality Premium Scorecard - Trafford CCG

Performance Reporting Month: Aug-2014

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															
QP1	Potential Years of Life Lost (PYLL)	Potential years of life lost (PYLL) from causes considered amenable to healthcare	Not Avail.	2083.14				Due Sep 15														
QP1(L)	Potential Years of Life Lost (PYLL)	Potential years of life lost (PYLL) from causes considered amenable to healthcare - (*LOCAL DATA*)	New	2083.14				See note >														Data is only available annually. BI Team are exploring local data sources to provide more frequent performance information.
QP2	Mental Health Measures	IAPT Roll-Out	14.7%	15.0%	2.0%	3.5%	YTD				3.5%											
QP3	Emergency Admissions	Composite measure on emergency admissions	New	1996.40							Due Dec 14											
QP3(L)	Emergency Admissions	Composite measure on emergency admissions - (*LOCAL DATA*)	2339.36	1996.40	858.41	981.50	YTD		217.90	203.00	187.00	200.50	173.10									Data is only available annually. BI Team are exploring local data sources to provide more frequent performance information.
QP4.1	Patient Experience	Friends and Family Action Plan – milestone achievement	New	RAG			-															
QP4.2	Patient Experience	Friends and Family Feedback – evidence of provider action	New	RAG			-															
QP4.3	Patient Experience	Friends and Family Roll Out – evidence of support	New	RAG			-															
QP4.4	Patient Experience	Patient experience of GP out-of-hours services	New	66.2%				Due Jul 15														
QP5a	Patient Safety Measure	Improving the reporting of medication-related safety incidents (CMFT)	New	2.5%				See note >														National publication timetable is not yet available.
QP5b	Patient Safety Measure	Improving the reporting of medication-related safety incidents (UHSM)	New	5.0%				See note >														National publication timetable is not yet available.
QPC3	Cancer 2 Week Waits	All cancer two week wait	97.4%	93.0%	93.0%	95.6%	YTD		96.3%	96.8%	94.4%	96.6%	94.0%									
QPC4	Ambulance Clinical Quality	Ambulance clinical quality - Category A (Red 1) 8 minute response time	75.9%	75.0%	75.0%	72.3%	YTD		75.7%	73.4%	71.5%	68.5%	72.7%									
QPC1	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%	94.9%	Latest Month		94.4%	94.9%	95.1%	94.9%	94.9%									
QPC2	A&E Waiting Times	A&E waiting time - total time in the A&E department (≤ 4 hrs)	94.9%	95.0%	95.0%	94.6%	YTD		92.6%	93.0%	94.1%	94.5%	94.6%	94.6%								
QPLP1	Cancer	Cervical Cancer Screening Coverage - Percentage of Eligible Women Screened Adequately within the Previous 5 Years (according to age) on 31st March (Datasource and methodology HSCIC)	G	80.0%	80.0%	78.1%	YTD		78.0%	78.1%	78.0%	78.1%										

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2014-15: Everyone Counts Scorecard - Trafford CCG

Performance Reporting Month: Aug-2014

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
EA1	Potential Years of Life Lost (PYLL)	Potential years of life lost (PYLL) from causes considered amenable to healthcare	Not Avail.	2083.14				Due Sep 15														
EA1(L)	Potential Years of Life Lost (PYLL)	Potential years of life lost (PYLL) from causes considered amenable to healthcare - (*LOCAL DATA*)	New	2083.14				See note >														Data is only available annually. BI Team are exploring local data sources to provide more frequent performance information.
EA2	Long Term Conditions	Health-related quality of life for people with long-term conditions	53.2%	75.1%				Due Sep 15														
EA2(L)	Long Term Conditions	Health-related quality of life for people with long-term conditions - (*LOCAL DATA*)	New	75.1%				See note >														Data is only available annually. BI Team are exploring local data sources to provide more frequent performance information.
EA3	Mental Health Measures	IAPT Roll-Out	14.7%	15.0%	2.0%	3.5%	YTD				3.5%											
EA4	Emergency Admissions	Composite measure on emergency admissions	New	1996.40							Due Dec 14											
EA4(L)	Emergency Admissions	Composite measure on emergency admissions - (*LOCAL DATA*)	2339.36	1996.40	858.41	981.50	YTD		217.90	203.00	187.00	200.50	173.10									Data is only available annually. BI Team are exploring local data sources to provide more frequent performance information.
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			68	Latest Month		64	64	66	67	68									Publication date for national targets has not been released.
EA6b	Friends and Family Test	Friends and Family Test Score: UHSM (Combined)	64			75	Latest Month		68	71	70	72	75									Publication date for national targets has not been released.
EA6d	Friends and Family Test	Response Rate: CMFT (Combined)	23.6%			26.7%	Latest Month		19.4%	20.2%	28.5%	25.8%	26.7%									Publication date for national targets has not been released.
EA6e	Friends and Family Test	Response Rate: UHSM (Combined)	23.3%			27.2%	Latest Month		23.8%	27.0%	24.0%	26.2%	27.2%									Publication date for national targets has not been released.
EA6g	Friends and Family Test	Friends and Family Test Score: CMFT (A&E)	64			65	Latest Month		61	60	63	66	65									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									Publication date for national targets has not been released.
EA6s	Friends and Family Test	Friends and Family Test Score: CMFT (Maternity)	New					See note >														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									Publication date for national targets has not been released.
EA6j	Friends and Family Test	Friends and Family Test Score: UHSM (Inpatient)	77			82	Latest Month		80	80	81	82	82									Publication date for national targets has not been released.
EA6t	Friends and Family Test	Friends and Family Test Score: UHSM (Maternity)	New					See note >														Awaiting national guidance on roll-out and target methodology.
EA6k	Friends and Family Test	Response Rate: CMFT (A&E)	21.7%	20.0%	15.0%	23.3%	Latest Month		19.2%	19.4%	23.3%	20.7%	23.3%									
EA6l	Friends and Family Test	Response Rate: CMFT (Inpatient)	30.5%	30.0%	25.0%	39.5%	Latest Month		20.2%	23.2%	48.1%	44.1%	39.5%									
EA6v	Friends and Family Test	Response Rate: CMFT (Maternity)	New					See note >														Awaiting national guidance on roll-out and target methodology.

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2014-15: Everyone Counts Scorecard - Trafford CCG

Performance Reporting Month: Aug-2014

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
EA6m	Friends and Family Test	Response Rate: UHSM (A&E)	17.2%	20.0%	15.0%	13.4%	Latest Month		17.6%	17.3%	16.1%	14.3%	13.4%									
EA6n	Friends and Family Test	Response Rate: UHSM (Inpatient)	32.4%	30.0%	25.0%	47.2%	Latest Month		33.2%	42.2%	36.5%	43.7%	47.2%									
EA6w	Friends and Family Test	Response Rate: UHSM (Maternity)	New						See note >													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.
EA7i(L)	Patient Experience of Primary Care	Poor patient experience of GP Services - (*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.
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%					See note >													National publication timetable is not yet available.
EA9b	Patient Safety Measure	Improving the reporting of medication-related safety incidents (UHSM)	New	5.0%					See note >													National publication timetable is not yet available.
EAS1	Dementia	Estimated diagnosis rate for people with dementia	51.2%	67.0%					See note >													National publication timetable is not yet available.
EAS1(L)	Dementia	Estimated diagnosis rate for people with dementia - (*LOCAL DATA*)	New	67.2%	52.4%	61.5%	YTD		61.5%	61.5%		Due Oct 14										Sourced directly from GP Systems
EAS2	Mental Health Measure	IAPT Recovery Rate	New	50.0%								Due Oct 14										
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								Assigned cases only
EAS4b	HCAI	Healthcare acquired infection (HCAI) measure (MRSA) - UNAVOIDABLE	New	0	0	0	YTD		0	0	0	0	0	0								
EAS5a	HCAI	Healthcare acquired infection (HCAI) measure (clostridium difficile infections) - Caused by Lapse in Care - NHS Patients	New	59	34	35	YTD		5	8	8	7	5	2								
EAS5b	HCAI	Healthcare acquired infection (HCAI) measure (clostridium difficile infections) - Overall - NHS Patients	New	TBC	TBC	0	YTD		0	0	0	0	0	0								
EB6	Cancer 2 Week Waits	All cancer two week wait	97.4%	93.0%	93.0%	95.6%	YTD		96.3%	96.8%	94.4%	96.6%	94.0%									
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%									
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%	99.1%	YTD		98.9%	98.5%	100.0%	100.0%	97.7%									

