NHS Gloucestershire and Swindon Integrated Operating Plan 2012/13

This integrated operating plan sets out the Cluster approach to and the key milestones for meeting the key priorities and delivering the reform agenda in 2012/13

3/20/2012

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1.0 Introduction

The Operating Framework for the NHS in 2012/13 required all PCT clusters to produce an integrated plan. The integrated plan should have a clear focus on Quality and the priorities set out in the NHS Operating framework. It should also set out a clear framework to achieve QIPP and Transformation & Reform goals.

The primary purpose of this document is to set out the Integrated Plan for the Cluster. This 2012/13 Integrated Plan for NHS Gloucestershire (NHSG) and Swindon (NHSS) sets out our approach to and the key milestones for meeting our priorities and delivering the reform agenda. During 2011/12 NHSG and NHSS combined to form a PCT cluster. In 2012/13 the cluster will be overseen by a single Board scrutinising a single integrated plan which will contain detailed plans for each PCT.

Within the appendices the Integrated Plan outlines the opportunities for quality improvements and financial efficiencies and sets out clear performance, quality and financial plans for 2012/13 a year of significant reform and change for the NHS. Plans commenced within 2011/12 will be taken forward and consolidated in 2012/13, with concerted focus on delivering productivity improvements through the redesign of urgent care, long term conditions and elective care pathways.

The plan describes the proposed processes and structures for implementation, and describes how the plan will be performance managed and reported at both Cluster and Clinical Commissioning Group levels.

2.0 Engagement

Effective patient and public engagement continues to be a strategic priority for NHS Gloucestershire and Swindon.

NHSG and NHSS have recently established a Reference Group to facilitate early discussions with LINK and HCCOSC representatives. This Reference Group will receive information about proposed service changes at the earliest stage in their development, allowing members of the Reference Group the opportunity to comment and influence them ahead of formal presentation to scheduled HCCOSC meetings. Information shared with the Reference Group will have been tested via a QIPP Service Change Checklist, which incorporates ‘The Four Tests’. In addition, the Reference Group will provide an early steer on the likely perceived ‘significance’ of any proposed changes in relation to statutory public consultation requirements relating to ‘significant variation’.

NHSG will also host a regular cycle of engagement / communications opportunities to ensure an ongoing constructive dialogue with key community partners (approx 300 circulation) during the development and delivery of the plan. Stakeholder Drop In sessions will be held in each of the six District Council areas, providing an opportunity for regular information exchange. It is envisaged that, where appropriate, these events will be led by

key clinicians and that local GP leaders will take up the opportunity to attend events in their respective localities in order to strengthen their relationships with key local community partners over time.

A Cluster Engagement Strategy is being developed which will build on existing mechanisms for engagement with key local community partners (stakeholders), such as the NHS Reference Group, Stakeholder Drop In sessions, surveys and additional processes for collecting patient experience feedback.

A Cluster development has been the scheduling of regular quarterly meetings between the 2 Link Chairs (Gloucestershire and Swindon) and the Chair of the Joint Cluster Integrated Governance Committee to discuss patient experience feedback in relation to commissioning for quality. The first meeting was held 23rd January 2012.

In Gloucestershire there is a clinical priorities forum where the clinical discussions in respect of the required system changes take place. There are primary and secondary care clinicians sitting on this board, who have been identified as the clinical leaders for the health economy. In Swindon there is the Community Change Programme Board, which has wide representation from the clinical community. Both of these fora have been involved in describing how the system will change.

3.0 Performance and Quality

3.1 Attainment of 2011/12 Performance Measures

There are many examples of good performance recorded in 2011/12 within the Gloucestershire and Swindon cluster. With respect to the integrated headline and supporting performance measures outlined in the Annual Operating Framework for the NHS in 2011/12 examples of the performance measures that were being achieved as at the end of Quarter 3 and are projected to deliver at the year end:

- Delivery of the MRSA objective
- All Referral to Treatment (RRT) targets (Admitted, non-admitted and Direct Access Audiology)
- Both Cat A Ambulance response time targets
- All 31 and 62 day Cancer access targets
- 90% VTE risk assessment target
- Mental Health measures (Early Intervention, Crisis Resolution/Home Treatment, Care Programme Approach and Improving Access to Psychological Therapies)
- 4 week smoking quitters
- Cervical screening test results available within 14 days
- Diabetic retinopathy screening

The following measures were not achieved at the end of Q3 and are not projected to deliver for the end of 2011/12:

- 95% 4 hour A&E target (Gloucestershire)
- Cancer 2 week access targets (Gloucestershire)
- Clostridium difficile infections (Gloucestershire)
- Delayed transfers of Care (Swindon)
- Bowel and Breast Screening (Swindon)
- Access to dentistry (both)

Recovery action plans implemented during 2011/12 have significantly improved performance in almost every area. With the exception Accident and Emergency it is anticipated that performance against all other measures will be on plan going into 2012/13.

The 4 hour A&E target has proved particularly difficult for our main provider, Gloucestershire Hospitals NHS Foundation Trust (GHNHSFT), to achieve in 2011/12 and performance has worsened up to the end of November. The problem is almost entirely confined to their Cheltenham site. To address performance issues at this site GHNHSFT actions include relocating 'Minors' to the fracture clinic which will leave more space in the main A&E for 'Majors' and implementing a revised Emergency Nurse Practitioner rota. Further actions will be taken as necessary to ensure that this target is achieved in 2012/13.

Other areas of potential risk to performance that will need strict monitoring and management in 2012/13 include admitted RTT performance in T&O and the acquisition of Great Western Ambulance Service (GWAS) by the South Western Ambulance Service (SWAS) in April 2013 and Avon and Wiltshire partnership NHS Trust mental health performance with a particular focus upon quality governance and risk management.

NHSG has achieved the 90% admitted RTT target in 2011/12 at an aggregated level, and within all specialties except T&O. Performance in T&O, although improved from the start of the year, has remained significantly below the 90% threshold in every month of 2011/12 with the main provider GHNHSFT. Any reduction in admitted T&O RTT performance will have an adverse impact on the aggregate target. This has been recognised as a potential risk in 2012/13 plans center around demand management and the development of new triage services to provide alternative services for patients. A reduction in demand will enable GHNHSFT to manage the demand within their available capacity.

NHSG are the lead commissioner for GWAS, who have projected to achieve both of their Category A response time targets in 2012/13. During 2012/13 GWAS will be actively involved in preparing to merge SWAS by April 2013, during this change process this may have a significant impact operationally. NHSG will therefore work closely with GWAS throughout 2012/13 to provide the assurance that operational performance does not dip during this transition period.

3.2 Priorities for 2012/13

The key priorities for 2012/13 are outlined in appendix 1, the relevant initiatives, targets, milestones and quality outcomes contributing to the attainment of each strategic priority are also included in the appendix.

The priorities outlined in appendix 1 incorporate all measures outlined in Annual Operating Framework for the NHS in 2012/13 (appendix 2), the outcome measures contained within the 5 domains of the NHS Outcome Framework for 2012/13 (appendix 3) plus the key areas set out in the Operating Framework: dementia care of older people, Carers, Military and Veterans Health and Health Visitors and family nurse partnerships. Alongside these are a number of key local priorities that have been carried forward from the previous year which include tendering for Drug and Alcohol Services to deliver on the recovery agenda.

All new developments for 2012/13 will have an equality impact assessment completed as part of the business case development framework and Project Initiation Documents.

3.3 High Impact Innovations

Gloucestershire and Swindon health economies are progressing five of the high impact innovations through a mixture of main stream commissioning, including QIPP programmes and using the CQUIN mechanism.

3.3.1 Assistive technologies

NHSG are working in partnership with primary care, Gloucestershire Care Services and GHNHSFT to roll out 2,000 Telehealth units to the population of Gloucestershire. Gloucestershire already has 400 people managed in Primary Care through Telehealth, the largest Primary Care managed group in the country, and this was in part achieved through use of CQUIN in 11/12, which is mainstreamed in 12/13.

NHSS are working with SEQOL and GWHNHSFT to roll out a further 100 units (on top of the 270 issued in 2011/12). This is a fundamental part of health community QIPP delivery plans.

3.3.2 Oesophageal Doppler Monitoring

NHSG & NHSS have developed a CQUIN scheme across their acute providers where they are the lead commissioner to support the regional work for the implementation of this type of technology to support patient care as part of their surgical experience. This will also support the QIPP agenda moving into 2013/14.

3.3.3 Child in a chair in a day

In recognising the importance of this stream of work, NHSG and NHSS identified wheelchairs as a priority are for an AQP tender during 2012/13. They are linked into the national work programme which will result in a clear specification for the assessment and provision of wheelchairs, which includes the timeliness of provision.

3.3.4 Digital by default

The QIPP discussions taking place in Gloucestershire and Swindon had already identified this as a high priority area as there are not many example of digital contacts within existing services. Work is currently taking place with clinicians to identify the high impact areas where this service re-design could be implemented. There are 2 phases of work, the use of email advice and guidance to replace first outpatient appointments where a GP could get an opinion from a Consultant and replacement of traditional follow up outpatient appointments with a telephone follow up appointment.

3.3.5 Carers for people with dementia

Carers of people with dementia have access to a range of respite or short break services; this has been one of the key features of the NHSG Dementia action plan. An increasing range of flexible short breaks and support services are being developed including peer group activities linked with carer support e.g. memory cafes and activity groups, the carers emergency service is already in place. This data is currently recorded by GCC and is reviewed by the Multi-agency Dementia PMB. Data collection is being reviewed to make sure that dementia specific activity is being recorded accurately, we are seeing an increased uptake (as more services come on stream) and this will continue into 2012/13 as dementia is a priority area.

NHS Swindon and the Borough Council were involved in the Carers Demonstration Project and from the work undertaken in this a carers strategy and a joint approach to the procurement of carer support services is being finalised. A range of carers support services are currently commissioned including carer and respite breaks; support for young carers and dementia care including a 'Forget me not' service and memory clinics. It is anticipated that over £1m will be invested in carer services in Swindon in 2012/13.

4.0 Finance

NHSG and NHSS are working through a programme management approach to funding services. Currently a benchmarking exercise is taking place with outputs shared with lead clinicians. This information will be used to target efficiency plans with primary and secondary care providers and will be included within the March submission.

The plan reflects the expected level of SHA/PCT surplus drawdown in accordance with SHA Guidance. Financially challenged NHS Trust payments are included where appropriate and there are no legacy debt issues to resolve.

The cluster has set aside 2% of their recurrent funding with the SHA for non-recurrent expenditure purposes and this will be released in line with local and SHA business planning guidance.

