Leicestershire County Council

Meeting: **Health Overview and Scrutiny Committee**

Date/Time: **Wednesday, 22 January 2014 at 2.00 pm**

Location: **Sparkenhoe Committee Room, County Hall, Glenfield**

Contact: **Mrs. R. Palmer (0116 305 6098)**

Email: **rosemary.palmer@leics.gov.uk**

Membership

Dr. S. Hill CC (Chairman)

Dr. T. Eynon CC	Mr. J. Miah CC
Dr. R. K. A. Feltham CC	Mr. M. T. Mullaney CC
Mr. S. J. Hampson CC	Mr. J. P. O'Shea CC
Mr. W. Liquorish JP CC	Mr. A. E. Pearson CC

Please note: this meeting will be filmed for live or subsequent broadcast via the Council's web site at http://www.leics.gov.uk/webcast – Notices will be on display at the meeting explaining the arrangements.

AGENDA

Item		Report by
1.	Minutes of the meeting held on 27 November 2013.	(Pages 5 - 14)
2.	Question Time.	
3.	Questions asked by members under Standing Order 7(3) and 7(5).	
4.	To advise of any other items which the Chairman has decided to take as urgent elsewhere on the agenda.	
5.	Declarations of interest in respect of items on the agenda.	
6.	Declarations of the Party Whip in accordance with Overview and Scrutiny Procedure Rule 16.	

7.	Presentation of Petitions under Standing Order 36.		
8.	Medium Term Financial Strategy 2014/15 - 2017/18	Director of Public Health and Director of Corporate Resources	(Pages 15 - 24)
9.	Quarter 2 Performance Report.	Chief Executive and Director of Public Health	(Pages 25 - 48)

10. Date of next meeting.

    The next meeting will be held on 12th March 2014 at 2.00pm

11. Any other items which the Chairman has decided to take as urgent.

QUESTIONING BY MEMBERS OF OVERVIEW AND SCRUTINY

Members serving on Overview and Scrutiny have a key role in providing constructive yet robust challenge to proposals put forward by the Cabinet and Officers. One of the most important skills is the ability to extract information by means of questions so that it can help inform comments and recommendations from Overview and Scrutiny bodies.

Members clearly cannot be expected to be experts in every topic under scrutiny and nor is there an expectation that they so be. Asking questions of 'experts' can be difficult and intimidating but often posing questions from a lay perspective would allow members to obtain a better perspective and understanding of the issue at hand.

Set out below are some key questions members may consider asking when considering reports on particular issues. The list of questions is not intended as a comprehensive list but as a general guide. Depending on the issue under consideration there may be specific questions members may wish to ask.

Key Questions:

- Why are we doing this?
- Why do we have to offer this service?
- How does this fit in with the Council's priorities?
- Which of our key partners are involved? Do they share the objectives and is the service to be joined up?
- Who is providing this service and why have we chosen this approach? What other options were considered and why were these discarded?
- Who has been consulted and what has the response been? How, if at all, have their views been taken into account in this proposal?

If it is a new service:

- Who are the main beneficiaries of the service? (could be a particular group or an area)
- What difference will providing this service make to them – What will be different and how will we know if we have succeeded?
- How much will it cost and how is it to be funded?
- What are the risks to the successful delivery of the service?

If it is a reduction in an existing service:

- Which groups are affected? Is the impact greater on any particular group and, if so, which group and what plans do you have to help mitigate the impact?
- When are the proposals to be implemented and do you have any transitional arrangements for those who will no longer receive the service?
- What savings do you expect to generate and what was expected in the budget? Are there any redundancies?
- What are the risks of not delivering as intended? If this happens, what contingency measures have you in place?

This page is intentionally left blank

Agenda Item 1

Leicestershire County Council

Minutes of a meeting of the Health Overview and Scrutiny Committee held at County Hall, Glenfield on Wednesday, 27 November 2013.

PRESENT

Dr. S. Hill CC (in the Chair)

Dr. T. Eynon CC	Mr. J. Miah CC
Dr. R. K. A. Feltham CC	Mr. M. T. Mullaney CC
Mr. S. J. Hampson CC	Mr. J. P. O'Shea CC
Mr. W. Liquorish JP CC	Mr. A. E. Pearson CC

In attendance.

Mr E F White CC, Cabinet Lead Member
Mr Geoff Smith OBE, Healthwatch Representative (minutes 31 – 34 refer)
Dr Dave Briggs, Managing Director, East Leicestershire and Rutland Clinical Commissioning Group (minutes 31 – 33 refer)
Dr Peter Miller, Chief Executive, Leicestershire Partnership NHS Trust (minute 31 refers)
Dr Satheesh Kumar, Medical Director, Leicestershire Partnership NHS Trust (minute 31 refers)
Ms Jane Taylor, Director of Emergency Care, Leicester, Leicestershire and Rutland (minute 32 refers)
Dr Kevin Harris, Medical Director, University Hospitals of Leicester NHS Trust (minute 33 refers)
Mr Andrew Seddon, Director of Finance and Business Services, University Hospitals of Leicester NHS Trust (minute 33 refers)
Ms Nicky Topham, Project Director, Site Reconfiguration, University Hospitals of Leicester NHS Trust (minute 33 refers)
Steve Firman, Programme Director, East Midlands Ambulance Service (minute 34 refers)
Roger Watson, Consultant Paramedic, East Midlands Ambulance Service (minute 34 refers)

23. Minutes of the meeting held on 11 September 2013.

The minutes of the meeting held on 11th September 2013 were taken as read, confirmed and signed.

24. Minutes of the meeting held on 12 September 2013.

The minutes of the meeting held on 12th September 2013 were taken as read, confirmed and signed.

25. Question Time.

The Chief Executive reported that no questions had been received under Standing Order 35.

26. Questions asked by members under Standing Order 7(3) and 7(5).

The Chief Executive reported that no questions had been received under Standing Order 7(3) and 7(5).

27. Urgent Items.

There were no urgent items for consideration.

28. Declarations of interest.

The Chairman invited members who wished to do so to declare any interest in respect of items on the agenda for the meeting.

Dr T Eynon CC declared a personal interest in all items on the agenda as a salaried GP.

29. Declarations of the Party Whip in accordance with Overview and Scrutiny Procedure Rule 16.

There were no declarations of the party whip.

30. Presentation of Petitions under Standing Order 36.

The Chief Executive reported that no petitions had been received under Standing Order 36.

31. Quality Improvement Programme.

The Committee considered a report from Leicestershire Partnership NHS Trust (LPT) which provided an update on the Quality Improvement Programme. A copy of the report marked 'Agenda Item 9' is filed with these minutes.

The Chairman welcomed the following people to the meeting for this item:-

Dr Peter Miller, Chief Executive of LPT
Dr Satheesh Kumar, Medical Director at LPT;
Dr Dave Briggs, Managing Director of East Leicestershire and Rutland Clinical Commissioning Group (ELRCCG), the lead commissioners for LPT.

Dr Briggs emphasised that the Quality Improvement Plan was ambitious and was intended to improve quality at LPT to a position that was significantly above the minimum standards. It was intended that, once a certain standard was achieved, there would be a reduction in the scrutiny of delivery, currently carried out by a newly established Quality Oversight Group. The timescales for delivery were challenging and it was intended that LPT would focus on delivering improvement in priority areas. However, timescales might slip in other areas.

Written comments had been received from Healthwatch Leicestershire and a copy is filed with these minutes. At the invitation of the Chairman, Geoff Smith OBE, the Healthwatch representative, commented that Healthwatch would welcome a shortening of the timescales for delivery of the Quality Improvement Programme. However, the timescales, which had been developed with staff and the Quality Oversight Group, were

ambitious and unlikely to be shortened. Dr Peter Miller confirmed that Healthwatch would be invited to future meetings of the Quality Oversight Group.

Arising from discussion the following points were raised:-

(i) The Quality Oversight Group would ensure that LPT and its commissioners were monitoring performance in the right areas and could demonstrate that people were receiving the care that they deserved. The Quality Improvement Plan had been rigorously tested during development to ensure that it was satisfactory. Work had already started on the key priority measures.

(ii) In order to achieve the necessary improvements in quality, LPT would need a sustainable change in culture. Strong leadership would be required to deliver this, for example every clinician would need to demonstrate leadership potential and not walk past poor practice. A cultural audit of several hundred members of staff had already been undertaken and would be repeated in order to measure whether the change had been implemented.

(iii) A variety of mechanisms were being put in place to improve the experience of patients and carers. These included strengthening the complaints process, undertaking surveys when patients were being discharged and collating patient feedback by ward to enable performance to be considered at ward level. In order to collect relevant data from staff as well, LPT wanted to create a culture which encouraged openness and the raising of concerns about poor performance. Policies to support this were in place. Senior managers were also visible on wards and would speak with staff and patients. The Committee commented that it was important to have the right balance to ensure that data collection was not overly bureaucratic and that key messages were not overlooked.

(iv) The model for providing psychological therapies on wards would be informed by NICE guidance but would also build on existing services available to inpatients such as self-help groups. Base level training in Cognitive Behavioural Therapies was also being planned for ward staff.

(v) The Supporting Leicestershire Families programme used an assessment tool called ‘Family Star’ to support and measure change. It used a scale of one to ten to outline key steps in a transition from dependence to independence. It was suggested that this model could be adapted by LPT to measure performance of therapies.

(vi) The Committee was pleased to note the number and range of activities available for in-patients. Most activities were undertaken in the Involvement Centre, within the safety of the Bradgate Unit but away from the wards. Those patients preparing for discharge were given support to go out into the community. The need to ensure that sufficient Occupational Therapists were available to provide these services was acknowledged by LPT.

(vii) The average length of stay on the Bradgate Unit was 44 days, with more than half of the patients detained by the Mental Health Act. The wards always had nearly 100% occupancy, which put the service under pressure. The Committee was pleased to note that, in order to reduce pressure on in-patient services, LPT also planned to improve the discharge process and how the Community Mental Health teams supported patients in the community. LPT was currently working to address

capacity issues in this area. Evidence showed that engaging with patients while they were in the community helped to prevent readmissions. To this end, LPT had also established a Recovery College which provided evidence based education in self-management. Less than 5% of LPT's patients were readmitted within one month of discharge, although this number had increased recently.

(viii) One of the actions in the Quality Improvement Programme was to set a standard time between agreeing to admit a patient and actually admitting them. The performance measure for this target was still being developed. However, it was noted that a police triage car was in operation and had reduced the number of patients who ended up being put on Section 136 by the police. This contained both a mental health clinician and a police officer and would ensure that the patient was kept safe until admitted.

(ix) Although 15% of police time was taken up with mental health issues, it was noted that most actions undertaken by the police to ensure that people with mental health problems were dealt with appropriately and sensitively were within the police's remit. It was important that the response to requests for support from the police was efficient.

(x) The length of time a One to One session lasted was a matter for professional judgement. One to One meetings had already been introduced as part of the Quality Improvement Programme. Patient feedback would be used to check if the One to One sessions were meaningful.

(xi) LPT did not offer a specific service to assist patients where their mental illness had caused a family breakdown. However, it had signed up to the Leicester, Leicestershire and Rutland Carers' Strategy which worked with families to prevent breakdown. Bereavement services were also available.

RESOLVED:

(a) That the development of the Quality Improvement Programme be noted;

(b) That a report on the outcomes of the work of the Quality Oversight Group be submitted to the Health Overview and Scrutiny Committee meeting in March 2014;

(c) That officers be requested to organise a visit to the Bradgate Unit for members of the Committee.

32. Emergency Care Update.

The Committee considered a report from West Leicestershire and East Leicestershire and Rutland Clinical Commissioning Groups (WLCCG and ELRCCG) which provided an update on performance of the local urgent and emergency care system, in particular the University Hospitals of Leicester NHS Trust's (UHL) performance against the four hour standard for Accident and Emergency (A&E) waiting times and the actions taken by the local health economy to address the underlying issues affecting the emergency pathway and its impact on A&E performance. A copy of the report marked 'Agenda Item 10' is filed with these minutes.

Written comments had been received from Healthwatch Leicestershire and a copy is filed with these minutes.

