

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

Narrative to underpin Unify template submitted by Leeds South & East CCG
(4 April 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 (15 mins) and post-handover performance (15 mins) remains below the 100% target. At LTHT in February, handover was 84.6% and post-handover was 68.1%. In 2012/13 (prior to handover data being recorded) it should be noted that only 56.5% of turnarounds were achieved in less than 30 mins 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.

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.

Role of providers

Providers have a number of responsibilities and requirements:

- Identify CIPs
- Share plans with commissioners
- 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 have continued 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. Further discussion has taken place at an extra-ordinary HWB meeting on 27 March. This work is informing the development of the 5 year citywide strategy and has also been informed by developing strategic intent and decisions

4.1 OUTCOME: PYLL

The paper attached at Appendix A sets out the methodology and rationale for our 5 year trajectory for PYLL. Leeds South & East CCG has a level of ambition for this measure that is higher than the minimum requirement of a 3.2% per annum improvement over 5 years. Our more ambitious target reflects the population need in LSE, and also the Leeds Health and Wellbeing Board stated intention to reduce health inequalities across the city. In summary, our overall intention is to halve the gap between LSE and the average of our best 5 peers by 2018, assuming that the peers also improve by 3.2% per annum. The trajectory assumes a 3.2% reduction in 2013/14 (although it will be well into 2014/15 before we have confirmation of whether this assumption is correct). Our ambition is for a 3.2% reduction in Years 1 and 2, with the gap closed further in Years 3, 4 and 5, reflecting an overall improvement of 26.6% over the five years.

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 South & East CCG aspires to halve the gap between itself (currently on 70.0) and the best in the country (79.7) over 5 years. Leeds South & East CCG would move from 70.0 in 2012/13 to 74.85 in 2018/19 (6.9% improvement in the 5 years).

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 FY2013/14 has then been scaled up to equal the reported FY2012/13 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 FY2014/15 to FY2018/19.

- 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 FY2012/13 and the forecast outturn position for FY2013/14 – whilst this is consistent with local intelligence on admissions trends over the last two years, differences are observed between the FY2012/13 forecast outturn position used to baseline the activity profiles submitted as part of the CCGs plans and the baseline position used to set the city-wide emergency admissions trajectory for the BCF.

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 FY2014/15 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 FY2018/19. A linear reduction profile has been applied and with factoring in seasonality, this equates to a 5.7% full year effect for FY2014/15 increasing 28.3% for FY2018/19.

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 FY2013/14 has been normalised back to the published indirectly standardised rate for FY2012/13 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 FY2014/15 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 South & East CCG aspires to improve from its current position of 149.3 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.

4.5 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 6.6, Leeds South & East CCG aspires to move to best quintile nationally (4.8) by the end of Year 5.

5. QUALITY PREMIUM: IAPT ROLL OUT

We have profiled our local trajectory to reach 15% by Quarter 4 of 2014/15 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 2013/14. The service had increased investment of £1.2 million in 2013/14 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 2014 - 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 ensure we achieve next year's target of 15% by Quarter 4 of 2014/15 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 F&F

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 South & East CCG has selected the following further indicator from Domain 4 of the CCG Outcomes Indicator Set:

- Improving women and their families' experience of maternity services

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 have plans in place to secure an improvement in this measure.

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. The table below indicates for each of these organisations the national position and the number of reports and % attributed to medicines related incidents:

	National position for incidents	Approximate number pa	% of these which are medicines related
LYPFT	15 th out of 56	700	10.8%
LTHT	7 th out of 30 Trusts	1600	9.1%
LCH	3 rd out of 19	1000	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 need to explore easier processes for reporting in primary care and develop a culture of familiarity 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 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. We aspire to deliver an overall increase (minimum of 5% increase from Q4 2013/14) in the total numbers of medication incident reports from across LTHT, LYPFT and LCH, with a minimum of a 20% increase from primary care, general practice.

In Leeds South & East CCG we are including this in the Practice Engagement Scheme. Practices are required to submit at least one incident report per 1000 patients over the year. This is expected to deliver about 250 reports during the year for LSE which is significantly more than the minimum 20% improvement described above. We believe this is an achievable level of ambition given the work we will have to do with our practices re culture change, training and hopefully simplifying the system for reporting.

8. LOCAL QUALITY PREMIUM

It is proposed that Bowel Screening Uptake rate is the local Quality Premium measure for LSE CCG for 2014 to 2016.

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%.

Rationale for 2014 to 2016

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 implementation. The QOF quality premium process was implemented at the beginning of Q3. Given the 13 week delay in the process from first invite to notification to the practice of none – return, practice contact to the patient and second invite we would not expect this to start to show any impact until late in Q4. The real impact would not therefore show until 2014/15.

Unfortunately the supporting publicity campaign has also been delayed. 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 delay in implementation the programme of work, 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.

This is an ambitious target and as such the programme of work to achieve this will be enhanced from the 2013/14 plan. The full programme of work will be included in the final Operational Plan.

9. CDiff trajectory

The national trajectories for CDiff are outlined in the table below:

	2014/15 target	2013/14 Target
Leeds North	65	45
Leeds South and East	106	82
Leeds West	97	98

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, and 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:

<i>persons with dementia</i>	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
<i>increase from previous year</i>	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 2013/14 is approximately 46%, but with variations between CCGs (as at February 2014 – Leeds North CCG 39.9%; Leeds South & East CCG 36.5%; Leeds West CCG 44.4%). 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.

Improvements have been made in waiting times to access the service. In Q3 less than 15% waited more than 1 month compared to 34% in Q1.

A recent comparative review of the service outcomes compared to a number of other similar services and NICE guidelines indicates that the current improvement plan is in line with good practice. The report will further inform the improvement plan and plans to commission additional services to meet the 15% access and 50% recovery rate targets. In addition the service provided by Leeds Community Healthcare is undertaking a capacity review. This will be reported to commissioners in June 2014.

12. Funding to support patients aged 75 or older

All Leeds CCGs have identified £5 per head of practice population to support patients aged over 75. Our approach involves allocating £2.64 of the £5.00 to the BCF. BCF monies will be used to fund a range of schemes that will improve services for older people through improved integrated working across primary, community and social care services. These integrated services will build upon and complement the requirements outlined within the Admissions Avoidance Enhanced Service, once published. The balance of the remaining £2.36 per patient is to be used to fund local CCG specific schemes. As such Leeds South & East CCG can confirm it has established a fund to support older people as set out in: Planning for Patients 2014/15 to 2018/19.

13. Activity data submission

The ProvCom template detailing 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 final 4 April final 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 have been the subject of discussion between LWCCG as the lead contractor and LTHT. They have also been discussed and agreed with the AT. There may be a need for some further small changes to CCG commissioning volumes and values once some further shifts in commissioning responsibilities between CCGs and NHS England have been finalised.

Activity: Elective Inpatient/Day Case activity

The 2014/15 position is based on contract activity plans agreed with the three Leeds CCGs' main providers. From 2015/16 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 that in year 1 we are planning growth of 1.9% to offset long RTT waits in some specialities and demographic growth of 1.3% in years 2-5. 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, from 15/16, we are intending to manage demand and activity down to no growth. In some high volume specialities 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 2013/14 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 FY2013/14. 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 2015/16 onwards (1.8% 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 to 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 FY2014/15, 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 FY2013/14, which has been derived using data from Apr-2014 to Nov-2014.

Triangulation to MAR data

The activity figures submitted by the Leeds CCGs on the ProvCom return have been derived from provider trading reports and SUS data and, as stipulated in the guidance, exclude specialist activity commissioned by Area Teams. These activity figures will not triangulate with the data submitted by providers in the Monthly Activity Return (MAR) as we are aware, and have raised with the Area Team via the CSU, that providers are generally not following national guidance to **exclude** specialist activity from their MAR returns.

14. 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 paper was circulated and was on the agenda for the Health and Wellbeing Board on 12 March. Due to time constraints, there wasn't an in-depth discussion at that meeting, although there was broad approval of the measures and trajectories. The paper was discussed further at an extra-ordinary HWB meeting on 27 March where the measures and trajectories were discussed and agreed.

15. First draft of 5 year strategy

The first draft of the 5 year strategy on a Leeds wide unit of planning coterminous with the Health and Wellbeing Board is being submitted separately.

