North Lincolnshire
Clinical Commissioning Group

Date:	13th October 2016
Meeting:	CCG Governing Body
Item Number:	8.5
Public/Private:	Public ☒ Private ☐

Author: *(Name, Title)*	Emma Mundey Performance & Information Manager
GB Lead: *(Name, Title)*	Ian Holborn Chief Finance Officer & Business Support

Report Title:
CCG Corporate Performance Report
Decisions to be made:
To receive and note the report and be assured that areas of underperformance are being addressed at a local level to meet agreed targets and commitments.

Continue to improve the quality of services	☒	**Improve patient experience**	☒
Reduced unwarranted variations in services	☒	**Reduce the inequalities gap in North Lincolnshire**	☒
Deliver the best outcomes for every patient	☒	**Statutory/Regulatory**	☒

Executive Summary (Question, Options, Recommendations):
The reports purpose is to provide the CCG with assurance against its corporate performance responsibilities as set out in the CCG Assurance Framework and against its commissioning plan. It informs the CCG Engine Room on an exception basis of its corporate performance position (In support of the Business Intelligence Zone which can be accessed live by those authorised to do so) on the following link where more detailed recovery actions against these standards can be found and supporting reports and analysis http://biz.nyhcsu.org.uk/nlccg/.

Equality Impact	Yes ☐ No ☒	
Sustainability	Yes ☐ No ☒	
Risk	Yes ☒ No ☐	The report supports the Quality/Performance section of the CCG Assurance Map, in particular Performance reporting – Financial and Quality. It provides management level assurance to the Engine Room and Governing Body to enable them to provide second line assurance to the CCG Council of Members. The content of the report also provides assurance in support of the NHS England Balanced Scorecard. In addition the report provides assurance against the CCG Board Assurance Framework (BAF) Risk FP1. Position monitored by CCG Engine Room and Governing Body. Reviews of monitoring reports. Added to BIZ. Audit Group monitors adequacy of controls
Legal	Yes ☒ No ☐	CCG's are accountable for the delivery of their statutory and local priorities.

Finance	Yes ☒ No ☐	Additional Quality funding is dependent on the delivery of the Quality Premium Measures; a summary of the position against this is contained in this report.

Patient, Public, Clinical and Stakeholder Engagement to date									
	N/A	***Y***	***N***	***Date***		***N/A***	***Y***	***N***	***Date***
Patient:	☐	☐	☐		**Clinical:**	☐	☐	☐	
Public:	☐	☐	☐		**Other:**	☐	☐	☐	

North Lincolnshire Clinical Commissioning Group

North Lincolnshire CCG Corporate Performance

Executive Summary

2016/2017

Author	Business Intelligence Team
Date	3rd October 2016
Meeting Date	13th October 2016

Performance Executive Summary: Position at 3rd October 2016

1. CCG Assurance

Are patient rights under the NHS Constitution being promoted?

Overall Constitution Indicator Performance

NOTE: Items rated at Blue indicate either no data or data quality issues.

Red	Amber	Green	Blue
5	2	20	3

The following indicators all remain strong and are currently achieving the required level of performance or more:

Indicator	Previous	Movement
RTT 52 Week Waits	G	⇔
6 Week Diagnostic Waits	G	⇧
12 Hour Trolley Waits	G	⇔
2 Week Cancer Referral to First Seen	G	⇧
2 Week Cancer Referral to First Seen – Breast Symptoms	G	⇧
31 Day Cancer Diagnosis to Treatment	G	⇧
31 Day Cancer Subsequent Treatment – Surgery	R	⇧
31 Day Cancer Subsequent Treatment – Radiotherapy	A	⇧
31 Day Cancer Subsequent Treatment - Drug Regimens	G	⇔
62 Day Cancer Referral to Treatment – Total	G	⇩
62 Day Cancer Referral to Treatment – Status Upgrade	G	⇔
62 Day Cancer Referral to Treatment – Screening	G	⇔
Mixed Sex Accommodation Breaches	G	⇔
Cancelled Operations (2nd Cancellations)	G	⇔
IAPT Entering Treatment	G	⇔
IAPT Recovery Rates	G	⇩
Mental Health Care Programme Approach (CPA) Follow Up	G	⇧
Early Intervention 2 Week Waiting Times	G	⇧
Incidence of Healthcare Associated Infection – MRSA	G	⇔
Incidence of Healthcare Associated Infection – C Difficile	G	⇔

Areas by Exception:

Area	RAG	⇩⇧ *From Previous Month*	Comments	Lead
18 Week Referral to Treatment Times: Admitted (Target 90%) Non-Admitted (Target 95%) Incomplete (Target 92%)	R	⇩	The August 2016 position against 18 week waits continue to be significantly below required levels: Admitted: 72.38% (July 70.07%) Non-Admitted: 88% (July 89.1%) Incomplete: 85.8% (July 87.3%) Due to the continued performance risk in this area, this has now become part of a wider recovery plan requested by NHS England. Northern Lincolnshire & Goole Hospitals NHSFT (NLAG) has provided a recovery trajectory, and a recovery plan has been produced and provided to NHSE on the 31st August. A copy of both of these documents can be found at Appendix 1 of this report.	RY

A&E 4 Hour Waiting Times (Target 95%)	A		Published A&E Trust wide performance in July 2016 is at 91.2% and did not meet the required level. Locally held indicative data shows that the August position has also deteriorated further, and as at 18th September 2016 the position continues on the same trend. In August 2016 the local Scunthorpe site position fell just short of the target at 94% and Diana Princess of Wales site in Grimsby was at 83.7% North Lincolnshire CCG continues to take part in weekly assurance calls with NHS England. Whilst our local site position is delivering a stronger level of performance, we are required to continue to take part until the Trust performance improves and is maintained. http://biz.nyhcsu.org.uk/nlccg/publications?subdir=exception-reports	JE
Category A Ambulance Response Times 8 Minute RED 1 (Target 75%)	A		Performance at East Midlands Ambulance Trust (EMAS) against the Category A 8 minute indicator for RED1 calls did not reach the required level in August 2016 (73.3%) but did improve to an Amber status. *The position for all ambulance Cat A response times are assessed at Trust level. The RED1 North Lincolnshire position is 71.7%.*	RY
Category A Ambulance Response Times 8 Minute RED 2 (Target 75%)	R		EMAS overall performance remains below the required level at 61.3% in August 2016. *North Lincolnshire performance in August 2016 is also below plan at 63.9%.*	RY
Category A Ambulance Response Times 19 Minute (Target 95%)	R		EMAS overall performance is 87.2% in August 2016. *North Lincolnshire's performance was 84.4%.* In accordance with the Service Development Improvement Plan within the 2016/17 contract EMAS have provided their divisional performance improvement trajectories for 2016/17. These have been calculated using the same methodology as that used for the regional performance improvement trajectory that has been included within the contract. The divisional trajectories have been produced in order to give local commissioners assurance in terms of local performance delivery and it is the intention to deliver performance in accordance with these trajectories. It should, however, be noted that the contractual position is for delivery at Trust level against the regional trajectory. Resources may be redeployed in such a way that might result in delivery of divisional trajectories being compromised, if that means that the regional trajectory will be achieved, whilst at the same time maintaining a safe service for all patients.	RY

			North Lincolnshire continues to be the strongest performing CCG on the Lincolnshire patch with South Lincolnshire having the lowest performance. Lincolnshire patch have achieved the improvement trajectory for RED2 and A19 but have not met the RED1 requirement. Commissioners have requested sight of the Trusts Performance Improvement Plans to provide assurance and describe planned actions and milestones at the Contract Partnership Board. This will be included in exception reports when received. http://biz.nyhcsu.org.uk/nlccg/publications?subdir=exception-reports	

Are health outcomes improving for local people (CCG Assurance Indicators Only)?