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2014-15: Everyone Counts Scorecard - Trafford CCG

Performance Reporting Month: Aug-2014

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	
EB9	Cancer 31 Day Waits	31-day standard for subsequent cancer treatments-surgery	97.6%	94.0%	94.0%	97.4%	YTD		94.4%	100.0%	100.0%	100.0%	93.8%										
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%										
EB11	Cancer 31 Day Waits	31-day standard for subsequent cancer treatments-radiotherapy	99.3%	94.0%	94.0%	100.0%	YTD		100.0%	100.0%	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%	90.9%	YTD		91.7%	84.4%	86.8%	93.8%	95.5%										
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%	97.3%	YTD		91.7%	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%	91.0%	YTD		100.0%	87.5%	88.9%	93.3%	84.6%										
EB15i	Ambulance Clinical Quality	Ambulance clinical quality - Category A (Red 1) 8 minute response time	75.9%	75.0%	75.0%	72.3%	YTD		75.7%	73.4%	71.5%	68.5%	72.7%										
EB15ii	Ambulance Clinical Quality	Ambulance clinical quality - Category A (Red 2) 8 minute response time	77.4%	75.0%	75.0%	72.1%	YTD		75.3%	74.7%	73.2%	69.2%	72.1%										
EB16	Ambulance Clinical Quality	Ambulance clinical quality - Category A 19 minute transportation time	95.8%	95.0%	95.0%	95.3%	YTD		96.2%	95.6%	95.4%	94.2%	95.3%										
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%										
SPECIALTY LEVEL >>>	RTT - SPECIALTY LEVEL >>>	- Admitted Adjusted Pathways: SPECIALTY LEVEL - Cardiothoracic Surgery	New	90.0%	90.0%	78.8%	YTD		71.4%	83.3%	83.3%	87.5%	66.7%										
SPECIALTY LEVEL >>>	RTT - SPECIALTY LEVEL >>>	- Admitted Adjusted Pathways: SPECIALTY LEVEL - General Surgery	New	90.0%	90.0%	89.2%	YTD		90.0%	89.7%	88.2%	88.7%	89.4%										
SPECIALTY LEVEL >>>	RTT - SPECIALTY LEVEL >>>	- Admitted Adjusted Pathways: SPECIALTY LEVEL - Trauma & Orthopaedics	New	90.0%	90.0%	88.8%	YTD		89.6%	91.0%	87.8%	86.5%	88.5%										
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%	96.9%	YTD		96.8%	96.6%	97.6%	96.7%	97.1%										
SPECIALTY LEVEL >>>	RTT - SPECIALTY LEVEL >>>	- Non-admitted Pathways: SPECIALTY LEVEL - Ophthalmology	New	95.0%	95.0%	94.6%	YTD		96.0%	94.7%	94.6%	92.6%	95.6%										
SPECIALTY LEVEL >>>	RTT - SPECIALTY LEVEL >>>	- Non-admitted Pathways: SPECIALTY LEVEL - Other	New	95.0%	95.0%	95.0%	YTD		94.0%	94.0%	96.2%	95.7%	95.0%										
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%	94.9%	Latest Month		94.4%	94.9%	95.1%	94.9%	94.9%										
SPECIALTY LEVEL >>>	RTT - SPECIALTY LEVEL >>>	- Incomplete Pathways: SPECIALTY LEVEL - Neurosurgery	New	92.0%	92.0%	75.0%	Latest Month		50.0%	100.0%	66.7%	90.9%	75.0%										
EB4	Diagnostic Test Waiting Times	Diagnostic test waiting times	0.4%	1.0%	1.0%	0.8%	YTD		0.7%	1.1%	0.5%	0.5%	1.2%										
Diagnostic Test Name >>>	Diagnostic Test Name >>>	Diagnostic test waiting times - PERIPHERAL_NEUROPHYS	New	1.0%	1.0%	7.1%	YTD		8.0%	1.9%	1.9%	2.0%	23.9%										
Diagnostic Test Name >>>	Diagnostic Test Name >>>	Diagnostic test waiting times - SLEEP_STUDIES	New	1.0%	1.0%	6.5%	YTD		5.0%	11.1%	0.0%	0.0%	25.0%										

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Performance Reporting Month: Aug-2014

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														
Diagnostic Test Name >>>	Diagnostic Test Name >>>	Diagnostic test waiting times - URODYNAMICS	New	1.0%	1.0%	3.4%	YTD		4.3%	4.5%	0.0%	9.1%	0.0%								
Diagnostic Test Name >>>	Diagnostic Test Name >>>	Diagnostic test waiting times - COLONOSCOPY	New	1.0%	1.0%	6.8%	YTD		4.3%	5.7%	7.2%	5.4%	10.3%								
Diagnostic Test Name >>>	Diagnostic Test Name >>>	Diagnostic test waiting times - CYSTOSCOPY	New	1.0%	1.0%	3.6%	YTD		5.1%	2.3%	3.7%	0.0%	7.4%								
Diagnostic Test Name >>>	Diagnostic Test Name >>>	Diagnostic test waiting times - GASTROSCOPY	New	1.0%	1.0%	3.7%	YTD		5.3%	3.8%	1.4%	2.6%	5.7%								
EBS5	A&E Waiting Times	A&E waiting time - total time in the A&E department (≤ 4 hrs)	94.9%	95.0%	95.0%	94.6%	YTD		92.6%	93.0%	94.1%	94.5%	94.6%	94.6%							
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							
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%	96.7%	YTD				96.7%										
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								
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								
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	0	YTD		0	0	0	1	0								
EBS5	Trolley Waits in A&E	Trolley waits in A&E	New	0	0	0	YTD		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								

2014-15: CCG Outcomes Indicator Set Scorecard - Trafford CCG

Performance Reporting Month: Aug-2014

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
C1.1	Potential Years of Life Lost (PYLL)	Potential years of life lost (PYLL) from causes considered amenable to healthcare	Not Avail.	2083.14				Due Sep 15														
C1.1(L)	Potential Years of Life Lost (PYLL)	Potential years of life lost (PYLL) from causes considered amenable to healthcare - (*LOCAL DATA*)	New	2083.14				See note >														Data is only available annually. BI Team are exploring local data sources to provide more frequent performance information.
C2.1	Long Term Conditions	Health-related quality of life for people with long-term conditions	53.2%	75.1%				Due Sep 15														
C2.1(L)	Long Term Conditions	Health-related quality of life for people with long-term conditions - (*LOCAL DATA*)	New	75.1%				See note >														Data is only available annually. BI Team are exploring local data sources to provide more frequent performance information.
C4.3a	Page 55	Friends and Family Test	Friends and Family Test Score: CMFT (Combined)	68		68	Latest Month	64	64	66	67	68										Publication date for national targets has not been released.
C4.3b		Friends and Family Test	Friends and Family Test Score: UHSM (Combined)	64		75	Latest Month	68	71	70	72	75										Publication date for national targets has not been released.
C4.3p		Friends and Family Test	Response Rate: CMFT (Combined)	23.6%		26.7%	Latest Month	19.4%	20.2%	28.5%	25.8%	26.7%										Publication date for national targets has not been released.
C4.3q		Friends and Family Test	Response Rate: UHSM (Combined)	23.3%		27.2%	Latest Month	23.8%	27.0%	24.0%	26.2%	27.2%										Publication date for national targets has not been released.
C4.3d		Friends and Family Test	Friends and Family Test Score: CMFT (A&E)	64		65	Latest Month	61	60	63	66	65										Publication date for national targets has not been released.
C4.3e		Friends and Family Test	Friends and Family Test Score: CMFT (Inpatient)	80		73	Latest Month	75	76	71	69	73										Publication date for national targets has not been released.
C4.3s		Friends and Family Test	Friends and Family Test Score: CMFT (Maternity)	New				See note >														Awaiting national guidance on roll-out and target methodology.
C4.3f		Friends and Family Test	Friends and Family Test Score: UHSM (A&E)	47		58	Latest Month	53	58	56	50	58										Publication date for national targets has not been released.
C4.3g		Friends and Family Test	Friends and Family Test Score: UHSM (Inpatient)	77		82	Latest Month	80	80	81	82	82										Publication date for national targets has not been released.
C4.3t		Friends and Family Test	Friends and Family Test Score: UHSM (Maternity)	New				See note >														Awaiting national guidance on roll-out and target methodology.
C4.3j		Friends and Family Test	Response Rate: CMFT (A&E)	21.7%	20.0%	15.0%	23.3%	Latest Month	19.2%	19.4%	23.3%	20.7%	23.3%									
C4.3k		Friends and Family Test	Response Rate: CMFT (Inpatient)	30.5%	30.0%	25.0%	39.5%	Latest Month	20.2%	23.2%	48.1%	44.1%	39.5%									
C4.3v		Friends and Family Test	Response Rate: CMFT (Maternity)	New					See note >													Awaiting national guidance on roll-out and target methodology.
C4.3l	Friends and Family Test	Response Rate: UHSM (A&E)	17.2%	20.0%	15.0%	13.4%	Latest Month	17.6%	17.3%	16.1%	14.3%	13.4%										
C4.3m	Friends and Family Test	Response Rate: UHSM (Inpatient)	32.4%	30.0%	25.0%	47.2%	Latest Month	33.2%	42.2%	36.5%	43.7%	47.2%										
C4.3w	Friends and Family Test	Response Rate: UHSM (Maternity)	New					See note >													Awaiting national guidance on roll-out and target methodology.	
C2.13	Dementia	Estimated diagnosis rate for people with dementia	51.2%	67.0%				See note >														National publication timetable is not yet available.

