

<p>Yorkshire and the Humber Strategic Health Authority</p> <p>BOARD MEETING</p>	 <p>Yorkshire and the Humber</p>
<p>Date: 8 September 2009</p>	<p>Report Author: Helen Dowdy, Associate Director of Strategy</p>
<p>Title of paper: Delivering Healthy Ambitions: Update on Planned Care Pathway</p>	
<p>Actions Requested: The Board is asked to note and comment on progress in delivery of the planned care pathway</p>	
<p>Governance Requirements</p>	
<p>SHA Objectives supported by this paper: Objective 2 : Healthy Ambitions</p>	
<p>Risk Management Relevant risks:</p> <p>2.1 Economic climate slows progress</p> <p>2.2 Enabling work streams (e.g. NPfIT) diverted to other priorities</p>	
<p>Risk Assessment:</p> <ul style="list-style-type: none"> • The content of this paper has been subject to a risk assessment. • Actions required to mitigate the identified risks are being pursued either through the Strategic or Operational Risk Registers as appropriate. 	
<p>Communication (including public and patient involvement): We now issue a regular bulletin to the local NHS and partners about Healthy Ambitions regional work programmes.</p>	
<p>Resource Implications: Resource implications – Funded through SHA budgets and through the Healthy Ambitions Investment Fund created by PCTs and managed by the SHA.</p>	
<p>Legal Implications: Not applicable</p>	
<p>Equality and Diversity: One of the key objectives underpinning all the programmes set out in Healthy Ambitions is to tackle unjustifiable variations in care, so that no particular population is disadvantaged. This helps to address the overarching equality and diversity agenda.</p>	

Yorkshire and the Humber Strategic Health Authority

8 September 2009

Delivering Healthy Ambitions: Update on Planned Care Pathway

Introduction

1. This paper updates the board on the work of the planned care pathway as part of the overall Healthy Ambitions programme. It sets out:
 - the case for change for planned care
 - the key features of the planned care programme
 - progress to date on key issues – particularly on the regional level programme of work – which has started with a major review of vascular services

Context

2. Healthy Ambitions (published in May 2008) is the strategic service framework for the region – covering the next five to ten years. Healthy Ambitions is one of the SHA's principal objectives and represents a very significant programme (to be delivered both locally and regionally).
3. Delivering Healthy Ambitions was published in March 2009 and sets out the overall framework for delivery across Y&H. In particular, this framework identified for each recommendation those areas that needed to be taken forward regionally, and those which needed to be taken forward locally.
4. This report looks at the progress on one pathway in particular – planned care - this is the second of a series of regular pathway reports to the board.

Planned Care Pathway

i) Background and Case for Change

5. Planned care covers a wide range of specialities and spans the spectrum of care. Whilst there have been dramatic improvements in recent years – for example in waiting times which are now no more than 18 weeks from referral to treatment – we know that there are still several ways in which we can make planned care more efficient and effective. Most of us are likely to undergo planned treatment of some kind or a planned diagnostic procedure at some time in our lives. The key elements of planned care services in NHS Y&H are set out below.
6. **General Medical Practice:** The pattern in location of GP surgeries reflects the varying density of the population. There are 813 GP practices in Yorkshire and the Humber; this means the average practice list size is around 6,400 people.

On average 33% (272) of practices had one or two partners, ranging from 15% in Wakefield to over 60% in Hull and NE Lincolnshire.

7. Increasing numbers of General Practitioners are developing clinical areas of special interest; these include sexual health, dermatology, musculo-skeletal problems, and urology. There are variable definitions of what a GP with a special interest is; there are no formal national accreditation processes. Individual PCTs and interested GPs have developed these roles usually with the engagement of consultants in the relevant speciality.
8. **Access to diagnostics:** Currently GPs have access to a wide range of haematological, biochemical, microbiological, histological, endoscopic and imaging tests. However the rapid expansion in diagnostics available in terms of the types of the investigation, “near patient” sampling and analysis, endoscopy, and imaging have not permeated through to all of general medical practice. There are examples in the region where new approaches have been developed for general practitioners to use and in some cases provide these diagnostics. These include for example lower GI endoscopy, echocardiography, ultrasonography and chest x-ray services for early diagnosis of cancer.
9. **Pharmacists:** Pharmacists have an important and developing role in NHS care. They have major roles in clinical care, medicines management, patient safety, enhancing compliance, self-care and “Expert Patient” programmes, and general health promotion. Increasingly appropriately trained pharmacists are expanding their clinical roles including the prescribing of drugs and medicines reviews.
10. **Dental services:** Dentists provide a comprehensive range of dental checks and treatments, as well as health promotion services. General dental practitioners refer significant numbers of people for orthodontic and maxillo-facial surgery. They are in the front line for early diagnosis of oral cancers.
11. **Community nursing services:** Community nursing services are the NHS bedrock of direct patient care. They look after people in all age groups by visiting them in their homes or seeing them in clinics. Community nursing teams provide increasingly important rapid response teams as well as supporting early discharge and day procedure initiatives.
12. By broadening and developing their skill base through initiatives like community matrons these services are expanding into proactive, planned management and support to people with long term conditions. There are excellent examples of these in Yorkshire and the Humber that are managing conditions such as chronic heart failure and lung disease. There is increasing evidence of the health benefits that these services are delivering.
13. **Specialist services:** Advances in specialist clinical practice and treatments over the last twenty or more years have been considerable. These developments have been associated with an increasing tendency to sub specialisation in almost all areas of accredited specialist medical practice. This

