Meeting: **Health Overview and Scrutiny Committee**

Date/Time: **Wednesday, 8 June 2016 at 2.00 pm**

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

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

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

Membership

Dr. S. Hill CC (Chairman)

Mrs. R. Camamile CC	Dr. R. K. A. Feltham CC
Mr. J. G. Coxon CC	Mr. J. Kaufman CC
Mrs. J. A. Dickinson CC	Ms. Betty Newton CC
Dr. T. Eynon CC	Mr. T. J. Pendleton 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.	Appointment of Chairman.	
2.	Election of Vice-Chairman.	
3.	Minutes of the meeting held on 30 March 2016.	(Pages 5 - 10)
4.	Question Time.	
5.	Questions asked by members under Standing Order 7(3) and 7(5).	
6.	To advise of any other items which the Chairman has decided to take as urgent elsewhere on the agenda.	

7. Declarations of interest in respect of items on the agenda.

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

9. Presentation of Petitions under Standing Order 36.

10. East Midlands Ambulance Service - Care Quality Commission Inspection outcomes.

    Mark Gregory, General Manager for EMAS Leicester, Leicestershire and Rutland, will provide a presentation on the Care Quality Commission (CQC) Inspection of East Midlands Ambulance Service NHS Trust. A copy of the CQC Inspection report can be found at this link:
    http://www.cqc.org.uk/sites/default/files/new_reports/AAAF4460.pdf

11. Provision of services from Central Nottinghamshire Clinical Services in Leicester, Leicestershire and Rutland. (Pages 11 - 14)

12. Better Care Together update. (Pages 15 - 28)

13. Integrating Points of Access. (Pages 29 - 34)

14. Future in Mind. (Pages 35 - 42)

15. Remodelling of the Stop Smoking Service. (Pages 43 - 48)

16. Health Performance Update. (Pages 49 - 68)

17. Date of next meeting.

    The next meeting of the Committee is scheduled to take place on 14 September 2016 at 2:00pm.

18. 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?

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Agenda Item 3

Minutes of a meeting of the Health Overview and Scrutiny Committee held at County Hall, Glenfield on Wednesday, 30 March 2016.

PRESENT

Dr. S. Hill CC (in the Chair)

Mrs. R. Camamile CC	Mr. J. Kaufman CC
Mrs. J. A. Dickinson CC	Mr. W. Liquorish JP CC
Dr. T. Eynon CC	Mr. A. E. Pearson CC
Dr. R. K. A. Feltham CC	Mr. S. D. Sheahan CC

In attendance

Mr. E. F. White CC, Cabinet Lead Member for Health;
Rick Moore, Chair of Healthwatch Leicestershire;
Tamsin Hooton, Director of Urgent and Emergency Care, West Leicestershire Clinical Commissioning Group (Minute 70 refers).
Mrs. C. M. Radford CC (Minute 71)
Mr. G. Welsh CC (Minute 71)

62. Minutes.

The minutes of the meeting held on 20 January 2016 were taken as read, confirmed and signed.

63. Question Time.

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

64. Questions asked by members.

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

65. Urgent items.

There were no urgent items for consideration.

66. 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.

The following declarations were made:

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

Mrs. J. A. Dickinson CC declared a personal interest in all items on the agenda as she had a relative employed by the University Hospitals of Leicester NHS Trust.

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

There were no declarations of the party whip.

68. Presentation of Petitions.

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

69. Better Care Fund Refresh 2016/17 Overview.

The Committee considered a report of the Director of Health and Care Integration which provided an overview of the progress to refresh and submit the Leicestershire Better Care Fund (BCF) plan including an update on the refreshed spending plan and outcome metrics for 2016/17 as at 17th March 2016. A copy of the report marked 'Agenda Item 8' is filed with these minutes.

In introducing the report the Director of Health and Care Integration provided the details of the emergency admissions avoidance schemes in place which were as follows:

- 7 day services in Primary Care run by East and West Leicestershire CCGs.
- The falls service.
- An older persons unit at Loughborough Hospital assessing those in need of urgent diagnostics and support with their Care Plan.
- Integrated Crisis response providing 72 hours care in a patient's own home.
- A new scheme for 2016/17 at Glenfield Hospital designed to avoid admissions for cardiac and respiratory problems.

Arising from discussion the Committee was advised as follows:-

(i) There was a requirement to include a measurement of patient and service user satisfaction within the Better Care Fund. Locally, the GP survey question regarding whether patients were satisfied with the support they received to manage long term conditions was used for this purpose. It was noted that the survey was sent to a random selection of patients each year and was administered nationally on behalf of CCGs, so it was sometimes difficult to measure year on year improvements and whether these had been actively influenced by local changes, using this survey. The Director of Health and Care Integration undertook to inform the Committee of local response rates to the most recent questionnaire and would seek this information from each CCG. It was noted that, in order to improve patient satisfaction in supporting people with long term conditions, community based case management had been introduced.

(ii) Clarification was provided regarding the terminology used in the Metrics in connection with assessing the amount of admissions. It was noted that Metric 4 referred to the total number of emergency admissions whereas Metric 6 was a subset of that and referred specifically to admissions related to injuries due to falls. The definition of an 'Avoided Admission' was discussed and the Director of Health and Care Integration explained that in each of the schemes data was recorded against a clinical definition to examine if the activities carried out within the

alternative pathway prevented an admission to hospital particularly in the 14 day period after an incident/accident occurred. However, it was recognised that this was an inexact concept to assess and clinical judgements would have to be made on what constituted an avoided admission. To support this work there was a clinical definition of an avoided admission for each scheme. Independent Evaluation including Clinical Audit was carried out to assess how the schemes were operating against the assumptions and gather evidence to inform future practice and commissioning arrangements. Members welcomed the robust attempt made through the Better Care Fund Plan to measure and evaluate the effectiveness of initiatives.

(iii) The Better Care Fund Plan did not include all schemes to reduce readmissions to hospital; further work in this area was being led by the Urgent Care Board and Vanguard initiatives. However, it was intended that the learning from the Better Care Fund work to date would be incorporated into future urgent care delivery models.

RESOLVED:

(a) That the progress made to refresh and submit the Leicestershire Better Care Fund (BCF) plan be noted;

(b) That officers be requested to inform the Committee of the response rate for the GP patient survey;

(c) That officers be requested to consider how the Better Care Fund Plan can support a reduction in the readmission rate for the University Hospitals of Leicester.

70. Urgent and Emergency Care Vanguard.

The Committee considered a report of West Leicestershire Clinical Commissioning Group (CCG) which provided an update on the Urgent Care Improvement work including the Leicester, Leicestershire and Rutland Urgent Care Vanguard. A copy of the report marked 'Agenda Item 9' is filed with these minutes.

The Chairman welcomed Tamsin Hooton, Director of Urgent and Emergency Care to the meeting for this item.

Arising from discussion Members were advised as follows:-

(i) 7 day working in acute hospitals would not necessarily result in all services being available 7 days a week. For instance, Ophthalmology day case treatment was categorised as an elective service and therefore would not be available 7 days a week. The Emergency Department would meet the needs of patients with urgent eye problems outside of normal working hours.

(ii) In response to concerns regarding the lack of clinical expertise of the people answering 111 calls, Members were reassured that the system did include a trigger to identify patients who required a more specialised clinical assessment and they would therefore be taken off the clinical navigation pathway so they could receive that assessment.

(iii) Some palliative care services provided by LOROS were funded by the NHS.

(iv) A Placement Bridging/Holding team was used when a patient's long term destination was residential care, but in the short term they were able to go home with support to be assessed in a home setting.

(v) Concern was expressed regarding the significant issue of the different NHS systems that were not always compatible and thereby failed to share information. Although this was beyond the remit of the Vanguard, it was contributing to improvements in this area by working in parallel with a project to integrate health and social care points of access across Leicester, Leicestershire and Rutland. Some resources from the Vanguard were also allocated towards ensuring that a summary care record for patients could be shared across health and care organisations. It was felt that the Committee should give further consideration to this issue relating to the interoperability of NHS systems and organisations and the creation of a single patient record accessible to patients and carers.

(vi) It was acknowledged that ambulance handover times at the Leicester Royal Infirmary were still unacceptably long. As a result of the Care Quality Commission Inspection of the Emergency Department undertaken at the end of 2015, weekly performance meetings were now held between UHL, EMAS and the Trust Development Authority. Some improvements had been made, particularly to the number of ambulances waiting over two hours. Some of the urgent care recovery plan actions were also starting to have an impact. The Vanguard was largely focused on strategic and longer term improvements but it also aimed to reduce the pressure on the ambulance service, for example through the multi-disciplinary team at the navigation hub which would provide senior clinical support for paramedics and support reductions in ambulance conveyances to the Accident & Emergency Department.

RESOLVED:

(a) That the update on the Urgent Care Improvement work including the Leicester, Leicestershire and Rutland Urgent Care Vanguard be noted.

(b) That officers be asked to identify options for scrutiny on the approach taken to the health and care system in Leicestershire, including the interoperability of systems.

71. <u>0-19 Healthy Child Programme Review and Re-Procurement.</u>

The Committee considered a report of the Director of Public Health which provided information on the 0-19 health needs assessment and sought it's views on the proposed model for the procurement and delivery of a 0-19 Healthy Child Programme. A copy of the report marked 'Agenda Item 10' is filed with these minutes.

Arising from discussion Members were advised as follows:-

(i) The proposed service would result in less duplication and would enable gaps in provision to be filled. An additional benefit was that the new service would use Public Health data to identify need as well as where the new service could work with other services and support communities to become more resilient. It was also expected that £0.5 million of savings would be made from the £9 million budget from integrating the services and working in a more joined up way.

(ii) Stakeholder engagement with the professional delivering the current service had been positive and that they would welcome the opportunity to work in a more holistic way, including engaging with local communities.

(iii) Work was being carried out to understand the pathways already in place for the emotional health and wellbeing of children and young people and to establish which organisations were providing and commissioning services, to make sure the system was as efficient as it could be. This involved working with the Children and Families Service and Clinical Commissioning Groups.

(iv) Ways of measuring outputs were being considered and the Outputs Star System used by the Supporting Leicestershire Families Programme was an option under review.

RESOLVED:

(a) That the 0-19 health needs assessment and proposed model for the procurement and delivery of a 0-19 Health Child Programme service (Health Visiting and School Nursing) for Leicestershire be supported;

(b) That the comments now made be submitted to the Cabinet for consideration at its meeting on 9 May 2016.