There are robust assurance processes in place to monitor and manage changes to planned QIPP savings and variances from plan. Progress against each QIPP scheme will be monitored at the QIPP Programme Board, monthly monitoring by PMO and management accountant reviews. Uncommitted headroom will be utilised where appropriate to pump

prime service change. The timing of local developments will be reviewed and local contingency funds utilised to mange any under performance and slippage in the delivery of QIPP schemes.

NHSG plan aims to achieve a £0.6m reduction in running costs in 12/13. NHSS plan aims to achieve a £1.335m reduction in running costs.

The PCT has identified the following areas for investment in 2012/13 to support delivery of the QIPP programme, meeting the national 'must do's' and resolving any patient quality concerns. Additionally all of the national programmes have been funded as outlined in the Operating framework including improving interactions with health and social care, cancer drugs funding, re-ablement investment, Clinical Commissioning funding and local capacity developments.

NHSG/NHSS key investments for 2012/13

Investment area	NHSG/NHSS	Description of the investment	Reason for investment
Diabetes	NHSG/NHSS	Expansion of community diabetes services, to include a countywide education programme, alongside intermediate tier service.	Shifting setting of care from secondary care to primary care Improving the management of patients with diabetes
Musculo/skeletal triage services	NHSG/NHSS	Development of the existing interface/triage services for musculo skeletal referrals, working towards a clinical programme approach.	Reducing secondary care attendances shifting setting of care Meeting 18 week referral to treat targets
Telehealth	NHSG/NHSS	Deployment of telehealth units	Reducing emergency admissions and A&E attendances Improving the awareness of the patients long term condition

Stroke Early Supported Discharge	NHSG	Expansion of the current service to ensure countywide coverage.	Reducing acute length of stay
Risk Stratification Tool	NHSG	Commissioning of a risk stratification tool to support delivery across a range of unscheduled care initiatives, such as case management, living well and telehealth.	Reducing emergency admissions and A&E attendances.
Developing community intensive support teams for learning disability patients	NHSG	Pump priming of transitional change to move in county learning disabilities care from a bed based model, to patients supported through an intensive support team.	QIPP Shifting settings of care
Mental health acute liaison	NHSS	Mental health support provided to the Great Western Hospital	QIPP Reducing inappropriate emergency admissions Reducing length of stay in acute hospital

PCT Headroom

NHSG have assumed that £5m is applied to the GHNHSFT contract to pump prime QIPP where there is identified service change. NHSS have applied £3m of headroom to GWH to pump prime QIPP.

In addition NHS Swindon has applied £1m of headroom to support SCG over performance. Both PCTS have asked for an intensive piece of work from SCG to review undelivered QIPP and in NHS Swindon recover an 11/12 over performance of £2.5m

5.0 QIPP

QIPP Overview

QIPP has been developed across the Gloucestershire and Swindon Health Communities, embedded with a programme management approach co-ordinated from NHSG, in order to enable and deliver the QIPP programme. The QIPP programme has developed in line with

national and regional work programmes, with strategic benchmarking information used to challenge the component projects built from a bottom up approach within each theme. Ownership of delivery, both for individual schemes and programmes of work, has developed across the health community, in particular with the major acute, community and mental health providers.

QIPP Programme

The main elements of the Cluster QIPP programme are shown in the table below (a full breakdown of the 3 year plans for the constituent PCT's, along with milestones, is given in Appendix 4):

QIPP Theme	Work Programmes
Shifting settings of care and Urgent Care	**NHSG** - The focus of the work programme is to develop against 3 key strands of work: Self Care management and Prevention, Primary and Community Assessment, Response and Care, and Acute Hospital Based Assessment and Ambulatory Care. - The work programme includes a range of system wide strategies, which will be delivered through an integrated approach with partner organisations from across the county, through initiatives such as Integrated Person Centred Approach (IPCA). - Pathway re-design will form a core part of the ongoing work programme, including a focus on streamlining admissions from Care Home Admissions, developing a community based model for the management of suspected DVT's and the use of the Ambulatory Day Unit's. - System wide levers will be developed and embedded to ensure the management of Demand, through the establishment of a Single Point of Clinical Access, and the development of Community Infrastructure through the development of a priority response service and established case management. - Expanding the Paediatric Community Care Nursing Team to cover weekends, in order to provide minor procedures outside of an acute hospital setting. - Develop more robust contractual mechanisms to cover the commissioning of Continuing Healthcare for

QIPP Theme	Work Programmes
	Paediatric patients. **NHSS** - Develop integrated urgent care service model: single entry point 'front door', assessment and streaming process for all presenting patients; redesigned clinical pathways. - Integrate current ED/AAU and Clover Centre Nurses and GPs combined into a single workforce; integrate out-of hours services. - Development of integrated SPA and redesign clinical pathways; develop common assessment protocols; work with primary care to enhance referral processes; work with GWAS to support to crew triage and reduce conveyance rates. - Public Health Service Review, looking into the potential problems and improvements for the Cardiology service. - Development of SWICC step up beds
Planned Care	**NHSG** - The development of Demand Management Schemes to reduce referrals into an acute setting, including countywide implementation of a GP Referral Peer Review scheme, embedding the use of Somerset Booking Office and the implementation of a specialist Paediatric Triage service. - Use of a programme management approach to develop the commissioning of clinical programme groups, with a focus on Trauma and Orthopaedics. This will also include specific pathway developments in relation to the implementation of a standardised Spinal, Hip and Knee pathway; alongside developing the use of Orthopaedic Interface services to ensure management within primary and community settings as appropriate. - Development of mandated pathways for Cataract procedures. - Effective management of INNF and Low priority Procedures, through the introduction and management of

QIPP Theme	Work Programmes
	a robust Prior Approvals Process linked to evidence based procedure list developed from practices nationally and in other areas. **NHSS** - Shifting Settings of Care - Shifting Day Case Procedures to Outpatient - Reducing Outpatient First appointments, by implementing a software tool to filter referrals from Primary Care - Reducing Outpatient Follow-up Appointments by implementing standard referral templates and incentivising the review of Follow Ups in Primary Care - Public Health lead Service Reviews into Surgical Intervention Rates in the areas of Trauma and Orthopaedics, Gynaecology and Dermatology - Standardising policies on Interventions Not Normally Funded across the Cluster
Management of patients with Long Term Conditions	**NHSG** - Development of a standardised pathway of care for the management of Respiratory patients, including the implementation of a Pulmonary Rehabilitation Service. - Delivery of an Intermediate Tier service for the effective management of Diabetes care, to ensure appropriate usage of primary, community, and acute care settings. - Early Supported Discharge delivery across the county - Enhancement of systematic long term condition management, using case management, and the effective use of community beds; ensuring links to the pathway developments implemented for an integrated care approach. - Deployment of 2000 more Telehealth units in the community, primarily aimed at COPD, Diabetes and Heart Failure. **NHSS** - Developing end of life register and care coordinating

QIPP Theme	Work Programmes
	centre for end of life patients, thus reducing no. of hospital admissions - Deploy greater numbers of Telehealth units to ensure patients are treated - Ensure enhanced care coordination for most complex LTC patients through the implementation of virtual wards - Implement proactive and personalised care planning for other LTC patients - Implement a scheme to increase the capability and capacity of community & primary care based diabetic care
Prescribing	**NHSG** - Sharing best practice, identifying specific actions or targeted improvements. - Controlling growth and reducing waste. **NHSS** - Reduce Prescribing costs below the national average by working with Primary Care to switch scripts to more cost effective alternatives - Implement a waste campaign to control prescribing inefficiency
Primary and Community Care	**NHSG** - Ensuring effective use and management of primary care, including enhanced services. - Improving efficiency and productivity with community based services. - Robust management of continuing healthcare. **NHSS** - Care manager reviews of all CHC cases to ensure appropriate package and use of brokerage to obtain best price on CHC packages - Review of Community Dental Service to ensure value for

QIPP Theme	Work Programmes
	money - Delivering savings within child community services based on benchmarking against national reference costs through redesign of child health services
Mental Health	**NHSG** - Introduction of liaison nurses to acute hospitals. - Rationalisation of out of area placements, moving patients to in county services. **NHSS** - Implementing Dual Diagnosis and Detox services - Reducing placements costs, through review by a skilled care coordinator - Delivering an Acute Trust Liaison Service reducing admissions and length of stay - Redesigning Mental Health services across Swindon to ensure they meet local priorities
Learning Disabilities	**NHSG** - Rationalisation of out of area placements, moving patients to in county services. - Ensuring equality of access to services for patients with learning disabilities. **NHSS** - Reduce Out of Area Placements/Care Packages - Rationalisation of units enabling independent living Enhance skill mix across the community teams to promote independence and choice
Non Clinical	**NHSG** - Enhancing the productivity and utilisation of estates. - Savings within back office, across both pay and non pay including reducing agency spend, reducing utilities.

QIPP Theme	Work Programmes
	NHSS - Integrated Estates Investment & DisInvestment Plan - New Integrated Workforce and management savings - Integrated IT / Telephony Solutions - Rationalised NHS Supplies Catalogue (Procurement/Supplies)

QIPP Success Stories from NHSG and NHSS

Project	Overview
Respiratory Services Project	Improving outcomes through empowering those with chronic conditions to self-manage and where possible access treatment closer to home delivered through case management, pulmonary rehabilitation and telehealth.
Out of Area Placements for People with Learning Disabilities	A project to enable people to return to community placements of their choosing Partnership working other agencies with a clear which benefited the individual Giving staff i.e. project managers and administrative staff, the opportunity to meet with clients with LD in order to make it meaningful to the project team involved.
Single Point of Clinical Access (SPCA)	Nurse-led telephone service provides clinicians, including GPs and paramedics, with support in accessing the required urgent services for their patients.
Eating Disorders	Provide assessment of adolescent patients with eating disorders, co-morbid mental health problems and other relevant issues. Provision of day care services for adults in county, to ensure reduced need to travel out of county.
GP Referral Peer Review	Development of locality based GP led prospective referral peer review in at least 3 specialties in all localities in Gloucestershire in order to improve the quality and efficiency of referral practice and reduce overall spend on outpatient

Project	Overview
	services.
Cataract Pathway	The agreement and implementation of clinical thresholds for second eye cataracts with the rationale that second eye procedures be undertaken at the most clinically optimal time. Reviewed pathway will reduce the numbers of second eye cataract operations carried out before clinically appropriate.
Glaucoma Intra Ocular Pressure Pathway	All eligible patients are referred to accredited community optometrists for assessment for high Intra Ocular Pressure, thereby increasing community management and reducing patient attendances at acute sites. Current monitoring shows that 50% of patients referred through the scheme do not require onward referral to consultant ophthalmologist.
Primary Care Front Door	Progress has been made by both Providers to develop an integrated governance policy to support a one door access to Urgent Care services. This is one of the first developments where Primary, Community and Acute Services have come together.
Step Up Beds	Successfully commissioned 26 new GP Step Up Beds to support unnecessary hospital admissions, with the drive to offer more choice to patients and personalised centred care.
Cellulitis Pathway	Implementation of a community based nurse lead Cellulitis service. Reducing attendance of patients at the Acute Trust and increasing patients seen in a more appropriate setting.

