NHS Leeds South and East Clinical Commissioning Group
One-Year Operational Plan 2016/17 - Submission to NHS England
Final Submission – 18 April 2016

Introduction

NHS Leeds South and East Clinical Commissioning Group (NHS LSE CCG) is required to develop a One-Year Operational Plan for 2016/17 that meets the requirements outlined in the NHS Planning Guidance; *Delivering the Forward View: NHS planning guidance 2016/17-2020/21.*

As part of the planning process for 2016/17, CCG's and providers are required to submit operating plans in the form of nationally mandated Excel templates for activity and finance, and numerical trajectories. In addition, there is a requirement to produce a one-year operational planning narrative that details the rationale behind the planned activity, and our ambitions as an organisation in delivering key national priorities and programmes of work in 2016/17 including year one of the emerging five-year Sustainability and Transformation Plan (STP) 2016/17-2020/21, New Models of Care (NMC), and NHS Right Care. This narrative is presented below; our Financial Plan, which will support delivery of our plans, is submitted separately.

An overview of NHS Leeds South and East CCG

NHS LSE CCG is one of three NHS organisations in Leeds. Responsible for the planning and commissioning of health services, the CCG is made up of 42 member GP practices responsible for a total population of approximately 257,000. Our area includes some of Leeds' most deprived communities, as well as the more affluent rural areas on the outskirts of the city. Our organisation is led by clinicians (healthcare professionals including GPs, nurses, managers and hospital consultants) who can really make a difference to local health services through their day-to-day knowledge of patient need and the health problems affecting our communities.

Aligning our plans to the Leeds Health and Wellbeing Strategy

Leeds is the UK's third largest city with a population of around 750,000, expected to rise to around 840,000 by 2021. It is also one of the greenest cities in the UK with 20 major parks and two thirds of the district is classified as rural.

Leeds is a truly diverse city with over 140 ethnic groups including black, Asian and other minority ethnic populations representing almost 19% of the total population (2011 census). In the coming years, Leeds is also expecting to see an increase in the number of children of primary school age as well as the numbers of those aged over 75 and over 85.

The health of people in Leeds is generally lower than the England average. This is strongly associated with the high levels of deprivation experienced by the 150,000 people in Leeds who are living in the most deprived neighbourhoods nationally. Whilst overall life expectancy has been increasing for all Leeds residents, the life expectancy for a man living in a deprived Leeds neighbourhood is 12 years lower than a man living in an affluent part of Leeds.

The major issues, contributing to lower health and wellbeing, identified in all Leeds Joint Strategic Needs Assessments (JSNAs) include: deprivation, mental health, smoking, alcohol, obesity, health conditions such as cancer and cardio vascular disease and dementia, children and young people's health, financial inclusion, housing, social isolation and older people, equality groups and Issues for localities.

The current Joint Health and Wellbeing Strategy (JHWBS) has identified a range of priorities to be addressed by all partners. Over the last two years, CCGs in Leeds have worked with other partners on a range of plans to address those priorities, and a summary of the current strategy is shown below.

Leeds Joint Health and Wellbeing Strategy 2013-2015

Vision for health & wellbeing: Leeds will be a healthy and caring city for all ages

Principle in all outcomes: People who are the poorest, will improve their health the fastest

Indicator: Reduce the differences in life expectancy between communities

Outcomes	Priorities	Indicators
People will live longer and have healthier lives	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	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
People will live full, active and independent lives	4. Increase the number of people supported to live safely in their own home 5. Ensure more people recover from ill health 6. Ensure more people cope better with their conditions	7. Rate of hospital admissions for care that could have been provided in the community 8. Permanent admissions to residential and nursing care homes, per 1,000 population 9. Proportion of people (65 and over) still at home 91 days after discharge into rehabilitation 10. Proportion of people feeling supported to manage their condition
People's quality of life will be improved by access to quality services	7. Improve people's mental health & wellbeing 8. Ensure people have equitable access to services 9. Ensure people have a positive experience of their care	11. The number of people who recover following use of psychological therapy 12. Improvement in access to GP primary care services 13. People's level of satisfaction with quality of services 14. Carer reported quality of life
People will be involved in decisions made about them	10. Ensure that people have a voice and influence in decision making 11. Increase the number of people that have more choice and control over their health and social care services	15. The proportion of people who report feeling involved in decisions about their care 16. Proportion of people using NHS and social care who receive self-directed support
People will live in healthy and sustainable communities	12. Maximise health improvement through action on housing 13. Increase advice and support to minimise debt and maximise people's income 14. Increase the number of people achieving their potential through education and lifelong learning 15. Support more people back into work and healthy employment	17. The number of properties achieving the decency standard 18. Number of households in fuel poverty 19. Amount of benefits gained for eligible families that would otherwise be unclaimed 20. The percentage of children gaining 5 good GCSEs including maths & English 21. Proportion of adults with learning disabilities in employment 22. Proportion of adults in contact with secondary mental health services in employment

City Wide Plans that underpin delivery of the current Joint Health and Wellbeing Strategy

Leeds CCGs, Local Authority and Partners are working together through the Health and Wellbeing Board (HWBB) and sub committees such as the Integrated Commissioning Executive (ICE) and the Transformation Board to deliver accessible and integrated health and wellbeing services that deliver safe, effective and high quality care and support. This includes;

- Promoting the NHS Health Check helping people reduce and manage their risk of heart disease, stroke, kidney disease and diabetes;
- Providing a range of services that support people to adopt healthy lifestyles;
- Ongoing move towards increased integration of health and social care services;
- Ongoing improvement in increasing access to a range of community mental health services e.g. Improving Access to Psychological Therapies (IAPT);
- Development of screening services and working with primary care to encourage greater uptake to support early detection of cancer;
- Development of a range of partnerships with Third Sector that support communities to improve their wellbeing e.g. services that reduce social isolation; provide opportunities for volunteering; act as a "gateway" to advice, information, and services; and promote health and wellbeing; and
- Securing capacity across a range of acute and community services that ensure that the Leeds population receive timely diagnosis and treatment for services. This ensures that if people do get ill they can be sure they have the best chance of recovery.

All three Leeds CCG plans continue to build on the above through working with the local authority and all sectors i.e. Primary, Community, Mental Health and Acute Services to ensure that we continue to offer safe, timely high quality services that work to keep people well and that when they fall ill will continue to be seen within national and locally agreed time limits.

The new Joint Health and Wellbeing Strategy 2016/17-2020/21

Leeds is nearing completion of its new JHWBS, which will set out a new five- year vision for the city and its people. The new strategy builds on many of the priorities outlined in its predecessor, and as such, the three Leeds CCGs Operational Plans have been developed to support both existing and emerging priorities outlined in the strategy. Our CCG plans recognise that there is a strong connection between people, populations and organisations, and our approaches reflect the emphasis on patient empowerment ensuring that "people will be actively involved in their health and their care".

Our CCG plans are closely aligned with the 12 priority areas outlined in the new JHWBS for Leeds, and the following provides some examples of how our plans will underpin delivery of it.

Priority 1 - A Child Friendly City and the best start in life: our plans support the goal of a child friendly city and include the following key initiatives in 2016:

a) Delivering year two of the Maternity Strategy for Leeds with a focus on improving perinatal mental health and services for women with learning disabilities
b) Improving access to children and young people's emotional and mental health services including delivery of a single point of access;
c) Implementing NMC, exploring what Primary Care can do in supporting vulnerable children and young people; and

d) Continuing to develop our local 'Best Start' zones work programme, focused on improving maternal and infant health.

