NHS
Leeds North
Clinical Commissioning Group

Everyone Counts: Planning for Patients 2014/15 to 2018/19

Narrative to underpin Unify template submitted by Leeds North CCG (14 February 2014)

1. Self certification: delivery of all NHS Constitution performance standards

Leeds CCGs have undertaken a review of all commitments outlined in the NHS constitution. The table below outlines our current understanding of projected year-end performance and degree of risk associated with delivery of standards in 2014/15.

Pledge	2013/14 Projected Delivery	Risk to Delivery 2014/15 – 2015/16
Referral To Treatment waiting times for non-urgent consultant-led treatment		
Admitted patients to start treatment within a maximum of 18 weeks from referral – 90%		
Non-admitted patients to start treatment within a maximum of 18 weeks from referral – 95%		
Patients on incomplete non-emergency pathways (yet to start treatment) should have been waiting no more than 18 weeks from referral – 92%		
Diagnostic test waiting times treatment		
Patients waiting for a diagnostic test should have been waiting less than 6 weeks from referral – 99%		
A&E waits treatment		
Patients should be admitted, transferred or discharged within 4hours of their arrival at an A&E department – 95%		
Cancer waits – 2 week wait treatment		
Maximum two-week wait for first outpatient appointment for patients referred urgently with suspected cancer by a GP – 93%		
Maximum two-week wait for first outpatient appointment for patients referred urgently with breast symptoms (where cancer was not initially suspected) – 93%		
Cancer waits – 31 days treatment		
Maximum one month (31-day) wait from diagnosis to first definitive treatment for all cancers – 96%		
Maximum 31-day wait for subsequent treatment where that treatment is surgery – 94%		
Maximum 31-day wait for subsequent treatment where that treatment is an anti-cancer drug regimen – 98%		
Maximum 31-day wait for subsequent treatment where the treatment is a course of radiotherapy – 94%		
Cancer waits – 62 days treatment		
Maximum two month (62-day) wait from urgent GP referral to first definitive treatment for cancer – 85%		
Maximum 62-day wait from referral from an NHS screening service to first definitive treatment for all cancers – 90%		
Maximum 62-day wait for first definitive treatment following a consultant's decision to upgrade the priority of the patient (all cancers) – no operational standard set		

Category A ambulance calls treatment		
Category A calls resulting in an emergency response arriving within 8minutes – 75% (standard to be met for both Red 1and Red 2calls separately)		
Category A calls resulting in an ambulance arriving at the scene within 19 minutes – 95%		
Cancelled Operations		
All patients who have operations cancelled, on or after the day of admission (including the day of surgery), for non-clinical reasons to be offered another binding date within 28 days, or the patient's treatment to be funded at the time and hospital of the patient's choice.		
Mental health		
Care Programme Approach (CPA): The proportion of people under adult mental illness specialties on CPA who were followed up within 7 days of discharge from psychiatric in-patient care during the period – 95%.		
ADDITIONAL REQUIREMENTS FOR 2014/15		
Mixed Sex Accommodation Breaches		
Minimise breaches		
Referral To Treatment waiting times for non-urgent consultant-led treatment		
Zero tolerance of over 52 week waiters		
A&E waits		
No waits from decision to admit to admission (trolley waits) over 12 hours		
Cancelled Operations		
No urgent operation to be cancelled for a 2nd time		
Ambulance Handovers		
All handovers between ambulance and A & E must take place within 15 minutes and crews should be ready to accept new calls within a further 15 minutes.		

Key Risks

Referral to Treatment (RTT) Admitted Patients (and new 52 week waiter target): There has been a 50% reduction in the numbers of over 18 week admitted patients during the year and numbers continue to decline, but this has impacted on the delivery of the 90% admitted standard. Whilst the 52 week standard has been met from part way through the year and all providers have successfully tackled their very longest waiting patients the growth in demand for some secondary and tertiary care services creates a risk to delivery of RTT waiting times at a specialty or sub specialty level. To address this the following actions are being undertaken:

- Leeds CCGs have commissioned appropriate additional levels of activity as compared with 2013-14 forecast out turn. CCGs have commissioned circa 3% additional new outpatients and between 1.3 and 1.9% in electives.