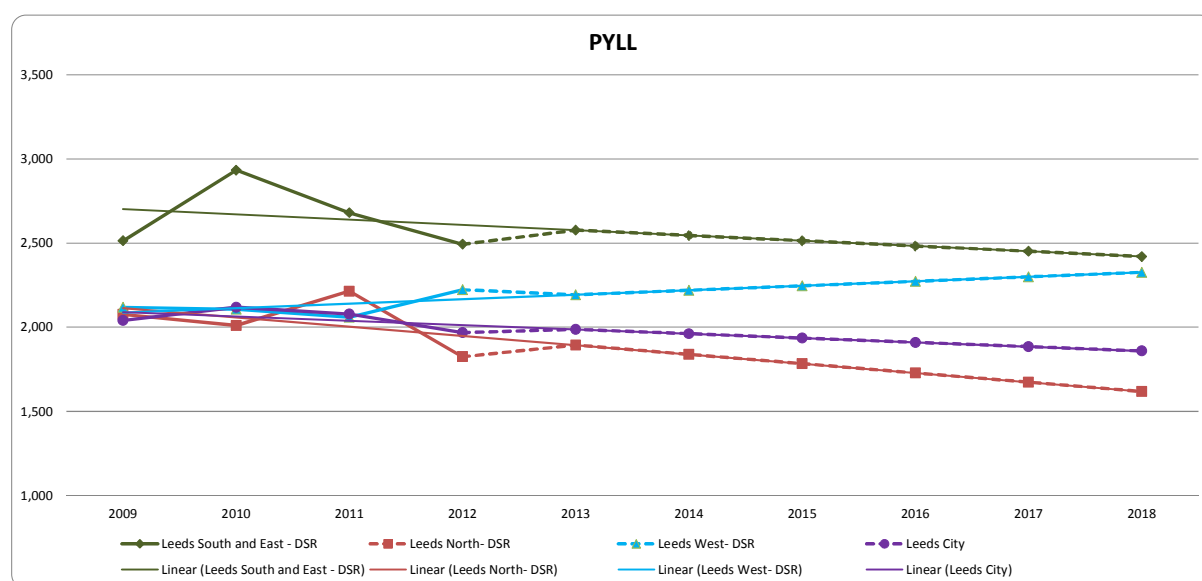
16. Better Care Fund submission

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.

APPENDIX A - Summary Paper – Priority Measure (5 Yr Plan) Potential Years of Life Lost

Area	Long Term Strategic Objective (Public Health Objective)
Measure	Potential years of life lost from causes considered amenable to healthcare (DSR per 100,000)
Data Source	Source: HSCIC - Potential years of life lost (PYLL) from causes considered amenable - healthcare - CCG Indicator 1.1 (NHS of 1a) <i>Directly age and sex standardised potential years of life lost (PYLL) per 100,000 for the CCG figures and crude rate per 100,000 for Leeds City Wide figures</i>

Measure Graph: Linea forecast if “do nothing additional / continue as is”:

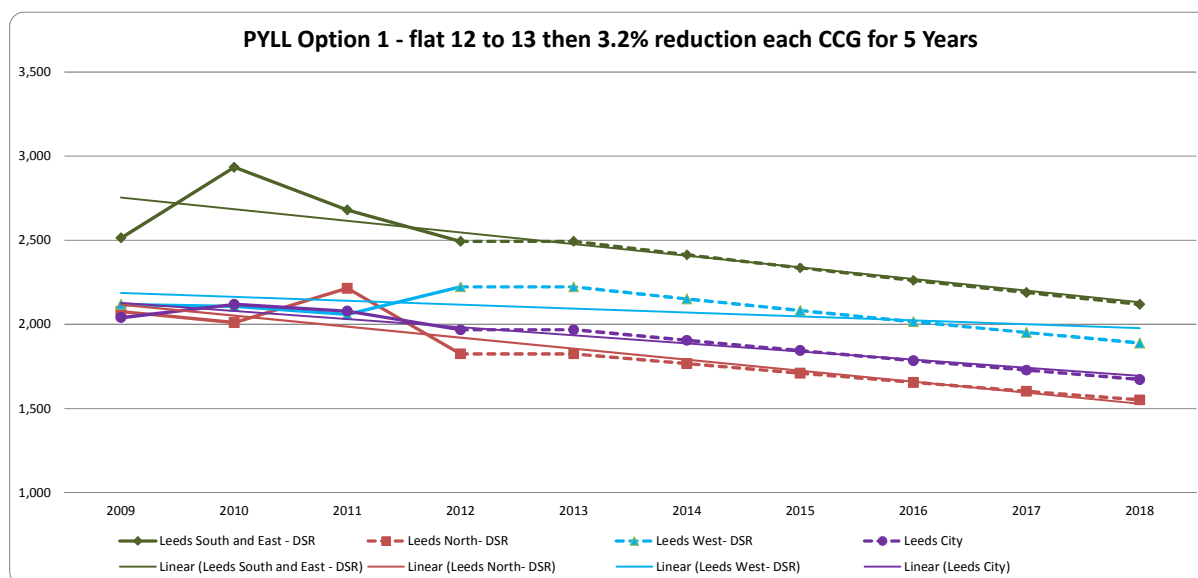


General Commentary	<p>Many, many variables will be contributing factors to this measure. It is therefore very difficult to accurately forecast. It should also be noted that operational changes within the health economy typically take many years to impact upon this measure.</p> <p><u>Leeds JHWS overview – relevance to this measure:</u></p> <p><i>Vision for health and wellbeing:</i> Leeds will be a healthy and caring city for all ages</p> <p><i>Principle in all outcomes:</i> People who are the poorest, will improve their health the fastest.</p> <p><i>Overarching Indicator:</i> Reduction in the differences in life expectancy between communities</p> <p><i>Outcome:</i> People will live longer and have healthier lives (most relevant to this measure)</p> <p>Leeds JHWS Priorities:</p> <ol style="list-style-type: none"> 1. Support more people to choose healthy lifestyles 2. Ensure everyone will have the best start in life 3. Ensure people have equitable access to screening and prevention services to reduce premature mortality
---------------------------	--

	<p>Indicators to monitor improvement:</p> <ol style="list-style-type: none"> 1. Percentage of adults over 18 that smoke 2. Rate of alcohol related admissions to hospital 3. Infant mortality rate 4. Excess weight in 10-11 year olds 5. Rate of early death (under 75s) from cancer. 6. Rate of early death (under 75s) from cardiovascular disease <p>Based on linear forecasts (See Chart above) from the “do nothing additional / continue as is” position</p> <p>Leeds City is forecasting a 6.0% improvement from 2012 to 2018 Leeds S&E is forecasting a 3.0% improvement from 2012 to 2018 Leeds North is forecasting a 11.3% improvement from 2012 to 2018 Leeds West is forecasting a 4.7% worsening position from 2012 to 2018</p>
<p>National Targets</p>	<p>Assume 3.2% in 2013/14 and plan for a minimum of 3.2% (DSR rate) improvement in 2014/15 – no specified minimum requirement in years 2 to 5; however, given national average of 3.2%, there is a strong suggestion that this figure is used as a guiding principle when considering CCG plans.</p>
<p>Key Benchmarks (Commissioning For Value Tool)</p>	<p>As at 2011 the CFV positions are:</p> <ul style="list-style-type: none"> • LSE is statistically significantly worse than its 10 Peers for both Male & Female measures. LSE requires a 14% Improvement (avg Male & Female) to get to "the best 5" level. • Leeds North is statistically significantly worse than its 10 Peers for Male measures and requires a 13% Improvement re male and an 11% (avg Male & Female) to get to "the best 5" level. • Leeds West is NOT statistically significantly worse than its 10 Peers (Male or Female). However it requires a 9% (avg Male & Female) to get to "the best 5" level. • The English average is Female 1,918 & Male 2,354 • The English Best is Female 974 & Male 1,311 • The English Worst is Female 3,750 & Male 3,963
<p>Points to Note eg Population Growth</p>	<p>Discussion with Public Health leads indicates that in order to achieve H&WB measure above work needs to focus on communities with the greatest need. This requires differential levels of ambition (and different levels of operational activity) across the 3 three CCGs.</p>
<p>Initiatives to impact upon this measure</p>	<p>Deep dive work (Respiratory & CVD) Primary Care cancer referral initiatives (Bowel & Breast) Best Start Improving quality and uptake of Health Checks Increasing pro-active care management (Community) Leeds Let’s change Smoking cessation & Alcohol initiatives Sexual Health (re-procurement – NB HIV & Aids impact)</p>