The Chairman welcomed Dr Dave Briggs, Managing Director of ELRCCG and Jane Taylor, Director of Emergency Care across Leicester, Leicestershire and Rutland, to the meeting for this item.

In his introduction to the item, Dr Briggs observed that a lot of good work had been carried out but that this had not translated to a sustained improvement in performance. The patient experience had been improved through a number of quality and safety metrics including a patient census which tracked every patient through the system and enabled partners to identify where to focus resources. It was hoped that this would result in a significant improvement in performance in the near future.

Arising from discussion the following points were raised:-

(i) The challenge in achieving the four hour waiting time target for A&E was the daily variation in performance. A sustained improvement in the flow through the hospital was also a significant challenge and key area of focus. In particular, improvements were being made to the discharge process.

(ii) UHL had received £10m from the Government to help deal with winter pressures. This had already been overcommitted to help improve A&E performance. The recent announcement of a further £150m from the Government would not be made available to UHL as they had received funding earlier in the programme.

(iii) It was acknowledged that achieving the four hour waiting time target in A&E had always been a challenge. This was because the local health economy had not transformed quickly enough over a number of years. This had worsened the crisis and meant that a number of significant improvements were required to meet the challenge. The improvements included the expansion of the Emergency Department which was felt to be a necessary investment in order for UHL to meet the target. Commissioners were of the view that the local emergency care system was now catching up rapidly with other areas.

(iv) The non-emergency telephone number, 111, had been introduced in Leicester, Leicestershire and Rutland after the national roll out to enable lessons to be learnt from issues that had arisen elsewhere in the country. Prior to its introduction, UHL had implemented the single front door which meant that 111 had not had an adverse impact on UHL's Emergency Department.

(v) Work was on-going to establish a single template for patient data across health and social care. There was also an ambition to develop a single data system that worked across partners' IT systems. In the meantime, improvements had been made to enable partners to share information more efficiently and an integrated discharge team had been established.

(vi) The integration of health and social care was a priority across the local health and care system. Areas that would initially be focussed on included IT and the frail elderly. The 'silver book', which had recently been launched and outlined care standards for older people over the first 24 hours of an urgent care episode, could be used to support work on improving care for frail elderly people. Members suggested that creating a 'silver e-book' could be a useful project.

(vii) Concern was expressed regarding the number of hospital admissions from care homes. It was recognised that this was a cultural problem, particularly with regard to end of life care and the CCGs had a significant programme of work aimed at supporting care homes to reduce admissions. This included giving care homes confidence in the Out of Hours service, proactively reviewing data on a weekly basis to address issues quickly and working with the East Midlands Ambulance Service. A workshop would be hosted by the CCGs for care homes' staff next week to identify how they could best be supported.

RESOLVED:

(a) That the performance of the local urgent and emergency care system and actions taken to address the underlying issues affecting the emergency pathway be noted;

(b) That a report on hospital admissions from Care Homes be submitted to a future meeting of the Health Overview and Scrutiny Committee.

33. Update on Current Issues

The Committee considered a report from the University Hospitals of Leicester NHS Trust (UHL) which provided an update on the proposed development of the Emergency Floor, UHL's mortality rates, the forthcoming Care Quality Commission (CQC) hospital inspection programme and UHL's financial position for 2013/14. The Committee also received a presentation providing details of the proposed improvements to the Emergency Floor. A copy of the report marked 'Agenda Item 11' and a copy of the slides forming the presentation is filed with these minutes.

The Chairman welcomed the following people to the meeting for this item:-

Dr Kevin Harris, Medical Director at UHL;
Andrew Seddon, Director of Finance and Business Services at UHL;
Nicky Topham, Project Director for Site Reconfiguration at UHL.

The Chairman also invited Dr Dave Briggs, Managing Director of East Leicestershire and Rutland CCG, to provide contextual details of the Better Care Together Programme which was aimed to make improvements across the local health and care system. Dr Briggs explained that a single joint strategic five year plan for health and social care in Leicestershire, Leicester and Rutland would be co-produced for sign-off in April 2014. This would be used to inform the individual operational plans of each organisation within the local health and care system. Although the Better Care Together project had been in operation for some time, looking at such issues as the Emergency Floor, the speed of change had recently escalated and would need to be on a bigger scale than previously anticipated.

Written comments had been received from Healthwatch Leicestershire and a copy is filed with these minutes. At the invitation of the Chairman, Geoff Smith OBE, Healthwatch representative, spoke in support of the new proposal for the Emergency Floor and requested that consideration be given to the Park and Ride schemes when considering access to the Leicester Royal Infirmary site.

Arising from discussion the following points were raised:-

Emergency Floor

(i) While there is no longer a need under the new plan for the Emergency Floor to move outpatient services to the Leicester General Hospital, it remained the Trust's long-term priority to move outpatient services away from the Leicester Royal Infirmary. It was intended that the old A&E Department would be turned into an assessment area once the new one had been built.

(ii) The NHS Trust Development Agency viewed the project as high priority. Informal feedback on the scheme had been supportive.

(iii) Concern was expressed that the new proposal would not improve access to the Leicester Royal Infirmary. However, the Committee was assured that improved access for ambulances and car parking were included in the scheme. A full site review of the car parking strategy would be carried out.

(iv) It was noted that the Keogh Review had advocated a reduction in the number of Emergency Departments nationally. It was felt that Leicester required a single Emergency Department in order to deliver the optimum outcomes for patients. However, the current Emergency Department was too small and had been intended for treating 100,000 patients per year, not the 160,000 patients per year that were currently being treated there. UHL was projecting an annual 3% growth in activity and it was intended that up to 200,000 patients could be treated in the new Emergency Department each year, thus making it sustainable for the future. A new build would also mean a more flexible space.

(v) Members suggested that Community Hospitals should be used more effectively, especially for patients requiring end of life care. It was agreed that patients should not attend A&E if it was of little or no benefit to them.

Hospital Mortality Rates

(vi) It was noted that there were very few hospitals with a similar configuration to UHL and it was therefore very difficult to benchmark levels of mortality against other Trusts.

CQC Wave 2 Acute Hospital Inspection Programme

(vii) Concern was expressed that coding issues appeared to be a long term recurring theme for UHL. The Committee expected that the CQC would seek reassurance in this area when they carried out the inspection.

Financial Position 2013/14

(viii) The Committee was advised that, at the end of month 7, UHL was facing a financial deficit of £17.3m, or 3.8%. However, it was on target to save just under £38m through its Cost Improvement Programme, just over £2m short of the total level of savings identified. UHL was still in discussion with commissioners regarding its financial position at the end of the year. Concern was expressed that achieving financial balance was a recurring problem for UHL.

(ix) Concern was expressed that UHL had 500 vacant nursing posts. It was noted that the number of vacancies had been substantially increased following an acuity

review. UHL was currently recruiting nurses in Portugal to fill the vacancies. However, the Committee was of the view that UHL should seek to employ agency staff directly and, to that end, should be having discussions with local agency staff to understand why they preferred to be employed by an agency and how they could be encouraged to accept a permanent contract from UHL.

RESOLVED:

That the update on the proposed development of the Emergency Floor, UHL's mortality rates, the forthcoming Care Quality Commission (CQC) hospital inspection programme and UHL's financial position for 2013/14 be noted.

34. Update on Implementation of the Estates Strategy.

The Committee considered a report of the East Midlands Ambulance Service (EMAS) which provided an update on progress with the Estates Strategy and, in particular, plans for ambulance stations within Leicestershire County. A copy of the report marked 'Agenda Item 12' is filed with these minutes.

The Chairman welcomed Steve Firman, Programme Director for the EMAS Estates Strategy and Roger Watson, Consultant Paramedic, to the meeting for this item.

In his introduction to the report, Roger Watson outlined recent issues relating to EMAS' performance which had resulted in a risk summit meeting. As a result of the risk summit, governance arrangements were being improved and extra Community Ambulance Team nurses were being put in place. It was also felt that the new Chief Executive, Sue Noyes, had created a positive atmosphere within the organisation, following the conclusion of an extremely challenging management restructure.

It was clear that EMAS had a role to play in improving the performance of the local emergency care system. Actions that were being taken included working with triage cars for patients with mental ill health, the 'GP in a car' initiative which had had a positive impact on the number of patients being conveyed to A&E as different pathways were being identified and the introduction of a post-registration course for paramedics to help them deal with non-emergency issues, particularly with regard to end of life care.

Written comments had been received from Healthwatch Leicestershire and a copy is filed with these minutes. At the invitation of the Chairman, Geoff Smith OBE, Healthwatch representative, welcomed the involvement of Healthwatch in the recent risk summit and the reassurance that, following the management restructure, EMAS appeared to be making improvements.

Arising from discussion the following points were raised:-

(i) EMAS found it challenging to meet the performance targets in rural areas. In order to make improvements, the standby system was being reviewed and cars manned by paramedics were being introduced in market towns. These 'zonal' cars would not leave the area as one of the key issues affecting performance identified by staff was the amount of time taken to return to the area they were supposed to be in. The Business Intelligence Unit was also using data to identify ways in which the target could be met.

(ii) The Committee was assured that current ambulance stations would not be closed until the new Community Ambulance Stations were in place. This was a change to the original implementation plan as a result of staff feedback. The Committee was pleased to note that EMAS was listening to feedback and changing its approach accordingly.

(iii) It was noted that the Estates Strategy had not been supported by all staff. EMAS was grateful to staff for raising their concerns with senior managers and had now listened to all staff and taken their views on board. Staff wanted to be in the community, where they could get to patients more quickly. They also had a better understanding of travel times than centrally based staff and so could provide advice on the best place for community ambulance stations. Members were pleased to note that staff and managers were now working together on the Estates Strategy and felt that this would bring confidence in the service back to local communities.

RESOLVED:

That the update on progress against the Estates Strategy and plans for ambulance stations in Leicestershire be noted.

35. Annual Report of the Director of Public Health

The Committee considered a report of the Director of Public Health which informed members of the publication of the Director of Public Health's Annual Report for 2013. A copy of the report marked 'Agenda Item 13' is filed with these minutes.

Mr E F White CC, Cabinet Lead Member for Health, spoke in support of the Annual Report and, in particular, drew members' attention to the case studies, arguments for investment and update on action taken since the previous year's report. He also thanked Dr Peter Marks, who was due to retire at the end of November, for his services.

The Committee welcomed the report, which was informative and useful and thanked those involved in producing it.

RESOLVED:

(a) That the Annual Report of the Director of Public Health be welcomed;

(b) That a letter of thanks be sent from the Committee to Dr Peter Marks in recognition of his services as Director of Public Health.

36. Date of next meeting.

It was noted that the next meeting of the Committee would be held on Wednesday 22 January at 2.00pm.

2.00 - 5.03 pm CHAIRMAN
27 November 2013

This page is intentionally left blank

Agenda Item 8

Leicestershire County Council

HEALTH OVERVIEW and SCRUTINY COMMITTEE: 22 JANUARY 2014

JOINT REPORT OF THE DIRECTOR OF PUBLIC HEALTH AND THE DIRECTOR OF CORPORATE RESOURCES

MEDIUM TERM FINANCIAL STRATEGY 2014/15 – 2017/18

Purpose

1. The purpose of this report is to:

   a) provide information on the proposed 2014/15 to 2017/18 Medium Term Financial Strategy (MTFS) as it relates to the Public Health Department; and
   b) ask the Committee to consider any issues as part of the consultation process and any response it may wish to make.

Policy Framework and Previous Decisions

2. The County Council agreed the current MTFS in February 2013. This has been the subject of a comprehensive review and revision in light of the current economic circumstances. The draft MTFS for 2014/15 – 2017/18 was considered by the Cabinet on 15 January 2014.

Background

3. Reports such as this are being presented to the relevant Overview and Scrutiny Committees. The views of this Committee will be reported to the Scrutiny Commission on 29 January. The Cabinet will consider the results of the scrutiny process before recommending a MTFS including a budget and capital programme for 2014/15 to the County Council on the 19 February 2014.

Financial Strategy

4. The MTFS is set out in the report to Cabinet on 15 January, a copy of which has been circulated to all members of the County Council. This report highlights the implications for the Public Health Department.