trend is continuing and is reflected in changes to training in medical and surgical specialities. Thus the true hospital general physician, general surgeon, and orthopaedic surgeon are increasingly rare. As the current generation of “traditionally” trained consultants retire they will be replaced by consultants in sub-specialities. Currently 37.1% of consultants across Y&H are over 50, 13.9% of those are 55 or over and 4.5% are 60 or over.

14. This, coupled with the European Working Time directive and changes to medical training, has and will continue to have significant impacts on the provision of planned care services. There are similar changes happening in nursing and other non-medical clinical staff training.
15. These advances in clinical care have also witnessed the development of a much more multi-disciplinary approach to treatment; these involve a wide range of non-medical and non-nursing clinical specialists. Increasingly planned care treatments are being provided through formal and informal clinical networks. Again the best example of this is cancer treatment.
16. **Outpatient services:** All NHS Trusts provide a broad range of outpatient services. These cover many specialist services with a good number supporting people with conditions usually managed in primary care. There is significant unexplained variation in the levels of outpatient appointments across the region. There are many examples in Yorkshire and the Humber where clinicians advised us that the numbers of outpatient attendances can be radically reduced, particularly in medical and surgical follow up appointments.
17. **Surgery:** Modern surgical and anaesthetic techniques mean that many surgical procedures can be undertaken as a day case. Nevertheless many operations are undertaken on an inpatient basis and there is considerable room for improvement in day surgery rates across NHSY&H. In units that have been taking part in regular data collection with the SHA we have seen large variation in day surgery activity for the British Association of Day Surgery basket of 25 procedures.
18. Complex low volume procedures require consideration particularly in high risk patients. A good example of this group is vascular patients undergoing aortic aneurysm surgery. There is large variation in the number of patients managed by different units.
19. The case for changes in planned care as seen by our clinical pathway group was summed up as follows:
 - We could be much more efficient – our day case rates vary from 29% to 67% for hernia repair (adults) by hospital.
 - There are too many follow-up outpatient appointments (with a threefold variation). This can waste people's time, result in unnecessary journeys to hospital and is an inefficient use of resources.
 - We don't make best use of latest technology e.g. by having telephone follow-ups or e-mailing the results of diagnostic tests.

- Specialist care in some places is not always staffed with the same level of expertise, and this is likely to have an impact on outcomes.

Addressing these issues not only will improve quality, but will help to ensure that the NHS makes the best use of its resources. This is integral to delivering our QIPP strategy.

b) Programme of Change

20. In order to tackle these issues, clinicians recommended five key areas for change. The key points are set out below.
21. **Improving clinical integration:** Clinical care pathways should be designed to achieve the quickest way to get a diagnosis and to commence treatment. Central to this will be generalist and specialist clinicians having significantly greater access to diagnostic services, underpinned by robust referral mechanisms.
22. **Improving local access to services:** Many more specialist consultations as well as diagnostic and treatment services could be provided closer to people's homes. In addition to patient convenience this supports closer generalist and specialist clinician integration. Many people would like more care to be provided at home. Technological developments in treatments and health monitoring means that the current range of home treatments and "Telecare" should be expanded and be more widely available.
23. **Improving the delivery of high volume procedures:** People requiring a "high volume" procedure (medical, surgical or diagnostic) should be offered day case services as routine when it is clinically appropriate. Day case rates for health economies should match the international best performer and that all health economies should have plans to achieve the day and short stay surgery targets contained in the British Association of Day Surgery Directory of Procedures.
 - a. The provision of complex treatments or "high volume" procedures on people with high operative or anaesthetic risk factors must be provided in clinically appropriate settings. It is likely that this means patients in with this level of clinical risk will not be treated in every hospital in NHSYH.
 - b. Emulating the organisation of modern cancer services, the role of "clinical network" hubs should be developed across a range of planned care specialities. Clinicians highlighted in particular the organisation and delivery of vascular surgery
24. **Improving low volume or more complex surgical care:** The provision of high dependency and intensive care services requires organisation across geographical areas and hospital networks in the region. Intensive care facilities should be organised so that the national guidelines for facilities and staffing are met.