- RTT performance is formally monitored through the monthly Elective Care Activity & Performance meeting which reviews performance at a specialty and sub-specialty level, identifying areas of growth in demand, risk and poor performance.

- Performance risks for 2014-15 have been identified in relation to a number of core and specialist commissioned services notably in relation to some specialist pathways e.g. neurosurgery and specialist foot and ankle surgery and we are encouraging LTHT to discuss these further with NHS England.

- CCGs are continuing their work on locally commissioned pathways for urology, gastroenterology, colorectal and endoscopy services across the city with the aim of improving the quality of referrals to hospital, broadening access to community alternatives and reducing demand in challenged specialties.

- CCGs are in discussion with their main providers to seek assurance on their ability to increase capacity above this level and will invest where required to support non recurrent clearance of backlogs. The new management team at LTHT is further reviewing all the outpatient waiting times and the potential impact on elective capacity required through the further clearance of these to more sustainable wait times.

- In addition to working with our acute providers we continue to develop systems for practice level peer review of referral behaviour to reduce variation in referrals. This approach is expected to have a further beneficial impact in normalizing referral patterns.

Diagnostic Waiting Times: Diagnostic performance has improved in 13/14 through increased capacity and improved performance management within providers. However there is an outstanding risk to ensuring that providers develop the endoscopy capacity in order to keep pace with growing demand. To address this:

- An additional 6% capacity has been commissioned for endoscopy procedures from the main provider and commissioners continue to ensure that other capacity is appropriately targeted. This is designed to support the work within the CCGs to improve early detection of cancer. Additional capacity has also been commissioned for growth in breast referrals and improvements in dementia diagnosis.

- Diagnostic performance is formally monitored through the monthly Elective Care Activity & Performance meeting and areas of pressure are identified.

A&E 4 Hour Wait: Local A&E departments have made significant improvements in performance during 2013-14 and offsetting the challenges related to the national availability of workforce. There has been a successful implementation of the Major Trauma Centre at Leeds General Infirmary and 111. ECIST visited LTHT during the year and their findings have been successfully implemented. To address future risks:

- Work has continued to divert GP admissions and assessment cases away from A&E via a Primary Care Access Line (PCAL). This includes access to geriatrician advice to support diversion and ‘hot clinics’.

- All CCGs have implemented a risk stratification tool in primary care and are now developing surveillance techniques with the aim of reducing avoidable admissions to hospital.

Cancer 62 Day Wait following screening and upgrades: The 62 day screening and upgrade targets are very volatile due to the small numbers. To mitigate this risk:

- Work is being undertaken to ensure that referrals get to providers as early as possible following screening.

- Additional endoscopy capacity is being commissioned to improve capacity for bowel screening positives

Cancer 62 Wait following GP referrals: Following significant improvements in 62 day performance during 12/13 and the early part of 13/14 performance has deteriorated in the final quarter. This has occurred due to capacity problems in urology, lung and gynaecology surgery which have now been addressed. There has also been deterioration in the numbers of referrals coming into LTHT after day 38 from external referrers. To address this the following actions are being implemented:

- LTHT's executive team is working with other providers to reiterate the importance of the referral arriving before day 38.

- Many of the pathways affected are specialist and are part commissioned by NHS England.

Ambulance: Handover (15mins) and post-handover performance (15 mins) remains below the 100% target. However it should be noted by commissioners that average handover time across the city is 9mins35s (8m39s @ LGI, 10m30s @SJUH), with a total turnaround time averaging 25m27s. In 2012/13 (prior to handover data being recorded) it should be noted that only 56.5% of turnarounds were achieved in less than 30mins so a significant improvement has been seen. Leeds commissioners are supporting a contracting position for 2014/15 where handover penalties will be fully applied, and any provider will be able to bid against these monies to improve turnaround performance. Significant increases in reporting compliance is one of the key areas where we would like to see improvement in 2014/15 (joint system compliance of 66% YTD).