QIPP Key Risks for the Cluster

The key risks in relation to the QIPP programme are shown in the table below:

Risk	Impact	Probability of Occurring	Score (multiplied)	Mitigation
Insufficient capacity to deliver initiatives	4	2	8	Ensure all QIPP projects have dedicated resource. Health Community approach to minimise duplication.
Investments required to deliver change	3	3	9	Robust financial modelling and monitoring of projects.

Risk	Impact	Probability of Occurring	Score (multiplied)	Mitigation
Cashable savings released from changes less than planned as health community	5	3	15	Robust financial modelling and monitoring of projects as a health community. Workforce modelling integral to planning.
Organisational restructuring resulting in loss of continuity and focus	4	3	12	Give leadership to health and social care community via GSF.
Change in clinical practice for all clinicians – medical engagement	5	3	15	Identifying levers and consequences of not engaging. Using clinical evidence for decision making. Medical engagement strategy and key clinicians engagement.
Staff Opposition	2	3	6	Engagement, focus and clarity of role.
Public opposition	2	3	6	Engagement, active listening and changing plans.
Organisational boundaries	2	2	4	Programme management arrangements engage senior managers and clinicians from all organizations.

The QIPP challenge is reflected in the contracts with our providers through the activity plans The QIPP assumptions require delivery of the following activity assumptions during 2012/13 and these will be monitored monthly and reported to Boards in a quarterly basis, unless exceptional concerns are identified.

Swindon activity assumptions

Activity type	Percentage variation between 2011/12 FOT (at month 9) compared to 2010/11 outturn	Activity assumptions for years 1 - 3		
		2012/13	2013/14	2014/15
Non –elective admissions	2.9%	-6%	-6.1%	-6.0%
Elective inpatients	-5.2%	-8.0%	-5.1%	-9.1%
Elective day cases	0.7%	-5.0%	-4.4%	-9.7%
GP referrals	-4.1%	-6.0%	-6.0%	-6.0%
Outpatients New (all)	-0.5%	-6.1%	-6.1%	-6.2%

Gloucestershire activity assumptions

Activity type	Percentage variation between 2011/12 FOT (at month 9) compared to 2010/11 outturn	Activity assumptions for years 1 - 3		
		2012/13	2013/14	2014/15
Non-Elective	-4.4%	-8.2%	-5.0%	-3.0%
Elective inpatients	-5.2%	-4.9%	-2.4%	-1.5%
Elective day cases	0.7%	-0.7%	-1.7%	-1.5%
GP referrals	-4.1%	-6.6%	-4.5%	-3.5%
Outpatients New (all)	-0.5%	-7.3%	-3.5%	-2.5%

6.0 Performance Management

Delivery of the Integrated Plan will be supported by a robust and challenging Performance Management Framework.

The Performance Management Framework will ensure that all initiatives, objectives and targets contained within the plan will be monitored and the risks assessed and circulated throughout the organisation.

Particular focus will be given to delivery of the QIPP agenda, financial balance, the priorities set out in The Operating Framework for the NHS in England for 2012/13 and the commitments outlined in the NHS Constitution.

6.1 Performance Reporting

Performance against the Annual Integrated Plan will be monitored monthly, although data on some performance targets will only be available on a quarterly basis.

Performance against all areas in the integrated plan will be reported to the PCT Cluster Board and the relevant Clinical Commissioning Group through a finance and performance report. Areas of risk and under-performance will be highlighted by RAG rating (red, amber or green) the indicators against agreed thresholds to highlight areas of under-performance (i.e. any indicator rated either red or amber).

The main Board report will only provide a position statement on those areas highlighted as under-performing (i.e. red or amber), or that are giving cause for concern, to draw attention to the Board of those areas that they need to be particularly aware of.

Current performance will also be discussed at the monthly PCT Executive Team performance meeting where the issues can be discussed more fully with the manager accountable for delivering the target.

Each quarter The Cluster Board and relevant Clinical Commissioning Group will receive a quarterly report covering progress against all initiatives, objectives and targets contained within the Annual Integrated Plan. This will provide a full position statement on progress against the annual Operating Plan as a whole. As with the monthly report each indicator will be RAG rated using the traffic light system of red, amber and green (RAG), dependant on progress within quarter and also discussed at the relevant NHSG Executive Team performance meeting when data is available.

6.2 Accountability and Performance Management

Each target/objective will be actively performance managed by the Performance Team and the Project Management Office (PMO) who have specific responsibility for QIPP benefits realisation. Accountability for each objective/indicator is allocated to an Owner (with direct responsibility for the service area) and a Sponsor, who is the Director to which the Owner reports to. The Performance Team/PMO will provide the Owner and Sponsor with an update of the performance of their targets as the data becomes available. The Owners and Sponsors are the persons responsible for ensuring the target/objective is met and will be required to provide an update on the actions currently being undertaken to recover any poor performance/scheme slippage as it comes to light.

It is through this system that performance against the Annual Integrated Plan objectives will be constantly monitored and progress against action plans constantly reviewed.

7.0 Workforce

2012/2013 will see some aspects of the workforce strategy for NHS Gloucestershire and Swindon remain unchanged; critically, the PCT continues in its commitment to being an 'Employer of choice' within the local market, recognising that excellence cannot be achieved without a motivated, engaged workforce.

However, 2012/2013 will clearly be a year in which there is significant focus on transition as the organisation prepares for the establishment of CCGs and CSOs. From a workforce perspective this will have a number of implications:

- There will be a significant focus on employee engagement – ensuring that staff are "bought into" the process, and supportive of it, regardless of what outcome it will have for them individually.
- The organisational structure will need further review (a significant restructure is underway in 2011/2012) to ensure resilience and efficiency, and in order to support the transition to replacement organisations.
- In order to migrate NHSG and NHSS staff to replacement organisations, people and function migration mapping work has been undertaken locally and fed back to the Department of Health who will be issuing national guidance shortly and which will assist with informing staff.
- Organisational and personal development activity will be critical to ensure that the organisation, its leaders and those within it are adequately prepared and resourced to meet the challenging demands that the transitional process will bring.

The workforce initiatives and milestones to support the successful transition to the new organisations are given in appendix *

8.0 Transition and Reform

The timetable and plan, for both PCT reform and CCG reform are included in appendix 5. This provides a clear timetable, with milestones against which progress can be monitored, to lead to the successful restructuring of the NHS commissioning and Public Health functions.

8.1 Commissioning Development – CCGs

Development of the CCGs in Gloucestershire and Swindon - following confirmation that both CCGs were successful in the risk assessment of their configuration and scored green against the 4 measures the CCGs are in the process of building their 'track records'. Both CCGs have agreed a development plan that will lead them to authorisation.

During 2011/12 the CCGs have been very involved in the planning round and contract negotiations with the community and acute sector and are actively leading the development and delivery of the QIPP programmes. The CCGs are also beginning to play a key role in the newly established health and wellbeing boards. CCG involvement and activity in leading the redesign of their local NHS in order to support the move to authorisation is being measured and collated and will provide the NHS Commissioning Board with the evidence it requires to approve authorisation.

Both Clinical Commissioning Group leadership teams have been involved in developing and influencing the underlying planning assumptions and key areas of focus for 2012/13. Formal sign off of the PCT level plans has taken place at CCG Shadow Boards (a formal sub-committee of the Cluster Board) on 12th January 2012 (Gloucestershire) and 18th January 2012 (Swindon). Key aspects of the plan are being disaggregated at CCG and CCG locality level in Gloucestershire – in particular detailed activity, finance and QIPP contribution plans.

The Swindon CCG is going through a reconfiguration process from its existing format as the Transformational Leadership Group into the Clinical Commissioning Group. The constitution of the new group has not yet been formalised.

The CCGs have been closely involved in defining the underlying assumptions informing the plan and in particular have played a key role in working up the QIPP programme.

The plan sets out the approach to delivering the commissioning development milestones:

- Progress to full authorisation – it sets out the Cluster commitment to early authorisation, progress to date on 'building a track record' (emphasising in particular CCG's lead roles within the 2012/13 commissioning and contracting round, addressing in year commissioning issues and QIPP delivery), 'preparing for establishment' (building an infrastructure and effective governance arrangements) and 'becoming a successful organisation' (following a development programme and investing in individual and Board development).

- The plan sets out the Cluster approach to budget delegation within a formal scheme of delegation and the allocation of non-pay running costs and staff within the context of a wider PCT Cluster restructuring process.

Effective Commissioning - During 2012/13 and into the future the CCGs will need to have processes in place to commission effectively including an up to date JSNA, service redesign, planning and reconfiguration along with procurement, contract monitoring and quality control. At present these support services are provided by the PCT however in future the CCGs will secure such services through directly employed staff or from a CSS.

Governance Arrangements – see appendix 4 Governance Structures

As budgets are allocated to CCGs it will be crucial that during 2012/13 an appropriate governance arrangement is in place in order to ensure safe and effective management of public funds.

Accountability - In future the formal line of accountability for CCGs will be to the NHS Commissioning Board. In the interim during 2012/13 the PCT Cluster Board will ensure that the CCGs are accountable to the Board for the management and performance of the delegated budgets and delivery of the QIPP. As a sub-committee the CCG Shadow Board will report to the PCT Cluster Board.

CCGs will also be accountable to their local population and their strategic alignment with the Health and Wellbeing Boards will facilitate this.

Transparency - As the future governing body , CCGs and their member practices will need to be transparent in their decision making. During 2012/13 all recommendations/ decisions made by the CCG will require ratification by the PCT Cluster Board. Once authorised, CCGs will be required to hold their meetings in public.

Probity - Following authorisation, and through the implementation of the Health and Social Care Bill the CCGs will be responsible to ensure that they and their constituent practice adhere to the Nolan principles as required of anyone holding a position in public life.

Clinical leadership and transformation

Gloucestershire has commenced a programme for 'Gloucestershire whole system change' which is currently being supported by Finnamores. The aim of the programme is to develop and implement a whole economy pan- Gloucestershire strategy and transformation plan. This strategy will be driven and led by the CCG and supported by the clinical priorities forum, linking with the Health and Wellbeing Board. The strategy should be completed by June 2012, with organisational strategies and implementation plans in place by March 2013 for the transfer of commissioning responsibilities to the CCG from April 2013.