25. As a result of the above issues the CPG recommended that five areas be reviewed across the region – these are: vascular surgery, interventional radiology, critical care services, upper GI surgery and urology. The ways in which these reviews are being prioritised and taken forward is covered later in this report.
26. **Improving Information systems:** Integration of safe clinical services will not happen without robust IT systems. Clinical IT systems must be integrated, and fully utilised by clinicians.

Implementation

27. As with all the pathway recommendations, PCTs across Yorkshire and the Humber have worked with the SHA to agree which should be taken forward locally and which might need action at regional level.
28. A considerable amount of work is being taken forward at a local level. Each PCT prioritised the recommendations in light of their own circumstances, taking account of the needs of their population, and this informed the development of their strategic plan. The strategic plans of each PCT were then assured through both our Clinical Reference Panel, and then as part of the world class commissioning assurance process. The WCC assurance process also tested the PCT board's own systems for monitoring progress against their strategic plan.
29. In the case of the planned care pathway, all fourteen PCTs have chosen to include some element of the recommendations in their strategic plan. Appendix A sets out the key reference points for the board. More information is available from PCTs.
30. Within the overall planned care work plan there are five areas where recommendations need to be taken forward at the regional level. These are the proposed reviews of vascular surgery, interventional radiology, critical care services, upper GI surgery and urology.
31. Of these service areas vascular surgery is being tackled first, and an update on the work in progress is shown at Appendix B. A draft service specification has now been agreed with significant clinical input, and preliminary expressions of interest have been invited from Trusts.
32. The relative priority of the remaining review areas will be assessed and agreed at the Strategic Commissioning Board meeting in September.
33. Regional work on a series of enablers is also underway – for example on the recommendations on:
 - Y&H IT strategy – NPfIT solutions that allow the transfer of patient information should be accelerated such that it becomes the norm to share records across different parts of the NHS.

- New and changed roles for staff – these are being reflected in workforce planning and in commissioning educational programmes for healthcare staff.

Detailed update reports on these key enablers are scheduled for future board meetings.

34. The board will recall that the Planned Care Pathway Delivery Board has oversight of the cross-regional elements, and advises on overall progress as per the arrangements outlined in *Delivering Healthy Ambitions*. This Board reports into the Strategic Commissioning Board – (made up of SHA and PCT Chief Executives, and with local authority and senior clinical input) as well as to the SHA. We will test out with the Planned Care PDB the top opportunities for improving quality and productivity, identified through the Delivery Healthy Ambitions – Better for less workstream. A high level overview of the delivery board’s work plan is shown at Appendix C.
35. The chair of the planned care pathway delivery board is Jan Sobieraj, Chief Executive of NHS Sheffield, who acts as a sponsor within the wider chief executives forum and assists the clinical leads and SHA Director Lead, Chris Welsh, to promote implementation of the pathway. Senior clinical leaders are Ian Jackson, Anaesthetist at York FT, Mark Baker Clinical Director at Leeds Teaching Hospitals NHS Trust, Karen Dearden lead nurse with the West Yorkshire Critical Care network and Wendy Quinn senior nurse from Harrogate FT.
36. In terms of measuring progress, the national Vital Signs indicators and the Better Care, Better Value indicators include a number of key measures relevant to the planned care pathway – including the 18 weeks referral to treatment standard and the extent of day case activity and variation in outpatients.
37. In addition specific measures to track the particular recommendations in the planned care pathway are being refined for agreement by the Planned Care Pathway Delivery Board in September. The current thinking is that we will agree with the local health economy to move into a performance management approach on a number of these indicators from 2010/11 onwards. To give the board an indication of what is being considered, a long list is summarised at appendix D.

Risks

38. The key risks identified in taking forward the planned care pathway have been identified as follows:
 - regional service reviews – the impact of these reviews on the system will need to be properly assessed and measured and their cumulative impact considered. We have set out a process for this, to be used for the first time in relation to the vascular surgery review;

- clinical engagement – newly appointed clinicians will need to be supported to make an early impact on driving forward the recommendations with their colleagues, particularly where this may suggest a change in individual clinical practice;
 - workforce availability and skill mix – this is an ongoing issue;
 - the financial downturn – although this will also present an incentive to drive more efficient pathways and practice, that deliver improved quality and productivity
 - NPfIT – speed of roll out of integrated IT solutions
 - establishing robust metrics and an approach to performance management which is accepted and effective across the region
39. These are all issues which both individual work programmes and the work overall of the SHA seek to address.