Priority 3 – Strong, engaged and well-connected communities: we will continue to build partnerships to reduce health inequalities, for example our work with the South East Leeds Health and Wellbeing Partnership Forum. In 2015/16 we launched our Third Sector Grants scheme, working with Leeds Community Foundation (LCF) to coordinate grants to voluntary and community organisations to support people and communities to improve their health and wellbeing by combating social isolation; providing opportunities for volunteering; acting as a "gateway" to advice, information, and services; and re-connecting people and communities. Linked to our Social Prescribing service, we are able identify gaps in the provision of services that support the health needs of our communities.

Priority 7 - Maximise the benefits from information and technology: Leeds commissioners are strong supporters of the Leeds Care Record (LCR) with ambitious plans to build on progress to date. Improving access to information through technology is a key enabler to the integration of services. Technology is also a key driver towards improving patient experience, quality and safety.

Priority 8 - A stronger focus on prevention: Strategic Aim 1 is all about promoting healthy lifestyle choices in the South and East Leeds population, in order to reduce inequalities in our communities and prevent our population from dying prematurely. We have a key aim to continue to reduce health inequalities and potential years of life lost (PYLL) over the next 3 years, and our approach will be to focus on shifting investment from treatment to prevention, placing significant focus on people and communities who have poor health and high prevalence of disease. Our plans will use evidence from the NHS Right Care Programme to identify areas of opportunity.

Priority 9 - Support self-care, with more people managing their own conditions: we will build on work already aimed at supporting self-care including social prescribing and focussed work in primary care through the Quality Improvement Scheme and Year of Care (YoC) approach to self-management. We will use the opportunity provided through co-commissioning of primary care to support our plans to better integrate services to enable patients to manage their own conditions.

Priority 10 - Promote mental and physical health equally: the Leeds Mental Health Framework (2014/15-2016/17) signed off by the HWBB has a stated priority of improving the integration of physical and mental health services, and is the guiding document for commissioning. Investment in Mental Health services in 2016/17 is a key priority for all health economies. The NHS in Leeds already funds mental health services as a higher percentage of overall spend when compared with other areas. Our plans in 2016/17 will focus on a number of key priorities which include:

a) Improving the quality of care available in a crisis and effective delivery of our local Crisis Care Concordat
b) Redesigning community based mental health services in partnership with the Local Authority and third sector;
c) Testing integration of mental health expertise with primary and community care through NMC.

Priority 12 – Best Care, Right Place, Right Time: CCGs are responsible for commissioning services which deliver key national constitution targets around access to services. In 2016/17, we will continue to commission to meet patient demand, improve standards of care and integrate services that deliver best care at the right time and place. As we move forward, we will develop plans that will continue to deliver these targets but with an approach that will

result in a shift in service provision from treatment to prevention, and in meeting the needs of our population through improved access and provision in community and primary care settings.

Specific responses to NHS England queries

The following narrative answers the four key questions received from the NHS England (NHSE) Area Team as part of the 2016/17 planning round.

1. **Provide a short narrative describing how the CCG's commissioning plans for 2016/17 will meet Constitutional standards and the nine must-do priorities identified in "Delivering the Forward View"**

The CCG is committed to improving the quality of services for its patients. This requires a good access to the full range of services including general practice, acute, community and mental health services, in a way which is timely, convenient and specifically tailored to different population groups. The table below outlines expected year-end performance (2015/16) in relation to key NHS Constitution standards, and an assessment of risks to delivery in 2016/17 as of March 2016.

Pledge	2015/16 Projected Delivery	Risk to Delivery 2016/17
Referral To Treatment waiting times for non-urgent consultant-led treatment		
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		
Maximum two-week wait for first outpatient appointment for patients referred urgently with breast symptoms (where cancer was not initially suspected)		
Cancer waits – 31 days treatment		
Maximum one month (31-day) wait from diagnosis to first definitive treatment for all cancers		
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		
Maximum 31-day wait for subsequent treatment where the treatment is a course of radiotherapy		
Cancer waits – 62 days treatment		
Maximum two month (62-day) wait from urgent GP referral to first definitive treatment for cancer		
Maximum 62-day wait from referral from an NHS screening service to first definitive treatment for all cancers		
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		
Ambulance Calls - All Handovers between ambulance and A&E must take place within 15 minutes		
Ambulance Calls - All crews should be ready to accept new calls within a further 15 minutes		
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%.		

We have worked closely with our main provider for acute services, Leeds Teaching Hospital Trust (LTHT), in ensuring we are commissioning sufficient capacity within provider capabilities, in order to deliver all NHS Constitution Standards in 2016/17. Working with LTHT and NHS Leeds West CCG (NHS LW CCG) as lead commissioner CCG, we will agree realistic and deliverable plans and trajectories, ensuring that the necessary capacity is available to deliver the care required and is fully embedded in our activity plans for next year. This will also support LTHT and the wider system in accessing the Sustainability and Transformation Fund for 2016/17.

Although we are planning to meet all national planning standards and commitments without any exceptions, there are risks in delivering the following Constitution Standards in 2016/17:

- The Accident and Emergency (A&E) four hour emergency care standard (ECS) – risk to delivery is greatest during winter, and remains a challenge for LTHT. During 2015/16, the system experienced unprecedented numbers of patients being admitted to hospital during November - March, with fewer patients attending for minor treatment. This has had a negative impact on our A&E 4 hour standard. Similarly there are risks associated with the delays in discharge processes in and out of hospital, leading to higher than usual numbers of patients needing a hospital bed.

  We are still in discussions with LTHT regarding finalising trajectories for A&E with NHS Improvement (NHSI). These discussions are taking place within the context of the following:

  a) On-going negotiations between LTHT and NHSI regarding expectations of recovery trajectories and access to the Sustainability and Transformation funds; and
  b) The development of the West Yorkshire (Leeds) STP and expected impact on demand on A&E and initiatives to support flow out of hospital.

  The CCG believes that its 2016/17 operational plan, alongside further work being undertaken within the STP, will secure the delivery of the ECS standard across 2016/17, and is working with partners to ensure a common position with regards to anticipated impact of those plans through the System Resilience Group (SRG) and other partnership forums. Therefore at this point in time, we are confident that we will be able to secure contract sign off for delivery of the national standard.

- Diagnostic test waiting time's treatment – although performance against this target locally is expected to be met in 2015/16, there is a risk to delivery in 2016/17. Commissioners will mitigate this by maximising plurality of provision.