<p>Proposed level of Ambition</p>	<p>Options:</p> <p>Option 1 The National Target is the minimum ambition i.e. 3.2% for each CCG.</p> <p>Option 2 Halve gap of peers (peers stand still)</p> <p>Option 3 Halve gap of peers (plus peers improve by 3.2%)</p> <p>Option 4 (New April 14 Option) North & West assume 3.2% reduction p.a. for 13/14 and subsequent 3.2% p.a. for each of the 5 years to 2018/19. LSE assume 3.2% reduction p.a. for 2013/14 then subsequent 3.2% p.a. for the next 2 years, then further (equal) reductions in order to halve gap of their improving peers by 2018/19.</p>
--	--

Measure Graph: Linea forecast proposed ambition(s)

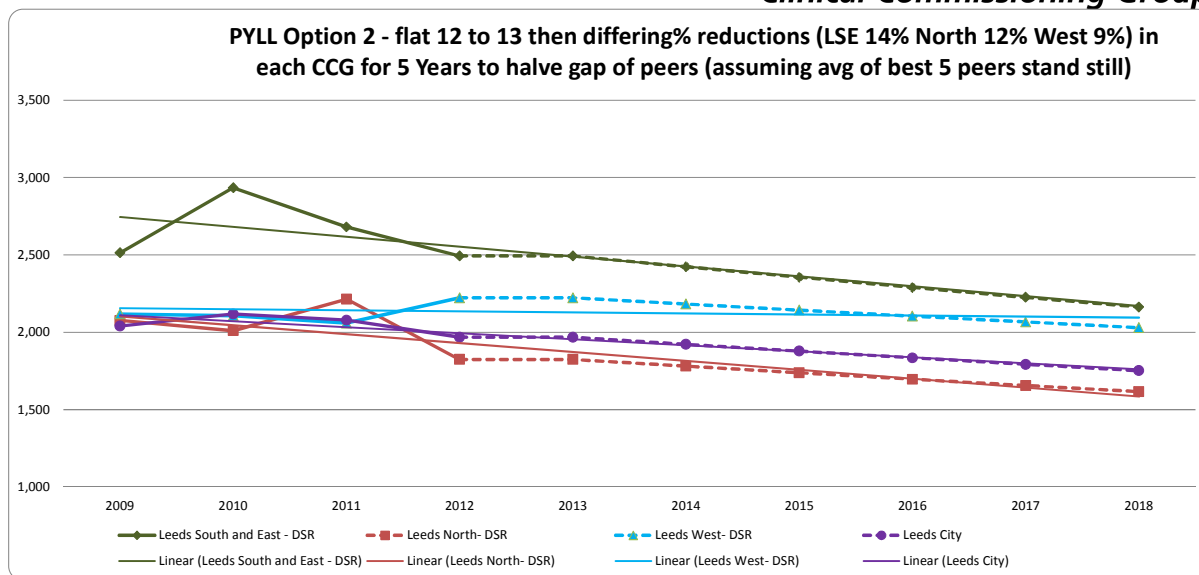


Leeds City would move from 1968 PYLL in 2012 to 1672 PYLL in 2018 (a 15% improvement in the 5 years to 2018.)

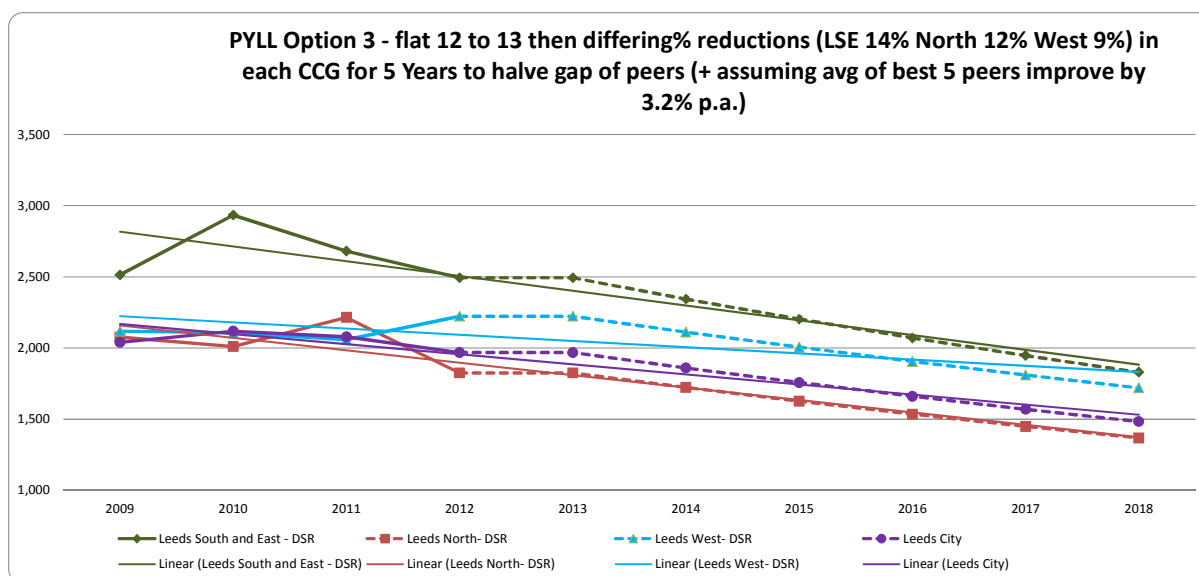
Leeds S&E would move from 2493 PYLL in 2012 to 2119 PYLL in 2018 (a 15% improvement in the 5 years to 2018.)

Leeds North would move from 1825 PYLL in 2012 to 1551 PYLL in 2018 (a 15% improvement in the 5 years to 2018.)

Leeds West would move from 2223 PYLL in 2012 to 1889 PYLL in 2018 (a 15% improvement in the 5 years to 2018.)



NB in this scenario – none of the CCGs would deliver the minimum national target improvement of 3.2% p.a. This scenario is therefore not applicable.



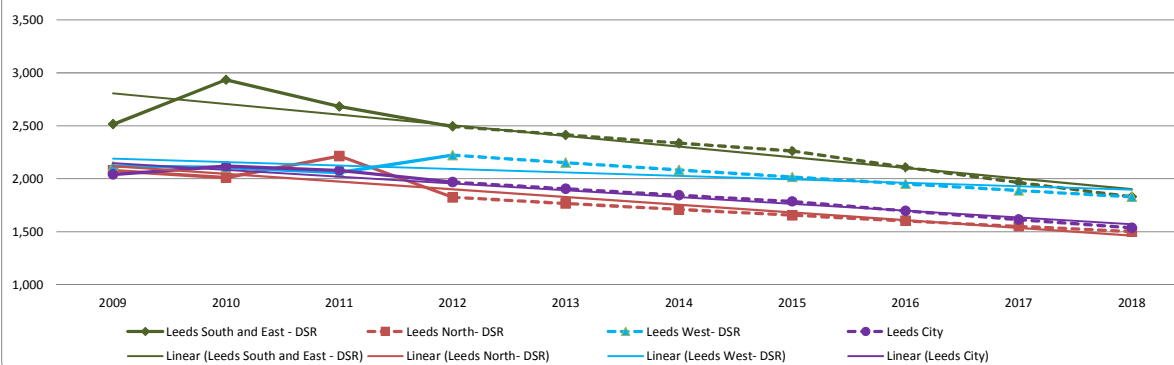
Leeds City would move from 1968 PYLL in 2012 to 1483 PYLL in 2018 (a 24.6% improvement in the 5 years to 2018.)

Leeds S&E would move from 2493 PYLL in 2012 to 1830 PYLL in 2018 (a 26.6% improvement in the 5 years to 2018.)

Leeds North would move from 1825 PYLL in 2012 to 1368 PYLL in 2018 (a 25% improvement in the 5 years to 2018.)

Leeds West would move from 2223 PYLL in 2012 to 1720 PYLL in 2018 (a 22.6% improvement in the 5 years to 2018.)

Option 4: PYLL (North & West) - assume 3.2% reduction for 13/14 & subsequent 3.2% p.a. until 18/19 A Total reduction of 18.3%. (LSE) Halve gap to peers assuming peers; Assume 3.2% reduction 13/14 to 15/16 & further reductions to 2018/19 to achieve 26.6%



Leeds City would move from 1968 PYLL in 2012 to 1536 PYLL in 2018 (a 21.9% improvement in the 6 years to 2018.)

Leeds S&E would move from 2493 PYLL in 2012 to 1830 PYLL in 2018 (a 26.6% improvement in the 6 years to 2018.)

Leeds North would move from 1825 PYLL in 2012 to 1501 PYLL in 2018 (a 18.3% improvement in the 6 years to 2018.)

Leeds West would move from 2223 PYLL in 2012 to 1829 PYLL in 2018 (a 18.3% improvement in the 6 years to 2018.)