Service Transformation

5. The Public Health Procurement Plan 2013/14 and 2014/15, approved by Cabinet in October 2013, set out the procurement timetable for public health services. These staggered re-procurements will enable Public Health to drive further efficiencies from providers in the same way that has been achieved in relation to the new sexual health service. Additionally, Public Health will continue to work closely with our colleagues across the County Council in identifying joint areas of work that will improve the health

of the population while avoiding duplication across departments. In doing so, the Department will create the 'headroom' within the Public Health Grant that will enable it to further consolidate public health and prevention within the County Council. This will allow a contribution to be made to the County Council's savings challenge whilst minimising the impact on existing public health services.

6. Public Health will continue to structure its services in line with the new Target Operating Model for the County Council. This envisages:-
   - A focus on prevention and early intervention to reduce demand for services
   - A focus on the customer/service user
   - Integration that reflects both an emphasis on the services provided by County Council, rather than by each department, and the integration and co-ordination of services across partner organisations
   - More community involvement in the delivery of appropriate services
   - A streamlined, concentrated and coordinated support service function

7. For Public Health services, this will enable alignment, and avoid duplication, with preventative services commissioned in other departments. Additionally it will enable the County Council to develop a single approach to harnessing the role of communities in preventing ill health and in making sure individuals are given the information they need to self-care successfully.

Proposed Revenue Budget

8. The Public Health Department is expected to be fully funded from the ring fenced Department of Health grant from 2014/15. The grant has included an allowance for pay and price inflation, for the two years of published information, and this is expected to continue.

9. The table below summarises the proposed 2014/15 net revenue budget and provisional budgets for the next three years. The proposed 2014/15 revenue budget is shown in detail in Appendix A.

	2014/15 £000	**2015/16 £000**	**2016/17 £000**	**2017/18 £000**
Updated original budget	0	0	- 500	-1,000
Other changes;				
Budget Transfers and Adjustments	1,420			
Sub Total	**1,420**	**0**	**- 500**	**-1,000**
Add proposed growth (Appendix B)				
Less proposed savings (Appendix B)	-1,420	-500	-500	
Proposed/Provisional budget (Appendix A)	**0**	**- 500**	**-1,000**	**-1,000**

10. The proposed net budget for 2014/15 is set out below:

	£000
Employees	2,627
Running Costs	22,574
Gross Costs	**25,201**
Income	-25,201
Net Budget	**0**

Other Changes and Transfers

11. A number of budget transfers (£1.4m) were affected through the 2013/14 financial year that are now adjusted for in the updated original budget. These occurred as a result of transfers enacted during the year arising from the creation of the Public Health Department. The main transfer was from the Chief Executive's Department (£1.2m) for the County Sports (and Physical Activity) Partnership, the Substance Misuse Strategic Team and the County Council's public health budget. A transfer was received from the Children and Young People's Service (£0.2m) in regard to teenage pregnancy matters and young person's substance misuse services.

12. Savings have been categorised in the appendices under the following classification;

    * item unchanged from previous MTFS
    ** item included in the previous MTFS, but amendments have been made
    No stars - new item

13. This star rating is included in the descriptions set out for savings below.

Savings

14. Details of proposed savings are set out in Appendix B and total £2.4m. These are detailed in the following paragraphs.

Efficiency Savings

15. S39 Expenditure managed by Public Health absorbed into the ring fenced budget; £1.4m in 2014/15.
    In 2013/14 the services within the Public Health Department were funded from a combination of grant from the Department of Health and the County Council's budget. To support the County Council's savings challenge it is proposed to use some existing spare capacity in the Department of Health grant, allowing the contribution from the County Council budget to be removed.

    The capacity in the Department of Health grant has arisen due to a combination of cost savings and an increased level of grant compared to historic expenditure. The savings are mainly attributable to the re-procurement of services since the transfer from the Primary Care Trust (PCT). The additional grant is due to recognition that Public Health expenditure in Leicestershire, by the PCT, had historically been below average.

16. S40 Preventative expenditure to be identified and absorbed into the ring fenced budget; £0.5m in 2015/16 rising to £1.0m in 2016/17.
    It is expected that additional capacity will be created in the Public Health budget over the next two years, as a result of procurements planned in 2014/15. This capacity is likely to be supplemented by above inflation increases in the Department of Health grant, beyond 2014/15, as the 2014/15 award for Leicestershire is still below the target allocation per head of population.

    It is proposed to use this additional capacity to fund selected preventative services that other service departments plan to provide in the MTFS. However these will need to have clear Public Health outcomes, and are still being considered.

It is proposed to utilise £5 million of the Public Health earmarked fund in a similar way, by using £1 million per annum to fund existing preventative services over the next five years.

Specific Grants and Contributions

17. In January 2013 the Department of Health allocated public health ring fenced grants to local authorities; a two year allocation was provided for the financial years 2013/14 and 2014/15. The funding was intended to enable relevant local authorities to discharge their new public health responsibilities, namely:
    i. improve significantly the health and wellbeing of the local population,
    ii. carry out health protection and health improvement functions delegated from the Secretary of State
    iii. reduce health inequalities across the life course, including within hard to reach groups
    iv. ensure the provision of population healthcare advice.

    The expectation is that funds will be utilised in-year, but if at the end of the financial year there is any underspend this can be carried over into the next financial year, as part of a public health earmarked fund.

18. In drawing up their priorities, local authorities, as members of Health and Wellbeing Boards will have a duty to work with Clinical Commissioning Groups (CCGs) and other partners to undertake an assessment of the current and future health and social care needs of the local community. The resulting strategies, to meet the community's needs, will influence how the grant is spent.

19. The level of grant awarded is based upon populations in the area weighted according to relative need. To smooth the transition to the new formula, from historical spend, all authorities will receive some increase, but the amount varies depending upon the distance from the Department of Health's target funding allocation, per head of population. The 2014/15 allocation of £21.9m (8% increase on 2013/14) for Leicestershire is £1.3m (6%) below the target produced by the needs based formula.

20. The Public Health Department also receives external funding, as the hosts of the Leicester-Shire and Rutland Sport partnership. The main, external, contributor is Sport England which provides funding to get more people playing and enjoying sport, to help those with talent get to the very top and more widely to promote the benefits of physical activity across all age ranges.

21. The table shows the specific grants and expected contributions to be received in 2014/15.

	2014/15 £000
Public Health Grant (Department of Health)	21,863
Leicestershire & Rutland local authorities (excluding LCC)	156
Sport England	964
Total Sports Partnership	**1,120**
TOTAL	**22,983**

Recommendation

22. The Committee are asked to consider the report and any response they may wish to make.

Equal Opportunities Implications

23. Many aspects of the County Council's MTFS budget are directed towards the needs of disadvantaged people. Where proposed savings are likely to have an adverse impact on service users protected under equalities legislation, Equality Impact Assessments must be undertaken at a formative stage of developing proposals prior to all final decisions being made. Assessments are being undertaken in light of the potential impact of proposals and the timing of the proposed changes.

Background Papers

Cabinet 15 January 2014 - Medium Term Financial Strategy 2014/15 to 2017/18

Circulation under local issues alert procedure

None.

Appendices

Appendix A – Revenue Budget 2014/15
Appendix B – Savings 2014/15 – 2017/18

Officers to Contact

Mike Sandys, Acting Director of Public Health, Public Health Department
Tel: 0116 305 4239
E-mail: mike.sandys@leics.gov.uk

Chris Tambini, Assistant Director, Strategic Finance, Property and Procurement, Corporate Resources Department
Tel: 0116 305 6199
E-mail: chris.tambini@leics.gov.uk

Declan Keegan, Finance Manager, Corporate Resources Department
Tel: 0116 305 7668
E-mail: declan.keegan@leics.gov.uk

This page is intentionally left blank

APPENDIX A

PUBLIC HEALTH DEPARTMENT

REVENUE BUDGET 2014-15

Budget 2013/14 £		Employees £	Running Expenses £	External Income £	Internal Income £	Net Total £
663,420	Leicester-Shire and Rutland Sport	843,614	2,242,488	-1,207,553	-1,217,149	661,400
-18,127,000	Public Health Leadership	1,782,985	452,734	-21,991,432	-332,726	-20,088,439
4,505,000	Sexual Health	0	4,670,018	0	0	4,670,018
998,000	NHS Health Check programme	0	750,000	0	0	750,000
123,000	Health Protection	0	210,000	0	0	210,000
311,000	Public Health Advice	0	320,000	0	0	320,000
629,000	Obesity Programmes	0	799,005	0	0	799,005
823,000	Physical Activity	0	941,702	0	0	941,702
5,608,000	Substance Misuse	0	5,453,762	0	-398,333	5,055,429
2,340,000	Smoking & Tobacco	0	2,322,729	0	0	2,322,729
1,839,000	Childrens Public Health 5-19	0	3,041,000	0	0	3,041,000
1,321,000	Public Health Improvement	0	1,319,356	-2,200	0	1,317,156
1,033,420	**TOTAL PUBLIC HEALTH**	**2,626,599**	**22,522,795**	**-23,201,185**	**-1,948,208**	**0**

This page is intentionally left blank

APPENDIX B

MTFS 2014/15 - 2017/18

PUBLIC HEALTH DEPARTMENT

Reference		2013/14 £000	2014/15 £000	2015/16 £000	2016/17 £000
	SAVINGS				
	Efficiency savings				
S39	Expenditure managed by Public Health absorbed into the ring fenced budget	-1,420	-1,420	-1,420	-1,420
S40	Preventative expenditure to be identified and absorbed into the ring fenced budget		-500	-1,000	-1,000
	TOTAL	**-1,420**	**-1,920**	**-2,420**	**-2,420**

Note
All items are new to the MTFS

This page is intentionally left blank

Agenda Item 9

Leicestershire County Council

HEALTH OVERVIEW AND SCRUTINY COMMITTEE: 22 JANUARY 2014

JOINT REPORT OF THE CHIEF EXECUTIVE AND DIRECTOR OF PUBLIC HEALTH

QUARTER 2 PERFORMANCE REPORT

Purpose of report

1. The purpose of this report is to provide the Committee with an overview of the performance monitoring and assurance framework across the health and wellbeing sector relating to the County Council and its area, CCG's, providers and partnership organisations. It also includes an overview of current performance. Any comments made by the Committee will be reported to the Health and Wellbeing Board.

Policy Framework and Previous Decisions

2. In response to the national Local Area Agreement (LAA) programme, performance was previously monitored by the Budget and Performance Monitoring Scrutiny Panel. However, the demise of the LAA and central targets in recent years meant that performance reporting at scrutiny level was included in the review of Scrutiny and Overview Committees conducted last year.

3. New arrangements including the abolition of the Budget and Performance Monitoring Scrutiny Panel were approved by the Constitution Committee on 12 June 2013. Performance of the County Council's Public Health Department and the Health and Wellbeing Board will now be reported on a quarterly basis to the Health Overview and Scrutiny Committee.

4. Following the Francis report, it has been identified that, as good practice, Health Overview and Scrutiny Committees should consider performance data on a regular basis as part of their overview role.

Current Performance Monitoring Arrangements.

5. Performance Monitoring is currently undertaken by the Health and Wellbeing Board on a quarterly basis. The performance report received by the Board includes two sections, delivery of the Joint Health and Wellbeing Strategy and performance information relating to key providers and commissioners that isn't included elsewhere.

Delivery of the Joint Health and Wellbeing Strategy

6. The Health and Wellbeing Board has a statutory requirement to produce a Joint Health and Wellbeing Strategy which is an overarching plan to improve the health and wellbeing of children and adults in the county and to reduce health inequalities. The Strategy has the following priorities:-
   - Getting it right from childhood
   - Managing the shift into early intervention and prevention
   - Supporting the ageing population
   - Improving mental health and wellbeing

7. The quarterly performance reports provide the Board with assurance that the priorities within the Joint Health and Wellbeing Strategy are being delivered by the relevant supporting boards. The supporting boards are:
   - Children's Commissioning Board;
   - Integrated Commissioning Board;
   - Staying Healthy Board; and
   - Mental Health Board (being established).