Areas of Exception:

Area	RAG	⇩⇧	Comments	Lead
Reducing potential years of life lost from causes considered amenable to healthcare (all ages) * Causes considered amenable to healthcare are those from which premature deaths should not occur in the presence of timely and effective health care. The Office for National Statistics (ONS) defines amenable mortality as follows: "A death is amenable if, in the light of medical knowledge and technology at the time of death, all or most deaths from that cause (subject to age limits if appropriate) could be avoided through good quality healthcare" Next Data update due December 2016.	R		The indicator is calculated using the Office for National Statistics Mortality data and the mid-year population data as a directly standardised rate (DSR) per 100,000 registered patients. The target of 2083 has not been met as at September 2015 the rate has deteriorated to 2250.5 (DSR). Causes considered amenable to healthcare are those from which premature deaths should not occur in the presence of timely and effective health care. The Office for National Statistics (ONS) defines amenable mortality as follows: "A death is amenable if, in the light of medical knowledge and technology at the time of death, all or most deaths from that cause (subject to age limits if appropriate) could be avoided through good quality healthcare" The actions from the CCGs strategic plan and commissioning intentions will all contribute to the improvement in this indicator. Specifically as outlined in the Strategic Plan 2014/15 – 2018/19 the following 3 interventions are aligned to securing additional years of life: • Long Term Condition (LTC) Self Care • Whole System Approach to LTC Care • Early Cancer Diagnosis Public Health Intelligence has undertaken a piece of work to look at the recent dip in life expectancy in older ages. The first draft report is available at Appendix 2 and can also be found on the BIZ: http://biz.nyhcsu.org.uk/nlccg/data/uploads/current/assurance-framework/Appendix2.pdf	LL

2. CCG Quality Premiums

2015/2016

Due to data availability it is too soon to forecast a value of the quality premium, however based on current performance the only element that would attract a financial payment is the 10% medicines management indicators. Based on the population of 171,000 this would be circa £86K (out of a total circa £860K).

The total quality premium payment is however reduced if its providers do not meet the NHS Constitution rights or pledges for patients in relation to (a) maximum 18-week waits from referral to treatment, (b) maximum four-hour waits in A&E departments, (c) maximum 14-day wait from a urgent GP referral for suspected cancer, and (d) maximum 8-minute responses for Category A red 1 ambulance calls.

Therefore due to the performance in these 4 areas at March 2016, the CCG is only expected to achieve 50% of the premium for 2015/2016 *(subject to confirmation by NHSE).*

Based on the calculations of the current performance above (circa £86K) this would be reduced to £43K due to the constitutional penalties.

2016/2017

For 2016/2017 the gateways in relation to Quality and Finance remain the same, as do the Constitutional penalties (with a slight adjustment to % weighting). It is too early to predict financial values against the premium so this will be included from September 2016 to allow for more data collection to be in place.

NHS North Lincolnshire 1617 Quality Premium Dashboard

Indicator	Baseline (period)	Current Target	Current Performance (period)	RAG	Comments
Cancer	2015	TBC once 2015 calendar year figure published	50.8% (2014)		Next update due June 2017
GP Patient Survey	July 2016	73%	70% (Jul '16)		Next update due January 2017
E-Referrals	March 2016	37.2% (Mar '16 = 17.2%)	13.7% (Jul '16)		Next update October 2016
Antibiotics Prescribed in Primary Care	2013/14	(a) <= 1.176 (b) <= 10%	(a) 1.133 (b) 9.8% (Aug '15 - Jul '16)	(a) (b)	Next update due November 2016
Reduction in Non-Elective COPD Admissions	2015	472	161 (Apr - Aug '16) FOT = 386		Next update due November 2016
Reduction in Elective Gastroscopy	2015	2118	971 (Apr - Aug '16) FOT = 2330		Next update due November 2016
Improve recorded prevalence of AF on GP registers against expected prevalence	2015	n = 3862 d = 4653 Ratio = 0.83 (83%)	n = 3623 d= 4653 Ratio = 0.78 (78%) (Feb '16)		In development

3. Highlight Report

This section of the report is meant to act as a soft intelligence section, and also to highlight any potential new or significant performance issues or risks. It may suggest action to be undertaken or simply be used to make the CCG aware of a status.

No	Description	Flag Type	Assigned	Status
1.	**2017/2019 Planning Guidance** NHSE have published the NHS Operational Planning and Contracting Guidance 2017 – 2019. For the first time, the planning guidance covers two financial years, to provide greater stability and support transformation. This is underpinned by a two-year tariff and two-year NHS Standard Contract. It provides local NHS organisations with an update on the national priorities for 2017/18 and 2018/19, as well as updating on longer term financial challenges for local systems. A link to the document, and all technical annexes can be found below: https://www.england.nhs.uk/ourwork/futurenhs/deliver-forward-view/	NEWS	ALL	Open
2.	**CCG Improvement and Assessment Framework 2016/17** This is now fully accessible and can be found using the following link: https://www.england.nhs.uk/commissioning/ccg-auth/	NEWS	ALL	Open
3.	**Key Actions** The previous report highlighted a number of specific areas that the CCG were reviewing in terms of contractual trading and performance delivery. Work continues in these areas, but as a first draft we can share an initial report in relation to: a. An increase in referrals and growing waiting list size could suggest that there is not sufficient capacity currently within the provider to deliver current levels of demand. This hypothesis is strengthened by the contract under trade on Elective Inpatients. If the Trust are able to secure this additional capacity the position will catch up causing further financial pressure on the contract. RTT Waiting List Size and activity demand trends review and next steps can be found at **Appendix 3.**			

	Work continues on the second area which is being covered by the BCF review. Once complete this will also be shared. b. Reporting from the Better care fund investments (specifically Rapid Access and Frail Elderly Assessment Teams) would suggest that these teams are impacting on the Elderly population in a positive way, but are not releasing the inpatient activity in the system. There appears to be a reducing length of stay but numbers of emergency admissions continue to rise. We plan to review rates of A&E attendance to admission and review casemix and demographic profiles. A reduced length of stay and no significant increase in A&E attendance should suggest the possibility of removing capacity from the system, yet we are still experiencing pressures on emergency admissions. Please also note the 3 new report packs included on the BIZ to better understand activity positions of the CCG, Unplanned Care: http://biz.nyhcsu.org.uk/nlccg/data/uploads/current/local-health-outcomes/upc.pdf Planned Care: http://biz.nyhcsu.org.uk/nlccg/data/uploads/current/local-health-outcomes/pc.pdf Headline Activity Volume: http://biz.nyhcsu.org.uk/nlccg/data/uploads/current/finance/totalact.pdf Your views on these reports and development ideas are greatly appreciated.				

