Leeds West CCG - One-Year Operational Plan 2016/17

Introduction

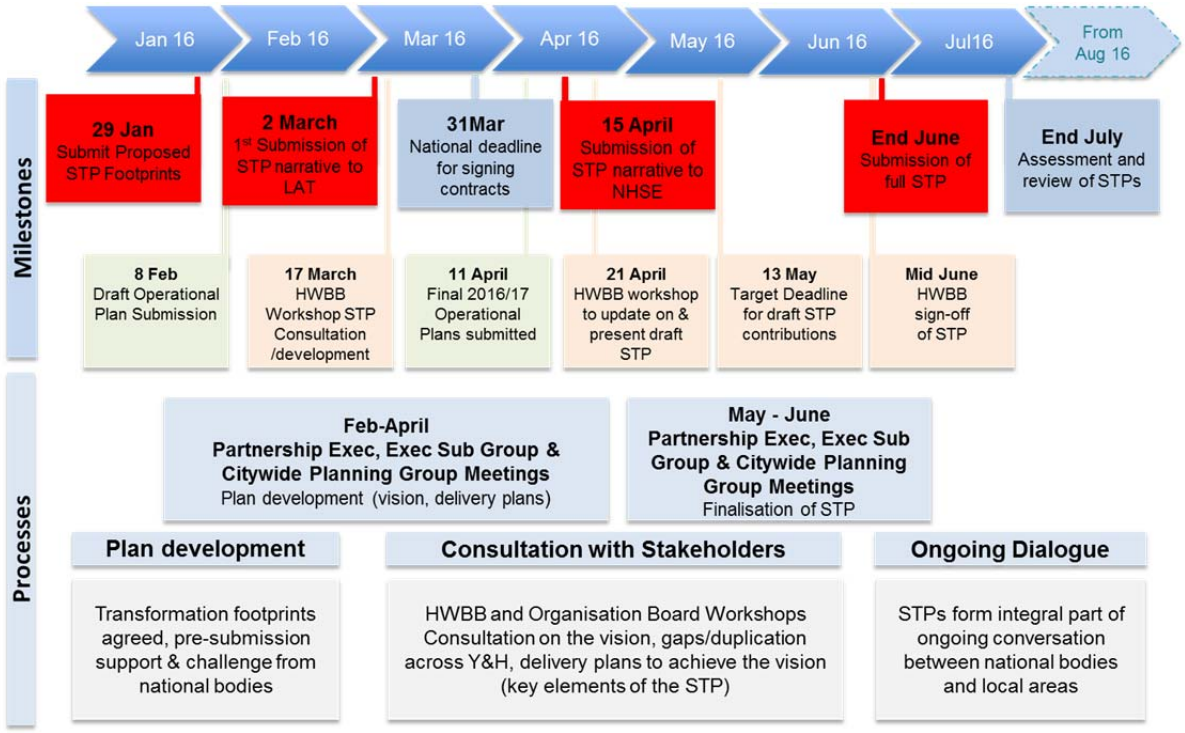
Leeds West CCG is required to develop an Operational Plan for 2016/17 that meets the requirements outlined in the NHS Planning Guidance; *Delivering the Forward View: NHS planning guidance 2016/17-2020/21.*

CCG's are required to submit plans in the form of a series of spreadsheet templates that capture activity and finance plans, numerical trajectories, and a narrative that describes the CCG's approach to delivering the national nine key-must dos and local priorities, and the content of the trajectories and narrative is outlined below.