Conclusion

40. The board is asked to note and comment on progress in delivery of the planned care pathway.

Helen Dowdy
Associate Director of Strategy
August 2009

Strategic Plan Analysis of Planned Care Initiatives

PCT	Initiative Covered in Strategic Plan Yes/No	Page Number (s)
NHS Barnsley	Yes, extensive. Examples include: <ul style="list-style-type: none"> • Sustaining 18 weeks • Implement the care pathways redesign process in Commissioning redesigned care pathways and services to maximise the opportunity for self referral and self assessment in Diabetes, CVD, COPD and acute mental health services • Increase access and choice as outlined in the Maternity Matters Strategy. • Contribute to improving access to tertiary services • Improve access to community based services through redesign of Ambulance Services 	33
NHS Bradford & Airedale	Yes, extensive. Examples include: <ul style="list-style-type: none"> • Focus on 18 week pressure areas including musculoskeletal/orthopaedic and ophthalmology pathways • Redesigning care throughout the cancer pathway to address the Cancer Reform Strategy • Stimulating the market for provision in specific elective services where patients currently experience longer waiting times 	75 – 80 & 129 – 132
NHS Calderdale	Yes, extensive. Examples include: <ul style="list-style-type: none"> • Deliver and sustain the 18 week targets for admitted and non-admitted patients • All GP referrals via the Choose & Book System • Ensure we are in the top quartile for out-patient activity, pre-operative bed days and lengths of stay by 2012 • New schemes to support improved patient pathways, including MSK, Ophthalmology, Dermatology, Urology, Podiatry with clear links to PBC 	18
NHS Doncaster	Yes, extensive. Examples include: <ul style="list-style-type: none"> • Virtual polyclinic service • Integrated IT systems • Local access to services • Better direct access to a wider range of diagnostics and therapy services • Clinical network hubs to be developed • Promote personal care plans 	108 – 110

PCT	Initiative Covered in Strategic Plan Yes/No	Page Number (s)
NHS East Riding of Yorkshire	Yes, extensive. Examples include: <ul style="list-style-type: none"> • Cancer • Early diagnostics • Waiting times • HCAI • CHD 	56 – 58
NHS Hull	Yes, extensive. Examples include: <ul style="list-style-type: none"> • 5 new GP practices; development of GP led health centre and 3 integrated care centres • Initiatives for CHD, Stroke, COPD, Diabetes to improve quality of disease registers • Shift of care outside hospital based on managed care plans • Development of ICC • Integrated IT systems 	148 – 151
NHS Kirklees	Yes, extensive. Examples include: <ul style="list-style-type: none"> • Redesign pathways to better manage referrals and deliver care in the appropriate setting • Capacity and demand planning • Commission activity to achieve standard • Monitor and react to stretch targets. 	26
NHS Leeds	Yes <ul style="list-style-type: none"> • Cancer Reform Strategy • Improving the quality of the healthcare environment • Dentistry development programme • Primary care development • People with learning disabilities • No Waits: Delivering 18 Weeks • Integrated Clinical Organisation Pilot – Primary and Community Care • Integrated Clinical Organisation Pilot – Service Transformation and Redesign 	19 – 39
NHS North Lincolnshire	Yes, extensive. Examples include: <ul style="list-style-type: none"> • Reduce OP follow ups • Community urology • Dermatology GPwSI • ENT GPwSI • Ophthalmology GPwSI • Pain management • Oral surgery DPwSI • Gynaecology GPwSI • Increase in Primary Care surgery • Cancer • Specialist commissioning 	57 – 62

PCT	Initiative Covered in Strategic Plan Yes/No	Page Number (s)
NHS North East Lincolnshire	Yes, extensive. Examples include: <ul style="list-style-type: none"> • Benchmarking performance • Improve quality of referrals • Diagnostics – local initiatives • Community pharmacy 	71 – 73
NHS North Yorkshire & York	To be reviewed at a later date	87
NHS Rotherham	Yes, extensive. Examples include: <ul style="list-style-type: none"> • Routinely offer day-case services as clinically appropriate • Provide more specialist consultations, diagnostics and treatment closer to patients homes • Incentivise elective care referrals via Choose and Book • Work with local providers, participating in national campaigns to raise awareness of screening • Improve the earlier detection of cancers and treatments for cancers 	38 – 39
NHS Sheffield	Yes, extensive. Examples include: <ul style="list-style-type: none"> • Planned Care • Specialised services • Cancer • Reducing inequalities in life expectancy 	85 & 103
NHS Wakefield	Yes, extensive. Examples include: <ul style="list-style-type: none"> • Routinely offer day-case services as clinically appropriate and relocate services for patients with complex treatment requirements to clinically appropriate settings • Provide more specialist consultations, diagnostics and treatment closer to patients homes, integrate specialist and generalist services and improve transport arrangements to support patients • Incentivise elective care referrals via Choose and Book and help patients to exercise choice, supported by accurate and accessible information • Work with local providers, participating in national campaigns to raise awareness of screening 	38

Vascular Review – Update

The clinicians working on the planned care pathway as part of the Next Stage Review recommended a review of the organisation and delivery of vascular services.