72. Public Health Commissioning Intentions.

The Committee considered a report of the Director of Public Health which introduced the Department's Commissioning Strategy and Commissioning Intentions. A copy of the report marked 'Agenda Item 11' is filed with these minutes.

Arising from discussions the following points were raised:-

(i) Members were pleased to note that the Commissioning Strategy included detail of the specific actions that were going to be carried out rather than just setting out broad aims.

(ii) As the County Council already had a service which engaged with travelling families, it was proposed to extend this to include public health services such as providing information and supporting families to register with a GP. Members queried whether the existing service, which would be decommissioned, included Health Visitors and the Director of Public Health agreed to check the details and provide the information to Members.

RESOLVED:

(a) That the Department's Commissioning Strategy and Commissioning Intentions be noted;

(b) That the comments now made be submitted to the Cabinet for consideration at its meeting on 19 April 2016.

73. Date of next meeting.

RESOLVED:

It was noted that the next meeting of the Commission would be held on 8 June 2016 at 14:00hrs.

2.00 - 3.45 pm
30 March 2016

CHAIRMAN

NHS
West Leicestershire
Clinical Commissioning Group

HEALTH OVERVIEW AND SCRUTINY COMMITTEE: 8 JUNE 2016

REPORT OF WEST LEICESTERSHIRE CCG

UPDATE ON CNCS AND BUSINESS CONTINUITY

Purpose of report

1. The purpose of this report is to update the Committee on business continuity in Out of Hours and Loughborough Urgent Care Centre.

Background

2. Central Nottinghamshire Clinical Services (CNCS) are a provider of GP out of hours and urgent care services in Leicestershire, Leicester and Rutland and central Nottinghamshire.

3. After a period of financial difficulty, CNCS filed a notice of intent to appoint an administrator and subsequently ceased trading on the 12th May. This paper gives some details on the background to the current position, the actions taken to secure service continuity through a caretaking provider and assesses the current level of assurance around service provision.

4. CNCS had experienced a number of significant challenges over the last year. The Leicestershire out-of-hours (OOH) services were rated as inadequate by the Care Quality Commission (CQC) in 2015 and, following a risk summit, an Oversight Group was established involving both Leicestershire and Nottinghamshire commissioners. Good progress was made in relation to the quality improvement plan, but CNCS were required to make significant investments to support governance processes and staff engagement. Leicester, Leicestershire and Rutland (LLR) funded a number of transitional posts in relation to the CQC improvement work, but CNCS did not recoup the full cost of additional resources from all commissioners. As a result of recent events, CNCS have suffered reputational damage with local GPs and had increasing difficulties in terms of rota coverage. Consequently, they regularly paid high agency rates and premiums to fill rotas at short notice and this increased the level of financial challenge for the organisation. The organisation had also experienced challenges with its leadership and organisational capacity in relation to both financial management and service improvement.

Arrangements for service continuity

5. The Clinical Commissioning Groups' first priority was to ensure safe clinical service continuity. A shortlist of potential caretaking providers was identified from which a preferred caretaking provider was recommended and agreed by each of the three

LLR Clinical Commissioning Groups (CCGs). The decision on caretaking provider was guided by the need to identify an experienced provider who could mobilise a safe service within an extremely short timeframe.

6. Derbyshire Health United (DHU) was confirmed on the 10th May as the caretaking provider for both LLR Out of Hours services and the Loughborough Urgent Care Centre (LUCC). Derbyshire Health United provides the NHS 111 service in the East Midlands, as well as Out of Hours and other urgent care services in Derbyshire. The CCGs are confident that DHU is a robust provider with strong leadership and is able to provide a stable service.

7. Following confirmation that it was the caretaking provider in LLR, DHU swiftly developed a mobilisation plan and has been working with CNCS and WLCCG to implement that plan.

8. CNCS ceased trading at midnight on the 12th May. This was earlier than the deadline in the initial high court notice of intent, due to CNCS having utilised all funds made available to it by the CCGs, and the advice of its insolvency practitioner that it could not continue to trade.

9. DHU took over as caretaker on midnight on the 12th May. The initial mobilisation period has gone smoothly and both OOH and LUCC services operated as usual. DHU executives were on site in all LLR bases over the night of the 12/13th May to oversee operations and provide assurances to staff engage about the changes. Staffing levels remained as expected, including agency staff and sessional staff.

10. The CCG is in close contact with DHU and the CNCS administrators and it continues to work to resolve all the legacy issues relating to CNCS folding. The CCG is meeting with DHU weekly to provide assurance on the ongoing work to transition the LLR services, including reviewing staffing levels, financial risk and quality assurance.

11. The CCGs are concerned both to ensure continued delivery of a high quality service and to ensure that DHU are not destabilised as a result of taking on CNCS's services. The caretaking arrangement will last until 31st March 2017. The CCGs plan to re-procure a redesigned model of community urgent care services, including OOH, from April 2017 as part of the Vanguard programme. The services formerly provided by CNCS will form part of that redesign work, moving to a more integrated model of care, and new contracts will be in place by 1st April 2017.

12. The WLCCG quality team carried out quality visits to all OOH sites and the LUCC on the evening of the 23rd May. They found no issues of concern. Key findings were that DHU executives had been visible to staff on the ground and engagement meetings had taken place. Staffing levels were appropriate to meet demand, with no gaps in service delivery impacting on the quality of care. Staff generally felt well informed by their managers of the changes. Medicines management processes had in some cases been strengthened.

13. There should be no noticeable impact on patients resulting from CNCS ceasing trading. Services are being operated as before, from the same premises and with the same access routes for patients. All CNCS operational staff in the LLR services have transferred to DHU, including operational managers, so there is a high degree

of continuity of provision and knowledge of the service. Access to patient records and IT systems has been transferred from CNCS to DHU in line with IG guidance.

14. Communications with patients and the public, GP practices and other stakeholders have been co-ordinated by WLCCG. Messages have focussed on 'business as usual' and stressing that patients can access services in the same way as previously.

15. The CCGs are reviewing lessons learnt in respect of the organisational failure of CNCS. Key issues include the role of commissioners in supporting providers' leadership and organisational capability, workforce and the cost of out of hours GP time.

Consultation

16. The change of provider was undertaken in an emergency situation and as such, does not require formal consultation. Given the timeframes, there was no opportunity to engage with stakeholders or the public on the change of provider. However, the CCGs are planning engagement with local people on the Vanguard changes before next April.

Resource Implications

17. The caretaking contract transferred to DHU is on the same basis as the previous CNCS contract. The CCGs are working with DHU to ensure that the appropriate due diligence is done on CNCS operating costs. The CCGs have provided DHU with an undertaking to ensure that DHU is not financially destabilised as a result of the caretaking agreement.

18. DHU are working with the CCGs to ensure that a robust cost improvement programme is put in place. A key aspect of this will be to reduce high levels of premium rates paid to fill clinical sessions as late notice.

Conclusions

19. The closure of CNCS as an organisation and the transition to new management has been managed as smoothly as possible. While clearly an unfortunate event, service continuity has been maintained and the service provided to patients has not deteriorated either in terms of levels of service or service quality.

Background papers

Report to the Health Overview and Scrutiny Committee on 10 June 2015 – Out of Hours Service Provided by Central Nottinghamshire Clinical Services
http://politics.leics.gov.uk/Published/C00001045/M00004237/AI00044069/$CNCSOOHReport.docA.ps.pdf

Circulation under the Local Issues Alert Procedure

Not required. The services affected are open to all LLR patients. The Loughborough Urgent Care Centre sees patients on a walk in basis, although the majority of patients are from West Leicestershire.

Officer to Contact

Tamsin Hooton, Director of Urgent and Emergency Care
Telephone: 07557 542 832
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Better care together
Leicester, Leicestershire & Rutland health and social care

HEALTH OVERVIEW AND SCRUTINY COMMITTEE: 8th June 2016

REPORT OF BETTER CARE TOGETHER

PLANNING FOR PUBLIC CONSULTATION

Purpose of report

1. To inform the Health Overview and Scrutiny Committee of the progress of the Better Care Together (BCT) programme towards public consultation on a number of the proposed changes that will impact the residents of Leicestershire, and to highlight the consultation plan.

Policy Framework and Previous Decisions

2. Progress in developing the BCT Programme was reported to the Health Overview and Scrutiny Committee on 9 September 2015. There was also an all Member Briefing on 22 July 2015 which provided a general update on the Programme.

Background

3. The BCT programme is a major health and social care change programme that aims to improve both the quality and sustainability of health and social care services across Leicestershire, Leicester and Rutland (LLR). The programme is run via a partnership of all three Clinical Commissioning Groups (CCG's), the three main healthcare providers and the three local authorities. Via the programme Leicester, Leicestershire and Rutland (LLR) has already implemented a number of service changes and will continue to do so throughout the year.

4. A number of changes proposed as a result of the BCT programme require public consultation prior to being implemented. The plan is to consult the public of LLR once NHS England have agreed that the system has passed the Department of Health's tests for proceeding to service reconfiguration. The programme has been reviewed by NHS England's reconfiguration panel and a number of the tests have been partially met with a few outstanding questions.

5. Two tests are however more challenging and since the business case was agreed by the LLR health and social care system at the beginning of the year it has become evident that due to learning from experience some of the assumptions in the present business case need to be updated, and this needs to be done before some of NHS England's requests for additional information can be met.

6. Additionally the NHS England national team have asked that the LLR system submits a Sustainability and Transformation Plan (STP) prior to moving into a consultation process. The STP process is a national requirement to all health organisations in England to provide five year plans that demonstrate how their area will improve the health and wellbeing of residents, improve the quality of services and be financially sustainable. As a result the planned timeline for consultation is presently not clear but targeted to be as soon as feasible following the submission of the STP at the end of June.

7. This paper provides an update to the HOSC on the present situation and a summary of the planned approach to consultation once NHS England approval to proceed has been given.