8. Each Board has produced an action plan which details the projects that will contribute towards the delivery of the priorities. Accompanying the action plans for each board is a dashboard which contains local indicators and relevant national indicators from the national outcomes frameworks. The outcomes frameworks list desired outcome across Public Health, NHS, Adult Social Care and Clinical Commissioning Groups. The frameworks include sets of indicators to show how these outcomes are to be measured. The supporting boards provide assurance commentary against the delivery of projects and associated dashboard indicators. The commentary highlights any performance issues or any drops in indicator performance or any projects that are off-track from timescales included on the action plans. These are then fed into the Health and Wellbeing dashboard, the latest version of which is attached as Appendix A. The supporting boards, their strategy priorities and the associated projects for delivery are in the chart shown in Appendix B.

9. The national outcomes frameworks for the NHS, CCG's Public Health and Adult Social Care list indicators across the health and care system. Some of these indicators are shared and where they are relevant to the supporting boards priorities are listed on their dashboards. The outcomes frameworks are attached as Appendices C, D, E and F. The accountability arrangements within the healthcare structure are complex. A previous report to the Shadow Health and Wellbeing Board of March 2013 provides further details on the complexities of the system and the role of Health and Wellbeing Boards within it. This can be found on the Council's website at http://politics.leics.gov.uk/ieListDocuments.aspx?CId=961&MId=3727&Ver=4

Health and Wellbeing Performance Information

10. To allow the Health and Wellbeing Board to fulfil its obligation to have strategic influence over commissioning decisions across health, public health and social care, the dashboard also includes performance information relating

to key providers and commissioners that isn't included in the dashboards of the supporting boards. These make up the rest of the dashboard and show indicators by exception (where performance is below target, worsened or changed significantly), relating to the CCG's, University Hospitals Leicester (UHL), East Midlands Ambulance Service (EMAS) and Public Health. It has been recognised that as a key provider to Leicestershire's residents, Leicestershire Partnership Trust (LPT) has not previously been included in the board performance reports and accompanying dashboard. Through redesign it is intended to include relevant information about LPT in future reports. Key performance indicators relating to LPT have been included in this report, by exception, extracted from the LPT's December meeting of their Board.

11. A summary of the performance report to the Health and Wellbeing Board in December is set out below. The Health and Wellbeing Board performance report and dashboard are written and compiled in conjunction with CCG Performance Leads within Greater East Midlands (GEM) Commissioning Support Unit. This enables reports to include the most up to date data that has been agreed through the boards of commissioners and providers. Where applicable, a short explanation of the relevance of each section is included within the report.

12. The performance framework across the health and social care system within Leicestershire has been noted by other areas as being at the forefront of this work. The Health and Wellbeing Board is continually driving to improve and keep as up to date as possible with performance reporting. Member involvement is key to this and comments offering ideas to enhance the reports and dashboards are welcomed. Currently, work is also underway to include the new integration indicators for the Better Care Fund, once finalised.

Public Health Performance Quarter 2

13. Public Health Performance is monitored by the Staying Healthy Board as part of the assurance process to the Health and Wellbeing Board.. The following data is drawn from the Staying Healthy dashboard and provides a summary of the Public Health indicators, from the Public Health Outcomes Framework, that showed a red rating for quarter 2 and associated commentary.

<u>PHOF 2.22ii: Percentage of eligible population aged 40-74 offered an NHS Health Check who received an NHS Health Check in the financial year</u>

14. This shows data for 2012/13 (latest data) and shows a score of 53.9% against a target of 65%. This is an improving trend in performance for 2.22ii recorded from Q1 in 2012/13 to Q4 in 2012/13. The number of the population eligible for health checks, across the two CCG areas is 204,873. The aspiration for health checks is to offer them to 20% of the eligible population for 2013/14 financial year. This equates to a target of 40,974. In quarter two, the year to date figures show 23,577 health checks were offered. Year to date this is 11.5% of the aspiration so is on track for delivery by the end of the year. Of the 23,577 people offered, 12,751 health checks were delivered. This equates to 53.9% delivered, this is short of the 65% aspiration but better than the average for England and in line with other East Midlands authorities.

PHOF: 3.02: Chlamydia diagnoses (15-24 year olds) - The chlamydia diagnosis rate among 15-24 year olds is a measure of chlamydia control activities that can be correlated to changes in chlamydia prevalence. Increasing the diagnosis rate will reduce the prevalence of asymptomatic infections. It is measured by Crude Rate of Chlamydia Diagnoses per 100,000 young adults aged 15-24

15. This is the latest data for quarter 1, 2013/14. Current data has a diagnosis rate of 1780.4 against the England average of 2016.1. This data relates to Q1 only and is an improvement from Q1 in 2012/13.

PHOF: 4.05 Mortality from cancer (NHSOF 1.4) - This indicator relates to Age-standardised rate of mortality from all cancers in persons less than 75 years per 100,000 population

16. The latest data for 2009-11 shows a mortality rate of 99.4. A decrease in rate was recorded from 2008-10 data. Although the rate is above the set target (94.6) the rate remains significantly better than England average (108.1).

Health and Wellbeing Strategy Delivery - Progress

17. Up to date Health and Wellbeing Strategy assurance comments are summarised and included in the dashboard that is attached as Appendix A to this report.

NHS Outcomes Framework

18. The NHS Outcomes Framework sets out the outcomes and corresponding indicators used to hold NHS England to account for improvements in health outcomes. A number of indicators in the NHS Outcomes Framework have been populated and are above the baseline or meeting the target for each CCG, these include:
    - Unplanned hospitalisation and emergency admission for ambulatory care sensitive conditions, asthma, diabetes and epilepsy in under 19s; emergency admissions for acute conditions that should not usually require admission and for children with lower respiratory tract infections
    - West Leicestershire CCG (WLCCG) Clostridium Difficile (CDIFF) incidences of Infection Control.

19. Incidences of MRSA have been reported for both WLCCG & East Leicestershire and Rutland CCG (ELRCCG) against a zero tolerance. For CDIFF, as at September 2013, there are 50 incidences of CDIFF against a national objective of 74 for ELRCCG. A forecast outturn position is reported of 100 incidences. Collaborative working with the Medicines Management Team has agreed a plan to audit 10 top GP prescribers of antibiotics associated with CDIFF Infection.

UHL – August/September 2013 Performance

The indicators within the dashboard are reported at CCG level. Data reported at provider level does differ, and delivery actions indicate where this is a risk.

18 Weeks Referral to Treatment (Data is at CCG level). The referral to treatment (RTT) operational standards are that 90% of admitted (to hospital) and 95% of non-admitted patients (out-patients) should start consultant-led treatment within 18 weeks of referral. In order to sustain delivery of these standards, 92% of patients who have not yet started treatment should have been waiting no longer than 18 weeks.

20. At August 2013, all 18 week targets were achieved. The admitted patient target of 90% is at risk at UHL, and there continues to be concerns at specialty level. Recovery trajectories at specialty level (e.g. Ophthalmology) are being reconfirmed, and commissioners are withholding 2% of the contract value due to non-delivery. A clinical lead for Referral To Treatment has been appointed at UHL and the National Intensive Support Team (IST) has been commissioned jointly by UHL and commissioners to provide extra support. Focus is on capacity and demand modelling, a review of UHL's internal policies, and advice on trigger points, with a remedial action plan sent to Commissioners in November 2013. A third party provider will be providing additional capacity over winter.

A and E - 4 Hour Waiting Time

21. At October 2013, Accident and Emergency performance was 86.91%, against a target of 95% for patients to be admitted, transferred or discharged within 4 hours. This shows a slight improvement on the June 2013 position of 85.37%.

UHL and Commissioners have established an Emergency Care Hub at LRI to drive improvements. It has identified the following: minimising inflow; minimising time in Emergency Department; speeding up access/discharge to the community; stream-lining ward processes to reduce length of stay, earlier discharge in the day and increase availability/capacity of medical beds. This work is closely monitored by the Commissioner led Urgent Care Board. Medium and Long Term Strategies are being established which will form 2014/15 Commissioning Intentions.

Ambulance Handovers

22. At September 2013, 14% of handovers between ambulance and A and E took place in over 30 minutes against a zero tolerance. This is a slight improvement on June 2013 position. Commissioners and UHL have agreed that re-investment penalties already levied will be used to support staffing and purchase extra trolleys fitted to Radio Frequency Infrared Devices (RFID) on achievement of the recovery trajectory. A remedial action plan is in place.

Delayed Transfers of Care (DTOC)

23. Delays are being monitored in-line with Monitor (the regulatory body for providers), and is reported as the number of patients discharged as a percentage of occupied bed days. As at October 2013, 4.37% were delayed against a national target of 3.5%. Actions are focusing on earlier discharge,

increase discharges by 11am to 15% and by 1pm to 30%. This is being considered for inclusion in the 2014/15 contract. A ward level discharge process has been established by a multi-agency integrated team.

Cancer 62 day waits

All patients should wait a maximum of 62 days from their urgent GP referral to their appointment.

24. At August 2013, West Leicestershire (WLCCG) is achieving the 85% standard with East Leicestershire and Rutland (ELRCCG) reporting 81.3%. This is an improvement on June 2013 position. UHL have achieved 88.2% overall. A dedicated senior manager is in place at UHL. On the day booking for CT scans at UHL and the use of PET scan capacity through a third party has commenced.

Cancelled Operations

25. At August 2013, 92.9% of patients were seen against a target of 95%. This is an improvement on June 2013 position. Commissioners have reviewed the recovery plan which currently covers: availability of beds, theatre time/list over-runs, higher priority patients and theatre capacity. At the October meeting with the provider it was agreed that additional plans will be added as appropriate. Further assurance has been sought on the escalation and re-booking procedures and the theatres transformation programme.

Never Events

26. There have been no additional Never Events reported. These are inexcusable actions in a healthcare setting, defined as the “kind of mistake that should never happen”.

Pressure Ulcers

27. Healthcare professionals use several grading systems to describe the severity of pressure ulcers with 4 being the worst grade.At August 2013 there had been 37 avoidable pressure ulcers (Grade 3 and 4) against a zero tolerance and there have been 73 (Grade 2) against a zero tolerance. Commissioners issued a contract query on 10 July 2013 for discussion on 23 July 2013. An action plan for 2013/14 has been refreshed and agreed by Commissioners.

Safety Thermometer

28. The NHS Safety Thermometer is a local improvement tool for measuring, monitoring and analysing patient harm and “harm free” care. At August 2013 (YTD) 2013, 93.52% of patients are harm free against a standard of 95%. The number patients who are harm free have remained constant on June 2013 position. This is in-line with the national position.

EMAS

Ambulance Response Times –

27. Emergency 999 calls to the ambulance service are prioritised into two categories to ensure life-threatening cases receive the quickest response:
    - Immediately life threatening – An emergency response will reach 75% of these calls within eight minutes. Where onward transport is required, 95% of life-threatening calls will receive an ambulance vehicle capable of transporting the patient safely within 19 minutes of the request for transport being made.
    - All other calls – For conditions that are not life threatening, response targets are set locally.

28. The A8 measure (immediately life threatening) is split into two parts, Red 1 and Red 2.
    - Red 1 calls are the most time critical and cover cardiac arrest patients who are not breathing and do not have a pulse, and other severe conditions. For Red 1 calls, the existing call connect clock start will remain, ensuring that patients who require immediate emergency ambulance care will continue to receive the most rapid response.
    - Red 2 calls, which are serious but less immediately time critical and cover conditions such as stroke and fits, a new clock start will allow call handlers to get more information about patients so that they receive the most appropriate ambulance resource based on their specific clinical needs.

29. As at September 2013, Category A (8 minutes) Red 1 for EMAS is 72.55% and Category A Red 2 is 72.99% against a target of 75%. Category A (19 minutes) EMAS is 93.70% against a target of 95%. Red 1 and Red 2 position has deteriorated from June 2013 position. A Risk Summit was held with NHS England's Area Team and EMAS in October 2013. A new interim Chief Executive is now in post.