2014-15: CCG Outcomes Indicator Set Scorecard - Trafford CCG

Performance Reporting Month: Aug-2014

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														
C2.13(L)	Dementia	Estimated diagnosis rate for people with dementia - (*LOCAL DATA*)	New	67.2%	52.4%	61.5%	YTD		61.5%	61.5%	Due Oct 14										Sourced directly from GP Systems
C5.3a	HCAI	Healthcare acquired infection (HCAI) measure (MRSA) - AVOIDABLE	0	0	0	0	YTD		0	0	0	0	0	0							Assigned cases only
C5.3b	HCAI	Healthcare acquired infection (HCAI) measure (MRSA) - UNAVOIDABLE	New	0	0	0	YTD		0	0	0	0	0	0							
C5.4a	HCAI	Healthcare acquired infection (HCAI) measure (clostridium difficile infections) - Caused by Lapse in Care - NHS Patients	New	59	34	35	YTD		5	8	8	7	5	2							
C5.4b	HCAI	Healthcare acquired infection (HCAI) measure (clostridium difficile infections) - Overall - NHS Patients	New	TBC	TBC	0	YTD		0	0	0	0	0	0							
C1.10	Mortality	One year survival from all cancers	Not Avail.	Latest Baseline Year				Due Mar 15													
C1.10(L)	Mortality	One year survival from all cancers - (*LOCAL DATA*)	New	Latest Baseline Year				See note >													New local indicator introduced end July - awaiting locally sourced data, if available
C1.11	Mortality	One year survival from breast, lung and colorectal cancers	Not Avail.	Latest Baseline Year				Due Mar 15													
C1.11(L)	Mortality	One year survival from breast, lung and colorectal cancers - (*LOCAL DATA*)	New	Latest Baseline Year				See note >													New local indicator introduced end July - awaiting locally sourced data, if available
C1.12	Mortality	People with severe mental illness who have received a list of physical checks	Not Avail.	Latest Baseline Year				Due Jun 15													
C1.12(L)	Mortality	People with severe mental illness who have received a list of physical checks - (*LOCAL DATA*)	New	Latest Baseline Year				See note >													New local indicator introduced end July - awaiting locally sourced data, if available
C1.13	Mortality	Antenatal assessments < 13 weeks	2,749		#N/A					630											
C1.13(L)	Mortality	Antenatal assessments < 13 weeks - (*LOCAL DATA*)	New					See note >													New local indicator introduced end July - awaiting locally sourced data, if available
C1.14	Mortality	Maternal smoking at delivery	7.3%	7.3%	#N/A					7.4%											
C1.14(L)	Mortality	Maternal smoking at delivery - (*LOCAL DATA*)	New	7.3%				See note >													New local indicator introduced end July - awaiting locally sourced data, if available
C1.15	Mortality	Breast feeding prevalence at 6-8 weeks	Not Avail.	Latest Baseline Year						Due Dec 14			Due Mar 15			Due Jun 15				Due Sep 15	2013-14's data was insufficient
C1.15(L)	Mortality	Breast feeding prevalence at 6-8 weeks - (*LOCAL DATA*)	New	Latest Baseline Year				See note >													New local indicator introduced end July - awaiting locally sourced data, if available
C1.16	Mortality	Cancer: diagnosis via emergency routes	New	Latest Baseline Year				Due Jun 15													
C1.16(L)	Mortality	Cancer: diagnosis via emergency routes - (*LOCAL DATA*)	New	Latest Baseline Year				See note >													New local indicator introduced end July - awaiting locally sourced data, if available
C1.17	Mortality	Cancer: record of stage at diagnosis	New	Latest Baseline Year				Due Jun 15													
C1.17(L)	Mortality	Cancer: record of stage at diagnosis - (*LOCAL DATA*)	New	Latest Baseline Year				See note >													New local indicator introduced end July - awaiting locally sourced data, if available

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2014-15: CCG Outcomes Indicator Set Scorecard - Trafford CCG

Performance Reporting Month: Aug-2014

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															
C1.18	Mortality	Cancer: early detection	New	Latest Baseline Year				Due Jun 15														
C1.18(L)	Mortality	Cancer: early detection - (*LOCAL DATA*)	New	Latest Baseline Year					See note >													New local indicator introduced end July - awaiting locally sourced data, if available
C1.19	Mortality	Lung cancer: record of stage at diagnosis	New	Latest Baseline Year				Due Mar 16														
C1.19(L)	Mortality	Lung cancer: record of stage at diagnosis - (*LOCAL DATA*)	New	Latest Baseline Year					See note >													New local indicator introduced end July - awaiting locally sourced data, if available
C1.2	Mortality	Under 75 mortality rate from cardiovascular disease	Not Avail.	TBC				Due Jun 15														
C1.2(L)	Mortality	Under 75 mortality rate from cardiovascular disease - (*LOCAL DATA*)	New	TBC					See note >													New local indicator introduced end July - awaiting locally sourced data, if available
C1.20	Mortality	Breast cancer: mortality	New	TBC				Due Jun 15														
C1.20(L)	Mortality	Breast cancer: mortality - (*LOCAL DATA*)	New	TBC					See note >													New local indicator introduced end July - awaiting locally sourced data, if available
C1.21	Mortality	Reducing premature mortality from the major causes of death: cardiovascular disease	New	TBC				Due Dec 15														
C1.21(L)	Mortality	Reducing premature mortality from the major causes of death: cardiovascular disease - (*LOCAL DATA*)	New	TBC					See note >													New local indicator introduced end July - awaiting locally sourced data, if available
C1.22	Mortality	Hip fracture: incidence	New	TBC				Due Dec 15														
C1.22(L)	Mortality	Hip fracture: incidence - (*LOCAL DATA*)	New	TBC					See note >													New local indicator introduced end July - awaiting locally sourced data, if available
C1.23	Mortality	Severe mental illness: smoking rates	New	TBC				Due Jun 15														
C1.23(L)	Mortality	Severe mental illness: smoking rates - (*LOCAL DATA*)	New	TBC					See note >													New local indicator introduced end July - awaiting locally sourced data, if available
C1.3	Mortality	Cardiac rehabilitation completion	Not Avail.	TBC				Due Dec 16														
C1.3(L)	Mortality	Cardiac rehabilitation completion - (*LOCAL DATA*)	New	TBC					See note >													New local indicator introduced end July - awaiting locally sourced data, if available
C1.4	Mortality	Myocardial infarction, stroke and stage 5 chronic kidney disease in people with diabetes	Not Avail.	TBC				Due Mar 16														
C1.4(L)	Mortality	Myocardial infarction, stroke and stage 5 chronic kidney disease in people with diabetes - (*LOCAL DATA*)	New	TBC					See note >													New local indicator introduced end July - awaiting locally sourced data, if available
C1.5	Mortality	Mortality within 30 days of hospital admission for stroke	Not Avail.	TBC				Due Dec 15														
C1.5(L)	Mortality	Mortality within 30 days of hospital admission for stroke - (*LOCAL DATA*)	New	TBC					See note >													New local indicator introduced end July - awaiting locally sourced data, if available
C1.6	Mortality	Under 75 mortality from respiratory disease	Not Avail.	TBC				Due Jun 15														

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2014-15: CCG Outcomes Indicator Set Scorecard - Trafford CCG

