INTRODUCTION

This report fulfils part of a national commitment to publish the performance of Primary Care Trusts (PCTs) against the Vital Signs.

The Vital Signs are a set of health targets and indicators that were introduced nationally to provide a set of outcome measures and performance indicators that reflect the priorities for the NHS. These comprise three tiers:
A) National requirements
B) National priorities for local delivery
C) Targets that are agreed with our partners as priorities for local action.

In a number of cases, Vital Signs are also national NHS targets, and contribute to our Annual Health Check performance ratings, which will be published for the 2008/09 year in October 2009. Some of the Vital Signs are also among the core outcome measures that we have adopted to act as signposts to enable us to measure the benefits to local health and healthcare that flow from our progress towards becoming a world class commissioner.

The two appendices to this report summarise how NHS South West Essex has performed in relation to Vital Signs, and how this compares with the rest of the East of England and the national picture, based on information that has been made available by the national Care Quality Commission.

This paper gives an overview of the results and sets these in the context of our local plans and actions to improve health care.

The local progress that we are making benefits in many ways from the contributions of our partners, including NHS provider Trusts and local authorities. We are continuing to build on the strong partnership working that has been achieved, and it is hoped that the key messages within this paper will inform our discussions and consultations with these partners and with patients and the public, to help determine the future priorities for local health care and health improvement.

Fuller information on our plans and progress may be found in the following documents:
- *Commissioning World Class Primary and Community Care*, our commissioning strategy for primary and community care services for 2009-14
- Our Annual Operational Plan for the year 2009/10, which sets out the specific plans for the current year
• Our Annual Report for 2008/09

THE SUMMARY INFORMATION

Vital Signs data

Appendix 1 gives an overview of the Vital Signs for which comparative data (usually for the period 2008/09 but in some cases older) has been compiled by the Care Quality Commission; and shows where our performance was better than expected, as expected or below expectations when compared with that of other PCTs. For some of the Vital Signs no data has been given, either because they are still in development or for other reasons.

Appendix 2 gives a more detailed breakdown of the data. The table shows the following for each Vital Sign:
• The planned and actual performance for the stated period
• An indication of the national average performance for each item
• An indication of whether our performance was better than expected of PCTs generally, in line with expectations, or less good than expected (“traffic lighted” green, amber or red) – see below
• A ranking of our performance among that of all 14 PCTs in the East of England
• Any relevant explanatory notes including comments on our plans to improve performance, and which of these indicators have been selected as core outcome measures to help assess our progress towards World Class Commissioner status.

Comparison with other PCTs’ performance

For the purposes of comparison, where relevant NHS South West Essex has been grouped with similar PCTs, either in terms of deprivation (for example in relation to the vital signs for mortality and smoking) or population turnover (for example indicators relating to health screening and immunisation); where this grouping applies, this is noted in the traffic lighted box. In cases where aspects of the population served by the PCT do not directly affect performance or where the available data does not allow for a comparator group to be identified, we have been compared with all PCTs in the country (for example vital signs that relate to access to treatment).

Vital Sign VSC1 (NHS Litigation Authority PCT Standards, Risk Management Assessment Level) has not been ranked as this is based on a single score and not suitable to be assessed in this way.
In overall terms, the rankings indicate that NHS South West Essex:

- Achieved better than expected performance in 14% of the Vital Signs
- Performed as expected in 73% of Vital Signs
- Performed less well than expected in 14% of the Vital Signs.

(percentages have been rounded to the nearest whole number)

Looking at the three groups of Vital Signs, the rankings show that NHS South West Essex achievement of the expected level of performance, or better than this, was:

- 86% in Tier 1 (ranked 4th out of 14 in East of England)
- 94% in Tier 2 (ranked 10th)
- 75% in Tier 3 (ranked 8th)

It should be stressed that the comparisons are subject to statistical variations, especially where small numbers are involved. It is also important to note that the PCT has agreed formal performance targets in relation to only a few of the optional Tier 3 Vital Signs.

However, the overall message is that while our achievement was generally as good as, or better than, might be expected for similar PCTs, we need to continue our efforts with partners and to tackle areas of underperformance.

DELIVERING OUR STRATEGY

Our vision is for the entire population served by NHS South West Essex to become one of the healthiest and best cared for in the country. Our ambition is to tackle health inequalities and reduce the gap in life expectancy affecting our poorest communities, at the same time raising standards of care and access right across our area, so that we can truly claim to deliver world class services throughout South West Essex.

To this end we have developed our plans around four strategic priorities:

- Improving access to high quality primary medical, dental and community services
- Improving the experience of those who use our services ensuring that services are safe and provided to a high quality
- Improving prevention and screening services to promote health and well-being
- Developing excellent, integrated and more localised services, especially for those people with a long term condition.

Developing services to meet the needs of our communities

The strategic themes are being delivered through a series of integrated work streams covering clinical pathways that address the East of England Improving Lives; Saving Lives Pledges, the Towards the Best Together clinical strategy and our local objectives. Each workstream has clear, measurable goals which can be used to demonstrate progress against our targets (relevant Vital Signs are noted by their reference numbers):
**Staying Healthy**

Over the next five years we will reduce the gap in health outcomes between key marginalised groups/the population living in the 20% most deprived geographical areas and the PCT average by empowering people to improve and protect their health.

*Initiatives here include:* Smoking cessation (VSB05), tackling childhood obesity (VSB09, core outcome) and adult obesity; and population screening programmes (VSA09/10/15, VSB13).

**Planned Care**

Over the next five years, we will deliver major improvements to primary and community care services and planned acute services. Patients will experience better access to a much wider choice of services within their local communities. Services will be personalised and convenient to patients, and will be truly integrated across the health and social care economy to create seamless care pathways. Patients will be empowered to make a greater range of decisions and have the confidence to support their own health and wellbeing.