Consultation

8. Based on the existing business case and without factoring in any potential changes due to developing knowledge at this stage the following proposed changes to services are presently expected to undergo public consultation:

   a. The reconfiguration of community hospital in-patient services including the potential removal of inpatient beds from some community hospitals, plus increasing the provision of day case and outpatient appointments in these hospitals and therefore generally providing services closer to peoples' homes

   b. The reconfiguration of services delivered in Hinckley and Bosworth including increasing day case and outpatient services and modernising diagnostics with the potential decommissioning of the old Victorian Hospital on the Mount road site (presently 50% of space is already not used for clinical purposes.)

   c. The reconfiguration of UHL acute services which will include building a new women's hospital at the Leicester Royal Infirmary (LRI) site, and new planned care treatment centre at the Glenfield site. Many (but not all) services will move off the Leicester General site (LGH).

   d. The reconfiguration of maternity birth services so that all women's services are moved to the new women's hospital and women will be able to choose to give birth at the women's hospital at the LRI, either a midwife led or an obstetrics (doctor led) unit, at home, or if consultation indicates it to be valued at a midwifery led unit at the LGH site.

9. In order to prepare the proposals for overall change and consultation presently being assured by NHS England the BCT programme has carried out significant engagement activity (over 500 events).

10. In appendix 1 the feedback from the events related to the consultation topics is described as are the actions taken as a result. This feedback has been used to inform both the proposed plans for change and the proposed consultation process.

11. The consultation will take place over 12 to 14 weeks (the additional two weeks being available if consulting over a significant holiday period), and will involve consulting the 1.1m residents of LLR by face to face contact, via brochures in key locations attended by the public and patients, and on line.

12. To make sure the programme is visible to all residents of LLR the programme plans to ensure that every household has some type of material directly posted through their door.

13. Many channels will be used, including:

- Public meetings
- Communication via Partner organisations existing routes
- Items in the News media
- Engagement with Social networks
- Regular updates to the BCT Website
- Distribution of Printed materials
- Face to face engagement with groups
- Briefings for specific stakeholders
- News bulletins
- PPI events
- Paid for advertising
- Targeted direct distribution of materials (including alternative formats)
- Links with existing health campaigns (flu etc.)

14. Additional effort will be made to connect with hard to reach groups and the programme will sponsor a number of voluntary agencies to connect with the groups they support and collate feedback so that people have someone they feel they can trust to discuss the topics with.

15. The goal is to receive over 10,000 responses.

Resource Implications

16. None to note

Conclusions

17. The plan to consult the public of LLR on major structural changes to health services is progressing through national governance and the proposals are presently being updated and used as part of the input to the STP process which will create national five year strategies to support improved health and wellbeing, quality and sustainability.

18. Permission from NHS England is required to initiate a consultation process and this has been linked to the achievement of an STP.

19. Once permission is given a robust consultation process will take place using a number of channels and with the goal to get 10,000 responses.

Background papers

Report to Health Overview and Scrutiny Committee on 9 September 2015 can be found at the following link:

http://politics.leics.gov.uk/documents/s111508/Better%20Care%20Together%20Update.pdf

Circulation under the Local Issues Alert Procedure

None.

Officer to Contact

Mary Barber - BCT Programme Director
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Email: mary.barber1@leicspart.nhs.uk

List of Appendices

Appendix 1: Summary of engagement on key consultation topics, feedback and how proposals have been impacted

Relevant Impact Assessments

Equality and Human Rights Implications

20. Changes will have equality impacts and these are being assessed throughout the process.

Crime and Disorder Implications

21. None identified.

Environmental Implications

22. None identified.

Partnership Working and associated issues

23. BCT is a partnership of all three LLR local authorities, the three NHS providers and the three CCGs

Consultation topic	As of April 2016: Engagement that has taken place (number of events/briefings etc.) Approximate number of people inter	As of April 2016: Approximate number of people engaged	Key themes emerging from engagement	How this engagement has been built into work stream plans
MATERNITY	Healthwatch, interested stakeholder groups and UHL patient partners PPAG, Healthwatch and UHL PPI representatives and members of the public involved in the options appraisal validation session 2015 Breast Friends. Discussion with Breast feeding support group 2015. 12 people attending Rutland women. Event sponsored by Healthwatch Rutland. 6 attendees. 2015 Charnwood Breast feeding support group 7 attendees discussed MLU options. 2015 Healthwatch, interested stakeholder groups and UHL patient partners in a midwifery led care options appraisal. 2015 Women and mothers Toddler Town Huncote. 2015 Healthwatch and internal stakeholders Women's preferred option discussion, 2015 Women and mothers Toddler town Wigston 2015 Healthwatch Women's project board (monthly meetings) Members of the public -UHL Annual General Meeting 2015 Sikh women Sikh community Centre Health fair 2015 Asian women Sharma women's centre 2015 BCT PPAG meeting bi-monthly- 20 people group assuring the plans of the programme Leicestershire Equalities Group 30 people representing different protected characteristics received a briefing about the shape of the proposed changes including the maternity proposals Members briefings - Briefings have been made to Leicestershire and Rutland county councillor and Leicester City overview and scrutiny members	Approximately 1400 people	Safety of both mother and baby Increasing the numbers of home births alongside making people aware that risks of home births are the same as MLU birth Recognition of challenges around providing midwifery-led care in Melton Mowbray Ensuring equitable access to services Need to offer additional/enhanced post-natal care to all women Recognition of financial constraints; need to offer more for less, whilst maintaining high quality standards of care. Benefit criteria prioritised at public event on 3/6.	All acute services to move to the LRI to ensure co-location of all emergency and obstetric-led services, and appropriate high quality environments with good clinical adjacencies, offering service efficiencies for consolidation. Consideration of King's Fund and NICE recommendations on best practice for childbirth and reconfiguration of maternity services. Option to provide a standalone MLU at the LGH for accessibility to ensure choice. Commitment to supporting an increase in home births and improving post-natal care for all women across LLR

	Health and Wellbeing Boards Briefings have been made to the Health and Wellbeing boards. These briefings were held in public and the papers made public. Leicester Mercury patients panel 6 members of the public have been briefed about the proposed changes Review BCT Partnership Board The partnership board have been briefed in public with a few members of the public present			
HINCKLEY HOSPITALS	2 public engagement events (attended by approx. 2000 people) Regular stakeholder events held in conjunction with the district council Regular key stakeholder meetings and briefings such as with local MPs and Councillors	Estimated at 2200	**Service access:** • Increase services offered at the GP practice • Improve access to diagnostics (bloods) • There is limited out-of-hours GP services • Recognise and utilise community and voluntary services • More education to support self-care and prevent illness **Services and access** • Everyone fed back a desire for services to stay local. There were mixed views around whether services should be provided in hospital or provided in a wider range of community venues • Everyone wanted improved diagnostic and pathology services, with shorter waiting times for diagnosis and results emerging as a significant issue for people and family carers • Family carers want smoother systems for delivery of medication and transition to adult care for children • Family carers find the process of making a GP appointment difficult and **Endoscopy** Is it acceptable to move endoscopy to another site? • Keep it local • Make sure it is accessible • Local is good for carers • There must be good transport links and parking • Keep it all it one place • New purpose built site needed - a modern ‘fit for the future facility’ with the right equipment • Must be staffed by specialists	• Offer the choice in the consultation of moving more planned care and diagnostic services to GP surgeries • Maintaining as many services as possible in the local area where it is sustainable to do so in the longer term (for example procedures requiring general anaesthetic via bottled gas will soon not be viable) • Endoscopy services will be enhanced and continued to be provided locally. • Local people will have the choice in the consultation of services provided in Hinckley Health Centre (adjacent to the current Hinckley and District hospital); ensuring services are local and accessible.

- Must be JAG accredited

Hinckley Health Centre or Hinckley & Bosworth site?

- Town centre location is good for Hinckley (HHC)
- Community Hospital site is good for wider Hinckley & Bosworth area (H&B)
- Can we do both?

What else should we think about?

- What's happening to the current site?
- Hinckley & District site could be sold for redevelopment and use the proceeds to pay for capital investment
- Is this futureproof? Will nanotechnology replace the need for endoscopy?
- Will this require bringing people in from outside Hinckley? What knock-on effect would that have?
-

Day cases

Is it acceptable to move day cases outside of Hinckley, e.g. GEH/UHL?

- Yes
  - But only if waiting times are reduced; is this likely?
  - If a one off
  - But deliver pre and post-op care locally
  - If it means seeing the specialist
  - GP premises are not fit for purpose
  - Only if we do not have the facilities in Hinckley
  - But not everything, minor day cases should be closer to home
  - Leave major procedures out of town
- No
  - Transport and parking issues
  - Access issues
  - Prefer local services
  - Expand local services
  - This goes against the ten principles of the project
  - Increase capacity at weekends
  - Good experience of services in Hinckley
  - Save people going across the border

If locally delivered, would it be best from Hinckley Health Centre or GP Practices?

- Hinckley Health Centre
  - Better on one site
  - Create a community hub
  - GP premises are not fit for purpose
  - Too much already on
- GP Practices
  - Federation solution
  - Carry out minor ops
  - Maximise GPwSIs
  - Clinic one a month?
  - Happy to travel for a one-off

- GPs
  - Economies of scale
  - Its familiar to people and the bus routes are in place
  - If consultants spend more time travelling they spend less time seeing patients
  - Multiple sites won't work
  - Is there enough funding and capacity within GP practices?
  - Will require joined up IT

What else should we think about?

- Right place, right time, right professional
- Will we still have choice?
- We need more data to make an informed decision. What's the volume?
- Specialist facility for cataracts?
- Think about recovery times and transport
- Is the workforce is available?
- What if multiple procedures are required?
- More important that facilities have maximum, 24/7 use
- It must be viable
- Joined up pre and post op care
- How does this fit with increasing age and obesity factors?
- If waiting times go up, it is not a good trade off
- Who owns the hospital?

Outpatients

What do you like about this option [to maintain outpatients at HHC]?

- Good transport links
- Local and accessible
- All under one roof
- Reduce waiting times
- Increase the offer
- Use the Health Centre & H&B Hospital to full capacity

What else should we think about?