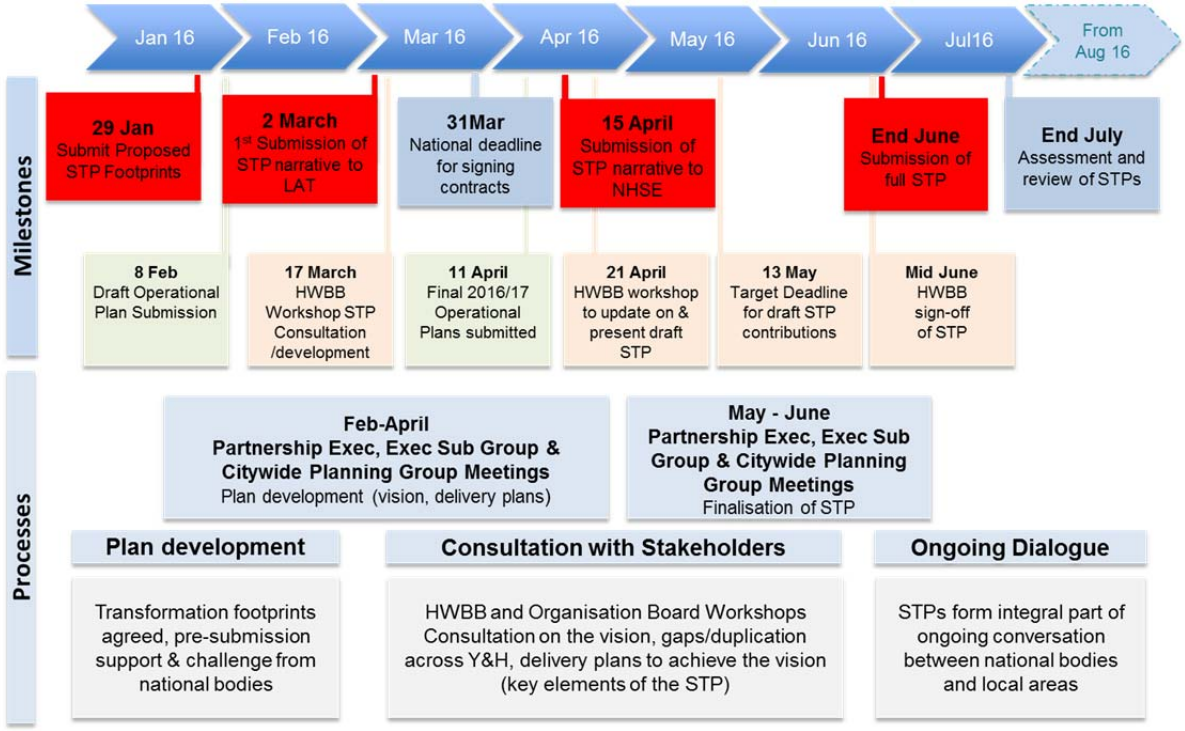
- Referral to Treatment (RTT) – although performance against this target locally is expected to be met in 2015/16, there is a risk to LTHT's ability to deliver the standard for incompletes in 2016/17. This is due to an expected increase in elective activity and the expected transfer of neurology outpatients from Mid Yorkshire. However, based on previous year's performance and analysis of waiters in South and East Leeds, we think it is reasonable to expect delivery of the 18 week RRT for incompletes during 2016/17.

- Ambulance handover targets – currently no Acute Trust has achieved this standard in 2015/16 which requires for 95% of patient handovers to take place within 15 minutes, and a further 15 minutes to prepare the crew and vehicles ready to respond to the next incident. This is currently a very challenging target due to the methods of data capture and being reliant on adequate capacity being available in the A&E department when there are surges of demand as the pattern of vehicles arriving is very unpredictable.

  We are still in discussions through our Lead Commissioner, with the Yorkshire Ambulance Service (YAS) regarding finalising trajectories for delivery of key response targets. Contracts for the service are still being finalised; as such, at this moment in time we remain confident that we will be able to secure contract sign-off for delivery of the national standard, and similar to the above, this will be closely monitored during 2016/17.

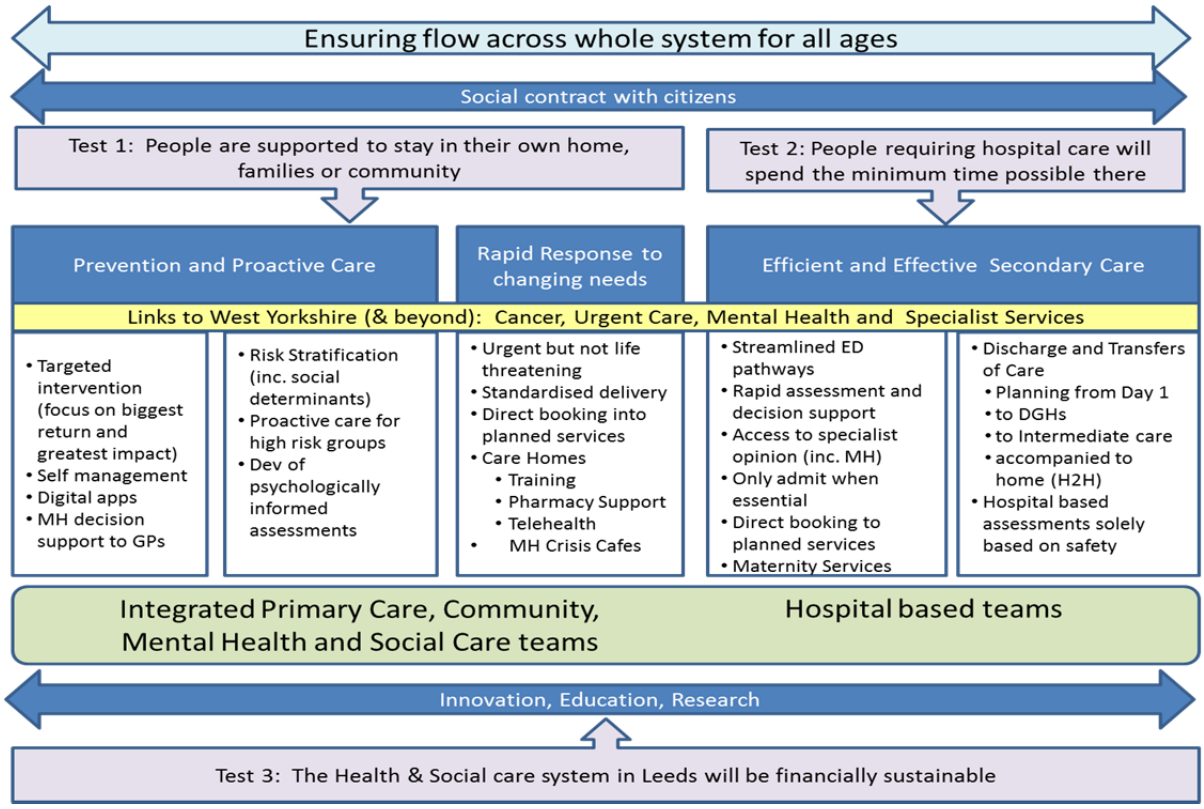
Must Do Number 1: Develop a high quality and agreed STP, and subsequently achieve what you determine are your most locally critical milestones for accelerating progress in 2016/17 towards achieving the triple aim as set out in the Forward View

The STP for Leeds is being developed through partnership working between all three NHS commissioners, all three NHS providers, and Leeds City Council (LCC). It will be a three-tiered plan with each tier focussing on initiatives appropriate to that tier. The three tiers are: West Yorkshire, Leeds and locality level, and it will be supported and signed off by all statutory organisations around the Leeds HWBB, ensuring local political support throughout the process. The following timeline presents an overview of how the Leeds STP will be developed alongside the local CCG One-Year Operational Plan.



At the core of the STP there will be a Leeds Service Description, which will set out what the services in Leeds will need to look like to address the local perspective of the identified three national gaps (health and wellbeing, care and quality and finance and efficiency). The Service Description will in turn be broken down into “elements”, each described in detail in a separate chapter of the STP.