Their view was that this was a priority and necessary to ensure the best standards for patients and to ensure services were delivered by specialist teams working as a part of a network with clear governance arrangements.

As a result of the recommendations made by these clinicians the SHA has agreed with the Y&H Specialised Commissioning Group (SCG) that it should undertake the vascular services review. It was agreed that this piece of work should be one of a small number of Healthy Ambitions recommendations to be taken forward at regional level. It will be overseen by the Planned Care Delivery Board as described in Delivering Healthy Ambitions.

The SCG launched the review in October 2008, with the following terms of reference:

- To agree the most appropriate patient pathway for patients requiring vascular services.
- To assess the level of need for these services across Yorkshire and the Humber.
- To develop service specifications and standards for the provision of these services, in order to identify options for providing resilient vascular services across the region, which deliver world class outcomes for patients, cater for local need and inform the delivery of planned and future vascular screening programmes.

The manager leading the review for the SCG is Pia Clinton-Tarestad, Chris Welsh, SHA Medical Director is SRO for the review at the SHA.

Progress so far includes:

- Producing a draft service specification for vascular services with input from vascular clinicians
- A stakeholder event involving clinicians and managers from Trusts across Y&H took place on 19th June to discuss areas of debate and reach clinical consensus.
- This event was successful in reaching a high degree of consensus about the standards to be met by providers of vascular services.
- Amongst the standards discussed, a small number of critical standards were identified which will influence the configuration of services across Y&H.

These are as follows:

- Each centre should receive a minimum of 32 aortic aneurysms per year and perform a minimum of 35 carotid endarterectomies per year. To put this in context across Y&H 750 aneurysms are repaired each year including 430 EVAR (keyhole) procedures. 430 carotid endarterectomies are performed across the region each year.

- Specialists with a significant interest and expertise in vascular intervention should commit at least half of their clinical practice to the care of vascular patients in order to maintain their expertise.
- ITU and HDU facilities with full haemodialysis support must be available on-site
- Each centre should be able to offer the full range of surgical and interventional radiological vascular procedures 24/7
- Each centre should have sustainable, consultant led rotas for both vascular surgery and interventional radiology.

There was discussion on the day regarding whether these standards could be delivered through multi-site centres working collaboratively and it was clear that providers are already exploring a range of service models.

A position statement was presented to the Yorkshire and Humber SCG meeting on Friday 17th July and agreement was reached to 'road test' the critical standards. As a result preliminary expressions of interest were invited from Trusts who would wish to be designated as vascular centres, based initially solely on delivering the critical standards set out above.

There is a need to explore in some detail the potential configurations that may emerge from this review and assess the likely impact of these.

The SHA has agreed a broad approach to conducting impact assessments on the recommendations from regional reviews with CEs. The assessment considers the viability of current services and the sustainability of services in the future as a result of the recommendations. The assessment covers three key domains;

- Activity
- Finance
- Workforce

A small group of PCT and Trust CEs (*Andy Buck, NHS Rotherham, Jayne Brown, NHS North Yorkshire & York, Miles Scott, Bradford Teaching Hospitals NHS FT, Rob Webster, NHS Calderdale, Martyn Pritchard, Yorkshire Ambulance Service NHS Trust, Diane Whittingham, Calderdale & Huddersfield NHS FT, Julia Squire, Mid Yorkshire Hospitals NHS Trust, John Lawlor, Harrogate District Hospital NHS FT*) has been established as a reference group. The primary role of this group is to assure the quality and scope of the impact assessments. This group will review the impact assessment process for the vascular review before the final recommendations are made to the Strategic Commissioning Board.

For those Trusts expressing a preliminary interest in becoming a centre, the next steps for the impact assessment process are:

- To give clinicians and managers an opportunity to explore with commissioners and Healthy Ambitions leaders the potential impact of these preliminary proposals. This will enable us to test the resilience and sustainability of the proposed centres and inform the next steps of the review.
- A two part event will be held during October when proposed centres will be asked to attend and answer questions to test the resilience and safety of the proposals, the intention being to tease out the key issues and test some of the clinical implications of the models proposed. We will also be inviting a number of those clinicians and

managers who expressed particular interest in being involved in this process to participate. 'Decision makers' (commissioners and SHA reps) will also be present to talk through the issues and make recommendations (these could be proposals for configurations, options or recommendations for further work).

Final proposals will be put to the Strategic Commission Board in November.