- Capacity and workforce
- More use of care navigators
- Parking
- Referral pathways (pre op and post op) and the transfer of information
- Mental health services?
- Physio services at the leisure centre
- Diagnosis and prevention
- Wider offer of services; what else could be delivered?
- Increase in the population
- Affordability

ACUTE HOSPITALS 3 TO 2	Patient representatives involved in service reconfig work stream involved in development of proposals 3 Members of BCT PPIMAG members attended option workshop Public Formal consultation in 2000 on moving from 3 sites to 2 Patient representatives and Healthwatch - Part of team who developed and confirmed the preferred option in 2013 Public BCT public engagement campaign in 2015 stating plans to move from three sites to two. 1000 respondents Public UHL "Delivering care at its best" engagement in 2015. Significant public engagement. BCT PPAG 20 people group assuring the plans of the programme on a bimonthly basis Overview and Scrutiny Approved changes to emergency floor layout and "mothballing" of some beds Leicestershire Equalities Group 30 people representing different protected characteristics received a briefing about the shape of the proposed changes including the UHL 3 to 2 shift Overview and Scrutiny 3 overview and scrutiny groups (Rutland, Leicestershire and Leicester City) have discussed the outline of the plan to increase ICS and reduce community hospital inpatient sites plus the shift of planned care to the community. These meetings were held in public and the papers made public. Member's briefings. Briefings have been made to Leicestershire and Rutland county councillor and Leicester City overview and scrutiny members Health and Wellbeing Boards. Briefings have been made to the Health and Wellbeing boards. These briefings were held in public and the papers made public. Mercury patients panel 6 members of the public have been briefed about the proposed changes BCT Partnership Board The partnership board have been briefed in public with a few members of the public present The documents UHL Strategic Direction (2014) and Delivering Caring at its Best (2015), which discuss the reduction of three to two sites were circulated to stakeholders and also via face to		• Overall acceptance and understanding of the need to reduce the number of sites that services are delivered from. • An understanding that some services for clinical best practice, need to be located together. • The Generals Hospital if not a location for acute health services, is a good location for non-acute care, and research	• Subject to the outcome of the consultation, a midwife led unit will be located at the General site.

	face meetings with key stakeholders.				
GENERAL COMMUNITY HOSPITALS RECONFIGURATION	Service reconfiguration work-stream Patient representative	An individual involved in the development of proposals as part of the project team	Approximately 1100	• Care closer to home which is easily accessible • big city hospitals should focus on specialist and emergency care, with some simpler care being done in the community hospitals/ GP services • When asked what was most important if someone in your family needed a simple health procedure which did not require a stay in hospital, waiting time was most important to approximately two thirds of people engaged with. • When asked what was most important If someone in your family needed a major operation waiting time was most important to most people.	• Increased number of planned care services to be carried out in the community in GP surgeries or community hospitals • An increased use of 'Hospital at Home' beds so that people, when ready to b discharged from acute care can recuperate at home with support from the Hospital at Home service.
	Members of the BCT Patient and Public assurance group (PPAG)	Three members of the PPAG attended three workshops to discuss the proposed changes and to agree which options were viable and which not			
	Alliance Patient and Public Group	A number of individuals as part of the project team that designed the planned shift of planned care services to community hospitals			
	Public	Public engagement campaign used to confirm the direction of travel for the programme and assess the view of the public on travel time. 1000 respondents			
	BCT PPAG	20 people group assuring the plans of the programme on a bimonthly basis			
	Leicestershire Equalities Group	30 people representing different protected characteristics received a briefing about the shape of the proposed changes including the increase in care at home and reduction of inpatient sites			
	Overview and Scrutiny	3 overview and scrutiny groups (Rutland, Leicestershire and Leicester City) have discussed			

COMMUNITY HOSPITALS (St Luke's Hospital, Market Harborough, Rutland Memorial Hospital, Feilding Palmer Hospital, Lutterworth, St Mary's hospital, Melton Mowbray)	**Public consultation (16 June to 5 October 2008) -** NHS Leicestershire County and Rutland (NHS LCR) held a public consultation about the future of community health services in Leicestershire and Rutland. More than 1000 responses (876 completed questionnaires) _____ **Public engagement survey (April-May 2012)** giving people the opportunity to give their views on community and elective care services. 365 completed surveys ELR CCG PPG Network discussion		Strong support for: • care closer to home (89% strongly agree or agree); • local diagnostics (98% strongly agree or agree); • increased GP Services (87% strongly agree or agree); • five one-stop hubs (84% strongly agree or agree); and • 82% of people would rather not travel to city centre care setting. Issues raised by respondents • accessibility; • need to resolve inequalities and address needs • extending opening hours and gaining immediate access • importance of "Diagnostics" • need to work with key partners. _____ Survey responses highlighted the preference for services to be local and the importance for services to be delivered as close to home as possible. The majority of respondents ranked local GP practice as the most preferred location for diagnostic, day case and out-patient services, closely followed by Melton Mowbray hospital, as an important location. Further to this, respondents asked for excellent, up to date equipment and treatment and more of it, saying that they are more likely to attend appointments if they can get treatment locally. It was suggested that diagnostics and outpatient appointments should be undertaken locally, with more complex treatments and operations to take place at larger hospitals. Many commented on how it feels to be treated in their local community stating more of a personal service and a community feeling of being cared for. There were many comments made on issues of visiting larger hospitals for treatment which also verifies the preference for local services. Some respondents stated that attending	Engagement processes have enabled us to understand current issues and the breadth of potential for bringing together community and primary care services. Our aim is for each locality to have the right level and range of services to serve the needs of local patients. To achieve this, Primary Care is placed at the core of our model development with a proposal for discussion centred on wraparound community services to achieve greater integration of health and social care professionals. We have identified a number of areas that need to be addressed through the proposed model to ensure a solid foundation for community services. These areas are not exhaustive and include: 1. Changing the current model of community services commissioning to give the CCG and its GPs more accountability to influence how services are delivered; 2. Creation of joint GP/Provider posts to enhance accountability; 3. Delivery of a rehabilitation and re-ablement model that moves services from a hospital to a home environment; 4. Improving access to community services that are currently considered sub-optimal including physiotherapy; 5. Expanding the times when care is available both at home and in health facilities; 6. Establishing clinical support networks and services in acute and primary care to identify, enable and manage both complex care, frail elderly and sub-acute care locally; 7. Making the most of the land and estate available to deliver local services avoiding unnecessary travel to acute hospitals; 8. Minimising service barriers through simplified specifications and joint commissioning of primary, social and community services; and 9. Changing the model of community services commissioning to focus on outcomes rather than inputs.

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Public engagement programme (October to December 2015) – Programme of engagement activity on the proposed model for the future delivery of community services in East Leicestershire and Rutland.

121 completed questionnaires.

Nine community groups, representing the seldom heard and including the nine protected characteristics, (Equality and Diversity Law 2010) were visited to listen to their views.

A total of 48 conversations took place with members of these groups.

ELR CCG PPG network discussion

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Workshop discussions at 3 x PPG Locality meetings (February 2016) – further outreach engagement to understand people's views in more detail

appointments at larger hospitals is more time consuming due to the distance of travel, long waiting times and difficulty in parking. Others commented that smaller units would have shorter waiting times and some said they liked community hospitals as they found them less intimidating. Other comments made highlighted that having local facilities frees up critical pressures of larger
hospitals.

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87% of respondents to the survey were supportive of our current proposed model for the future delivery of community services.
The findings of the survey, which was conducted over 13 weeks in the Autumn of 2015, show that there is wide support overall for services closer to home, joined up working and better communication at all levels.

Those respondents that did have concerns mentioned a variety of areas, including:

- the resources that would be needed to implement these changes – affordability and 'do-ability'
- the complexities of change on such a scale
- staffing levels and recruitment
- 'public transport' and car parking
- communication between professionals and about the services available
- lack of detail about the model – how will this affect me and my family?

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When asked "What does the term 'community services' mean to you?", discussions were focused around four key areas:

- services/professionals
- conditions
- locations
- types of patients

Although the responses varied across the three events, there were some common themes emerging, particularly relating to the services/professionals that people saw coming under 'community services. Services/professionals discussed more than once included:

- District nursing care
- Psychological/mental health services
- Pharmacy
- Opticians
- Dentist
- GPs

Our proposed model is likely to require significant organisational change both within each locality and by community service providers requiring leadership, time, skill and resources to ensure change is achievable.

Robust governance arrangements including joint working with and through Local Authority structures will be essential to ensuring strategic alignment and successful local implementation.

Most aspects of the proposed model do not require formal public consultation over and above robust engagement.

Issues affecting ELR community hospital in-patient beds form part of the Better Care Consultation.

Further engagement will be undertaken as we move forward with developing the community services model to ensure there are sustainable and appropriate services to meet local people's needs in our communities.

			• Health Visitors • Midwives When the discussion included which groups of patients used community services, older people were cited most frequently. All three groups also discussed wider definitions and services not typically classed as 'healthcare' such as: • voluntary groups • social services • preventative care The findings of this engagement give an insight into the expectations of local people in respect of the services that should be available in the community.	

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Leicestershire County Council

HEALTH OVERVIEW AND SCRUTINY COMMITTEE: 8 JUNE 2016

INTEGRATING LEICESTER, LEICESTERSHIRE AND RUTLAND POINTS OF ACCESS

REPORT OF THE DIRECTOR OF ADULTS AND COMMUNITIES

Purpose of report

1. The purpose of the report is to inform the Committee of the Business Case which has been developed for Integrating Leicester, Leicestershire and Rutland (LLR) Points of Access across health and social care partners. Members are asked to support the overall vision and direction of travel as set out in the Business Case (attached as Appendix A).

Policy Framework and Previous Decisions

2. The relevant policy framework includes:

- Better Care Together Five Year Strategic Plan 2014-2019;
- Better Care Fund Plan 2016-2017;
- The Care Act 2014;
- Leicestershire County Council Provisional Medium Term Financial Strategy 2016/17–2019/20;
- Leicestershire County Council Strategic Plan 2014–2018 (Leading Leicestershire: Transforming Public Services).

Background

3. The development of the LLR Better Care Together Five Year Plan has highlighted the need to consider how single points of access across LLR could be simplified and reconfigured in support of demand management and the “left shift” so that professionals and service users make the best use of the most appropriate service in the most appropriate setting of care, and that the information and signposting provided is responsive and consistent with local pathways.

4. The Integrating LLR Points of Access project group, with NHS and Adult Social Care representation (and broader local authority services eg First Contact) from across LLR, was set up to scope this work in the context of the future model of urgent care for LLR and the national context for redesigning urgent care which is a key priority from NHS England’s Five Year Forward View.

5. The overall aims of the Integrating LLR Points of Access project are to:

- Deliver high quality, citizen centred, integrated care pathways, delivered in the appropriate place and at the appropriate time by the appropriate person, supported by staff/citizens;
- Reduce inequalities in care (both physical and mental) across and within communities in LLR;
- Support the improvement of health and wellbeing outcomes for citizens across LLR;
- Optimise both the opportunities for integration and the use of physical assets across the health and social care economy;
- Support the achievement of more appropriate use of health, social and community services;
- Services to be accessible to as many people as possible within the community;
- All health and social care organisations in LLR to achieve financial sustainability, by adapting the resource profile where appropriate;
- Improve the utilisation of our workforce and the development of new capacity and capabilities where appropriate, in our people and the technology we use.