Context for 2016/17 Operational Plan

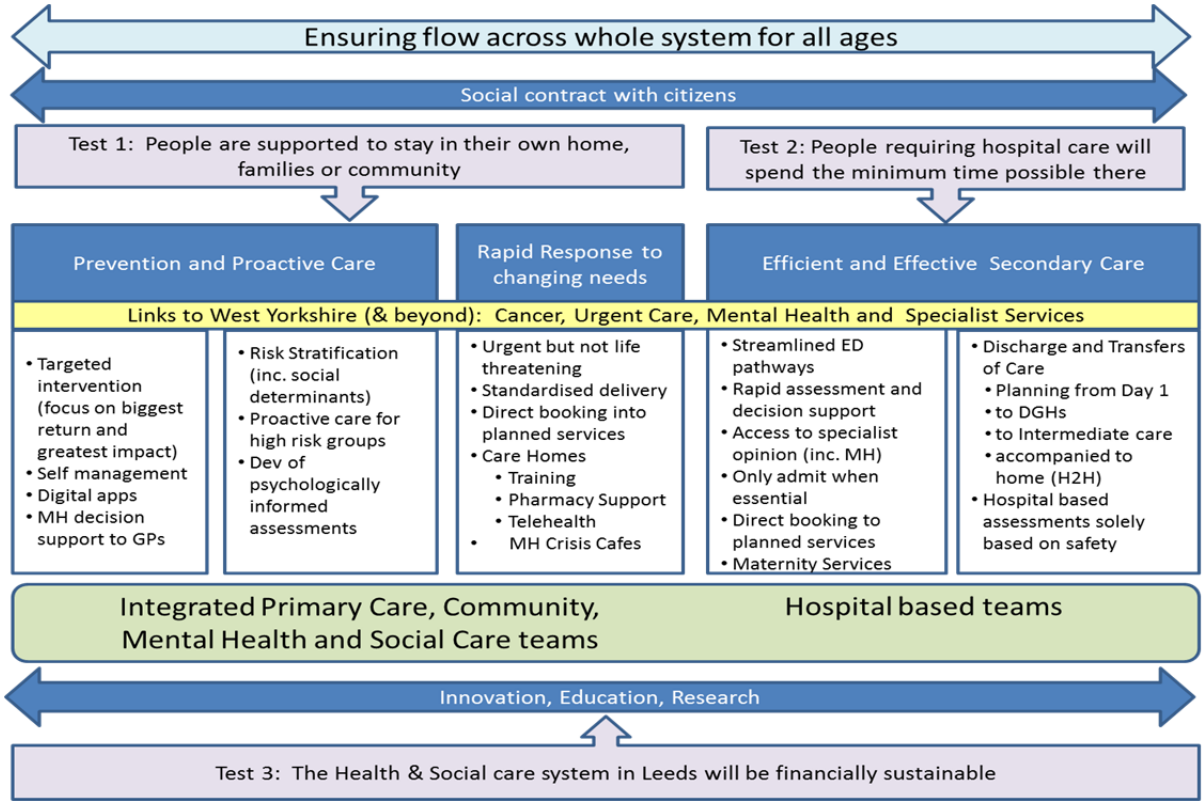
Must Do Number 1: Develop a high quality and agreed STP, and subsequently achieve what you determine are your most locally critical milestones for accelerating progress in 2016/17 towards achieving the triple aim as set out in the Forward View

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 Health and Wellbeing Board (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:



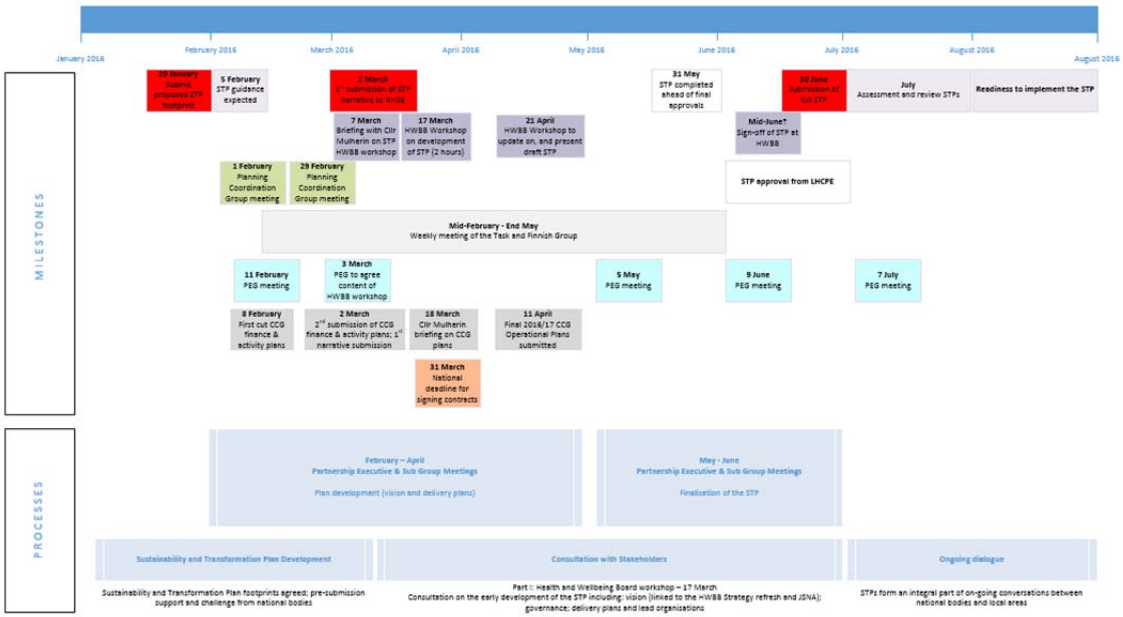
NB. The three tests referred to above are the super-ordinate objectives that the seven statutory partners have agreed will drive whole system improvement within the City.

