Leeds Health & Wellbeing Board

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Report of **CCG Planning Leads**

Report to: **Leeds Health & Wellbeing Board**

Date: **27 March 2014**

Subject: **The 3 Leeds CCGs' 2-year operational plans**

Are there implications for equality and diversity and cohesion and integration?	☐ Yes	☒ No
Is the decision eligible for Call-In?	☐ Yes	☒ No
Does the report contain confidential or exempt information? If relevant, Access to Information Procedure Rule number: Appendix number:	☐ Yes	☒ No
Term of reference under which the report is submitted:		

Summary of main issues

The Government published planning guidance called Everyone Counts: Planning for patients 2014/15 – 2018/19 in December of last year. This sets out the requirements for CCGs to submit a number of pieces of information to support our planning. They include financial templates, provider activity forecasts, the city's Better Care Fund plan and our 2-year CCG operational plans. All of these documents were submitted in draft format on 14 February, and final versions will be submitted by 4 April.

Each CCG is required to set an appropriate level of ambition for improvement against each of the Quality Premium national indicators, and the locally determined Quality Premium indicator. In signing off local plans, the Health and Wellbeing Board should be mindful of the link to the levels of ambition on outcomes that CCGs have been asked to set as part of their wider strategic and operational plans. Both the effectiveness of reablement and avoidable emergency admissions outcomes metrics are consistent with national metrics for the Better Care Fund, and so the Health and Wellbeing Board will need to ensure consistency between the CCG levels of ambitions and the Better Care Fund plans.

Recommendations

The Health and Wellbeing Board is asked to:

- Agree the levels of ambition and trajectories for Potential years of Life Lost for each CCG
- Agree the locally chosen Quality Premium for all three CCG
- Agree the locally chosen patient experience Quality Premium measure for each CCG
- Agree the locally chosen ambition for medicines error reporting for all three CCGs

1. Purpose of this report

1.1 In the Leeds health economy, we have already worked with many stakeholders including the Health and Wellbeing Board to agree existing CCG plans. We will maintain this engagement and ensure that this process continues as broader plans are refreshed and updated in the light of progress to date. The Health and Wellbeing Board will want to assure itself that CCG plans are consistent with the overarching Joint Health & Wellbeing Strategy for the area.

There are some very specific areas of the CCG 2 year operational plans however which need to be discussed and agreed with the HWB and this paper sets out those specific areas within our 2-year operational plans for each of the three Leeds CCGs.

2. Background information

2.1 Previous background papers were circulated and presented to the HWB at its meeting on 12 February 2014

2.2 The methodology for setting our trajectories has started with information made nationally available by NHS England through various databases. This has initially been used to produce baselines and data-only based trajectories. We have then compared ourselves with our demographically similar peer group CCGs (defined by NHS England) to suggest revised trajectories for our levels of ambition. We have then spoken with key stakeholders including our provider management groups, clinical leads, commissioning leads, data analysts and Public Health colleagues from the Local Authority to "sensecheck" their thoughts on these proposed trajectories. Following our draft submission on 14 February, we have continued to work with our partners to ensure our ambitions are realistic, achievable, yet have a reasonable degree of stretch to them. This work will continue until the submission of the final plan on 4 April.

2.3 Outcome measures

2.3.1 Potential Years of Life Lost (PYLL) from causes considered amenable to healthcare

Reducing premature mortality is an aim that is shared between the NHS and public health frameworks. The contribution that can be delivered by the NHS is best measured by potential years of life lost from causes considered amenable to healthcare. CCGs will be able to determine which aspects of premature mortality are of greatest relevance in their local population.