Current Position

6. LLR has various single points of access (SPA) that provide support to the health and social care service provision. These include separate customer service call centres for each of the local authorities and a number of general and specialist customer call centres with Health settings. Each “SPA” currently operates separately, and in very different ways.

7. Operationally, it is recognised that there is an opportunity to deliver a more consistent, targeted service to both customers and professionals by integrating our approach across existing points of access.

8. The model proposed in this Business Case has been designed to support the new urgent care system for LLR which is being developed as part of the local Vanguard site. The new urgent care system will feature improved clinical triage. This Business Case demonstrates the opportunities to integrate existing “SPAs” so that the infrastructure supporting the urgent care system, including supporting the new clinical triage systems, can be as integrated as much as possible for both professionals and patients in the future.

Business Case

9. This Business Case outlines how these objectives can be achieved through implementing a new Target Operating Model (TOM). It also examines the associated activities, costs, benefits, risks and mitigations that will be involved in delivering this new, more integrated way of working.

10. This Business Case has been developed within the context of current levels of performance, the strategic direction of the in-scope services, aligned to the Better Care Together (BCT) Five-Year Plan and the Vanguard - Workstream 1 programme. In summary, the document details the following:

    - An integrated TOM for Health and Adult Social Care points of access across LLR;
    - A proposed approach and business case to achieve implementation of integrated services;

- A financial appraisal of the current service delivery model versus the recommended TOM for Health and Adult Social Care including implementation costs, realisable financial and non-financial benefits;
- The associated change activities required to deliver the overarching aims and objectives of the programme;
- Risks, Issues and Constraints associated with a programme of this scale across multiple organisations and the mitigating actions.

11. The Business Case finds that there are significant advantages of moving to a single uniform way of operating, at a single or much reduced number of sites and under one management structure. At a high-level these are:

- Realisable savings that may be achieved through rationalisation of the management structures, teams and facilities that undertake contact centre activities in Health and Adult Social Care;
- Savings that can be achieved through more effective ways of working in the teams that execute service requests;
- A more effective, responsive and better experience for the recipients of the services (professionals, patients and service users);
- Better information on which to make LLR wide decisions on demand management and targeted interventions.

12. It is recognised that there are a number of challenges of moving to this model and the approach outlined in the Business Case seeks to address these through risk mitigation and effective programme management. The challenges are as follows:

- Each of the organisations involved, both politically and organisationally will want (or be able) to move at different speeds towards the optimal solution;
- The ability to integrate the ways of working and the technology that supports it;
- To be able to design and implement a cost effective approach that can effectively support the varying demographics across the LLR region.

13. These challenges create a number of risks that will need to be mitigated and actively managed through the life of the programme if the LLR vision and the benefits are to be achieved. These major risks are:

- The organisations involved may not be able to reach agreement on progressing through the implementation phases;
- The overall benefits may be diluted as the timelines for benefit realisation become extended and the economies of scale of running a concertinaed implementation phase are reduced;
- The timelines for the IT integration and the Vanguard projects may have a material impact on the progress on this project;
- As this level of integration has not been achieved before, the LLR system may not have confidence to move at the pace required to deliver the benefits identified in the Business Case.

14. The Business Case, the approach that this phase of the programme has taken and the recommended implementation approach seeks to address these risks by:

- Ensuring that there is a commonly understood and agreed set of aims, objectives and Design Principles that are aligned to the LLR overall vision. This has created a framework to guide the programme though the design and implementation phases;
- Developing a set of reasonable assumptions that will allow the programme to move through each of the phases with known, unknown and managed risk;
- A phased implementation approach to standardise and optimise the ways of working across all the organisations involved to drive out savings early in the programme to help build credibility and confidence;
- The baselining and collection of more detailed, comparative information in the early stages of the programme. This, in conjunction with the detailed design stages, will allow the stakeholders to make the integration and co-location decisions in the later stages of the project and within the context of the framework;
- Ensuring there is a detailed co-design stage at the start of the transition stage to both support decision making and start the engagement of the operational teams, service users and patients in the change;
- Ensuring that the programme strategies that will support the change e.g. benefit management, stakeholder management, change and communications are developed and co-designed early in the project;
- Ensuring that there are activities within the programme and in the operational teams that facilitates the collection of standardised data to allow the organisations to make good decisions over the 30-month programme period and beyond;
- Ensuring that the key programme resources with the necessary skills and capacity, from across the in-scope organisations are identified early by undertaking a skills and capacity assessment to determine any skills gaps and plan for sourcing alternative programme resources if required.

15. The approach taken in developing the Business Case provides the foundation for the next stage of the programme, as it was designed to engage the teams who will have responsibility for delivering the model and to begin the process of involving the wider Health and Adult Social Care services and stakeholder groups. These teams are an integral part of the proposed changes. Their intellectual capital combined with the experience of consultants from 4OC has been used to co-design the proposed future TOM and the method for delivery, and hopefully, in the process has cemented their commitment to the upcoming changes.

Resource Implications

16. At this Business Case approval stage in the project, no funding is being requested from individual organisations. The current phase of the project (Business Case preparation) has been funded from Vanguard monies allocated to the Leicestershire Better Care Fund for this purpose. The LLR wide Project Board have agreed to recruit a temporary Programme Manager to ensure the pace and momentum around this project is maintained. The costs for this support are being funded from the same source of funds.

17. The LLR Points of Access Project Board will provide a further report on the resource implications of the implementation of the programme in due course.

18. These requirements depend on the outcome of the Business Case approval stage and the number of partners across LLR who participate in phase 1 (and future phases).

Conclusions

19. The Business Case will be presented to management teams and boards across health and social care partners in the forthcoming months. The report recommends supporting the overall vision and direction of travel as set out in the Business Case attached.

20. Management teams and boards from across the partnership are being asked to consider the following recommendations:

a) Support the overall vision and direction of travel as set out in the Business Case;
b) Make a recommendation to the Board to support the commitment to enter into phase one of the programme (operational readiness and standardisation across existing call centres);
c) Agree to participate in a further strategic gateway/decision point once this standardisation has been achieved, whereby organisations will determine their entry into the next stage of integration (phase 2);
d) At this Business Case approval stage in the project, no funding is being requested from individual organisations. The current phase of the project (Business Case preparation) has been funded from Vanguard monies allocated to the Leicestershire Better Care Fund for this purpose. The LLR wide Project Board have agreed to recruit a temporary Programme Manager to ensure the pace and momentum around this project is maintained. The costs for this support are being funded from the same source of funds.
e) The LLR Points of Access Project Board will provide a further report on the resource implications of the implementation of the programme in due course.
f) These requirements depend on the outcome of the Business Case approval stage and the number of partners across LLR who participate in phase 1 (and future phases).

21. A further strategic gateway/decision point will take place once the standardisation as set out in phase 1 has been achieved. At this point organisations will determine their entry into the next phase of integration at which point a detailed resource and implementation plan will also be presented.

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Circulation under Local Issues Alert Procedure

None.

Background papers

- 14 January 2015 – Report to the Cabinet "Better care Together – Leicester, Leicestershire and Rutland Five Year Strategic Plan - http://ow.ly/ZwQgI
- 6 February 2015 - Report to the Cabinet "Medium Term Financial Strategy 2015/16 - 2018/19" - http://ow.ly/ZwQl0
- 12 January 2016 - Report to the Cabinet - "Medium Term Financial Strategy 2016/17 to 2019/20" - http://ow.ly/ZwQVa

Relevant Impact Assessments

Equality and Human Rights Implications

22. An Equalities and Human Rights Impact Assessment (EHRIA) was conducted and the subsequent action plan approved by the Adult and Communities Departmental Equalities Group in January 2016.

23. There will be subsequent EHRIAs conducted in relation to specific service areas and projects as these emerge from the action plan.

Leicestershire County Council

HEALTH OVERVIEW AND SCRUTINY COMMITTEE: 8TH JUNE 2016

REPORT OF THE DIRECTOR OF CHILDREN AND FAMILY SERVICES

'FUTURE IN MIND' (MENTAL HEALTH AND WELLBEING OF CHILDREN AND YOUNG PEOPLE) AND BETTER CARE TOGETHER WORK STREAM

Purpose of Report

1. Outcome 4 of Leicestershire's Health and Wellbeing Strategy 2013-16 is 'Improving mental health and wellbeing' and includes priorities for children and young people. Its ambition was further strengthened by the publication of the national report 'Future in Mind' which sets out a clear direction for local leadership across the system to work together to improve mental health services and outcomes for children and young people.

2. The Leicester, Leicestershire and Rutland (LLR) Better Care Together programme has eight work streams, one of which is focused on children's services. This work stream has three distinct programme areas: children's hospital; community based services; and emotional health and wellbeing. The Senior Responsible Officers for this work stream are the Chief Nurse for the Leicester City Clinical Commissioning Group (LCCCG) and the Director of Children and Family Services for Leicestershire County Council.

3. The Health and Wellbeing Board has received five reports about the progress of the Better Care Together programme for improving the mental health and wellbeing of children and young people. At its meeting in January the Board agreed that the next progress report would be presented in six months.

4. The County Council's Health Overview and Scrutiny Committee has also asked for information about the progress of this work. This report provides that information.

Policy Framework and Previous Decisions

5. In October 2015, the Health and Wellbeing Board agreed the Transformational Plan to improve the mental health and wellbeing for children and young people. The Plan was also approved by the CCG

Board. The Plan was then submitted to NHS England and received full approval in November 2015.

Financial implications

6. The approval of the Plan secured five years funding for the whole care pathway, from universal preventative programmes to specialist acute services. £1.87m of non-recurrent funding was received in November 2015 relating to the 2015/16 allocation. There was the expectation that this allocation would be made recurrent on top of any national growth in allocations for future years.

7. Following receipt of the confirmed allocations for 2016-17 and beyond, on 8th January, and subsequent clarification supplied by NHS England, the minimum growth uplift for CCGs for 2016-17 was identified as 3.05%. However, the uplift did not include an amount specifically for the delivery of the Transformational Plan. The CCGs were also required to fund the following pressures from that uplift:

   - Provider tariff uplift of 1.1% to 1.8%;
   - Demographic and other activity growth (discussed nationally as between 2.7% and 3.5%);
   - Growth in prescribing, continuing healthcare and a range of other areas that traditionally significantly exceed demographic growth;
   - Compliance with "business rules" to ensure maintenance of 1% surplus, 1% uncommitted headroom and 0.5% uncommitted contingency.
   - Any other cost pressures and investments faced by providers or the CCGs.