The purpose of this report is to provide the North Lincolnshire CCG Engine Room and Governing Body with an updated summary position on an exception basis on the national performance indicators as set out in the NHS Outcomes Framework and Everyone Counts guidance and which form part of the CCG Assurance Framework.

This is supported by the Business Intelligence Zone (BIZ) which will be reviewed as part of the CCG Engine Room meeting, and can be visited by **CCG members** at any time on the following link: http://biz.nyhcsu.org.uk/nlccg/ - Please use this link and save to your favourites, any comments would also be appreciated. You can also sign up to receive a newsfeed e-mail alert. If you require any assistance with the site please contact either Emma Mundey in the Performance & Information Department or your CCG Relationship Manager.

In all cases of deviation from target, an **Exception Report** is raised whereby the lead in this area must provide underlying cause information as well as recovery actions if applicable. These reports are also available on the BIZ.

Emma Mundey, Business Intelligence Manager
North Lincolnshire CCG

APPENDIX 1 Part 1 - Northern Lincolnshire & Goole Hospitals NHSFT RTT Recovery Plan

Together we care, we respect, we deliver

Northern Lincolnshire and Goole NHS
NHS Foundation Trust

RTT Recovery Plan

Introduction

Historically the trust has performed well against this measure. Continued demand seen across certain specialties and planned operational changes to alleviate the demand pressures has seen a dip in performance to below 92%. Through both internal actions taken, and structured discussions with commissioners the trust is forecasting a return to delivery of this measure from Quarter 3 in some specialties, and end of quarter 4 in others. The trust is reliant on the ability to influence community wide pathway changes.

Each specialty is continually reviewing plans, which includes various actions from efficiencies, to workload expansion.

The Trust has also seen a high demand in Cancer referrals, which is added to outpatients, diagnostics and theatre capacity. Combined with the trusts focus on follow up patients as per CQC requirements, the table below therefore shows a revised projection for when each specialty will start to achieve 18 weeks given the context the specialties are working within which is a fluctuating environment with competing demands.

The Trust has also engaged with NHS Improvement in order to stress test the plans we have in place.

	Actual				Trajectory							
	April	May	June	July	August	September	October	November	December	January	February	March
RTT Performance	89.40%	88.70%	86.80%	85.50%	81.20%	81.80%	82.20%	82.90%	83.80%	85.70%	88.20%	92%

(end of quarter assumption)	Previously submitted 18 ww forecast	Revised submitted forecast	Difference
Cardiology	Q3	Q3	Same
Colorectal	Q4	Q4	Same
Dermatology	Q3	Q3	Same
General Surgery	Q4	Q4	Same
Ophthalmology	Q4	Q4	Same
Oral Surgery	Q3	Q4	Revised
Orthodontics	Q3	Q4	Revised
Pain Management	Q3	Q4	Revised
Respiratory Medicine	Q3	Q3	Same
Trauma and Orthopaedics	Q4	Q4	Same
Upper GI	Q4	Q4	Same
Urology	Q4	Q4	Same
ENT	not submitted	Q4	N/a
Paediatrics	not submitted	Continue to meet	N/a
Gynaecology	not submitted	Continue to meet	N/a
General Medicine	not submitted	Q4	N/a
Gastro	not submitted	Q3	N/a

Risks

This is reliant on being able to fill the current vacant posts (sickness/leavers) via subtsantive appointments. Should locums/agency be required this will increase the financial pressures.

The Trust has committed to focussing on the follow up outpatient recovery plan, which is using a lot of the capacity in the system, the trust would therefore require additional funding support that is over and above what is currently in the contract, to enable the trajectory above to be achieved.

The Trust is also committed to maintaining the cancer position, and as such this will take priority over the 18 week position.

The trust has revised all job plans, in line with the outcome of service reviews and is in the process of implementation, but additional capacity identified through efficiencies is reliant on clinican agreement, if this is not achieved, and mediation is enacted this will be a delay in the trajectory.

There will be pressures in winter due to bed demand for non-elective patients that may impact on elective capacity.

APPENDIX 1 Part 2 – NHSE Submitted Recovery Plan

NHS England North Region

CCG RTT Recovery Plan

Name of CCG; North Lincolnshire CCG

Author: D. Thomson

CCG RTT Recovery Plan - Performance

CCG Name	April 2016	May 2016	June 2016	July 2016	August 2016	Sept 2016	Oct 2016	Nov 2016	Dec 2016	Jan 2017	Feb 2017	March 2017
RTT Performance	89.4%	88.7%	86.8%	85.5%								
RTT Trajectory as submitted in CCG 2016/17 Operational Plan					81.20%	81.80%	82.20%	82.90%	83.80%	85.70%	88.20%	92%
Elective Activity (monthly)	11,882	12,538	13,471									
Elective Planned Activity (monthly) as submitted in CCG 2016/17 Operational Plan	13,735	13,081	14,390	13,735	14,390	14,390	13,735	14,390	13,081	13,735	13,081	15,044
Elective Cumulative Variance (%)	-13.49%	-4.15%	-6.39%									

Current Backlog	No. 18 weeks Waiters
	2293

RTT Recovery Date	Elective Activity Recovery Date
February 2017	*N/A as the trust are currently underperforming on Elective activity.*

CCG RTT Recovery Plan - Issues

The identified issues within North Lincolnshire and Goole (NL&G) foundation trust contributing to the current referral to treatment (RTT) targets not being met and the subsequent issues around patients waiting for both first and follow-up appointments have been identified as;

- *Inability to fill medical and nursing posts for over 12 months with an average vacancy rate of 13% and 10% respectively during this period,*
- *Poor utilisation of the E-referral system (electronic booking), and the trust not releasing adequate appointment "slots"*
- *Poor internal processes in place for tracking outpatient appointments; both new and follow-up,*
- *A lack of co-operation and joint working – requested data and information – which has included capacity planning and activity data.*
- *Still awaiting first sight of Northern Lincolnshire and Goole foundation trusts recovery plan.*

