NHS Airedale, Bradford and Leeds

	Agenda item PU2012/154	
DATE OF BOARD MEETING: 6 December 2012	**Category of Paper** **Tick(✓)**	
Executive Director Lead: Dr Andy Harris, NHS Leeds South & East CCG Philomena Corrigan, NHS Leeds West CCG Nigel Gray, NHS Leeds North CCG	**Decision and Approval**	
Paper Author: Graham Brown, Performance Manager Martin Wright, Chief Finance Officer, NHS Leeds North CCG Russel Hart-Davies, Quality Development Manager	**Position Statement**	✓
Paper Title: CCG Performance Reports – Leeds CCGs	**Information**	
	Confidential Discussion	

SUMMARY

1. This report presents to the NHS Airedale, Bradford & Leeds Cluster Board the performance reports for commissioning activity delegated to Clinical Commissioning Groups.

PUBLICATION UNDER FREEDOM OF INFORMATION ACT

2. This paper has been made available under the Freedom of Information Act.

BACKGROUND

3. The Cluster Board have delegated functions to the Clinical Commissioning Groups for management during their shadow period. This report highlights to the Cluster Board the impact of the CCGs on areas of Financial Management (Paper PU2012/160 provides narrative relating to the financial performance of healthcare commissioning and prescribing), Provider Performance and Quality & Safety. These reports have been or will be considered by each of the CCGs Governing Bodies.

PROPOSAL

4. The Cluster Board are asked to review and challenge the information presented:

(a) Financial Management (Annex A);
(b) Provider Performance (Annex B); and
(c) Quality & Safety (Annex C).

RECOMMENDATION

5. The Board is asked to:

(a) **receive** the three performance reports presented.

Leeds CCGs

Annex A

SUMMARY FINANCIAL INFORMATION - COMMISSIONING COSTS

HEALTHCARE SERVICES:

	Annual Budget			Year to date			Annual	
	Recurrent	Non Rec.	Total	Budget	Actual	Variance	Expenditure	Variance
Secondary Care - NHS	461,192	9,464	470,656	274,457	273,612	-844	469,257	-1,399
Secondary Care - Non NHS	28,450	-35	28,414	16,575	15,972	-603	27,505	-909
Urgent Care	44,825	538	45,362	25,914	26,220	306	45,169	-194
Long Term Conditions	101,174	20,508	121,682	74,780	74,550	-231	121,534	-147
Mental Health & Learning Difficulties	115,989	2,282	118,271	68,408	68,942	534	118,436	165
Sub Total	**751,630**	**32,755**	**784,385**	**460,134**	**459,295**	**-838**	**781,901**	**-2,484**
Childrens	2,045	0	2,045	1,329	1,305	-24	2,253	209
Continuing Care	37,784	3,979	41,763	22,028	24,327	2,299	41,701	-61
Safeguarding	477	147	624	364	364	1	624	0
Sub Total	**40,305**	**4,126**	**44,431**	**23,721**	**25,996**	**2,276**	**44,578**	**148**
Prescribing	125,505	0	125,505	73,211	69,350	-3,861	118,513	-6,992
Practice Based Commisioning	5,100	90	5,190	3,027	3,006	-22	5,190	-0
Healthcare Earmarked Reserves	2,219	454	2,674	739	424	-315	2,127	-547
Transformation	0	27,111	27,111	15,815	15,815	0	27,111	0
Total - Healthcare Services	**924,759**	**64,537**	**989,296**	**576,647**	**573,886**	**-2,761**	**979,421**	**-9,875**

NHS Airedale, Bradford and Leeds

Paper Title:
Corporate Performance Report – November 2012: Leeds West CCG, Leeds North CCG, Leeds South & East CCG and NHS Leeds

Paper Author:
Graham Brown: Performance Manager

SUMMARY

1. This report provides an overview of performance against key indicators for the CCGs within the NHS Leeds section of the NHS Airedale, Bradford and Leeds PCT Cluster. The report enables members of the CCG Governing Bodies to understand the current key performance issues. The indicators of performance include those from the Commissioning Outcomes Framework (COF), though data is not available for all the indicator lines, as described within the body of the report. The report also now includes high level reports on the performance of joint work with other organisations. To this end, the Leeds City Priority Report Cards, produced quarterly, covering the Health and Wellbeing Board performance report and the Children's Trust Board performance report are appended. A glossary and note explaining the key terms in the field of performance management is attached at back of this report.

BACKGROUND

2. The background for the report provides context for delivery of strategic level and operational plans. It does this through the provision of performance information on key indicators. This report will allow CCGs to fulfil delegated responsibility to oversee performance matters and to provide due assurance to the PCT Cluster that appropriate management oversight, against key national indicators, is being delivered.

FINANCIAL IMPLICATIONS AND RISK

3. The report identifies strategic level performance risks, in terms of specific indicators. There are no identified new direct financial implications for this approach to performance management.

COMMUNICATIONS AND INVOLVEMENT

4. The report content shows how the CCG and the NHS Leeds' health economy is performing, a key factor in effective communication with patients, partners and other stakeholders.

PUBLICATION UNDER FREEDOM OF INFORMATION ACT

5. This paper has been made available under the Freedom of Information Act.

RECOMMENDATION

6. CCG Governing Bodies are asked to:
   (a) **Receive** the Performance Report and to use it in providing appropriate assurance to the PCT Cluster, as agreed.

NHS
Airedale, Bradford and Leeds

Performance Scorecard

- Provisional live data for the proposed 2013/14 Commissioning Outcomes Framework
- Live data for the 2012/13 Operating Framework
- City Priority (Obsessions) Report Cards:
Health & Wellbeing; Children's Services

- **Leeds North CCG**
- **Leeds South & East CCG**
- **Leeds West CCG**
- **Leeds Citywide**

November 2012

Interpreting the Commissioning Outcomes and Operating Framework scorecards:

	Below the target/standard threshold	▼	Worse than previous position
	Below target/standard, but above threshold	◀▶	Same as previous position
	Equal to or better than target/standard	▲	Better than previous position

Red, amber, green highlights have been applied against local or national target, where available. Some indicators have no target.

Standards/targets and thresholds:
Standards or targets are shown (where they available) for each indicator line. They are usually specified by DH, but in some cases are locally set. Thresholds for achievement are applied where there is a tolerance around a specific target. Thresholds vary according to the circumstances. For example, ambulance call wait times have a tolerance of 5% of the target applied. In practice this works out to mean that with performance of 75%, this is described as achieved, below that down to 71.3% underachieved, and below 71.3%, failure to achieve. Thresholds are used to provide some flexibility in interpretation of performance. Thresholds are a mixture of DH guidance and where there is no such guidance, local intelligence and best practice is used.

Greyed cells:
Where data cells in the tables are greyed out, it means that data is not available. Some data may be available at the citywide level, but a breakdown to CCG level data may not be possible, especially so with new COF or with provider indicators, for example. Where data is not shown, that is not say it won't be available in the near future, as efforts are made to build data streams to support future publication prior to April 2013.

Indicator lines shaded thus:
Where indicator descriptions are shaded in this way, it signifies the use of a new Commissioning Outcomes Framework indicator. This is the CCG performance system to be used from April 2013. As this system is under development by NICE and NHSCB, some of the data is not yet available through national means. Where this is the case, and where it is possible, local data has been used for all or part of the construction of the data shown, to give as robust a representation of performance as possible. Indicator lines with no shading show that the indicator is not proposed to be included in the COF. Further guidance on the future inclusion of these lines in the NHS performance systems is awaited.

Interpreting the City Priority (Obsessions) Cards:

There are two sets of report cards within this section, both describing the work of partnerships of the CCGs/PCT with Leeds City Council. One of the sets of cards covers the Health & Wellbeing partnership, while the other set covers the work of the Children's Trust partnership. Each of these bodies has described a small, key set of 'obsessions' which are formally reported at the highest levels and are described as priorities for the city, drawing in the full range of service providers and commissioners across the city. The cards take the form determined by the high level partnerships and are produced on a quarterly basis through Leeds City Council. The NHS health content is at present signed off through PCT professional networks, though steps are being taken to ensure full, formal CCG sign-off takes place, within the new NHS structures. The content of the cards is reasonably self-explanatory, with charts showing performance against the selected indicators, some of which also appear in elsewhere in the main body of this report. Narrative, where required, describes remedial actions where performance is below that required. All of the data shown within the cards is at the whole city level, reflecting the nature of the partnerships.

Preventing people from dying prematurely

		Reporting period	Standard/ Target	Leeds North CCG			Leeds South & East CCG			Leeds West CCG			Leeds Citywide		
				Current	Change	YTD	Current	Change	YTD	Current	Change	YTD	Current	Change	YTD
COF 1.1	U-75 mortality rate from cardiovascular disease	2008-11	none	60.3	▲	-	78.4	▲	-	63.3	▲	-	67.5	▲	-
COF 1.2	U-75 mortality rate from respiratory disease	2008-11	none	22.2	▼	-	34.1	▲	-	25.4	▼	-	27.4	▼	-
COF 1.23	People with dementia prescribed anti-psychotics														
COF 1.24	Myocardial infarction, stroke and stage 5 CKD in people with diabetes														
COF 1.25	Antenatal assessments <13 weeks	Q2	90%										100%	◀▶	100%
COF 1.26	Maternal smoking in pregnancy	Q2	none	13.3%		n/a	26.9%		n/a	17.5%		n/a	20.3%		n/a
COF 1.27	Smoking at delivery	Q2	none	8.6%		n/a	16.2%		n/a	9.6%		n/a	12.0%	▼	12.3%
COF 1.28	Breast feeding initiation	Q2	51%										69.0%	▼	69.1%
COF 1.29	Breast feeding prevalence at 6-8 weeks	Q2	50%										47.1%	▲	46.7%
COF 1.30	People with severe mental illness - received a list of physical checks														
COF 1.34	Mortality within 30 days of hospital admission for stroke														
COF 1.4	U-75 mortality rate for cancer	2008-11		94.9	▲	-	129.7	▲	-	104.5	▲	-	110.3	▲	-
PHQ01	Ambulance category A calls responded to within 8 mins	Sep 2012	75%										76.6%	▼	75.9%
PHQ02	Ambulance category A calls responded to within 19 mins	Sep 2012	95%										99.6%	▲	99.6%
PHQ03	Cancer 62 day standard - referral to treatment	Sep 2012	85%										89.2%	▼	91.7%
PHQ04	Cancer 62 day wait for first treatment - referral from screening	Sep 2012	90%										95.8%	▲	94.3%
PHQ05	Cancer 62 day wait for first treatment - consultant upgrade	Sep 2012	90%										93.8%	▲	94.2%
PHQ06	Cancer 31 day standard diagnosis to treatment time	Sep 2012	96%										98.2%	▼	98.9%
PHQ07	Cancer 31 day standard for subsequent treatment - Surgery	Sep 2012	94%										97.6%	▼	97.2%
PHQ08	Cancer 31 day standard for subsequent treatment - Drug	Sep 2012	98%										100.0%	◀▶	100.0%
PHQ09	Cancer 31 day standard for subsequent treatment - Radiotherapy	Sep 2012	93%										97.1%	▼	98.0%
Provider: Yorkshire Ambulance Service															
PHQ01	Ambulance category A calls responded to within 8 mins	Sep 2012	75%	73.1%	▼	74.7%									
PHQ02	Ambulance category A calls responded to within 19 mins	Sep 2012	95%	98.3%	▲	98.8%									