Planned Care Pathway Delivery Board

Progress and Workstreams

Board established:

- Chair: Jan Sobieraj – Sheffield PCT
- Clinical Leads: Ian Jackson, Mark Baker, Karen Dearden, Wendy Quinn
- SHA Lead: Ian Holmes
- Plus: Patient Reps, Clinicians, Commissioners, LA Reps, Workforce, IM&T
- 1 meeting so far: agreed work programme, key actions and modes of working.

Workstream 1

Healthy Ambitions recommended five 'regional reviews' for planned care:

- Vascular Services – currently live – update at appendix C
- Interventional Radiology
- Critical Care
- Upper GI Surgery
- Urology

The board has agreed the following roles with respect to the regional reviews:

- Proposing a running order for remaining regional reviews to the Strategic Commissioning Group at its meeting on 25 Sept
- Providing ongoing oversight and advice to reviews
- Providing specific clinical advice to the reviews as required

Healthy Ambitions also made other 17 specific recommendations regarding planned care. The board has discussed and prioritised these and the key actions over the next 6 months are as follows:

Workstream 2

- Identify good practice and develop recommendations to improve pathways and speed up diagnosis and treatment, including: developing robust referral mechanisms, improving communications across critical points of the pathway, and standardisation of referral information.

Workstream 3

- Assess and make recommendations to strengthen system levers to support services closer to home.

Workstream 4

- Identify specialties with largest variation in day case rates and length of stay - and make recommendations for improvement.

Workstream 5

Oversight of the workforce and IM&T requirements to ensure alignment.

The metrics long list for Planned Care

Planned Care Metrics Examples
Proportion of women aged 25-49 who have received cervical screening
Proportion of women aged 50-64 who have received cervical screening
Percentage of patients first seen by a specialist within two weeks when urgently referred by their GP with suspected cancer
Proportion of patients waiting no more than 31 days for cancer treatment
Percentage of patients seen within 18 weeks for admitted pathways
Percentage of patients seen within 18 weeks for non-admitted pathways
Incidence of Clostridium Difficile
NHS reported waits for elective care
GP written referrals for 1st OP appt in General & Acute specialities
Other referrals for 1st OP appt in General & Acute specialities
First outpatient attendances (consultant led) following GP referral in general and acute specialities
All first outpatient attendances (consultant led) in general and acute specialities
Total elective G&A day case FFCEs
Planned elective G&A day case FFCEs
Total elective G&A ordinary admission FFCEs
People with long term conditions feeling independent and in control of their condition
Planned elective G&A ordinary admission FFCEs
Non-elective G&A FFCEs, excluding well babies
Activity for 15 key diagnostics tests
Delayed transfers of care
Category A calls meeting 19 minute standards
Category A calls meeting 8 minute standards
Category B calls meeting 19 minute standards
Cancer mortality rate
Percentage of patients receiving their first definitive treatment for cancer within two months of urgent referral for suspected cancer
MRSA Infection
Incidence of Clostridium Difficile
Percentage compliance with peer review by team (local and specialist gynaecological, breast, lung, urology, colorectal, oesophageal, gastric, pancreatic, head and neck, ovarian and bladder cancers)
Pathology services: percentage compliance with 3D measures
Imaging services: percentage compliance with 3B measures
Radiotherapy: percentage compliance with 3E measures
Proportion of incident cases reviewed by Multi-Disciplinary Team (MDT) for all cancers
Compliance with 3C-100 to 3C-500 measures (chemotherapy services)
Proportion of stroke patients given a mood and cognitive status assessment exceptions.
Proportion of stroke patients who get specialist input in the appropriate time: Physiotherapist (72 hours), communication difficulties - Speech and Language Therapy (SLT) (7 days), occupational therapist (7 days)
Proportion of sites with early supported discharge team attached to the stroke multidisciplinary team
Average waiting time for neurovascular clinics
Percentage of patients following myocardial infarction discharged on aspirin
Percentage of patients following myocardial infarction discharged on beta-blockers
Percentage of patients following myocardial infarction discharged on statins