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 NHS England (NHSE) on the STP. All partners are prepared for this.

Planning Timeline for 2016/17



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 identified three national gaps. The Service Description will in turn be broken down into “elements”, each described in detail in a separate chapter of the STP. At this stage the Service Description elements are likely to include:

- System Flow – including efficient and effective service user journeys into, through and out of acute hospitals and care homes;
- The “Locality Offer” – around prevention, community health care, primary care and adult social care;
- Rapid Response and Sub-Acute Services;
- Children’s Health and Care;
- Maternity Services; and
- The West Yorkshire Footprint.

Other chapters that the STP will cover include:

- A roadmap, setting out key milestones which will need to be achieved to ensure that the Service Description is delivered;
- 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; and
- How the anticipated benefits will be measured.

The consultation discussion process is to be undertaken over the next three months on the STP and will undoubtedly inform our Operational Plan for 2016/17, in particular from October 2016 onwards. All partners including the three Leeds CCGs are prepared for this and recognise that plans (including activity and related finance) may need refreshing mid-way through the year.

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 numbers 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. It 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 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 Health and Wellbeing Strategy (see later re New Strategy) 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 a summary of the current strategy is shown overleaf.

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	16. The proportion of people who report feeling involved in decisions about their care 18. 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 16. 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 JHWBS

Leeds CCGs, Local Authority and Partners are working together through the HWB Board and sub committees such as the Integrated Commissioning Executive 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. 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.
- 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

Leeds CCG plans continue to build on the above through working with LA 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.

New HWB Strategy

Leeds is nearing completion of its new Health and Wellbeing Strategy, which will set out a new five-year vision for Leeds and its people. The new strategy builds on many of the priorities outlined in its predecessor. As such the 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".

Leeds West CCGs plans are closely aligned with the12 priority areas outlined in the new health and wellbeing strategy for Leeds. The following provides some examples of how CCG plans underpin the delivery of the new health and wellbeing strategy.

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

a) Delivering Maternity Strategy for Leeds 2015 with focus on improving perinatal mental health to improve the lives of women, their children and their families.
b) Improving access to child and adolescent mental health services including delivery of a single point of access
c) Protected expenditure on mental health and prioritised additional investment in mental health focusing on children and families.

Priority 3 – Strong, engaged and well-connected communities: Our approach includes testing the benefits of social prescribing services (known as Patient Empowerment Programme) designed to meet the holistic needs of patients. The services have helped

develop a range of partnerships with Third Sector that support people and communities to improve their wellbeing by combating social isolation; providing opportunities for volunteering; acting as a "gateway" to advice, information, and services; and re-connecting people and communities.

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

Priority 8 - A stronger focus on prevention: Leeds West CCG has a key aim to reduce health inequalities over the next five years. Our approach will be to focus on shifting investment from treatment to prevention placing significant focus on people/communities who have poor health and/or high prevalence of disease. Our plans will use evidence from RightCare approach to identify areas of opportunity.