Enhancing quality of life for people with long term conditions

		Reporting period (end)	Monthly/ Q'ly Standard (City)	YTD Standard/ Target (City)	Leeds North CCG			Leeds South & East CCG			Leeds West CCG			Leeds Citywide		
					Current	Change	YTD	Current	Change	YTD	Current	Change	YTD	Current	Change	YTD
COF 2	**Health related quality of life for people with LTC**															
COF 2.1 PHQ14	**Proportion of people feeling supported to manage their condition**	Sep 2011	none	none										69.3%	▲	
COF 2.3i PHQ15	**Emergency admissions for 19 ambulatory conditions (per 100,000)**	Sep 2012	none	none	64.1	▼	446.4	83.6	▼	607.2	64.0	▼	421.5	70.1	▼	484.7
COF 2.3ii PHQ16	**Unplanned hospitalisation for asthma, diabetes and epilepsy for u-19s**	Sep 2012	none	none	41.1	▲	132.4	40.6	▲	151.5	22.7	▲	140.9	33.8	▲	142.5
COF 2.23	**People with COPD & MRC dyspnoea scale >=3 referred to pulmonary rehab**															
COF 2.62	**People with diabetes who have received nine care processes**															
COF 2.53	**People with diabetes diagnosed <1 year referred to structured education**															
COF 2.61	**Complications associated with diabetes**															
COF 2.62	**Lower limb amputation in people with diabetes**	Sep 2012	none	none	522.2	▲	1969.8	925.9	▲	3060.1	495.9	▼	3030.3	1944.0	▲	8060.3
COF 2.63	**People with diabetes - emergency admission for diabetic ketoacidosis**	Sep 2012	none	none	1055.4	▼	4269.3	558.7	▲	3274.2	829.2	▼	4464.9	2443.3	▼	12008.3
COF 2.77	**Emergency admissions for alcohol related liver disease**	Sep 2012	none	none	0.0	▼	5.9	4.2	◀▶	24.5	2.2	▼	14.5	6.5	▼	45.0
COF 2.79 PHQ12	**CPA 7 day follow-up rate**	Sep 2012	95%	-										96.2%	▼	**96.1%**
COF 2.87	**People with stroke discharged with a joint health and social care plan**		85%	-												
COF 2.88	**Stroke patients - psychological support for mood behaviour cognitive disturbance <6 months**		40%	-												
COF 2.89	**People with stroke who are reviewed 6 months after leaving hospital**		95%	-												
COF 2.90	**Stroke patients supported by a skilled stroke early supported discharge team**	Jun 2012	40%	-										43%	▼	**43%**
PHQ10	**Early intervention in psychosis services - New cases**	Oct 2012	11	73	2	▼	13	1	▼	18	5	▲	29	10	▼	**69**
PHQ11	**Crisis resolution services/home treatment episodes**	Sep 2012	95%	-										95.7%	▼	**116.1%**
PHQ13	**Improve access to psychological therapy: % receiving treatment**	Sep 2012	0.81%	-	0.80%	▼	**4.26%**	0.65%	▼	**3.97%**	0.92%	▼	**5.22%**	0.80%	▼	**4.68%**
PHQ13	**Improve access to psychological therapy: % Moving to recovery**	Sep 2012	50%	-	48.8%	▲	**46.5%**	41.0%	▲	**37.4%**	46.2%	▲	**48.3%**	45.5%	▲	**44.4%**
PHQ31	**NHS Healthchecks offered (40-74) YTD**	Sep 2012	5%	5%	5.0%	▲	**11.2%**	6.2%	▲	**10.7%**	7.6%	▲	**12.3%**	6.2%	▲	**11.5%**
PHQ30	**4-week smoking quitters (% of target)**	Sep 2012	100%	-	136.8%		**136.8%**	90.9%		**90.9%**	73.6%		**73.6%**	124.8%	▲	**107.3%**

Performance Narrative:

PHQ10: Over the last two months performance is on an upward trend and the shortfall is slowly being recovered. There have been issues for the service since it underwent the transition to a single point of access. These issues are being addressed through regular communication with the service manager and monitoring of the situation. On the basis of the last two months performance, the expectation is that the target will be met next month, and for the YTD situation to improve month on month with an expectation that the target of 124 will be met at year end.

PHQ 13: The indicator rate was nationally set based on evidence of a "pure" CBT service model. The Leeds service is a hybrid model including non-CBT elements. A number of clients do not reach the defined recovery level, but nonetheless benefit. Further work is being done nationally on recognising this "effect size". The recovery rates are also very dependent on the level of the need being presented. The Leeds service maintains a recovery figure between 40-49%, representative of the broader population served. Some elements of the service such as Step 3 counselling achieve recovery rates of over 50% but this is one element of a much larger and complex service. The aim of the service is to achieve 50% but it will depend on the needs presented, an individual's engagement in therapy and the time-limited nature of the service.

Technical Notes:

COF 2.62, COF 2.63, COF 2.77: This indicator is based on SUS data, showing the rate per 100,000 population of the indictaor condition. It does not precisely match the COF definition, but it is the nearest to it from data available. Small numbers of procedures are involved, so the rate may fluctuate far more than normally might be expected.

PHQ10: There are no targets for this numerical indicator at CCG level, so traffic lights are not used. The CCG totals may not add to whole city figure due to some patients being from out of area and some not being allocated to CCGs. The citywide data is wholly accurate and is based on achievement of the nationally defined target.

PHQ13: As there is no guidance on how the citywide target should be allocated to CCGs, the MH Fair Shares split has been applied to the city-wide population deemed to require services, as a temporary measure.

PHQ 15, 16, 17: Traffic lights are not used, as there is no set threshold for what might be considered as 'good' performance. It should also be noted that wide variations from one report to the other may occur, at the CCG level. This seems to be due to small absolute numbers that can vary significantly from one quarter to another. Further work may be required to ensure this data can be interpreted accurately. The data source for the activity information is a local construction, based on SUS data.

PHQ30: The citywide data is based on performance to Sep while the CCG performance is based on performance to the end of June. The citywide data for Q1 has also been adjusted to take account of quits that were not orginally counted. There is no data available at the CCG level before June, which is why there is no trend arrow. CCG reported performance is based on allocation of actual quits to CCG geography, while the citywide target, used to compute achievement, is spilt according to Fair Shares. This could in some circumstances lead to questionable results at the CCG level.

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

		Reporting period	Monthly Standard/ Target (City)	YTD Standard/ Target (City)	Leeds North CCG			Leeds South & East CCG			Leeds West CCG			Leeds Citywide		
					Current	Change	YTD	Current	Change	YTD	Current	Change	YTD	Current	Change	YTD
COF 3a PHQ17	**Emergency admissions: acute conditions**	Sep 2012	none	none	77.9	▼	460.8	100.9	▼	767.1	86.0	▲	522.0	83.8	▼	548.2
COF 3b	**Emergency admissions <30 days of discharge**	Sep 2012	none	none	11.1%	▼	10.8%	13.4%	▲	12.7%	11.2%	▼	12.6%	12.0%	▼	12.2%
COF 3.1i	**PROMS: Hips**	2011/12	none	none										0.449		
COF 3.1ii	**PROMS: Knees**	2011/12	none	none										0.354		
COF 3.1iii	**PROMS: Groin hernia**	2011/12	none	none										0.109		
COF 3.1iv	**PROMS: Varicose veins**	2011/12	none	none										0.114		
COF 3.2	**Emergency admissions for children with LRTI**	Sep 2012	none	none	16.0	▲	70.8	6.5	▼	91.3	9.1	▲	84.0	9.9	▲	83.2
COF 3.10	**Emergency admissions: COPD**	Sep 2012	none	none	22.7%	▼	17.7%	14.0%	▼	17.9%	20.0%	▼	16.0%	18.1%	▼	17.2%
COF 3.26i	**Recovery following talking therapies for people of all ages**															
COF 3.26ii	**Recovery following talking therapies for people older than 65**															
COF 3.33	**People who have had stroke who receive thrombolysis**															
COF 3.34	**People with stroke admitted to acute stroke unit within 4 hrs of arrival**	Jun 2012	90%	-										59%	▼	59%
COF 3.35	**Stroke - specialist swallowing assessment <4hrs of admission**															

Performance Narrative:
COF 3.34: The COF includes several stroke indicators, derived from the Accelerated Stroke Improvements metrics. All nine indicators linked directly to quality makers in the National Stroke Strategy. Two of these were already measured by the pre-existing Tier 1 Vital Sign on stroke, used in the NHS Operating Framework. The remainder represented were not given the same profile and a balance was struck between the need to track progress and what it was possible to collect using existing information systems. The metrics were previously submitted to the SHA and have only recently commenced central submission. This meant that efforts were directed towards achieving the high profile targets within Vital Signs and as a result of this focus, no hospital within the Yorkshire & Humber region achieved the target of 90%. The indicators that now form the COF are the priorities within the Stroke Commissioning group and discussions are underway to develop an action plan to implement them in full. Separate discussions are taking place around the delivery of a 24/7 thrombolysis service and the delivery of other targets within primary and community care.

Technical Notes:
The indicators in this dashboard are not yet available through national data streams to CCG level. Those that are shown at that level are derived from local interrogation of SUS data, using the definitions set out in the COF proposals. There may not be a precise match between methodologies or data and consequently the end results.
COF 3b: The information shown here is from SUS, and does not match exactly with the COF definition, but is the best that can obtained at this time. The data is shown as a percentage rate , based on the number of readmissions against all admissions.
COF 3.2: This indicator uses SUS data, and does not match exactly that within the COF. It is however the nearest approximation that can be made available using currently available data. It shows the rate of emergency admissions, from the CCG population of all children. Relatively small numbers are involved and this could give rise to wider than usual fluctuations in the rates seen.
COF 3.10: The data used for this indicator is from SUS and will not match exactly with the COF definition. The data is shown as a percentage rate of emergency admissions.

Ensuring that people have a positive experience of care

		Reporting period	Standard/ Target	Leeds North CCG			Leeds South & East CCG			Leeds West CCG			Leeds Citywide		
				Current	Change	YTD	Current	Change	YTD	Current	Change	YTD	Current	Change	YTD
COF 4a	**Patient experience of GP out-of-hours services**	Sep 2011	none										66%	▲	
COF 4.20	**Access to community mental services by people from BME groups**														
COF 4.21	**Access to psychological therapies by people from BME groups**														
PHQ19	**18 week RTT - % admitted**	Sep 2012	90%	89.74%	▼	**91.4%**	92.46%	▲	**90.4%**	89.98%	▲	**90.8%**	90.73%	▼	**90.8%**
PHQ20	**18 week RTT - % non admitted**	Sep 2012	95%	98.27%	▼	**98.5%**	97.90%	▲	**98.3%**	98.34%	▲	**98.3%**	98.17%	▲	**98.4%**
PHQ21	**18 week RTT - % incomplete pathways**	Sep 2012	92%	95.46%	▲	**96.0%**	94.92%	▲	**95.7%**	95.09%	▲	**95.6%**	95.16%	▲	**95.8%**
PHQ22	**Diagnostic waiters (% seen within 6 weeks)**	Sep 2012	99%										99.5%	◀▶	**99.5%**
PHQ24	**Cancer urgent referral to first outpatient appointment waiting times**	Sep 2012	93%										94.6%	▼	**95.7%**
PHQ25	**Cancer two week wait for breast symptoms**	Sep 2012	93%										94.5%	▼	**94.9%**
Provider: Leeds Teaching Hospitals Trust															
PHQ18	**Patient experience of hospital care (Outpatients)**	Dec 2011	none	94.9%	▼										
PHQ23	**A&E waiting times (Type 1 - % seen in 4 hours)**	Oct 2012	95%	93.3%	▼	**94.6%**									
	A&E waiting times (All Types, Inc Wharfedale MIU - % seen in 4 hours)	Oct 2012	95%	94.0%	▼	**95.2%**									
PHQ26	**Mixed sex accommodation breaches (rate per 1,000 FCEs)**	Aug 2012	0	0	◀▶	**0**									

Technical Notes:
Where indicators are not broken down to CCG level it is because such data is not available through existing data streams.
PHQ19 & 20: At the CCG level only, these indicators are based on LTHT information only, for Leeds patients. This is not the same definition as specified nationally, but is best intelligence currently available. The actual numbers counted for CCGs will total lower than the citywide figure, even though the rates may appear similar. Both indicators are also based on 'clock stops' during the period in question, meaning that there may be circumstances where a patient did not have an outpatient consultation, for example, but who will have been counted, nevertheless. This especially occurs in the data for non-admitted patients. Even with the caveats, the information is felt to be useful enough to give an approximation of the general position. The data source for the CCG data is SUS.

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

		Reporting period	Monthly Standard/ Target	YTD Standard/ Target	Current	Change	YTD
Leeds (Commissioner basis)							
PHQ27	**MRSA**	Oct 2012	2	16	0	◀▶	**14**
PHQ28	**C.Diff**	Oct 2012	21	152	26	◀▶	**179**
Provider: Leeds Teaching Hospitals Trust							
PHQ27	**MRSA**	Oct 2012	1	8	0	◀▶	**11**
PHQ28	**C.Diff**	Oct 2012	11	85	14	▲	**93**
PHQ29	**Percentage of adult patients admitted and assessed for risk of VTE**	Aug 2012	90%	-	93.3%	▼	**94.7%**

Performance Narrative:

PHQ27: Cases of MRSA at LTHT remain above trajectory; however there have been no cases since August. In response to the large proportion of cases involving vascular access devices at LTHT, there is now a plan to address this specific area of practice. The revised MRSA policy introduced earlier this year focuses largely on reducing the likelihood of MRSA acquisition in hospital and has resulted in an increased demand for isolation facilities; therefore performance in the time taken to isolate according to this policy has declined, with a month on month increase of 'failure to isolate' reports. To address this, LTHT are reviewing how they use the bed management software and considering point of care MRSA screening for use in A&E as an addition to the current screening programme. They have also issued guidance to staff on how to prioritise patients for isolation when capacity is an issue. LTHT MRSA screening compliance for October was reported as 96%. There has been one community MRSA bacteraemia in October. Investigation is ongoing and early indications are that patient behaviour is a major contributing factor. As a Primary Care Organisation we are currently on trajectory.