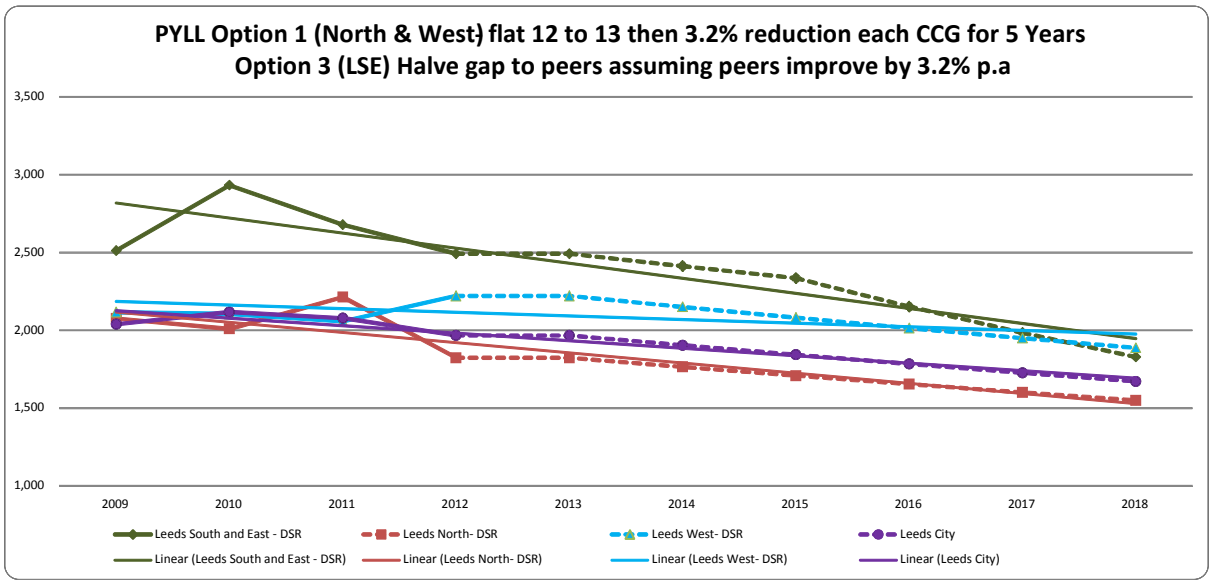
CCGs will have the most significant impact in reducing premature mortality by determining which contributing factors are of greatest impact to their local population, particularly taking into account the causes of premature mortality for those living in areas of deprivation.

There is a collection of indicators that are used to help organisations to measure health and represents a number of causes and conditions that are considered to

be amenable to healthcare – which for all of our CCG populations is dominated by CVD, cancer and respiratory diseases. A full list of these is available at Appendix 1.

Nationally there is an expectation that all CCGs aspire to improve on this indicator by a minimum of 3.2% per annum for the next five years. The graph below contains the four year baseline of available data up to 2011/12 and on which to base our trajectories in Leeds. It illustrates the ambitions set for each CCG which are currently set at different levels for each CCG in order to address differential need.

Potential years of life lost from causes considered amenable to healthcare (DSR per 100,000)



Leeds City would move from 1968 PYLL/100,000 (DSR) in 2012 to 1587 PYLL/100,000 (DSR) in 2018 (a 19.4% improvement in the 5 years to 2018).

<u>Leeds North CCG</u>

The CCG would move from 1825 PYLL/100,000 (DSR) in 2012 to 1551 PYLL/100,000 (DSR) in 2018 (a 15% improvement in the 5 years to 2018).

Leeds North recognises that it has set a trajectory that is aligned to the National minimum level. In comparison to other Leeds CCGs and those with similar demographics, its performance in this outcome measure is already just below the National top quintile and its citizens have fewer years of life lost that are amenable to healthcare than those in these other CCGs. As such, it appears that initiatives previously undertaken across the city have already had a greater effect for the Leeds North population; evidence exists to show that working locally with practices on their active maintenance and management of patient lists has resulted in a reduction in PYLL. Setting a trajectory of “do nothing more” suggests that by continuing to do what we are currently doing, we would achieve 11.3% reduction in this measure over the five years. Setting a higher ambition could be difficult to achieve given the data evidence that citizens of Leeds North have already benefitted more from current initiatives and therefore there are fewer people to target; additionally, further

significant achievement of ambition might result in an increasing inequality across the City. Leeds North has therefore chosen its ambition at the national minimum, and will concentrate its efforts on targeted areas of deprivation across its population.

Leeds South and East CCG
The CCG would move from 2493 PYLL/100,000 (DSR) in 2012 to 1830 PYLL/100,000 (DSR) in 2018 (a 26.6% improvement in the 5 years to 2018).

Leeds South & East has set a more ambitious trajectory on this measure to reflect the needs of its population, the need for Leeds as a city to address inequalities across the city, and the distance it is currently from its peer group average. The additional modelling will inform the feasibility of this and the level of ambition will then be revisited.

Leeds West CCG
Although Leeds West CCG does not have the lowest PYLL in Leeds or when compared to the best in the country our figures are in line with CCGs who have a similar demography.

Leeds West CCG is therefore proposing that we aim to reduce PYLL by 3.2% per annum over the next 5 years. If achieved the CCG would move from 2223 PYLL in 2012 to 1889 PYLL in 2018 (a 15% improvement in the 5 years to 2018).