2. Self certification: assurance re provider CIPs

The 3 CCGs have developed a process to fulfil the requirement to assure provider CIPs are deliverable without impacting on quality/safety of patient care. The CCGs undertake clinically-led quality impact assessment of all Cost Improvement Plans (CIPs) undertaken by its providers, with oversight by Nursing and Medical Directors of both providers and CCGs. In July 2012 the National Quality Board produced a guide on how to assess provider cost improvement plans; this has been used to support the development of this process.

<u>Role of providers</u>
Providers have a number of responsibilities and requirements:

- Identify CIPs
- Share plans with providers
- Assess impact upon quality of CIPs
- Evidence impact assessment on quality
- Assure Medical and Nursing Directors of the quality assurance process and governance frameworks through which this is monitored
- Be able to describe how risks to CIPs are managed
- Approve CIP Plans

Role of Commissioners

Medical and Nursing Directors of CCGs provide assurance to their Governing Body/Board and Chief Officer of the collaborative approach and management of this process. Other colleagues will need to be involved at various stages throughout. This includes finance, commissioning and performance colleagues.

CCG Governing Bodies/Boards will need to satisfy themselves that providers have a robust assessment process that oversees potential quality indicators that a change to a service or service provision may have on quality.

Process

Each of the Leeds CCGs is the lead commissioner for one of the 3 main providers across the city. The lead commissioner Medical Directors and Directors of Nursing lead on the process with their lead contracted provider.

The Medical Directors and Nursing Directors for all 3 CCGs meet face to face with provider Medical and Nursing Directors, initially to understand the nature and content of the CIPs and be assured that they have been appropriately assessed for impact upon quality. Continued assurance is sought on an ongoing basis. The method, content and frequency is dependent on the level of information shared.

Providers are asked to present their CIPs to the Medical and Nursing Directors of the CCGs. The content of the meeting will include the following elements:

- Has the Chief Executive agreed the governance arrangements and secured Board Endorsement
- Are the Medical and Nurse Directors engaged and leading the process?
- Is the board reporting regime clear?
- Are the arrangements for providing assurance to the board, commissioners, and external agencies clear and ongoing with documented evidence?
- Is the senior management team engaged with this process within directorates/business support units?
- Are other stakeholders briefed and engaged as appropriate?
- Are CIP reports generated and circulated regularly?
- Are arrangements in place to ensure quality is assessed as part of performance reviews to ensure integration with finance, workforce and performance assessment?
- Is the CIP process embedded in governance processes to ensure that risks are identified early and mechanisms in place to manage this?
- Is there a process in place for staff to be able to confidentially report concerns about CIP schemes and their potential impact on safety of staff and patients and experience?

Surveillance:

CIPs are subject to change and need to be dynamic documents since revisions in policy or circumstances require adjustments to the CIP during the year. CCGs seek ongoing surveillance and assurance throughout the year via progress meetings held between the Medical and Nursing Directors of both organisations. Meetings are held quarterly as standard, with further meetings arranged as required where risks have been identified or the CCG has concerns.

Star Chamber

The National Quality Board strongly recommends that CCGs establish and lead a small group comprising staff from areas such as quality, workforce, finance and performance to help undertake the assessment. This approach can be regarded as a 'Star Chamber' and is recommended over the virtual exchange of information, as it is recognised that there is no substitute for face to face discussion when assessing soft intelligence against quantitative data.