8.2 Commissioning Support for the Cluster

The plan builds on the progress that has already been made in developing the Cluster commissioning support offer and the creation of a commissioning support organisation. It confirms that shadow arrangements (with a draft service level agreement) will be in place from April 2012.

It also outlines progress in assessing the opportunity to provide services at scale across a wider geographical footprint.

Work is currently underway nationally to develop a proposal for a national communications and engagement shared service to provide communications and engagement support to CCGs. This work is being led by a national steering group. It is unclear at this time whether CCGs will choose to support this proposal.

8.3 Direct Commissioning

The plan sets out key milestones for the transition from the PCT Cluster to the NHS Commisioning Board (including plans for the alignment of staff and functions).

In particular these include:

- Plans to review practice registered patient lists
- The progress in identifying which staff are eligible to transfer to the NHS Commissioning Board direct commissioning functions (the alignment of which has taken place as part of the wider restructuring process).
- A process for ensuring a 'stock take' of contracts for services that the NHS Commissioning Board will directly commission will be ready for transition.

The plan identifies the Director of Commissioning Development as the lead for Primary Care commissioning transition and sets out plans for divestment of remaining PCTMS and PCTDS contracts.

8.4 Health and Wellbeing Boards

The Swindon Shadow Health and Wellbeing Board (SSHWB) was formally established in October and met for the first time on 31st October 2011. They are in the process of developing a work plan and their communications and engagement strategy.

Gloucestershire Shadow Health and Wellbeing Board (GSHWB) was formally established in December 2011, the inaugural meeting took place on the 8th December 2011.

The GSHWB has progressed the work programme for 2012 which will be reviewed and revised at each meeting in light of emerging legislation and local issues. The GSHWB have also approved the proposal to develop the Joint Health and Wellbeing Strategy (JHWS) and work commenced January 2012. It is proposed to endorse the JHWS in September 2012 and this will inform the commissioning plans for 2013/14. The JSNA will be updated within the same timescale in order to inform the high level priorities for the HWB.

The GSHWB will also develop a Communication and Engagement Strategy (CES), which will aim to co-ordinate the engagement with the public and partners related to health and social care.

8.5 Health Inequalities and Partnership Working

Partnership working is supported in each locality by a Consultant in Public Health and a Public Health Manager who attend a variety of partnership meetings and ensure that health inequalities are considered as part of any commissioning process. Information from the Joint Strategic Needs Assessment is used to inform this work. The Public Health Directorate also has representatives at the countywide partnership groups.

The Joint Health and Well-being Strategy is currently being developed using the principles outlined in the Marmot Review (Fair Society, Healthy Lives) on health inequalities. It has been proposed that the framework for the strategy will map to Marmot's life course approach and addresses the areas for action set out in 'Healthy Lives Healthy People', namely: starting well; developing well; living well; working well; and ageing well.

8.6 Public Health Transition Plan

The Swindon transition plan was produced in August 2011 and has been refreshed; the draft of the new plan was discussed at the Healthy Wellbeing Board on 11th January 2012 and submitted to the SHA.

The Programme Brief for Gloucestershire was signed off in March 2011 by the NHS Cluster Chief Executive and the GCC Chief Executive. The Transition Team met fortnightly with regular updates to the Transition Board, and from January 2012 it has met weekly.

The overall benefit of this programme is to ensure successful transfer of Public Health (PH) functions from NHS Gloucestershire (NHSG) to Gloucestershire County Council (GCC). To ensure public health functions / strategies are aligned both to new policies and approaches; and to GCC's new structures and priorities as set out in Healthy Lives, Healthy People.

The NHSG Public Health Transition Programme consists of seven work streams: Leadership; Programmes and Functions; Workforce Development; Finance and Governance; Strategic Communication, Business Continuity, and Research, Intelligence and Information. Together these work streams will provide assurance across the following transition areas identified by the SHA:

The transition plan provides a clear local plan which sets out the main elements of the transfer. Further work will continue until the end of February 2012 to assign key milestones and deadlines for each of these elements where not already identified, following publication of the additional documents to support this process including Public Health Indicators / outcomes, budget allocations and workforce strategy.

Work is underway to develop a clear local plan to migrate those functions and commissioning arrangements not transferring to the Local Authority. Executive signoff and agreement will inform how services will be delivered during transition, and will provide clarity of the delivery of critical PH programmes locally.

- **Delivering Public Health responsibilities during transition and preparing for 2013/14**

A Resource plan is in place to target areas identified where performance targets may be missed, and/or where additional resource needs to be allocated, ensuring effective business continuity is maintained during each phase of the transition and service delivery is not compromised. Business Continuity is one of our transition work streams.

- **Workforce**

The Workforce return was completed and submitted in November 2011, outlining the split of PH staff by function. The HR Concordat was published in December 2011, and NHSG/S HR personnel have been identified to support the sender/receiver and TUPE arrangements when required. This is picked up under the workforce development work stream.

- **Enabling Infrastructure**

The Public Health finance return was submitted in September 2011. Resources have been allocated from within existing budgets in 2011/12 to cover in-year transition costs (eg IT transition). We are waiting for the publication of the ring fenced budget allocation for the shadow year to enable detailed work to commence on financial arrangements for 2012/13.

Contracts have been identified and quantified, along with any intentions for destination commissioning organisations post 2013, with handover plans in progress. This piece of work sits in the programmes and functions work stream.

- **Communication and Engagement**

Plans are being progressed to develop a series of "Showcase" events to raise LA staff awareness of the PH offer. The Communication and Engagement plan is being developed through this work stream.

A robust communication plan is in place, and takes account of links with wider stakeholders including the shadow Clinical Commissioning Group, the Shadow Health and Wellbeing Board, other council's, local professional groups, other health providers including NHS and the VCS.

Following the weekly Transition Board, a communication is circulated to the wider Public Health Department.

8.7 Provider Development

Great Western Ambulance Service

NHS Gloucestershire is the lead commissioner for Great Western Ambulance Service (GWAS). Following a review of the feasibility of GWAS as a standalone organisation it was agreed that they would not move forward as a standalone Foundation Trust, but that a partner organisation would be sought. Following a consultation with all existing ambulance services in England South West Ambulance Service indicated an interest in acquisition. NHSG will support GWAS through this acquisition process which is expected to be completed by 31st March 2013.

Gloucestershire Care Services

Following a legal challenge, NHS Gloucestershire will be undertaking a procurement exercise in order to establish a provider of its current community health services. This will include appropriate levels of staff and public engagement. Meanwhile Gloucestershire Care Services will continue as part of NHS Gloucestershire.

Avon Wiltshire Partnership Trust

NHS Swindon commissions mental health services from Avon and Wiltshire Partnership Trust (AWP). A significant element of the AWP services is under notice and is being tendered by NHS Bristol. NHS Swindon will work with NHS Bristol to determine viability of AWP as a provider of mental health services ensuring continued provision through this period of change.

Any Qualified Provider

In 2011/12 a procurement exercise for AQP elective services took place, which resulted in a number of new independent sector provider contracts being awarded for Gloucestershire and Swindon cluster.

During January 2012 AQP contracts will be issued for the provision of direct endoscopy services, aimed at increasing capacity and improving access and choice for patients to this diagnostic service.

By September 2012 in conjunction with the national work stream NHSG and NHSS will have in place AQP contracts for wheelchair services and direct access MRI and CT.

9.0 Informatics

In line with the reform agenda the transition of Informatics support is broken down into 2 sections that will sit in different locations: Public Health and Commissioning.

9.1 Public Health informatics

The IT elements of the Public Health transition into the Local Authority will be completed in two phases. Phase 1 will establish the IT infrastructure that enables the Public Health team to have access to both NHS and Gloucestershire County Council Knowledge Resources has been completed during 2011/12. Phase 2 commenced in Q4 2011/12 to manage the move of the Public Health Intelligence Unit and deliver integration for the service between Health and Social Care during 2012/13.

9.2 PCT Cluster informatics:

IT infrastructure changes were introduced during 2011/12 to enable the joint Cluster Executive Team and supporting staff to work effectively across two geographies.

Planned outcomes for 2012/13 include:

- Single Informatics Programme Portfolio – end Q1 2012/13;
- Cluster wide data warehouse –end Q2 2112/13;
- Full deployment of NHS mail for all commissioning staff to enable geographically independent working – end Q3 2012/13.

Restructuring and alignment of informatics teams across the cluster to make full use of existing workforce capacity and capability during transition, identify and manage skills gaps and achieve savings where duplicated functions or services will be completed by the end of Q4 2012/13.

9.3 Legacy Management

A framework for knowledge capture for staff transitioning to new bodies has been developed and will be implemented during 2012/13 so that successor organisations will have a source of local knowledge and experience.

A comprehensive inventory linking estates, IT infrastructure and contracts is in place and will be fully populated during 2012/13. IT infrastructure is being rationalised where possible for handover to successor bodies at end 2012/13.

9.4 Maintaining Progress

QIPP enabling informatics projects and digital initiatives are managed through the IT portfolio and handed over to 'business as usual' on completion. This includes the Summary Care Record project which achieved 54% upload in Gloucestershire during 2011/12. There are issues including N3 connectivity in Gloucestershire that have resulting in remaining practices delaying upload. Records will be uploaded during 2012/13 as issues are resolved, aiming for full roll-out by Q4 2012/13. Swindon commences upload in Q1 2012/13.

9.5 Preparing for Future State

- Patient access to information: Two GP practices in Gloucestershire and Swindon are currently enabled to provide clinical records to patients. Of those practices one are routinely providing access. During 2012/13 we will work with a small group of practices to understand fully the implications and requirements for wider patient access in anticipation of national guidance.

- Cross cutting information: continued development of data warehouse and business intelligence capabilities is planned during 2012/13 to further improve the information available in support of clinical commissioning.

- Supporting Clinical Commissioning: informatics services will continue to be developed or re-aligned during 2012/13 to meet emerging requirements in anticipation of the formal establishment of Commissioning Support Organisations.