*Initiatives here include:* Patient satisfaction with access to primary care and GP practices offering extended opening hours (VSA06-07); access to dentistry (VSB18); reducing waiting times (VSA04-05, VSA08-13); minimising *Clostridium difficile* and MRSA infections (VSA01-03, core outcome).

**Mental Health**

Our vision is for all those living with mental health problems and learning disabilities to have rapid access to a range of services, delivered in the right location which aid people’s recovery. We aim to commission services which provide early assessment and treatment to minimise the debilitating effects of mental health problems. We are conscious of the need to develop integrated pathways which offer appropriate support to patients and their carers and develop improved partnership working with our partners from social services and the charitable and voluntary sectors.

*Initiatives here include:* Improving access to psychological therapies (core outcome); reducing the rise in alcohol related hospital admissions (VSC26); reducing the inequalities in health care and services for those people with a learning disability and their carers.

**Maternity, newborn and children’s health**

We will revolutionise the way that health services are provided to children and young people, ensuring delivery through multi-disciplinary teams of health professionals, and those from other sectors, and increasing our focus on the prevention of ill health. Over the next five years we will deliver one to one maternity care, quality antenatal support and local accessible services for maternity booking and scanning, and delivery of the Child Health Promotion Programme.

*Initiatives here include:* Breastfeeding prevalence at 6-8 weeks (VSB11); women having a health and social care assessment of needs and risk by 12 weeks of pregnancy (VSB12); childhood immunisations (VSB10).
**End of life**
Within five years we will have commissioned flexible and coordinated palliative care services. These will be delivered by a skilled and competent workforce, including the charity and voluntary sector, to everyone, whatever their diagnosis. This will give people control, choice and independence and enable them to die in their preferred place of choice.

*Initiatives here include:* Increase support and care to all care homes (residential and nursing); increase capacity for end of life care, i.e. beds in hospices; increase the proportion of deaths at home (core outcome).

**Unplanned care**
We will improve the quality and provision of care for people with long term conditions by developing integrated pathways that deliver high quality, person-centred and holistic care, enabling more people to be cared for and supported in the community. We will empower patients to take greater control and better management of their own condition through the implementation of personal health plans, and by increasing the availability of and access to rehabilitation and general and condition specific education for patients.

*Initiatives here include:* Increase access and choice for the population of SW Essex to emergency care; improve patient experience of emergency services (VSB15-16); waiting time in A&E.

**Long term conditions**
In the next five years we will have commissioned an enhanced range of integrated services, from community and paramedic services through Minor Injuries Unit to the acute setting, which accommodate a hierarchy of choices for all patients requiring unplanned care. Services will be located so as to meet these needs in an equitable and dynamic way to ensure that marginalised groups do not suffer any disadvantage.

*Initiatives here include:* Increase the capacity of stroke rehabilitation and long term support in the community (VSA14); improved care of patients suffering from diabetes; improve delivery of heart failure pathway (VSB02, VSC23).

**Meeting the needs of our communities**
At the heart of our commissioning is the redesign of service provision to deliver a new model of care. This model will promote patient empowerment, well-being and be responsive to the planned and unplanned health needs of the population. High quality primary and community care services will be pivotal to realising this vision. To achieve this, we will commission services in a way that transcends the traditional boundaries of primary, intermediate and secondary care.

The service reconfiguration planning will be based around a model of care that provides the infrastructure to deliver integrated care centred on the patient. The tiers of the model are:

- **Tier 0:** Self-care/prevention: empowering the individual to manage their own health and healthcare
- **Tier 1:** Primary care, which will continue to be the keystone of the NHS.
Tier 2: Virtual wards / health centres to deliver integrated virtual ward teams forged from a strong partnership between the primary and community service. 13 virtual wards have been identified, taking into account levels of deprivation and practice population numbers. This includes new health centres planned for Laindon and Wickford.

Tier 3: Community hospital services: Development of community hospitals at the forefront of healthcare innovation, which will enable people to access care closer to their homes. This includes the Brentwood Community Hospital and a new generation community hospital to be commissioned for Thurrock.

Tier 4: Secondary care
Tier 5: Tertiary specialist care.

A detailed Strategic Service Development Plan has been developed, which will enable the delivery of needs-based service developments for each of our communities reflecting this vision.

WORKING TOWARDS HEALTHY LIVES FOR CHILDREN WITH A DISABILITY

This report is also an opportunity to highlight our progress and plans in relation to children with special needs.

Implementation of the Government’s Child Health Strategy, Healthy Lives, Brighter Futures, published in February 2009, is a key national and local priority. The strategy confirmed the funding being made available to PCTs during the three years 2008/09 – 2010/11 to improve services and outcomes for disabled children. This supports implementation of Aiming High for Disabled Children and the children’s palliative care strategy, Better Care, Better Lives, and is in addition to the resources being allocated to local authorities over the same period.

The aim of this investment is to transform and drive up the capacity, range and quality of services for children with disabilities and complex health needs. Specific services and improvements that we and our local authority partners are commissioning or providing in the four priority areas identified in the strategy are summarised below:

Short Breaks

NHS South West Essex has a joint agency agenda with match funding between Essex County Council and Thurrock Unitary Authority. Essentially this is a Children’s Trust led agenda factored into the Children’s Trust performance framework for Thurrock and Essex. This will be reported to the Children’s Trust Board on a quarterly basis in terms of progressing towards joint agency targets.

The children and young people performance framework will also be reported to the PCT board on a quarterly basis. All the priorities are described in the Children and Young People’s plans.

NHS South West Essex has performed an analysis to determine the number of children with disabilities and special educational needs (SEN) in our area to inform
future service planning and provision, along with increasing the provision of additional need.