2.3.2 Reducing emergency admissions

This measure is based on the admissions for diagnoses measuring emergency admissions for those conditions (sometimes referred to as 'ambulatory care sensitive conditions') that could usually have been avoided through better management in primary or community care. This is a composite measure of:

a) unplanned hospitalisation for chronic ambulatory care sensitive conditions (adults);
b) unplanned hospitalisation for asthma, diabetes and epilepsy in children;
c) emergency admissions for acute conditions that should not usually require hospital admission (adults);
d) emergency admissions for children with lower respiratory tract infection.

Reducing emergency admissions is part of the successful Leeds application for Pioneer status, which in turn is covered within the submission of the Better Care Fund plan. As such this outcome measure is contained within the Better Care Fund plan, being considered separately by the Health and Wellbeing Board. As the initiatives to deliver the strategy and the BCF are developed and the financial and impact modelling is done, the trajectory may be revised further.

2.4 Quality Premiums

2.4.1 Friends and Family Test

CCGs will work with NHS providers to develop a systematic approach to improving patient experience (in line with the Keogh Review report), with significant patient involvement. This should include ensuring that the views of patients and related

data, including information from complaints and Patient Led Assessments of the Care Environment, are gathered, used, acted upon and publicly reported. CCGs should develop similar, higher level systematic approaches, linked to Quality Surveillance Groups that help identify action needed to improve patient experience along pathways.

The NHS Friends and Family Test is part of this systematic approach to improving patient experience and is based on one simple question that ensures that local hospitals and the public get regular, up to date feedback on what patients think about their services The CCGs have committed to work with all local providers to support roll out of the Friends and Family Test to the agreed national timescales.

Additionally each CCG is required to select a further measure from one of the patient experience indicators set out in the CCG Outcomes Indicator Set. Each of these measures is taken from a selection of questions posed in National surveys undertaken by the Care Quality Commission (CQC). The requirement is simply to show an improvement from our current position. In all cases, no baseline is available as they are a composite of a sub-set of questions taken from a National survey. There is no indication which questions these are. There is inclusion, as a CQUIN (Commissioning for Quality and Innovation), within provider contracts where appropriate

Leeds North CCG

In line with our choice of the local Quality Premium (see below), Leeds North CCG has selected Improving Patients' experience of Community Mental Health Services as an improvement measure. The indicator is a composite measure, calculated as the average score of four survey questions from the CQC's Community Mental Health Survey. The questions relate to patients' experience of contact with a health and social care worker.

Leeds South and East CCG

Leeds South & East has selected 'Improving women and their families' experience of maternity services' as its additional measure. The CCG is the lead commissioner citywide for Maternity Services, and with the potential reconfiguration of Maternity Services in the city it will be important to focus on maintaining and improving patient experience of these services. We will be working with our providers over the forthcoming few weeks to agree our level of ambition and to ensure that they have plans in place to improve scoring in line with the agreed trajectory.

Leeds West CCG

Leeds West has chosen Patient Experience of Outpatient Services as its Quality Premium measure. The indicator is a composite measure, calculated as the average score of some of the survey questions from the CQC's Outpatient Survey. The questions relate to patients reported experience when attending outpatients across the city's hospitals. Our main focus will be improving patients' experience of services at our main provider.

2.4.2 Quality Premium: Self certification re improving reporting of medication errors

Research shows that organisations which regularly report more patient safety incidents usually have a stronger learning culture where patient safety is a high priority. By improving reporting in the short term, the NHS can build the foundations for driving improvement in the safety of care received by patients.

At a system level, through high reporting, the whole of the NHS can learn from the experiences of individual organisations.

A Health Economy wide push on medication safety would improve the effectiveness and safety of patient care and, for around 1 in every 10 people who receive NHS care, improving their experience.

This is an area that Leeds is good at, and can capitalise on in terms of patient care and national reputation.

Figures from the NRLS indicate that each of our providers are in the top quartile in comparison with similar organisations. The table below indicates for each of these organisations the national position and the number of reports and % attributed to medicines related incidents

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	National position for incidents	Approximate number pa	% of these which are medicines related
LYPFT	15th out of 56	700	10.8%
LTHT	7th out of 30 Trusts	1600	9.1%
LCH	3rd out of 19	500	24.1%
Primary Care	Unknown*	100 - 200	47.9%

Greater access and better awareness than other areas so likely to be higher than most

Using our local reporting system, we know that GP reporting is however less developed. There may be a number of reasons for this including: poorer supporting systems for incident reporting in primary care, the need for cross organisational and computer communication between CCG and practice for incident clarification and follow up, lower awareness of reporting systems available and the nature of the reporting interface which is not easily utilised by GP clinicians.