PHQ28: The Leeds health economy continues to exceed trajectory. Interface working across organisations by the infection control teams continues. Shared learning opportunities from regional commissioners of infection control at the NHS NoE group are also being exploited. Plans are in place for an improved environmental cleaning strategy at LTHT using hydrogen peroxide vapour and capital investment has been requested for this. If implemented along with robust infection control policy, this strategy should result in a reduction of hospital acquisition. In the community the ongoing work around antimicrobial prescribing continues to highlight where practice needs to improve, though overall prescribing audit results are favourable demonstrating reductions in antimicrobials associated with C.diff. Extended surveillance of community cases hopes to identify factors that put people at higher risk of developing C.diff, though this work is in its early stages..

Technical Notes:

These indicators are not proposed to be at CCG level, at this stage. They are shown here for NHS Leeds as a commissioner and by LTHT as the chief provider, duplicating the perspectives taken by the SHA and DH.

Resources

		Reporting period	Monthly Standard/ Target	YTD Standard/ Target	Current	Change	YTD
Leeds Citywide							
PHS06	**Non-elective FFCEs**	Sep 2012	7,008	42,324	6,080	▼	37,905
PHS07	**GP written referrals to hospital**	Sep 2012	13,801	79,950	12,072	▼	79,052
PHS08	**Other referrals to hospital**	Sep 2012	9,899	56,747	8,768	▼	59,709
PHS09	**OP attendances following GP referral**	Sep 2012	11,746	64,656	9,750	▼	60,362
PHS10	**All OP attendances**	Sep 2012	20,559	112,258	17,376	▼	109,962
PHS11	**Elective FFCEs**	Sep 2012	8,449	47,120	7,704	▼	47,027
PHS12	**A&E attendances**	Oct 2012	-	-	19,272	▲	132,151
PHS13	**Ambulance urgent and emergency journeys**	Sep 2012	8,385	51,182	8,757	▲	53,579
PHS14	**Diagnostic activity: endoscopy based tests**	Sep 2012	1,675	9,147	1,820	▼	11,479
PHS15	**Diagnostic activity: non-endoscopy based tests**	Sep 2012	16,931	92,449	15,494	▼	95,338
PHS16	**18 week RTT - incomplete pathways at month end (number)**	Sep 2012	43,967	-	44,671	▲	
PHS17	**Health visitor numbers (WTEs)**	Oct 2012	139.3	-	141.9	▲	

Technical Notes:
These indicator lines apply to PCT Cluster organisations only. The traffic lights for the activity lines (PHS06 to PHS11 and PHS14 to PHS16), are based on variance from plan. Red is used for a variance in excess of +/-10% from plan, amber for between 5% and 10% variance and green for a variance within 5% of the plan. for both the applicable month and the YTD. It should be noted though, that it may be that lower levels of activity are desirable in some instances, for example in levels of non-elective activity, though a significant variance may still need to be understood and explained. The data source for the activity lines is the Monthly Activity Return (MAR). This differs from the measures of activity that will be seen within the context of the contracts that are held with providers. The MAR data is however used to report to DH within the Single Integrated Plan process and it also supports QIPP.

Reform

		Reporting period	Standard/ Target	Current	Change	YTD
Leeds Citywide						
PHF07	**Bookings to services where named consultant available**	Aug 2012	none	71.1%	▼	73.3%
PHF08	**Choose and Book (1st outpatient booking) GP utilisation %**	Sep 2012	51.4%	**67.8%**	▲	**56.0%**
PHF09	**Trend in value of patients treated in non-NHS hospitals**	Sep 2012	none	14.7%	▲	14.1%

Technical Notes:
These indicator lines apply to PCT Cluster organisations.
PHF08: The YTD figure here is based on an average of each month's performance to date.

Children's Trust – Children and Young People's Plan Report Cards January 2012

Children Leeds

Meeting: Children's Trust Board 30 January 2012
Outcome 1: Children and Young People are safe from harm
LCC lead: Steve Walker

Population: All children and young people in Leeds
Priority 1: Help children to live in safe and supportive families
CTB lead: Jane Held and Bridget Emery

Why is this an obsession Outcomes for children are better when they are able to live safely within their own family and community. The high numbers of looked after children in Leeds impacts on the resources available to provide preventative services aimed at supporting children to live within their families safely.

Amber ⟷

RAG: Efforts are impacting on a reduction in the numbers entering care. **DOT:** Marginal reduction in numbers of looked after children

Story behind the baseline

The overall numbers of looked after children in Leeds continues to be on an upward trend with 1444 looked after children at the end of November, 24 more than 12 months previously. The rate per 10,000 dropped slightly in November from 95.3 to 94.9 (6 children) but remains in line with the Core Cities comparator group 10/11 position.

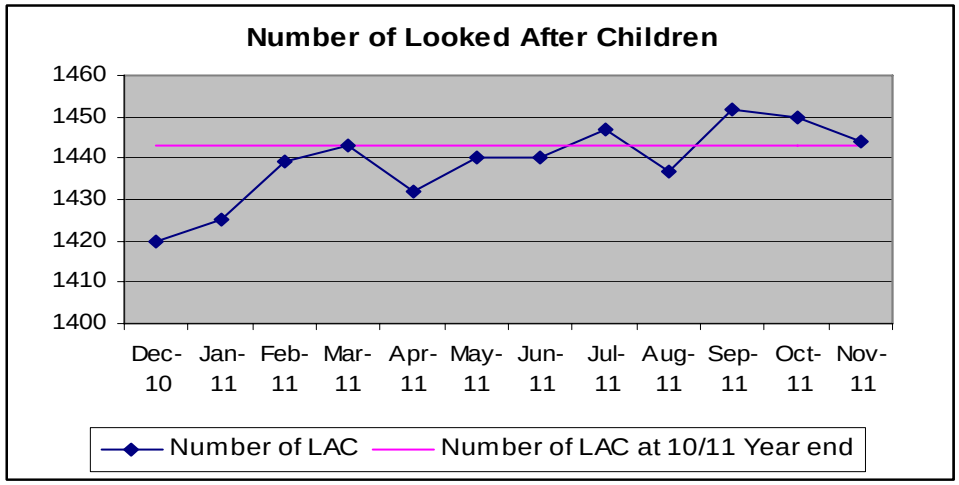
The rate at which children are entering care in Leeds has been on a downward trend since 2007/08. This trend has continued into the current year. If the rate of entry to care so far this year remains unchanged total numbers entering care for the full year would be 376.

Since 2007/08 the rate of children leaving care has also been on an overall downward trend. Although this year there are signs of a levelling off of this trend. If current rates of leaving care continue 418 episodes of care will have ceased by the end of March 2012.

Numbers entering and leaving care 2007 - 2011

	2007-08	2008-9	2009-10	2010-11	April-Nov 2011
Entering	508	448	463	425	282
Leaving	503	474	387	401	279

Curve: Number of looked after children



The number of IFA's and external residential placements has continued to grow throughout this financial year although external placement numbers in the 3rd Quarter have remained fairly stable. (276 IFAs and 101 external residential placements at 18/12/11).
Work is ongoing to reduce the average weekly cost of IFAs and external residential placements through regional collaboration. Target savings are 2.5% on IFAs (current weekly average cost £780) and 5% on external residential placements (current weekly average cost £2850).

What do children and young people think As part of the review of the Looked After Children Strategy, young people from the Have a Voice Council, Corporate Carers and the LAC Operational Group are considering progress against the CYPP outcomes. The first consultation took place with young people on 14th December, focussing on the "Having Fun Growing Up" outcome. Young people contributed ideas for improving their experiences of being looked after.

Looked after young people were consulted on "The Promise" in July and September. Responses highlighted the importance of feeling listened to, being able to make decisions about their lives, being helped to keep in contact with their families, staying healthy and safe. The findings were presented to Corporate Carers in Dec 2011

What we have done

- Improved our Ofsted rating for safeguarding from Inadequate to Adequate (with Good capacity to improve) and had our Notice to Improve lifted.
- Adopted the findings of the universal review. Early Start Team is now in place in Seacroft/Manston.
- All 3 early adopter clusters and a number of other clusters have held OBA workshops on "reducing the need for children to be in care".
- Additional resources have been identified for approx. 18 posts across the city.
- Family support services have been re-modelled and will be delivered to families where there is a high risk of children entering care or custody from January 2012.
- Appointed two MST Supervisors and interviews underway for 8 therapists. Recruits will attend full MST training in January, significantly increasing capacity of the team from February 2012, to provide increased intensive support to families (where one or more children have recently become looked after) to return children home where appropriate and safe. Also agreed for the MST service to accept direct referrals from the Youth Court Team.
- Following introduction in July 2011 of new "Strengthening Families" model of child protection conferences, improved decision making has been promoted and the model is being well received by families and professionals.
- Increased resource to Independent Reviewing Team and IRO role strengthened, particularly to provide challenge and ensure plans for permanence are in place.
- A new Fostering and Adoption Recruitment and Assessment Manager appointed. Communication Strategies have been reviewed and new website is being launched in March '12. Potential fosterers and adopters searching on Google now see LCC's fostering and adoption site first. This has already generated more expressions of interest.
- Re-visited plans for children looked after (under a voluntary agreement with parents) to check plans to return home were being expedited where appropriate.

What works locally

The TSL role, being piloted in JESS, Inner East and Bramley is beginning to show some success. All three pilot clusters now have in place a list of their most vulnerable families. Using the Top 100 methodology they have identified those families that need a coordinated support package, and have identified the most appropriate lead agency.

New actions

- Undertake OBA workshops in all 27 clusters on reducing the need for children to become looked after.
- Increase use of the Common Assessment Framework (CAFs).
- It is proposed to use the Common Assessment Framework as primary assessment tool for children with complex needs.
- Implement the recommendations from the review of "Front door" practice (as agreed by LSCB) in late March 2012.
- Resources identified and business case approved for expanded Family Group Conference service. Recruitment and training now to be undertaken.
- Identify premises for the MST service in the South and West North West areas.
- Complete recruitment to an expanded Family Group Conference service.
- Develop a systematic process for reviewing children subject to Special Guardianship Orders to identify and meet post SGO support needs.
- Leeds to hold a multi-agency OBA session on developing a response to the Government's Troubled Families Initiative on 28th Feb.
- Identifying children (0-5) subject to CPPs to provide them with children's centre services, particularly 2 year olds for child care/early learning (using govt. funding).
- Following completion of the review of the Placement Service (for looked after children), the business case for a new structure to be considered by CSLT.
- Residential Review to be completed.

Data development

A review of management information needs is underway which aims to identify current gaps and agree solutions which will meet partnership and business and needs. More regular information is being made available to clusters on referrals, CAFs and requests for service.
Performance Monitoring tool developed for the new Family Intervention Service providers to be implemented in January. This will provide regular information on the effectiveness of the new service and outcomes achieved for children and families.

Partners with a role to play

Children and young people, parents, schools, health visitors, family outreach workers, police, VCFS, childcare services, Youth Offending services. Community groups, drug and alcohol services, probation, adult services, housing, media, business, GPs, transport services, mental health (CAMHS).

Children's Trust – Children and Young People's Plan Report Cards January 2012

Children Leeds

Meeting:	Children's Trust Board - 30 January 2012	**Population:**	Pupils in Leeds schools (Years 1-11)
Outcome 2:	Children and young people do well at all levels of learning and have the skills for life	**Priority 3a:**	Improve behaviour, attendance and achievement
LCC lead:	Paul Brennan	**CTB lead:**	To be confirmed at 30 Jan CTB meeting

Why is this an obsession There are strong links between attendance, attainment, being NEET and youth offending. Particular pupil groups who experience multiple poor outcomes are more likely to have poor attendance, e.g., those living in deprived areas; looked after children; pupils eligible for free school meals; pupils with special education needs and some BME groups.