**Equipment**

We have an integrated equipment service jointly commissioned by Essex PCTs and the Local Authorities. This is part of the community contract and performance is monitored through this contract outcomes framework. Meetings are held on a monthly basis. Our Community Provider hosts the resource for this function. However, NHS South West Essex invested considerable new resource in to this arrangement during 2008/09 financial year.

**Wheelchair services**

As part of the wider initiative to deliver regional access targets, NHS South West Essex is currently working with a number of providers to ensure achievement of a maximum 18 week referral to treatment (RTT) wait for non consultant led services. Our local SW Essex Community Wheelchair Services (geographically covering the majority of the PCT) have demonstrated a dramatic improvement in patient access, achieved through attracting additional external provision and re-engineering of local service care pathways.

An external provider organisation in the form of NHS Southwark community services, has initially been commissioned to assess and prescribe wheelchairs and associated equipment, with additional investment. However, the PCT may seek further assistance from NHS Southwark to ensure the PCT comfortably meets a guarantee of every patient having a maximum of 18 week wait for treatment by March 2010.

A relatively small pocket of NHS South West Essex is covered by a separate wheelchair service provider, Outer North East London (ONEL). The ONEL paediatric wheelchair service is supported by ‘Whizz-Kidz’ under an existing contractual arrangement. Reaching a commonality across NHS South West Essex of wheelchair services is a requirement for future planning and provision.

**Palliative Care**

In terms of service development and performance for children and young people with palliative care needs, NHS South West Essex chairs the newly formed Southend Essex and Thurrock (SET) Palliative care strategic network group. The group will be accountable locally to the Children’s Trust (or equivalent) and regionally to the East of England Children’s Palliative Care Strategy Group.

The notes of each meeting will be formally recorded with feedback and recommendations shared with the East of England Children’s Palliative Care Strategy Group on a quarterly basis.

In addition to the above accountability arrangements the group will ensure there are appropriate links with other local and regional planning groups covering disability and cancer services. Where the group identify issues relating to the commissioning of
services which the group require advice and support these will be notified to the East of England PCTs/Local Authority Commissioners Network for discussion.

NHS South West Essex commissions specific respite support for palliative care from Essex Palliative Integrated Care Children’s Respite service (EPIC) which supports children in their own home. We also support Little Havens Children’s Hospice. In this financial year we are negotiating to support the Hospice on a case by case basis. We are also considering supporting the Hospice with some infrastructure developments to refurbish individual children’s rooms. We have a shared care arrangement with our tertiary (specialist) health providers such as Great Ormond Street Hospital (GOSH) and the Children’s Continuing Care Nursing Team (CCNT) also support children in their own home with continuing and palliative care needs.

NHS South West Essex is commencing work on the progressive 0-19 care pathway, which will inform service development for children with continuing and palliative care needs. Through the lead commissioner arrangement we are discussing ways forward for family based need within the PCT and Local Authorities. One of our priorities is to develop a performance framework with our current providers, EPIC and Little Havens.

Consistency of provision across Essex and the preferred place of care (PPC) are gaps that NHS South West Essex is addressing.

**Vital Sign VSC33 relates to parents’ experience of services for disabled children but the PCT does not have an agreed target for this indicator and data are not yet available for this area.**

**WORKING IN PARTNERSHIP**

NHS South West Essex believes that effective partnerships are essential to improve health and effectively care for the most vulnerable in our community - to ensure delivery of the key targets in health improvement and health inequalities together with other key partners; to jointly commission services; and to support the monitoring process.

To this end it continues to participate actively in relevant Local Strategic Partnership (LSP) arrangements. These include the LSPs for the two ‘top tier’ local authorities covering SW Essex, Thurrock Council and Essex County Council, as well as the second-tier authorities, Brentwood Borough Council and Basildon District Council. Top tier authorities are responsible for the development of a Local Area Agreement (LAA) identifying priorities for action and targets for improvement, which are agreed and monitored by central government. In 2008/09, NHS South West Essex took part in the review and refreshment of both the Thurrock and Essex LAAs. This included a number of key health-related priorities which could best be addressed through a co-ordinated, multi-agency approach including reducing the prevalence of smoking and childhood obesity, action to tackle health inequalities and care for vulnerable children, people with mental health problems and the frail elderly. Specific targets in the LAAs include:
• Smoking quitters (VSB05)
• Child and adolescent mental health services (VSB12)
• Reducing teenage pregnancy (VSB08)
• Tackling delayed discharges (VSC10) and
• Halting the rise in alcohol related hospital admissions (VSC26).

Robust action plans have been developed to ensure delivery of these targets, a number of which are supported by the Vital Signs indicators. The PCT has contributed to their implementation in a variety of ways: for example, jointly commissioning with social care partners a range of initiatives to meet the needs of frail older people, and addressing the needs of children and young people through local Children’s Trust arrangements.

Although there has been significant progress, we recognise that the formal strategic partnerships are at varying levels of development and, as the leader of the local NHS, we will continue to explore how these partnerships can further develop and strengthen to make a real difference to local people. We need to build the confidence of our partners through committing to achievable goals, linked to the organisations’ and Local Strategic Partnerships’ priorities, and to integrate Practice-based Commissioning into our partnership working. We also need to work with our partners to develop robust governance structures so that the contribution of all members is clear, and to improve communication both between the partners and with the communities whom we serve, and with whom we are engaging to enable them to influence the future direction of local health care.

We have also carried out widespread consultation with local people on our strategy, including a programme of public meetings; articles in the press; an interactive consultation on our website; and discussions with hard to reach groups. We have also focused specifically on the goals in our plan in further meetings with stakeholders, and a series of citizens’ juries. The challenge is to build this into an ongoing programme of effective engagement with our local communities.