The following schematic shows how these elements work together to form whole system flow:



NB. The three tests referred to above are the super-ordinate objectives that the seven statutory partners have agreed will drive whole system improvement within the City.

Other chapters will focus on implementation including:

- Consideration of the new service delivery mechanisms that will be required, including new organisational forms and relationships and innovative contracting arrangements
- How the Service Description will be implemented, including how Leeds will ensure it has the right level of capability and capacity to be successful;
- The impact that new service models will have for the key enablers of workforce, technology, estates and finance;
- How the anticipated benefits will be measured; and
- A roadmap, setting out key milestones which will need to be achieved to ensure that the Service Description is delivered.

The 2016/17 operational plans produced by each partner have been developed in accordance with the Planning Guidance and cognisant of the work taking place on the STP. These plans may need refreshing in the late summer/early autumn in the light of feedback from NHSE on the STP. All partners are prepared for this.

Must Do Number 2: Return the system to aggregate financial balance. This includes secondary care providers delivering efficiency savings through actively engaging with the Lord Carter provider productivity work programme and complying with the maximum total agency spend and hourly rates set out by NHS Improvement. CCGs will additionally be expected to deliver savings by tackling unwarranted variation in demand through implementing the Right Care programme in every locality

NHS LSE CCG have a strong track record in managing their financial resources and achieving their statutory financial duties. However, following a detailed analysis of the

financial planning assumptions across Health and Social Care as part of the city's five-year planning process, it concluded that if nothing changes in how health and social care services are currently provided in Leeds, collectively, those organisations will be facing a deficit position of circa £650m by the financial year 2020/21.

This needs to be considered in the context of the Leeds wide health and social care economy going into 2016/17. The financial plan continues to underpin our strategic priorities and has been updated to reflect:

- New commitments identified within the 2016/17 operating framework;
- New initiatives that underpin the work of the Transformation Board;
- Local priorities as developed by the Leeds CCGs working with partners that reflect local needs as identified through the JSNA; and
- Emerging priorities identified through engagement with patients and public and clinicians at CCG level.

Given the size of the overall financial challenge, and given that all statutory organisations are closely interlinked with integrated patient pathways, only whole system changes implemented and supported by all those organisations can have the required impact needed to retain financial balance within the health economy of Leeds. Many Quality, Innovation, Productivity and Prevention (QIPP) targets are therefore agreed to be delivered on a citywide footprint by providers and commissioners through a combination of transformation, innovation and organisational efficiency (including CCG running costs). Assumptions and key initiatives are described below within the context of key areas and programmes of work that will contribute to the system's ability in returning to financial balance.

Lord Carter Review

We will work with NHS Leeds North CCG (NHS LN CCG) and NHS LW CCG in supporting our main providers to embed the initiatives and proposals identified within the Carter Review.

Health and Care Partnership Executive

The system has responded by establishing a Health and Care Partnership Executive Group, with all partners represented to collectively tackle the financial deficit and bring the health economy back into balance. The requirement of a STP only strengthens this imperative and focuses individuals, organisations and the system to deliver genuine system savings.

Transformation

Leeds CCGs have an established Transformation Board. The board has developed a range of programmes to improve outcomes and quality, and reduce demand on the acute sector.

NHS Right Care programme

NHS Right Care is one of the approaches we will be using to support delivery of sustainable financial savings, in addition to improving the quality of services and care patients receive during 2016/17. To date, we have used Right Care as a resource to identify some of our local commissioning intentions through Commissioning for Value (CfV) insight and focus packs, the Spend and Outcomes Quadrant (SPOT), and Atlases of variation. By using this information, we have been able to ensure our plans are focused on those opportunities which have the potential to provide the biggest improvements in health outcomes for our population, resource allocation, and reducing inequalities in health.

The CCG is planning to establish a local Right Care Group early in 2016/17, which will report into the newly established citywide Sustainability Group for Leeds. Question 4 provides more information on our plans in relation to Right Care and how this will help us to reduce activity in our acute contracts in 2016/17.

Local QIPP Plan

The following points illustrate some of our plans to deliver financial savings in the context of commissioner QIPP in 2016/17. Please note, savings are net of planned growth to meet NHS Constitution standards:

- Introducing Shared Decision Making (SDM) in additional MSK pathways – in line with our plans to adopt the NHS Right Care approach to Patient Decision Aids. This is aimed at reducing elective activity and making estimated savings of £1.2m;
- Primary Care Quality Improvement Scheme and the systematic approach to Long Term Condition (LTC) management, aimed at reducing avoidable emergency admissions of people living with COPD and diabetes
- Social Prescribing, early diagnosis schemes - local and citywide schemes to reduce growth in unplanned attendances and admissions, along with the Primary Care Quality Improvement Scheme, are expected to make estimated savings of £0.5m; and
- Prescribing – the CCG has a number of local schemes to manage growth, deliver prescribing savings, and increase the capacity and capabilities within primary care with the introduction of a comprehensive clinical pharmacy service.

The schemes impact has been tapered from 1 April 2016, with the expectation they will be fully in-place by October 2016. For more information on our QIPP plans see our financial plans.

The CCG's financial plan has been prepared in line with guidance; *Delivering the Forward View: NHS planning guidance 2016/17 – 2020/21*, to reflect notified allocations, allocation growth and NHS England Business Rules, alongside local estimates of requirements relating to demographic growth, activity growth and risks. Our financial plans are subject to change pending management and mitigation of risks associated with contract negotiations.

Must Do Number 3: Develop and implement a local plan to address the sustainability and quality of general practice, including workforce and workload issues to do individually within own CCGs

With 42 member practices, covering the areas of Halton, Garforth, Richmond Hill, Middleton, Swillington, Kippax and Rothwell, our role to date has been about supporting our member practices to develop primary care and transform care delivered upstream. However, from 1 April 2016 we will be taking over the commissioning of primary care services, and developing a local primary care strategy that will outline our approach to this, and the overall transformation of primary care services in meeting patient needs.

We have been formally approved to take on the responsibility for commissioning primary care medical services (general practice only) from 1 April 2016. Since CCG's were established, general practice services have been commissioned by NHSE on a regional basis. Our aim by having the whole budget will be to use this resource more efficiently in supporting general practice to deliver a service that truly meets the needs of our local population.

As part of this process, the three CCGs in Leeds are currently agreeing what will be 'bought, made or shared' across the CCGs and with NHSE. The CCG has identified the resource necessary to ensure the CCG can increase capacity in this area – which includes the appointment to a Deputy Director of Primary Care role - and in ensuring we fulfil our responsibility as delegated commissioner for primary care in 2016/17, we are developing a local primary care strategy with our member practices.

Throughout 2015/16, the CCG has supported the development of primary care through the formation of four collaborative hubs to:

- Increase capacity either in or out of core hours depending on population need; and
- Create new posts within primary care such as clinical pharmacists; patient liaison workers to actively support individual patients to navigate the system; and expanding nursing roles linked to local population needs.

In 2016/17 we will use this model to significantly enhance the quality of primary care, giving patient's greater empowerment in their own care management. We will continue to implement the YoC approach to long term condition management; end of life care; significant event reporting; improving screening uptake; and collaborative work; in addition to investing in informatics to enable patients and health professionals to have modern tools that allow enhanced access to records and health information, and new ways of working.