The role of the Star Chamber will be to bring all those involved in the CIP process to ensure all aspects have been captured. The Star Chamber will meet twice per year (March and September) as part of the Leeds Quality Surveillance Group and as part of the yearly planning process. The Star Chamber will:

- Be clinically led by the Medical and Nursing Directors
- Challenge the efficacy of CIPs
- Provide a reliable audit trail for future reference

Members of the Star Chamber:

- Nursing and Medical Directors
- Finance Officers
- Directors of commissioning
- A representative of Healthwatch

Members of the Star Chamber who are not formal members of the Leeds Quality Surveillance Group will be invited to the review meeting twice per year as described. The agenda for the Quality Surveillance Group will be given over to the review on the agreed dates.

Directors will take responsibility for ensuring that any comments or concerns regarding the assessment are captured and actioned as part of the ongoing review process.

3. Assurance re zero MRSA in 2014/15 and 2015/16

A comprehensive action plan has been agreed with LTHT, reviewed and refreshed during the last quarter. The TDA has subsequently been involved in reviewing the LTHT action plan, and there has been a further revision as a result. The plan identifies all the themes and trends contributing to risk factors around MRSA, identifies named leads and responsibilities, and is discussed regularly at the LTHT Quality Provider Group.

Various mechanisms exist within CCGs – such as the Leeds Quality Surveillance Group and the HCAI Operational Group, which consists of Public Health, Medicines Management, CCG Director of Quality and Nursing, and the quality team. It identifies and reviews themes and trends, and looks to tailor training and support as a result. Post Infection Reviews are also in place which identify where cases are attributed to. Where there is cross over into primary care/community the Operational Group will look at any further training needs.

4. Outcome measures

The methodology for setting our trajectories has started with information nationally available through the Atlas of Variation and the Levels of Ambition Tool. This has initially been used to produce a data-only based trajectory. We have then used our Commissioning for Value Peer Group CCGs 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 will continue to work with our partners to ensure our ambitions are realistic, achievable, yet have a reasonable degree of stretch to them. There was an item on the Health and Wellbeing Board agenda on 12 February to share the background and methodology before seeking discussion and agreement to our proposed trajectories and measures on 12 March. This will be based on development of trajectories for supporting measures and modelling impact and cost. These measures will be based on best measures for action plans to deliver improvement. Initial trajectories submitted may therefore need to be revised based on this more detailed modelling. This work will inform the development of the 5 year citywide strategy and will also be informed by developing strategic intent and decisions.

4.1 OUTCOME: Potential Years of Life Lost

The paper attached at Appendix A sets out the methodology and rationale for our 5 year trajectory for PYLL. Leeds North CCG has a level of ambition for this measure that meets the National requirement of 3.2% The four year baseline of available data up to 2011/12 suggests that we have achieved an average of 3% per annum over this period. These four years do show significant variation however, so until we are able to understand what contributes to this level of achievement, we could not honestly set a higher ambition at this point.

4.2 OUTCOME: Improving health related quality of life for people with LTCs

The paper attached at Appendix B sets out the methodology and rationale for our 5 year trajectory for improving health related quality of life for people with LTCs. Leeds North CCG aspires to halve the gap between itself (currently on 74.7) and the best in the country (79.7) over 5 years. These current proposals would see Leeds North CCG would move from 74.7 in 2012/13 to 74.85 in 2018/19 (3.3% improvement in the 5 years). We are working across our members, portfolio leads and executive to consider a more ambitious target; in five years' time modelling suggests best in country would be 82.0.

4.3 OUTCOME: Reducing emergency admissions

The methodology used to derive the five year annual trajectory for the composite measure of 'avoidable' emergency admissions to hospital is outlined below (consistent with BCF submission).

Step 1: Calculate expected numbers of 'avoidable' admissions assuming the age-sex structure of the CCG changes in line with the ONS 2011 Subnational Population Projections for Leeds over the next five years.

- For this calculation emergency admissions data by CCG, single year of age and gender have been sourced from the Secondary Users Service for all providers.
- Post-reconciliation data up until the 31st October 2013 have been used for this purpose.