8. In order to be able to produce a balanced financial plan for 2016/17, CCGs were therefore required to stringently review and prioritise all developmental and growth areas and as a result £1.87m of recurring budget has been provided to support the implementation of the Plan. The release of this funding is contingent on Clinical Commissioning Board (CCB) approval of Business Cases for each delivery element of the Plan.

Governance

9. A Steering Group was established to progress the Transformation Plan via the Women and Children's work stream of Better Care Together. The Steering Group is co-chaired by the Leicester City CCG Chief Nurse and Leicestershire County Council's Director of Children and Family Services. There is good representation from commissioners and providers across health (including GPs), the 3 local authorities (including Public Health), the voluntary and community sector (through Voluntary Action Leicester - VAL), the Office of the Police and Crime Commissioner, NHS England, and Healthwatch.

10. The Steering Group reports to the three Health and Wellbeing Boards in LLR, as well as through the individual agency assurance and authorisation mechanisms. It also contributes to the Better Care Together governance arrangements as required by virtue of being an identified work stream: 'Children'.

11. Five multi-agency task and finish Delivery Groups were created: Prevention, Early Help, CAMHS Access and Home Treatment, Crisis, and Workforce. These groups have formulated Business Cases for consideration by the Clinical Commissioning Board during June and July 2016.

Progress

12. Partners have worked closely since March 2015 to collaborate on the development and submission of the Transformation Plan and its subsequent delivery. The Plan was launched on 14th April 2016 through an event organized by and held at the offices of VAL. Key Performance Indicators have been identified and a Performance Dashboard will be finalised at the June 2016 meeting of the Steering Group. It is anticipated that the first quarter performance reporting will be available in September 2016. Other progress to date is set out below in relation to the five delivery areas.

EATING DISORDERS

13. The CCB has agreed recurrent investment of £443k into an Leicestershire Partnership Trust (LPT) Eating Disorders Service. This has resulted in the recruitment of permanent staff and will lead to meeting the access target and prompt support for this group of children and young people, including reducing the demand on the Child and Adolescent Mental Health Services (CAMHS) Access Service (see below).

CAMHS ACCESS

14. Over the past few years the providers of CAMHS have failed to meet the 13 week target for the first access to services appointment. There was a backlog of breaches against the 13 week performance indicator, meaning that at the time of the last report to the Health and Wellbeing Board, 250 young people were waiting for more than 13 weeks. Immediate additional resource of approximately £82k was provided supporting four locums with a target to address the backlog to a zero base position by the end of June, by which time a new pathway will be in place. As a result of the additional resource that has been provided and the change in the access to services pathway, the number of children and young people waiting as a result of backlog in May had reduced to 27 and the target to remove the backlog by the end of June is on track.

15. An innovative new pathway has been developed which focuses on a consistent streamlined model across LLR that ensures earlier assessment leading to earlier treatment, where necessary. This involves delivering a structured mental health assessment within 8 weeks of the first contact. The previous 6 points of access have been incorporated into one multi-disciplinary, multi-agency hub, staffed by CAMHS Multi Disciplinary Team clinicians at the Valentine Centre. The additional investment is approximately £192k per annum and the Business Case was presented to the CCB on 26th May 2016.

16. By the end of June a dedicated care navigator system will be in place, ensuring that children and young people with mental health difficulties are able to receive the right care at the right time in a co-ordinated way close to where they live. Care navigation ensures that if CAMHS is not the appropriate service, the child or young person is given access to alternative appropriate support, including access to building resilience resources to support service users and families in supporting themselves.

17. The new pathway also ensures that there is integration with Tier 4 services (where there are significant concerns about the child or young person), the new crisis model, specialist treatment packages, short-term treatment and discharge, discharge to self-care and also the early help offers in all three local authority areas.

CRISIS AND HOME TREATMENT SERVICES

18. This is a system of rapid response and multi-agency assessment of mental health, leading to community services provided by a specialist team with the potential to offer comprehensive acute psychiatric care at home or in the community until the crisis is resolved, usually without hospital admission.

19. The services will be aligned to and work in collaboration with the Adult Crisis Response and Home Treatment service, thus enabling the delivery of a 24/7 assessment of children and young people referred into the service at the point of crisis.

20. The Veritas Report highlighted the need to create a crisis response service to include multi-disciplinary assessment and joined up working between health and social care. The proposed service will avoid the unnecessary use of the Emergency Department and eliminate or reduce the need to use POD 5 in the Agnes Unit for children and young people requiring immediate intervention.

21. The new service team include a consultant psychiatrist, 1 clinical team manager, 5 community psychiatric nurses, 4 social workers, plus administration, ICT, etc. The full Business Case for the new service, requiring resource of £662k in 2016/17 and £1.15m ongoing, will be presented to the Emotional Health and Wellbeing Steering Group in

June before presentation for approval to the CCB in June.

TARGETED EARLY HELP

22. A new multi-agency 'first response' and early help service will provide a clear offer across the three local authority areas, providing targeted support for children and young people with complex emotional, behavioural, and mental health needs which challenge universal services.

23. The service will be aligned to the redesigned LPT primary mental health service, to deliver a community interface model that will have dedicated capacity in communities and named primary health personnel in each LPT/LA neighbourhood. The service will include 6 full time mental health nurses, a co-ordinator and resource for spot purchasing and additional commissioning.

24. This will be further supported by the Children and Young People's 'Improving Access to Psychological Therapies' programme which will upskill staff across all sectors, provide additional capacity in staff supervision and leadership support.

25. The service will interface with the new CAMHS Access model and resilience services and tools.

26. The full Business Case for the new service, requiring resource of £196k in 2016/17 and £352k ongoing, will be presented to the Emotional Health and Wellbeing Steering Group in June before presentation for approval to the CCB in June.

RESILIENCE and WORKFORCE LEARNING AND DEVELOPMENT

27. Business Cases to support the further development of universal services (resilience) and multi-agency workforce learning and development are in preparation and it is anticipated that they will be presented to the CCB in July.

28. A number of new universal services have already been commissioned over the past few months including an online counselling service – 'Kooth', which is already being well-used and has received excellent feedback from service users.

Vanguard

29. "The Vanguard Programme is focused on the delivery of a simplified, integrated system of urgent and emergency care that wraps care around the patients, is easier for patients and staff to navigate and blurs organisational boundaries. The current system is overly complex, containing a number of different entry and exit points and multiple hand overs. The Vanguard Programme seeks to implement the

recommendations of the Keogh review and simplify the urgent and emergency care system, with an emphasis on better self-care, a more consistent, 7 day urgent care system and a redesigned emergency department".

30. As part of the overall Vanguard, a clinical reference group has been established, chaired by a Consultant at Leicester Royal Infirmary. There are 6 strands within the Vanguard project, one of which is mental health and therefore the children and young people's Emotional Health and Wellbeing Steering Group is represented.

31. A Vanguard bid was submitted to support 'All-age Liaison Psychiatry'. At the time of writing, it is anticipated that feedback will be received by 31st May 2016.

32. A further Vanguard will open in August and it is intended to bid for additional resources for an appropriate 'Place of Safety' for children and young people.

Single Pathway

33. During the summer, further work will be completed to ensure that a single pathway to services is developed, incorporating all of the new services set out above and then publicized across all sectors to ensure understanding of the pathway and easy access to it.

Key Performance Indicators

34. A new KPI dashboard will be presented to the Steering Group in June. Once agreed, this will be reported to the Health and Wellbeing Board, the CCBs, and the Better Care Together Board.

Background papers

Report to Health and Wellbeing Board on 7 January 2016 can be accessed via the following link:
http://politics.leics.gov.uk/documents/s115368/HWB%20CAMHS%20Update.pdf

Circulation under the Local Issues Alert Procedure

No

Equality and Human Rights Implications

Effective and early interventions for mental health difficulties can be an important part of reducing inequalities in other outcomes e.g. education attendance and attainment for groups of children and young people with multiple and complex needs, such as adopted children, those not in education or training and children and young people in and leaving care.

The national ‘Future in Mind’ report recognised that commissioners and providers across the whole system need to work together to develop appropriate and bespoke whole care pathways that incorporate models of effective, evidence based interventions for vulnerable children and young people, ensuring those with protected characteristics such as learning disabilities are not turned away.

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Agenda Item 15

Leicestershire County Council

HEALTH OVERVIEW AND SCRUTINY COMMITTEE: 8 JUNE 2016

REPORT OF DIRECTOR OF PUBLIC HEALTH

REMODELLING OF STOP SMOKING SERVICE PROVISION

Purpose of report

1. The purpose of this report is to seek the views of the Health Overview and Scrutiny Committee on the proposed new model for Stop Smoking Service. Formal consultation on these proposals commenced 16 May 2016.

Policy Framework and Previous Decisions

2. The requirement to save £1.1 million from the stop smoking service budget formed part of the Medium Term Financial Strategy 2016/17 – 2019/20 which was considered by the Health Overview and Scrutiny Committee on 8 January 2016 and the Cabinet on 12 February 2016 prior to it being approved by the County Council on 17 February 2016.

3. The Health Overview and Scrutiny Committee also considered the Commissioning Intentions of the Public Health Department at its meeting on 30 March. This included the proposal to decommission the current Stop Smoking service and redesign and commission a new more targeted service including a quit line and face to face support. The Commissioning Intentions were approved by the Cabinet on 19 April 2016.

Background

4. There is a need for stop smoking support to be available in the Leicestershire community as more people die every year from smoking related disease than the next 6 causes of premature death combined. Health inequalities could also grow without a stop smoking service being in place. Leicestershire's overall smoking prevalence is 17% with the Routine and Manual (R&M) prevalence being 28% (not significantly different from the England average), demonstrating the health inequalities gap that needs addressing and could potentially grow without cessation support being available

5. Locally, the current service offer is universal access offer across Leicestershire County. Service delivery is largely face to face and based in GP surgeries and community pharmacies. Although there is an option for text and/or telephone support, this is not the current focus of the service. The service also currently provides an advisor who works exclusively with children in care as well as foster carers and their families.

