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

## Narrative to support Unify submission by Leeds West CCG 04/04/2014

### 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% | AMBER | GREEN |
| Non-admitted patients to start treatment within a maximum of 18 weeks from referral – 95% | GREEN | GREEN |
| Patients on incomplete non-emergency pathways (yet to start treatment) should have been waiting no more than 18 weeks from referral – 92% | GREEN | GREEN |
| **Diagnostic test waiting times treatment** | | |
| Patients waiting for a diagnostic test should have been waiting less than 6 weeks from referral – 99% | GREEN | GREEN |
| **A&E waits treatment** | | |
| Patients should be admitted, transferred or discharged within 4hours of their arrival at an A&E department – 95% | GREEN | GREEN |
| **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% | GREEN | GREEN |
| Maximum two-week wait for first outpatient appointment for patients referred urgently with breast symptoms (where cancer was not initially suspected) – 93% | GREEN | GREEN |
| **Cancer waits – 31 days treatment** | | |
| Maximum one month (31-day) wait from diagnosis to first definitive treatment for all cancers – 96% | GREEN | GREEN |
| Maximum 31-day wait for subsequent treatment where that treatment is surgery – 94% | GREEN | GREEN |
| Maximum 31-day wait for subsequent treatment where that treatment is an anti-cancer drug regimen – 98% | GREEN | GREEN |
| Maximum 31-day wait for subsequent treatment where the treatment is a course of radiotherapy – 94% | GREEN | GREEN |
| **Cancer waits – 62 days treatment** | | |
| Maximum two month (62-day) wait from urgent GP referral to first definitive treatment for cancer – 85% | AMBER | GREEN |
| Maximum 62-day wait from referral from an NHS screening service to first definitive treatment for all cancers – 90% | GREEN | GREEN |
| 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 | GREEN | GREEN |
| **Category A ambulance calls treatment** | | |
| Category A calls resulting in an emergency response arriving | GREEN | GREEN |

| | | |
|---|---|---|
| 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% | GREEN | GREEN |
| **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. | GREEN | GREEN |
| **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%. | GREEN | GREEN |
| **ADDITIONAL REQUIREMENTS FOR 2014/15** | | |
| **Mixed Sex Accommodation Breaches** | | |
| Minimise breaches | GREEN | GREEN |
| **Referral To Treatment waiting times for non-urgent consultant-led treatment** | | |
| Zero tolerance of over 52 week waiters | GREEN | GREEN |
| **A&E waits** | | |
| No waits from decision to admit to admission (trolley waits) over 12 hours | GREEN | GREEN |
| **Cancelled Operations** | | |
| No urgent operation to be cancelled for a 2nd time | GREEN | GREEN |
| **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. | AMBER | GREEN |

## *Key Risks*

**Referral to Treatment (RTT) Admitted Patients (and new 52 week waiter target):** There has been more than 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. The 52 week standard is now been met and sustained and all providers have successfully tackled their very longest waiting patients. However, 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 these risks 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. We are finalising allocations for

14/15 with a view to the spinal pathway being fully commissioned by CCGs and we are encouraging LTHT to discuss the foot and ankle service 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 2013/14 through increased capacity and improved performance management within providers. Whilst we anticipate that we will meet the overall threshold of 1% across diagnostic modalities there remains an outstanding risk that we will not meet waits in individual modalities, and in particular endoscopy. To minimise this risk we are working with providers to ensure that capacity is increasing to keep pace with growing demand. As such:

- 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 2 Week Wait following GP referral**: Leeds CCGs continue to work with LTHT to minimise risk of 2 week wait breaches. While there have been some problems in Q4 these have been resolved, and LTHT has a renewed focus on capacity and demand planning for these pathways.

**Cancer 62 Day Wait following screening and upgrades**: Leeds CCGs continue to work with LTHT to minimise risk of breaches on all 62 day cancer waits. However there remains a risk in terms of maintaining 62 day target for patients referred from screening or subject to a consultant upgrade. This is due to these targets being 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 2013/14 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 and CCGs are working with commissioners 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.

<u>Role of providers</u>

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 “sense check” 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: 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 West CCG ambition for this measure is to deliver the national requirement of a 3.2% improvement in 2014/15 and subsequent years. Our target reflects the population need in LWCCG, and the fact that Leeds West PYLL compares favourably with similar CCGs.

### 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 West CCG aspires to halve the gap between itself (currently on 74.2) and the best in the country (79.7) over 5 years. Leeds West CCG would move from 74.2 in 2012/13 to 76.95 in 2018/19 (2.75% 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 31 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 West CCG aspires to improve from its current position of 149.4 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 5.9, LW 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 - 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: 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 West CCG has selected the following further indicator from Domain 4 of the CCG Outcomes Indicator Set:

- Improving Patients experience of Outpatients Services

The CCG is the lead commissioner citywide for Outpatient Services, and working with LTHT to improve quality of all 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 our providers over the forthcoming few weeks to agree our level of ambition and to ensure that they have plans in place to improve scoring in line with the agreed trajectory.

**7. Quality Premium: Self-certification re: Improving reporting of medication errors**

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

A Health Economy wide push on medication safety would improve the effectiveness and safety of patient care and, for around 1 in every 10 people who receive NHS care, improving their experience. This is an area that Leeds is good at, and can capitalise on in terms of patient care and national reputation.

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

| | National position for incidents | Approximate number pa | % of these which are medicines related |
|---|---|---|---|
| LYPFT | 15th out of 56 | 700 | 10.8% |
| LTHT | 7th out of 30 Trusts | 1600 | 9.1% |
| LCH | 3rd out of 19 | 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 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 familiarly by practices that allows quicker reporting process. We will also need to explore developing incentives to practices to encourage reporting. This will vary across CCGs.