KEY PERFORMANCE DELIVERABLES 2012-13						
PRIORITY		**KEY PERFORMANCE INDICATOR**	**SUPPORTING INITIATIVES**	**PERFORMANCE MONITORING/MILESTONES**	**LEAD DIRECTOR**	
					Glos'shire	**Swindon**
PLANNED CARE						
Maintain national and locally determined acute care access standards	18 week Referral to treatment	Ensure that 90% of admitted pathways are seen within 18 weeks (PHQ19)	Review and re-commission of orthopaedic interface services Strengthen compliance with clinically agreed orthopaedic pathways Further expansion of GP referral Peer review scheme to include all specialities Review referrals to community physiotherapy	Threshold to be achieved and monitored monthly	Mark Walkingshaw	Paul Bearman
		Ensure that 95% of non-admitted pathways are seen within 18 weeks (PHQ20)		Threshold to be achieved and monitored monthly	Mark Walkingshaw	Paul Bearman
		Ensure that 92% of incomplete pathways have not waited longer than 18 weeks (PHQ21)		Threshold to be achieved and monitored monthly	Mark Walkingshaw	Paul Bearman
		Ensure that 95% of direct access audiology patients are seen within 18 weeks		Threshold to be achieved and monitored monthly	Mark Walkingshaw	Paul Bearman
		Comply with 18 week RTT best practice ensuring that: • Breaches, and the reason for the breach, are reported to the Board • Monitor and validate all patients that have waited over 35 weeks • Review all planned waiting lists monthly • Surgical pathways are reviewed to		Progress reviewed monthly	Mark Walkingshaw	Paul Bearman

KEY PERFORMANCE DELIVERABLES 2012-13						
PRIORITY		**KEY PERFORMANCE INDICATOR**	**SUPPORTING INITIATIVES**	**PERFORMANCE MONITORING/MILESTONES**	**LEAD DIRECTOR**	
					Glos'shire	**Swindon**
		reviewed to minimise diagnostic and out patient waiting times ensure				
	Access to diagnostic tests	Ensure that less that 1% of patients waiting for one of the 15 key diagnostic tests have waited longer than 6 weeks (PHQ22)	Review provision of endoscopy services, included through the AQP process, and ensure appropriate levels are commissioned Procure limited GP access to MRI and CT through the AQP route	Threshold to be achieved and monitored monthly	Mark Walkingshaw	Paul Bearman
Improve the offer and uptake of patient choice in line with national policy	Increase Choice	Ensure choice of a consultant led team where available (PHF07)		Threshold to be achieved and monitored monthly	Mark Walkingshaw	Paul Bearman
		Increase the proportion of GP referrals for first out-patient appointment through Choose and Book (PHF08)	Maintain a choice of at least 3 – 5 elective care providers within Gloucestershire and Swindon and immediate area for high volume elective treatment Provide greater choice through the Any Qualified Provider	Threshold to be achieved and monitored monthly	Mark Walkingshaw	Paul Bearman

KEY PERFORMANCE DELIVERABLES 2012-13						
PRIORITY		**KEY PERFORMANCE INDICATOR**	**SUPPORTING INITIATIVES**	**PERFORMANCE MONITORING/MILESTONES**	**LEAD DIRECTOR**	
					Glos'shire	**Swindon**
			Programme			
Military and veterans health	Ensure that the principles of the Armed Forces Network Covenant are met	Meeting veterans' prosthetic needs Improving mental health services for veterans (this is included in all MH specifications in the contract)			Mark Walkingshaw Sue Morgan	Paul Bearman Paul Bearman (Claire Allen)
CANCER						
Improve cancer services and prevent people from dying prematurely	Cancer 2 week waits	93% of patients should be seen within 2 weeks of an urgent GP referral for suspected cancer (PHQ24)	GP direct access to diagnostics Further develop cancer action plans with participating practices and increase the number of practices with plans	Threshold to be achieved and monitored monthly	Mark Walkingshaw	Paul Bearman
		93% of patients should be seen within 2 weeks of an urgent referral for breast symptoms where cancer is not initially suspected (PHQ25)		Threshold to be achieved and monitored monthly	Mark Walkingshaw	Paul Bearman
Improve cancer services and prevent people from dying prematurely	Cancer 62 day waits	85% of patients should receive their first definitive treatment for cancer within 62-days of an urgent GP referral for suspected cancer (PHQ03)		Threshold to be achieved and monitored monthly	Mark Walkingshaw	Paul Bearman
		90% of patients should receive their first definitive treatment for cancer within 62-days of referral from an		Threshold to be achieved and monitored monthly	Mark Walkingshaw	Paul Bearman

KEY PERFORMANCE DELIVERABLES 2012-13						
PRIORITY		**KEY PERFORMANCE INDICATOR**	**SUPPORTING INITIATIVES**	**PERFORMANCE MONITORING/MILESTONES**	**LEAD DIRECTOR**	
					Glos'shire	**Swindon**
		NHS Cancer Screening Service (PHQ04)				
		Patients receiving first definitive treatment for cancer within 62-days of a consultant decision to upgrade their priority status (PHQ05)		Threshold to be achieved and monitored monthly	Mark Walkingshaw	Paul Bearman
	Cancer 31 day waits	96% of patients should receive their first definitive treatment within one month of a cancer diagnosis (PHQ06)		Threshold to be achieved and monitored monthly	Mark Walkingshaw	Paul Bearman
		94% of patients should receive their subsequent treatment for cancer within 31-days where that treatment is Surgery (PHQ07)		Threshold to be achieved and monitored monthly	Mark Walkingshaw	Paul Bearman
Improve cancer services and prevent people from dying prematurely		98% of patients should receive their subsequent treatment for cancer within 31-days where that treatment is an Anti-Cancer Drug Regime (PHQ08)		Threshold to be achieved and monitored monthly	Mark Walkingshaw	Paul Bearman
		94% of patients should receive their subsequent treatment for cancer within 31-days where that		Threshold to be achieved and monitored monthly	Mark Walkingshaw	Paul Bearman

KEY PERFORMANCE DELIVERABLES 2012-13						
PRIORITY		**KEY PERFORMANCE INDICATOR**	**SUPPORTING INITIATIVES**	**PERFORMANCE MONITORING/MILESTONES**	**LEAD DIRECTOR**	
					Glos'shire	**Swindon**
		treatment is a Radiotherapy Treatment Course (PHQ09)				
Improve the effectiveness of screening programmes	Increase bowel screening capacity	People to receive test within 14 days	Secure additional capacity through additional contracts with other providers via AQP		Mark Walkingshaw	Paul Bearman
UNSCHEDULED CARE						
Improve access to unscheduled care also ensuring that national and local standards are met	Accident and emergency	95% of A&E patients should be treated, admitted or discharged within 4 hours of arrival (PHQ22)		Threshold to be achieved and monitored monthly Urgent care dashboard	Linda Prosser	Gill May
		Achieve the minimum performance standards for the Patient Impact and Timeliness A&E Indicators		Performance to be assessed quarterly but published monthly by providers Urgent care dashboard	Linda Prosser	Gill May
		Improve data quality and performance against the 4 A&E Quality Indicators		Performance to be assessed quarterly but published monthly by providers	Linda Prosser	Gill May
	Ambulance	75% of Cat A responses within 8 minutes (PHQ01)		Threshold to be achieved and monitored monthly Urgent care dashboard	Linda Prosser	Gill May
		95% of Cat A responses within 19 minutes (PHQ02)		Threshold to be achieved and monitored monthly Urgent care dashboard	Linda Prosser	Gill May
Improve access to unscheduled care also ensuring that national	Ambulance	Reduce the number of ambulance urgent & emergency journeys	CQUIN to support reduced conveyance rates.	Monitored monthly Urgent care dashboard	Linda Prosser	Gill May

KEY PERFORMANCE DELIVERABLES 2012-13						
PRIORITY		**KEY PERFORMANCE INDICATOR**	**SUPPORTING INITIATIVES**	**PERFORMANCE MONITORING/MILESTONES**	**LEAD DIRECTOR**	
					Glos'shire	**Swindon**
and local standards are met		(PHS13)	Improved care plan usage.			
		Reduce the number of over 15 minute ambulance handover delays		Monitored monthly Urgent care dashboard		Gill May
		Improve quality of care by ensuring that plans are in place to monitor and deliver ongoing improved performance against the Ambulance Service Quality Indicators		Performance to be assessed quarterly but published monthly by providers	Linda Prosser	Gill May
		Clinical desk expansion and increase in proportion of patients dealt with in Hear and Treat category		Monitored monthly against plan	Linda Prosser	Gill May
Implementation of Trauma Network	Ambulance		CQUIN scheme with GWAS linked to training requirements for the network	Contract monitoring of CQUIN quarterly basis	Linda Prosser	Gill May
	Acute Trust		Reconfiguration of services – trauma move to one site	Review action plan	Mark Walkingshaw	
	Develop plans to implement a NHS111 service in Gloucestershire and Swindon by April 2013	Service to be in place by 1st April 2013	Determine impact on current contractual arrangements Decommission existing OOHs call handling service	Progress to be monitored quarterly against milestones	Linda Prosser	Gill May

KEY PERFORMANCE DELIVERABLES 2012-13						
PRIORITY		**KEY PERFORMANCE INDICATOR**	**SUPPORTING INITIATIVES**	**PERFORMANCE MONITORING/MILESTONES**	**LEAD DIRECTOR**	
					Glos'shire	**Swindon**
			Assess impact on patient accessible services Implementation of CMS by all pproviders			
Emergency preparedness and resilience planning	Winter Plan	Ensure a robust Winter Plan is in place to ensure that the Gloucestershire and Swindon Health Communities are prepared for various winter pressure scenarios		Review actual performance against the plan through the operational months	Linda Prosser	Gill May
	Olympics	To provide effective health services to support the Olympic 2012 plan	Active planning with GWAS. Production of plan for other organisations	Progress to monitored against plan	Linda Prosser	Gill May
Ensure that Care home residents receive the best possible care including adequate support to prevent admissions		Reduction in non-elective admissions (PHS06)	Development of the Dementia Quality Mark (DQM) for accreditation in Care Homes	Progress to be monitored quarterly against milestones yet to be established Urgent care dashboard	Linda Prosser	Gill May
Acute assessment and ambulatory care – full delivery of the ambulatory care model		Increase in ambulatory episodes Reduction in non-elective admissions (PHS06)	Creation of ambulatory tariff Increase space for ambulatory	Progress to be monitored quarterly against milestones yet to be established	Linda Prosser	Gill May

KEY PERFORMANCE DELIVERABLES 2012-13						
PRIORITY		**KEY PERFORMANCE INDICATOR**	**SUPPORTING INITIATIVES**	**PERFORMANCE MONITORING/MILESTONES**	**LEAD DIRECTOR**	
					Glos'shire	**Swindon**
			approach with ambulatory day unit of each hospital site Use of best practice tariff with Great Western Hospital and Gloucestershire Hospitals Foundation Trust			
LONG TERM CONDITIONS						
Assistive Technology	Systematic adoption of assistive technology	Number of Telehealth units in use	Rollout of Telehealth at scale and telecare		Linda Prosser	Gill May
End of life Care	Ensure implementation of the End of life care strategy – promoting high quality care for all adults at the end of life	Increase the percentage of deaths in place of choice on 2011/12 levels	Increased use of personalised care plans. Flags on GWAS system		Linda Prosser	Gill May
Improve the use and coverage personalised care plans		Reduction in non-elective admissions (PHS06) Increase the percentage of patients with a PCP Increase the number of people with LTC feeling independent and in control of their condition	Greater sharing of existing plans particularly with GWAS GPs to provide high quality referral information to acute hospitals Acute hospitals to	Progress to be monitored quarterly against milestones yet to be established	Linda Prosser	Gill May