Theme	Action	Date of Action	What is impact of action	When will this impact be realised
Contract Management	*1. The CCG is working with the trust to identify and prioritise patients who have waited for over 18 weeks either for a new or review outpatient appointments in all specialties.*	26/08/16	To identify and prioritise those patients most in need of specialist/acute care and work with the trust to ensure that these patients are reviewed and seen.	TBC - Discussions are on-going with alternative providers to secure additional capacity.
	2. On a daily/weekly basis the CCG will monitor patients in each specialty who have been waiting for over 18 weeks ensuring that a clinical review is undertaken by the trust for those that have waited for the longest period of time, to ensure patients are prioritised according to clinical need.	26/08/16	To ensure that all patients identified as requiring medical care are prioritised and booked into an outpatient clinic within an appropriate timescale, and ensuring that these patients (where appropriate) receive a care management plan to expedite treatment.	As Above
	3. The CCG has identified which specialties are not meeting the RRT 18 week target and are in discussion with alternative providers (both contracted and independent sector) to ascertain available capacity locally. Communications with Primary Care will support referral to alternative providers	On-going	To reduce the demand on new outpatient appointments in those specialties identified to allow North Lincolnshire and Goole foundation trust to prioritise its outpatient backlog and bring waiting times back in line with RTT 18 week targets.	As Above
Outsourcing	*1. The CCG has notified the trust that it is in discussion with a number of NHS and Independent sector providers with a view to securing capacity for all identified specialties where there is lack of capacity and RTT 18 week targets are not being met with a view to re-directing new referrals.*	25/08/16	*A reduction in new referrals into Northern Lincolnshire and Goole foundation trusts outpatient department within those specialties where the 18 week RTT target is not being met will reduce demand in those specialties allowing for patients currently on the waiting list backlog to be prioritised and seen.*	As Above
	2. The CCG has identified via the E-referral system which providers have capacity for those specialties experiencing RTT issues. These providers have been contacted to ascertain whether they have additional capacity for those specialties where RTT 18 week pressures exist. Providers contacted have also confirmed that they will accept traditional referrals which supports those practices not currently using E-Referrals. *Where there are capacity issues independent sector providers and existing providers currently providing other outpatient clinics via the E-referral system have been contacted to ascertain whether they have capacity and/or are able to provide additional specialties . These providers include; Spire, St Hughes, Care UK and New Medica.* *Patients will be offered a choice of location and provider at point of referral (Primary Care). The CCG are in discussion with Primary Care (GP surgeries) to ensure that patients are diverted to alternative providers at the point of referral.* *North Lincolnshire CCG are and will continue to work closely with North East Lincolnshire CCG around RTT issues and capacity planning.*	On-going	Identification of alternative provision both from NHS and Independent sector providers will reduce the demand on those specialties where it has been identified an RTT 18 week target is not currently being met and where patient backlogs exist. Patients will continue to be offered choice at the point of referral .	As Above

CCG RTT Recovery Plan – Outsourcing Arrangements (Continued).

Speciality with Issue	Have you been able to make outsourcing arrangement	CCG direct / or provide subcontracting arrangements	Name of alternative provider	Date activity will come on line	Level of additional activity secured
Urology	Yes	CCG Direct			TBC
Trauma and Orthopaedics	Yes	CCG Direct			TBC
ENT	Yes	CCG Direct			TBC
Ophthalmology	Yes	Subcontracting	New Medica	Provisional (Meeting set for 12th September).	New – 316 Review – 790 (Provisional per month)
Oral Surgery	No	NHSE			TBC
Orthodontics	No	NHSE			TBC
Pain Management	Yes	CCG Direct			TBC
Gastroenterology	Not Yet				
Cardiology	Not Yet				
Dermatology	Yes	CCG Direct			TBC
Respiratory Medicine	Not Yet				
Gynaecology	Not Yet				

List of specialities where there is no additional capacity available

- Oral Surgery
- *Orthodontics*
- *Gastroenterology*
- *Cardiology*
- *Respiratory Medicine*
- *Gynaecology*

APPENDIX 2 - Performance report – PYLL - September 6th 2016

Performance report - Potential Years of Life Lost (PYLL) from causes considered amenable to healthcare

(CCG OIS Domain 1 – Preventing People from Dying Prematurely. Indicator 1.1 and NHS OF Domain 1 Indicator 1a).

Definition: This indicator measures the number of years of life lost per 100,000 registered patients from conditions which are considered as usually treatable or amenable to healthcare. The list of causes defined as 'amenable to healthcare' is listed in appendix 1.

Method: Years of life lost are measured by using the average life expectancy for each five year age band, and applying this to each person who died from one of the amenable cases, to calculate how many additional years they might have been expected to live in the presence of timely and effective care. Total years of life lost are then directly standardised for age and sex against the England average and expressed as a rate per 100,000. The data are calculated per calendar year and for 3 year pooled periods.

Background

In 2014, NHS England asked all CCGS, together with their NHS England area teams, to jointly produce 5 year strategic plans (2014/15-to 2018/19) setting out their health outcome ambitions against seven overarching outcomes selected from the NHS Outcomes Framework. One of these key outcomes was PYLL for conditions considered amenable to healthcare, (NHS OF 1a, also CCG OI1.1).

CCGs were instructed to take the 2012 rate as the 2013 baseline and to set targets for 2018/19. The aim was to set more ambitious targets for improvement than were already forecast for 2018/19 by simply extrapolating forward from historic annual trend data, although local CCGs were allowed some flexibility to set realistic targets based on their local disease profile, and expected rates of reduction over time.

Figure 1 shows the historic and projected trend in North Lincolnshire based on annual data made available by PHE in 2014. (These annual rates differ slightly from the indicator data since published by NHS Digital, as they were based on CCG rather than unitary authority populations. However, these methodological differences have little impact locally on the overall trend). Figure 1 also shows the annual targets set in 2014 and the actual rates recorded since then. (Data are published by NHS Digital for each area at least 12 months in arrears).

When data for 2014 were published by NHS Digital in early 2016, this showed an upturn in local rates, with an annual figure 3% above the agreed target. (The actual rate for 2015 in Figure 1 is based on our local data sources).

APPENDIX 2 - Performance report – PYLL - September 6th 2016

Following discussions at the June CCG Governing Body it was agreed that a piece of work would be undertaken jointly by the CCG and Public Health Intelligence to investigate why this was the case and where improvements could be made. It was agreed that the outcome of this work would be discussed by the CCG executive team, and the outcome brought back to the CCG Governing Body. The results of this joint work are summarised below.

Key Facts

Each year between 180-200 people die in North Lincolnshire of 'healthcare amenable conditions', which together account for approximately 4,000 potential years of life lost annually in North Lincolnshire. (Figure 1 presents this data as a rate per 100,000 with the target for 2017/18).

