Appendix 3

Local priorities – supporting analysis

Indicator description	Baseline	Trajectory end 13/14	Supporting analysis	Numerator/ Denominator	Monitoring arrangements
Hospital admissions wholly attributable to alcohol (including alcoholic liver disease)	12/13 forecast 4,292  	4,017 Reduction of 275 hospital admissions	The historical data indicates around 4,000 admissions wholly attributable to alcohol. The number of admissions was stable between 2010/11 and 11/12; but it is forecast that it will increase by around 12% between 11/12 and 12/13. It is unclear for the increase, but it seems to have happened fairly evenly across primary and secondary diagnoses (could be linked to coding). Unable to access historical data per 2010/11 as dataset was unvalidated and from different database – therefore long-term historical view unavailable. Longer term view is available for former NI39 indicator (alcohol-related hospital admissions) and shows year on year increases and rates, particularly for Coventry patients, higher than regional averages and comparable areas <u>Actions to reduce hospital admissions - assumptions for the impact:</u> 1. If the various IBA schemes in primary and secondary care are delivered appropriately, it should result in around 200 fewer admissions per annum across Coventry and Rugby. 2. As well as delivering IBA, the alcohol liaison nurse team at UH will help manage around 30	tbc	Need to include on corporate performance dashboard

Indicator description	Baseline	Trajectory end 13/14	Supporting analysis	Numerator/ Denominator	Monitoring arrangements
			patients per month drinking at higher risk levels. Some of these will require hospital admissions (but for shorter periods) and some will be counted among those receiving specialist treatment. However, the improved targeting and greater level of intervention may account for 50 fewer admissions per annum. 3. The multiple attender service will have a small caseload (probably not more than 15 throughout the year). Assuming each will be admitted 2-3 times per annum (plus numerous attendances), and a 70% reduction in admissions, this service will result in around 25 fewer admissions. 4. The impact of Integrated Acute Liaison is not really known. It will certainly facilitate improved pathways to specialist services and the alcohol liaison nurse team. Hence, overall these services should lead to <u>at least 275 fewer admissions</u> (this ignores the impact of the RAID service). There are other interventions which may increase this reduction, such as Making Every Contact Count and the development of IBA within the hospital (as part of the ALN service), which could increase this reduction further. Specialist alcohol services are provided by the Recovery Partnership and have been recommissioned, partly to increase capacity.		

Indicator description	Baseline	Trajectory end 13/14	Supporting analysis	Numerator/ Denominator	Monitoring arrangements
Maternal Smoking at Time of Delivery SATOD	**Data analysis incomplete regarding reduction in smoking rates between booking at delivery** <u>Smoking at time of delivery</u> Rugby data is only available for 11/12 and 12/13, hence not possible to use a 3-year average for the whole CCG. Coventry 3-year average for 2009-2012 is 14.1% 13/14 YTD CCG position	Tbc <u>Smoking at time of delivery</u> 13.4% proposed reduction of 0.1% from YTD position of 13.5%	Rugby smoking at time of delivery figures are higher than for Coventry consistently. The overall CRCCG figure is running at 13.5%, but we only have 2 year's data (since the introduction of CO monitoring in UHCW) so the trajectory should reflect this. The West Midlands figures over the last 3 years have not changed significantly and are running at over 15%, so it would be unrealistic to set a trajectory significantly below that figure and to expect any large reduction in one year for CRCCG. However, important to note that the % smoking at time of delivery is closely linked to % smoking at booking, and reflects the particular cohort. It is possible to have a high prevalence of smoking at booking which could mean the % at delivery is also high – not necessarily reflecting the impact of interventions by stop smoking teams, during a woman's pregnancy. It would be preferable to set a trajectory based on a % reduction between the time of booking and at delivery, rather than a downward trajectory between different cohorts at time of delivery. Further data analysis is being requested on this and if available, will be used for a trajectory rather than a downward trajectory in smoking at time of delivery rates. However, the NHS Outcomes Indicator Set suggests the smoking at time of delivery. Hence, this trajectory	<u>Smoking at time of delivery</u> 847 mothers smoking at delivery out of a forecast number of 6318 births in 2013-4.	Already included on corporate performance dashboard.

Indicator description	Baseline	Trajectory end 13/14	Supporting analysis	Numerator/ Denominator	Monitoring arrangements
	is 13.5%.  Y:\PrimaryCare\ Coventry and Rugby		has been developed and we will need to negotiate with the LAT (this should be a second choice however).		
Cervical screening coverage rates	Coverage over last 5 years for CCG is 77.23% (baseline data April 2011 – March 2012)  Y:\PrimaryCare\ Coventry and Rugby	78.5% coverage	Equates to an additional 17 patients per practice, or an additional 25 patients per practice to those practices with coverage rates of less than 70%	80,974 numerator 103,151 denominator	Commissioning responsibility with LAT, however, need to include on CCG corporate performance dashboard