KEY PERFORMANCE DELIVERABLES 2012-13						
PRIORITY		**KEY PERFORMANCE INDICATOR**	**SUPPORTING INITIATIVES**	**PERFORMANCE MONITORING/MILESTONES**	**LEAD DIRECTOR**	
					Glos'shire	**Swindon**
		Improve compliance with PCPs.	provide more timely and accurate discharge information to care Homes			
Improve stroke services	Increase the proportion of time stroke patients spend on a stroke unit	90% of patients admitted with a stroke should spend at least 80% of their time on a stroke unit	Stroke services to be combined on one site in with main provider GHNHSFT		Linda Prosser	Gill May
	Increase the proportion of patients experiencing a stroke that have been assessed and treated within 24 hours	60% of people at high risk of Stroke, who experience a TIA, should be assessed and treated within 24 hours			Linda Prosser	Gill May
Enhancing quality of life for people with long term conditions (Outcomes Framework Domain 2)	Ensuring people feel supported to manage their condition	Increase the percentage of people feeling supported to manage their condition (OF 2.1)			Linda Prosser	Gill May
	Improving functional ability in people with long term conditions	Increase the employment of people with long term conditions (OF 2.2)			Linda Prosser	Gill May
	Reducing time spent in hospital by people with long term conditions	Reduce unplanned hospitalisation for chronic ambulatory care sensitive conditions (OF 2.3i)			Linda Prosser	Gill May

KEY PERFORMANCE DELIVERABLES 2012-13						
PRIORITY		**KEY PERFORMANCE INDICATOR**	**SUPPORTING INITIATIVES**	**PERFORMANCE MONITORING/MILESTONES**	**LEAD DIRECTOR**	
					Glos'shire	**Swindon**
		Reduce unplanned hospitalisation for asthma, diabetes and epilepsy in under 19s (OF 2.3ii)				
	Enhance quality of life for carers	Improve health-related quality of life for carers (OF 2.4)			Linda Prosser	Gill May
DEMENTIA						
Improve early diagnosis and treatment of dementia	Improve quality of care in general practice and ensure best clinical outcome for patients	Increase QOF dementia register to 60%. Reduction in admissions		Progress to be monitored quarterly against milestones yet to be established	Linda Prosser	Gill May
	NICE	Ensure that providers are compliant with NICE quality standards			Linda Prosser	Gill May
	Provide PET scans for younger onset of dementia	Reduced length of stay Reduced delayed discharges		Progress to be monitored quarterly against milestones yet to be established	Linda Prosser	Gill May
	Reduce inappropriate antipsychotic prescribing for people with dementia	Reduction in antipsychotic prescribing		Progress to be monitored quarterly against milestones yet to be established	Linda Prosser	Gill May
	Care in acute and community hospitals	Improve dementia standards to support quality improvements		Progress to be monitored quarterly against milestones yet to be established	Linda Prosser	Gill May

KEY PERFORMANCE DELIVERABLES 2012-13						
PRIORITY		**KEY PERFORMANCE INDICATOR**	**SUPPORTING INITIATIVES**	**PERFORMANCE MONITORING/MILESTONES**	**LEAD DIRECTOR**	
					Glos'shire	**Swindon**
	Dementia: home based care and support	County wide Community Dementia Nurse service and Dementia Advisor service		Progress to be monitored quarterly against milestones yet to be established	Linda Prosser	Gill May
CARERS						
Carers Strategy	Joint assessment of carers local needs	Agree and sign off plan with Local Authorities that: Identifies the financial contribution made to support carers Identifies how much of the total is being spent on carers breaks Identifies an indicative number of breaks that should be available within funding		Progress to be monitored quarterly against milestones yet to be established Plan to be published on PCT website by 30th September 2012		Paul Bearman (Claire Allen)
MENTAL HEALTH & DRUG AND ALCOHOL SERVICES						
Improving safety and access to Mental Health Services	Early Intervention	Ensure that 70 new cases of psychosis are served by the early intervention team in the year in Gloucestershire and 26 in Swindon(PHQ10)		Monitored quarterly against trajectory yet to be determined	Sue Morgan	Paul Bearman (Claire Allen)
	Crisis Resolution and Home Treatment	Ensure 939 inpatient admissions to have been gatekept by CR/HT in Gloucestershire and 409 in		Monitored quarterly against trajectory yet to be determined	Sue Morgan	Paul Bearman (Claire

KEY PERFORMANCE DELIVERABLES 2012-13						
PRIORITY		**KEY PERFORMANCE INDICATOR**	**SUPPORTING INITIATIVES**	**PERFORMANCE MONITORING/MILESTONES**	**LEAD DIRECTOR**	
					Glos'shire	**Swindon**
		Swindon (PHQ11)				Allen)
	Care Programme Approach	At least 95% of people under adult mental health specialties on CPA to be followed up within 7 days of discharge (PHQ12)		Threshold to be achieved and monitored quarterly	Sue Morgan	Paul Bearman (Claire Allen)
	No Health without Mental health	Implement government strategy outlined in DoH No Health without Mental Health document (DH 2011)	Development of local Mental Health strategy coproduced with the Voluntary & Community sector, service users and carers	Timeframe to be agreed	Sue Morgan	Paul Bearman (Claire Allen)
	Improve patient safety	Learn lessons from SUIs and specific reviews implementing the necessary improvements			Sue Morgan	Paul Bearman (Claire Allen)
Improving access to psychological Services	Improving access to psychological services	Proportion of people with depression referred for psychological therapy and proportion referred for therapy receiving it (PHQ13)	Proposed integration of IAPT and PHMT to establish one Primary Care Mental Health Service Training for non-mental health professionals to enhance user experience and mental health wellbeing	Monitored quarterly (target and milestones still to be agreed)	Sue Morgan	Paul Bearman (Claire Allen)

KEY PERFORMANCE DELIVERABLES 2012-13						
PRIORITY		**KEY PERFORMANCE INDICATOR**	**SUPPORTING INITIATIVES**	**PERFORMANCE MONITORING/MILESTONES**	**LEAD DIRECTOR**	
					Glos'shire	**Swindon**
Tendering Drug and alcohol service	Increase number of drug users successfully completing drug treatment	An increase of the number of users completing treatment on that recorded in 2011/12		Monitored quarterly (target and milestones still to be agreed)	Sue Morgan	Paul Bearman (Claire Allen)
	Implement alcohol liaison nurse	A reduction in repeat admissions to hospital		Monitored quarterly (target and milestones still to be agreed)	Sue Morgan	N/A Swindon
	Re-provision of substance misuse treatment services	Revised model to deliver the recovery agenda		Monitored quarterly (target and milestones still to be agreed)	Sue Morgan	N/A Swindon
Enhancing quality of life for people with long term conditions (Outcomes Framework Domain 2)	Enhance quality for people with mental illness	Increase the employment of people with mental illness (OF 2.5)			Sue Morgan	Paul Bearman (Claire Allen)
LEARNING DISABILITIES						
Implement the recommendations of the Winterbourne Review - provide care closer to home	Decommissioning of inpatient beds and replace with funding for community based placements	Provide care closer to home Reductions in admissions to Hospital Reduction in length of stay		Carried out in 3 phases. Phase one by March 2012, phase 2 October 2012 and phase 3 by end of 2012/13	Sue Morgan	N/A Swindon
	Creation of new Intensive Support Service				Sue Morgan	N/A Swindon
	Review of pathways for people who present a challenge				Sue Morgan	Paul Bearman

KEY PERFORMANCE DELIVERABLES 2012-13						
PRIORITY		**KEY PERFORMANCE INDICATOR**	**SUPPORTING INITIATIVES**	**PERFORMANCE MONITORING/MILESTONES**	**LEAD DIRECTOR**	
					Glos'shire	**Swindon**
	to services					(Angela Plummer)
PRIMARY AND COMMUNITY CARE						
Improve access to community services	Maintain current referral to treatment performance in Gloucestershire for patients referred to an AHP	95% of patients referred to a AHP run service in Gloucestershire should start their treatment within 8 weeks of being referred		Threshold to be achieved and monitored quarterly	Linda Prosser	N/A Swindon
	Gloucestershire two week local offer	All patients referred in Gloucestershire to adult & Paediatric physiotherapy, adult & Paediatric OT, Paediatric SLT and for an assessment for a wheelchair should be seen within an average of two weeks			Linda Prosser	N/A Swindon
Improving health outcomes through the effective use of preventative strategies	Smoking	Ensure that the 4 week smoking quitter target is achieved (PHQ30)		Monitored quarterly (target and milestones still to be agreed)	Shona Arora	Jose Ortega
	Health Checks	Percentage of people aged 40-74 who have received a health check (PHQ31)		Monitored quarterly (target and milestones still to be agreed)	Shona Arora	Jose Ortega
	Ensure children and young people have access to the recommended routine vaccinations	Immunisation against MMR Hib Immunisation rate for children aged 1			Debra Elliott	Debra Elliott

KEY PERFORMANCE DELIVERABLES 2012-13						
PRIORITY		KEY PERFORMANCE INDICATOR	SUPPORTING INITIATIVES	PERFORMANCE MONITORING/MILESTONES	LEAD DIRECTOR	
					Glos'shire	Swindon
		Pneumococcal immunisation rate for children aged 2 Hib/MenC booster for children aged 2 MMR for children aged 2 DTaP/IPV immunisation rate for children aged 5 MMR immunisation rate for children aged 5 HPV immunisation rate for girls aged around 12-13 years Td/IPV immunisation rate for children aged 13-18 years rate for girls aged around 12-13 years Td/IPV immunisation rate for children aged 13-18 years				
	Influenza immunisation for those in the 65 and over plus at-risk group	Percentage uptake			Debra Elliott	Debra Elliott