30. Data is now available at CCG level. This is set out below for September 2013:

    - Red 1 – WL 65.68% & ELR 63.85% (Target 75%)
    - Red 2 – WL 67.8% & ELR 62.82% (Target 75%)
    - Cat 19 – WL 93.05% & ELR 90.06% (Target 95%)

    Providing data at a rural / urban level is not yet available.

CCG Local Priorities

West Leicestershire CCG

Reduction in Emergency Admissions from Care Homes

31. As at August 2013, there have been 928 admissions against a 645 baseline. From November 2013, LPT will be using the quality profile in the first cohort of homes to assess their needs with a view to creating individual action plans.

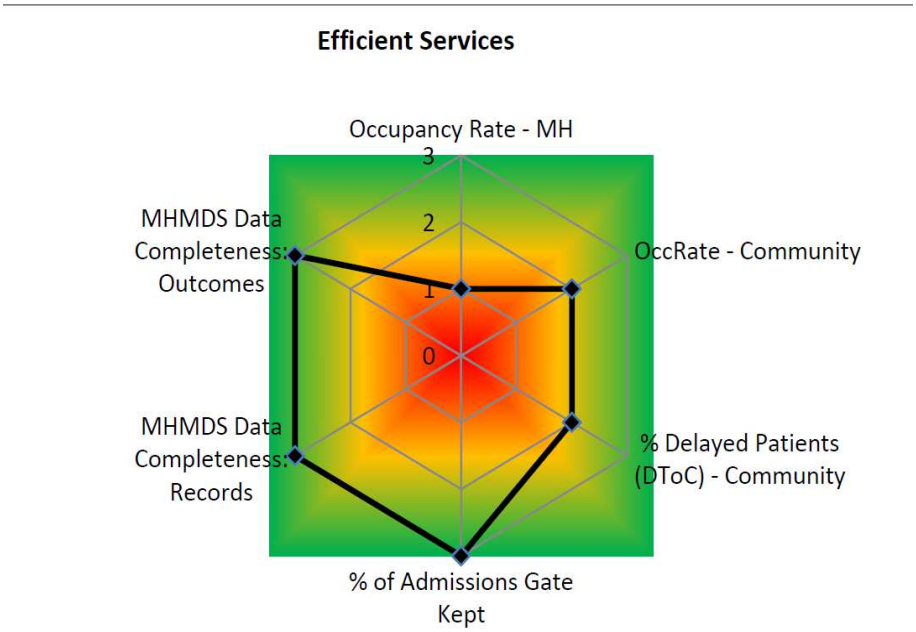
East Leicestershire CCG

Transient Ischaemic Attack (TIA) (mini-stroke) - Increase in people who are scanned and treated in 24 hours

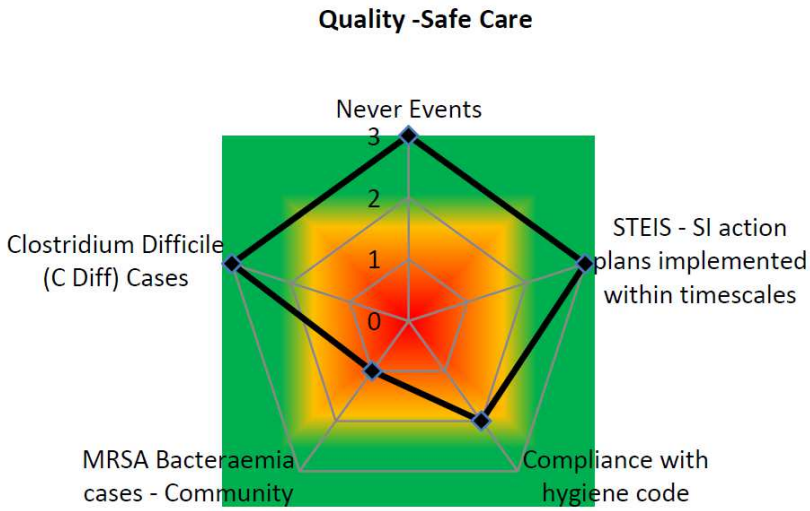
32. As at September 2013, performance was 66.9% against a 70% target. Performance has improved significantly with fluctuations being due to small numbers.

Leicestershire Partnership Trust –

33. Below is an extract from November's performance, report to the December meeting of the Leicestershire Partnership Trust Board by exception.



- **% Delayed Patients (Community)** – Performance has increased compared to October and reads as 2.74% for November 2013 against the commissioner target of 2.12% for the month.
- **% Delayed Patients (MH)** – Performance against this indicator has decreased for the Month of November to 7.1% from 5.4% and remains within the Monitor 7.5% target.
- **Occupancy Rate – Mental Health –** The trust target for this indicator is <=85% and the current month actual is at 90.5% compared to 90.6% during October and remains over the required target.



- **Non-Compliance with CQC Essential Standards (Enforcement Actions)** - The Committee's attention is drawn to the CQC inspection report lifting the enforcement actions. The report was published in November following a CQC inspection carried out on the Bradgate Unit during September

- **Compliance with hygiene code:** There has been a lack of safe systems of work in place on one of the CHS wards with regards to the disposal of body fluids. This has resulted in an Amber rating for the month of November. Health code assessment forms continue to be populated and are currently under review to support assurance requirements.

- **MRSA Bacteraemia:** A MRSA bacteraemia has been identified within the East locality of CHS division. This case has been attributed to LPT with identification of some care failings. Year-end target of 0 (Zero) is based on the Commissioner target.

- **Infection Control: C Diff (MH & Community)** – Monitor target reflects the annual de minimus limit set at 12 cases as set out in the Monitor Risk Assurance Framework 2013/14 and is monitored each quarter. The Commissioner threshold is set at 7 cases and is reported monthly as per the Quality Schedule for 2013/14. The Clostridium Difficile case within CHS division brings the total number of cases for LPT to date to 6. A Route Cause Analysis is being undertaken.

- **Feedback from Quality Assurance Committee – 10th December 2013 -** The Committee received the report and the following was noted by exception;
  C Diff – The Committee noted the C Diff performance and requested that the commissioner maximum target (7 cases) is reflected in the IQPR as well as the Monitor target (12 cases).

Background papers

Leicestershire Partnership Trust Board Papers can be found at the following link:
http://www.leicspart.nhs.uk/_Aboutus-Trustboardmeetings2013.aspx

University Hospitals Leicester Trust Board meetings can be found at the following link:
http://www.leicspart.nhs.uk/_Aboutus-Trustboardmeetings2013.aspx

Further information on the health system can be found in a previous report to the Shadow Health and Wellbeing Board March 2013:
http://politics.leics.gov.uk/ieListDocuments.aspx?CId=961&MId=3727&Ver=4

Recommendations

34. The Committee is asked to:

a) note the progress made to date in developing the performance framework alongside reporting arrangements to support the Committee's role;

b) note the performance summary, issues identified this quarter and actions planned in response to improve performance; and

c) comment on any recommendations or other issues with regard to the report.

List of appendices

Appendix A - Health and Wellbeing Board Dashboard Quarter 2
Appendix B - Supporting Boards Strategy Priorities and Project Delivery Map for Joint Health and Wellbeing Strategy.
Appendix C - NHS Outcomes Framework
Appendix D - Public Health Outcomes Framework
Appendix E - Adult Social Care Outcomes Framework
Appendix F - CCG Outcomes Framework

Officers to Contact

Mike Sandys
Acting Director of Public Health, Leicestershire County Council
Tel: 0116 305 4239
Mob: 07730 583171
Email: mike.sandys@leics.gov.uk

Lisa Carter
Performance Manager, Leicestershire County Council
Tel: 0116 3053932
Email: lisa.carter@leics.gov.uk

Andy Brown
Performance & Business Intelligence Team Leader, Leicestershire County Council
Tel: 0116 3056096
Email: andy.brown@leics.gov.uk

Sarah Cooke
Head of Performance (Leicester & Lincoln)

Greater East Midlands Commissioning Support Unit
Tel: 0116 295 7272
Mobile: 07795126428
Email: Sarah.Cooke@gemcsu.nhs.uk

This page is intentionally left blank

Health & Wellbeing Board Dashboard

Health & Wellbeing Strategy

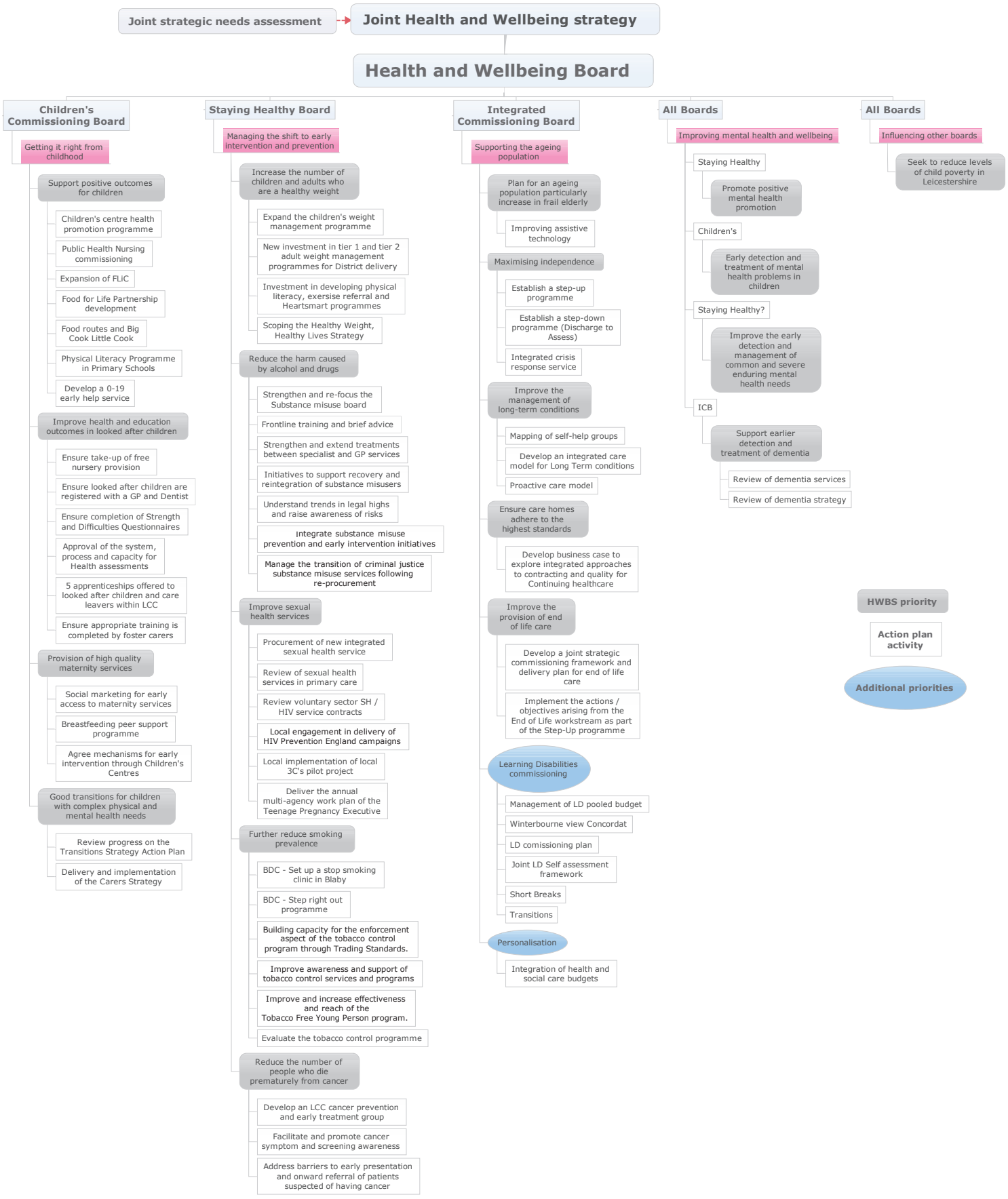
	Priority	RAG	Comment
Getting it right from childhood	1. Supporting positive outcomes for children and families	A	Update due from the Children and Young People's Commissioning Board on 10th December
	2. Improve health and educational outcomes in looked after children	A	Update due from the Children and Young People's Commissioning Board on 10th December
	3. Provision of high quality maternity services	A	Update due from the Children and Young People's Commissioning Board on 10th December
	4. Ensuring a good transition between child and adult services for children with complex physical	A	Update due from the Children and Young People's Commissioning Board on 10th December
Early intervention and prevention	5. Increasing the number of children and adults who are a healthy weight.	G	The following projects & programmes have been commissioned: Food For Life Partnership, Food Routes, Big Cook Little Cook, Breast Feeding Peer support coordination for H& B & NWL, Delivery of training for Early Year settings on Purposeful Physical Play
	6. Reducing the harm caused by drugs and alcohol	A	Actions progressing to plan. Meeting planned with Probation leads to discuss local impact of Transforming Rehabilitation programme.
	7. Improving sexual health services	A	The procurement of the integrated sexual health service (ISHS) is on track to commence 1 January 2014. Primary care and Voluntary Sector sexual health services are included in the PH Directorate procurement plan for 2014-16 and progress is underway. LASS and Trade are delivering HIV prevention campaigns targeting UK-based Africans and gay & bisexual men, including activities on National HIV testing week, November 2013. LCR will not be participating in the national 3c's pilot project for chlamydia screening in general practice. This is due to resource implications during the mobilisation phase of the ISHS and insufficient expressions of interest from general practice. The Chlamydia Screening Programme continue to provide support to practices. The Teenage pregnancy actions are progressing to plan.
	8. Further reducing the prevelance of smoking	A	Actions largely progressing to plan. Remedial action plan is being implemented by the stop smoking service in addition to developing work with CCG locality managers to increase GP referrals to smoking cessation
	9. Reducing the number of peopl who die prematurley from cancer	G	Progress has been made in relation to feeding into cancer action plan via helping shape cancer strategy in West Leicestershire CCG (includes work on early detection and prevention). Also work to disseminate recently completed GP cancer audit.
Supporting the ageing population	10. Providing appropriate housing and adaptations to enable the frail elderly to live longer in their own homes	A	Telehealth project team in place and guidance in place for assessments. Project 2 is delayed at present but will now be delivered in April 14.
	11. Improving stroke care and rehabilitation services, preventing falls and reducing preventable hospital admissions	G	Pilot Crisis Response service in HART established and now open to GP referals.Proposals for CHS night time service and residential and step down agreed by ICB.
	12. Improving the management of long term conditions	G	**Mapping of self help groups** completed and directory in place. Gaps in services identified and plans in place to address. Web site agreed with GEM. **Integrated care model** in place across East Leicestershire including Rutland. Roll out to all GP practices almost complete and will be in place by Jan 2014 and evaluation complete. **Proactive care model:** Risk stratification tool in use and in on-going development. Integrated model in development and on track for 2014. Monitor and evaluation tool available
	13. Ensuring care homes adhere to the highest standards of dignity and quality ensure carer training in organisations is improved	G	A Business Case to explore options for the future of procurement, contracting & quality for CHC funded placements with a view to integrate these with Council functions is being developed & will be reported to the ICB in 2014.
	14. Improving the provision of end of life care and support for people who wish to die at home and support for their carers	G	A Self-assessment has been completed for Leicestershire and Action plan developed.
Mental Health	15. Positive mental health promotion	G	Currently in the process of commissioning a 'menu' of training opportunities for School staff, School Nurses & SLF staff including- Mental Health Awareness, Mental Health 1st Aid, Life Coaching & Self Harm
	16. Early detection and treatment of mental health problems in children	A	Update due from the Children and Young People's Commissioning Board on 10th December
	17. Improving the early detection and management of people with common and severe and enduring mental health needs	G	Commissioned a range of adult and children and young people's mental health interventions aimed at promoting mental health and wellbeing and early detection of mental health illness.
	18. Ensuring the earlier detection and treatment of dementia and support for people with dementia and their carers	G	**Dementia services:** This work is on track to deliver by April 14. **Dementia Strategy:** Review underway and will be completed by March 14