Priority 9 - Support self-care, with more people managing their own conditions: Leeds West CCG will build on work already in train aimed at supporting self care including social prescribing and focussed work in primary care. 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 on conditions

Priority 10 - Promote mental and physical health equally: Investment in Mental Health services 2016 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 will focus on a number of key priorities which include

a) Improving the quality of care available in a crisis
b) Improving community based mental health services.
c) Testing integration of mental health expertise with primary and community care.

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 CCGs continue to commission to meet patient demand, improve standards of care and integrate services to 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 will result in a shift in service provision from treatment to prevention and to shift focus from meeting needs through improved access and provision in community and primary care settings.

This shift from treatment to prevention and improving access to improved primary and community services will take time. As such CCG plans for 2016-17 aim to balance the need to secure existing services in the coming year with the requirement to create the financial headroom to deliver the prevention and 'service transformation' agenda in future years.

Health and Wellbeing in Leeds West
Leeds West is one of three CCGs that work together with Leeds City Council and other Health and Social Care partners to meet the health needs of the population of Leeds.

NHS Leeds West Clinical Commissioning Group (LWCCG) is responsible for the commissioning of wide range of health services for a population of approximately 356,332 people registered with a GP in Leeds West CCG.

Approximately 7% of the Leeds West CCG population live in the 10% most deprived LSOAs in the country. This equates to approximately 25,000 people in LWCCG population who live within the most deprived 10% LSOAs in the country and of these approximately 3000 live in the most deprived 3%.

These areas are found in the inner west and inner north-west areas of the city, and the three most deprived Medium SOA areas are: 7792 people in Broadleas, Ganners & Sandfords; 8528 in Armley and New Wortley; 6784 people in Farnley.

We have analysed our key health problems using a combination of local including the Leeds JSNA, information available through the Atlas of Variation, Levels of Ambition and Right Care Tools. We have built on available intelligence with insights from local clinicians and through engagement with our local population. We have used this information to agree local priorities that include targeted improvements in Healthy Living, Sexual Health, Long Term Conditions, Cardiovascular Disease, Mental Health, Planned Care, Urgent Care and Cancer.

Leeds West CCG have appointed Clinical Leads that focus on each of our health priorities and develop and lead a range of initiatives within Leeds West to support improvement in each of the local priority areas.
A key CCG focus will be to develop primary care to ensure that it has the capacity and capability to better support patient to look after themselves, to better support those with long term conditions and to support ongoing goals of improving integrated working between health, social care and third sector.

<u>Developing General Practice</u>: 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

Leeds West Clinical Commissioning Group is made up of 37 member practices covering the areas of Morley, Headingley, Horsforth, Holt Park, Armley, Wortley, Bramley and Yeadon. Our current role supports member practices in their role as Clinical Commissioners and the development of primary care providers with a particular emphasis on quality and improvements.

Leeds West CCG is currently refreshing its strategy and has a bold approach to the development of Primary care in Leeds West. Our Primary Care Improvement Strategy identifies a range of key enabling workstreams which support our overall approach to the transformation of primary care services and improving services for patients including:

Primary care, provided at scale
With rising demand and challenges facing the workforce, there is a need for general practice to continue to build capacity and resilience and therefore we have seen the development of networks of practices which are looking at ways of working together.

All 37 member practices are part of ‘Leeds West Primary Care’, this is a formally constituted Primary care organisation, led by the GP members, which supports the delivery of the ‘Prime

Ministers GP Access Fund'; This structure supports our members to work together as one with a strong united voice.

Improving the workforce, education and training and premises

It is well documented that there is a need to look at alternative workforce models in General practice as a result of the recruitment and retention challenge. Leeds West have identified that we have a moderate risk associated with GPs aged 55 and over plus a greater risk with practice nurses. A number of initiatives are in development to help support greater resilience in our workforce, including:

- Career seminars for those close to retirement looking at options for supporting colleagues to stay in practice
- Development of alternative workforce models including the employment of physician associates and pharmacists
- Greater collaboration with other independent contractors such as community pharmacy with the Pharmacy First scheme to support patients to self-manage as a possible alternative to general practice.