Step 2: The SUS-based 'avoidable' admissions total for FY13/14 has then been scaled up to equal the reported FY12/13 admissions total from the Level of Ambitions Atlas to reflect

differences in coding completeness between SUS and HES, and this scaling factor has been applied to the time series of projected SUS-based admissions totals for FY14/15 to FY18/19.

- This correction uplifts the SUS-based figure by approximately 10% which is consistent with incomplete coding on SUS
- This step assumes no change in the net total of 'avoidable' emergency admissions between FY12/13 and the forecast outturn position for FY13/14 which is consistent with local intelligence on admissions trends over the last two years.

Step 3: Planning assumptions have been applied to the HES-scaled admission totals to reflect the estimated impact of a range of planned interventions aiming to reduce patients' reliance on emergency care

- This impact starts in FY14/15 with a 10% reduction by the end of March-2015 on the monthly total after factoring in demographic growth, with the impact increasing to 30% by the end of FY18/19. A linear reduction profile has been applied and with factoring in seasonality, this equates to a 5.7% full year effect for FY14/15 increasing 28.3% for FY18/19.

Step 4: The net annual admission totals have then been converted by into crude rates per 100,000 with reference to the ONS 2011 Subnational Populations Projections

Step 5: The crude rate for FY13/14 has been normalised back to the published indirectly standardised rate for FY12/13 from the Level of Ambitions Atlas and the scaling factor has then been applied to the full time series to provide estimated indirectly standardised rates by year

- Please note this approach has been taken in the absence of the age-sex admissions dataset for England that has been used by NHS England for the indirect standardisation. Inaccuracies in this approach will add uncertainties to the derived rates, although these will likely be small compared to the level of ambition that has been set.

For the FY14/15 Quarterly Emergency Admissions Composite Indicator totals, the same methodology has been applied, with an additional step to superimposed seasonality based monthly data for the last three years.

4.4 OUTCOME: Positive experience of hospital care

The paper attached at Appendix C sets out the methodology and rationale for our 5 year trajectory for improving patient experience of hospital care. Leeds North CCG aspires to improve from its current position of 146.1 to 142.1 by the end of Year 2, and to best quintile (135.6) by the end of Year 4, maintaining that position for Year 5. We are working across our members, portfolio leads and executive to consider a more ambitious target; our performance is already slightly higher than Leeds West and Leeds South & East CCGs, and we need understand if this is because of the higher number of our patients attending a Harrogate District FT. If this is the case, we would be able to consider a higher ambition.

OUTCOME: positive experience of care outside hospital

The paper attached at Appendix D sets out the methodology and rationale for our 5 year trajectory for improving patient experience of care outside hospital. Currently scoring 5.8, Leeds North CCG aspires to move to best quintile nationally (4.8) by the end of Year 5. Again, Leeds North is already achieving a greater level performance against this measurement compared with Leeds West and Leeds South & East CCGs, and we are looking at stretching our ambitions in line with the current differentials.

5. QUALITY PREMIUM: IAPT ROLL OUT

We have profiled our local trajectory to reach 15% over year 14/15 detailed as citywide and split across the three CCGs based on our prevalence level of 105,015. We operate a citywide service with a single point of access – so the same model is applied across all three CCGs.

Current challenges

This year we are working to achieve 13% service capability by March 2014 – with an overall service total of just over 10% for the year 13/14. The service had increased investment of £1.2 million in 13/14 to implement service restructuring and remodelling to enable it to achieve 13% capability. This has included:

- Reconfiguration to introduce telephone triaging
- Introduction of agency staff to clear waiting lists
- Increase in staff establishment
- Introduction of Step 3 online therapy – to increase out of hours options (60 licences with Big White Wall, of which only 20 so far taken up)
- Remodelling of Step 2 offer so that at least 40% of referrals go through groups rather than 1-1. This has included training of staff and introduction of large stress seminars for 60 people at a time; and the expansion of other group-work options.
- Review of all patients sitting on patient choice list to ensure that they still want to wait for particular slot etc.
- Introduction of text reminders to reduce DNA
- Encouragement of self -referral to improve engagement rate, and reduce wasted time chasing up GP referrals that don't wish to attend.