ENABLING PROGRESS

We recognise that the foundation of delivering best value and improving service quality across commissioned services is by having strong working relationships with our suppliers. We will create solid and long lasting partnerships with them through robust business processes and transparent, effective contractual arrangements. In 2009/10 we will be implementing the National NHS Standard Contracts across our key providers in the acute, mental health and community sectors and will be working to roll out these contracts across all providers by 2010/11. An integral element of these contracts is the requirement for both providers and commissioners to foster continuous improvement in service delivery and to integrate both quality and information development into our working relationships.

At the same time the market for healthcare provision in South West Essex is undergoing a period of change as the PCT seeks to focus on its commissioning activities and divest itself of its provider arm. In addition we are seeking to improve
standards and choice by developing our market. As we market test our provider base it will be important that we engage providers in the process in a constructive way to lay the foundations for positive working relationships going forward.

To support progress, we have been identifying key areas in contracts for promoting and incentivising quality improvements using the Commissioning for Quality and Innovation (CQUIN) Framework in 2009/10. In addition we are exploring the opportunities for further improvements in improving quality whilst driving productivity and using innovation to drive and embed change through the QIPP (quality, innovation, productivity and prevention) framework.

Within the PCT itself we have put in place an organisational development plan to help us meet the challenge of becoming a world class commissioner. Our OD plan has been developed to support the delivery of our strategic plan and ensure we have the right environment in place to develop ourselves to be the local leaders of the NHS. As part of this we are revising our internal management arrangements to enable a more focused and co-ordinated approach to commissioning and to drive up organisational performance.

IMPROVING OUR PERFORMANCE

The PCT has worked to maintain and where possible improve performance to meet the needs of its local community, and to make further progress in tackling the national priorities for healthcare.

Addressing Annual Health Check and other targets

The Annual Health Check was introduced in place of star ratings, with the aim of presenting a more rounded and meaningful picture of NHS organisations’ performance. This includes assessments of our performance against a range of national targets and indicators, many of which are also among the Vital Signs, as noted in the Appendix. Further targets have been identified as priorities for action although they do not form part of the annual health check, for example tackling MRSA infections. Some targets and indicators have also been adopted as core outcome measures that will in future act as signposts to enable us to measure the benefits to local health and healthcare that flow from our progress towards becoming a world class commissioner.

The 2008/09 health check results will be published in October 2009. In terms of the national targets we have been aiming to maintain the strong results that were achieved in the previous year, and have been focusing efforts on improving performance on key targets and especially addressing areas of underperformance. Progress includes:

- Working with healthcare providers to ensure delivery of the 18-week referral-to-treatment maximum waiting time target (Vital Sign VSA04/05).
- Maintaining excellent performance in meeting the key cancer waiting time targets, so that all patients with suspected cancers are seen within a fortnight of urgent referral by their GP and over 99% of patients diagnosed with cancer are seen by
a consultant within a month. We have now extended this to subsequent treatments for cancer (VSA10-13).

- Delivering the PCT’s target of helping over 3,200 smokers to quit, supported by the PCT’s Stop Smoking Service (VSB05).
- Investing in additional services to improve access to dental care (VSB18).
- Investing in GP practices to enable them to extend the opening hours that are offered to patients. Currently nearly 80% of local practices are offering increased opening times and we are working with local GPs to increase this further (VSA07).
- Minimising healthcare associated infections in local services. *Clostridium difficile* infections have been kept well within the challenging target levels that were set for Basildon & Thurrock University Hospitals Foundation Trust and the PCT as a whole; and local acute providers have mostly held the numbers of MRSA infections below the planned ceilings. We have agreed more ambitious targets for 2009/10 with our local providers and offered them incentives through the Commissioning for Quality and Innovation (CQUIN) Framework for achieving further progress (VSA01-03).
- Extending the programme for Chlamydia screening among young people so that the number tested in the year was more than four times the coverage in the previous year, and more than achieved our target of reaching 17% of the eligible population; in the current year we are working to increase the level of coverage to 25% (VSB13).
- Taking forward a number of initiatives with partners to tackle childhood obesity, including the MEND (Mind, Exercise, Nutrition…Do it!) programmes for overweight children and their families, and provision of playground equipment and training for teachers to promote physical activity (VSB09).
- We have identified the need to improve patient satisfaction with access to primary care services, which is assessed through an annual survey. Although the overall result for the 2008/09 survey was below the planned level, the PCT has improved its ranking from 12th to 10th in the East of England and there are fewer poorly performing practices than identified in the previous year. The PCT has commissioned an external company to work with practices to improve their access (VSA06).
- We are working to raise uptake levels in childhood immunisation, particularly in relation to MMR vaccination and immunisation for Diphtheria, Tetanus, Polio and Pertussis. There has been a major catch-up spearheaded by the “spotty bus” campaign targeting school age children; encouragement for GP practices to undertake more immunisations; and public health nurses being trained to deliver immunisations for all ages (VSB10).
- We are striving to achieve the recommendations of the National Stroke Strategy, with priority targets around patients spending at least 90% of their time on a stroke unit, and treating sufferers of Transient Ischaemic Attacks (TIAs) within 24 hours. Initiatives here include the introduction of a 24 hour stroke service at Basildon & Thurrock University Hospitals Foundation Trust, and significant work being undertaken by the local Capacity Board to ensure that health and social care system flows with respect to patient throughput are optimised between acute, community and primary care (VSA14).
- We are working to improve performance in the measurement of prevalence of breastfeeding at 6 to 8 weeks and to raise breastfeeding prevalence rates
(VSB11). This has proved very challenging for local services, and currently there is a very low level of recording and therefore incomplete data from the Child Health Service and GPs. A social enterprise pilot scheme has been commissioned by the PCT that has collection of data for this indicator as part of its remit, and implementation of the 0 – 19 years universal patient pathway across South West Essex will aid this.