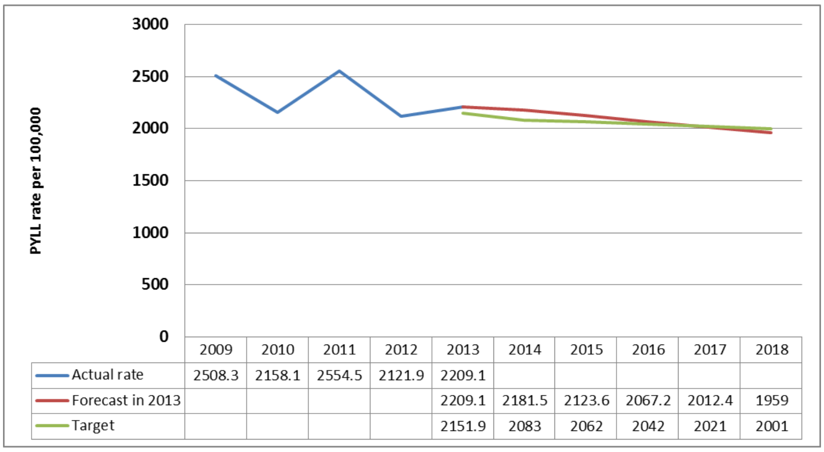
Table 1: No of deaths from conditions 'amenable to healthcare' in North Lincolnshire and total potential years of life lost (PYLL)

	2009*	2010*	2011*	2012*	2013*	2014**	2015**
No of deaths (actual)	204	174	205	166	171	187	179
PYLL no (actual)	4535	3900	4573	3759	3907	4112	3978
PYLL rate (actual)	2508	2158	2555	2122	2209	2360	2298

*Source: *PHE and **PCMD, 2016 (** based on local calculations)*

As the Table 1 and Figure 1 show, both the annual number of such deaths and PYLL rates have fluctuated since 2009 in North Lincolnshire, and whilst the trend appears to be downward, the differences in annual rates is not statistically significant. In other words there has been little change in such death rates since 2009 in North Lincolnshire.

Figure 1: Historic trends, forecasts and targets for PYLL rates amenable to health care in North Lincolnshire 2009- 2018

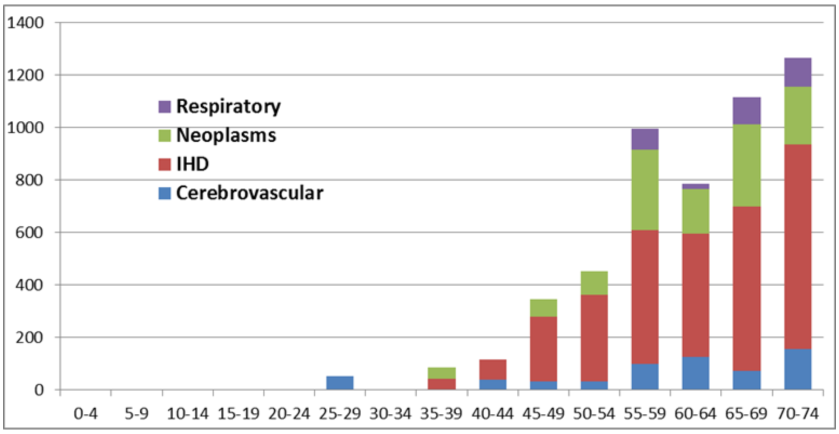


Source: PHE, PCMD

APPENDIX 2 - Performance report – PYLL - September 6th 2016

Men account for over half (58%) of these deaths in North Lincolnshire, as they do nationally.

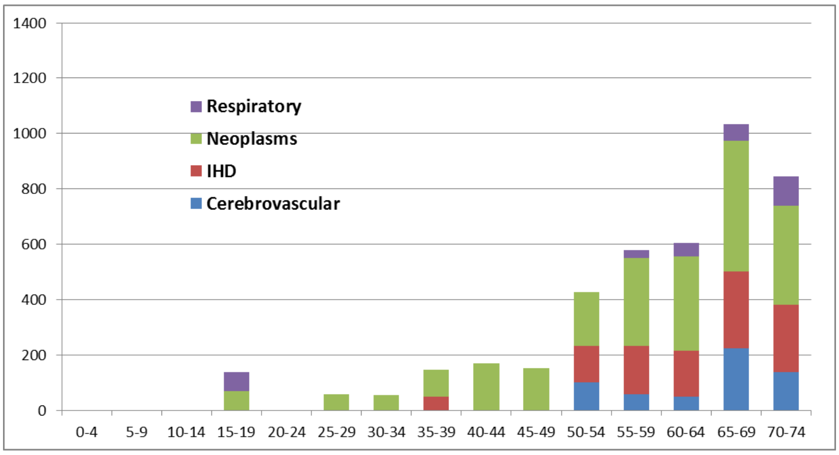
Figure 2: North Lincolnshire rates of PYLL from causes considered amenable to health care, by disease group, males (2013-15)



Source: PCMD, 2016

Amongst men, 'amenable' heart disease accounts for the largest proportion (50%) of such deaths, followed by 'amenable' cancers, (20%), which are mainly premature deaths from bowel cancer.

Figure 3: North Lincolnshire rates of PYLL from causes considered amenable to health care, by disease group, females (2013-15)



Source: PCMD, 2016

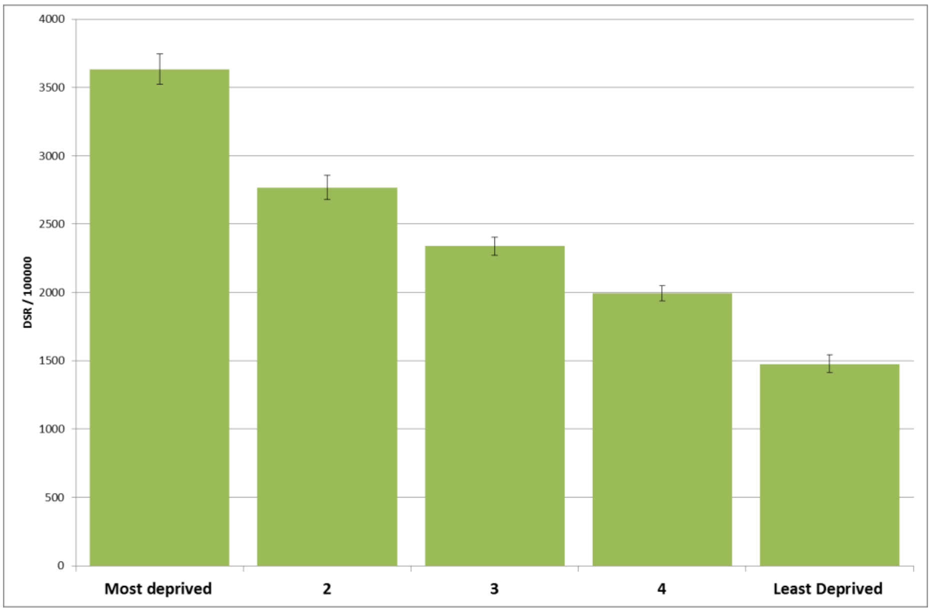
Amongst women, cancer accounts for the largest proportion (40%) of deaths from amenable causes, mainly premature deaths from breast and colorectal cancers.