Performance Reporting Month: Aug-2014

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
C1.6(L)	Mortality	Under 75 mortality from respiratory disease - (*LOCAL DATA*)	New	TBC				See note >														New local indicator introduced end July - awaiting locally sourced data, if available
C1.7	Mortality	Under 75 mortality rate from liver disease	20.30	Latest Baseline Year Latest				Due Jun 15														
C1.7(L)	Mortality	Under 75 mortality rate from liver disease - (*LOCAL DATA*)	New	Latest Baseline Year Latest				See note >														New local indicator introduced end July - awaiting locally sourced data, if available
C1.8	Mortality	Emergency admissions for alcohol-related liver disease	36.10	Latest Baseline Year Latest							Due Dec 14			Due Mar 15								Directly standardised rate (DSR) per 100,000 population, rolling YTD up to that quarter
C1.8(L)	Mortality	Emergency admissions for alcohol-related liver disease - (*LOCAL DATA*)	New	Latest Baseline Year Latest				See note >														New local indicator introduced end July - awaiting locally sourced data, if available
C1.9	Mortality	Under 75 mortality rate from cancer	129.90	Latest Baseline Year Latest				Due Jun 15														
C1.9(L)	Mortality	Under 75 mortality rate from cancer - (*LOCAL DATA*)	New	Latest Baseline Year Latest				See note >														New local indicator introduced end July - awaiting locally sourced data, if available
C2.10	Long Term Conditions	Access to psychological therapy services by people from BME groups	Not Avail.	Latest Baseline Year Latest							Due Dec 15											
C2.11	Long Term Conditions	Recovery following talking therapies for people of all ages	Not Avail.	Latest Baseline Year Latest							Due Dec 14											
C2.12	Long Term Conditions	Recovery following talking therapies for people older than 65	Not Avail.	Latest Baseline Year Latest							Due Dec 14			Due Mar 15			Due Jun 15				Due Sep 15	
C2.14	Dementia	People with dementia prescribed anti-psychotic medication	Not Avail.	Latest Baseline Year Latest				Due Sep 15														
C2.15	Long Term Conditions	Health related quality of life for carers	New	Latest Baseline Year Latest				Due Sep 15														
C2.16	Long Term Conditions	Health related quality of life for people with a long-term mental health condition	New	Latest Baseline Year Latest				Due Sep 15														
C2.2	Long Term Conditions	A greater proportion of people aged 18 and over suffering from a long-term condition feeling supported to manage their condition	71.3%	71.3%										Due Sep 15								
C2.3	Long Term Conditions	People with COPD and Medical Research Council (MRC) Dyspnoea Scale ≥3 referred to a pulmonary rehabilitation programme	Not Avail.	Latest Baseline Year Latest				Due Jun 15														
C2.4	Long Term Conditions	People with diabetes who have received all nine care processes.	Not Avail.	Latest Baseline Year Latest				Due Mar 16														
C2.5	Long Term Conditions	People with diabetes diagnosed less than a year who are referred to structured education	Not Avail.	Latest Baseline Year Latest				Due Mar 16														
C2.6	Emergency Admissions	Unplanned hospitalisation for chronic ambulatory care sensitive (ACS) conditions (adults)	New	852.20				Due Dec 14														
C2.6(L)	Emergency Admissions	Unplanned hospitalisation for chronic ambulatory care sensitive (ACS) conditions (adults) - (*LOCAL DATA*)	852.20	852.20	325.16	337.30	YTD		76.80	74.00	61.00	71.30	54.20									
C2.7	Emergency Admissions	Unplanned hospitalisation for asthma, diabetes and epilepsy (under 19s)	New	68.90				Due Dec 14														
C2.7(L)	Emergency Admissions	Unplanned hospitalisation for asthma, diabetes and epilepsy (under 19s) - (*LOCAL DATA*)	68.90	68.90	15.46	26.70	YTD		6.70	6.40	3.00	6.30	4.30									

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2014-15: CCG Outcomes Indicator Set Scorecard - Trafford CCG

Performance Reporting Month: Aug-2014

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
C2.8	Long Term Conditions	Complications associated with diabetes, including emergency admission for diabetic ketoacidosis and lower limb amputation	Not Avail.	Latest Baseline Year				Due Mar 16														
C2.9	Long Term Conditions	Access to community health services by people from BME groups	Not Avail.	Latest Baseline Year							Due Dec 15											
C3.1	Emergency Admissions	Emergency admissions for acute conditions that should not usually require hospital admission	New	1420.36				Due Dec 14														
C3.1(L)	Emergency Admissions	Emergency admissions for acute conditions that should not usually require hospital admission - (*LOCAL DATA*)	1420.36	1420.36	556.49	636.60	YTD		136.50	127.70	124.70	129.20	118.50									
C3.10	Improving Recovery	Proportion of patients recovering to their previous levels of mobility or walking ability at 30 days	New	Latest Baseline Year				Due Dec 15														
C3.10	Improving Recovery	Proportion of patients recovering to their previous levels of mobility or walking ability at 120 days	New	Latest Baseline Year				Due Dec 15														
C3.11	Improving Recovery	Hip fracture: formal hip fracture programme	New	Latest Baseline Year				Due Dec 15														
C3.12	Improving Recovery	Hip fracture: timely surgery	New	Latest Baseline Year				Due Dec 15														
C3.13	Improving Recovery	Hip fracture: multifactorial risk assessment	New	Latest Baseline Year				Due Dec 15														
C3.14	Improving Recovery	Alcohol: admissions	New	Latest Baseline Year							Due Dec 14											
C3.15	Improving Recovery	Alcohol: readmissions	New	Latest Baseline Year							Due Dec 14											
C3.16	Improving Recovery	Readmissions to mental health within 30 days of discharge	New	Latest Baseline Year							Due Dec 14											
C3.17	Improving Recovery	Proportion of adults in contact with secondary mental health services in paid employment	New	Latest Baseline Year							Due Dec 14											
C3.2	Emergency Re-Admissions	Emergency readmissions within 30 days of discharge from hospital	Not Avail.	Latest Baseline Year				See note >														Readmissions methodology not yet signed off
C3.2(L)	Emergency Re-Admissions	Emergency readmissions within 30 days of discharge from hospital - (*LOCAL DATA*)	New	Latest Baseline Year				See note >														Readmissions methodology not yet signed off
C3.3a	PROMS	PROMS: Hip Replacement	0.41	0.41							Due Nov 14											
C3.3b	PROMS	PROMS: Knee Replacement	0.34	0.34							Due Nov 14											
C3.3c	PROMS	PROMS: Groin Hernia	0.08	0.08							Due Nov 14											
C3.3d	PROMS	PROMS: Varicose Veins	*	Not Avail.							Due Nov 14											
C3.4	Emergency Admissions	Emergency admissions for children with lower respiratory tract infections (LRTIs)	New	79.36							Due Dec 14											
C3.4(L)	Emergency Admissions	Emergency admissions for children with lower respiratory tract infections (LRTIs) - (*LOCAL DATA*)	79.36	79.36							See note >											New local indicator introduced end July - awaiting locally sourced data, if available

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2014-15: CCG Outcomes Indicator Set Scorecard - Trafford CCG

Performance Reporting Month: Aug-2014

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															
C3.5	Improving Recovery	People who have had a stroke who are admitted to an acute stroke unit within four hours of arrival to hospital	Not Avail.	Latest Baseline Year				Due Dec 15														
C3.6	Improving Recovery	People who have had a stroke who receive thrombolysis following an acute stroke	Not Avail.	Latest Baseline Year				Due Dec 15														
C3.7	Improving Recovery	People who have had a stroke who are discharged from hospital with a joint health and social care plan	Not Avail.	Latest Baseline Year				Due Dec 15														
C3.8	Improving Recovery	People who have had a stroke who receive a follow up assessment between 4-8 months after initial admission	Not Avail.	Latest Baseline Year				Due Dec 15														
C3.9	Improving Recovery	Patients who have had an acute stroke who spend 90% or more of their stay on a stroke unit	New	80.0%				Due Dec 15														
C4.1	Patient Experience of Primary Care	Patient experience of GP out-of-hours services	New	TBC				Due Sep 15														
C4.2	Patient Experience of Hospital Care	Patient experience of hospital care	New	TBC				Due Sep 15														
C4.4	Patient Experience of Outpatient Care	Patient experience of outpatient services	Not Avail.	TBC				See note >														NB N3C are still working with the survey co-ordinator to agree the spec for the measures & necessary data sharing agreements
C4.5	Patient Experience of Inpatient's Personal Needs	Responsiveness to inpatients' personal needs	Not Avail.	TBC				Due Sep 15														
C4.6	Patient Experience of A&E Services	Patient experience of accident and emergency (A&E) services	7.30	TBC				Due Mar 16														
C4.7	Patient Experience of Maternity Services	Women's experience of maternity services	Not Avail.	TBC				See note >														NB N3C are still working with the survey co-ordinator to agree the spec for the measures & necessary data sharing
C4.8	Patient Experience of Community Mental Health Services	Patient experience of community mental health services	Not Avail.	TBC				See note >														NB N3C are still working with the survey co-ordinator to agree the spec for the measures & necessary data sharing
C4.9	Patient experience at the end of their lives	Bereaved carers' views on the quality of care in the last three months of life	New	TBC				tbc														
C5.1	Avoidable Harm	Patient safety incidents reported	Not Avail.	Latest Baseline Year										Due Jun 15								Due Dec 15