We expect these developments, together with the establishment of a GP Federation involving 28 practices, to significantly enhance the sustainability of local general practice. With rising demand and challenges facing the workforce, there is a need for general practice to continue to build capacity and resilience through collaborative working. In addition to this we have trained GPs, managers and nurses in improvement methodology so that they can continually improve their own services and pathways. We are also committed to rolling out a comprehensive clinical pharmacy service in 2016/17 which will provide significant workforce to enhance capacity and capabilities within general practice.

In addition to the above, is the establishment of a patient centred NMC in 2016/17. Identified in the NHS Five Year Forward View, the model will proactively coordinate resources across organisational boundaries to meet the defined needs of a population. The model is built on the concept of a Local Team who will provide support to a population cohort working in an integral way with the current primary care team, including supporting those housebound patients and the local population living in care homes. Teams will be responsive to population need, dovetailing their activity with existing practice across the health care system in Leeds, and it is expected that this NMC will enhance and support the development of primary care at scale. We expect this way of working to pave the way for a new commissioning and contracting approach across the broader commissioning portfolio.

Must Do Number 4: Get back on track with access standards for A&E and ambulance waits, ensuring more than 95 percent of patients wait no more than four hours in A&E, and that all ambulance trusts respond to 75 percent of Category A calls within eight minutes; including through making progress in implementing the urgent and emergency care review and associated ambulance standard pilots

<u>Systems Resilience Group</u>

The Leeds SRG takes overall responsibility for ensuring the Leeds System remains resilient at times of the year and is prepared to deal with both predicted and unplanned surges in demand across the system. The SRG understands the important role of maintaining constant system has in delivering performance and quality and as a result continues to

invest across the system within all sectors. Despite excellent relationships and collaborative working which saw a much improved Delayed Transfer of Care (DTOC) position at a time of immense pressure, Leeds will fail to meet the ECS for 2015/16.

The SRG consistently review all investments and core services to guarantee continuous improvement, and explores options for new ways of working across organisational boundaries, in ensuring all available resources are maximised at peak times of the year.

A&E Four Hour Wait

The consistant achievement of the A&E four hour wait target (the ECS) remains a test for the Leeds system and LTHT. Whilst numbers of attendances in 2015/16 have been comparable with the previous years, performance has regularly remained below 95% since November 2015 due to high numbers of attendances on individual days, high admissions, impacting on the system's ability to recover.

The main challenge is associated with the higher level of acuity and complexity of patients presenting through the A&E department and exacerbated through the complications associated with discharging patients into either health or social care setting. We continue to work with the Trust Development Agency (TDA) to look at our discharge processes, where changes being implemented include:

- Improved multi agency working;
- Standardising internal LTHT board round processes;
- Implementation of new electronic (S2) referral systems using hospital's EPR;
- Implementing new AHP electronic referral processes;
- Increased use of multidisciplinary ward rounds to pull patients though the system;
- More robust approach to implementing choice;
- Embedding discharge to assess approach across many wards; and
- Redesigning equipment ordering processes.

In addition we will focus on developing our assessment units at the hospital front door. Where possible, this will ensure that a patient's episode of care is planned, enabling the deployment of valuable resources within the emergency department to reduce prolonged waits supporting the achievement of the ECS moving forward.

There are opportunities for the Leeds system to look deeper into why ECS has not been achieved and how we can evoke a system response at times of severe pressure to enable rapid recovery. The system wide implementation of a robust escalation management process Resource, Escalation, Action, Plan (REAP) continues to engage all partners including Primary Care. The REAP system provides 6 levels of escalation determined by a set of triggers that identify the specific areas of pressure to activate a targeted response and recover back to a more manageable position.

Longer term Leeds is developing an Urgent and Emergency Care Strategy and how NMC will provide opportunities for us to view the system differently focusing on out of hospital care. Leeds also works closely with colleagues across West Yorkshire on the Vanguard initiative in moving quicker, further, faster, in transforming the wider system to deliver the national Urgent and Emergency Care Review.

Ambulance Targets

The YAS continues to face a growth in demand especially in red calls across Yorkshire and the Humber. Red 1, 8 minute performance year to date (YTD) is currently at 76.9% for the

CCG; 66.2% for NHS LN CCG; and 68.3% for NHS LW CCG, against a national target of 75%. YAS wide, performance is slightly under target at 71.2%, and CCG's continue to work with their commissioning partners and YAS to address the main areas of concern including areas for additional investment.

YAS continue to explore opportunities to expand the skills and capabilities of their workforce to support developments across the urgent care system and support the growth in demand of more complex cases. Despite the support from commissioners, the implementation of clinical business unit improvement plans and investment schemes, there is still a significant risk to the delivery of the national quality indicators.

Proposals contained within the 2016/17 contracting and commissioning arrangements are designed to address the current issues and provide a new approach to the commissioning of ambulance services. The new strategy / group will include vanguard work streams, be consistent with recommendations from the Keogh review and will incorporate the three Yorkshire and Humber Urgent and Emergency Care Networks in order to improve the outcomes and experience for the local populations.

Must Do Number 5: Improvement against and maintenance of the NHS Constitution standards that more than 92 percent of patients on non-emergency pathways wait no more than 18 weeks from referral to treatment, including offering patient choice

RTT - the RTT standard has been delivered in 2015/16. Despite overall delivery key challenges remain in a number of specialties including orthopaedics and spinal surgery, plastic surgery and dental specialties. Work is ongoing with LTHT to secure capacity to deliver 92% target across all specialities in 2016/17 and with commissioning colleagues from all CCGs and NHSE to consider how we can better manage demand in some areas, particularly in dental specialties and in some regional specialties. The key risks to deliver lie in increased demand where it is not possible to grow or fund sufficient additional capacity, and on the inpatient side particularly where LTHT is seeing growth in patients previously treated in other hospitals, without sufficient additional theatre capacity available. This is a particular concern for specialties on the LGI site. There are also capacity risks linked to the agency spending cap.

In recognition of growth in demand Leeds CCGs are commissioning between 2% and 4% more elective activity across all providers. Activity growth varies between specialties with activity growth commissioned focussed on areas where there is a waiting list backlog and/or where we have seen growth in demand.

Trajectories have been developed on basis of commissioned activity and on assumption that providers can manage case-mix in a way that ensures that patients can be seen in order of priority.

Note: In the past the local Independent Sector providers have been able to provide additional capacity to support the elective care position, but this has not been so forthcoming in 2015/16. To mitigate this LTHT is working to improve internal productivity as far as possible and are working collaboratively with other providers to try to maximise access to theatres locally.

Must Do Number 6: Deliver the NHS Constitution 62 day cancer waiting standard, including by securing adequate diagnostic capacity; continue to deliver the constitutional two week and 31 day cancer standards and make progress in improving one-year survival rates by delivering a year-on-year improvement in the proportion of cancers diagnosed at stage one and stage two; and reducing the proportion of cancers diagnosed following an emergency admission

Cancer 62 wait following GP referrals

There has been a substantial improvement in the position of both Leeds CCGs and LTHT during 2015/16 with all cancer standards including 62 days being met in Quarter 3 of 2015/16. The LTHT position is still somewhat reliant on reductions in the numbers of late referrals from other providers, but a great deal of work has been done internally within LTHT to improve pathways and capacity within the organisation. LTHT's executive team continues to work with other providers and CCGs are working with commissioners to reiterate the importance of the referral arriving before day 38. It is anticipated that the West Yorkshire Wide Healthy Futures Programme will support long-term sustainability of the 62 Day Target across LTHT. Individual CCG performance is still at risk in some months because of small numbers being treated in any one month, but overall the risks to non-delivery are significantly reduced. There is excellent joint working in place, and all parties are committed to develop and improve cancer pathways and cancer outcomes as well as timeliness of appointments and treatments. There is, however, recognition that the new guidance may create additional demand at a faster rate than capacity can be created and there are risks particularly around diagnostic capacity which we are working jointly to address.