APPENDIX 2 - Performance report – PYLL - September 6th 2016

Deprivation

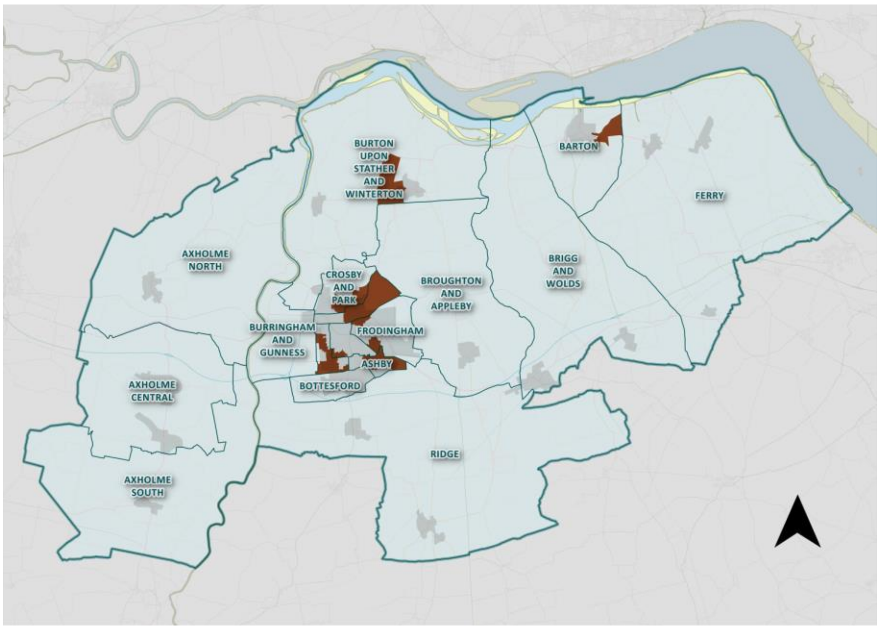
Pooled over 5 years rates of PYLL were highest in the most deprived 20% neighbourhoods in North Lincolnshire, with rates almost twice that in the least deprived 20% North Lincolnshire areas.

Figure 4: PYLL rates from conditions amenable to healthcare by deprivation fifths (IMD2010) in North Lincolnshire (2011-2015)



Source: PCMD, 2016

Figure 5: Map showing distribution of deprivation in North Lincolnshire, with most deprived fifth neighbourhoods (LLSOAs) highlighted IMD 2010



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Care Networks

The largest number of such deaths was in South Care Network, with an average of 60 deaths a year from causes considered amenable to healthcare. In East and West Care networks the average was 50 such deaths per annum. Expressed as a rate per 100,000, South care network had the highest rate of PYLL, with noticeably higher rates of potentially preventable heart disease amongst the under 60s.

Figure 6: North Lincolnshire Care Networks by GP practice

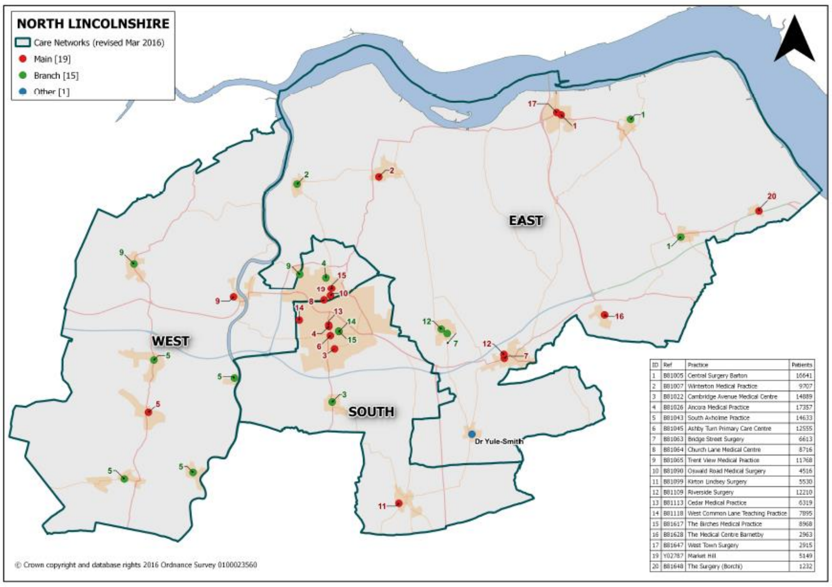
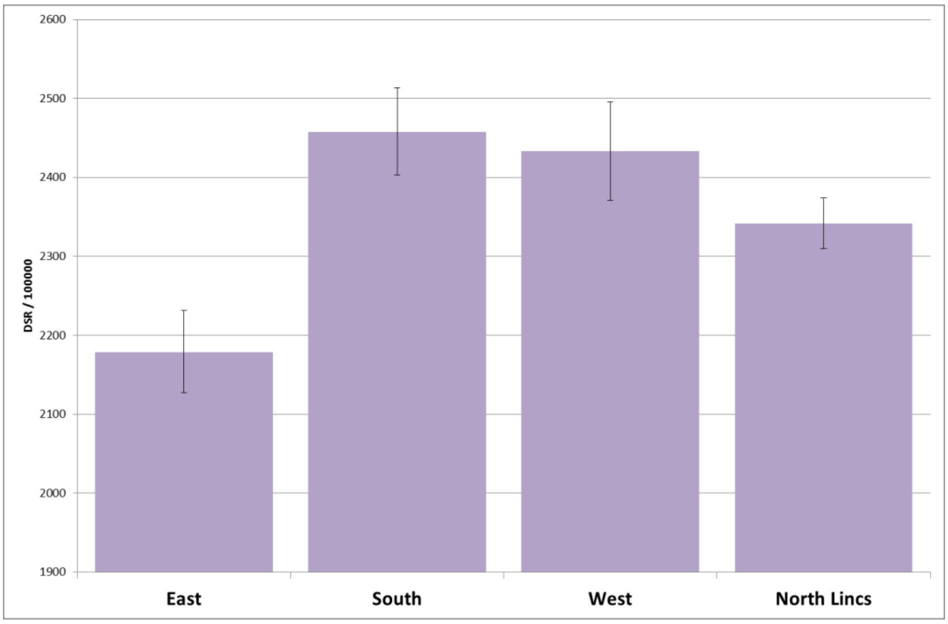


Figure 7: PYLL rates from conditions amenable to healthcare by care networks in North Lincolnshire 2013-2015 (persons)