Amber ↑

RAG: Longer-term gap to national performance **Direction of travel:** Some indicator improvements in 2010/11

Story behind the baseline

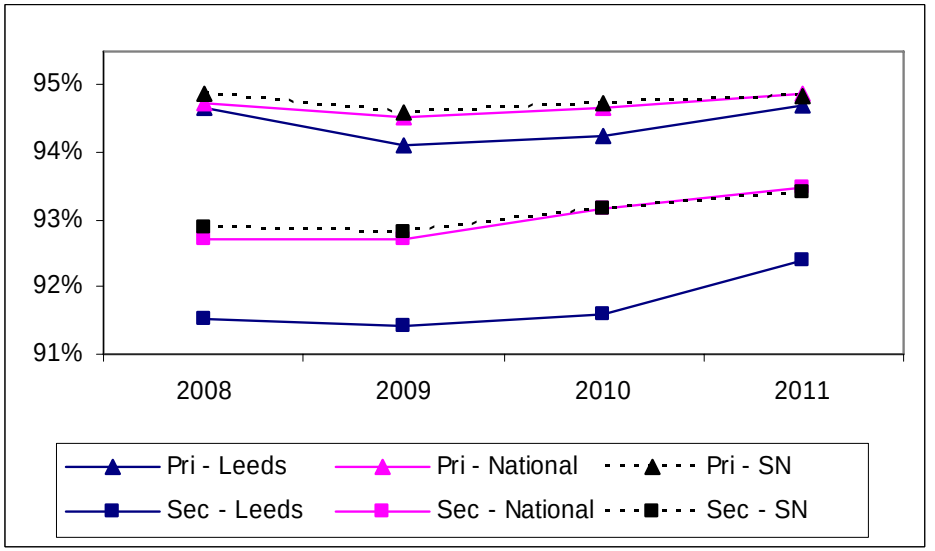
The vast majority of children in Leeds attend school regularly without the need for any additional or targeted support. However a significant cohort of children in Leeds miss an unacceptable amount of school.

The reasons for irregular school attendance are complex and are often located in a child's home or family circumstances and the wider community, not only school.

Illness is the biggest reason for absence across all phases. Medical and dental appointments during school hours also contribute to around 5% of all absence from school. In the primary phase, it is significant that poorest attendance is seen in year 1. This is a trend reflected nationally and is therefore not just a Leeds issue.

The level of *"agreed family holidays"* is lower in Leeds secondary schools than nationally, whereas *"not agreed family holidays"* are higher. This evidences Leeds' schools willingness to challenge requests by parents to remove their children from school for holidays. Primary pupils, however, are twice as likely to be absent from school during term time due to requests for holidays which possibly reflects a disparity between parental attitudes to the importance of the primary curriculum. Many clusters are taking collective action in their 'turning the curve' action plans to develop consistency around authorising term-time holiday requests.

Curve: School attendance rates[1]



The number of persistently absent (PA) pupils, who miss 15% or more of school, has been falling in Leeds primary and secondary schools, but remains above national levels. There is a significant over-representation of pupils in the secondary PA cohort who are eligible for free school meals, and pupils who have special educational needs; in particular pupils whose need is classified as "School Action Plus."

[1] Half-terms 1 to 4 of the 2010/11 academic year, the most recent period for which comparative data is available. Source: school census. SN = statistical neighbour

What do children and young people think As part of local research undertaken into the reasons for persistent absence, young people told us that the key factors in absence are: problems at home and with parents; issues with the curriculum and lessons; and bullying was also mentioned as a factor. Groups such as young carers had particular issues affecting their school attendance.

What we have done

- The Leeds Education Challenge makes a city-wide pledge to ensure that, "Every child and young person of school age will be in school or in learning." Two activity strands of the Leeds Education Challenge – families and community engagement and the 14-19 strand - have a focus on improving attendance.
- The roll out is in progress of the Targeted Services Leaders who will be responsible for deploying the Attendance Improvement Officers employed by LCC. A pathfinder approach may be taken with some clusters testing out the model where there are already Targeted Service Leaders in post. Work is taking place on the service level agreement that would need to be in place and discussions with clusters about how they could deliver this function are taking place.
- There are a significant number of clusters who are developing best practice around support for attendance. For example, the Bramley cluster are already using the "Top 100" methodology to take a broad view of families in need and to allocate lead practitioners to best effect. Other clusters are developing multi-agency "Care and Support" meetings to deliver family support around a range of needs. Use of the Common Assessment Framework is being promoted.

New actions

As at December 2011, 21 clusters have held Outcomes Based Accountability workshops to gather a wide range of partners, to address attendance and persistent absence. From these workshops "Turning the Curve" activity plans that have been produced. A consistent theme and commitment in these plans is to early intervention. Some examples of actions identified within clusters are:

- Engaging with parents where attendance is low in nursery, or at children's centres, to embed good practice before starting school.
- The use of parenting classes to help families create routines that support regular school attendance.
- Working with parents who may themselves have had negative experiences of education, to reinforce the importance of attendance and its positive impact on attainment.
- The use of minibuses, walking buses or door-knocking by family support workers to ensure that children set off from home and come into school.
- Reward schemes for parents who improve their children's attendance, as well as for the young people themselves.

What works locally

Early intervention by schools at the first sign of falling attendance levels tends to be most effective, through initiatives such as first day absence calls and texting. Challenging parental responses to illness and requests for term-time holidays can also help improve attendance, as can incentive schemes that reward good and improved attendance; working directly with families through family outreach; and encouraging partnership responses to poor attendance.

Data development

A dashboard is currently being developed to report attendance monthly to clusters, including persistent absence and unauthorised absence. There are some coverage issues to resolve, so that all schools are included. Circulation is scheduled for the spring term.

Partners with a role to play Children and young people, parents, schools, health visitors, family outreach workers, police, VCFS, childcare services, community groups, drug and alcohol services, probation, adult services, housing services, Connexions, media, business, Chamber of Commerce, GPs, transport services.

Children's Trust – Children and Young People's Plan Report Cards January 2012

Children Leeds

Meeting: Children's Trust Board - 30 January 2012
Population: Young people of academic age 16, 17 and 18 (age on 31 Aug)
Outcome 2: Children and young people do well at all levels of learning and have the skills for life
Priority 4a: Increase numbers in employment, education or training (EET)
LCC lead: Paul Brennan
CTB lead: Martin Fleetwood and Diana Towler

Why is this an obsession Being in EET increases young people's confidence, prospects and economic independence and therefore supports the city's overall economic performance. By targeting groups and areas where NEET is a particular challenge, we can raise aspirations and prospects for young people who often have multiple poor outcomes. The current economic downturn presents challenges for young people looking to enter the workplace for the first time.

Amber ⬆

RAG: Gap to national performance **Direction of travel:** Good rates of young people in learning

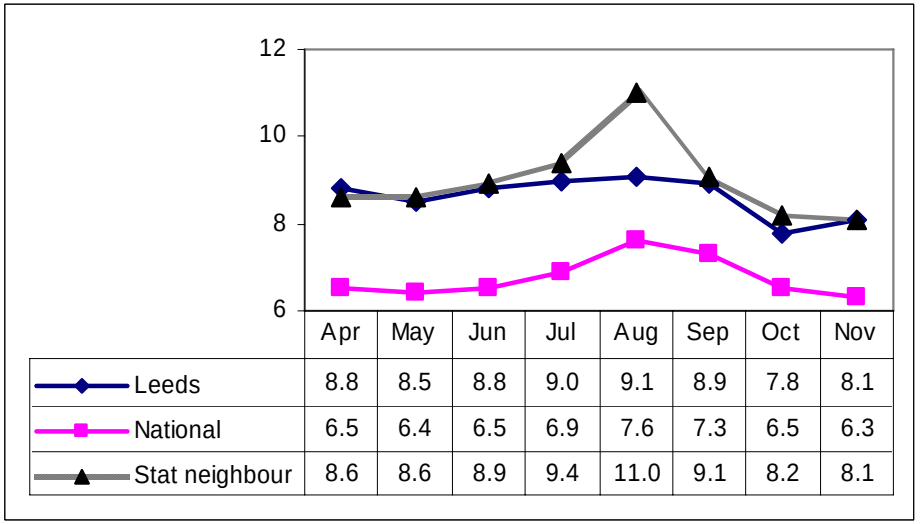
Story behind the baseline

At the end of November there were 1926 NEET young people in Leeds who were known to the Connexions service. Leeds has a higher NEET rate than national levels. The rate of young people in learning (78.4%) is slightly above the national level. The rate in learning is important to monitor alongside NEET rates, for when raising the participation age (RPA) to 18 comes into effect in 2015.

The government monitors local authority performance based on data from November to January each year. The Leeds NEET rate for November 2011 was 8.1%, compared to 9.2% in November 2010.

Affecting the baseline is a rise in the proportion of young people whose status is 'Not Known' to 11.4% (2770 young people), compared to 7.8% in November 2010. Where young people's status is unknown, they cannot be targeted for support. The rise in Not Knowns is in part down to national reductions in funding for Connexions services. Levels of 'Not Known' have also risen to a similar rate nationally (11.2%, Nov 11).

Curve: Percentage of young people who are NEET (April-Nov 2011)



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov
Leeds	8.8	8.5	8.8	9.0	9.1	8.9	7.8	8.1
National	6.5	6.4	6.5	6.9	7.6	7.3	6.5	6.3
Stat neighbour	8.6	8.6	8.9	9.4	11.0	9.1	8.2	8.1

Young people become NEET for complex and diverse reasons. NEET levels are higher in deprived areas, and for teenage parents, young people with special educational needs, those with lower school attendance, lower levels of qualifications and young offenders. NEET rates are more than 50% among young parents and pregnant young women.

Transition between learning opportunities can trigger disengagement; as can missing out on good quality impartial information, advice and guidance (IAG). Family networks have a major influence on a young person's decision-making. Improvement activity includes work with families to ensure young people are positive about their ability to succeed, access to IAG to help choose the right learning pathway; and support at transition points.

Risks include: changes to the provision of careers education and IAG with more responsibility for schools in September 2012, but without increases in funding; reductions in post-16 funding for all providers, but that will hit schools particularly hard; and changes to which vocational qualifications count in the performance tables. Another factor is the economic downturn and its likely impact on apprenticeship and other employment opportunities.

What do children and young people think A diverse group of NEET young people were consulted as part of the development of the Children and Young People's Plan. Young people said that the current economic climate had a big impact on their employability, however they also experienced other difficulties in finding employment, education or training, such as: difficulties using the systems in Jobcentres; access to IT to apply for jobs or courses; lack of confidence; struggling with interview skills; travel and financial barriers; poor reading and writing skills; and coping with complex personal circumstances.

What we have done

- Work is continuing with schools to support them in meeting new statutory requirements for careers education and IAG responsibilities.
- Leeds City Council has invested over £400,000 with matched funding from Leeds City College and Jobcentre Plus as part of the YOUth Inspire programme, managed by Learning Partnerships which will support 580 young people aged 16-24 to access the support and skills training needed to help them secure a job, apprenticeship or further work-related training.
- In the autumn term high schools received NEET rates for 16-18 year olds (Years 12-14) previously at their school; allowing them to see outcomes for their former pupils and focus resources on current pupils at risk of becoming NEET.
- Arrangements for administering the new 16-19 bursary scheme are now in place.
- To increase parental engagement, parent and carer advice pages have been developed on Leeds Pathways. There is a development plan in place to ensure that labour marker information that is accessible to young people and parents is available on Leeds Pathways. This will include video clips of local employers explaining the qualities they look for.

New actions

- The Education Business Partnership are making funding available for secondary schools to take up programmes that will help young people develop the skills they need to make the transition into work and improve their career management skills.
- Training is being offered to primary schools about career-related learning in Key Stage 2. Some children growing up in workless households may assume that the world of work is not them; career related learning can help raise aspirations from a young age.
- Plans are being developed to prepare for RPA, including identifying the needs of priority groups who do not engage with the current learning offer, through the 11-19 (25) Learning and Support Partnership and its sub-groups.
- One of the priorities of the Child Friendly City programme is to increase work experience opportunities across the city; and to ensure that young people know where to go to find out about job vacancies, apprenticeships, work experience and careers IAG. Young people will be leading work to make this priority happen.
- Increase understanding of the help available through Jobcentre Plus as a result of the introduction of the Youth Employment Support offer and the development of the Youth Contract.

What works locally

Accurate data and tracking, increased information sharing and improved learning options have all contributed to reducing NEET. At the same time the loss of some funding and the economic downturn pose major challenges.