NHS Outcomes Framework

Supporting Indicator	Target	Latest data	DoT	Target RAG
West Leicestershire CCG				
Domain 2 Enhancing quality of life for people with Long Term Conditions				
Unplanned Hospitalisation for chronic ambulatory care sensitive conditions (adults) per 100,000 population	Reduction or zero % change between 2012/13 and 2013/14	654.48 (FOT to Aug 13) against 736.65 12/13 Outturn	⇧	G
Unplanned Hospitalisation for asthma, diabetes and epilepsy in under 19s per 100,000 population	Reduction or zero % change between 2012/13 and 2013/14	105.67 (FOT to Aug 13 13) against 126.46 12/13 Outturn	⇩	G
Domain 3 Helping people to recover from episodes of ill health or following injury				
Emergency Admissions for acute conditions that should not usually require hospital admission	Reduction or zero % change between 2012/13 and 2013/14	870.5 (FOT Aug 13) against 928.15 12/13 Outturn	⇩	G
Emergency Admissions for children with Lower Respiratory Tract Infections (LRTI) per 100,000 population	Reduction or zero % change between 2012/13 and 2013/14	81.29 (FOT to Aug 13) against 143.40 12/13 Outturn	⇧	G
Domain 4 Ensuring that people have a positive experience of care				
Patient experience of hospital care	Above 76.5 England Average (2012/13 baseline)	74.9% UHL Survey Score	⇔	A
Friends & Family Test (1) Roll Out of Programme (2) FFT Score	(1) Yes (2) 68.8% (March 2015)	(1) Yes (2) 66 (Aug 13)	⇧	G
Domain 5 Treating and caring for people in a safe environment and protecting them from avoidable harm				
Incidence of health associated infection MRSA	Zero Tolerance	2	⇩	R
Incidence of health associated infection CDIFF	88 (WL CCG)	84 (WL CCG FOT to Sept 13)	⇩	G
East Leicestershire & Rutland CCG				
Domain 2 Enhancing quality of life for people with Long Term Conditions				
Unplanned Hospitalisation for chronic ambulatory care sensitive conditions (adults) per 100,000 population	Reduction or zero % change between 2012/13 and 2013/14	638.4 (FOT Aug 13) against 763.24 12/13 Outturn	⇧	G
Unplanned Hospitalisation for asthma, diabetes and epilepsy in under 19s per 100,000 population	Reduction or zero % change between 2012/13 and 2013/14	87.9 (FOT Aug 13) against 145.94 12/13 Outturn	⇩	G
Domain 3 Helping people to recover from episodes of ill health or following injury				
Emergency Admissions for acute conditions that should not usually require hospital admission	Reduction or zero % change between 2012/13 and 2013/14	946.2 (FOT Aug 13) against 994.49 12/13 Outturn	⇧	G
Emergency Admissions for children with Lower Respiratory Tract Infections (LRTI) per 100,000 population	Reduction or zero % change between 2012/13 and 2013/14	56.26 (FOT Aug 13) against 181.66 12/13 Outturn	⇧	G
Domain 4 Ensuring that people have a positive experience of care				
Patient experience of hospital care	Above 76.5 England Average (2012/13 baseline)	74.9% UHL Survey Score	Data for 2013/14 is due in the Autumn	A
Friends & Family Test (1) Roll Out of Programme (2) FFT Score	(1) Yes (2) 68.8% (March 2015)	(1) Yes (2) 66 (Aug 13)	⇧	G
Domain 5 Treating and caring for people in a safe environment and protecting them from avoidable harm				
Incidence of health associated infection MRSA	Zero Tolerance	1	⇔	R
Incidence of health associated infection CDIFF	74 (ELR CCG)	100 (ELR CCG FOT to Sept 13)	⇩	R
Indicators - Data not yet available				
There are a number of indicators where data will be available in the year, these include mortality rates and patient experience				B

NHS Constitution				
Supporting Indicator	**Target**	**Latest data**	**DoT**	**Target RAG**
UHL				
18 Week Referral to Treatment Admitted (All Providers)				
West Leicestershire CCG	90%	90.7% (Aug 13)	⇧	G
East Leicestershire & Rutland CCG		90.7% (Aug 13)	⇩	G
18 Week Referral to Treatment Non Admitted (All				
West Leicestershire CCG	95%	97.3% (Aug 13)	⇔	G
East Leicestershire & Rutland CCG		96.8% (Aug 13)	⇩	G
18 Week Referral to Treatment Incomplete				
West Leicestershire CCG	92%	95.0% (Aug 13)	⇩	G
East Leicestershire & Rutland CCG		94.7% (Aug 13)	⇩	G
52 Week Waiters	Zero Tolerance	0	⇔	G
Diagnostic Waiting Times < 6 weeks				
West Leicestershire CCG	99%	99.5% (Aug 13)	⇔	G
East Leicestershire & Rutland CCG		99.1% (Aug 13)	⇔	G
ED Waiting Time < 4 Hours	95%	86.91% (YTD 16/10/13)	⇧	R
ED Handovers between ED & Ambulance < 30 mins	Zero Tolerance	14% (Sept 13)	⇩	R
Delayed Transfers of Care - no. of patients as a % of occupied bed days	3.50%	4.37% (03/10/13)	⇧	R
Cancer 62 Day Waiting Time (All Providers)				
West Leicestershire CCG	85%	85% (April 13 - Aug 13)	⇧	G
East Leicestershire & Rutland CCG	85%	81.3% (April 13 - Aug 13)	⇧	A
Cancelled Operations	95%	92.9% (April 13 - Aug 13)	⇧	R
Never Events	0	1 (YTD to Aug 13)	⇔	R
Pressure Ulcers (avoidable Grade 3 & 4)	Zero Tolerance	37 (YTD to Aug 13)	⇩	R
Pressure Ulcers (Grade 2)	Zero Tolerance	73 (YTS Aug 13)	⇩	R
Safety Thermometer (% No Harms)	95%	93.52% (Aug 13)	⇩	R
EMAS				
Ambulance Response Times Cat A Red 1 (8 minutes) conditions life threatening & most time critical	75%	72.55%% (Sept 13)	⇩	A
Ambulance Response Times Cat A Red 2 (8 minutes) conditions life threatening & most time critical, less so than Red 1	75%	72.99% (Sept 13)	⇩	A
Ambulance Response Times Cat A - ambulance arriving at the scene within 19 minutes	95%	93.49% (Sept 13)	⇩	A
NHS Health Checks				
% of people who are eligable who have been offered a health check	20%	11.5% ytd	⇔	G
% of people who have received a health check	65%	53.90%	⇔	R

CCGs Local KPIs				
Supporting Indicator	**Target**	**Latest data**	**DoT**	**Target RAG**
West Leicestershire CCG				
% increase in people dying at home	1627 (27%)	Data sharing agreement in place. Data available in Q3	⇔	B
% reduction in emergency admissions from care homes. (No. of emergency admissions reported)	645 (10%)	928 (Oct - Aug 13)	⇩	R
% reduction emergency medical readmissions of people aged 65+ within 30 days of discharge	10%	1500 FOT April 13 - Aug 13	⇔	G
Diagnosis rate for people with dementia	55%	51.7% (12/13 outturn) Data available in Autumn	⇔	B
% of people who enter psychological therapies	15%	11.8% (YTD Sept 13)	⇩	R
East Leicestershire & Rutland CCG				
% increase in people dying at home	30%	Data sharing agreement in place. Data available in Q2	⇔	B
% of people who have a stroke who are scanned & treated in 24 hrs	70%	66.9% (YTD Sept 2013)	⇧	A
IAPT - % of people who are moving to recovery	52%	52.4% (YTD Sept 2013)	⇩	G
Diagnosis rate for people with dementia	55%	47.7% (12/13 outturn) Data available in Autumn	⇔	B
% of people who enter psychological therapies	15%	13% (Sept 13)	⇧	R