4th April Submitted Position -Option 4. See above. (North & West assume 3.2% reduction for 13/14 and subsequent 3.2% p.a. for each of the five years to 18/19. LSE 3.2% reduction for 3 years then further reductions to halve the gap to improving peers by 18/19 which equates to 26.6% reduction in total.)

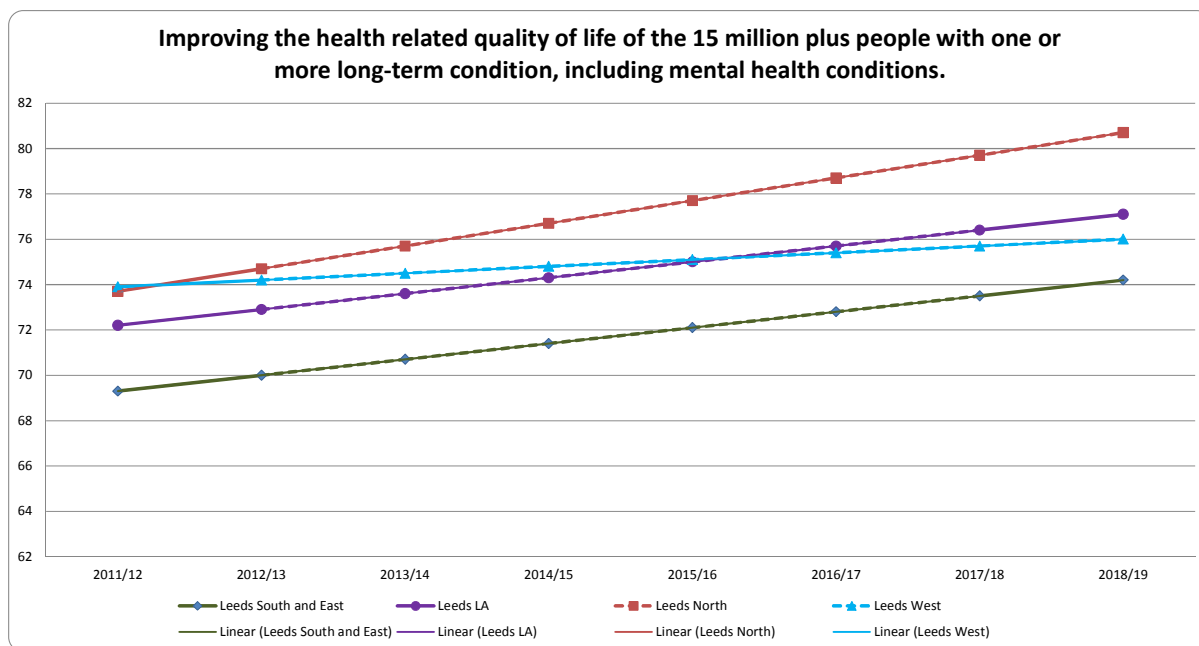
The North & West CCGs have increased their commitment from the Feb 14 submission by reducing by 3.2% in 13/14. However, they have maintained the general 3.2% reduction year on year, as they are in line with national benchmarks for their Peer Groups. LSE CCG has also amended the assumed position for 2013/14 and is still intending to be more ambitious with a target to reflect population need and addressing health inequalities across the city.

<p>Cost / Benefit Analysis (affordability)</p>	<p>Given a view on the level of ambition, based on trend and peer review, the impact (cost / benefit) of the agreed actions will be modelled (April to June 2014) to assess whether the proposed actions will deliver the required change within a sustainable cost base.</p>
---	---

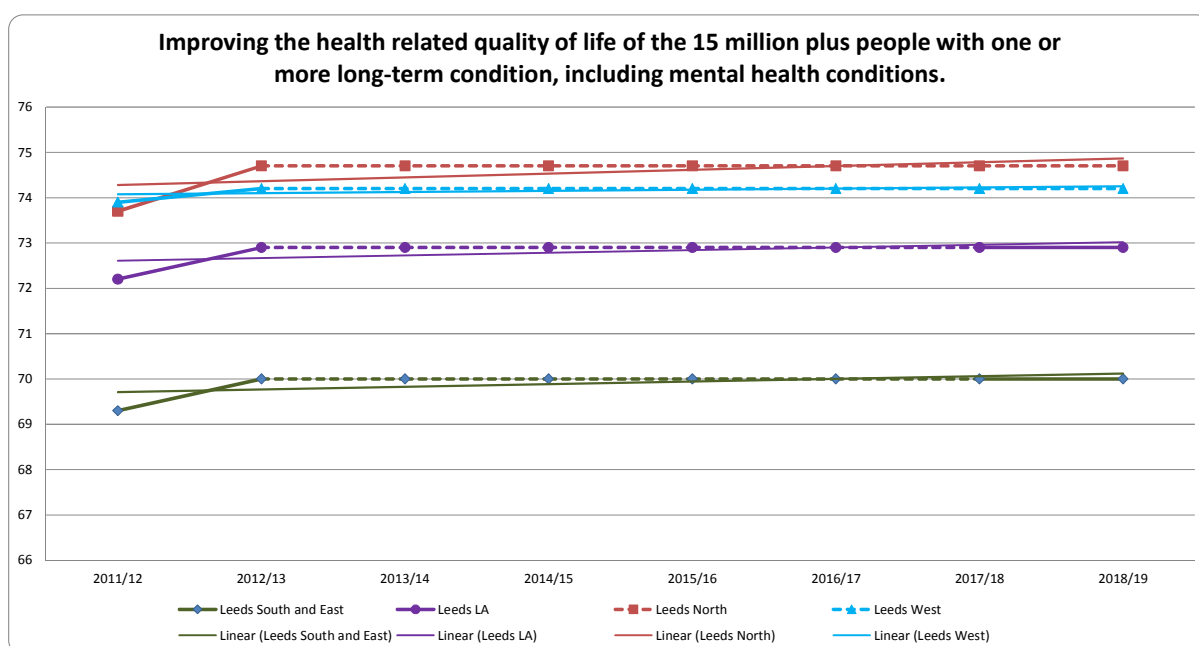
**APPENDIX B - Summary Paper – Priority Measures (5 Yr Plan) Integration Area - Health related
quality of life for people with Long Term Conditions**

Area	Integration
Measure(s)	Health related quality of life for people with Long Term Conditions
Data Source	<i>NHS England Ambitions Atlas EQ-5D for people with long term conditions: Crude Rates per 100 people</i>

Measure Graph: Linea forecast if “do nothing additional/ continue as is”

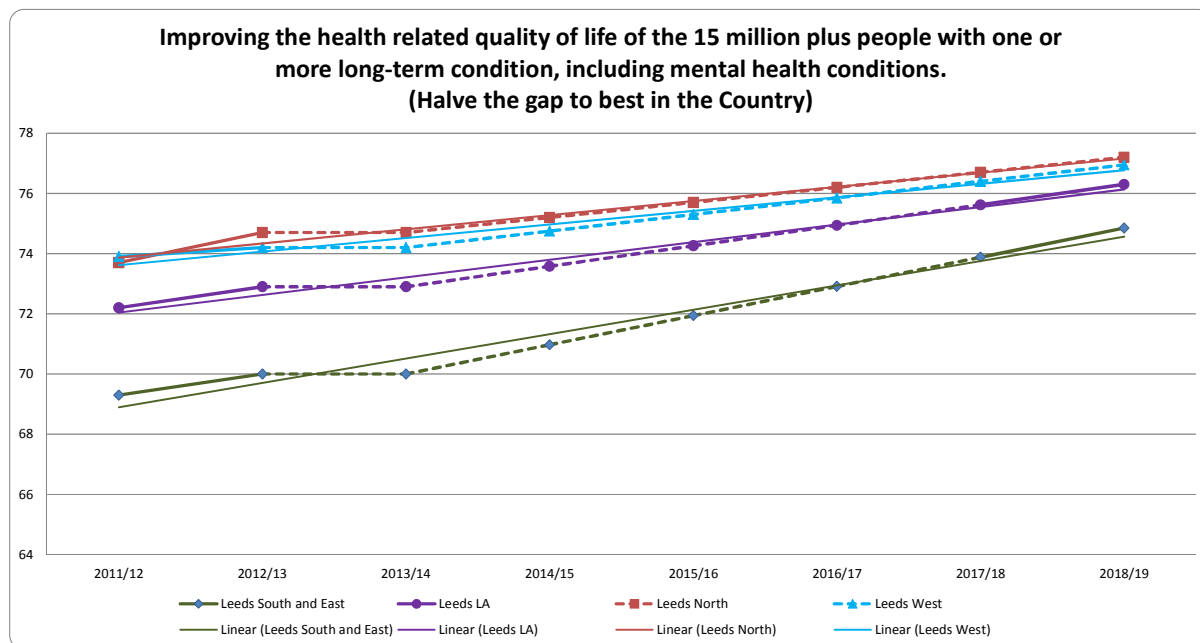


NB only two data points – therefore belief that most appropriate that baseline should be a flat line from 2012/13:



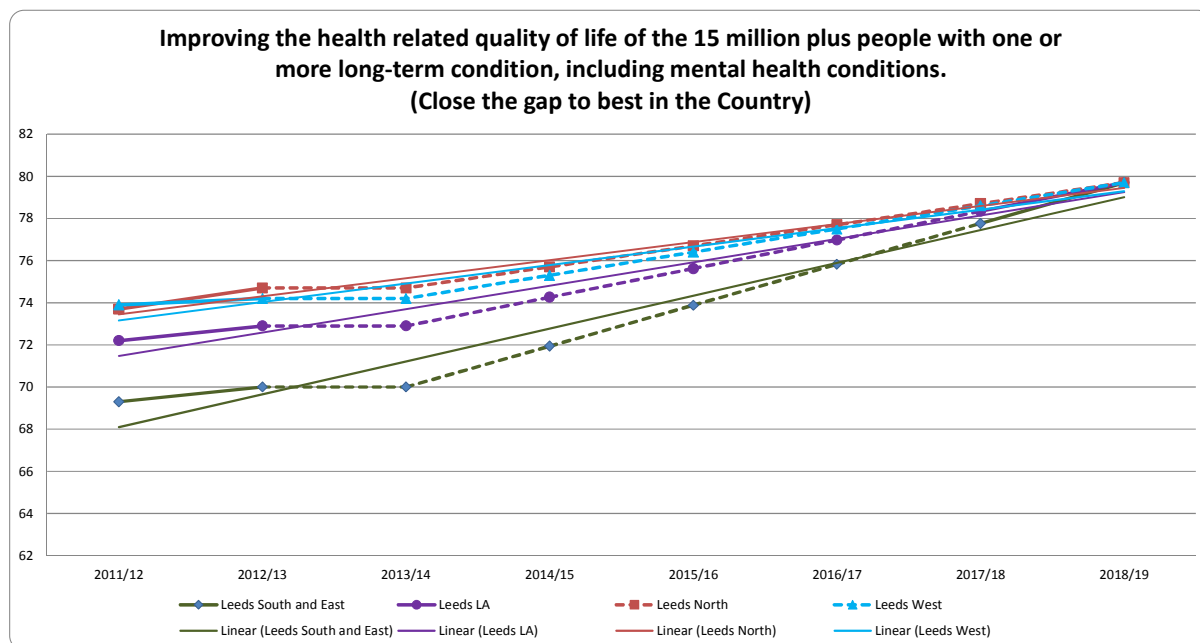
<p>General Commentary</p>	<p>As at 12/13: Leeds City is 72.9 LSE is 70.0 Leeds North is 74.7 Leeds West is 74.2</p> <p>Only 2 data points – so not a strong forecast 5 year forecast re “Do Nothing additional”. Therefore Benchmarking with Peers is a better indicator to assist with recommended forecasts.</p>
<p>Targets</p>	<p>No National Targets – working on basis of 3 individual CCG Targets</p>
<p>Key Benchmarks (Operational Planning Tool)</p>	<ul style="list-style-type: none"> • Leeds City is slightly better than the top 25% average 10 LSE Peers with the 12/13 data set (72.9 vs 72.4) • LSE is equal to average 10 LSE Peers (NB North and West will have a different set of CFV peers i.e. top 10 and this could change the benchmark position). <p>NB Best in the country is 79.7 as at 12/13</p>
<p>Initiatives to impact this measure</p>	<p>Self-Management / Integration programme (incl Sign Posting initiatives) Improved Primary Care initiatives Medicines Management Pulmonary Rehab Cardiac Rehab IAPT Deep Dives (Respiratory & CVD)</p>
<p>Forecast Commentary / Proposed level of Ambition</p>	<p>Option 1: Each CCG to halve the gap between itself and the best in the Country i.e. 79.7 within 5 years</p> <p>Option 2: Each CCG to close the gap between itself and the best in the Country i.e. 79.7 within 5 years</p> <p>Option 3: Each CCG to close the gap between itself and the best in the Country (assuming the best continues to improve i.e. 82.0 within 5 years)</p> <p>Option 4: (New Option Apr 14) West & S&E CCGs to halve the gap between itself and the best in the Country i.e. 79.7 within 5 years. However, Leeds North is setting a more challenging target to achieve 79.55 by 18/19.</p>

(Option 1) Halve the Gap to the Best in the Country



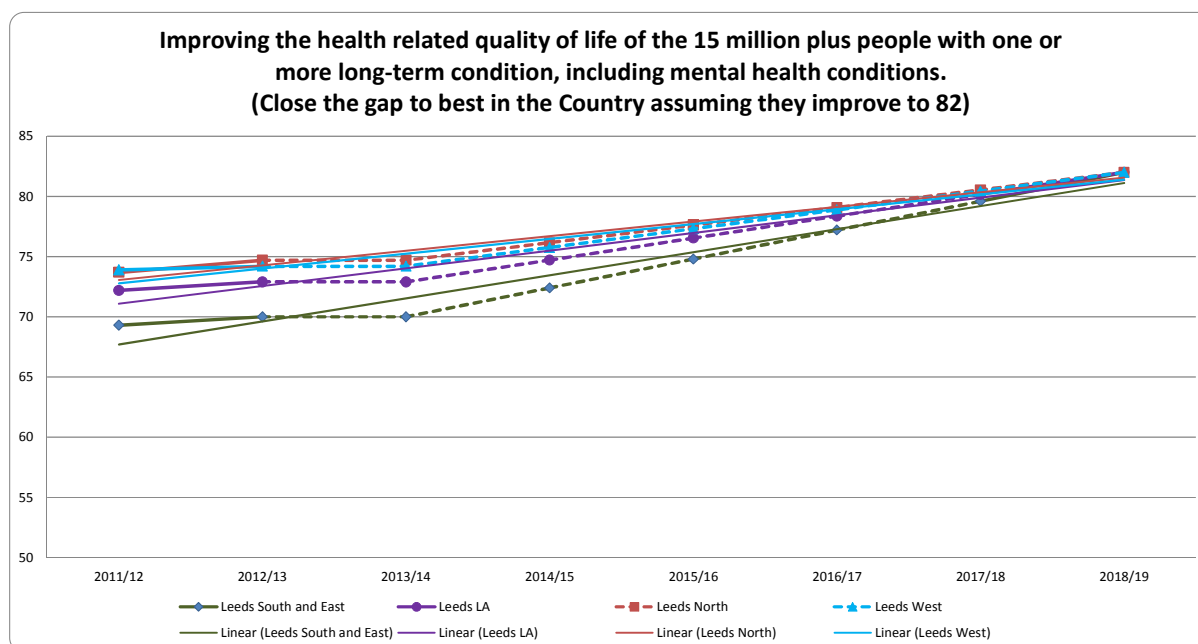
Leeds City would move from 72.9 in 2012/13 to 76.3 in 2018/19 (4.7% improvement in the 5 yrs).
 Leeds S&E would move from 70.0 in 2012/13 to 74.85 in 2018/19 (6.9% improvement in the 5 yrs).
 Leeds North would move from 74.7 in 2012/13 to 77.2 in 2018/19 (3.3% improvement in the 5 yrs).
 Leeds West would move from 74.2 in 2012/13 to 76.95 in 2018/19 (3.7% improvement in the 5 yrs).