Data development

- Planning for systems and data transfer processes in preparation for the end of the Connexions service.
- Improved data exchange agreements to reduce the tracking of young people who are in contact with other services, e.g., Jobcentre Plus and the National Apprenticeship Service.

Partners with a role to play Adult social care, schools and FE colleges, Connexions, housing services, young people, parents and family, employers, 14-19 confederations, Jobcentre Plus, offsite providers

Meeting: Health and Wellbeing Board

Population: All adults in Leeds

Outcome: people live longer and have healthier live

Priority: Help protect people from the harmful effects of tobacco.

Why and where is this a priority

Smoking is the single biggest preventable cause of ill health and mortality being one of the most significant contributing factors to life expectancy, health inequalities and ill health, particularly cancer, coronary heart disease and respiratory disease.

AMBER

Story behind the baseline

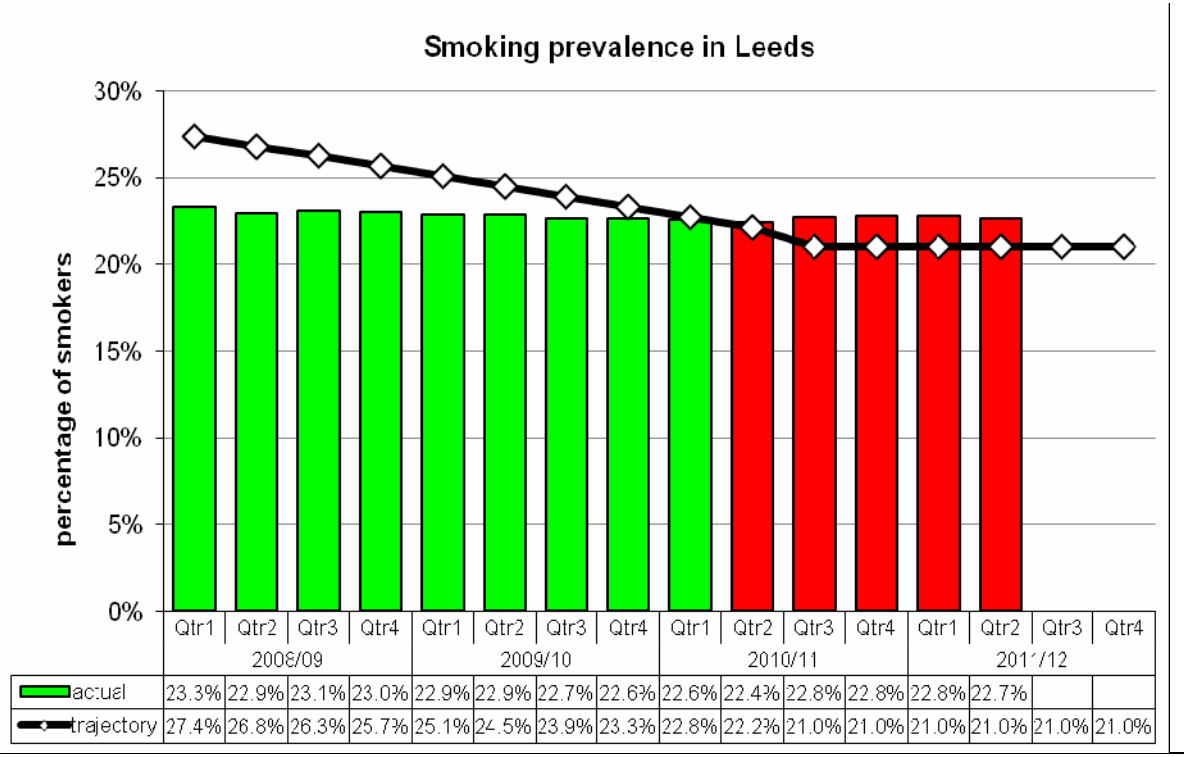
Headline Indicator: Reduce the number of adults over 18 that smoke.

- Smoking prevalence (as recorded by GP practice registers) has declined steadily since 2006 and is now remaining static between 22 and 23%.
- Smoking prevalence in the MSOA deprivation quintiles has remained relatively constant over the last two years. There have been some rises and falls but these have only by around 1% and there is no clear trend from these either upwards on downwards. This reflects the general national picture although some areas are reporting increasing smoking prevalence rates.
- There is a link between smoking prevalence and deprivation with the prevalence in the least deprived quintile being around 13% and the prevalence in the most deprived quintile being over twice that, around 33%. The other three quintiles are relatively evenly spaced between these two, in order of deprivation.
- The new national action plan has suggested aspirational prevalence levels of:
- Adult smoking prevalence 18.5% or less by 2015
- Smoking prevalence among young people 12% or less by 2015
- Smoking during pregnancy 11% or less by 2015
- However prevalence rates nationally have remained static over the last 2 years

- Current investment in tobacco control activity in Leeds is maintaining a constant prevalence, however some areas within the region are reporting increased levels of smoking

- To reduce smoking prevalence by 1% in Leeds would mean 6230 fewer people smoking who otherwise would be.

Figures received from the smoking cessation service (both 4 week and 52 week quit rates) indicate that the current level of service provision could potentially achieve approximately 40% of the 6230 fewer smokers required to reduce prevalence by 1% over a 3 year period. This indicates that other tobacco control initiatives will be necessary if reduced prevalence is to be achieved.



What do key stakeholders think

A new tobacco control action plan for Leeds is being developed which will help to identify the key stakeholders to involve. Integrated into the plan will be an action to conduct a full stakeholder process to help develop an effective Tobacco Control Alliance for Leeds

What we did

- Worked with a number of 3rd sector organisations as part of the 'Leeds Let's Change' programme which aims to increase the numbers of people currently accessing support to change unhealthy behaviours.
- To date, 17 practices have signed up to become part of the Leeds Let's Change programme with a further 26 being approached in 2012. This first phase of the programme aims to ensure all practices within deprived Leeds are engaged and active with the programme.
- A full programme of training has commenced which is open to all frontline staff who may be in a position to support and motivate people access support in changing behaviour including stopping smoking. So far 2 training courses have been delivered with a further 26 being planned through out next year.

What worked locally /Case study of impact

A regionally funded marketing campaign was developed to signpost the public into clinics within the communities with high smoking prevalence.

The service highlighted areas with high foot fall for designated trained promoters to engage with the public and book directly into local clinics. This increased the awareness of the service and access to the clinics, it also gave the service an opportunity reach smokers who may not access services.

Within the pregnancy service, the team have recently trained a small number of midwives to undertake CO monitoring routinely for all their pregnant women.

This gives an opportunity to raise the issue of smoking and refer on to the service for support. Nice guidance suggests that all pregnant women should have carbon monoxide test and routinely be referred at each appropriate intervention. Due to a lack of resource we are unable to provide all midwives with monitors to record carbon monoxide levels

New Actions

- Work has commenced on drafting a citywide action plan which will aim to reduce smoking prevalence. We are currently engaging with possible contributors to the plan and ascertaining the actions which are likely to have the greatest impact and return on investment.
- The Leeds Let's Change programme will be officially launched in January with an event for professionals and a series of promotional community events which are being supported by a media campaign
- Consultation for plain packaging of tobacco has now been delayed until next spring; a co-ordinated response to the consultation will be developed. This will ideally involve a diverse range of stakeholders including community groups, councillors, GPs etc. to have the greatest impact.
- A new service level agreement for locally commissioned smoking cessation services within primary care is currently being finalised, which will update the current SLA to take into account changes within smoking cessation and improve standards and quality assurance of services

Data Development

- Data is collected on a quarterly basis from GP registers to monitor prevalence in the general population and via midwifery services to monitor smoking prevalence among pregnant women. Although the quantity of data collected form these sources have improved over the years there is limited available information to fully understand the demographic breakdown for the population as a whole although this has improved in terms of pregnant women
- Data is collected from stop smoking services to monitor the numbers of people accessing services and the outcome at 4 and 52 weeks. The data can provide a detail insight re.the demographic profile of service users.
- Data regarding smoking and young people is currently collected through the annual 'Every Child Matters' survey which is completed by children in yrs 5,6,7,9,and 11. Although again this has limitations in demographic details.

Risks and Challenges

- Since 2009 there has been no citywide steering group to drive the tobacco agenda forward, the group is to be reconvened following the development of the action plan with identified leads for each of the priority areas of work, however, due to the nature of tobacco control and the need for a comprehensive programme, success will be dependant on the commitment and involvement of key partners and stakeholders.
- The disbanding of the regional government office which organised collaborative work across Yorkshire and the Humber such as the SOS smoking in pregnancy scheme. A Regional Social Marketing Manager post has remained and is currently employed by Wakefield Council
- Lack of additional funding and competing priorities continue to pose a risk to the programme although the research programme will contribute to developing capacity and ensuring existing resource is utilised to the best possible effect

Meeting: Health and Wellbeing Board **Population:** All adults in Leeds

Outcome: People are supported by high quality services to live full, active and independent lives.

Priority: Support more people to live safely in their own homes.

Why and where is this a priority: The vision for the future is to enable people, regardless of age, with complex health and social care needs, including those with mental health needs, to be cared for at home or closer to home avoiding the need for unplanned hospital attendances and admissions and reducing the need for long term admission to residential or nursing care homes.

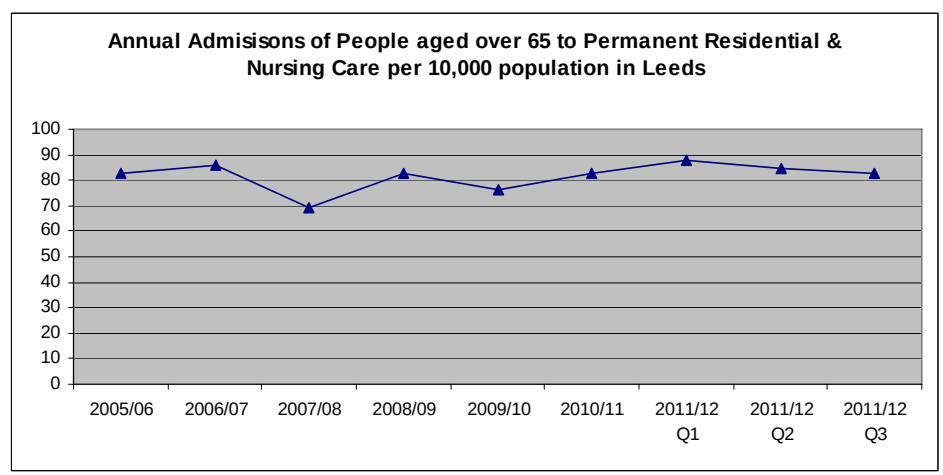
GREEN

Story behind the baseline

Headline Indicator: Reduce the rate of emergency admissions to hospital.

Reduce the number of older people admitted permanently to residential & nursing care homes care homes.

Although there are annual fluctuations, there has been an overall downward trend in the number of older people starting to require financial support by the Local Authority for permanent admission to care homes over the last six years. In 2005/6 985 people received support and in 2010/11 this had reduced to 910. This admission rate has been better than the national average and inline with regional figures until 2010/11. The upward trend continued into quarter 1 of 2011/12 but has been declining for the last two quarters. The number of older people living in residential and nursing care has however remained very static since 2008/9, as has the number of weeks residential and nursing care financially supported by the Council. This is because the average length of stay has reduced from 656 days (nursing) and 674 days (residential) in 08/09 to 538 (nursing) and 552 (residential) in 10/11. This suggests that older people are retaining independence for longer periods and are requiring care home support at later stages in their lives.



(Source:) ESCR

Over the last few years the city has faced a number of challenges which have increased pressures upon the Local Authority to support people with their care. These include rising demographic pressures; an increasing number of older people who had previously funded their own residential and nursing care exhausting their own resources, and ongoing changes to the health delivery infrastructure generating short term pressures on community services as hospital ward places are reduced and investment is transferred into community alternatives.

Development and agreement of a data set for performance information in relation to emergency admissions to hospital is still ongoing.

What do key stakeholders think

The key messages emerging from stakeholders so far are:

Help people to continue to live independently in their own homes by meeting local needs locally, providing support closer to peoples homes means public money can be used more efficiently. People need access to high quality information to allow them to make informed choices about how and where they receive care.

What we did

Financial approval for work on a Wellbeing Centre at Holt Park has now been approved by the Department of Health following a successful business case. Building work starts from January 9th.