Percentage of patients following myocardial infarction discharged on ACE inhibitors
Percentage of patients following myocardial infarction discharged on clopidogrel
Length of wait from discharge to cardiac rehabilitation
30 day mortality after first time CABG (Also in Mortality section)
30 day mortality after first time aortic valve replacement (Also in Mortality section)
30 day mortality after angioplasty (Also in Mortality section)
30 day mortality following congenital heart disease surgery (Also in Mortality section)
Bloodstream infections - Central line
Surgical site infections - Orthopaedic
Pressure ulcer incidence per 10,000 patients
Mortality following a knee replacement
Mortality following a hip replacement
Consistent reporting of patient safety events reported to the National Reporting and Learning System (NRLS)
Timely reporting of patient safety events reported to the Reporting and Learning System (RLS)
Rate of patient safety events occurring in trusts that were submitted to the Reporting and Learning System (RLS)
Score for patients who reported that their admission date was not changed by the hospital
Score for patients who reported that on arrival at the hospital they did not have to wait a long time to get a bed on a ward
Score for patients who reported that they always or sometimes got enough help from staff to eat their meals
Score for patients who reported that their family or someone close had the opportunity to talk to a doctor if they wanted to
Score for patients who said that they found a member of hospital staff to talk to about their worries and fears
Score for patients who thought that the hospital staff did everything they could to help control their pain
Score for patients who reported that the 'right amount' of information was given about conditions/treatments by healthcare professionals
Score for patients who reported that they were involved as much as they wanted to be in decisions about their care and treatment
Score for patients who reported that they were involved in decisions about their discharge from hospital
Score for patients who reported that when leaving hospital they were given written or printed information about what they should or should not do
Score for patients who reported that staff explained the purpose of the medicines they were to take at home in a way they could understand
Score for patients who reported that staff told them about medication side effects to watch out for when they went home
Score for patients who reported that staff told them how to take their medication in a way they could understand
Score for patients who reported they were given clear written or printed information about their medicines
Score for patients who reported that staff told them about any danger signals to watch out for after they went home
Score for patients who reported that the doctors or nurses gave their family or someone close to them all the information they needed to help care for them
Score for patients who reported they were told who to contact if they were worried about their condition or treatment after they left hospital
Score for patients who reported that they received copies of letters sent between hospital doctors and their GP

Percentage of staff who reported that in the last month they had seen any errors, near misses or incidents that could have hurt Patients/service users
Score of for patients who reported that during their hospital stay they were asked to give their views on the quality of care
Score for patients who reported that whilst in hospital they saw posters or leaflets explaining how to complain about the care or treatment they received
Score for patient who reported that after moving wards they did not share a sleeping area with a member of the opposite sex
Score for patients who reported that they did not have to use the same bathroom or shower area as patients of the opposite sex
Score for patients who said they were given enough privacy when discussing their condition or treatment
The practice can produce a register of patients with asthma, excluding patients with asthma who have been prescribed no asthma-related drugs in the previous twelve months
The percentage of patients with asthma between the ages of 14 and 19 in whom there is a record of smoking status in the previous 15 months
The percentage of patients with asthma who have had an asthma review in the previous 15 months
The percentage of patients aged eight and over diagnosed as having asthma from 1 April 2006 with measures of variability or reversibility
The percentage of patients with hypertension in whom there is a record of the blood pressure in the previous 9 months
The percentage of patients with hypertension in whom the last blood pressure (measured in the previous 9 months) is 150/90 or less
The percentage of patients with coronary heart disease who are currently treated with a beta blocker (unless a contraindication or side-effects are recorded)
The percentage of patients with a history of myocardial infarction (diagnosed after 1 April 2003) who are currently treated with an ACE inhibitor or Angiotensin II antagonist
The percentage of patients with coronary heart disease who have a record of influenza immunisation in the preceding 1 September to 31 March
The percentage of patients with coronary heart disease in whom the last blood pressure reading (measured in the previous 15 months) is 150/90 or less
The percentage of patients with coronary heart disease whose notes have a record of total cholesterol in the previous 15 months
The percentage of patients with coronary heart disease whose last measured total cholesterol (measured in the previous 15 months) is 5mmol/l or less
The percentage of patients with coronary heart disease with a record in the previous 15 months that aspirin, an alternative antiplatelet therapy, or an anti-coagulant is being taken (unless a contraindication or side-effects are recorded)
The percentage of patients on the CKD register whose notes have a record of an albumin:creatinine ratio (or protein:creatinine ratio) test in the previous 15 months
The percentage of patients with COPD with a record of FeV1 in the previous 15 months
The percentage of all patients with COPD diagnosed after 1st April 2008 in whom the diagnosis has been confirmed by post bronchodilator spirometry
The percentage of patients with COPD who have had a review, undertaken by a healthcare professional, including an assessment of breathlessness using the MRC dyspnoea score in the preceding 15 months
The percentage of patients with COPD who have had influenza immunisation in the preceding 1 September to 31 March
In those patients with a new diagnosis of depression and assessment of severity recorded between the preceding 1 April to 31 March, the percentage of patients who have had a further assessment of severity 5-12 weeks (inclusive) after the initial recording
The percentage of patients with diabetes with a record of neuropathy testing in the previous 15 months