KEY PERFORMANCE DELIVERABLES 2012-13						
PRIORITY		KEY PERFORMANCE INDICATOR	SUPPORTING INITIATIVES	PERFORMANCE MONITORING/MILESTONES	LEAD DIRECTOR	
					Glos'shire	Swindon
	Pneumococcal vaccinations for those in the 65 and over plus at-risk group	Percentage uptake			Debra Elliott	Debra Elliott
	Monitor childhood obesity through the National Childhood Measurement Programme	Percentage of children in reception and year 6 recorded as obese			Shona Arora	Jose Ortega
	Support GP clusters to develop/procure community based adult weight management services	Reduction in adult obesity			Shona Arora	Jose Ortega
	Revise maternal obesity care pathway and develop/procure support services for pregnant women with a BMI >35	Percentage of pregnant women with a BMI >35			Shona Arora	Jose Ortega
Preventing people from dying prematurely (Outcomes Framework Domain 1)	Reducing premature mortality from major causes of death	Reduce under 75 mortality rate from cardiovascular disease (OF1.1) Reduce under 75 mortality rate from respiratory disease (OF1.2)			Shona Arora	Jose Ortega

KEY PERFORMANCE DELIVERABLES 2012-13						
PRIORITY		KEY PERFORMANCE INDICATOR	SUPPORTING INITIATIVES	PERFORMANCE MONITORING/MILESTONES	LEAD DIRECTOR	
					Glos'shire	Swindon
		Reduce under 75 mortality rate from liver disease (OF1.3) Improve cancer survival rates (OF1.4) 1 and 5 year survival from colorectal cancer 1 and 5 year survival from breast cancer 1 and 5 year survival from lung cancer Under 75 mortality rate from cancer				
	Reducing premature death in people with serious mental illness	Reduce under 75 mortality rate in people with serious mental illness (OF 1.5)			Shona Arora	Jose Ortega
	Reducing deaths in babies and young children	Reduce infant mortality (OF 1.6i) Reduce neonatal mortality and stillbirths (OF 1.6ii)			Shona Arora	Jose Ortega
Improve delivery of sexual health services	Reduction in teenage pregnancy	50% reduction in teenage pregnancy rates by 2014 based on 1998 levels			Shona Arora	Jose Ortega

KEY PERFORMANCE DELIVERABLES 2012-13						
PRIORITY		**KEY PERFORMANCE INDICATOR**	**SUPPORTING INITIATIVES**	**PERFORMANCE MONITORING/MILESTONES**	**LEAD DIRECTOR**	
					Glos'shire	**Swindon**
	Increased diagnosis and positivity for Chlamydia Screening	Attain at least 2400 positive tests per 100.000 of the 15-24 population	Carry out full review of Chlamydia Screening Office function in Gloucestershire Increase screening in core services		Shona Arora	Jose Ortega
QUALITY						
Treating and caring for people in a safe environment and protect them from avoidable harm	MRSA	Ensure that rates of MRSA are kept below baseline target (PHQ27)		Performance to be monitored monthly against trajectory (yet to be determined)	Jill Crook	Jill Crook
	C. diff.	Ensure that rates of C. diff. are kept below baseline target (PHQ28)		Performance to be monitored monthly against trajectory (yet to be determined)	Jill Crook	Jill Crook
	VTE	Ensure that 90% of all adult inpatients have had a VTE risk assessment (PHQ29)		Threshold to be achieved and monitored monthly	Jill Crook	Jill Crook
Mixed sex accommodation		Keep the number of unjustified mixed sex accommodation breaches to a minimum (PHQ26)		Progress to be monitored monthly	Jill Crook	Jill Crook
Safeguarding	Sustain focus on adult and child safeguards	A designated professional is identified to support local safeguarding boards			Jill Crook	Jill Crook
		Ensure internal systems are in place to escalate and intervene as required in response to			Jill Crook	Jill Crook

KEY PERFORMANCE DELIVERABLES 2012-13						
PRIORITY		**KEY PERFORMANCE INDICATOR**	**SUPPORTING INITIATIVES**	**PERFORMANCE MONITORING/MILESTONES**	**LEAD DIRECTOR**	
					Glos'shire	**Swindon**
		safeguarding alerts				
Helping people to recover from episodes of ill health or following injury Outcomes Framework domain 3)	Improving outcomes for planned procedures	Improving patient reported outcome measures (PROMs) for the following elective procedures (OF3.1) • Hip replacement • Knee replacement • Groin hernia • Varicose veins			Jill Crook	Jill Crook
	Prevent lower tract infections (LRTI) in children becoming serious	Reduce the number of emergency admissions for children with LRTI (OF 3.2)			Sue Morgan	Paul Bearman (Louise Tappa)
	Improving recovery from a stroke	Data to be obtained from the Sentinel Stroke National Audit Programme (SSNAP) (OF 3.4)			Linda Prosser	Gill May
	Improving recovery from fragility fractures	Increase the proportion of patients recovering to their previous levels of mobility/walking ability at i) 30 and ii) 120 days (OF 3.%)			NHSG Contract Lead for GHNHSFT	Gill May
	Helping older people to recover their independence after illness	Increase the proportion of older people (65 and over) who were i) still at home 91 days after discharge into rehabilitation and ii)			Linda Prosser	Gill May

KEY PERFORMANCE DELIVERABLES 2012-13						
PRIORITY		KEY PERFORMANCE INDICATOR	SUPPORTING INITIATIVES	PERFORMANCE MONITORING/MILESTONES	LEAD DIRECTOR	
					Glos'shire	Swindon
		offered rehabilitation following discharge from an acute or community hospital (OF 3.6)				
Ensuring that people have a positive experience of care (Outcomes Framework domain 4)	Improving people's experience of outpatient care	Improve patient experience of outpatient services (OF 4.1)			Jill Crook	Jill Crook
	Improving hospital's responsiveness to personal needs	Improve responsiveness to inpatients personal needs (OF 4.2)			Jill Crook	Jill Crook
	Improving people's experience of accident and emergency services	Improve patient experience of A&E services (OF 4.3)			Jill Crook	Jill Crook
	Improving access to primary care services	Improve access to primary care services, i0 GP services and ii) NHS dental services (OF 4.4):			Debra Elliott	Jill Crook
	Improving women and their families experience of maternity services	Improve women's experience of maternity services (OF 4.5)			Jill Crook	Jill Crook
	Improving the experience of care for people at the end of their lives	Indicator to be derived (OF 4.6)			Jill Crook	Jill Crook
	Improving the experience of care	Improve patient's experience of community			Jill Crook	Jill Crook

KEY PERFORMANCE DELIVERABLES 2012-13						
PRIORITY		**KEY PERFORMANCE INDICATOR**	**SUPPORTING INITIATIVES**	**PERFORMANCE MONITORING/MILESTONES**	**LEAD DIRECTOR**	
					Glos'shire	**Swindon**
	for people with mental illness	mental health services (OF 4.7)				
Treating and caring for people in a safe environment and protecting them from avoidable harm (Outcomes Frame work domain 5)	Reducing incidence of avoidable harm	Reducing the incidence of hospital related venous thromboembolism (VTE) (OF 5.1) Reducing the incidence of healthcare associated infection (HCAI i) MRSA and ii) C. difficile (OF 5.2) Reducing the incidence of newly acquired category 2, 3 and 4 pressure ulcers (OF 5.3) Reducing the incidence of medication errors causing serious harm (OF 5.4)			Jill Crook	Jill Crook
	Improving the safety of maternity services	Admission of full-term babies to neonatal care (OF 5.5)			Sue Morgan	Paul Bearman (Louise Tappa)
	Delivering safe care to children in acute settings	Reduction in incidence of harm to children due to 'failure to monitor' (OF 5.6)			Sue Morgan	Paul Bearman (Louise Tappa)
CHILDREN, YOUNG PEOPLE AND MATERNITY						

KEY PERFORMANCE DELIVERABLES 2012-13						
PRIORITY		**KEY PERFORMANCE INDICATOR**	**SUPPORTING INITIATIVES**	**PERFORMANCE MONITORING/MILESTONES**	**LEAD DIRECTOR**	
					Glos'shire	**Swindon**
Health Visitors	Increase Health Visitors by 2015 by 4200 nationally	Increase WTE health visitors to 92.73 in Gloucestershire and 29.17 In Swindon LA by March 2013.		Monitored monthly, trajectory to be agreed	Sue Morgan	Paul Bearman (Louise Tappa)
Maternity	Increase in normal births and a reduction in caesarean sections	A 1% increase in the percentage of mothers giving birth normally based on 2011/12 levels			Sue Morgan	Paul Bearman (Louise Tappa)
	Reduce perinatal mortality including stillbirths. Reduce infant mortality and low birth weights	An increase in the normal birth weight based on 2011/12 levels			Sue Morgan	Paul Bearman (Louise Tappa)
	Reduce smoking in pregnancy	100% of women who are smoking in pregnancy to be referred to the smoking cessation service Reduction in low birth weight, still births and infant mortality			Shona Arora	Jose Ortega
	Increase the number of mothers breastfeeding at 6-8 weeks	At least 52% of mothers should be breastfeeding at 6 to 8 weeks. Increase breastfeeding at 6 to 8 weeks by 10% in those areas in			Shona Arora	Jose Ortega

KEY PERFORMANCE DELIVERABLES 2012-13						
PRIORITY		**KEY PERFORMANCE INDICATOR**	**SUPPORTING INITIATIVES**	**PERFORMANCE MONITORING/MILESTONES**	**LEAD DIRECTOR**	
					Glos'shire	**Swindon**
		Gloucestershire with the lowest rates in 2011/12				
INFORMATICS						
Managing Transition	Move of Public Health Intelligence Unit to Gloucestershire County Council	Integration for the service between Health and Social care		Phase I completed during 2011/12. Phase II to be completed during Q2 2012/13/	Sylvia Tute	
	PCT Cluster	Single Informatics Programme Portfolio		June 2012	Sylvia Tute	
		Cluster wide data warehouse		September 2012	Sylvia Tute	
		Full deployment of NHS mail for all commissioning staff		December 2012	Sylvia Tute	
	Legacy Management	Full inventory linking estates and IT infrastructure and contracts		To be completed by 31st March 2013.	Sylvia Tute	
	Maintaining progress	Full roll-out of Summary care Record project to all practices in Gloucestershire		Currently 54% coverage, 100% by 31st March2013	Sylvia Tute	
	Patient access	Work with practices to understand fully the implications and requirements for wider patient access in		To be completed by 31st March 2013.	Sylvia Tute	

KEY PERFORMANCE DELIVERABLES 2012-13						
PRIORITY		**KEY PERFORMANCE INDICATOR**	**SUPPORTING INITIATIVES**	**PERFORMANCE MONITORING/MILESTONES**	**LEAD DIRECTOR**	
					Glos'shire	**Swindon**
		anticipation of national guidance				
WORKFORCE						
NHSG continues in its commitment to being an 'Employer of choice' within the local market, recognising that excellence cannot be achieved without a motivated, engaged workforce	CCG	Ensure the CCG has the necessary commissioning support services to support it through authorisation; Support the CCG to agree and adopt final commissioning support arrangements for taking on full statutory duties			Debra Elliott	Debra Elliott
	CSU	Support the development of the CSU, ensuring that its staff, infrastructure and operating processes are professional, fit for purpose, provide value for money and represent excellent customer service.			Mary Hutton	Mary Hutton
	Transition	Put in place appropriate plans for individuals to support their own transition beyond the PCT. Manage the transition process lawfully and sensitively; Provide appropriate support and development opportunities for staff			Nuala Ring	Nuala Ring