We will continue to develop processes for reporting in primary care and develop a culture of familiarly by practices that allows quicker reporting process. We will also need to explore developing incentives to practices to encourage reporting. This will vary across CCGs.

The targets that we have set reflect the differences observed and the respective challenges involved. The modest challenge in primary care reflects the need to develop better systems, to engage practices who previously have not been engaged and to allow for local variations in incentives to be implemented.

Medicines incident reporting is just one element of the CCG quality and safety agenda and fits with a raft of other CCG initiatives around cross systems reporting and learning.

As part of the Quality Premium proposal it is recommended that we include an undertaking from the CCG, LCH, LTHT and LYPFT to continue to work collaboratively to improve Medication Safety, building on the work of the Medicines Safety Exchange (a sub-group of the Leeds Area Prescribing Committee) and leading the development of the Patient Safety Collaborative and National Medicines Safety Network.

The recommendation of the Leeds CCG's Joint Medicines Optimisation Group is to take a collaborative city wide approach. An overall increase (minimum of 5% increase from Q4 2013/14) in the total numbers of medication incident reports from across LTHT, LYPFT, LCH and General Practice with a minimum of a 20% increase from primary care, general practice.

Each CCG may determine a further stretch target for General Practice reporting according to local arrangements, systems and agreed incentives– for example this might be equivalent to 1 medication incident report per practice per month. With around 120 practices in Leeds, this equates to a target of reporting some 1500 medication errors. Each CCG will determine a stretch target for General Practice reporting.

Additionally further work is to be undertaken on the potential use of CQUINs for LCH and LYPFT as an incentive to achieve more stringent trust specific targets.

2.4.3 Local Quality Premium

Leeds North CCG

From the national CCG outcome indicators set, Leeds North CCG has selected 'People with severe mental illness who have received a list of physical checks' as the CCG local Quality Premium indicator. This is in line with Health and Wellbeing Board and CCG priorities for mental health and reflects the specific interest in mental health held by the CCG, in its capacity as the lead contractor of mental health services for Leeds.

During 2014/15 we will work with our practices to deliver an improvement in the number of patients with SMI who have received a list of six physical health checks. LNCCG view increasing the parity of esteem for people with mental health issues as a key priority and want to deliver a measured improvement in this area.

The CCG has undertaken a structured approach to analyse the most locally appropriate measures as a potential local QP for the CCG. This has included data analysis, input from Public Health, extensive engagement with clinical and managerial stakeholders. The chosen indicator directly supports the Health and Wellbeing Board's priorities of improved access to improve peoples' mental health and wellbeing and ensuring people have equitable access to services.

The proposed measure is that the CCG will deliver a 10 percentage point increase in a composite measure consisting of the three of the six indicators which will be removed from QOF in 2014/15 (cholesterol:hdi ratio, BMI and HbA1c). The CCG will work with practices in year to ensure existing levels of attainment of these three checks are maintained and improved.

Leeds South and East CCG

It is proposed that Bowel Screening Uptake rate is the local Quality Premium measure for LSE CCG for 2014 to 2016. This is in line with Priority 3 in the Joint Health and Wellbeing Strategy, to ensure that people have equitable access to screening and prevention services to reduce premature mortality. Bowel screening uptake has been a local quality premium measure for 2013/14. Selection was made on the basis of low uptake rate across the CCG at 53.8% at the end of 2012/13. In addition there is great variability between practices with a range from 16.2% to 70.2%.

The plans to improve uptake in 2013/14 initially included:

- Development of local QOF quality premium for patient follow-up for non-attenders
- Initial publicity campaign
- Discussion on options for pre-appointment letters to be sent from practices to patients to inform them of programme

Due to difficulties with staffing to support development of the programme there has been a significant delay in implementation, including the supporting publicity campaign. At this stage it is proposed that this should now take place in April 2014 in order to be tied into national bowel cancer screening month activities. This will also enable us to work with community groups in the more challenging areas in order to set up access to community support in line with the timing of the publicity campaign. The latest available data is for July 2013. This gives a CCG rate of 52.5% and a range from 17.8% to 66.7%.