Option 2:



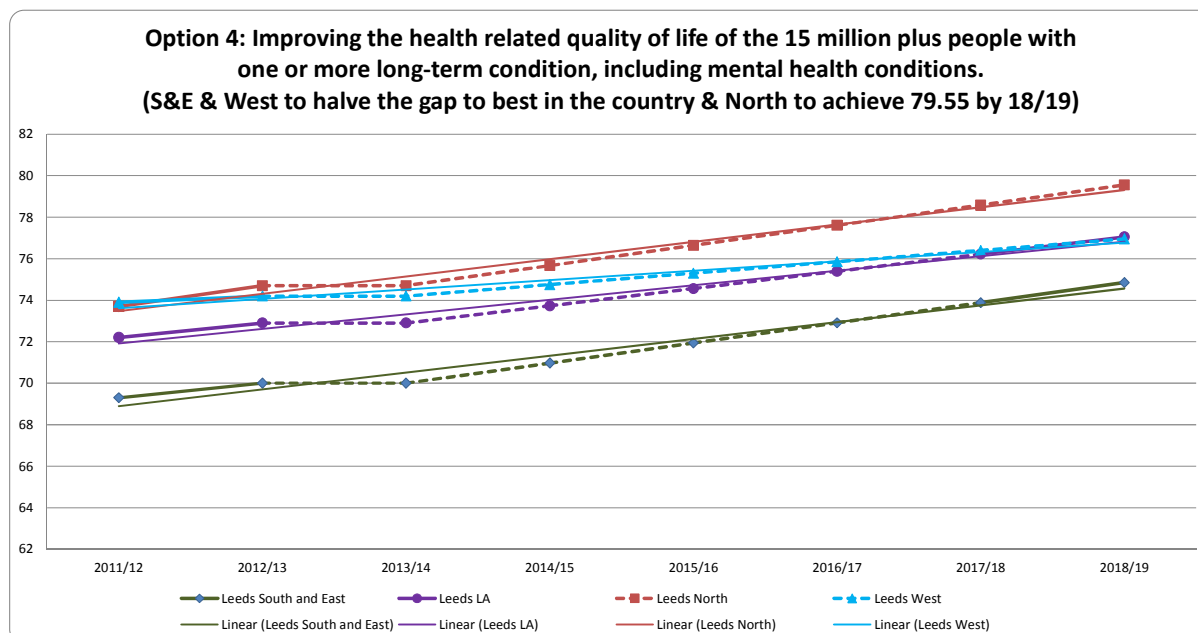
Leeds City would move from 72.9 in 2012/13 to 79.7 in 2018/19 (6.7% improvement in the 5 yrs).
 Leeds S&E would move from 70.0 in 2012/13 to 79.7 in 2018/19 (13.9% improvement in the 5 yrs).
 Leeds North would move from 74.7 in 2012/13 to 79.7 in 2018/19 (7.4% improvement in the 5 yrs).
 Leeds West would move from 74.2 in 2012/13 to 79.7 in 2018/19 (9.3% improvement in the 5 yrs).

Option 3:



Leeds City would move from 72.9 in 2012/13 to 82.0 in 2018/19 (9.8% improvement in the 5 yrs).
 Leeds S&E would move from 70.0 in 2012/13 to 82.0 in 2018/19 (17.1% improvement in the 5 yrs).
 Leeds North would move from 74.7 in 2012/13 to 82.0 in 2018/19 (10.5% improvement in the 5 yrs).
 Leeds West would move from 74.2 in 2012/13 to 82.0 in 2018/19 (12.5% improvement in the 5 yrs).

Option 4: (New April 14 Option)



Leeds City would move from 72.9 in 2012/13 to 77.05 in 2018/19 (5.7% improvement in the 5 yrs).
 Leeds S&E would move from 70.0 in 2012/13 to 74.85 in 2018/19 (6.9% improvement in the 5 yrs).
 Leeds North would move from 74.7 in 2012/13 to 79.55 in 2018/19 (6.5% improvement in the 5 yrs).
 Leeds West would move from 74.2 in 2012/13 to 76.95 in 2018/19 (3.7% improvement in the 5 yrs).

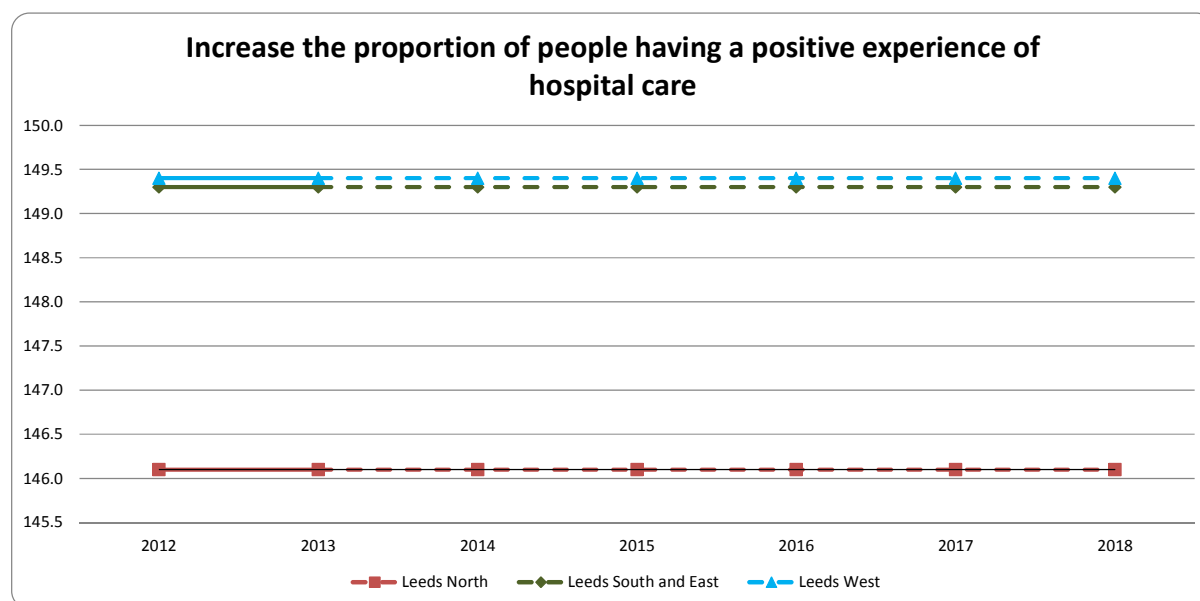
Submitted Option (April 14) - Option 4: West & S&E CCGs to halve the gap between itself and the best in the Country i.e. 79.7 within 5 years However, Leeds North is setting a more challenging target to achieve 79.55 by 18/19.

Cost / Benefit Analysis (affordability)	Given a view on the level of ambition, based on trend and peer review, the impact (cost / benefit) of the agreed actions will be modelled (April to June 2014) to assess whether the proposed actions will deliver the required change within a sustainable cost base.
--	--

APPENDIX C - Summary Paper – Priority Measures (5 Yr Plan) – Patient experience of inpatient care

Area	Quality
Measure(s)	Patient experience of inpatient care
Data Source	Source: NHS England Ambitions Atlas Rate of responses of a 'poor' experience of inpatient care per 100 patients.

Measure Graph: Linea forecast if “do nothing additional/ continue as is”

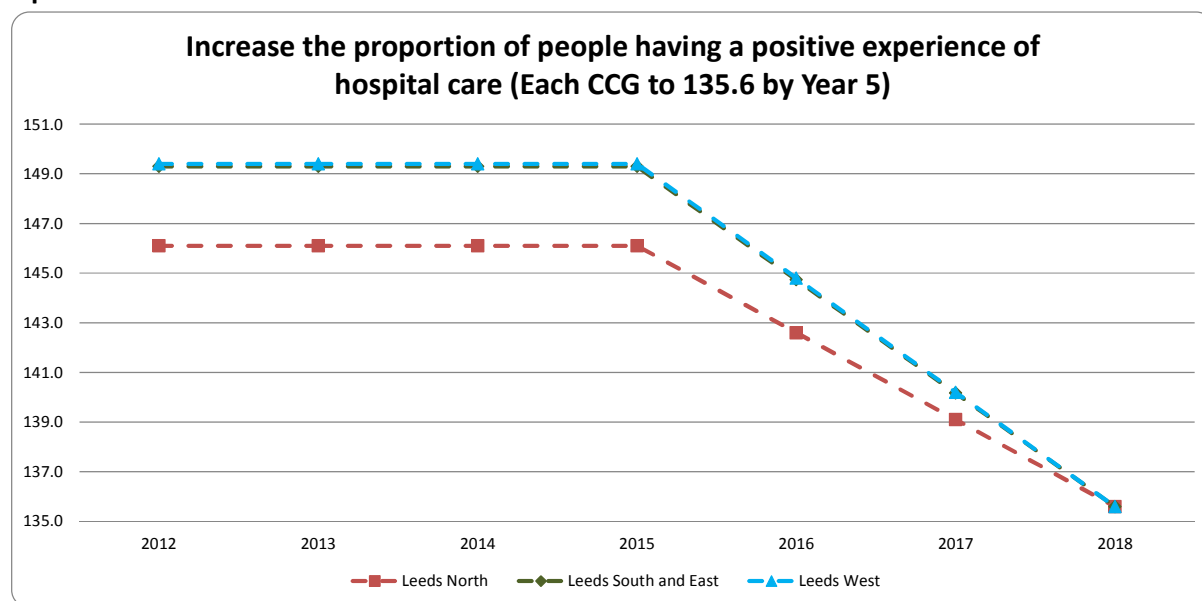


General Commentary	15 questions from the inpatient survey (incl waiting times / apt changes / conflicting messages / delays to discharge / decision involvement / communication / noise / cleanliness / food / dignity / respect etc.) A count of negative responses (poor or very poor) within the patient survey – main target will be LTHT for all three CCGs and Harrogate for Leeds North CCG. (Low score best)
Targets	No national target identified.
Key Benchmarks	Data in Ambitions Atlas 2012 data Leeds South and East - 149.3 Leeds North – 146.1 Leeds West – 149.4 Best in England – Newcastle 108.6 Worst in England – 208.8 England average 142 Top quintile 135.6
Initiatives to impact on this measure	CQINS in LTHT contract Discharge planning Constitution plans Work on 6 Cs Shared decision making with Acutes
Forecast	Option 1 – stay flat years 1 & 2 and then 3-5 each CCG aims for best quintile