Efficient use of resources to effect change

Leeds West CCG Governing Body is piloting increased access to primary care services. We now have **18 practices** delivering services 12 hours a day (Monday to Friday or Monday to Thursday plus Saturday mornings) and **15 practices** delivering services 7 days per week. The scheme is being closely evaluated. A formal mid-term evaluation report showed that the scheme had:

- increased primary care availability
- increased patient satisfaction
- reduced demand on A&E and Out of Hours services
- increased engagement from member practices in wider primary care transformation

In January 2015, the 37 member practices of Leeds West CCG submitted a *successful* bid to the Prime Ministers GP Access Fund to implement further initiatives which support the broader aspects of accessing services. The proposal has brought an additional investment of **£1.47million**. Our challenge fund initiatives have a specific focus on technology, which include:

- Provide alternative modes of accessing GP services e.g. Video and E-consultations
- Testing telecare/telemonitoring technologies
- Allowing GPs to video in to MDT case conferences and
- Increasing community staff ease of access to the clinically accountable GP
- Increasing the awareness of and subsequent use of online services (appointment booking and cancelling, ordering repeat prescriptions, access to and updating personal medical records, reviewing test results).
- Development of consistent website for primary care in Leeds West.

Organisational development and new care models

As part of the Five Year Forward View, NHS England invited expressions of interest to participate in a programme of testing out one of four identified new models of care. Leeds West CCG is in the process of revising our overall CCG strategy to outline our approach to developing new care models with some early testing of models taking place in Armley. The approach being taken will be development of a NMoC Multispeciality Community Provider model, where the current integrated nursing team will be enhanced to encompass local GP's, therapy, mental health and local voluntary organisations, working together in a new

way around patients. The MCP will be led by a local leadership team with clinical and community representation.

Co-commissioning Primary Care

Leeds West CCG has been formally approved to take on the responsibility for commissioning primary medical services (general practice only) with effect from 1 April 2016. Currently, general practice services are commissioned by NHS England on a Regional basis with CCGs more and more commissioning local services from general practice. Our aim by having the whole budget we will be able to use this resource more efficiently to support our local populations and need to support our strategic direction.

Improving Services and Delivering the NHS Constitution

The CCG is committed to improving the quality of services for its patients i.e. 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 year-end performance (2015/16) in relation to key NHS Constitution pledges and an assessment of risks to delivery in 2016/17.

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 4 hours 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		
Mental health		
IAPT 15% Prevalence Access Target		
IAPT 50% Recovery Target		
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%.		
2016/17 Additional 5YFV - Mental Health Priorities		
Over 50 percent of people experiencing a first episode of psychosis will commence treatment with a NICE approved care package within two weeks of referral		
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.		
95 percent of people with common mental health conditions referred to the Improved Access to Psychological Therapies (IAPT) programme will be treated within 18 weeks		
Meet a dementia diagnosis rate of at least two-thirds of the estimated number of people with dementia		

In relation to performance against NHS Constitution Standards for 2016/17, we will ensure our plans for delivery against these are aligned to the plans of our main provider of acute services, Leeds Teaching Hospital Trust (LTHT). Working with LTHT and NHS Leeds West CCG (NHS LW CCG) as lead CCG, we will agree realistic and deliverable plans and trajectories, ensuring that the necessary capacity is available to deliver the care required to achieve the trajectory, which will be fully embedded in our activity plans. This will also support LTHT and the wider system to access the Sustainability and Transformation Fund for 2016/17.

Urgent and Emergency Care: 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

Systems Resilience Group: The Leeds System Resilience Group 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.

The SRG consistently review all investments and core services to guarantee continuous improvement, explore options for new ways of working across organisational boundaries and ensuring all available resources are maximised.