Although all these changes are being introduced and will bring about significant improvements there have been delays due to staff recruitment (there is a lack of qualified staff, and trainee places are not carrying full caseload and they can leave once trained). Many Step 3 staff are now working for agencies for increased flexibility and income; there is national churn at Step 2 as seen as entry level post. This can leave the service carrying at least 5 vacancies at any one time (out of 80 staff) which impacts directly on capacity.

Challenges to achieving 15% target

The changes brought in this year are aimed at bringing us to a 13% capability position by March - this will need to be embedded and ensure that it is sustainable; particularly in relation to staff retention. On that basis we are relatively confident that we can reach 13.6% as whole year total by March 2015 – which would represent a 3.6% increase from this year.

In order to achieve next year's target of 15% throughout 14/15 we will provide a development fund for the service consortium to bid into, for service improvement initiatives.

Other developments to deliver an impact include:

- Increase in the offer of self-help, peer support and resilience training – for those for whom a pure therapeutic intervention is inappropriate
- Introduction of social prescribing – initially as a pilot in South Leeds area – more suitable for those who have complex social issues that are not best resolved by IAPT

- Expansion of our job retention service – currently being piloted as direct referral from GPs
- Managing patient expectations – to improve take up of group-work as first step – Introduction of GP education programme
- Introduction of citywide mental health information "portal " – that will improve public access to information – business case and specification being worked up in 2014
- Improvement in access to specialist psychiatric advice into primary care to reduce referrals to secondary care unnecessarily- and direct some of these patients to IAPT.

Depending on performance of our current provider/s we might also consider retendering the service – but this will impact on target achievement as the process is instigated and completed.

6. QUALITY PREMIUM: self certification re Friends & Family

The CCGs will support all providers to implement F&F roll out to the agreed national timescales.

There are national CQUINs in place in all providers to improve F&F response rates and/or implement any new requirements.

We will work with all our providers to identify any areas of concern and agree action plans where necessary for rectification. LTHT have already undertaken a review of results of patient survey and F&F test outputs and are implementing changes where necessary to improve scores.

Leeds North CCG has selected the following further indicator from Domain 4 of the CCG Outcomes Indicator Set:

- Improving Patients experience of Outpatients Services

LTHT hare currently in the process of completing an outpatient improvement initiative, which we envisage, will support improvement in these services. We will be working with LTHT over the forthcoming weeks to agree our level of ambition and to ensure that they have plans in place to improve in line with the agreed trajectory.

7. QUALITY PREMIUM: self certification re improving reporting of medication errors

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 – acute, mental health and community. Using our local reporting system, we know that GP reporting is however less developed. The targets that we have set reflect these differences.

We are well placed to bring about significant improvements based on our learning from incident reports through our work to support and develop primary care, the introduction of the Leeds Care Record and our existing collaborative approach demonstrated by the

Medicines Safety Exchange. Leeds also has good links with local universities and the resources they have in terms of evidence based improvements in safer care.

A tipping point in primary care reporting could be reached whereby increases in reporting would be sustained beyond the end of 2014/15.

Medicines incident reporting is just one element of Medication safety and 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 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.

8. LOCAL QUALITY PREMIUM

From the national CCG outcome indicators set, Leeds North CCG have 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 achieve the CCG will 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.

9. CDiff trajectory

Awaiting national trajectories

A comprehensive action plan has been agreed with LTHT, which was reviewed and refreshed during the last quarter. The TDA has subsequently been involved in reviewing the LTHT action plan, and there has been a further revision as a result. The plan identifies all the themes and trends contributing to risk factors around CDiff, identifies named leads and responsibilities, and is discussed regularly at the LTHT Quality Provider Group.