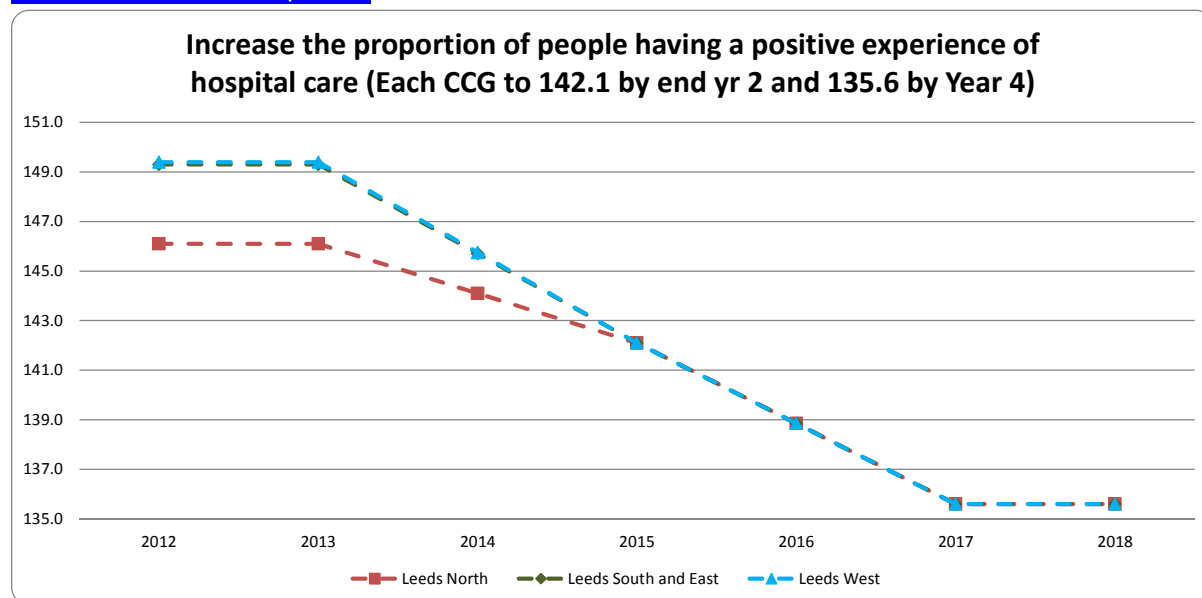
<p>Commentary / Proposed level of Ambition</p>	<p>nationally i.e. 135.6 for all providers by year 5</p> <p>Option 2 start now, 142.1 by end of year 2 & year 4 135.6 – then maintain top quintile position nationally.</p> <p>All 3 CCGs committed to Option 2</p>
---	---

Measure Graph: Linea forecast proposed ambition(s)

Option 1



Submitted Position - Option 2

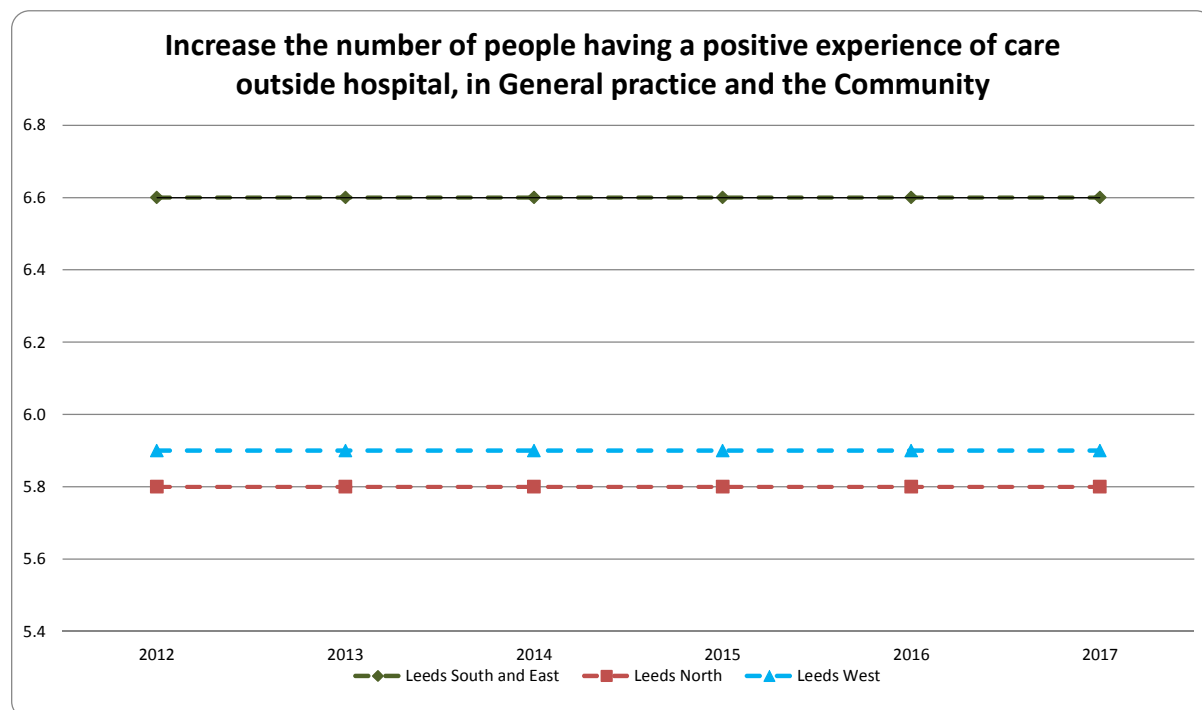


<p>Cost / Benefit Analysis (affordability)</p>	<p>Given a view on the level of ambition, based on trend and peer review, the impact (cost / benefit) of the agreed actions will be modelled to assess whether the proposed actions will deliver the required change and the associated cost.</p>
---	---

APPENDIX D - Summary Paper – Priority Measures (5 Yr Plan) – Patient experience of Primary Care GP services

Area	Quality
Measure(s)	Patient experience of Primary Care GP services
Data Source	Source: NHS England Ambitions Atlas Units - This is a composite rate per 100 patients of 'fairly poor' or 'very poor' across GP services and GP out of hour services (Crude Rates)

Measure Graph: Linea forecast if “do nothing additional / continue as is”