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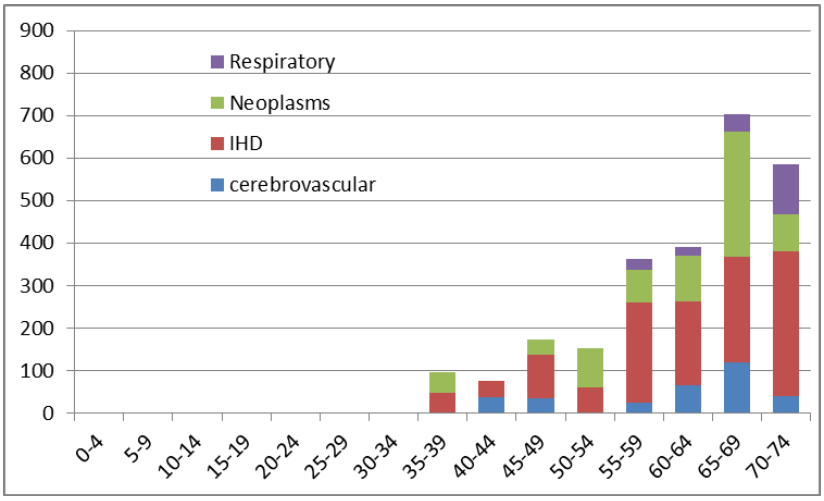
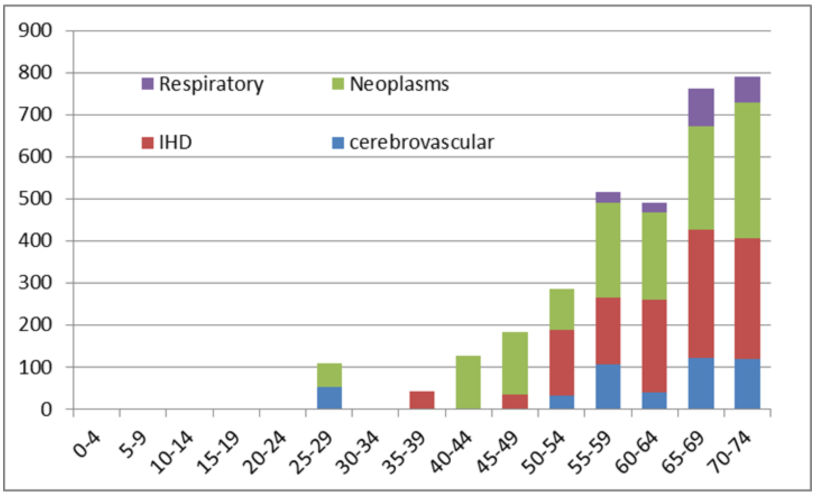
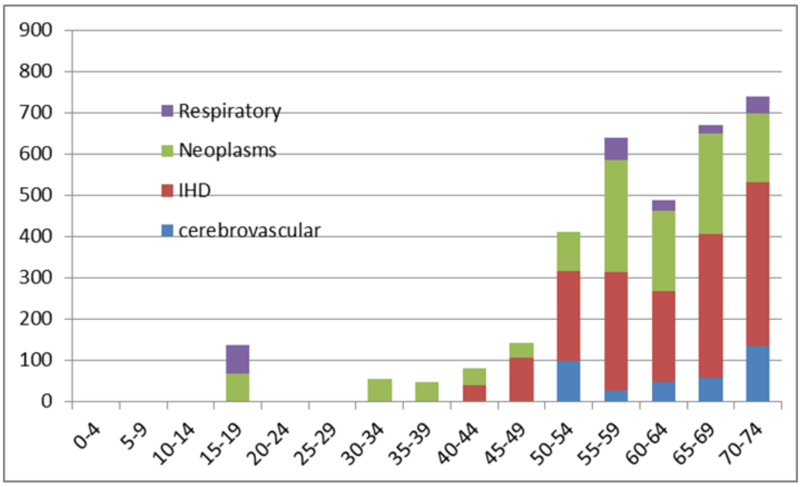
West Care Network



East Care Network



South Care Network



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Summary points

1) Whilst the published and locally calculated annual PYLL data indicate a recent rise in this rate locally, which is above national trends and agreed targets, these differences are not statistically significant. Even 3 year pooled data suggest no statistically significant rise, or fall, in local PYLL rates since 2009.
2) However there are significant social differences in the distribution of such deaths, with statistically higher rates in our most deprived 20%.
3) In other words whilst North Lincolnshire has historically enjoyed better than national declines in premature deaths, especially from heart disease and stroke, these gains would appear to have flattened out, as we are left with the most vulnerable people who are often regarded as 'harder to reach' and /or the more complex to treat.
4) It may be that we have reached 'saturation point' with existing approaches, and that further improvements will only be achieved through more targeted and systematic approaches to finding, screening and treating these high risk groups, including men and women living in our most deprived communities, some of whom may have other chronic illnesses, as well as mental health and/or substance misuse problems.
5) Indeed it is likely that there is some overlap between this indicator and the excess mortality indicator of people with SMI, which is currently the subject of a local CQuin with RDaSH. There may be some additional opportunities to reduce premature deaths amenable to healthcare identified within this parallel work stream, through more targeted screening, and case management of LTCs in people with serious mental illness, or substance misuse issues.
6) The vast majority of those who died prematurely from breast or bowel cancer in North Lincolnshire between 2011-15 would have been eligible for at least 2 cancer screens prior to death. However the data do not tell us how many of these cancers were detected via screening, GP 2 week referral or emergency route, or at what stage these cancers were detected. Nor do we know how long people who died prematurely from heart disease were known to services and in receipt of optimal treatment.
7) Clearly there is potential for more systematic and targeted approaches to improving take up of screening and health checks and self-management of LTCs in high risk areas and with high risk groups, as highlighted in the Joint H&WB Strategy update.
8) Some of the bids under development as part of the Humber Coast and Vale STP prevention workstream submission will contribute to this target, as well as other actions recommended in the local Burden of Disease (BoD) project.
9) It would be useful to identify and align any other potential workstreams which through more systematic and consistent targeting would contribute to narrowing this social gap in health outcomes.