Through the Leeds Health and Social Care Transformation Programme the following key actions have been undertaken:

- The procurement of a Yorkshire and Humber wide 111 service to include a West Yorkshire wide consult and treat service commenced. A programme of engagement is underway. Public engagement in relation to the location of the GP out of hours service started on the 4th December and will conclude on 4th March 2012.
- Through the Integrated Health and Social Care Team project, demonstrator sites are being established in Kippax/Garforth, Pudsey and Meanwood. Formal launches are being undertaken with frontline staff. Local project groups have been established to drive delivery within the three demonstrator sites.
- The rollout of risk stratification is being prioritised for practices within the demonstrator sites, education and engagement plans include members of the Integrated Health and Social Care Teams. This will allow the identification of those most at risk of hospital admission and who could benefit from early diagnosis and treatment.

What worked locally /Case study of impact

Reablement - David's story: "Without the encouragement and support from the SkILs team I would have had to go into a home".

After an operation and a spell in hospital David was advised to have at least three months' bed rest. He wasn't mobile enough to be able to get in and out of bed, go to the toilet, or shower himself. Mark from the Skills for Independent Living (SkILs) team has been helping to care for David with a combination of physiotherapy at the hospital, equipment around the home, such as grab rails, perching stool, some personal care and 'telecare' – electronic equipment including medication prompts and smoke/gas detectors. This gives David the reassurance he needs to live independently in his own home.

New Actions

A joint action plan will be implemented to align reablement and intermediate care services and is overseen by a steering group. The group is currently examining examples of fully integrated services to inform future actions. Adult Social Care and NHS Leeds have agreed to jointly commission a resource at Harry Booth house as part of a wider integrated Community Intermediate Care (CIC) bed provision and will become operational from June 2012.

Procurement of a Yorkshire and Humber wide 111 service to continue, Invitation to Tender to be issued March 2012.

Outcomes of the public engagement exercise to inform the location of the GP out of Hours Service.

The Integrated Health and Social Care Teams project, will prepare for the co-location of staff within the demonstrator sites.

The roll out of risk stratification education and engagement within demonstrator sites is expected to be completed by March 2012.

Development of a joint information sharing protocol is underway which will underpin the sharing of information across the Integrated Health and Social Care Teams.

The NHS and social care are progressing understanding approaches, to assisted technology services.

Data Development

Work to develop intelligence systems and sharing across social care and health continue and will be important in determining the impact of transformation work within different parts of the system.

Risks and Challenges

- There is a risk of inadequate resources being available to support Leeds Health and Social Care Transformation Programme and project infrastructure and the implementation stage of the projects given the current capacity available.
- Failure to develop and maintain effective partnership working and processes at both locality and city-wide strategic level between Leeds City Council and its partners to reduce health inequalities.
- Adults' Social Care Services fails to deliver the whole of its Business Systems Transformation Programme.
- Insufficient or poor quality Business Intelligence has a detrimental effect on the ability of ASC to meet its overall objectives.

Meeting: Health and Wellbeing Board

Population: All adults in Leeds

Outcome: People are supported by high quality services to live full, active and independent lives services.

Priority: Give people choice and control over their health and social care services

Why and where is this a priority The vision for the future is to enable people, regardless of age, with complex health and social care needs, including those with mental health needs, to be cared for at home or closer to home and to have increased choice and control over their health and social care services

Overall Progress:

AMBER

Story behind the baseline:

Leeds like many other cities has a large population whose needs include both social care and health services. Long term conditions account for 70% of health and social care costs, and almost three quarters of the gap in life expectancy between those living in the most deprived areas of Leeds and Leeds overall.

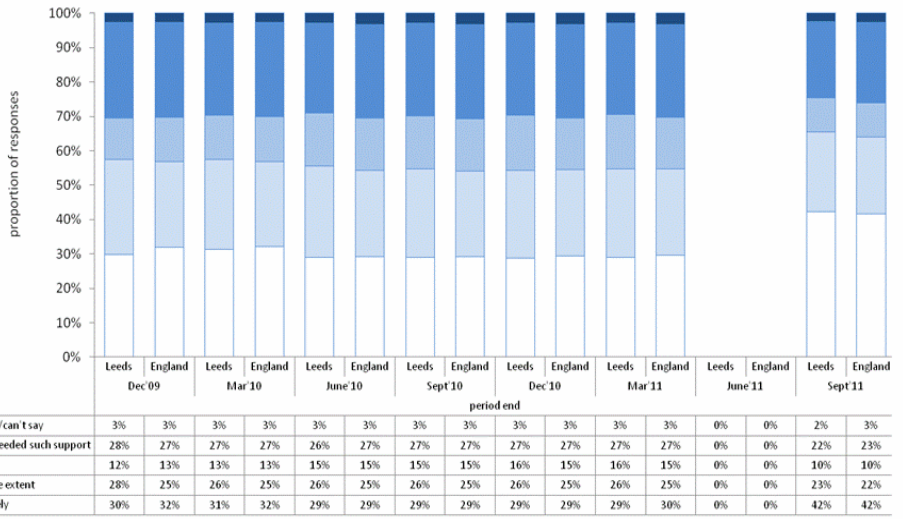
The statistics for Leeds follow the national trend of a slight increase in the negative experience people are feeling in terms of the support they are receiving to manage their long term condition.

'Transforming Social Care' LAC (DH) (2008) outlined the national policy for all people to be given the opportunity to design their support or care arrangements in a way that best suits their specific needs. At the end of 2009/10 17% of all service users had had this opportunity. By the end of 2010/11 this had increased to 29% of all service users (4,550 people) and by December 2011, the percentage has increased to 33% (5,303 people).

Available benchmarking data suggests that Leeds performance is inline with the average nationally.

Headline Indicator: Increase the proportion of people with long-term conditions feeling supported to be independent and manage their condition.

National and Local patient responses to the GP survey Question
Had enough support from local services to help manage long-term health condition(s)



	Dec'09 Leeds	Dec'09 England	Mar'10 Leeds	Mar'10 England	June'10 Leeds	June'10 England	Sept'10 Leeds	Sept'10 England	Dec'10 Leeds	Dec'10 England	Mar'11 Leeds	Mar'11 England	June'11 Leeds	June'11 England	Sept'11 Leeds	Sept'11 England
Don't know/can't say	3%	3%	3%	3%	3%	3%	3%	3%	3%	3%	3%	3%	0%	0%	2%	3%
I have not needed such support	28%	27%	27%	27%	26%	27%	27%	27%	27%	27%	27%	27%	0%	0%	22%	23%
No	12%	13%	13%	13%	15%	15%	15%	15%	16%	15%	16%	15%	0%	0%	10%	10%
Yes, to some extent	28%	25%	26%	25%	26%	25%	26%	25%	26%	25%	26%	25%	0%	0%	23%	22%
Yes, definitely	30%	32%	31%	32%	29%	29%	29%	29%	29%	29%	29%	30%	0%	0%	42%	42%

data source: GP Survey results http://www.gp-patient.co.uk/

What do key stakeholders think:

The key messages emerging from stakeholders so far are:

Help people to continue to live independently in their own homes by meeting local needs locally, providing support closer to peoples homes means public money can be used more efficiently. People need access to high quality information to allow them to make informed choices about how and where they receive care.

What we did

- Leeds has mainstreamed self-directed support via care management for new service users with eligible care needs during 2010/11.
- Refresher training on self-directed support has now taken place for all assessment teams.
- A project board has been established to undertake work from the Combining Personalisation and Community Engagement pilot. Dedicated social work support has been identified to support the project. This will enable community based services to extend services funded by self-directed support.
- A cross directorate project team has been established to review specific actions required to develop care options and housing for older people.

Through the Leeds Health and Social Care Transformation Programme, the following key actions have been undertaken:

- The Integrated Health and Social Care Teams project is establishing demonstrator sites in Kippax/Garforth, Pudsey and Meanwood. Roll out of the risk stratification tool is being prioritised to practices within the 3 demonstrator sites.
- The Diabetes project to provide services closer to home for those with type 2 diabetes has now been fully integrated in to business as usual. Key elements and lessons learnt from this project have been captured.
- Staff have received training in the use of blood gas analysers for patients receiving Home Oxygen

What worked locally /Case study of impact Self Directed Support - For the last six months Olive has been using a personal budget to employ a team of five personal assistants. “The main difference the personal budget has made is that we can dramatically improve Mum's quality of life during the day and there’s a lot more flexibility. For example, previously an agency worker spent just half an hour providing lunch – Mum needs an hour for a meal. Mum gets up to all sorts of activities with her daytime personal assistant – reading and looking through books together, singing along to the old timers, doing simple jigsaws even feeding the ducks on the Wharfe or visiting the garden centre. Compare that to just sitting staring at the TV. The personal assistants are hand-picked and really care. And Mum gets to see the same friendly faces. In many ways they treat her like their own mum rather than there just being a procession of strangers who watch the clock and rush in and out.

New Actions

- Work is currently being undertaken to assess the needs of and identify suitable alternative services for older people and mental health service users of day services whose current service provision is to be decommissioned. Progress has included finding people suitable community based alternatives with the Neighbourhood Networks and the Community Alternatives Team. This work is due for completion by June 2012.
- A cross directorate project team aims to analyse the demand and supply for older peoples housing and care options and take a report to Executive Board in March 2012.
- The Integrated Health and Social Care Teams project, will prepare for the co-location of staff within the demonstrator sites.
- The roll out of risk stratification education and engagement within demonstrator sites is expected to be completed by March 2012.
- A city wide Home Oxygen workshop is planned for February 2012, which will include staff from the district nursing service, intermediate care services and Adult Social Care.

Data Development

- Work to develop intelligence systems and sharing across social care and health continues and will be important in determining the impact of transformation work within different parts of the system.

Risks and Challenges:

- Self Directed Support is not financially sustainable.
- Failure to transform services mean that the need for self-directed support is not met.
- Failure to develop and maintain effective partnership working and processes at both locality and city-wide strategic level between partners to reduce health inequalities.
- The Directorate fails to efficiently and effectively manage the changing workforce requirements to deliver personalised services within available financial resources.

Meeting: Health and Wellbeing Board

Population: All people in Leeds

Outcome: inequalities in health are reduced, for example, people will not have poorer poorest improve their health because of where they live, what group they belong to or how much money they have

Priority: Make sure that people who are the health the fastest.

Why and where is this a priority: 20 % of the population of Leeds live in the 10% most deprived Super Output Areas (SOAs) in England accounting for approximately 150,000 people. There are also significant numbers of vulnerable people living across Leeds. There are range of social, economic and environmental factors that affect their health and wellbeing and which are contributing to the growing health inequalities within Leeds for men and women by areas of deprivation:

- There is a 10.1 year gap in life expectancy for men between City & Hunslet and Harewood (71.6 years:81.7years)
- There is a 9.6 year gap in life expectancy for women between City & Hunslet and Adel/Wharfedale (76.1year:85.7years)

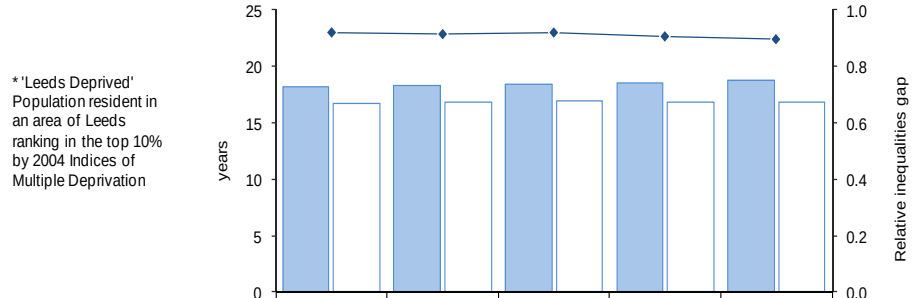
Overall Progress: RED

Headline Indicator

- Reduce the differences in life expectancy between communities
- Reduce the difference in healthy life expectancy between communities

Story behind the baseline: Overall life expectancy in Leeds is increasing however there is a much lower level of life expectancy for those living the most deprived areas of Leeds and the absolute gap between these statistics is increasing. The key causes of premature mortality are cardiovascular disease, cancer, and respiratory disease. All premature mortality data for these diseases in Leeds have a significant gap between the rates in the non deprived areas and the deprived areas of Leeds. For some diseases such as respiratory and stroke mortality rates are showing an increase (see individual disease data for detail). Causes of mortality from these diseases are multifaceted and include the impact of the wider determinants of health such as housing, transport, employment and poverty, as well an individual's lifestyle (in relation to smoking/alcohol/physical activity and healthy eating) , and their access to appropriate and effective services.