Through the Leeds Cancer Strategy Board we are developing an action plan to increase early presentation, detection and treatment of cancer which will result in improvements on proportion of patients diagnosed at stages 1 and 2 and a reduction in emergency presentations.

We are working with partners across the city to ensure there is a robust and sufficient system capacity to diagnose and treat new presentations of cancer in a timely manner including closer working between primary and secondary care, increasing open access diagnostics, and working with specialised services. There is also a need to focus on prevention of cancer and increasing access, screening uptake and early cancer diagnosis in vulnerable populations as the incidence of cancer will increase in the whole population over time.

Looking forward we will look to risk stratify follow-ups, for low risk patients, where clinically possible by pathway. We are also working toward implementing the Recovery Package for Cancer survivors. This includes:

- Health Needs Assessment
- Long Term consequences of treatment
- Recurrence
- Treatment summary
- Cancer Care Review
- Patient Educational Support

Locally, the CCG has been effective during 2015/16 in increasing the uptake of cancer screening services, especially bowel, and referrals for two week wait (2WW) suspected cancer services. Increasing the uptake of bowel cancer screening (BCS) was one of our local Quality Premium (QP) measures in 2015/16, where we have seen uptake of the test increase from 53.2% (August 2014) to 55.5% (August 2015) against a target of 56.35% following full implementation of the project. The CCG is confident that they will meet the 2015/16 QP target, and is looking to continue local investment in this area in 2016/17 as we recognise the importance of achieving earlier diagnosis in improving health outcomes and health inequalities for our population.

Must Do Number 7: Achieve and maintain the two new mental health access standards

a) more than 50 percent of people experiencing a first episode of psychosis will commence treatment with a NICE approved care package within two weeks of referral;

b) 75 percent of people with common mental health conditions referred to the Improved Access to Psychological Therapies (IAPT) programme will be treated within six weeks of referral, with 95 percent treated within 18 weeks. Continue to meet a dementia diagnosis rate of at least two-thirds of the estimated number of people with dementia.

We, along with all key partners in the city have signed up to joint citywide Leeds Mental Health Framework with a stated vision that 'Leeds is a city that values people's mental wellbeing equally to their physical health. Our ambition is for people to be confident that others will respond positively to their mental health needs without prejudice or discrimination and with a positive and hopeful approach to our future recovery, wellbeing and ability.'

The current MH Framework is aligned to expectations contained within the previous national strategy, and the Achieving Better Access 2020 report. Our most recent Programme of transformation work reflects some of the priorities stated in the February 2016 Mental Health Taskforce report, and current priorities include:

- Development of a citywide Information Portal to improve self-management, access and reduce crisis led contact with services;
- Redesign of community mental health services as enabler of NMC and including the development of a Single Point of Access;
- Crisis Care Concordat delivery – revision of Urgent Care pathway and alternatives to admission to achieve parity of esteem;
- Children and Families improvement – links with Children and Families commissioners in improving transitions, perinatal mental health and contributing to children's and young people's transformation plan; and
- Refresh of our local Mental Health Needs Assessment.

<u>IAPT Access and Recovery Targets</u>

Current performance indicates that waiting time targets will be achieved in 2015/16 and going forward into 2016/17. Recovery rates have shown significant improvement but access rates remain lower than required to hit the 15% prevalence rates, and we are not yet achieving 50% (see note below about level of acuity being reported by the NHSE Intensive Support Team (IST)).

Access to first treatment - 18wk (95% per month	100% - December local data
Access to first treatment - 6wk (75% per month	98.55% - December local data
Recovery rate (50% monthly)	45.4% - December local data
Access rate 1.25% monthly) to meet citywide prevalence rate annually of 15%.	0.74% - December local data

<u>15% prevalence access and 50% recovery rate</u>

A total of 8282 people had entered the service by the end of November 2015, 2,222 people less than the NHSE Area Team target (27%). Despite being significantly below target, 6% more people had accessed IAPT than in the same period in 2014/15.

As presented in the table above, we are not currently achieving IAPT recovery rates. However, Leeds is consistently in-line nationally with 'Reliable Improvement', an additional measure not yet mandated but definition and process of data capture agreed nationally and reported. Reliable Improvement refers to the number of people that have shown any degree of real improvement, improving by a set number of points on assessment scales, i.e. 'distanced travelled'. IAPT developed this complimentary measure to allow better understanding of the benefit that people get from treatment.

Breakdown of the most recent Reliable Improvement data (HSCIC, September 2015):

- National - 62%
- NHS LSE CCG - 65%
- NHS LN CCG – 67%
- NHS LW CCG – 59%

On current performance, it is unlikely that the three Leeds CCGs will meet the required 15% access and 50% recovery by quarter four in 2015/16. This is despite considerable efforts to improve access through on-line assessment, increased marketing and introduction of webinars and SilverCloud remodelling of the service. This is of real concern to us because we know our population has a higher prevalence of mental ill health; however we also know that the current model of psychological therapy is not quite right in meeting the needs of our population.

At the request of Leeds commissioners, The NHSE Intensive Support Team (IST) reviewed the Leeds IAPT service model in December 2015. Feedback from the NHSE IST was that the level of acuity of patients was higher than national average, the quality of the service was good and the overall model was right but productivity and flow could be improved. The outcome of this work has been used to inform the 2016/17 service specification. Work is already taking place to implement the NHSE IST recommendations, in particular increasing overall productivity.

The NHSE IST also plans to support the service to review their current clinical pathway with a view to improving capacity/flow through the service and reducing waiting times for Step 3 1:1 therapies. The service is expected to implement the changes to rapidly realign in order to meet the targets for 2016/17. Additional elements of service change will also contribute to improved efficiency - the development of single point of access for all mental health services to reduce number of referrals that are not suitable for IAPT, and piloting new approaches in primary care that provide a more "wraparound" role with additional social prescribing and other brief interventions, thus ensuring the right people are reaching the IAPT service.

As a result Leeds CCGS are expecting to deliver IAPT access and recovery rates targets by end 2016/17.

<u>IAPT Meeting new access targets (6 and 18 weeks)</u>

The CCG is currently meeting the waiting time targets for first treatment for both 6 and 18 weeks and this will be maintained in 2016/17.

<u>Dementia Diagnosis</u>

There are 5,872 people diagnosed with dementia on Leeds GP dementia registers (end December 2015); at end March 2015, Leeds as a whole had achieved a diagnosis rate (actual diagnosis as a proportion of estimated prevalence) of 66.9%, meeting the NHS England ambition of two-thirds. Considered as separate CCGs, NHS LSE CCG achieved 69.5%, NHS LW CCG 66.8%, and only NHS LN CCG was just below the national ambition at 64.1%. This is likely to be caused by the prevalence research not reflecting local population characteristics (e.g. prevalence of vascular disease and Type 2 diabetes). The national target is expected to be met in 2016/17.