Author: Louise Garnett, Public Health Intelligence North Lincolnshire Council

Appendix 1: List of conditions considered amenable to healthcare

ICD 10 codes	Condition group and cause	Ages included
Amenable Infections		
A15-19, B90	Tuberculosis	0-74 years
A38-A41, A46, A48.1, B50-B54, G00, G03, J02, L03	Selective invasive bacterial and protozoal infections	0-74 years
B17.1, B18.2	Hepatitis C	0-74 years
B20-B24	HIV/AIDS	0-74 years
Amenable Neoplasms		
C18-21	Colorectal cancer	0-74 years
C43	Malignant skin melanoma	0-74 years
C50	Malignant breast cancer (female)	0-74 years
C53	Malignant neoplasm cervix uteri	0-74 years
C67	Malignant neoplasm bladder	0-74 years
C73	Malignant neoplasm thyroid gland	0-74 years
C81	Hodgkin's disease	0-74 years
Leukaemia	C91,C920	0-74 years
Benign neoplasms	D10-D36	0-74 years
Amenable CVD		
101-9	Rheumatic and other valvular heart disease	0-74 years
I10-15	Hypertensive diseases	0-74 years
I20-5	Ischaemic heart disease	0-74 years
I60-9	Cerebrovascular disease	0-74 years
Amenable respiratory diseases		
Influenza	J09-11	0-74 years
Pneumonia	J12-18	0-74 years
Asthma	J45-6	0-74 years
Nutritional metabolic and endocrine		
Diabetes mellitus		0-49 years
Neurological		
Epilepsy	G40-1	0-74 years
Digestive disorders		
Gastric and duodenal ulcer	K25-8	0-74 years
Acute abdomen, appendicitis, intestinal obstruction, cholecystitis/lithiasis, pancreatitis, hernia	K35-8, K40-6, K80-3, K85, K86.1- K86.9, K91.5	0-74 years
Genito urinary disorders		
Nephritis and nephrosis	N00-N07, N17-N19, N25-N27	0-74 years
Obstructive uropathy and prostatic hyperplasia	N13, N20-N21, N35, N40, N99.1	0-74 years
Maternal and infant		

Complications of perinatal period	P00-P96, A33	All
Congenital malformations, deformations and chromosomal anomalies	Q00-Q99	0-74 years
Injuries		
Misadventures to patients during surgical and medical care	Y60-9, Y83-4	All

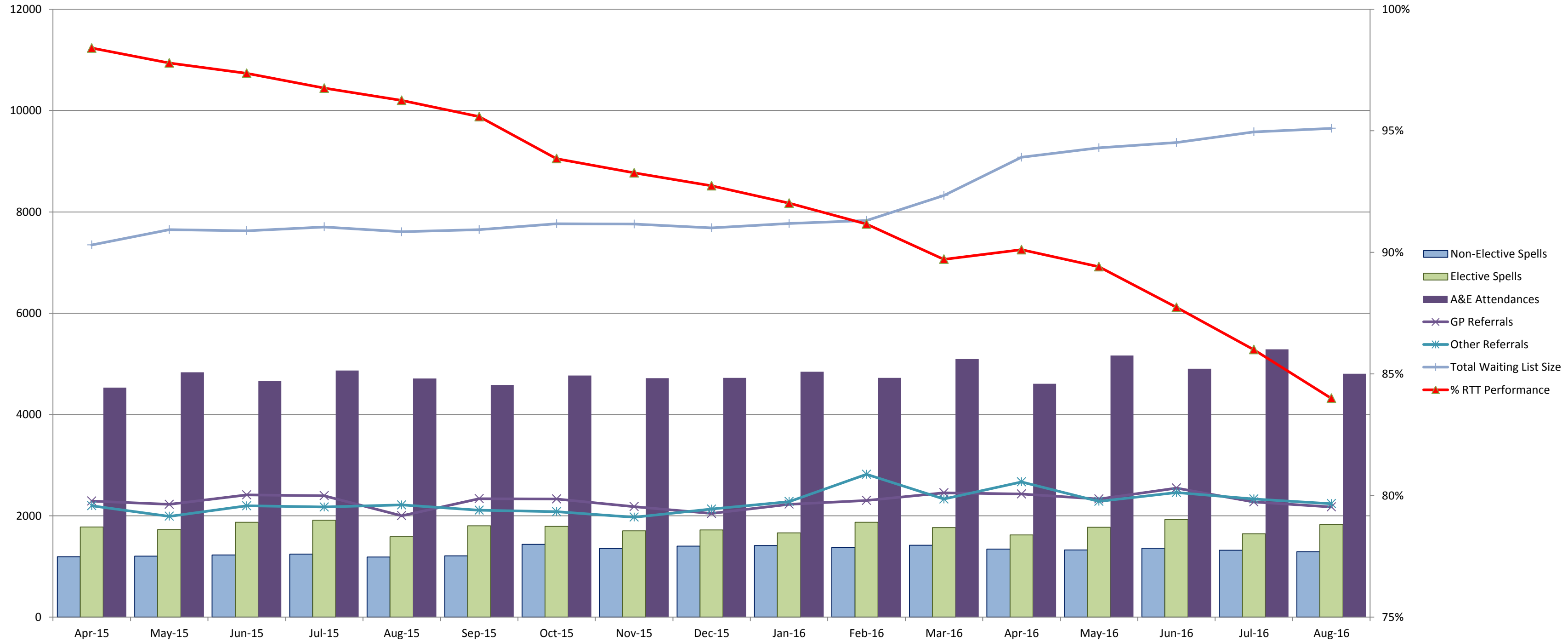
Source: NHS Digital

NHS
North Lincolnshire
Clinical Commissioning Group

DRAFT NLCCG Inpatient Activity Review: Northern Lincolnshire & Goole Hospitals NHSFT

Overall Activity Summary

	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Apr-Aug Growth 15/16 to 16/17
A&E Attendances	4533	4831	4657	4867	4713	4582	4767	4716	4721	4845	4724	5097	4607	5166	4901	5286	4802	4.7%
Non-Elective Spells	1195	1203	1227	1246	1189	1207	1435	1354	1402	1415	1381	1420	1342	1326	1360	1321	1290	8.7%
Elective Spells	1778	1727	1875	1914	1587	1802	1790	1704	1724	1664	1870	1765	1625	1776	1924	1647	1826	-0.9%
Total Waiting List Size	7347	7649	7627	7704	7606	7650	7765	7759	7686	7770	7831	8324	9077	9265	9369	9580	9651	19.2%
RTT % Performance	98%	98%	97%	97%	96%	96%	94%	93%	93%	92%	91%	90%	90%	89%	88%	86%	84%	-11.3%
GP Referrals	2290	2224	2413	2397	2002	2339	2332	2182	2044	2228	2302	2453	2429	2332	2549	2274	2175	3.7%
Other Referrals	2200	1990	2195	2173	2214	2109	2079	1974	2131	2282	2818	2329	2669	2284	2458	2332	2241	10.1%



The table above shows a small level of growth in most areas of CCG controlled hospital demand, with 8.7% period on period growth in Non-Elective Inpatients, 4.7% A&E Attendances and 3.7% GP Referrals. In terms of the growth seen in Other referrals, we are aware of an issue in reporting of Ophthalmology workload transfers which is adversely affecting the figures so the 10.1% figure is over stated.

What cannot be explained by an increase in demand is the significant increase in the total waiting list size that has been created from around March 2016, which in turn has effected the Elective Inpatient position (currently showing negative growth of 0.9%). This would lead us to believe that the cause must relate to internal Trust capacity or processes causing the regular level of work to change.

Next steps would be to present this to the Trust using the Contract meeting process to further understand the context and causes behind this position, and expected recovery of Waiting Time performance, which will also in turn will inform year end forcasting.