The percentage of patients with diabetes who have a record of the blood pressure in the previous 15 months
The percentage of patients with diabetes in whom the last blood pressure reading is 145/85 or less
The percentage of patients with diabetes who have a record of micro-albuminuria testing in the previous 15 months (exception reporting for patients with proteinuria)
The percentage of patients with diabetes with a diagnosis of proteinuria or micro-albuminuria who are treated with ACE inhibitors (or A2 antagonists)
The percentage of patients with diabetes who have a record of total cholesterol in the previous 15 months
The percentage of patients with diabetes whose last measured total cholesterol within the previous 15 months is 5mmol/l or less
The percentage of patients with diabetes who have had influenza immunisation in the preceding 1 September to 31 March
The practice can produce a register of all patients aged 17 years and over with diabetes mellitus, which specifies whether the patient has Type 1 or Type 2 diabetes
The percentage of patients with diabetes whose notes record BMI in the previous 15 months
The percentage of patients with diabetes who have a record of retinal screening in the previous 15 months
The percentage of patients with diabetes who have a record of estimated glomerular filtration rate (eGFR) or serum creatinine testing in the previous 15 months
The percentage of patients with diabetes in whom the last HbA1c is 7 or less (or equivalent test/reference range depending on local laboratory) in the previous 15 months
The percentage of patients with diabetes in whom the last HbA1c is 8 or less (or equivalent test/reference range depending on local laboratory) in the previous 15 months
The percentage of patients with diabetes in whom the last HbA1c is 9 or less (or equivalent test/reference range depending on local laboratory) in the previous 15 months
The percentage of patients with diabetes who have a record of HbA1c or equivalent in the previous 15 months
The percentage of patients with diabetes with a record of the presence or absence of peripheral pulses in the previous 15 months
The practice can produce a register of patients aged 18 and over receiving drug treatment for epilepsy
The percentage of patients age 18 and over on drug treatment for epilepsy who have a record of seizure frequency in the previous 15 months
The percentage of patients aged 18 and over on drug treatment for epilepsy who have a record of medication review involving the patient and/or carer in the previous 15 months
The percentage of patients aged 18 and over on drug treatment for epilepsy who have been seizure free for the last 12 months recorded in the previous 15 months
The percentage of patients with a diagnosis of heart failure (diagnosed after 1 April 2006) which has been confirmed by an echocardiogram or by specialist assessment
The percentage of patients with a current diagnosis of heart failure due to LVD who are currently treated with an ACE inhibitor or Angiotensin Receptor Blocker, who can tolerate therapy and for whom there is no contra-indication
The percentage of patients with a current diagnosis of heart failure due to LVD who are currently treated with an ACE inhibitor or Angiotensin Receptor Blocker, who can tolerate therapy and for whom there is no contra-indication
In those patients with a new diagnosis of hypertension (excluding those with pre-existing CHD, diabetes, stroke and/or TIA) recorded between the preceding 1 April and 31 March: the percentage of patients who have had a face to face cardiovascular risk assessment

The percentage of people with hypertension diagnosed after 1 April 2009 who are given lifestyle advice in the last 15 months for: increasing physical activity, smoking cessation, safe alcohol consumption and healthy diet
The practice can produce a register of women who have been prescribed any method of contraception at least once in the last year, or other appropriate interval e.g. 5 years for an IUS
The percentage of women prescribed an oral or patch contraceptive method who have also received information from the practice about long acting reversible methods of contraception in the previous 15 months
The percentage of women prescribed emergency hormonal contraception at least once in the year by the practice who have received information from the practice about long acting reversible methods of contraception at the time of, or within one month of, the prescription
The percentage of patients with TIA or stroke who have had influenza immunisation in the preceding 1 September to 31 March
The percentage of patients with a stroke shown to be nonhaemorrhagic, or a history of TIA, who have a record that an antiplatelet agent (aspirin, clopidogrel, dipyridamole or a combination), or an anti-coagulant is being taken (unless a contraindication or side effects are recorded)
The percentage of new patients with a stroke or TIA who have been referred for further investigation
The percentage of patients with TIA or stroke who have a record of blood pressure in the notes in the preceding 15 months
The percentage of patients with a history of TIA or stroke in whom the last blood pressure reading (measured in the previous 15 months) is 150/90 or less
The percentage of patients with TIA or stroke who have a record of total cholesterol in the last 15 months
The percentage of patients with TIA or stroke whose last measured total cholesterol (measured in the previous 15 months) is 5mmol/l or less
The practice can produce a register of patients with hypothyroidism
The percentage of patients with hypothyroidism with thyroid function tests recorded in the previous 15 months
Diagnostics waiting times: percentage within 6 weeks or less
Percentage of BADS (British Association of Day Surgery) Directory of Procedures (including electronic assessment) carried out as a day case or within appropriate length of stay
Vaccination for measles, mumps and rubella
Vaccination for whooping cough
Vaccination: influenza, for patients with chronic obstructive pulmonary disease
Vaccination: influenza, for patients with coronary heart disease
Vaccination: influenza, for patients with diabetes mellitus
Vaccination: influenza, for patients with stroke or transient ischaemic attack