A&E 4 Hour Wait: Leeds will fail to meet the Emergency Care Standard (ECS) for 2015/16. The consistent achievement of the ECS remains a test for the Leeds system and Leeds Teaching Hospital Trust (LTHT). Whilst numbers of attendances in 2015/16 have been comparable with the previous years, performance has regularly remained below 95% due to high numbers of attendances on individual days and high admissions and the system 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 to implement changes agreed through workshop facilitated by the Trust Development Agency to look at our discharge processes. Changes being implemented include

a) Improved multi agency working
b) Standardising internal LTHT board round processes
c) Implementation of new electronic (S2) referral systems using hospitals EPR
d) Implementing new AHP electronic referral processes
e) Increased use of multidisciplinary ward rounds to pull patients through the system.
f) More robust approach to implementing choice
g) Embedding discharge to assess approach across many wards
h) Redesigning equipment ordering processes

In addition we will focus on the 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 reducing prolonged waits supporting the achievement of 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 New Models of Care 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.

Note: We are still in discussions with LTHT regarding finalising trajectories for A&E. These discussions are taking place within the context of

a) Ongoing negotiations between LTHT and NHS Improvement with regards to expectations regarding recovery trajectories and access to Sustainability funds

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 it 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 SRG and other partnership forums.

As such at this present moment in time we remain confident that we will be able to secure contract sign off for delivery of national standard

Ambulance Targets: Yorkshire Ambulance Service continues to face a growth in demand especially in red calls across Yorkshire and the Humber. Red 1, 8 minute performance YTD is currently at 66.2% for Leeds North, 76.5% for Leeds South and East and 68.3 5 for Leeds West against a target of 75%. YAS wide, performance is slightly under target at 71.4%. 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 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.

Note: We are still in discussions, through our Lead Commissioner, with YAS regarding finalising trajectories for delivery of key response targets. Contracts for the service are still being finalised. As such at this present moment in time we remain confident that we will be able to secure contract sign off for delivery of national standard

Elective Care: 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

Referral to Treatment - 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 LTH 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.

Cancer: 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, a 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

<u>Mental Health</u>: 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.

Leeds West CCG along with all key city partners have signed up to joint citywide Leeds Mental Health Framework with a stated vision: '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 current Programme of Transformation work reflects some of the priorities stated in the February 2016 Mental Health Taskforce report. 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 New Models of Care 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 C&YP transformation plan

- Refresh of our local Mental Health Needs Assessment.

IAPT Access and Recovery Targets: Current performance indicates that waiting time targets will be achieved in 2015/16 and going forward to 2016/17. Also, recovery rates have shown significant improvement but access rates remain lower than required to hit 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).

	NHS LW CCG
Access to first treatment - 18wk (95% per month	100% - December local data
Access to first treatment - 6wk (75% per month	99.62% - December local data
Recovery rate (50% monthly)	46.4% - December local data
Access rate 1.25% monthly to meet citywide prevalence rate annually of 15%.	0.92% - December local data

15% Prevalence Access and 50% Recovery Rate: A total of 8282 people had entered the service by the end of November 2015, 2,222 people less than the NHS Area Team target

(27%). Despite being significantly below target, 6% more people had accessed IAPT than in the same period in 2014/15.

As noted above Leeds West CCG is not currently achieving IAPT recovery rates. However, Leeds is consistently in line nationally with 'Reliable Improvement',. 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. The Reliable Improvement measure is not yet mandated but definition and process of data capture have been agreed nationally and are reported.

Breakdown of the most recent reliable improvement data (HSCIC, September 2015):

* National 62%
* Leeds North CCG 67%
* LSE CCG 65%
* Leeds West CCG 59%

On current performance it is unlikely that the 3 Leeds CCGs will meet the required 15% access and 50% recovery by Q4 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.

At the request of Leeds commissioners, The NHS England (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

IAPT Meeting new access targets (6 and 18 weeks) - the Leeds service across each 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.

Dementia Diagnosis - 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, Leeds South & East achieved 69.5%, Leeds West 66.8%, and only Leeds North 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.

<u>Learning Disabilities</u>: 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 CTRs has been established and led by the lead commissioner (LD) in LNGG 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.

<u>Quality and Safety</u>: 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 CCGs in Leeds have developed and agreed a Quality Strategy, which 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 – Leeds South and East CCG 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 the 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

In 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 CCG 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.