Joint strategic needs assessment
Joint Health and Wellbeing strategy
Health and Wellbeing Board
Children's Commissioning Board
Getting it right from childhood
Support positive outcomes for children
Children's centre health promotion programme
Public Health Nursing commissioning
Expansion of FLiC
Food for Life Partnership development
Food routes and Big Cook Little Cook
Physical Literacy Programme in Primary Schools
Develop a 0-19 early help service
Improve health and education outcomes in looked after children
Ensure take-up of free nursery provision
Ensure looked after children are registered with a GP and Dentist
Ensure completion of Strength and Difficulties Questionnaires
Approval of the system, process and capacity for Health assessments
5 apprenticeships offered to looked after children and care leavers within LCC
Ensure appropriate training is completed by foster carers
Provision of high quality maternity services
Social marketing for early access to maternity services
Breastfeeding peer support programme
Agree mechanisms for early intervention through Children's Centres
Good transitions for children with complex physical and mental health needs
Review progress on the Transitions Strategy Action Plan
Delivery and implementation of the Carers Strategy
Staying Healthy Board
Managing the shift to early intervention and prevention
Increase the number of children and adults who are a healthy weight
Expand the children's weight management programme
New investment in tier 1 and tier 2 adult weight management programmes for District delivery
Investment in developing physical literacy, exersise referral and Heartsmart programmes
Scoping the Healthy Weight, Healthy Lives Strategy
Reduce the harm caused by alcohol and drugs
Strengthen and re-focus the Substance misuse board
Frontline training and brief advice
Strengthen and extend treatments between specialist and GP services
Initiatives to support recovery and reintegration of substance misusers
Understand trends in legal highs and raise awareness of risks
Integrate substance misuse prevention and early intervention initiatives
Manage the transition of criminal justice substance misuse services following re-procurement
Improve sexual health services
Procurement of new integrated sexual health service
Review of sexual health services in primary care
Review voluntary sector SH / HIV service contracts
Local engagement in delivery of HIV Prevention England campaigns
Local implementation of local 3C's pilot project
Deliver the annual multi-agency work plan of the Teenage Pregnancy Executive
Further reduce smoking prevalence
BDC - Set up a stop smoking clinic in Blaby
BDC - Step right out programme
Building capacity for the enforcement aspect of the tobacco control program through Trading Standards.
Improve awareness and support of tobacco control services and programs
Improve and increase effectiveness and reach of the Tobacco Free Young Person program.
Evaluate the tobacco control programme
Reduce the number of people who die prematurely from cancer
Develop an LCC cancer prevention and early treatment group
Facilitate and promote cancer symptom and screening awareness
Address barriers to early presentation and onward referral of patients suspected of having cancer
Integrated Commissioning Board
Supporting the ageing population
Plan for an ageing population particularly increase in frail elderly
Improving assistive technology
Maximising independence
Establish a step-up programme
Establish a step-down programme (Discharge to Assess)
Integrated crisis response service
Improve the management of long-term conditions
Mapping of self-help groups
Develop an integrated care model for Long Term conditions
Proactive care model
Ensure care homes adhere to the highest standards
Develop business case to explore integrated approaches to contracting and quality for Continuing healthcare
Improve the provision of end of life care
Develop a joint strategic commissioning framework and delivery plan for end of life care
Implement the actions / objectives arising from the End of Life workstream as part of the Step-Up programme
Learning Disabilities commissioning
Management of LD pooled budget
Winterbourne view Concordat
LD comissioning plan
Joint LD Self assessment framework
Short Breaks
Transitions
Personalisation
Integration of health and social care budgets
All Boards
Improving mental health and wellbeing
Staying Healthy
Promote positive mental health promotion
Children's
Early detection and treatment of mental health problems in children
Staying Healthy?
Improve the early detection and management of common and severe enduring mental health needs
ICB
Support earlier detection and treatment of dementia
Review of dementia services
Review of dementia strategy
All Boards
Influencing other boards
Seek to reduce levels of child poverty in Leicestershire
HWBS priority
Action plan activity
Additional priorities

This page is intentionally left blank

NHS Outcomes Framework 2013/14

at a glance

1 Preventing people from dying prematurely

Overarching indicators

1a Potential Years of Life Lost (PYLL) from causes considered amenable to healthcare
i Adults ii *Children and young people*
1b Life expectancy at 75
i Males ii Females

Improvement areas

Reducing premature mortality from the major causes of death
1.1 Under 75 mortality rate from cardiovascular disease* (PHOF 4.4)
1.2 Under 75 mortality rate from respiratory disease* (PHOF 4.7)
1.3 Under 75 mortality rate from liver disease* (PHOF 4.6)
1.4 Under 75 mortality rate from cancer* (PHOF 4.5)
i *One- and* ii *Five-year survival from all cancers*
iii *One- and* iv *Five-year survival from breast, lung and colorectal cancer*

Reducing premature death in people with serious mental illness
1.5 Excess under 75 mortality rate in adults with serious mental illness* (PHOF 4.9)

Reducing deaths in babies and young children
1.6 i Infant mortality* (PHOF 4.1)
ii Neonatal mortality and stillbirths
iii *Five year survival from all cancers in children*

Reducing premature death in people with a learning disability
1.7 *Excess under 60 mortality rate in adults with a learning disability*

2 Enhancing quality of life for people with long-term conditions

Overarching indicator

2 Health-related quality of life for people with long-term conditions** (ASCOF 1A)

Improvement areas

Ensuring people feel supported to manage their condition
2.1 Proportion of people feeling supported to manage their condition**

Improving functional ability in people with long-term conditions
2.2 Employment of people with long-term conditions** * (ASCOF 1E PHOF 1.8)

Reducing time spent in hospital by people with long-term conditions
2.3 i Unplanned hospitalisation for chronic ambulatory care sensitive conditions (adults)
ii Unplanned hospitalisation for asthma, diabetes and epilepsy in under 19s

Enhancing quality of life for carers
2.4 Health-related quality of life for carers** (ASCOF 1D)

Enhancing quality of life for people with mental illness
2.5 Employment of people with mental illness **** (ASCOF 1F & PHOF 1.8)

Enhancing quality of life for people with dementia
2.6 i Estimated diagnosis rate for people with dementia* (PHOF 4.16)
ii *A measure of the effectiveness of post-diagnosis care in sustaining independence and improving quality of life****** (ASCOF 2F)

3 Helping people to recover from episodes of ill health or following injury

Overarching indicators

3a Emergency admissions for acute conditions that should not usually require hospital admission
3b Emergency readmissions within 30 days of discharge from hospital* (PHOF 4.11)

Improvement areas

Improving outcomes from planned treatments
3.1 Total health gain as assessed by patients for elective procedures
i Hip replacement ii Knee replacement iii Groin hernia iv Varicose veins
v *Psychological therapies*

Preventing lower respiratory tract infections (LRTI) in children from becoming serious
3.2 Emergency admissions for children with LRTI

Improving recovery from injuries and trauma
3.3 Proportion of people who recover from major trauma

Improving recovery from stroke
3.4 Proportion of stroke patients reporting an improvement in activity/lifestyle on the Modified Rankin Scale at 6 months

Improving recovery from fragility fractures
3.5 Proportion of patients recovering to their previous levels of mobility/walking ability at i 30 and ii 120 days

Helping older people to recover their independence after illness or injury
3.6 i Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/ rehabilitation service*** (ASCOF 2B)
ii Proportion offered rehabilitation following discharge from acute or community hospital

4 Ensuring that people have a positive experience of care

Overarching indicators

4a Patient experience of primary care
i GP services
ii GP Out of Hours services
iii NHS Dental Services
4b Patient experience of hospital care
4c *Friends and family test*

Improvement areas

Improving people's experience of outpatient care
4.1 Patient experience of outpatient services

Improving hospitals' responsiveness to personal needs
4.2 Responsiveness to in-patients' personal needs

Improving people's experience of accident and emergency services
4.3 Patient experience of A&E services

Improving access to primary care services
4.4 Access to i GP services and ii NHS dental services

Improving women and their families' experience of maternity services
4.5 Women's experience of maternity services

Improving the experience of care for people at the end of their lives
4.6 Bereaved carers' views on the quality of care in the last 3 months of life

Improving experience of healthcare for people with mental illness
4.7 Patient experience of community mental health services

Improving children and young people's experience of healthcare
4.8 *An indicator is under development*

Improving people's experience of integrated care
4.9 *An indicator is under development* *** (ASCOF 3E)

5 Treating and caring for people in a safe environment and protect them from avoidable harm

Overarching indicators

5a Patient safety incidents reported
5b Safety incidents involving severe harm or death
5c *Hospital deaths attributable to problems in care*

Improvement areas

Reducing the incidence of avoidable harm
5.1 Incidence of hospital-related venous thromboembolism (VTE)
5.2 Incidence of healthcare associated infection (HCAI)
i MRSA
ii C. difficile
5.3 Incidence of newly-acquired category 2, 3 and 4 pressure ulcers
5.4 Incidence of medication errors causing serious harm

Improving the safety of maternity services
5.5 Admission of full-term babies to neonatal care

Delivering safe care to children in acute settings
5.6 Incidence of harm to children due to 'failure to monitor'

Alignment across the Health and Social Care System

* Indicator shared with Public Health Outcomes Framework (PHOF)
** Indicator complementary with Adult Social Care Outcomes Framework (ASCOF)
*** Indicator shared with Adult Social Care Outcomes Framework
**** Indicator complementary with Adult Social Care Outcomes Framework and Public Health Outcomes Framework

Indicators in italics are placeholders, pending development or identification

This page is intentionally left blank

Public Health Outcomes Framework 2013-2016

At a glance (Autumn 2012)

VISION

To improve and protect the nation's health and wellbeing and improve the health of the poorest fastest

Outcome measures

Outcome 1) Increased healthy life expectancy, i.e. taking account of the health quality as well as the length of life
Outcome 2) Reduced differences in life expectancy and healthy life expectancy between communities (through greater improvements in more disadvantaged communities)

Alignment across the Health and Care System
*Indicator shared with the NHS Outcomes Framework.
** Complementary to indicators in the NHS Outcomes Framework
† Indicator shared with the Adult Social Care Outcomes Framework
†† Complementary to indicators in the Adult Social Care Outcomes Framework
Indicators in italics are placeholders, pending development or identification

1 Improving the wider determinants of health

Objective

Improvements against wider factors which affect health and wellbeing and health inequalities

Indicators

1.1 Children in poverty
1.2 School readiness (Placeholder)
1.3 Pupil absence
1.4 First time entrants to the youth justice system
1.5 16-18 year olds not in education, employment or training
1.6 Adults with a learning disability / in contact with secondary mental health services who live in stable and appropriate accommodation† *(ASCOF 1G and 1H)*
1.7 People in prison who have a mental illness or a significant mental illness (Placeholder)
1.8 Employment for those with long-term health conditions including adults with a learning disability or who are in contact with secondary mental health services *(i-NHSOF 2.2) †† (ii-ASCOF 1E) **(iii-NHSOF 2.5) †† (iii-ASCOF 1F)*
1.9 Sickness absence rate
1.10 Killed and seriously injured casualties on England's roads
1.11 Domestic abuse (Placeholder)
1.12 Violent crime (including sexual violence)
1.13 Re-offending levels
1.14 The percentage of the population affected by noise
1.15 Statutory homelessness
1.16 Utilisation of outdoor space for exercise / health reasons
1.17 Fuel poverty (Placeholder)
1.18 Social isolation (Placeholder) † (ASCOF 1I)
1.19 Older people's perception of community safety (Placeholder) †† (ASCOF 4A)

2 Health improvement

Objective

People are helped to live healthy lifestyles, make healthy choices and reduce health inequalities

Indicators

2.1 Low birth weight of term babies
2.2 Breastfeeding
2.3 Smoking status at time of delivery
2.4 Under 18 conceptions
2.5 Child development at 2 – 2.1/2 years (Placeholder)
2.6 Excess weight in 4-5 and 10-11 year olds
2.7 Hospital admissions caused by unintentional and deliberate injuries in under 18s
2.8 Emotional well-being of looked after children
2.9 Smoking prevalence – 15 year olds (Placeholder)
2.10 Self-harm (Placeholder)
2.11 Diet
2.12 Excess weight in adults
2.13 Proportion of physically active and inactive adults
2.14 Smoking prevalence – adults (over 18s)
2.15 Successful completion of drug treatment
2.16 People entering prison with substance dependence issues who are previously not known to community treatment
2.17 Recorded diabetes
2.18 Alcohol-related admissions to hospital (Placeholder)
2.19 Cancer diagnosed at stage 1 and 2
2.20 Cancer screening coverage
2.21 Access to non-cancer screening programmes
2.22 Take up of the NHS Health Check programme – by those eligible
2.23 Self-reported well-being
2.24 Injuries due to falls in people aged 65 and over