Given the delays, the latest data on uptake rates and the ambition to improve emergency presentations for cancer it is proposed that LSE continue to focus on improving overall uptake rates for bowel cancer screening and significantly reducing variation in uptake rates. The ambition will be to achieve an overall 60% uptake across the year and therefore to achieve over 60% by Q4. Draft modelling on which the draft submission is based would give 65% in Q4. This may be revised for the final submission if later data is available on which to revise planning assumptions.

Leeds West CCG

Alcohol misuse is also a key Health and Wellbeing Strategy priority for the city. NHS Leeds West CCG has high levels of emergency admissions as a result of alcoholic related liver disease when compared to national benchmarks i.e. currently 42.6 people per 100,000 per year as against a national average of 25.7.

As levels of admission are an indicator of impact and any actions we put in place are likely to take some time to filter through we are proposing using % of estimated numbers of alcohol dependent drinkers being provided with specialist treatment as the measure by which we will track our progress in addressing this issue in year

Through our commissioning plans we will aim to raise our treatment rate from 12% in 2013/14 to 14% in the coming year. This will mean a 12.5% increase in numbers treated over the coming year.

3. Main issues

3.1 This paper has summarised some of the extensive work to get us to this point in time since the Government issued Everyone Counts in December 2013 and subsequent further planning guidance to accompany this. The areas for the Board's consideration link very clearly to the priorities of the JHWS, the Better Care Fund and also the 5-year strategic plan. Agreement and understanding of this work is a component part of the wider process.

4. Health and Wellbeing Board Governance

4.1 Consultation and Engagement

4.1.1 A cross-city planning group has helped lead the process involving Chief Finance Officers, Directors of Commissioning, Planning Leads and Provider Management Leads. Providers are aware of this process and ambitions through negotiation strategy. This group reports directly to the CCG Network. The work on trajectories has been shared with Public Health colleagues, Boards, Governing Bodies, GP Portfolio Leads and PPI groups. As the trajectories are further informed by trajectories for sub indicators and financial modelling these bodies will continue to be engaged and informed. It forms part of the refresh of CCG plans which will be published on our respective websites shortly.

4.2 Equality and Diversity / Cohesion and Integration

4.2.1 On their own, the outcome measures and quality premiums for these trajectories are nationally set. We are committed to undertaking the relevant impact assessments and whatever further work is necessary to address all nine protected characteristics. We are especially mindful of recent feedback from the recent Equality Advisory Panel event which highlighted a number of opportunities in this area.

4.2.2 All Leeds CCGs will give particular emphasis to Equality and Diversity as plans are developed and investment agreed in order to address inequalities within the CCG area and between the CCG and the rest of Leeds in line with the CCG and Joint Health and Wellbeing Strategy aims.

4.3 Resources and value for money

4.3.1 These outcome measures cover many existing programmes of work and projects. It is for each of these to be held account though existing governance mechanisms both within individual CCGs and across the City. Where any additional expenditure is required there are established processes for all commissioning intentions and these will have already been included.

4.3.2 We will be held to account for these together with existing performance measures within the NHS Constitution and Mandate.

4.4 Legal Implications, Access to Information and Call In

4.4.1 There are no direct legal implications of this report. There is no confidential information of implications regarding access to information. It is not subject to call-in.

4.5 Risk Management

4.5.1 There are a number of risks associated with setting these ambitions:

- Inability to effectively communicate the variations in ambition to citizens may cause disquiet
- Misalignment with provider plans might result in capacity issues in the system to meet demand
- There is a financial risk associated with the non-achievement of Quality Premiums, and there needs to be a balance between realism and aspiration in the trajectories that are set

4.5.2 There are of course mitigation actions in place for all of these risks to minimise them to:

- Continuing to work closely with all providers in developing services and pathways that support our ambitions
- Robust engagement with our member practices to support achievement of Quality Premiums
- Planned engagement process established patients, practices and existing involvement governance structures such as Patient Assurance Groups
- Engagement with the 5 year strategy to ensure alignement with provider plans through the Transformation Board

5. Conclusions

5.1 It is important that these specific trajectories and measures are aligned to the ambitions of the Joint Health and Wellbeing Strategy.

6. Recommendations

6.1 The Health and Wellbeing Board is asked to:

- Agree the levels of ambition and trajectories for Potential years of Life Lost for each CCG
- Agree the locally chosen Quality Premium for all three CCG
- Agree the locally chosen patient experience Quality Premium measure for each CCG
- Agree the locally chosen ambition for medicines error reporting for all three CCGs