There is also an antibiotic prescribing strategy in place across the city. Reporting throughout 2013/14 has highlighted the in depth work with Public Health and the Medicines Management Team with regard to gaining further knowledge into cases within primary care and insight following review. A number of themes and trends have been identified to help manage targeted training and education across Leeds. The HCAI Operational Group continues to work through these concerns, and as a result of this, refreshing the action plan to highlight the work that is taking place. The Directors of Nursing is currently looking at a joint campaign with PH England to address some of the themes identified across our community.

10. Dementia diagnosis rate

- We have plans to achieve the 67% diagnosis rate. Investment in the Leeds memory service from April 2013 has greatly reduced waiting times; LTHT are performing well on the dementia CQUIN "find-assess-refer" element and generating 70 – 80 referrals per month; 90% of Leeds GPs have signed up to the dementia DES.
- We are planning a dementia diagnosis and self-management model with GPs, LYPFT, patients and carers. It is a primary-care based model with specialist in-reach, and additional capacity in the form of "eldercare facilitator" roles. This model will boost diagnosis and post-diagnosis support during 2014-15 (after procurement / recruitment) with whole year effect in 2015-16; hence the further improvement projected to March 2016.

Calculations and sources

- Estimated dementia prevalence for each CCG is:

persons with dementia	2013	2014	**2015**	**2016**
Leeds North	2,389	2,448	**2,509**	**2,568**
Leeds S&E	2,567	2,631	**2,696**	**2,760**
Leeds West	3,544	3,632	**3,722**	**3,810**
Total	8,500	8,711	8,927	9,138

The NHS England Dementia Prevalence Calculator (v3), gives the 2013 figures. For later years, annual percentage increases have been applied using Leeds population projections (Office of National Statistics) and research consensus on age-related prevalence of dementia:

Year	2013	2014	2015	2016
estimated people with dementia (Leeds local authority population)	8,544	8,756	8,973	9,185
increase from previous year	*2.4%*	*2.5%*	*2.5%*	*2.4%*

Applying these percentage increases to the 2013 CCG figures, gives the 2015 and 2016 estimates for CCG dementia prevalence. The NHS England Calculator does not at present

give projected prevalence estimates for future years (although the previous version 2 did, which was helpful for planning purposes).

11. IAPT recovery rate

We have set a trajectory to meet the national requirement of 50% recovery rates by March 2015. Current citywide performance for 13/14 is approximately 46%, but with variations between CCGs (as at December 2013 – Leeds North CCG 40.9%; Leeds South & East CCG 40.9%; Leeds West CCG 47.5%). There are inevitably fluctuating rates across months and across CCGs – this reflects the range of individuals and differing levels of need that present to the service. The service is currently reporting that the level of acuity of those presenting to the service has gone up - which has not only necessitated increased treatment sessions, but has also impacted on recovery rates.

Other service developments already described in Section 5 above are anticipated to impact on improving recovery rates.

12. Activity data submission

The ProvCom template detailed our activity data submission has been submitted separately.

Context
Leeds CCGs have made working assumptions around the growth in both finance and activity to support the Feb 14th planning submissions. The proposals on elective care measures were discussed and agreed at the cross-city APMG on 29 January, and the non-elective assumptions at the cross city Strategy Workshop on the same day. The figures for emergency admissions are consistent and embed the assumptions of the Better Care Fund. These are necessarily provisional figures and do not take full account of any programmes being progressed by the LAT on a West Yorkshire footprint, These assumptions may be further adjusted before the next submission in early April.

Activity: Elective Inpatient/Day Case activity
The 14/15 position is based on the 13/14 outturn plus 2.4% providers to allow for some further clearance of long waits at LTHT and Mid Yorkshire, From 15/16 we are projecting demographic growth in elective activity of 1.3% in each of the subsequent years. Given the age profile of the population and drive to improve earlier referral to improve potential years of life lost, there may be higher actual demand growth, however we are planning to offset this by tightening up of some of the criteria for procedures of potentially limited clinical value, and the introduction of more conservative management options in areas such as pain management service.