Financial resilience; delivering value for money for taxpayers and patients: 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

Leeds CCGs have strong track records in managing their financial resources. However this stewardship needs to be considered in the context of the Leeds wide Health and Social Care economy. The 2016/17 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 CCG working with partners that reflect local needs as identified through the Joint Health Needs Assessment,
- Emerging priorities identified through engagement with patients and public and clinicians at CCG level

A detailed analysis of the financial planning assumptions of all NHS Organisations in Leeds, NHS England's Specialised Services spending position with LTHT and of the Adult Social Care at Leeds City Council was undertaken in 2015-16 as part of the City's 5 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 £850 million by the financial year 2020/21.

Given the size of the overall financial challenge, and given that all statutory organisations are closely interlinked with patient pathways crisscrossing across all their services, only whole system changes implemented and supported by all those organisations can have the requisite rectifying impact needed to retain financial balance within the Health economy. Many QIPP targets are therefore agreed to be delivered on a city-wide 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 context of three key stands of work that will contribute to the systems wide QiPP.

Carter Review: Leeds West and associate CCGs will work with all providers to secure their ownership and embedding of the initiatives and proposals identified within the Carter Review

Transformation: Leeds CCGs have an established Transformation Board. The Board has developed a range of programmes to improve outcomes, quality and reduce demand on acute sector. The primary transformation schemes impacting on acute activity are as follows

RightCare: Leeds West and partner CCGs will continue to use the intelligence and insight provided by the RightCare tools to support delivery of sustainable financial savings. This will build on previous work undertaken as a result of a Deep Dive undertaken in 2014 to identify areas of focus.

We have assumed some contribution to our non-elective line through primary care actions incentivised towards improving reducing smoking rates and the primary care management of CVD, and Diabetes. There is still significant work to undertake to support right care. As such we have established a city-wide working group to further scope opportunities and better understand timescales including assessing the potential impact on overall activity (in all sectors including primary care) and spend in future years – likely to be minimal in year one.

New Models of Care: The Leeds Transformation Board has undertaken a range of workshops to support thinking on development of new models of care. Our STP will provide further information on changes we anticipate over coming years to support development and delivery of these new models

Our financial plans and proposed annual budgets have been submitted separately and are based on our current understanding of available resources, risks and developments known at this time. Our financial plans are subject to change pending management and mitigation of risks associated with contract negotiation

Activity Plans: *4. 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

Leeds CCGs have made working assumptions around the growth in activity to support the delivery of key national priorities for the 2 March planning submissions. All activity plans have been agreed through the city wide Acute Provider Management Group (APMG). Provisional figures may be further adjusted before the final submission in early April. Details on our activity plans are as below.

A&E Attendances - Although there were significant pressures in January 2016 overall we have seen a reduction in attendances in 2015/16. We believe this to be as a result of our having invested not only in primary care schemes, but also in a Primary Care Access Line to enable GPs to divert patients directly to assessment/admission avoiding ED attendances.

Our analysis of latest trends and demographics has led us to plan growth at 0.5% in 2016/17. However in the longer term we expect attendances to plateau over the next 5 years as a result of the impact of Better Care Fund initiatives, seven day working, primary care development and the further work on the Urgent Care Strategy.

Transformational/Right Care: Initiatives supporting reduction in emergency admissions:

- RightCare: Increasing referral to prevention services such as smoking cessation and alcohol treatments to reduce longer term demand on acute services
- RightCare: Proactive Management of CVD and Diabetes
- Transformation:Increased primary care capacity

Comparisons to IHAM: The IHAM model does not reflect recent trends experienced in Leeds. Whilst IHAM projects 2.3% we have assumed 1% as do nothing in line with local demography and recent growth trends. We believe we can limit this to 0.5% due to the predicted impact of a range of initiatives in place – as described above. In addition we have worked across the health economy to increase alternatives to A&E attendance, and have more actions planned (e.g. non conveyance of patients by ambulance crews in specific circumstances)

Outpatients - We are anticipating a 4.7% growth in 1st attendances, but some of this growth relates to the correction of a recording error in local fracture clinics in 2015/16. We expect a 2% growth in follow ups. This is in line with commissioners' and providers' joint ambitions to free up capacity for new referrals and introduce innovative pathways wherever possible. (Follow ups in 2015/16 are also reduced by the coding error in fracture clinic). We are commissioning an overall 2.5% growth in electives and day cases to maintain progress on waiting times and RTT and pick up additional cancer conversions and cancer diagnostics.