Life Expectancy at 65, 2002-2004 to 2007-2009, three year averages, Leeds, Leeds Deprived



	2003 - 2005	2004 - 2006	2005 - 2007	2006 - 2008	2007 - 2009
Leeds	18.2	18.3	18.4	18.5	18.8
Leeds Deprived population	16.7	16.8	16.9	16.8	16.8
Relative Gap Leeds Deprived* vs Leeds	0.92	0.91	0.92	0.91	0.90

data source: Hospital Episode Statistics (HES); GP registered populations

What do key stakeholders think

Public consultation exercises have been recently completed to understand attitudes of people living in the more deprived populations of Leeds to inform service development for early diagnosis of cancer, healthy living services, NHS Health Check, and use of leisure facilities. The findings have been used, and will be used, to increase the access and acceptability of services, interventions and information for target groups.

What we did

Healthy Built Environment and Transport:

- Recommendations from the Rapid Health Impact Assessment carried out with a wide range of stakeholders integrated into the Core Strategy.
- Consultation response on LCC Open Space Assessment completed
- Initial discussions to explore South/East Health and Wellbeing Partnership

New Actions

Healthy Built Environment and Transport:

- Health and LCC planning to integrate health paper within the Core Strategy
- Seek resources and strengthen action to improve health through open spaces, sport and recreation policy.
- Establish a Health and Planning Reference Group to facilitate health

involvement in shaping the Aire Valley Action Plan.

- Childhood Obesity Urban Design Group developed good practice leaflet for planners and Child Friendly City Initiative work with Youth Council to improve active travel.

Healthy workplace: New city wide framework developed targeting working age adults living in areas of deprivation; with mental health (MH); and physical and learning disabilities.

Financial inclusion:

- New MH employment support service includes job retention support for acute and primary care MH service users; employment support targeted at those on Incapacity Benefit
- Appointed Citywide Employment Coordinator to work across MH and employment agencies
- Fuel Poverty Public Health Campaign implemented Autumn 2011.
- 35 'Hot Spots' training sessions have been delivered to Leeds organisations
- 'Biq Squeeze Event' attended by 70 front line workers increasing skills on giving advice to maximise family income
- Debt advice: a new telephone advice gateway introduced with one common phone number for use across all advice agencies.

Ensure equitable access to services that improve health:

- further funding has been agreed to extend the current programme to increase early diagnosis of lung cancer in inner south/ east Leeds until April 2013
- 3 Clinical Commissioning Groups (CCGs) conducted their initial authorisation assessment including importance of equitable access for those most in need

What worked locally /Case study of impact: Following recent publication of the Cold Weather Plan, Leeds was successful in achieving Warm Homes Healthy People grants for c. £200K to raise knowledge and awareness of staff and target audience to prompt early intervention; provide a Crisis Fund specifically for emergency repairs to existing heating, plus emergency temporary heating; provide a Strategic Heating Servicing Fund to prevent vulnerable residents' heating breaking down in winter; expand the Groundwork Leeds Green Doctor Service to provide practical advice on using heating systems efficiently, cold weather information and physical assistance such as pipe lagging for households at risk of cold related ill health; establish a Community Grants Fund with Leeds Community Foundation, to which community organisations can bid for projects providing cold weather assistance to their service users.

involvement in key planning policies and initiatives

- Progress options to utilise leisure centres to increase healthy lifestyle opportunities for the most disadvantage

Healthy workplace:

Partnership action plan to be completed to encourage people back to work, keep people healthy in work and support people to return to work.

Financial inclusion:

- Community Development Finance Institution for Leeds to expand the availability of affordable financial services to low income households. Aim is for CDFI to be in place in first quarter of 2012/13.
- Debt advice: training of volunteers for the telephone gateway project to take place in first quarter of 2012.
- Fuel poverty: Further Hot Spots training sessions to be undertaken for frontline staff, particularly for staff based in health settings.

Ensure equitable access to services that improve health:

- Launch of 'Leeds Lets Change' healthy lifestyle programme January 2012
- Action to increase use of healthy lifestyle services through use of the Leeds Wellbeing portal by NHS services and the public
- Prioritisation process to take place for all new investments within each CCG based on prioritisation toolkit, CCG profiles and practice profiles to be developed based on JSNA
- Agree public health work programme to support GP practices focusing on target practices
- CCG authorisation process to continue to include equitable access

Data Development

- Health and wellbeing survey using Citizens panel to be developed and completed in 2012

Risks and Challenges

- Sustainability of and scale of funding available to meet the needs of the size of the population in Leeds
- Increase in energy prices and other costs living with increases risk to health and wellbeing of more vulnerable people
- City wide structures under development (Health and Wellbeing Board) and other City Partnership Boards
- Balancing the planning for housing growth with the need to retain green field sites and development in areas of deprivation with aspirations of developers for attractive sites.

Glossary and note on some key performance terms

A&E. Accident and emergency services.

Ambulatory conditions. Chronic medical conditions that can often be managed outside hospital.

BME. Describes black and minority ethnic persons and refers to people who do not define themselves as white.

CAMHS. Children and Adolescent Mental Health Services, for young people to the age of 16.

CBT. Cognitive Behaviour Therapy, a technique used to treat mental health patients.

CCG, Clinical Commissioning Group. Groups, led by GPs that will, from April 2013, be responsible for designing and commissioning (buying) local health services, including most hospital care. There will be three CCGs in Leeds, commencing to operate formally from April 1 2013.

Choose and Book. A national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital or clinic.

CKD. Chronic kidney disease.

Clock stops. The point in time at which a patient is deemed to be no longer waiting perhaps ,but not always, because they have been seen and treated.

Commissioning Outcomes Framework (COF). The set of health outcomes on which CCGs will be performance managed by the NHSCB.

Common Assessment Framework (CAF). A process used by practitioners to identify a child's or young person's needs early, assess those needs holistically, deliver coordinated services and review progress.

COPD. This refers to Chronic Obstructive Pulmonary Disease, the occurrence of chronic bronchitis or emphysema, often co-existing diseases of the lungs in which the airways become narrowed.

CPA. Care Programme Approach, a system of addressing the clinical needs of mental health patients.

CPP. Child Protection Plan, an order put in place for where a child is at risk of significant harm, through abuse or neglect.

CSLT. Children's Services Leadership Team.

DNA. Did not attend, used to describe patients who fail to present for agreed appointments.

Endoscopy. A minor medical procedure which allows a doctor to look inside human bodies using an instrument called an endoscope.

FFCE/FCE. First/Finished Consultant Episode, a term used to describe the point at which a patient receives care from a consultant or consultant-led team.

Diabetic Ketoacidosis. A condition caused by a drop in insulin levels in the body.

LAC. Looked after children, or children in care.

IFA. Independent fostering agency (placements of children).

IRO. Independent Reviewing Officer, a person who quality assures the care planning process for each child, and to ensure that his/her current wishes and feelings are given full consideration.

JESS. Describes a school based cluster of services for children, set in South Leeds.

LCC. Leeds City Council.

LCH. Leeds Community Healthcare Trust.

LRTI. Lower respiratory tract infection, can be pneumonia, but also describe other types of infection including acute bronchitis. Often more serious than upper tract infections.

LTC. Long term condition, a condition that cannot be cured but can be managed through medication and/or therapy.

LTHT. Leeds Teaching Hospitals Trust.

MAR. Monthly activity return, a statement of GP and hospital activity, used to support the delivery of the SIP and QIPP. It does not cover all types of activity and should be seen as separate to the information provided via SUS.

MH. Mental health.

MH Fairs Shares split. A locally agreed simple mechanism for apportioning population and finance across the Clinical Commissioning Groups, in the absence of detailed national guidance.

MIU. Minor injury unit, a place where minor injuries and accidents can be treated. Leeds has two such units, one at the St Georges Centre and one at Wharfedale Hospital.

MRC Dysnopea Scale. The Medical Research Council Dysnopea Scale is a measure of breathlessness, associated with COPD.

MRSA & C.Diff. Methicillin-resistant Staphylococcus aureus & Clostridium Difficile, both are infections that can on occasions be associated with healthcare.

MST. Multisystemic therapy is a family/community-based treatment designed to address serious antisocial behaviors of children and adolescents, who are at risk for out-of-home placement.

Myocardial infarction. Another term for heart attack.

NHSABL. NHS Airedale, Bradford and Leeds, the Primary Care Trust. Due to be abolished at the end of March 2013, to be replaced in large part by CCGs.

NHS Commissioning Board (NHSCB). The top level body of management within the NHS, formally established in Oct 2012.

NHS Healthcheck. Carried out by GP practices, to check the health status of people aged 40-74 for overall health and key medical conditions, including diabetes and blood pressure.

OBA. Outcome Based Accountability, a conceptual approach to planning services and assessing their performance that focuses on outcomes, that services are intended to achieve.

Operating Framework. The set of NHS national standards and targets, often seen as the 'mustdo's'.

PROMS. Patient reported Outcome Measures, a system of reporting based on patinet responses to healthcare questionnaires.

Pulmonary rehab. A therapy designed to help cope with breathlessness and feel stronger and fitter.

QIPP. Quality, Innovation, Productivity and Prevention, an NHS programme to drive up quality, whilst delivering efficiency.

RPA. Raising the Participation Age to 17, for young people to stay in education or training.

RTT. Referral to treatment time, used to support delivery of the national standard to deliver care for hospital patients within 18 weeks.

Single Integrated Plan (SIP). A commissioner based plan agreed with DH, setting out key objectives and including plans for activity levels during the year.

SGO. Special Guardianship Order, intended to provide legal permanence for children who cannot grow up with their birth families. Gives the special guardian legal parental responsibility until the child is 18, but does not completely remove parental responsibility.

SUS. Secondary Uses Service, a nationally organised system for collating and reporting secondary care activity. It is the basis of management of provider contracts.

Threshold. Usually is applied to describe the point at which performance is judged to be acceptable or not. A threshold often lies around a fixed target.

Thrombolysis. Describes the breakdown of blood clots by pharmacological means, colloquially referred to as administering 'clot busting' drugs.

TSL. In Children's Services, Targeted Service Leader has allocated lead professional responsibility to a setting/service in line with agreed protocols.

U-(75/19). Under the stated age.

Unify, Omnibus, Exeter. These are all systems that are used nationally to gather NHS data from providers of care. Commissioners of care, including PCTs, often are also required to submit returns using these systems, too.

Vital Signs. A term originally used to describe a now largely superseded set of NHS performance standards and now sometimes used to describe standards for managing services outside the Operating Framework. .

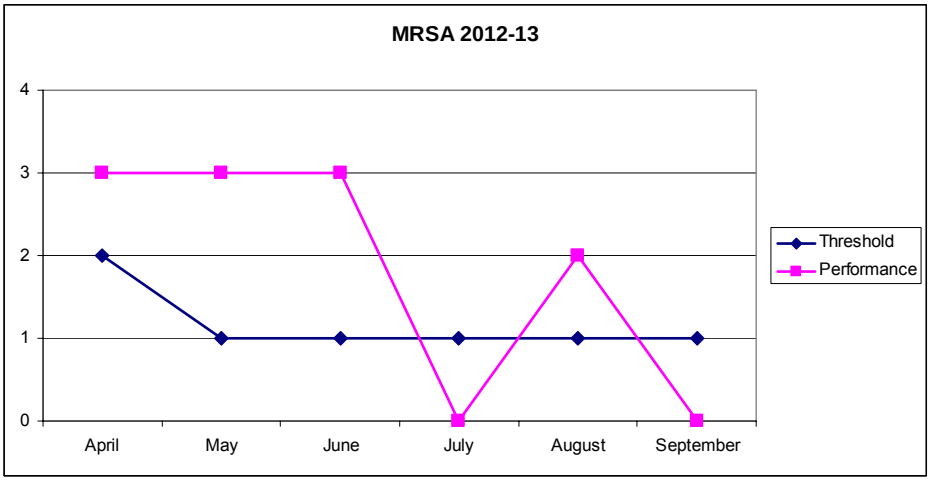
VTE. Venous thromboembolism or deep vein thrombosis/pulmonary embolism, a condition that can occur in patients admitted to hospital.