Must Do Number 8: Deliver actions set out in local plans to transform care for people with learning disabilities, including implementing enhanced community provision, reducing inpatient capacity, and rolling out care and treatment reviews in line with published policy

We have plans in place, developed in partnership with health and social care providers, to ensure that those people with learning disabilities and highly complex needs receive timely and effective care and support to minimise reliance on specialist inpatient care and receive improved access to and outcomes from general healthcare in the NHS.

This includes investment in a joint health and social care planning team for young people in transition from children to adult services and adults with highly complex needs to ensure that care and support is developed and commissioned on a person centred basis. Plans also include review and development of respite care, and re-development of existing inpatient and community learning disability services, and the planned development of a specialist community service provision for people currently placed in out of area hospitals

In response to the national plan a local Transforming Care Partnership (TCP) has been established in 2015 under the leadership of NHS LN CCG Accountable Officer as the SRO. A programme of Care and Treatment Review's has been established and led by the lead commissioner (for Learning Disabilities) in NHS LN CCG on behalf of the three CGGs. The Local partnership has developed its first draft plan for submission as required and will work with NSHE to agree the final plan for implementation by 1 April 2016.

Must Do Number 9: Develop and implement an affordable plan to make improvements in quality particularly for organisations in special measures. In addition, providers are required to participate in the annual publication of avoidable mortality rates by individual trusts

The CCG recognises the three main tenets of quality i.e. patient safety, patient experience and clinical effectiveness. The CCG's commissioning intentions will ensure that providers are supported to manage additional demand for services associated with public health and primary care initiatives as well as demographic changes. The three CCGs' Quality Strategy focuses particularly on experience, effectiveness and safety and sets out the approach and intentions of the CCGs in the commissioning and monitoring of quality and services. It forms the blueprint for the quality teams across the city in how we commission and monitor services and is mapped against the requirements of the NHS national contract for health services and other national requirements, as well as planning for the development of new requirements.

The strategy is owned by the medical and nursing executive directors of the three Clinical Commissioning Groups and has oversight by the respective Quality and Assurance committees of each CCG. It is published on our website to inform the public of our intentions and ambitions in support of our statutory duties.

Building on the recommendations of the Francis, Keogh, and Berwick reports the strategy outlines our responsibilities, describes what we mean by the term 'quality' and how we assure ourselves that people within the populations we serve receive high quality care. It sets out our ambitions for improvement and also the governance arrangements that ensure Governing Bodies are sighted on the quality of services commissioned. It is based upon the five domains of quality as defined by Darzi and more lately the Care Quality Commission – Safety, Clinical Effectiveness, Patient Experience, Well-Led and Responsive.

In support of the strategy, the CCGS in Leeds have a range of initiatives and approaches to improving the safety of services and quality of care received. The following outlines key areas of focus:

Compassion in practice

In 2012 Jane Cummings, the Chief Nursing Officer for England published a vision and strategy for nursing entitled 'Compassion in Practice'; this is due to be refreshed in 2016. The CCG endorses and supports these commitments, and works with providers to ensure that they develop and implement plans to ensure that the values are adhered to by the nursing workforce.

Safeguarding

We host the Head of Safeguarding/Lead Designated Nurse for the three CCG's in Leeds and the citywide Safeguarding Team. The Lead Nurse works closely with the Nursing Directors of the CCGS to ensure a clear line of accountability for safeguarding. This accountability is reflected in each organisations governance arrangements within which Chief Officers in each CCG have overall responsibility for safeguarding.

The CCG Directors of Nursing and Head of Safeguarding/Senior Designated Nurse represent the CCGs on the Leeds Safeguarding Adult Board and the Local Safeguarding Children Board. Sub groups of both boards have representation from the CCGs by the Directors of Nursing and Designated Nurse.

Application of the Mental Capacity Act (MCA)

The Designated Nurse for Adults leads on the MCA and works closely with the main providers within Leeds to support the quality and improvement of MCA. The MCA is included as a standard within all CCG contracts, which are monitored closely through the quality contract meetings.

Prevent – Implementing Standards

The Prevent agenda is included in the Safeguarding standards that are incorporated into all contracts for the main providers. All providers have identified Prevent leads at operational level and exec level. All providers have included Prevent as part of safeguarding training and have started / have plans to start delivering health WRAP training. The Prevent agenda is also a KPI that is monitored through the Quality and Contracts meetings with providers

Response to Francis, Berwick and Winterbourne View

The CCG has assessed itself against the recommendations of these key national reports and developed action plans in response. The work is now incorporated into our everyday practice.

Serious Incidents and Never Events

The CCG has robust assurance mechanisms in place to monitor patient safety within providers and to ensure that all serious incidents (including never events) are robustly investigated, have appropriate actions plans developed as a result and ensure that learning is shared and implemented. Every serious incident is discussed at the relevant provider quality monitoring group and all provider serious incident reports are reviewed by a director-led quality and governance team for completeness and appropriateness of actions and associated learning.

Patient safety alerting system

Providers are monitored for compliance with national patient safety alerts via the respective quality meetings, and action plans requested and monitored where there is continued non-compliance. A new national process for the sharing of alerts and the associated provider responses was introduced in February 2014.

Health Care Associated Infections (HCAI)

The CCGs will ensure that HCAIs across the city are monitored and learning acted upon through the implementation of a multi-disciplinary HCAI improvement group. The group will be responsible for the oversight of HCAI in the city across providers (primary and secondary). The group will have oversight of post infection reviews for C. Difficile and MRSA and of associated themes and trends and will review the actions identified as a result of the reviews.

Zero tolerance of MRSA

The CCGs expects providers to remain compliant with the national threshold of zero incidences of MRSA. MRSA bacteraemia infections are closely monitored and the CCG has mechanisms in place to ensure that we are alerted to those that occur within providers and in the community. Multi-disciplinary post-infection reviews take place on all incidences of MRSA bacteraemia to determine likely or definitive origin and identify learning. Providers are required to demonstrate that learning has been implemented and where the bacteraemia occurs in primary care, the medicines management team ensures that learning is disseminated and shared with primary care clinicians. For secondary care providers, appropriate financial penalties are applied where the case has been determined as avoidable.

Reduce Clostridium Difficile infections

C.Difficile thresholds are allocated on an annual basis to NHS Trusts and CCGs and the CCGs are committed to ensuring that these are complied with and appropriate actions are in place to support continued reduction. To ensure compliance provider C.Difficile infections are closely monitored through the provider quality meetings and action plans reviewed where the provider is outside of their agreed threshold. An antibiotic prescribing strategy has been developed to support monitoring work undertaken by the medicines management team with GPs and other clinicians. The medicines management team produces regular reports on antibiotic prescribing which are shared with clinicians and practices.

Harm Free Care

The National Patient Safety Thermometer (PST) is a tool that measures prevalence of the four most common types of harm – falls, pressure ulcers, venous thrombo-embolisms and catheter related urinary tract infections. Providers are assessed as to the degree of harm-free care that is provided, and the CCGs expect that Trust's demonstrate harm-free care rates of 95% and above in line with Monitor and Trust Development Authority expectations.

Safety thermometer scores are reported to and monitored by the relevant provider quality monitoring groups to the CCG Quality group via the CCG quality report.