1st Outpatient Activity
The position with first outpatients is similar to electives where in year 1 we are planning growth of 3.1% to offset RTT waits in some specialities and demographic growth of 1.3% in years 2-5 outpatient activity of 1.3%. However this growth in years 2-5 may increase in some areas to reduce health inequalities and improve earlier detection of cancer. To ensure we live within the planned growth however we have plans to move towards more non-face to face contacts/advice and different locations for some pathways. We have built in actions to help achieve this within our service development and improvement plans, CQUIN and quality requirements.

Follow up OP Activity
Without further commissioning interventions, we would logically plan for a demand growth of 1.3% in each subsequent year in follow up activity. However, we are intended to manage

demand and activity down to no growth. In some high volume specialties we are planning for some pathways to transfer to primary care and/or to no follow up, and reducing the numbers of face to face contacts/frequency of contacts/increased use of nurse-delivered pathways. However, these productivity improvements are likely to be needed in part simply to offset the growth that would be required to enable life- long follow up for patients in an increasing number of chronic disease pathways including cancer survivorship, rheumatology, ophthalmology etc. Our aim, therefore, is to hold demand flat, which is an improvement in real terms against demographic growth, and to achieve a reduction in spend for the same level of activity.

Non Elective Activity
During 13/14 we have seen a 3% reduction in Emergency admissions overall (YTD). Notably zero and 1 day length of stay admissions reduced by 9% (1st 8 months) compared to a 1% increase in stays of 2 or more days as a result of moving towards better hospital based assessment pathways to avoid admissions.

In line with planning assumptions for the three CCGs joint five year strategy, by 2018/19 the age-sex standardised rate of emergency admissions is projected to be 15% below comparable rates for FY13/14. After correcting for demographic growth (using the ONS 2011 Sub national Population Projections as the reference), this equates to a net reduction on current activity levels (Nov-2012 to Oct-2013) of around 7.5% (or 6,100 fewer admissions per year). We have profiled this conservatively for next year (0.2%) with greater impact from 2015/166 onwards (1.9% per year). This is consistent with and embeds the ambitions as submitted by BCF

It is anticipated that this reduction will be achieved by implementing a variety of intervention (under the umbrella of the Better Care Fund and City-wide transformation programme) that aim to improve the management of patients at risk of unplanned hospital admission (reducing demand for urgent care provision) and promote out of hospital alternatives to hospital admission for urgent cases.

Emergency Department Attendances
Our expectation is that ED attendances will plateau over the next year, as the increasing impact of the Better Care Fund, seven day working, primary care development and the further work on the Urgent Care Strategy offset the growth that would otherwise be expected as a consequence of demographic growth. As a conservative position, A&E attendances are planned remain the same as 2013/14 for the next five years.

The trajectory for the composite measure of avoidable emergency admissions reflects the non-elective activity profile, with both trajectories showing a real-terms reduction in FY14/15, and each year thereafter. Small differences between these trajectories can be attributed to differences in the baseline periods used to construct each trajectory, with the former being based on the 12 month period Oct-2013 to Sep-2013, and the latter being based on the forecast outturn for FY13/14, which has been derived using data from Apr-2014 to Nov-2014.

13. Health and Wellbeing Board agreement

A paper describing the background and methodology to our submission was presented to the health and Wellbeing Board at its meeting on 12 February. A more detailed discussion with the

Health and Wellbeing Board will take place at its meeting on 12 March, when we will be seeking discussion and agreement to our proposed trajectories and measures.

14. Narrative on 5 year strategy

The narrative required regarding process for producing the 5 year strategy on a Leeds wide footprint is being submitted separately along with this paper.

15. Better Care Fund submission

The BCF templates for Leeds are being submitted separately. We have ensured that trajectories and activity figures in the Unify templates are consistent with those described in the BCF submission.