3 Health protection

Objective

The population's health is protected from major incidents and other threats, whilst reducing health inequalities

Indicators

3.1 Fraction of mortality attributable to particulate air pollution
3.2 Chlamydia diagnoses (15-24 year olds)
3.3 Population vaccination coverage
3.4 People presenting with HIV at a late stage of infection
3.5 Treatment completion for TB
3.6 Public sector organisations with board approved sustainable development management plan
3.7 Comprehensive, agreed inter-agency plans for responding to public health incidents (Placeholder)

4 Healthcare public health and preventing premature mortality

Objective

Reduced numbers of people living with preventable ill health and people dying prematurely, whilst reducing the gap between communities

Indicators

4.1 Infant mortality* *(NHSOF 1.6i)*
4.2 Tooth decay in children aged 5
4.3 Mortality rate from causes considered preventable ** *(NHSOF 1a)*
4.4 Under 75 mortality rate from all cardiovascular diseases (including heart disease and stroke)* *(NHSOF 1.1)*
4.5 Under 75 mortality rate from cancer* *(NHSOF 1.4i)*
4.6 Under 75 mortality rate from liver disease* *(NHSOF 1.3)*
4.7 Under 75 mortality rate from respiratory diseases* *(NHSOF 1.2)*
4.8 Mortality rate from infectious and parasitic diseases
4.9 Excess under 75 mortality rate in adults with serious mental illness* *(NHSOF 1.5)*
4.10 Suicide rate
4.11 Emergency readmissions within 30 days of discharge from hospital* *(NHSOF 3b)*
4.12 Preventable sight loss
4.13 Health-related quality of life for older people (Placeholder)
4.14 Hip fractures in people aged 65 and over
4.15 Excess winter deaths
4.16 Estimated diagnosis rate for people with dementia * *(NHSOF 2.6i)*

This page is intentionally left blank

Annex A: Adult Social Care Outcomes Framework 2013/14 at a glance

1 Enhancing quality of life for people with care and support needs

Overarching measure

1A. Social care-related quality of life * (NHSOF 2)

Outcome measures

People manage their own support as much as they wish, so that are in control of what, how and when support is delivered to match their needs.

1B. Proportion of people who use services who have control over their daily life
To be revised from 2014/15: 1C. Proportion of people using social care who receive self-directed support, and those receiving direct payments

Carers can balance their caring roles and maintain their desired quality of life.

1D. Carer-reported quality of life * (NHSOF 2.4)

People are able to find employment when they want, maintain a family and social life and contribute to community life, and avoid loneliness or isolation.

1E. Proportion of adults with a learning disability in paid employment *** (PHOF 1.8, NHSOF 2.2)
1F. Proportion of adults in contact with secondary mental health services in paid employment *** (PHOF 1.8, NHSOF 2.5)
1G. Proportion of adults with a learning disability who live in their own home or with their family ** (PHOF 1.6)
1H. Proportion of adults in contact with secondary mental health services living independently, with of without support ** (PHOF 1.6)

New measure for 2013/14:
1I. Proportion of people who use services and their carers, who reported that they had as much social contact as they would like. ** (PHOF 1.18)

2 Delaying and reducing the need for care and support

Overarching measures

2A. Permanent admissions to residential and nursing care homes, per 1,000 population

Outcome measures

Everybody has the opportunity to have the best health and wellbeing throughout their life, and can access support and information to help them manage their care needs.

Earlier diagnosis, intervention and reablement means that people and their carers are less dependent on intensive services.

2B. Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services ** (NHSOF 3.6i)

New measure for 2014/15: 2D. The outcomes of short-term services: sequel to service.
New placeholder 2E: Effectiveness of reablement services

When people develop care needs, the support they receive takes place in the most appropriate setting, and enables them to regain their independence.

2C. Delayed transfers of care from hospital, and those which are attributable to adult social care

New placeholder 2F: *Dementia - a* measure of the effectiveness of post-diagnosis care in sustaining independence and improving quality of life .** *(NHSOF 2.6ii)*

3 Ensuring that people have a positive experience of care and support

Overarching measure

People who use social care and their carers are satisfied with their experience of care and support services.

3A. Overall satisfaction of people who use services with their care and support
3B. Overall satisfaction of carers with social services
New placeholder 3E: Improving people's experience of integrated care ** (NHS OF 4.9)

Outcome measures

Carers feel that they are respected as equal partners throughout the care process.

3C. The proportion of carers who report that they have been included or consulted in discussions about the person they care for

People know what choices are available to them locally, what they are entitled to, and who to contact when they need help.

3D. The proportion of people who use services and carers who find it easy to find information about support

People, including those involved in making decisions on social care, respect the dignity of the individual and ensure support is sensitive to the circumstances of each individual.

This information can be taken from the Adult Social Care Survey and used for analysis at the local level.

4 Safeguarding adults whose circumstances make them vulnerable and protecting from avoidable harm

Overarching measure

4A. The proportion of people who use services who feel safe * (PHOF 1.19)

Outcome measures

Everyone enjoys physical safety and feels secure.
People are free from physical and emotional abuse, harassment, neglect and self-harm.
People are protected as far as possible from avoidable harm, disease and injuries.
People are supported to plan ahead and have the freedom to manage risks the way that they wish.

4B. The proportion of people who use services who say that those services have made them feel safe and secure

New placeholder 4C: Proportion of completed safeguarding referrals where people report they feel safe

Aligning across the Health and Care System

** Indicator complementary*
*** Indicator shared*
**** Indicator complementary with the Public Health Outcomes Framework and the NHS Outcomes framework*

Shared indicators: The same indicator is included in each outcomes framework, reflecting a shared role in making progress
Complementary indicators: A similar indicator is included in each outcomes framework and these look at the same issue

This page is intentionally left blank

NHS Commissioning Board

THE CCG OUTCOMES INDICATOR SET 2013/14

THE NHS CONSTITUTION
the NHS belongs to us all

NHS Commissioning Board

CCG Outcomes Indicator Set 2013/14

1 Preventing people from dying prematurely

Overarching indicator

- Potential years of life lost from causes considered amenable to healthcare: adults, children and young people (NHS OF 1a i & ii) ^

Improvement areas

Reducing premature mortality from the major causes of death
- Under 75 mortality from cardiovascular disease (NHS OF 1.1) ^ *
- Cardiac rehabilitation completion
- Myocardial infarction, stroke & stage 5 kidney disease in people with diabetes
- Mortality within 30 days of hospital admission for stroke
- Under 75 mortality from respiratory disease (NHS OF 1.2) ^ *
- Under 75 mortality from liver disease (NHS OF 1.3) ^
- Emergency admissions for alcohol related liver disease
- Under 75 mortality from cancer (NHS OF 1.4) ^ *
- One and five year survival from all cancers (NHS OF 1.4.i and ii) ^
- One and five year survival from breast, lung & colorectal cancers (NHS OF 1.4 iii and iv) ^

Reducing premature death in people with serious mental illness
- People with severe mental illness who have received a list of physical checks

Reducing deaths in babies and young children
- Antenatal assessment < 13 weeks
- Maternal smoking at delivery
- Breastfeeding prevalence at 6-8 weeks

Reducing premature deaths in people with learning disabilities
NHS OF indicator in development. No CCG measure at present

2 Enhancing quality of life for people with long-term conditions

Overarching indicator

- Health-related quality of life for people with long-term conditions (NHS OF 2) ^ **

Improvement areas

Ensuring people feel supported to manage their condition
- People feeling supported to manage their condition (NHS OF 2.1) ^ * **

Improving functional ability in people with long-term conditions
- People with COPD & Medical Research Council Dyspnoea scale ≤3 referred to a pulmonary rehabilitation programme
- People with diabetes who have received nine care processes
- People with diabetes diagnosed less than one year referred to structured education

Reducing time spent in hospital by people with long-term conditions
- Unplanned hospitalisation for chronic ambulatory care sensitive conditions (adults) (NHS OF 2.3.i) ^
- Unplanned hospitalisation for asthma, diabetes and epilepsy in under 19s (NHS OF 2.3.ii) ^
- Complications associated with diabetes including emergency admission for diabetic ketoacidosis and lower limb amputation

Enhancing quality of life for carers
No CCG measure at present

Enhancing quality of life for people with mental illness
- Access to community mental health services by people from BME groups
- Access to psychological therapy services by people from BME groups
- Recovery following talking therapies (all ages and older than 65)

Enhancing quality of life for people with dementia
- Estimated diagnosis rate for people with dementia (NHS OF 2.6i)
- People with dementia prescribed anti-psychotic medication

3 Helping people to recover from episodes of ill health or following injury

Overarching indicators

- Emergency admissions for acute conditions that should not usually require hospital admission (NHS OF 3a) ^
- Emergency readmissions within 30 days of discharge from hospital (NHS OF 3b) *

Improvement areas

Improving outcomes from planned treatments
- Increased health gain as assessed by patients for elective procedures a) hip replacement b) knee replacement c) groin hernia d) varicose veins (NHS OF 3.1 i - iv)

Preventing lower respiratory tract infections in children from becoming serious
- Emergency admissions for children with lower respiratory tract infections (NHS OF 3.2) ^

Improving recovery from injuries and trauma
NHS OF indicator in development. No CCG measure at present

Improving recovery from stroke
People who have had a stroke who
- are admitted to an acute stroke unit within four hours of arrival to hospital
- receive thrombolysis following an acute stroke
- are discharged from hospital with a joint health and social care plan
- receive a follow-up assessment between 4-8 months after initial admission

Improving recovery from fragility fractures
No CCG measure at present

Helping older people to recover their independence after illness or injury
No CCG measure at present

4 Ensuring that people have a positive experience of care

Overarching indicators

Patient experience of primary and hospital care
- Patient experience of GP out of hours services (NHS OF 4a ii) ^
- Patient experience of hospital care (NHS OF 4 b)
- Friends and family test for acute inpatient care and A&E (NHS OF 4c)

Improvement areas

Improving people's experience of outpatient care
- Patient experience of outpatient services (NHS OF 4.1)

Improving hospitals' responsiveness to personal needs
- Responsiveness to in-patients' personal needs (NHS OF 4.2)

Improving people's experience of accident and emergency services
- Patient experience of A&E services (NHS OF 4.3)

Improving women and their families' experience of maternity services
- Women's experience of maternity services (NHS OF 4.5)

Improving the experience of care for people at the end of their lives
No CCG measure at present

Improving experience of healthcare for people with mental illness
- Patient experience of community mental health services (NHS OF 4.7)

Improving children and young people's experience of healthcare
NHS OF indicator in development. .No CCG measure at present

Improving people's experience of integrated care
NHS OF indicator in development. No CCG measure at present

5 Treating and caring for people in a safe environment and protecting them from avoidable harm

Overarching indicator

- Patient safety incidents reported (NHS OF 5a)

Improvement areas

Reducing the incidence of avoidable harm
- Incidence of venous thromboembolism (VTE) (NHS OF 5.1)
- Incidence of healthcare associated infection: MRSA (NHS OF 5.2.i)
- Incidence of healthcare associated infection: C difficile (NHS OF 5.2.ii)

No CCG measures at present for category 2, 3 and 4 pressure ulcers and incidence of medication errors causing serious harm

Improving the safety of maternity services
No CCG measure at present

Delivering safe care to children in acute settings
No CCG measure at present

CCG Outcomes Indicator Set 2013/14 at a glance

NOTES & LEGEND

NHS OF: indicator derived from NHS Outcomes Framework

^ NHS OF indicator that is also measurable at local authority level

* NHS OF indicator shared with Public Health Outcomes Framework

** NHS OF indicator complementary with Adult Social Care Outcomes Framework

Other indicators are developed from NICE quality standards or other existing data collections.