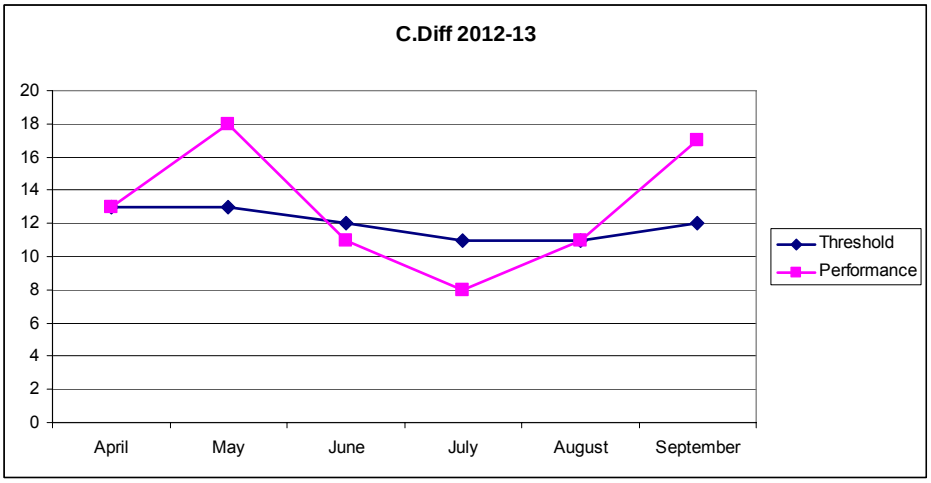
ANNEX C

Quality Summary and Exceptions Report Main Providers

Leeds Teaching Hospitals

1. HCAI





- Concerns relating to increasing number of C.Diff infections, particularly going into the winter period
- Concerns relating to low numbers of staff registered on ESR as having received infection prevention and control training
- Vascular access devices team delay in implementation
- Difficulties in implementing proactive hydrogen peroxide decontamination programme due to lack of availability of decant facilities

2. Serious Incidents

	09/10	10/11	11/12	12/13 (to date)
Leeds Teaching Hospitals NHS Trust	25	20	24	12

- Number of SI's has remained more or less static over the past four years.
- All serious incidents are discussed and monitored at the Quality and Audit meeting. In future this will be undertaken through the quality and performance group.

3. Never Events

The Trust has reported two never events in September:

- Misplaced naso-gastric tube – tube inserted into pleural space but not clear on x-ray. Feeding commenced – patient required chest drain. The Trust has previously reported two misplaced naso-gastric tube never events,

- Wrong site surgery – excision of incorrect lesion from patient's back. The Trust has reported one previous similar incident.

The CCG is awaiting reports and action plans on both incidents. The Trust has reported a total of eight never events since February 2011

4. Mixed Sex Accommodation Breaches

- There have been no breaches of EMSA guidelines this year.

5. CQC Inspections

The CQC has published four reports this contractual year relating to site visits.

April – ENT and orthopaedics LGI. Inspectors found that the Trust was not meeting two of the three standards inspected and issued a compliance notice.

May – Orthopaedics and cardiology LGI. Inspectors found the Trust to be compliant with the standards inspected and that required improvements had been made.

May - Termination of pregnancy SJUH. Inspectors found the Trust to be compliant with the standard inspected

May – Acute medicine, stroke rehabilitation, medical admissions SJUH. Inspectors found the Trust to be compliant with the standards inspected.

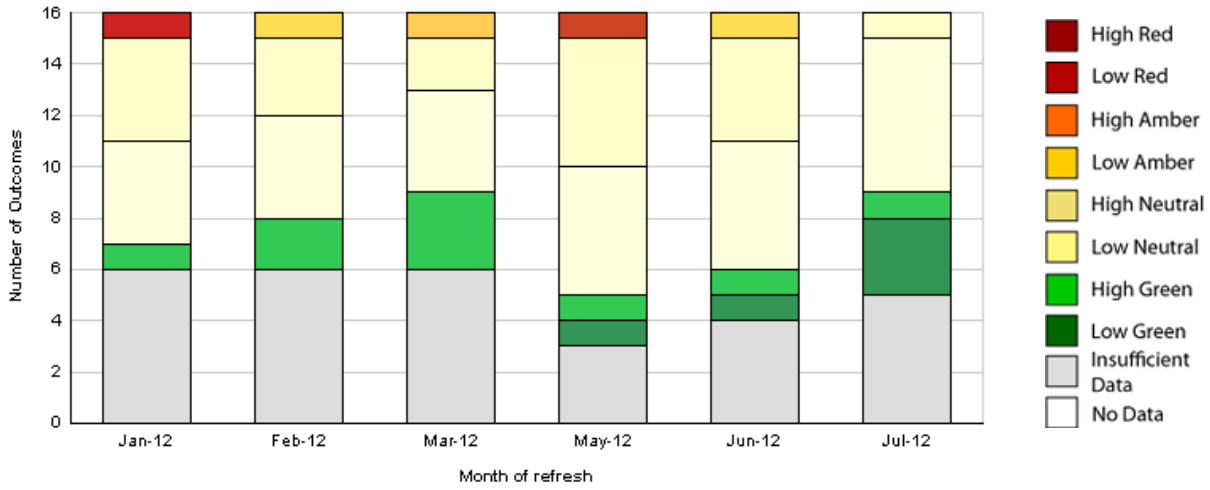
At time of reporting the CQC have just completed an unannounced visit to an othoapaedic ward and a neurosurgical ward. Early indications are that there were no findings of major concern. A written report with outcomes will follow.

6. CQUIN

Indicator Name	Indicator Weighting	Notional Financial Value of Indicator	Q1 Performance
VTE Risk Assessment	5%	£700,000	Met *
Patient Experience	5%	£700,000	N/A
Assessment for dementia	5%	£700,000	N/A
Patient Safety Thermometer	5%	£700,000	N/A
Pressure Ulcers	11%	£1,540,000	Met
Falls	11%	£1,540,000	Met
Respiratory Care Bundles	12%	£1,680,000	N/A
Learning Disabilities	11%	£1,540,000	Met
Patient Discharge	11%	£1,540,000	N/A
Fractured Neck of Femur	11%	£1,540,000	Met
Clinical pathways	13%	£1,820,000	Met*
	Total	**£14,000,000**	

*It was considered by the commissioner that the Q1 submission did not include the appropriate data. It was recognised that further work was required that would lead to a robust proposal in Q2.

7. Quality and Risk Profile



NB The areas marked 'insufficient data' indicates that the CQC have assessed that there is insufficient information available/published to be able to make a judgement of risk of non-compliance. It is not a reflection of the provider

8. Issues of note

Staffing

- LTH have been actively recruiting externally over the course of the spring and summer with significant success.
- Since the beginning of July have had 72 registered staff commence in post with a further 48 staff with a confirmed start date and 147 with completed pre-employment checks but start dates to confirm. A further 70 registered staff have been appointed and are in the process of pre-employment checks.
- New starters are being prioritised to areas of highest vacancy.
- Continue to be actively recruiting clinical support workers and a further cohort of 20 apprentice clinical support workers commenced in September
- Concerns raised regarding apparent reduction in ICU/HDU beds at SJUH. Update received from Craig Brigg. Number of beds stated as closed on the sitrep doesn't reflect true state.
- Staffing issues relate to reduced junior medical cover and loss of the second anaesthetic registrar rota

Friends and Family Test

- All acute Trusts required to implement 'Friends and Family' test by April of next year. However there is an expectation that Trusts will be submitting data by December of this year.
- SHA requiring state of readiness survey to be completed by 11th October
- Final guidance only just released this week

Leeds and York Partnership Foundation Trust

1. HCAI

There have been no reported cases of MRSA or C.Diff this year

2. Serious Incidents

	09/10	10/11	11/12	12/13 (to date)
Leeds and York Partnership Foundation Trust	20	17	29	10*

*Three of these relate to services provided in North Yorkshire and commissioned by NHS North Yorkshire and York PCT

- Work is ongoing in improving the reporting and investigation times for SI's and production of associated action plans, supported by a CQUIN indicator. This has led to significant improvement in performance.

3. Never Events

- There have been no reported never events this year

4. Mixed Sex Accommodation Breaches

- There have been no breaches of EMSA guidelines this year.

5. CQC Inspections

The CQC has published two reports this contractual year following inspection visits.

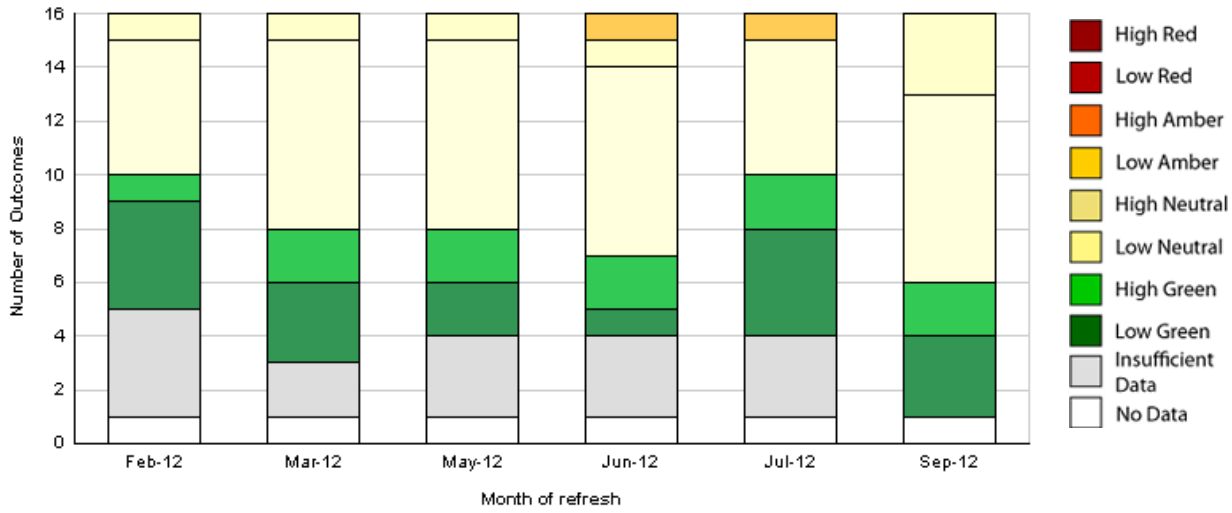
April – Learning disabilities at St Mary's Hospital. Inspectors found the Trust to be compliant with the standards inspected.

May – Low secure forensic inpatients at the Newsham Centre, Seacroft Hospital. Inspectors found the Trust to be compliant with the standards inspected.

6. CQUIN

Indicator Name	Indicator Weighting	Notional Financial Value of Indicator	Q1 Performance
Improving clinical outcomes for people with a learning disability	15%	£338,294	Met
Improving the service user experience at Care Programme Approach reviews	15%	£338,294	N/A
Engaging dementia inpatients in structured activity	15%	£338,294	Met
Improving the implementation of action plan goals following a serious untoward incident which relates to a community patient suspected suicide	20%	£451,059	Met
Patient Safety Thermometer	20%	£451,059	N/A
Improve the health and wellbeing of service users in rehabilitation community units.	15%	£338,294	Met
	Total	**£2,255,294**	

7. Quality and Risk Profile



NB The areas marked 'insufficient data' indicates that the CQC have assessed that there is insufficient information available/published to be able to make a judgement of risk of non-compliance. It is not a reflection of the provider

8. Issues of Note

- There are at present no particular areas of concern in relation to the quality of care provided by L&YPFT
- The corporate governance team continues to work with the Trust in improving the timeliness of reporting of serious untoward incidents.
- A routine thematic review of SIs in currently underway.

Leeds Community Healthcare

1. HCAI

There have been no reported cases of provider attributable MRSA or C.Diff infections this year

2. Serious Incidents

	09/10	10/11	11/12	12/13 (to date)
Leeds Community Healthcare	15	5	6	2

3. Never Events

- There have been no reported never events this year

4. Mixed Sex Accommodation Breaches

- There have been no breaches of EMSA guidelines this year.

5. CQC Inspections

- There have been no CQC inspection visits conducted this contractual year.

6. CQUIN

Indicator Name	Indicator Weighting	Notional Financial Value of Indicator	Q1 Performance
Patient Safety Thermometer	6.7%	£167,955	N/A
VTE Risk Assessment	6.7%	£167,955	Met
Dementia screening and diagnosis	6.7%	£167,955	N/A
Health Assessments for Looked After Children	23.9%	£599,123	Met
Development of Peer Review	28%	£701,901	Met
Making Every Contact Count	28%	£701,901	Met
	Total	**£2,506,790**	

7. Quality and Risk Profile

- At present the CQC does not publish QRPs for community health providers

8. Issues of Note

- There are at present no particular areas of concern highlighted in relation to the quality of care provided by LCH

Russell Hart-Davies
Quality Development Manager
October 2012