- NHS Health Checks programme: one important example of how local improvement actions impact on the vital signs is our contribution to the national initiative to provide a million checks in England during 2009/10 and to build this up to offering a five-yearly check to all adults aged between 40 and 74 years by 2011/12. At the same time we will commission services to ensure that patients found to be at high risk of cardiovascular disease are effectively supported to achieve lifestyle change and offered effective treatment where necessary to reduce that risk. These initiatives will contribute directly over time to our performance in relation to the Vital Signs for all age all cause mortality (VSB01); cardiovascular disease mortality (VSB02); and vascular risk (VSC23). They will also benefit those relating to life style changes such as smoking quitters (VSB05).

For 2009/10 onwards the Annual Health Check is being replaced by periodic reviews undertaken by the national Care Quality Commission, and will cover an assessment of commissioning processes using information from the World Class Commissioning assurance system; performance against national priority targets and indicators; and value for money, including a Use of Resources assessment. These results will feed into a Comprehensive Area Assessment that will be published to inform local people how well public bodies are working together to meet the needs of the people they serve.

LOOKING AHEAD

NHS South West Essex and its partners are making strong progress across an expanding agenda, while indicating that there is more work to do in tackling specific areas and a general need to maintain focus on key areas of performance.

We intend to continue giving high priority to delivering further improvements in partnership with our local stakeholders and communities, and will continue to report on progress in a variety of ways.

If you would like to know more

Further information, including copies of the other documents referred to in this report, may be obtained through our web site: www.swessex.nhs.uk

or by emailing info@swessex.nhs.uk

telephone: 01268 705000

or by writing to us at the following address:

NHS South West Essex, Head Office, Phoenix Court, Christopher Martin Road, Basildon, Essex SS14 3HG.
## South West Essex Primary Care Trust

<table>
<thead>
<tr>
<th>Vital Signs</th>
<th>Performance</th>
<th>Tier 1</th>
<th>Tier 2</th>
<th>Tier 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>VSA03: Clostridium difficile: number of cases for PCT (percentage of target)</td>
<td>54.23%</td>
<td>NA</td>
<td>NA</td>
<td></td>
</tr>
<tr>
<td>VSA04: Proportion of patients seen within 18 weeks for admitted pathways</td>
<td>94.56%</td>
<td>NA</td>
<td>NA</td>
<td></td>
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<tr>
<td>VSA06: Patient reported measure of GP access - ability to get an appointment within 2 working days</td>
<td>83.98%</td>
<td>NA</td>
<td>NA</td>
<td></td>
</tr>
<tr>
<td>VSA08: Proportion of women screened for breast cancer (aged 53-70)</td>
<td>72.35%</td>
<td>78.48%</td>
<td>E</td>
<td></td>
</tr>
<tr>
<td>VSA11: Proportion of patients waiting no more than 31 days for subsequent cancer (surgery and drug) treatments</td>
<td>99.40%</td>
<td>NA</td>
<td>NA</td>
<td></td>
</tr>
<tr>
<td>VSB01: All-age all-cause mortality rate per 100,000 population (females)</td>
<td>88.87%</td>
<td>NA</td>
<td>D</td>
<td></td>
</tr>
<tr>
<td>VSB08: Under 18 conception rate per 1,000 females aged 15-17</td>
<td>114.70</td>
<td>7.97</td>
<td>D</td>
<td></td>
</tr>
<tr>
<td>VSB09: Obesity among primary school aged children (reception year)</td>
<td>10.78%</td>
<td>8.69%</td>
<td>D</td>
<td></td>
</tr>
<tr>
<td>VSB11: Prevalence of Breastfeeding at 6-8 weeks - proportion of infants with breastfeeding status recorded</td>
<td>86.17%</td>
<td>84.42%</td>
<td>D</td>
<td></td>
</tr>
<tr>
<td>VSB13: Chlamydia screening - proportion of young people aged 15-24 who have been tested</td>
<td>20.44%</td>
<td>17.62%</td>
<td>E</td>
<td></td>
</tr>
<tr>
<td>VSB14: Number of drug users recorded as being in effective treatment - proportion of all those admitted into treatment</td>
<td>88.76%</td>
<td>86.70%</td>
<td>D</td>
<td></td>
</tr>
<tr>
<td>VSB15: Self reported experience of patients</td>
<td>297.43</td>
<td>NA</td>
<td>NA</td>
<td></td>
</tr>
<tr>
<td>VSB17: NHS staff survey scores-based measures of job satisfaction</td>
<td>3.63</td>
<td>NA</td>
<td>NA</td>
<td></td>
</tr>
<tr>
<td>VSB18: Access to primary dental services: proportion of population seen by a dentist in the past 24 months</td>
<td>54.53%</td>
<td>NA</td>
<td>NA</td>
<td></td>
</tr>
<tr>
<td>VSC01: NHS Litigation Authority PCT standards, risk management assessment levels</td>
<td>1</td>
<td>NA</td>
<td>NA</td>
<td></td>
</tr>
<tr>
<td>VSC03: Adults (18 and over) assisted to live independently - number per 100,000 population</td>
<td>278.46</td>
<td>NA</td>
<td>NA</td>
<td></td>
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<tr>
<td>VSC10: Number of delayed transfers of care per 100,000 population (aged 18 and over)</td>
<td>5.68</td>
<td>NA</td>
<td>NA</td>
<td></td>
</tr>
<tr>
<td>VSC12: Timeliness of social care assessment - proportion of new clients with assessments completed within 4 weeks of first contact</td>
<td>71.42%</td>
<td>NA</td>
<td>NA</td>
<td></td>
</tr>
<tr>
<td>VSC13: Timeliness of social care packages - proportion of new clients with services received within 4 weeks of assessment</td>
<td>90.27%</td>
<td>NA</td>
<td>NA</td>
<td></td>
</tr>
<tr>
<td>VSC15: Proportion of all deaths that occur at home</td>
<td>19.64%</td>
<td>NA</td>
<td>NA</td>
<td></td>
</tr>
<tr>
<td>VSC17: Adults and older people receiving social care through direct payments and/or individual budgets per 100,000 population (aged 18 and over)</td>
<td>65.80</td>
<td>NA</td>
<td>NA</td>
<td></td>
</tr>
<tr>
<td>VSC18: Proportion of carers receiving a 'carer's break' or a specific service for carers</td>
<td>13.92%</td>
<td>NA</td>
<td>NA</td>
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</tr>
</tbody>
</table>
## Tier 1 - National Requirements