Quality Impact Assessment of Provider Cost Improvement Programmes

The CCGs require that providers gives us assurance that their Cost Improvement Plans (CIPs) have been robustly assessed for potential impacts upon quality and that mitigating actions are in place where this has been identified. Providers present their plans and associated quality impact assessments to the CCG Medical Director and Director of Nursing and Quality at the beginning of each financial year, and quarterly monitoring meetings take place throughout the year thereafter. A robust process has been developed which also includes an end of year review by appropriate stakeholders including finance, commissioning and Healthwatch colleagues.

Safer Staffing

Our providers are required to publish details of their staffing levels on their websites and to their Boards. The CCG ensures continued oversight of provider staffing levels via the joint CCG/provider quality meetings where staffing levels information is discussed and monitored through inclusion of data in the Quality Report which is presented to the Quality Committee and included as a standing item for review at provider quality meetings.

Improving Patient Experience

The Patients Voice: The CCG has a responsibility to ensure that patients' experience of care is the best that it can be and that it uses patient experience to inform its performance management and commissioning decisions. To support this the CCG monitors a wide variety of patient experience information including national patient surveys, friends and family scores, PALS enquiries, complaints and public comment mechanisms such as Patient Opinion, NHS Choices and social media sites. Themes and trends are identified and acted upon accordingly. Friends and Family Test results are included in the CCG's monthly quality report which is submitted to the assurance/quality committee which in turn reports to the Governing Body.

Mortality Reviews

Mortality rates are reviewed as a standing item at the acute provider quality meetings. In support of good practice, the CCGs' main acute provider has implemented a mortality review programme to monitor deaths within the Trust; current mortality rates are within expected range and are regularly published as part of the Trust's Quality and Performance Report presented to their Board and published on their website. All of the main providers have undertaken a review of their unexpected deaths as part of a national review programme.

2. Provide a response to the local queries identified on the planning trajectories (performance and activity) submitted on 8 February

Please see the response to key must do number 7 which provides information on what we are planning to do in 2016/17 to improve performance against IAPT.

3. Provide a narrative description and quantify each of the key shifts in activity which combine to deliver the commissioning plans illustrated in the waterfall diagram, covering:

(i) Non-recurrent changes to activity
(ii) Underlying trends in activity including demographic growth

(iii) Transformational change and QIPP initiatives

NHS LSE CCG alongside its partner commissioning organisations in Leeds has agreed assumptions around growth in activity to support the delivery of key national priorities. All activity plans have been agreed through the citywide Acute Provider Management Group (APMG) and details on our activity plans are presented below.

To reflect potentially additional activity increases over and above our current commissioning intentions, the CCG on instruction from NHSE has increased its net growth accordingly. The CCG will continue its intentions to deliver its QIPP plans that are referred to in this plan.

(i) Non-recurrent changes to activity

The main non-recurrent changes relate to a coding change in fracture clinics at LTHT. The trust is legitimately allowed to charge a first outpatient attendance, moving from historic coding as follow-ups. This will therefore have an increase on new outpatient activity by 0.9% with a corresponding reduction in follow-ups.

(ii) Underlying trends in activity including demographic growth

The CCG has reviewed its historic activity trends, current waiting list and assessed deliverable capacity within its main providers. The exercise has led to anticipated increases across all key areas.

Increases in Elective (1.2%) and Outpatients (3.4%), reflects demographic increases and current waiting list and proposed capacity increases across the CCGs main acute providers.

For non-electives, we are expecting growth of 2.9%. The cost of non-elective admissions has risen in 2015/16. A coding review undertaken in year which confirmed there has been a significant increase in acuity of patients. In addition to this, the changes in the marginal rate emergency tariff will increase the cost of non-elective admissions substantially for the CCG.

Despite the significant pressures in A&E during winter 2015/16, there has been no increase in attendances, which we believe can be attributed to local schemes delivered in primary care and the community, and we expect this to continue in 2016/17. With this in mind, and based on our analysis of latest trends and demographics, we have planned for growth of 1% in A&E activity in 2016/17. Our expectation is that attendances will continue to plateau over the next five years, as the increasing impact of the Better Care Fund (BCF) schemes, seven day working, primary care development and further work planned on urgent and emergency care offset the growth that would otherwise be expected as a consequence of demographic growth.

(iii) Transformational change and QIPP initiatives

A number of transformational schemes have been factored into our plans and represent a reduction across all activity lines.

The biggest reduction of 1.8% is in non-elective admissions as a result of the predicted impact of our local schemes including the systematic approach to Long Term Condition (LTC) management (of COPD and diabetes) and extended hours in Primary Care, as part of Level 3 of the Quality Improvement Scheme.

We will also be continuing other schemes started in 2015/16 that we expect to have an impact on unplanned activity e.g. Social Prescribing. Some of these form part of our QIPP plan (see key must do number two).

We have also identified a number of opportunities through the NHS Right Care Programme that represent a reduction of 0.7% in elective activity, and 1.8% in outpatients. Schemes include; Shared Decision Making (SDM) in MSK (hips) aimed at reducing elective activity, and a reduction expected in outpatients in respect of reducing variation in general practice, as well as SDM.

We are currently identifying new local commissioning intentions for 2016/17 focused on prevention. These include a cut-down to quit smoking proposal, cancer awareness, and expanding the care homes scheme, all of which will reduce longer term demand on acute services.

Please note: we would be cautious about attributing specific impacts of the Vanguard work at this stage, over and above any impact associated with primary care as assumptions are likely to overlap.

Finally, we are also anticipating growth in elective admissions of 2.5% following implementation of the NICE cancer guidelines for 2WW referrals (policy changes). As a result of implementing the Leeds Cancer Strategy and the updated 2WW guidance to reduce thresholds for referral, we are anticipating further activity and growth in outpatients and inpatients in key specialties including; upper and lower GI surgery, urology, gynaecology, and endoscopy, which could in-turn impact on us meeting some of the NHS Constitution Standards in 2016/17 (see question one).

4. Outline the process you are undertaking to align plans with providers and identify any provider where there is a significant risk that your contract will not be agreed by 14 March

We are in discussion with LTHT, other main providers and CCG associates to confirm our best assessment of the activity required, that is deliverable, in 2016/17. It should be noted that significant elements of LTHT activity is not commissioned by the Leeds CCGs and as such, it is difficult to reconcile our plans with their overall activity plans as submitted to the TDA. Within the main block contracts for community and mental health services, activity levels are reviewed at least annually against patterns of demand to take account of service developments and pathway changes.

Due to the late publication of the final 2016/17 national contract documentation, the CCG continues to work to the revised deadline of 25th April. Assurance will continue via the weekly contract tracker and any emerging risks will be notified accordingly.

Discussions are ongoing with all major providers, including our Independent Sector and AQP providers. Discussions are being undertaken in a challenging financial environment and as such there may be risks and challenges associated with sign off as we progress.

<u>Securing Provider Capacity</u>

The CCG has worked with its providers to ensure enough capacity is planned to deliver NHS Constitution Standards whilst maintaining the safety and quality of care**.**

Despite the additional capacity there remain some risks, primarily the current reliance of the system on the independent sector capacity to support some services particularly in diagnostics. The Independent sector is signalling increasing reluctance to provide additional

capacity at affordable costs and as such LTHT is seeking to bring much of this work in house. Their ability to achieve this will in part depend on their ability to both recruit to posts and to generate some efficiencies in their services. The requirement to cap agency spend also creates further uncertainty which all providers are working through.