2014-15: Full Set of KPIs Scorecard - UHSM

Performance Reporting Month: Aug-2014

Code	Indicator name	Detail	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														
CB_A15a	HCAI	Overall Number of Cases of MRSA Bacteraemia - AVOIDABLE	0	0	0	YTD	0	0	0	0	0									Provisional assignment.
CB_A15b	HCAI	Overall Number of Cases of MRSA Bacteraemia - UNAVOIDABLE	0	0	1	YTD	0	0	0	0	1									Provisional assignment.
CB_A16a	HCAI	Number of Cases of C. Difficile Caused by Lapse in Care - NHS Patients	39	17	16	YTD	3	2	4	4	3									Provisional assignment.
CB_A16b	HCAI	Overall Number of Cases of C. Difficile - NHS Patients	See Note																	Targets not applicable. Provisional assignment.
CB_A16c	HCAI	Number of Cases of C. Difficile Caused by Lapse in Care - in Intermediate Care	4	1	1	YTD	0	0	1	0	0									Provisional assignment.
CB_A16d	HCAI	Number of Cases of C. Difficile - in Intermediate Care (UNAVOIDABLE)	TBC	0	3	YTD	0	0	1	0	2									Provisional assignment.
CB_B1	Referral to Treatment	The Percentage within 18 weeks for Completed Admitted RTT Pathways	90.0%	90.0%	91.2%	YTD	91.9%	91.7%	90.0%	91.3%	91.0%									
SPECIALTY LEVEL >>>	RTT - SPECIALTY LEVEL >>>	- Admitted Adjusted Pathways: SPECIALTY LEVEL - Cardiology	90.0%	90.0%	81.7%	YTD	80.7%	81.0%	87.9%	80.9%	77.7%									
SPECIALTY LEVEL >>>	RTT - SPECIALTY LEVEL >>>	- Admitted Adjusted Pathways: SPECIALTY LEVEL - General Surgery	90.0%	90.0%	83.6%	YTD	83.3%	84.4%	80.5%	83.1%	87.7%									
SPECIALTY LEVEL >>>	RTT - SPECIALTY LEVEL >>>	- Admitted Adjusted Pathways: SPECIALTY LEVEL - Trauma & Orthopaedics	90.0%	90.0%	81.0%	YTD	84.6%	79.6%	74.7%	81.3%	83.4%									
CB_B2	Referral to Treatment	The Percentage within 18 weeks for Completed Non-Admitted RTT Pathways	95.0%	95.0%	97.1%	YTD	97.2%	97.0%	97.5%	96.8%	96.9%									
SPECIALTY LEVEL >>>	RTT - SPECIALTY LEVEL >>>	- Non-admitted Pathways: SPECIALTY LEVEL - Gastroenterology	95.0%	95.0%	93.6%	YTD	86.6%	95.2%	95.2%	92.7%	97.2%									
SPECIALTY LEVEL >>>	RTT - SPECIALTY LEVEL >>>	- Non-admitted Pathways: SPECIALTY LEVEL - Thoracic Medicine	95.0%	95.0%	93.8%	YTD	92.9%	94.7%	94.6%	92.4%	94.0%									
SPECIALTY LEVEL >>>	RTT - SPECIALTY LEVEL >>>	- Non-admitted Pathways: SPECIALTY LEVEL - Trauma & Orthopaedics	95.0%	95.0%	93.0%	YTD	89.9%	90.8%	95.1%	93.2%	95.7%									
CB_B3	Referral to Treatment	The Percentage within 18 weeks for Incomplete RTT Pathways	92.0%	92.0%	95.2%	YTD	95.3%	95.1%	95.4%	95.0%	95.2%									
SPECIALTY LEVEL >>>	RTT - SPECIALTY LEVEL >>>	- Incomplete Pathways: SPECIALTY LEVEL - Cardiothoracic Surgery	92.0%	92.0%	91.8%	YTD	88.9%	89.0%	91.5%	94.7%	94.8%									
SPECIALTY LEVEL >>>	RTT - SPECIALTY LEVEL >>>	- Incomplete Pathways: SPECIALTY LEVEL - Trauma & Orthopaedics	92.0%	92.0%	91.1%	YTD	92.3%	90.6%	90.8%	91.5%	90.2%									
CB_S6c	Referral to Treatment	The Number of RTT Pathways > 52 weeks for Incomplete Pathways	0	0	0	YTD	0	0	0	0	0									
CB_S7a	Ambulance Handover Time	Ambulance Handover Delays of over 30 minutes - Wythenshawe Hosp	0	0	427	YTD	131	92	72	79	53									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	84	YTD	32	23	17	7	5									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%	82.9%	YTD	80.2%	83.0%	82.1%	83.6%	86.1%									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%	92.3%	YTD	90.2%	90.4%	91.3%	91.5%	92.3%									Monthly reported figure is YTD performance.
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									
CB_S10	Cancelled Operations	Number of Urgent Operations Cancelled for a Second Time	0	0	0	YTD	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%	1.4%	YTD	1.7%	0.7%	0.8%	0.7%	3.4%									
Diagnostic Test Name	Diagnostic Test Name >>>	Diagnostic test waiting times - DEXA_SCAN	1.0%	1.0%	1.9%	YTD	1.0%	0.6%	7.1%	0.0%	0.0%									
Diagnostic Test Name	Diagnostic Test Name >>>	Diagnostic test waiting times - PERIPHERAL_NEUROPHYS	1.0%	1.0%	17.3%	YTD	24.0%	6.0%	2.5%	8.7%	41.8%									
Diagnostic Test Name	Diagnostic Test Name >>>	Diagnostic test waiting times - SLEEP_STUDIES	1.0%	1.0%	5.8%	YTD	9.5%	5.9%	0.0%	0.0%	6.3%									
Diagnostic Test Name	Diagnostic Test Name >>>	Diagnostic test waiting times - URODYNAMICS	1.0%	1.0%	2.7%	YTD	6.7%	3.1%	3.3%	0.0%	0.0%									