Non-recurrent changes to activity: The main non-recurrent change affecting activity in 2016/17 relates to a coding shift to correct a coding error in 2015/16 in fracture clinics. The impact is to shift a number of Follow Up outpatients to New for 2016/17.

Transformation/Right Care/QIPP: Full year impact of a change to local pain management services.

Policy changes: We are anticipating further activity growth as a result of the implementation of the Cancer Strategy. These impacts will largely be as a result of anticipated guidance re thresholds for 2 week wait referral. As a result we have included growth in outpatients and

inpatients in key specialties, including upper and lower GI surgery, urology and gynaecology and in endoscopy.

Comparison to IHAM: The IHAM model growth of 4.7% is for all outpatients quoted above compares total outpatients in the IHAM model to new outpatients in the CCG submission. Looking at like for like numbers (i.e. new and follow up together) combined shift our planned grow this 3% i.e. in line with the IHAM assumptions. The bulk of the increase in new attendances is due to an error in LTHT recording in 15/16 (fracture clinic) which overstated the follow up patients and understated the new patients. The correction returns the position to 14/15 recording levels. Part of the growth in 16/17 relates to an agreement to pay for pre-operative assessment activity not previously recorded, and group follow ups for cancer in a new model of care. This is high volume but low cost activity.

Electives - We are planning for a 3.4% increase in elective activity for 2016/17..

Policy Changes: This increase includes substantial further growth for endoscopies as previously recommended by the Chief Medical Officer in line with Cancer strategy

Comparison to IHAM: Our assumed demographic and other trend growth is 1% as compared to IHAM model of 1.8%. The growth above this relates to policy change which requires higher level of endoscopy in line with previous advice from the CMO; It would appear that this diagnostic demand has been reflected in the IHAM model

Non-electives - We are planning limited growth to 1% in line with demographics. However the unit costs of non-electives will rise considerably both as a result of the changes in Marginal Rate of Emergency Tariff and in line with the admission avoidance schemes which mean that those patients who ARE admitted are likely to be more complex, increasing the overall casemix. A coding review undertaken this year, commissioned by Leeds CCGS, has confirmed that coding/casemix shift is in the main appropriately recorded i.e. there has been a significant increase in acuity of admitted patients.

Transformational/Right Care: Initiatives supporting reduction in emergency admissions:

- RightCare: Increasing referral to prevention services such as smoking cessation and alcohol treatments to reduce longer term demand on acute services
- RightCare: Proactive Management of CVD and Diabetes
- Transformation: Increased primary care capacity

Comparison to IHAM: Our local do nothing assumption is 2% growth similar to the IHAM model. However, we are planning for 1% reduction as a result of predicted impact of our local schemes, including extended primary care, enhanced intermediate care response in the locality and the ongoing impact of improved use of our Primary Care Access Line. We have capped growth in spend to 1.5% in 15/16 above 14/15 so do not believe a 1% target is unachievable. (NB we are awaiting final decisions with our main provider about the recording of assessment unit patients – if these are recorded as admissions in 16/17 that will impact on the growth plan and will be finalised in our final submission.)

Note: We would be cautious about attributing specific impacts of the Vanguard at this stage over and above any impact associated with primary care as assumptions are likely to overlap

Contract – Alignment of CCG and Provider Capacity Plans: ***3. 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 25 April***

We remain in discussion with Leeds Teaching Hospitals and with CCG associates to confirm our joint best assessment of the activity required and deliverability of key national performance trajectories. Our current understanding is that activity and financial agreement will be reached at the Contract Management Board on Wednesday 20th April. It should be noted that a 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 and performance trajectories as submitted to the TDA/NHS Improvement. As a result the date for final sign off of the LTHT contract remains unclear due to current arbitration process and need for alignment of plans across multiple commissioners

Discussions are also ongoing with all other major providers, including YAS, 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.