### Cleanliness and healthcare associated infections

<table>
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<th>East of England Ranking</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>VSA03 Clotridium difficile: number of cases for PCT</td>
<td>2008/09</td>
<td>284</td>
<td>154</td>
<td>54.23%</td>
<td>74.57%</td>
<td>3rd</td>
<td>This is also one of our World Class Commissioning outcomes. 2009/10 trajectory has been reduced substantially to 150.</td>
</tr>
<tr>
<td>VSA04 Proportion of patients seen within 18 weeks for admitted pathways</td>
<td>Jan - Mar 09</td>
<td>90%</td>
<td>5438/5751</td>
<td>94.56%</td>
<td>92.91%</td>
<td>1st</td>
<td>We are continuing to meet this target in 2009/10.</td>
</tr>
<tr>
<td>VSA06 Patient reported measure of GP access - ability to get an appointment within 2 working days</td>
<td>Quarter 4 2008/09</td>
<td>85%</td>
<td>10378/12357</td>
<td>83.96%</td>
<td>85.13%</td>
<td>12th</td>
<td>The reported percentage is slightly higher than that reported in our own performance data because the Care Quality Commission excludes from its results those patients who answered that they could not remember. This is one of our World Class Commissioning outcomes. We also had a target of 50% of practices to offer extended hours, and by the end of 2008/09 had achieved 80%. We are aiming to make further progress in the current year.</td>
</tr>
</tbody>
</table>

### Access to personalised and effective care

<table>
<thead>
<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>VSA09 Proportion of women screened for breast cancer (aged 53-70)</td>
<td>2007/08</td>
<td>80%</td>
<td>28726/39705</td>
<td>72.35%</td>
<td>75.92%</td>
<td>13th</td>
<td>2008/09 results 72.7% for women aged 53-64, 71.4% for women aged 65-70.</td>
</tr>
<tr>
<td>VSA11 Proportion of patients waiting no more than 31 days for subsequent cancer (surgery and drug) treatments</td>
<td>Quarter 4 2008/09</td>
<td>100%</td>
<td>166/167</td>
<td>99.40%</td>
<td>97.41%</td>
<td>3rd</td>
<td>New commitment in national cancer strategy.</td>
</tr>
<tr>
<td>VSA13 Proportion of patients with suspected cancer, detected through GP, national screening programmes or hospital specialists who wait less than 62 days from referral to treatment</td>
<td>Quarter 4 2008/09</td>
<td>100% by March 20 10</td>
<td>89.29%</td>
<td>88.25%</td>
<td>7th</td>
<td>New commitment in national cancer strategy.</td>
<td></td>
</tr>
</tbody>
</table>

### Improving Health and Reducing Health Inequalities

<table>
<thead>
<tr>
<th>Reference</th>
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<th>Rate</th>
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<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>VSA14 Implementation of the stroke strategy: patients who spent at least 90% of their time on a stroke unit</td>
<td>Quarter 4 2008/09</td>
<td>64%</td>
<td>47/80</td>
<td>58.75%</td>
<td>47.31%</td>
<td>4th</td>
<td>Our target is to improve to 70% during 2009/10 and we are working with local services to achieve this.</td>
</tr>
</tbody>
</table>