2014-15: Full Set of KPIs Scorecard - UHSM

Performance Reporting Month: Aug-2014

Code	Indicator name	Detail	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														
Diagnostic Test Name	Diagnostic Test Name >>>	Diagnostic test waiting times - COLONOSCOPY	1.0%	1.0%	5.4%	YTD		4.8%	3.7%	0.0%	2.4%	12.7%								
Diagnostic Test Name	Diagnostic Test Name >>>	Diagnostic test waiting times - FLEXI_SIGMOIDOSCOPY	1.0%	1.0%	2.0%	YTD		0.0%	0.0%	1.0%	2.0%	10.9%								
Diagnostic Test Name	Diagnostic Test Name >>>	Diagnostic test waiting times - CYSTOSCOPY	1.0%	1.0%	8.6%	YTD		12.9%	4.7%	11.1%	0.0%	16.7%								
Diagnostic Test Name	Diagnostic Test Name >>>	Diagnostic test waiting times - GASTROSCOPY	1.0%	1.0%	2.5%	YTD		3.1%	2.4%	0.9%	2.3%	3.7%								
CB_B17a	Mixed Sex Accommodation	MSA Breach Number	0	0	0	YTD		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%	96.6%	YTD		97.1%	97.1%	96.2%	96.2%									
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%	97.5%	YTD		99.4%	97.6%	96.9%	96.2%									
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%	98.4%	YTD		99.5%	98.6%	98.0%	97.7%									
CB_B9	Cancer 31 Day Waits	Percentage of Patients Receiving Subsequent Surgery within a maximum Waiting Time of 31 Days	94.0%	94.0%	97.8%	YTD		98.0%	100.0%	100.0%	93.3%									
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%									
CB_B11	Cancer 31 Day Waits	Percentage of Patients Receiving a Subsequent/Adjuvant Radiotherapy Treatment within a maximum Waiting Time of 31	94.0%																	
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%	85.2%	YTD		85.8%	90.4%	82.3%	82.3%									
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%	99.6%	YTD		98.5%	100.0%	100.0%	100.0%									
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%	83.1%	YTD		90.5%	86.0%	84.4%	73.7%									
CB_B18	Cancelled Operations	Number of Patients not offered another Binding Date within 28 days of a Cancelled Operation	0	0	1	YTD				1										1 patient out of 191 has breached
D05	Complaints	% of complaints responded to within timescale agreed at the outset upon receipt of the complaint with the complainant ("the response	90.0%	90.0%	89.4%	YTD		89.7%	83.7%	82.0%	97.9%	95.1%								
No Referral	VTE	VTE risk assessment: all inpatient Service Users undergoing risk assessment for VTE	95.0%	95.0%	95.2%	YTD		95.1%	95.2%	95.2%	95.2%	95.2%								
LTC2	LTCs	Screening of patients with LTCs for anxiety/depression - COPD patients	B/Line Yr		45.8%	YTD		44.4%	40.3%	50.0%	36.1%	78.6%								
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%								
RHB1	Readmissions	Readmissions within 28 days - COPD patients	B/Line Yr		11.7%	YTD		9.1%	15.0%	12.5%	11.1%	10.7%								Issue discussed re significant time-lag before these figures can be considered
RHB3	Readmissions	No Admissions to hospital within 91 days of Referral - COPD patients	B/Line Yr		2.4%	YTD		0.0%	0.0%	12.5%	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 its
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 its
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%	72.9%	YTD		85.7%	54.3%	90.5%	78.6%	69.4%								
GM07	Stroke	Quality stroke care - proportion of patients arriving in a designated stroke bed within 4 hours of arrival	60.0%	60.0%	66.7%	YTD		75.0%	44.4%	90.9%	87.5%	66.7%								
GM08	Stroke	Quality stroke care - proportion of high risk TIA cases investigated and treated within 24 hours	60.0%	60.0%	71.1%	YTD		100.0%	90.0%	60.7%	71.4%	57.9%								
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%	93.4%	YTD		94.5%	95.6%	93.4%	90.2%	93.5%								

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2014-15: Full Set of KPIs Scorecard - UHSM

Performance Reporting Month: Aug-2014

Code	Indicator name	Detail	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																
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%					74.9%													
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%					96.5%													
D06	Complaints	% of complaints acknowledged in 3 working days of the day following receipt of the complaint	90.0%	90.0%	90.2%	YTD			90.2%													
D07	Complaints	% of complaints where, following investigation, an action plan has been put in place, acted upon, completed within an agreed	90.0%		na	YTD			na													
D09	Delayed Transfers	Delayed transfers of care (lost bed days/nights) to be kept to a minimum level - NHS Only	TBC		2,048	YTD		334	343	381	530	460										
D02	Pharmacy	Evidence of a strategy to bring arrangements for homecare medicines in line with nationally agreed best practice	Y																			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																				Awaiting further clarification from the CCG/CSU
No Ref03	Formulary	Formulary published	Y		G	YTD																
No Ref03	Duty of Candour	Duty of Candour	0	0	0	YTD		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%	99.8%	YTD		99.8%	99.8%	99.8%	99.8%	99.8%										
No Ref05	NHS Number	Completion of a valid NHS Number field in A&E commissioning data sets submitted via SUS	95.0%	95.0%	98.0%	YTD		98.1%	98.2%	98.0%	98.0%	97.8%										
E02	Choose & Book	Slot Issues																				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.

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2014-15: Full Set of KPIs Scorecard - CMFT

Performance Reporting Month: Aug-2014

Code	Indicator name	Detail	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														
CB_A15a	HCAI	Overall Number of Cases of MRSA Bacteraemia - AVOIDABLE	0	0	2	YTD	1	0	1	0	0									Apr = Oldham CCG; May = Ctrl Mcr CCG; May = T&G CCG. Provisional assignment.
CB_A15b	HCAI	Overall Number of Cases of MRSA Bacteraemia - UNAVOIDABLE	0	0	1	YTD	0	1	0	0	0									Provisional assignment.
CB_A16a	HCAI	Number of Cases of C. Difficile Caused by Lapse in Care - NHS Patients	66	28	3	YTD	0	0	1	2	0									Provisional assignment.
CB_A16b	HCAI	Overall Number of Cases of C. Difficile - NHS Patients	See Note		38	YTD	6	8	4	7	13									Targets not applicable. Provisional assignment.
CB_B1	Referral to Treatment	The Percentage within 18 weeks for Completed Admitted RTT Pathways	90.0%	90.0%	90.6%	YTD	91.0%	90.7%	90.9%	90.2%	90.0%									
SPECIALTY LEVEL >>>	RTT - SPECIALTY LEVEL >>>	- Admitted Adjusted Pathways: SPECIALTY LEVEL - Other	90.0%	90.0%	84.8%	YTD	86.7%	86.3%	84.1%	84.4%	81.8%									
CB_B2	Referral to Treatment	The Percentage within 18 weeks for Completed Non-Admitted RTT Pathways	95.0%	95.0%	95.9%	YTD	95.3%	95.8%	96.4%	95.9%	95.9%									
SPECIALTY LEVEL >>>	RTT - SPECIALTY LEVEL >>>	- Non-admitted Pathways: SPECIALTY LEVEL - Other	95.0%	95.0%	92.8%	YTD	91.0%	92.9%	93.8%	93.5%	93.0%									
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%									
SPECIALTY LEVEL >>>	RTT - SPECIALTY LEVEL >>>	- Incomplete Pathways: SPECIALTY LEVEL - Other	92.0%	92.0%	89.8%	YTD	90.0%	90.7%	90.3%	89.2%	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									
CB_S7a	Ambulance Handover Time	Ambulance Handover Delays of over 30 minutes - MRI	0	0	584	YTD	152	159	45	94	134									
CB_S7b	Ambulance Handover Time	Ambulance Handover Delays of over 1 hour - MRI	0	0	118	YTD	47	37	3	14	17									
CB_S7a	Ambulance Handover Time	Ambulance Handover Delays of over 30 minutes - TGH	0	0	1	YTD	0	1	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									
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%									
CB_B5	A&E Waiting Times	Percentage of Patients spending 4 hours or less in A&E	95.0%	95.0%	95.6%	YTD	93.3%	93.8%	95.3%	95.6%	95.6%									Monthly reported figure is YTD performance.
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									
CB_S14	Cancelled Operations	Number of Urgent Operations Cancelled for a Second Time	0	0	0	YTD	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%	2.3%	YTD	2.6%	3.1%	1.9%	2.1%	1.9%									
Diagnostic Test Name	Diagnostic Test Name >>>	Diagnostic test waiting times - MRI	1.0%	1.0%	3.3%	YTD	4.7%	5.2%	2.6%	2.6%	1.0%									Published data
Diagnostic Test Name	Diagnostic Test Name >>>	Diagnostic test waiting times - ELECTROPHYSIOLOGY	1.0%	1.0%	62.5%	YTD	100.0%	50.0%	100.0%	50.0%	0.0%									Published data
Diagnostic Test Name	Diagnostic Test Name >>>	Diagnostic test waiting times - SLEEP_STUDIES	1.0%	1.0%	1.9%	YTD	1.6%	1.1%	1.5%	2.7%	2.2%									Published data
Diagnostic Test Name	Diagnostic Test Name >>>	Diagnostic test waiting times - URODYNAMICS	1.0%	1.0%	11.0%	YTD	0.0%	6.7%	7.1%	14.3%	29.4%									Published data
Diagnostic Test Name	Diagnostic Test Name >>>	Diagnostic test waiting times - COLONOSCOPY	1.0%	1.0%	19.7%	YTD	8.9%	16.0%	26.5%	19.7%	34.4%									Published data
Diagnostic Test Name	Diagnostic Test Name >>>	Diagnostic test waiting times - FLEXI_SIGMOIDOSCOPY	1.0%	1.0%	1.1%	YTD	0.7%	0.0%	1.7%	0.7%	2.8%									Published data
Diagnostic Test Name	Diagnostic Test Name >>>	Diagnostic test waiting times - CYSTOSCOPY	1.0%	1.0%	13.2%	YTD	16.7%	15.0%	7.3%	12.5%	13.9%									Published data
Diagnostic Test Name	Diagnostic Test Name >>>	Diagnostic test waiting times - GASTROSCOPY	1.0%	1.0%	13.8%	YTD	15.3%	17.1%	12.0%	9.8%	15.3%									Published data
CB_B17a	Mixed Sex Accommodation	MSA Breach Number	0	0	0	YTD	0	0	0	0	0									