APPENDIX 2 – Performance measures from Annual Operating Framework for the NHS in 2012/13

Annex – National performance measures

Quality

1 Preventing people from dying prematurely

- Ambulance quality (Category A response times)
- Cancer 31 day, 62 day waits

2 Enhancing quality of life for people with long term conditions

- Mental health measures (Early intervention; Crisis resolution; CPA follow up, IAPT)
- Long term condition measures (Proportion of people feeling supported to manage their condition; Unplanned hospitalisation for chronic ambulatory care sensitive conditions (adults); Unplanned hospitalisation for asthma, diabetes and epilepsy in under 19s)

3 Helping people to recover from episodes of ill health or following injury

- Emergency admissions for acute conditions that should not usually require hospital admission

4 Ensuring that people have a positive experience of care

- Patient experience of hospital care
- Referral to Treatment and diagnostic waits (incl. incomplete pathways)
- A&E total time
- Cancer 2 week waits
- Mixed-sex accommodation breaches

5 Treating and caring for people in a safe environment and protecting them from avoidable harm

- Incidence of MRSA
- Incidence of *C. difficile*
- Risk assessment of hospital-related venous thromboembolism (VTE)

Public Health

- Smoking quitters
- Health checks

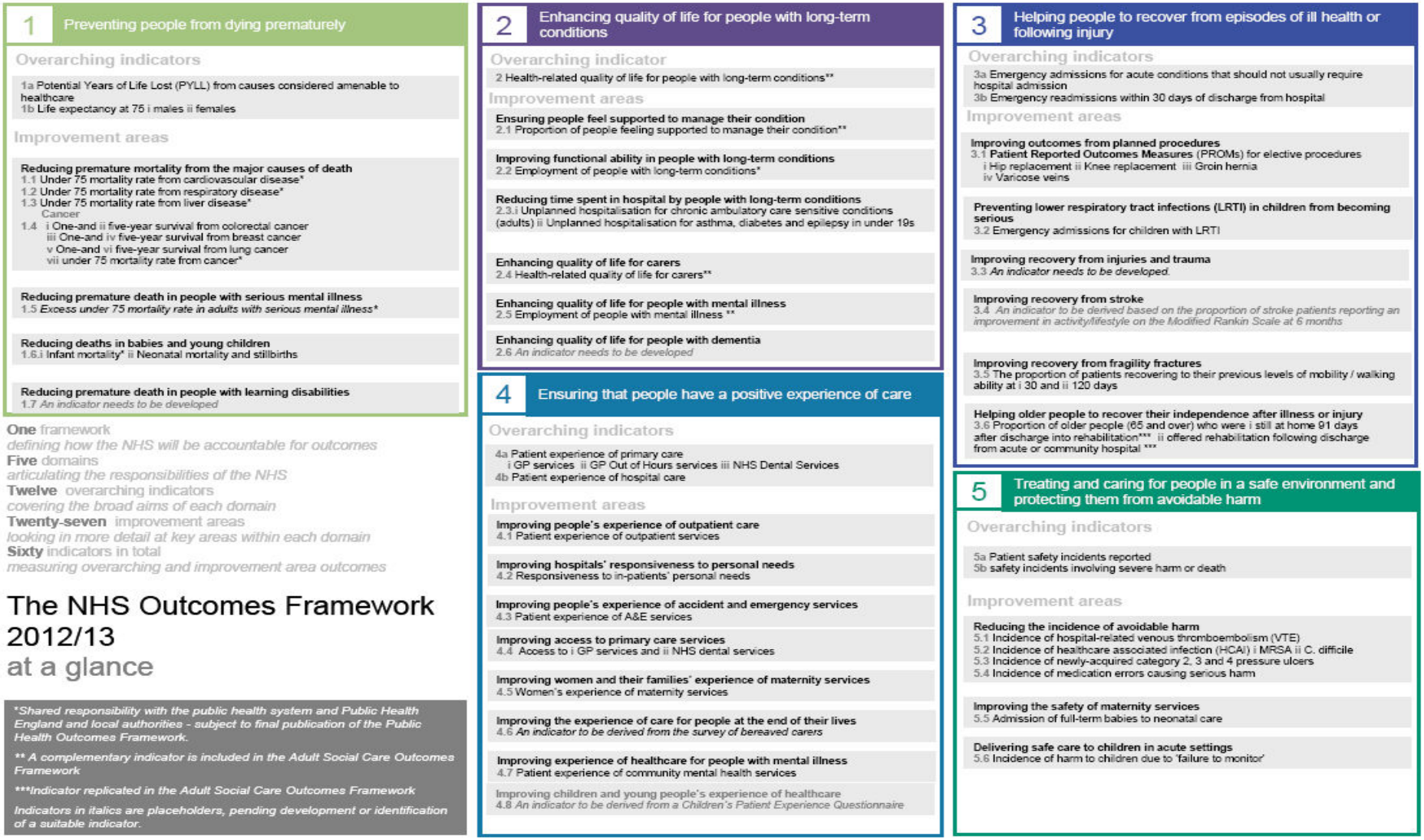
Resources

- Financial forecast outturn & performance against plan
- Financial performance score for NHS trusts
- Delivery of running cost targets
- Progress on financial aspects of QIPP
- Acute bed capacity
- Activity (eg Elective and non-elective consultant episodes; Outpatients; Referrals)
- Numbers waiting on an incomplete Referral to Treatment pathway
- Health visitor numbers
- Workforce productivity
- Total pay costs
- Workforce numbers (clinical staff and non-clinical)

Reform

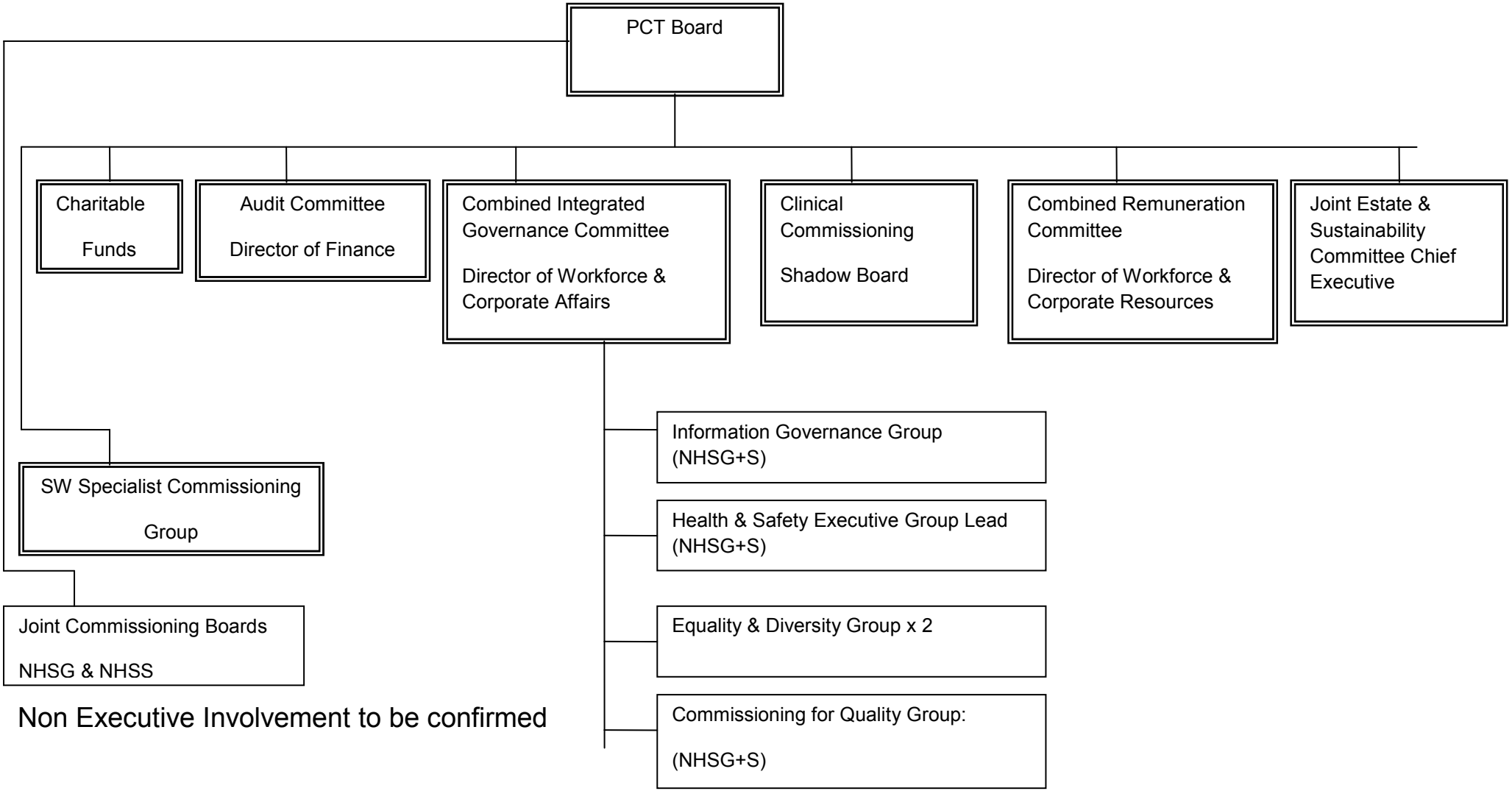
- **Commissioning Development**
  - % delegated budgets
  - Measure of £ per head devolved running costs
  - % authorisation of clinical commissioning groups
  - % of General Practice lists reviewed and "cleaned"
- **Public Health**
  - Completed transfers of public health functions to local authorities
- **FT pipeline**
  - Progress against TFA milestones
- **Choice**
  - Bookings to services where named consultant led team was available (even if not selected)
  - Proportion of GP referrals to first outpatient appointments booked using Choose and Book
  - Trend in value/volume of patients being treated at non-NHS hospitals
- **Information to Patients**
  - % of patients with electronic access to their medical records

APPENDIX 3 – Outcome measures from NHS Outcome Framework for 2012/13



Appendix 4 – Governance Structures

Executive Director Leads – Board Sub Committees



Non Executive Involvement to be confirmed