## Tier 2 - National Priorities for Local Delivery

### Health improvement and reducing health inequalities

<table>
<thead>
<tr>
<th>Reference</th>
<th>Reporting Period</th>
<th>Plan</th>
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<th>Rate</th>
<th>Better / As Expected / Below</th>
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</tr>
</thead>
<tbody>
<tr>
<td>VSB01 All-age all cause mortality rate per 100,000 population</td>
<td>2008</td>
<td>Females</td>
<td>497</td>
<td>489.81</td>
<td>N/A</td>
<td>492.79</td>
<td>5th</td>
</tr>
<tr>
<td>VSB02 Cardiovascular disease (CVD) Mortality - rate per 100,000 population aged 75 or under</td>
<td>2008</td>
<td>65</td>
<td>66.87</td>
<td>N/A</td>
<td>72.18</td>
<td>5th</td>
<td>Rate improving and was close to the planned figure.</td>
</tr>
<tr>
<td>VSB03 Cancer mortality - rate per 100,000 population aged 75 or under</td>
<td>2008</td>
<td>102</td>
<td>114.7</td>
<td>N/A</td>
<td>114.1</td>
<td>8th</td>
<td>This is also one of our World Class Commissioning outcomes. Rate above plan but is improving.</td>
</tr>
<tr>
<td>VSB04 Suicide &amp; injury of undetermined intent mortality rate per 100,000 population (East of England)</td>
<td>January 2005 - December 2007</td>
<td>N/A</td>
<td>5.78</td>
<td>N/A</td>
<td>N/A</td>
<td>1st</td>
<td>Plans for this indicator are based on the East of England as a whole and so there is not a specific planned rate for the PCT.</td>
</tr>
<tr>
<td>Target Reference</td>
<td>Reporting Period</td>
<td>Plan</td>
<td>Actual</td>
<td>Rate</td>
<td>National Average</td>
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</tr>
<tr>
<td>VSB05 Smoking quit rate per 100,000 population</td>
<td>NP (total)</td>
<td>2007/08</td>
<td>N/A</td>
<td>1038.8</td>
<td>N/A</td>
<td>N/A</td>
<td>4th</td>
</tr>
<tr>
<td></td>
<td>NI 123 LAA Th/Ess WCC</td>
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<tr>
<td>VSB06 Percentage of women who have seen a midwife or an obstetrician for health and social care assessment of needs and risk by 12 weeks of their pregnancy</td>
<td>NP</td>
<td>Quarter 4 2008/09</td>
<td>75% (2008/09)</td>
<td>888/1227</td>
<td>69.54%</td>
<td>77.35%</td>
<td>14th</td>
</tr>
<tr>
<td></td>
<td>NI 126</td>
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<tr>
<td>VSB08 Under 18 conception rate per 1,000 females aged 15-17</td>
<td>NP</td>
<td>2007</td>
<td>37.5</td>
<td>123/3022</td>
<td>40.7</td>
<td>41.08%</td>
<td>9th</td>
</tr>
<tr>
<td></td>
<td>NI 112 LAA Th/Ess</td>
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</tr>
<tr>
<td>VSB09: Obesity among primary school aged children (Reception Year and Year 6)</td>
<td>NP</td>
<td>2007/08 school year</td>
<td>Year R</td>
<td>437/4054</td>
<td>10.78%</td>
<td>9.65%</td>
<td>11th</td>
</tr>
<tr>
<td></td>
<td>NI 55 LAA Ess</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>NI 56 LAA Th/Ess WCC</td>
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<tr>
<td>VSB10 Individuals who complete immunisation by recommended ages - percentage</td>
<td>NP</td>
<td>2008/09</td>
<td>95%</td>
<td>25498/29996</td>
<td>85.01%</td>
<td>84.03%</td>
<td>7th</td>
</tr>
<tr>
<td></td>
<td>WCC (MMR)</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>VSB11 Prevalence of Breastfeeding at 6-8 weeks - proportion of infants with breastfeeding status recorded</td>
<td>NP</td>
<td>Quarter 4 2008/09</td>
<td>75%</td>
<td>925/1400</td>
<td>66.07%</td>
<td>81.34%</td>
<td>12th</td>
</tr>
<tr>
<td></td>
<td>NI 53</td>
<td></td>
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</tr>
<tr>
<td>VSB12 Commissioning a comprehensive child and adolescent mental health service</td>
<td>NP</td>
<td>Quarter 3 2008/09</td>
<td>16 (maximum rating)</td>
<td>13</td>
<td>81.25%</td>
<td>86.64%</td>
<td>3rd</td>
</tr>
<tr>
<td></td>
<td>NI 51 LAA Th/Ess</td>
<td></td>
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</tr>
<tr>
<td>VSB13 Chlamydia screening (as a proxy for Chlamydia prevalence): proportion of young people aged 15-24 who have been tested</td>
<td>NP</td>
<td>2008/09</td>
<td>17%</td>
<td>9751/47700</td>
<td>20.44%</td>
<td>15.90%</td>
<td>3rd</td>
</tr>
<tr>
<td></td>
<td>NI 113 LAA Th</td>
<td></td>
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</tr>
<tr>
<td>VSB14 Number of drug users recorded as being in effective treatment - proportion of all those admitted into treatment</td>
<td>NP</td>
<td>2008/09</td>
<td>N/A</td>
<td>79/89</td>
<td>88.76%</td>
<td>85.23%</td>
<td>4th</td>
</tr>
<tr>
<td></td>
<td>NI 140</td>
<td></td>
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</tbody>
</table>
### Reputation, satisfaction and confidence in the NHS

<table>
<thead>
<tr>
<th>Target Reference</th>
<th>Reporting Period</th>
<th>Plan</th>
<th>Actual Rate</th>
<th>National Average Rate</th>
<th>Better/As Expected / Below</th>
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</tr>
</thead>
<tbody>
<tr>
<td>VSB15 Self reported experience of patients</td>
<td>NP WCC</td>
<td>Spring 2009</td>
<td>N/A</td>
<td>297.43</td>
<td>N/A</td>
<td>301.37</td>
<td>8th</td>
</tr>
<tr>
<td>VSB17 NHS staff survey scores-based measures of job satisfaction</td>
<td>NP</td>
<td>Autumn 2008</td>
<td>3.4</td>
<td>3.63</td>
<td>N/A</td>
<td>3.57</td>
<td>1st</td>
</tr>
</tbody>
</table>