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Performance Reporting Month: Aug-2014

Code	Indicator name	Detail	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															
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%	95.0%	YTD		94.3%	94.8%	94.5%	96.3%										
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%	97.5%	YTD		97.5%	96.3%	97.1%	98.9%										
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		94.4%	100.0%	100.0%	100.0%										
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%										No activity reported for May14
CB_B11	Cancer 31 Day Waits	Percentage of Patients Receiving a Subsequent/Adjuvant Radiotherapy Treatment within a maximum Waiting Time of 31	94.0%																		No activity reported to date
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%	80.7%	YTD		85.9%	69.3%	77.3%	89.1%										
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%	80.0%	YTD		66.7%	66.7%	100.0%	100.0%										
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%	92.3%	YTD		93.8%	87.5%	94.3%											
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									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	90.0%																		
No Ref01	VTE	VTE risk assessment: all inpatient Service Users undergoing risk assessment for VTE	95.0%	95.0%	95.9%	YTD		95.8%	96.0%	96.2%	95.8%	95.9%									
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
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%	74.3%	YTD		65.2%	79.3%	72.7%	75.0%	78.3%									
GM07	Stroke	Quality stroke care - proportion of patients arriving in a designated stroke bed within 4 hours of arrival	60.0%	60.0%	38.6%	YTD		28.6%	37.5%	35.7%	28.6%	83.3%									
GM08	Stroke	Quality stroke care - proportion of high risk TIA cases investigated and treated within 24 hours	60.0%	60.0%	62.5%	YTD		66.7%	66.7%	100.0%	0.0%	75.0%									
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%	78.0%	YTD		76.5%	77.7%	77.3%	79.1%	79.1%									
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	90.0%	90.0%	96.4%	YTD		95.2%	95.5%	97.3%	97.3%	96.2%									
GM13	Pharmacy	All patients on wards with daily pharmacy visit should have medicines reconciled by a pharmacist within 24 hours of admission	95.0%	95.0%	65.4%	YTD				65.4%											
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	90.0%																		
D09	Delayed Transfers	Delayed transfers of care (lost bed days/nights) to be kept to a minimum level - NHS Only	TBC		853	YTD		122	113	179	131	308									
No Ref02	Formulary	Formulary published	Y		G	YTD															
No Ref03	Duty of Candour	Duty of Candour	0	0	0	YTD		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%																		

2014-15: Full Set of KPIs Scorecard - CMFT

Performance Reporting Month: Aug-2014

Code	Indicator name	Detail	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															
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		20.4%	YTD		16.8%	16.6%	19.4%	25.7%	23.4%										
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.

2014-15: Full Set of KPIs Scorecard - PCFT

Performance Reporting Month: Sep-2014

Code	Indicator name	Detail	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															
CB_B2	Referral to Treatment	The Percentage within 18 weeks for Completed Non-Admitted RTT Pathways	95.0%	95.0%			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%	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									
H03	Complaints	% of complaints responded to within timescale agreed at the outset upon receipt of the complaint with the complainant ("the response	90.0%	90.0%			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%			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%			100.0%									
No Ref 63	Formulary	Failure to publish Formulary	Yes																		
No Ref 63	Duty of Candour	Duty of Candour	0	0			0	0	0	0	0	0									
AS49	Overarching	KPI Compliance	80.0%	80.0%			88.9%	88.9%	100.0%	81.8%	73.0%	64.0%									
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%			89.0%	89.0%	100.0%	82.0%	73.0%	64.0%									
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%			90.9%	95.0%	93.8%	78.6%	N/A	94.0%									
GM03	Children & Families	% Breastfeeding status recorded	95.0%	95.0%					96.7%			96.0%									
GM04	Children & Families	% Fully or partially breastfed	54.0%	54.0%					54.4%			55.0%									
GM08	Health Visitors	Number HVs (WTE)	51	51			52	51	50	51	50	50									
GM09	Harm free Care	Number of Grade 2> pressure ulcer	TBC				7	11	10	10	12	6									(Rate per 1000)
GM15	Dementia	% Dementia case notes with carer views	93.0%	93.0%			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%			80.0%									
GM30	Children & Families	% New mothers with an assessment postnatal depression	95.0%	95.0%			90.0%	96.0%	93.0%	91.0%	93.0%	94.0%									
GM32	Children & Families	% Looked after children 0-5 yr with twice yearly assessments	90.0%	90.0%					92.9%			94.0%									
GM33	Children & Families	% Looked after children 5 yr+ with annual assessments	90.0%	90.0%					97.5%			96.0%									
GM11 - T	Training	% eligible staff completing mandatory adult protection training	95.0%	90.0%					91.7%			96.0%									
GM12-T	Training	% eligible staff completing domestic abuse training	90.0%	90.0%					86.4%			76.0%									
GM13-T	Training	% eligible staff completing mandatory infection control training	90.0%	90.0%					56.4%			93.0%									
GM14-T	Training	% eligible staff completing basic level dementia awareness training	90.0%	90.0%					67.7%			61.0%									
GM29-T	Training	% eligible staff receiving health promotion training	90.0%	90.0%					91.5%			90.0%									
GM34-T	Training	% eligible staff completing mandatory child protection training	90.0%	90.0%					89.3%			84.0%									
GM27	Making every contact count	% Adults / children assessed for nutritional requirements	65.0%																		
AS01	CNRT	Patients whose first treatment appointment is within 6 weeks for routine patients from referrals	90.0%	90.0%			73.0%	86.0%	90.0%	88.0%	87.0%	89.0%									
AS02	CNRT	Urgent referrals whose first treatment appointment is within 2 weeks for from receipt of referral	90.0%	90.0%			100.0%	78.6%	94.4%	100.0%	83.0%	95.0%									

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Performance Reporting Month: Sep-2014

Code	Indicator name	Detail	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														
AS03	CNRT	Patients for whom reason for referral is captured	80.0%	80.0%			97.3%	94.3%	92.1%	97.0%	89.0%	98.0%								
AS04	Community Rehabilitation	Patients whose first contact with a therapist is within 1 working day for urgent referrals	80.0%	80.0%			96.8%	96.0%	98.4%	98.4%	100.0%	96.0%								
AS05	Community Rehabilitation	Patients whose first contact with a therapist is within 10 working day for routine referrals	80.0%	80.0%			68.4%	79.8%	73.2%	79.0%	82.0%	82.0%								
AS06	Community Rehabilitation	Patients for whom the reason for referral is captured	80.0%	80.0%			98.6%	98.6%	96.9%	98.3%	97.0%	95.0%								
AS07	Continenence	Urgent patients whose first attendance is within 10 working days from receipt of referral	80.0%	80.0%			91.7%	100.0%	100.0%	100.0%	NA	100.0%								
AS08	Continenence	Reason for referral including main diagnosis is capture	80.0%	80.0%			97.2%	94.8%	96.0%	97.0%	97.0%	96.0%								
AS10	District Nurse	Patients whose first contact is within 3 working days for routine and non-urgent patients from referral excluding those with a specified	80.0%	80.0%			80.4%	81.1%	76.5%	79.0%	77.0%	75.0%								
AS11	District Nurse	Reason for referral including main diagnosis is captured	80.0%	80.0%			94.1%	96.9%	96.0%	97.0%	95.0%	98.0%								
AS12	Ear Care	Patients whose first appointment is within 2 weeks of referral	95.0%	95.0%			68.1%	70.7%	48.1%	46.9%	68.0%	51.0%								
AS13	Ear Care	Percentage of patients for whom the intervention is captured	90.0%	90.0%			81.0%	94.0%	91.0%	89.0%	93.0%	92.0%								
AS14	Ear Care	Percentage of GP practices that access the service	80.0%	80.0%			94.0%	97.0%	97.0%	97.0%	97.0%	97.0%								
AS15	MSK	Patients whose first attendance is within 18 weeks from referral	100.0%	100.0%			98.4%	99.2%	100.0%	100.0%	99.0%	100.0%								
AS16	MSK	Patients for whom the reason for referral is captured- body part	80.0%	80.0%			95.5%	96.0%	96.2%	95.8%	96.0%	95.0%								
AS17	Nutrition & Dietetics	Patients whose first attendance is within 6 weeks from receipt of referral	80.0%	80.0%			82.1%	77.1%	83.9%	72.7%	68.0%	66.0%								
AS18	Nutrition & Dietetics	Patients for whom the reason for referral is captured	80.0%	80.0%			97.0%	91.2%	94.1%	96.9%	98.0%	92.0%								
AS19	Nutrition & Dietetics	Percentage of GP practices that access the service	80.0%	80.0%			94.4%	97.2%	97.2%	97.2%	97.2%	97.0%								
AS20	OSRC	Assessment is within 7 days for urgent appointments	80.0%	80.0%			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%	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%	97.9%	99.3%	98.1%	99.0%	98.0%								
AS25	Phlebotomy	Patients for whom category is allocated (HV, anti-coag, primary care) including clinic contacts	90.0%	90.0%			99.1%	99.3%	98.1%	98.0%	97.0%	93.0%								
AS26	Pulmonary Rehabilitation	Patients whose first attendance at a course is within 8 weeks from referral	90.0%	90.0%			0.0%	0.0%	0.0%	3.8%	8.0%	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%	100.0%	100.0%	100.0%	100.0%	100.0%								
AS28	Pulmonary Rehabilitation	Patients who complete 80% of the course	70.0%	70.0%			57.0%	100.0%	62.0%	29.0%	53.0%	43.0%								
AS29	SPC Services	Patients whose first contact is within 3 days for specialist palliative care nurses from receipt of referral	80.0%	80.0%			40.0%	85.0%	78.0%	54.0%	63.0%	62.0%								
AS30	SPC Services	Patients for whom the reason for referral is captured	90.0%	90.0%			100.0%	100.0%	100.0%	100.0%	100.0%	100.0%								
AS31	SWMS	Referrals acknowledged and processed within 3 working days of referral receipt	95.0%	95.0%			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%			100.0%	95.7%	100.0%	100.0%	93.0%	94.0%								
AS35	SWMS	Clients have an initial weight, blood pressure and BMI recorded	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%	100.0%	100.0%	100.0%	100.0%	100.0%								