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

Medicines incident reporting is just one element of 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. 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.

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.

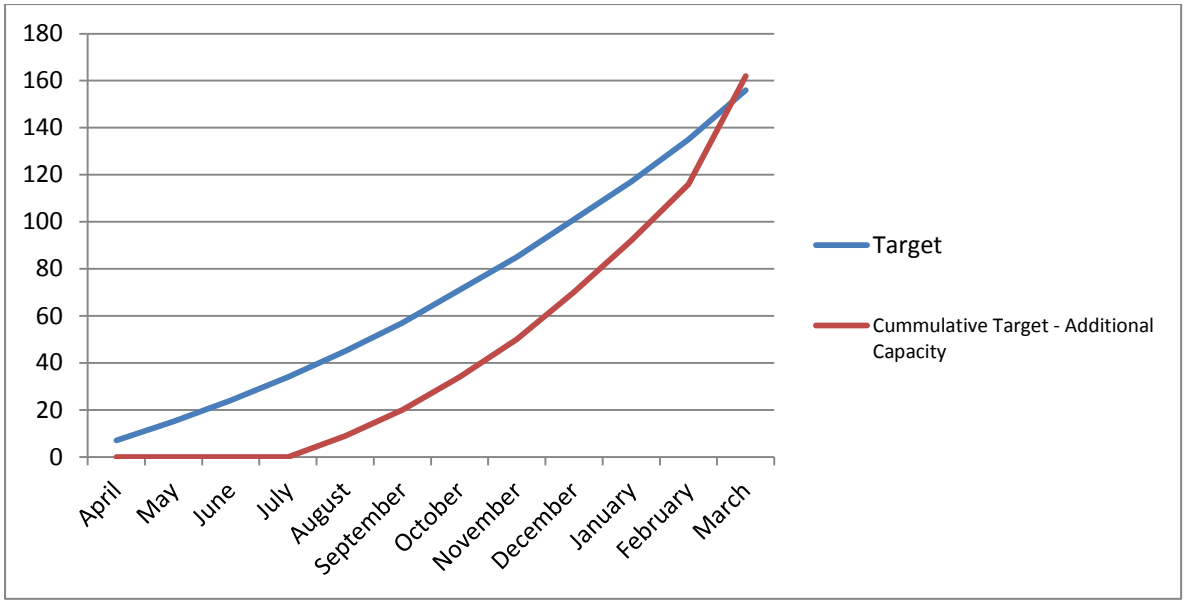
**8. Local Quality Premium**

Alcohol misuse is also a key Health and Wellbeing Strategy priority for the city. Both the city and NHS Leeds West CCG has high levels of emergency admissions when compared to national benchmarks of mortality and admissions as a result of alcoholic related liver disease. As a result of the above and feedback from the public our member practices have identified reduction in alcohol related harm as a key priority for Leeds west CCG

**Progress to date:**

Working in partnership with colleagues in public health at the Local Authority a specialist community alcohol treatment worker was appointed the service was implemented in August 2013, and is operational from a clinic in the area of highest need. A second worker has also been recruited which will increase further the number of community treatments on offer. The second worker will be operational from March 2014. We have also worked with our 38 member practices around identification and referral of suitable patients.

Below is a graph detailing the performance against trajectory to date. There is a straight line to August 2014 for when staff have been successfully appointed.




***Additional capacity***

The above show that we have just begun to meet the trajectory for additional treatments in quarter 3 and with the additional capacity being implemented from 1st March 2014 we are confident that we will meet the target for the year by the end of Quarter 4.

**Proposal for 2014/15**

We continue to believe alcohol admissions and liver disease is a key priority for our CCG and as such we would wish to continue to make progress in this areas. Through a new appointment we will provide an additional 150-160 treatment places which will raise our treatment rate from 12% to 14% an increase of 12.5% on previous year

| Indicator Definition (please specify the local measures chosen) | | Numerator | Denominator | Measure |
|---|---|---|---|---|
| **Local Priority 1** | Number of Alcohol Dependent Patient In Treatment as % | 1060 | 75450 | 14% |

Latest figures indicate that work undertaken to date has reduced hospital admission rates for liver disease. Figures available from H&SC Information centre for Leeds West CC for indicator 1.8 Alcohol related liver disease are shown below

2011/12 - 52.7/100,000
2012/13 - 42.6/100,000

However given that the England average for 12/13 for 25.7 we believe we have some way to go. As the indicator for admissions always lags and is difficult to measure we would suggest using alcohol treatment numbers as a proxy for in year progress

## 9. CDiff trajectory

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

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.

Estimated dementia prevalence for each CCG is:

| *persons with dementia* | 2013 | 2014 | **2015** | **2016** |
|---|---|---|---|---|
| Leeds West | 3,544 | 3,632 | **3,722** | **3,810** |
| Leeds North | 2,389 | 2,448 | **2,509** | **2,568** |
| Leeds S&E | 2,567 | 2,631 | **2,696** | **2,760** |
| 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 |
|---|---|---|---|---|
| **People with dementia in Leeds LA (estimate)** | 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 February 2014 – Leeds West CCG 44.4%, Leeds North CCG 39.9%; Leeds South & East CCG 36.5%). 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.

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. 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.

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 Leeds Community health service is undertaking a capacity review. This will be reported to commissioner in June 2014.

**12. Activity data submission**

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.

**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 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 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 2015/166 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.

**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 paper was circulated and put on the agenda for the Health and Wellbeing Board on 12 March. Due to time constraints, there wasn't an in-depth discussion at the 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.

**14. 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.

**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

**16. Paragraph 36 of Everyone Counts:**

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 West CCG can confirm it has established a fund to support older people as set out in: Planning for Patients 2014/15 to 2018/19.