6. Only five per cent of the 17% of people who smoke in Leicestershire currently access the stop smoking service. The way in which smokers want to quit is also changing, with data published for the past two years showing a significant overall reduction in the number of smokers accessing services nationally. The use of e-cigarettes has significantly increased in popularity and smokers accessing the current service have been enquiring more about telephone and text-based support. Global evidence also suggests that the majority of smokers worldwide quit successfully for the long-term without resource intensive face-to-face support.

7. Taking these factors into account, this paper proposes a new service model that is evidence based, has demonstrated effectiveness internationally and is achievable within a reduced financial envelope.

Proposals/Options

8. It is proposed that the new Stop Smoking Service will be in place by January 2017. The proposal is for three different levels of service to be provided, as follows:-
    - The first level will be a universal offer of supported self-help, provided by First Contact Plus, the multi-agency partnership service which provides countywide early intervention and prevention services for vulnerable individuals aged 16+. It will include access to online resources.
    - The second level will consist of a quitline offering advice and support. The local quitline will provide telephone via a freephone number along with text based and online support. In order to increase the likelihood of successfully quitting, an NRT (Nicotine Replacement Therapy) starter kit and prescription medication will be part of the offer of support as appropriate.
    - The third level will be a targeted face to face offer for those smokers who will most benefit from the more resource-intense face to face offer, such as pregnant women or children in care.

9. The new service would also maintain specialist training support for professionals in the community working with vulnerable groups, from Very Brief Advice (VBA) to motivational interviewing and providing face to face support.

10. The proposals reflect NICE programme guidance on smoking cessation which lists self-help materials, telephone counselling and helplines as stop smoking interventions that are cost-effective. A recent study published in the journal *Addiction* reviewed the efficacy, effectiveness and affordability of health care interventions to promote and assist tobacco cessation. The study concluded that brief advice from a health-care worker, telephone helplines; automated text messaging, and printed self-help materials are globally affordable and effective health-care interventions to promote and assist smoking cessation.

11. The proposals are also informed by international evidence from countries such as Australia, New Zealand, Sweden, Canada and the US which have all successfully implemented quitlines in various formats to help smokers to successfully quit for years.

12. International quitline experience and evidence supports making NRT available alongside support. In practice; however, not all smokers complete a long term course of NRT. It is proposed that the new service will offer an NRT starter pack through the quitline. The rationale for offering a starter pack on a weekly basis is

financial and supported by evidence from the University of Surrey that suggests better (closer) management of medications reduces fallout and encourages patients to complete a course of medication.

13. Prescription (Rx) only medications - Chantix (Varenacline) and Wellbutrin (Bupropion) – will continue to be available through Primary Care alongside support. Currently, Public Health reimburses the Clinical Commissioning Groups (CCGs) for these prescription medications based on a monthly invoice of prescription activity. Options are being explored that would encourage access to smokers who would most benefit from Rx only medications and could also reduce Public Health's financial obligation for Rx only meds.

14. The face to face support is intended to be targeted at specific groups where health inequalities have been identified. This could take a number of forms. Options that are being considered include:-
    - Option A - supporting primary care providers and or other healthcare professionals to provide targeted face to face stop smoking support.
    - Option B - working with Healthcare professionals to ensure they are trained in Very Brief Advice and that they refer to the main support service (the quitline).
    - Option C - providing the same level of training and support given to Healthcare professionals to other professionals working in the community, such as Supporting Leicestershire Families, Local Area Communities coordinators, etc.

15. The preferred option is a combination of B and C that would have the service maintain a strong training and support function to professionals in the community and they will be encouraged and supported to provide Very Brief Advice (VBA) and offer their patients/ clients face to face support as part of the offer to quit.

16. Evidence supports the involvement of primary care in stop smoking services, even if it is limited to VBA and referral **"***An offer of help with stopping by a GP appears to be more effective than advice to stop in promoting smoking cessation*.**"**

Consultation

17. A six week countywide stakeholder consultation on the proposed changes formally commenced 16 May 2016 (it closes midnight on 27 June 2016). The consultation is available and encouraged for anyone who lives, works or is registered to a GP in Leicestershire. In addition to the normal routes for consultation, it has been made available to a wide variety of partners and stakeholders.

18. The consultation process includes presenting at key stakeholder meetings (including local providers, community pharmacists, CCGs and Practice Manager Forums) and speaking with stakeholders and stakeholder groups (the County Council's workers groups, GPs, community pharmacists and smokers themselves). Results will be analysed and used to inform a final version of the remodelled stop smoking service specification.

Resource Implications

19. The remodelling of the stop smoking service is expected to achieve a contribution towards MTFS savings target of £1,100,000 per annum. The total remaining budget for the service will be £600,000 per annum.

20. As part of the service remodel, it is likely that TUPE will apply. We are working with HR as we develop the service model in order to ensure the process goes smoothly.

Timetable for Decisions

21. Following the consideration of this report by the Health and Overview Scrutiny Committee, the final model and re-procurement plan will be presented to the Cabinet on 18th July 2016. This will ensure the timetable for the project is met and a new service can be in place as required by 1st January 2017.

Conclusions

22. The Scrutiny Committee is asked to comment on the new model for smoking cessation as part of the consultation process on the proposed changes in the service.

Background papers

Report to Health Overview and Scrutiny Committee on 20 January 2016: Medium Term Financial Strategy 2016/17 – 2019/20 http://ow.ly/j0bi300wAzs

Report to Cabinet on 12 February 2016: Medium Term Financial Strategy 2016/17 – 2019/20 http://ow.ly/TxB6300wAVR

Report to Health Overview and Scrutiny Committee on 30 March 2016: Commissioning Intentions http://ow.ly/oWiH300wB89

Report to Cabinet on 19 April 2016: Review of the County Council's Strategic Plan and embedding a new approach to Transformation and Commissioning http://ow.ly/ASmt300wBcz

Circulation under Local Issues Alert Procedure

None.

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Relevant Impact Assessments

Equality and Human Rights Implications

23. As part of the development of the new Stop Smoking Service model an Equality Human Rights Impact Assessment (EHRIA) has been undertaken to identify equality issues which need to be taken into account.

24. The EHRIA screening concludes:
    - there is no evidence that this policy will have a different affect or adverse impact on any section of the community;
    - no sections of the community will face barriers in benefiting from the proposal;
    - there will be a positive impact from the proposals in that access to stop smoking support is expected to increase across all parts of the population.

25. There is therefore no requirement for a full EHRIA report.

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HEALTH OVERVIEW AND SCRUTINY COMMITTEE: 8 JUNE 2016

REPORT OF THE CHIEF EXECUTIVE AND COMMISSIONING SUPPORT PERFORMANCE SERVICE

PERFORMANCE UPDATE AT END OF QUARTER 4 2015/16

Purpose of Report

1. The purpose of the report is to provide the Committee with an update on health performance issues based on the available data at the end of quarter 4 of 2015/16.

Background

2. The Committee currently receives a joint report on performance from the County Council's Chief Executive's Department and the Arden/GEM Commissioning Support Performance Service. This particular report encompasses:

   a. Performance against key metrics and priorities set out in the Better Care Fund plan;
   b. An update on key provider performance issues and performance priorities; and
   c. An update on wider public health metrics and performance.

3. The Health Performance Framework and reporting will be refreshed from Autumn 2016 to reflect changes in national health performance reporting as well as new priority areas and metrics emerging from a refresh of the local Health and Wellbeing Strategy, which is underway.

Better Care Fund and Integration Projects

4. The following section of the report summarises final performance against the targets within the previous Better Care Fund (BCF) plan. See table below. Three of the targets have been achieved whilst three didn't achieve the level of improvement sought (though two did improve overall). An outline of some of the wider achievements and delivery from the first BCF Plan is set out in **Appendix 1**.

BCF Metric	Plan Target 2015/16	Actual 2015/16	Status
Metric 1 - permanent admissions of older people to residential and nursing care homes, per 100K pop per year	670.39	642	Achieved
Metric 2 - proportion of older people still at home 91 days after discharge from hospital into reablement/rehabilitation	82.01%	87.50%	Achieved
Metric 3 - delayed transfers of care from hospital per 100K pop	275.60, 256.00, 350.79, 350.48 for Q1 - Q4 respectively	238.74, 233.81, 216.28, 314.98	Achieved
Metric 4 - total non-elective admissions into hospital per 100K pop, per month (2015)	717.44	738.07	Not achieved – see para 5-9
Metric 5 - patient/service user experience - patients satisfied with support to manage long term conditions	66.4%	61.6%	Not achieved - improvement on baseline of 60.9%
Metric 6 - emergency admissions for injuries due to falls people aged 65+, rate per 100K pop per month	140.47	147.34	Not achieved; improvement on 2014/15

5. In relation to **emergency admissions reduction** a number of schemes have been funded through the Better Care Fund plan to help reduce the increasing number of admissions. The schemes achieved 1,581 avoided admissions between 1st January 2015 and 31st December 2015, against a target of 2,041. The schemes involved are 7 day GP services, the Older Persons' Unit at Loughborough, Integrated Crisis Response Service and Loughborough Urgent Care Centre additional pathways.

6. Some of the progress on reducing emergency admissions from the previous BCF Plan activity includes -

- ✓ Implemented the frail older people's assessment unit at Loughborough Hospital with 540 people referred and 377 avoided admissions between January to December 2015.
- ✓ Trained 81% of paramedics in the falls risk assessment tool so that an average of 37% people per month are now not conveyed to hospital; but receive care and support at home instead.
- ✓ Implemented Night Nursing so that the existing Integrated Crisis Response Service can operate 24/7, with 470 referrals and 437 avoided admissions achieved in the Night Nursing Service during 2015.

- ✓ Piloted seven day services in primary care across both Clinical Commissioning Groups (CCGs) with evaluation findings informing models and admissions avoidance assumptions for 2016 onwards.

7. The Leicestershire BCF plan during 2015/16 had a strong focus on admissions avoidance, with the admission avoidance schemes implemented and performance managed intensively throughout the year. These schemes have had demonstrable impact, albeit the overall rise in emergency admissions across Leicester, Leicestershire and Rutland (LLR) has remained extremely challenging. Four BCF schemes were formally evaluated as part of the BCF refresh. Two new admissions avoidance schemes are also being incorporated within the 2016/17 plan. Driving down the number of admissions and readmissions continues to be an important feature of the approach.