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Performance Reporting Month: Sep-2014

Code	Indicator name	Detail	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														
AS37	SWMS	Clients that have co-morbidity & drug therapy status (where appropriate) recorded pre & post treatment	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%			20.0%	20.0%	16.7%	0.0%	0.0%	20.0%								
AS42	Tissue Viability	% patients assessed within 25 working days from receipt of referral	90.0%	90.0%			83.3%	100.0%	100.0%	72.2%	80.0%	87.0%								
AS43	Tissue Viability	% GP practices that access the service	80.0%	80.0%			25.0%	50.0%	58.3%	66.7%	75.0%	78.0%								
AS44	SALT Adults	Patients for whom the reason for referral is captured	90.0%	90.0%			92.5%	96.0%	100.0%	96.0%	95.0%	98.0%								
AS46	SALT Adults	First assessment is completed within 1 week for routine dysphagia	90.0%	90.0%			25.9%	60.6%	62.1%	82.5%	71.0%	77.0%								
UE16	Heart Failure	Routine patients whose first attendance is within 28 days from referral	80.0%	80.0%			100.0%	68.8%	97.1%	85.0%	71.0%	50.0%								
UE17	Heart Failure	Urgent patients whose first attendance is within 7 days from referral	80.0%	80.0%			NA	NA	100.0%	NA	NA	0.0%								
UE18	Heart Failure	Patients for whom the intervention is captured (titration of drugs, education, care planning)	90.0%	90.0%			100.0%	94.0%	100.0%	93.9%	81.0%	95.0%								
UE19	Heart Failure	Percentage of GP practices that access the service	80.0%	80.0%			36.1%	55.6%	72.2%	72.2%	78.0%	83.0%								
CY01	CAHMS	First contact with CAMHS worker is within the same working day for emergency self harm referrals	90.0%	90.0%			100.0%	100.0%	100.0%	100.0%	100.0%	100.0%								
CY02	CAHMS	Contact with CAMHS worker is within 9 days for urgent referrals/self harm follow ups	90.0%	90.0%			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%			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%			88.8%	93.3%	81.8%	96.1%	88.0%	99.0%								
CY05	Community Paediatric Medical	Timely medical assessments for SEN within 42 days of receipt of referral	90.0%	90.0%			50.0%	100.0%	100.0%	93.0%	100.0%	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%			100.0%	83.3%	100.0%	100.0%	100.0%	100.0%								
CY07	Community Paediatric Medical	Timely medical assessments of looked after children within 28 days of receipt of referral	90.0%	90.0%			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%			88.6%	91.1%	92.2%	94.2%	93.0%	88.0%								
CY09	Health Management	% records that are accurate on relevant systems	90.0%	90.0%			99.2%	99.2%	99.0%	98.9%	99.0%	99.0%								
CY10	Health Management	% child health system returns completed and submitted within required timescales.	100.0%	100.0%			NA	100.0%	100.0%	n/a	100.0%	100.0%								
CY11	Health Visiting	Children receiving primary birth visit within 14 days of birth	100.0%	100.0%					95.5%			96.0%								
CY12	Health Visiting	Children who by 32 months have been offered a 2 yr check as in HCP	100.0%	100.0%					93.0%			97.0%								
CY26	Safeguarding Health	% young offenders receiving an offer of a health assessment NB Deleted but will provide	80.0%	80.0%			100.0%	77.8%	100.0%		54.0%	81.0%								
CY27	School Nursing	% new contacts for self harm acknowledged within 2 working days	80.0%	80.0%			100.0%	100.0%	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	NA	NA								
CY30	SALT Children	% referrals for children <6 months old with dysphagia whose initial assessment by a qualified therapist and management plan has	80.0%	80.0%			NA	0.0%	NA	NA	NA	NA								
CY14	Occupational Therapy	Patients for whom reason for referral is captured	80.0%	80.0%			90.6%	97.7%	92.7%	93.7%	98.0%	97.0%								
CY16	Occupational Therapy	Allocated equipment for 0-5 year olds is reviewed at 4 monthly intervals	95.0%	95.0%			100.0%	100.0%	100.0%	100.0%	100.0%	100.0%								
CY17	Occupational Therapy	Allocated equipment for 5-11 yr olds is reviewed at 8 monthly intervals	95.0%	95.0%			71.4%	100.0%	100.0%	100.0%	100.0%	100.0%								

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Performance Reporting Month: Sep-2014

Code	Indicator name	Detail	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															
CY18	Occupational Therapy	Allocated equipment for 11-16 yr olds is reviewed at annual intervals	95.0%	95.0%			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%			40.8%	53.1%	65.6%	78.0%	86.0%	91.0%									
CY21	Physiotherapy	Patients for whom the reason for referral is captured	80.0%	80.0%			90.6%	97.7%	92.7%	93.7%	98.0%	97.0%									
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%			91.1%	89.0%	92.0%	71.0%	78.0%	82.0%									
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	90.0%	90.0%			100.0%	100.0%	100.0%	100.0%	100.0%	80.0%									
UE03	Urgent Care	Data - % of patients for whom the reason for referral is captured	90.0%	90.0%			100.0%	100.0%	98.3%	97.9%	98.0%	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%	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%	100.0%	100.0%	100.0%	100.0%	100.0%									
UE06	Enhanced Care (medically stable patients cared for	Access - % of non-urgent patients whose referral is triaged within 3 working days and first attendance is commenced within 10 working	90.0%	90.0%			87.5%	93.8%	91.5%	81.4%	76.0%	70.0%									
UE07	Enhanced Care (medically stable patients cared for	Data - %patients for whom the reason for referral is captured	90.0%	90.0%			100.0%	100.0%	98.4%	91.0%	90.0%	87.0%									
UE08	Enhanced Care (medically stable patients cared for	Quality - % of appropriate non-urgent patients on the enhanced care caseload who have an advanced care plan that identifies their	B/Line Yr				Due Nov 14														
UE09	Enhanced Care (medically stable patients cared for	Quality - %of patients on Enhanced Care Team caseload who die in their preferred place of care.	B/Line Yr				Due Nov 14														
UE10	Enhanced Care (medically stable patients cared for	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%	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	B/Line Yr				100.0%	100.0%	100.0%	75.0%	83.0%	86.0%									
UE12	IV Therapy	Data - % of patients for whom the reason for IV Therapy is captured	B/Line Yr				100.0%	100.0%	92.3%	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%	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	90.0%				Due Nov 14														
IND-C	Health Visitors	Number of mothers who received a first face to face antenatal contact with a Health Visitor.	B/Line Yr				Due Nov 14														
D04	New to Follow up Ratio	In Development	B/Line Yr				Due Nov 14														

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