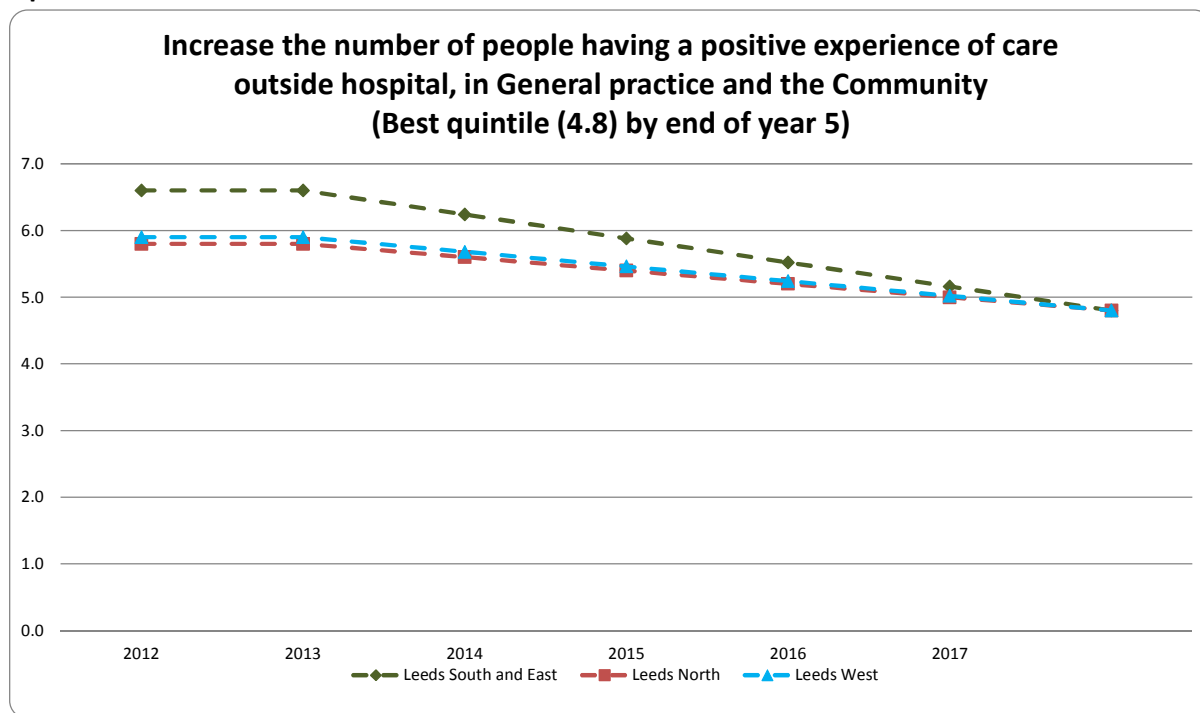


General Commentary	Higher the score, the worse the position Composite measure of GP in hours and GP OOH.
Targets	No national target identified. Anticipated to be an individual CCG target focus.
Key Benchmarks	England best 2.6 (Surrey) England worst 13.0 (Bradford) England average 6.1 Best quintile 4.8
Initiatives to impact on this measure	In Hours: Practice MOTs Practice engagement schemes Members meetings New GP Contract 7 Day working Primary Care Strategy Out of Hours: 111 CQINS in OOH Contract

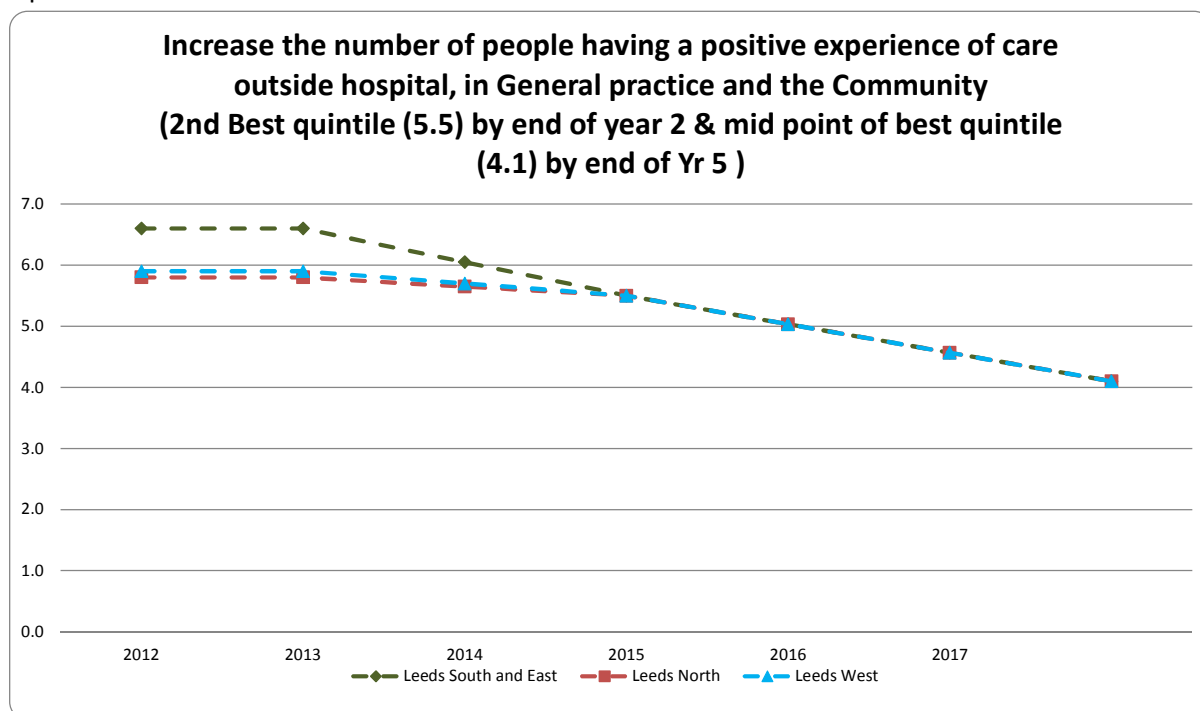
<p>Forecast Commentary / Proposed level of Ambition</p>	<p>Option 1 to get to best quintile by year 5 Option 2 to get to second best quintile by year 2 and to get to mid point of best quintile by year 5 Option 3 (New April 14) LSE & West to get to best quintile by year 5 and North to maintain its position relative to LSE</p>
--	---

Measure Graph: Linea forecast proposed ambition(s)

Option 1

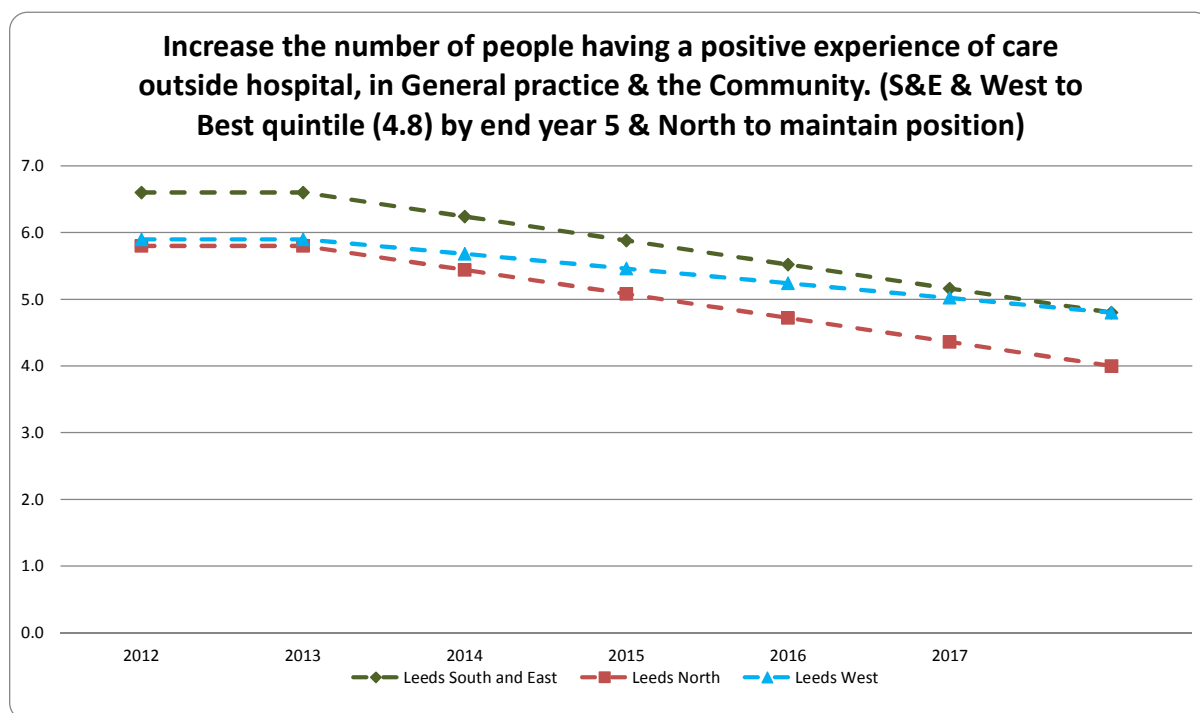


Option 2



Option 3: (New in April 14) – Submitted Proposal

LSE & West to get to best quintile by year 5 and North to maintain its position relative to LSE



Leeds S&E would move from 6.6 in 2013 to 4.8 in 2018 (27% improvement in the 5 years).
 Leeds North would move from 5.8 in 2013 to 4.0 in 2018 (31% improvement in the 5 years).
 Leeds West would move from 5.9 in 2013 to 4.8 in 2018 (19% improvement in the 5 years).

Cost / Benefit Analysis (affordability)	Given a view on the level of ambition, based on trend and peer review, the impact (cost / benefit) of the agreed actions will be modelled (April to June 2014) to assess whether the proposed actions will deliver the required change within a sustainable cost base.
--	--