### Access to personalised and effective care

<table>
<thead>
<tr>
<th>Tier 3 - Local Action</th>
<th>Cleanliness and healthcare associated infections</th>
<th>VSC01 NHS Litigation Authority PCT standards, risk management assessment levels</th>
<th>March 2009</th>
<th>N/A</th>
<th>Level 1</th>
<th>N/A</th>
<th>N/A</th>
<th>N/A</th>
<th>The PCT does not have an agreed target for this Vital Sign, which is based on the NHS Litigation Authority Risk Management Standards. We are one of four PCTs in the East of England to have achieved the first level of the newly issued standards.</th>
</tr>
</thead>
<tbody>
<tr>
<td>VSC03 Adults (18 and over) assisted to live independently - number per 100,000 population</td>
<td>NI 136</td>
<td>2008</td>
<td>841.85 age 18-64</td>
<td>1942.74 age 65+ = 2784.58</td>
<td>N/A</td>
<td>3143.05</td>
<td>13th</td>
<td>Proportion of adults (18 and over) supported directly through social care to live independently at home. This indicates the number of adults assisted through funded support or through organisations that receive social services grant funded services. The PCT does not have an agreed target for this Vital Sign.</td>
<td></td>
</tr>
<tr>
<td>VSC10 Number of delayed transfers of care per 100,000 population (aged 18 and over)</td>
<td>EC NI 131 LAA Th Quarters 2-4 2008/09</td>
<td>N/A</td>
<td>17/305362</td>
<td>5.68</td>
<td>10.82</td>
<td></td>
<td>4th</td>
<td>The PCT does not have an agreed target for this Vital Sign but it equates to the Existing Commitment national target for delayed transfers (2008/09 target level to be announced). Within this the mental health team will be aiming to contain delays for mental health and learning disability patients to a maximum of 7.5%.</td>
<td></td>
</tr>
<tr>
<td>VSC12 Timeliness of social care assessment - proportion of new clients with assessments completed within 4 weeks of first contact</td>
<td>NI 132</td>
<td>2008</td>
<td>1082/1515</td>
<td>71.42%</td>
<td>79.53</td>
<td></td>
<td>9th</td>
<td>The PCT and its partners do not have an agreed target for this Vital Sign.</td>
<td></td>
</tr>
<tr>
<td>VSC13 Timeliness of social care packages - proportion of new clients with services received within 4 weeks of assessment</td>
<td>NI 133</td>
<td>2008</td>
<td>371/411</td>
<td>90.27%</td>
<td>90.94</td>
<td></td>
<td>13th</td>
<td>The PCT and its partners do not have an agreed target for this Vital Sign.</td>
<td></td>
</tr>
<tr>
<td>VSC15 Proportion of all deaths that occur at home</td>
<td>WCC</td>
<td>2007</td>
<td>N/A</td>
<td>19.64%</td>
<td>N/A</td>
<td>N/A</td>
<td>8th</td>
<td>This is also one of our World Class Commissioning outcomes. 2008 actual was 18.8% against a plan of 20.5%; our aim is to reach 23.5% in 2009 and 27% in 2010.</td>
<td></td>
</tr>
<tr>
<td>VSC17 Adults receiving direct payments/individual budgets per 100,000 population (aged 18 and over)</td>
<td>NI 130</td>
<td>2008</td>
<td>65.8</td>
<td>N/A</td>
<td>166.57</td>
<td></td>
<td>14th</td>
<td>Adults and older people receiving social care through direct payments and/or individual budgets. The PCT and its partners do not have an agreed target for this Vital Sign.</td>
<td></td>
</tr>
<tr>
<td>Target Reference</td>
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</tr>
<tr>
<td>VSC18 Proportion of carers receiving a ‘carer’s break’ or a specific carers’ service</td>
<td>NI 135</td>
<td>2008</td>
<td>N/A</td>
<td>479/3442</td>
<td>13.92%</td>
<td>21.96</td>
<td>9th</td>
<td>Expressed as a percentage of clients receiving community based services. The PCT and its partners do not have an agreed target for this Vital Sign. The mental health team will be collecting data on this area and as a first step will be establishing a baseline against which improvement targets can be developed.</td>
<td></td>
</tr>
<tr>
<td>VSC21 Proportion of total admissions that have ambulatory care sensitive diagnoses</td>
<td>2008</td>
<td>N/A</td>
<td>10.22</td>
<td>N/A</td>
<td>N/A</td>
<td>2nd</td>
<td>This indicates how far hospital admissions have been avoided through providing proper ambulatory care. The PCT does not have an agreed target for this Vital Sign.</td>
<td></td>
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<tr>
<td>Health improvement and reducing health inequalities</td>
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</tr>
<tr>
<td>VSC23 Vascular risk score</td>
<td>Quarter 4 2008/09</td>
<td>N/A</td>
<td>80/81</td>
<td>98.77%</td>
<td>64.35</td>
<td>1st</td>
<td>The proportion of GP practices with validated registers of patients without symptoms of cardiovascular disease with an absolute risk of cardiovascular events greater than 20% over the next 10 years. The PCT does not have an agreed target for this Vital Sign; however, all but one practice in the PCT area has validated registers in operation.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>VSC26 Rate of hospital admissions per 100,000 population for alcohol related harm</td>
<td>NI 39 LAA Ess WCC 2008</td>
<td>N/A</td>
<td>1096.75</td>
<td>N/A</td>
<td>1384.04</td>
<td>Based on deprivation</td>
<td>2nd</td>
<td>The PCT does not have an agreed Vital Sign trajectory for this, but it is one of our World Class Commissioning outcomes. Our aim is to slow the rate of increase in alcohol related admissions.</td>
<td></td>
</tr>
<tr>
<td>VSC27 Proportion of patients with diabetes in whom the last HbA1c is 7.5 or less</td>
<td>2007/08</td>
<td>14344</td>
<td>10567/14344</td>
<td>73.67</td>
<td>66.8</td>
<td>Based on deprivation</td>
<td>1st</td>
<td>This is an indicator of the management of diabetes and a measure of long term health. The PCT does not have an agreed target for this Vital Sign.</td>
<td></td>
</tr>
<tr>
<td>VSC29 Rate of deliberate or unintended injuries to people aged under 19 (per 10,000)</td>
<td>NI 70</td>
<td>2007/08</td>
<td>N/A</td>
<td>94.97</td>
<td>N/A</td>
<td>Based on deprivation</td>
<td>4th</td>
<td>Hospital admissions caused by unintended and deliberate injuries to children and young people aged under 19 (rate per 10,000 population under 19). This is an indicator of child safety in the community. The PCT does not have an agreed target for this Vital Sign.</td>
<td></td>
</tr>
</tbody>
</table>

Key to abbreviations in target references
- NI National Indicator
- LAA Local Area Agreement
- Th Thurrock
- Ess Essex
- WCC World Class Commissioning outcome