8. It can be demonstrated that three of the four emergency admissions avoidance schemes in Leicestershire (GP seven day services pilots were the fourth) have delivered measurable impact in 2015/16 in terms of admissions avoidance in the BCF target cohort (older people). This is evidenced in falls non-conveyance figures for example, data from the new Care and Healthtrak system, clinical audit and independent academic evaluation outputs which support/triangulate these findings. A more rigorous implementation plan for falls prevention is being implemented in 2016/17 as part of a new LLR wide Falls Strategy.

9. Despite the schemes contributing to the achievement of reducing the increase in emergency admissions they have yet to achieve the full target trajectory. An action plan to address and improve the utilisation of the schemes continues and is being monitored by the Step Up/Step Down Programme Board in order to continually assess the confidence level of the schemes meeting the required targets.

10. In relation to **delayed transfers of care** included in the BCF is a metric relating to the number of *days* people are delayed in hospital awaiting discharge. The BCF had four quarterly targets for 2015/16, each of which has been met. Delayed Transfer of Care (DToCs) *attributable to adult social care* are calculated by taking an average of the number of delays on the last Thursday of each month. There has been significant improvement during 2015/16 such that the average of 5.6 is a marked improvement on 11.5 during the previous year.

11. Overall the number of days lost due to a delayed transfer of care has fallen during 2015/16 compared to the previous year. For NHS attributable delays the number of days has fallen by a third to 12,400. For adult social care attributable delays there has been a 44% reduction down to 1,800 days in 2015/16.

12. **Comparing performance in Leicestershire to other similar and regional authorities** - For this group of councils the average of all delays, regardless of who they were attributable to has remained similar to the previous year whilst the average for Leicestershire has reduced from 15.9 delays per 100K population in 14/15 to 9.0 delays in 2015/16. For the same group of authorities the average number of people delayed attributable to adult social care has increased from 2.9

per 100k in 2014/15 to 3.6 in 2015/16. In contrast during the same period Leicestershire's delays have dropped from 2.2 per 100k pop in 14/15 to 1.0 per 100k in 2015/16.

13. **Appendix 2** contains more information on the **new BCF Plan indicators and targets** applying from April 2016. Future reporting to the Committee will be against these new targets. These are all 2016/17 targets.

    1. Metric 1 – residential and nursing home admissions – 630.1 per 100k per year
    2. Metric 2 – reablement – 84.2% for each rolling 3 month period
    3. Metric 3 – DTOC quarterly targets - 238.03, 233.25, 215.90, 220.69 per 100k
    4. Metric 4 – non-elective admissions – 726.38 per 100K per month
    5. Metric 5 – patient experience – 63.5%
    6. Metric 6 – falls – 145.24 per 100K per month

Provider and CCG Dashboard - Appendix 3

14. Attached as Appendix 3 is a dashboard that summarises information on provider and CCG performance. The Everyone Counts Dashboard sets out the rights and pledges that patients are entitled to through the NHS. 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.

15. In March NHS England published a new **Improvement and Assessment Framework (IAF) for CCGs**. From 2016/17 this will replace the existing CCG Assurance Framework. The Framework includes a set of 57 indicators across 29 areas. In the Government's Mandate to NHS England the new framework takes an enhanced and more central place in the overall arrangements for public accountability of the NHS. The IAF has been designed to supply indicators for adoption in Sustainability and Transformation Plans as markers of success. Future reports will look to include relevant indicators from the new Framework, taking into account contents of the local Sustainability and Transformation Plan and revised Health and Wellbeing Strategy. In the meantime the contents of this report are based on the performance framework in place for 2015/16.

University Hospitals of Leicester (UHL) Emergency Department (ED). Waiting Time < 4 Hours

16. Concerns about emergency care continue. UHL have seen a slight increase in performance in April 2016, although performance remains much worse than this time last year. Due to ward reconfiguration work, medicine has access to 28 fewer beds now at the LRI than the same time last year. UHL problems continue to be driven primarily by high attendance and admissions, although admissions in the first three weeks of this financial year are similar to last year. Key updates include that UHL have now recruited to the vacant Head of Nursing and Head of Operations posts in the Emergency Department (ED) and are trialling all ward admissions being reviewed by an ED senior decision maker or Acute Physician. The Clinical Management Group (CMG) is also increasing its management presence within ED to support and push performance improvements in May.

17. The following remain the three most important areas for the health system to focus on: Admission avoidance – ensuring people receive care in the setting best suited to their needs rather than the Emergency Department. Preventative care – putting more emphasis on helping people to stay well with particular support to those with known long-term conditions or complex needs. Discharge processes across the whole system - ensuring there are simple discharge pathways with swift and efficient transfers of care.

Ambulance Response Times, Handovers between UHL ED and Ambulance and Ambulance Crew Clear

18. East Midlands Ambulance Service (EMAS) and UHL continue to have weekly conference calls to manage improvements in ambulance handovers. The team has continued to improve internal processes and an escalation process for patients on ambulances (POAs) has been introduced to support early decision making and management of flow, decreasing long waits for handover. The trial of using minors as majors to increase capacity by 9 cubicles in April made a significant difference to ambulance handovers and as such an expansion of the trial is being planned. Improvement is still required as UHL remains an outlier for long ambulance handovers, and as such this is a priority for the Group to improve.

Cancelled Operations - non re-admitted in 28 days

19. The availability of beds, particularly those in ITU, is monitored daily and interventions will be made where necessary. The planned opening of an additional 6 ITU beds at the LRI is anticipated by the end of April. Theatre Managers have increased theatre capacity for the increased cancer demand by making additional lists available. Theatre capacity planning for 2016/17 is well underway and incorporates the increased demand. The day ward has now been allocated exclusively for surgical patients in order to try to increase the elective throughput.

52 Week waiters at UHL. *(This relates to 227 Orthodontic patients (all CCGs), this service is commissioned by NHS England)*

20. With the Trust Development Authority and NHS England, UHL have identified treatment opportunities from across the regional health economy for the majority of the patients on the orthodontics waiting list and are in talks with two further providers, which would guarantee capacity for all patients to be treated in the East Midlands area either in a community provider or a secondary care trust. The service team are in the process of transferring patients to these providers, explaining the drop in reported numbers from the end of February (261).The Trust is reporting weekly to the Trust Development Authority.

Diagnostic Waiting Times < 6 weeks

21. Imaging-machine stability remains an issue; all extra capacity is being utilised in MRI to minimise the number of breaches. Some extra sessions continue that run up to midnight. Endoscopy - twice-weekly phone calls are taking place between

the performance function and the Endoscopy service team to ensure momentum and help problem solving. While Imaging-machine stability capacity is now being scaled back, there will be 2 Medinet and one 'Your World' list in April to ensure that the capacity lost through the junior doctor strikes is accounted for. The extra capacity is complemented by a robust action plan addressing general performance issues in the service, with particular focus on ensuring that all lists are fully booked and efforts to improve cancer performance via access to Endoscopy tests.

Cancer

22. Current cancer performance is an area of concern across UHL and focus on recovery is one of the Trust's highest priorities. The weekly cancer action board chaired by the Director of Performance and Information, with mandatory attendance by all tumour site leads ensures that corrective actions are taken. The Trust has initiated a programme, 'Next Steps' for cancer patients in 3 key tumour sites. The pilot started in the Prostate pathway in early April.

Improved Access to Psychological Therapies

23. Performance in March has improved significantly with both CCGs falling just short of the national target of 15% (WL – 14.6% and ELR – 14%). Examples of actions to address performance include increasing the number of agency staff, introducing 2 evening assessment clinics run by staff on overtime, ensuring that all cancellations through the service are filled with assessments and one of the high intensity agency staff will be undertaking extra work to undertake an assessment clinic.

Unplanned Hospitalisation and Emergency admissions

24. In relation to West Leicestershire CCG examples of schemes aimed at reducing emergency admissions include weekly real time data review providing feedback to practices; on the day access schemes, acute visiting service (AVS), weekend Access Service: On Call GP/Emergency Care Practitioner (ECP) and care home weekend AVS. ELR actions are to include extended GP services, implementing the primary care weekend access scheme targeting 2% at risk/end of life/ moderate-frequent flyer patients; maximising appropriate use of increased specialist medical cover to allow increased referrals from GPs, Acute Visiting Service (AVS) and EMAS. Deploying LHIS support to access GP care plans for ED clinicians and upskilling ED ward clerks in accessing primary care information via LHIS.

Estimated diagnosis rate of people with dementia

25. In relation to West Leicestershire the March 16 dementia diagnosis rate figures shows the CCG has achieved 66.4% diagnosis rate narrowly missing the national 67% target by 25 patients. The CCG will be looking to continue the momentum in 2016/17 by running the Dementia Quality Toolkit in those practices with Care Homes. ELR are working with LPT to look at ELR waiting list times for the Memory Access Clinic. A full afternoon educational session focussed on GPs/Nurses/HCAs/Practice Managers and admin staff is being arranged for June

2016 to increase clinical knowledge and general awareness and understanding of dementia. The first BCT Dementia delivery group meeting took place on the 22nd of March with ELR Clinical Lead Dr Girish Purohit as Chair and Caroline Kirkpatrick (ELR) managerial lead.

Incidence of health associated infection CDIFF

26. As previously reported the maximum number of CDiff cases across West Leicestershire was exceeded in 2015/16 by 28 cases. Across ELR the national standard was exceeded by 1 case in 2015/16. The standard remains the same in 2016/17 for all CCGs and Providers. Work will continue to review cases to identify any common themes.

Public Health Outcomes Performance – Appendix 4

27. Appendix 4 sets out current performance against targets set in the current performance framework for public health. In February 2016 Public Health England published an update to the public health outcomes framework (PHOF). In terms of high level outcomes 14 indicators are presented and Leicestershire is better than the England average for six of these. No indicators perform significantly worse than the England average.

28. The PHOF also summarises a range of other performance indicators grouped under four domains. Overall Leicestershire performs well for a wide range of indicators (Better 96, Similar 52). However, there are a small number of areas where Leicestershire performs below average. These are summarised below for information:-
    - Wider Determinants of Health – school readiness, social isolation;
    - Health Improvement – newborn bloodspot screening coverage, NHS health checks take-up;
    - Health Protection – chlamydia detection, flu vaccination coverage;
    - Health Care – preventable sight loss, excess winter deaths - males aged 85+.

29. In relation to newborn bloodspot screening coverage the indicator measures the timeliness in getting results rather than actual coverage. Performance is dependent on the performance of relevant specialist centres rather than the County Council Public Health function. In relation to flu vaccination this is commissioned by Public Health England. However the public health team is working to improve the role of the Health Protection Board across the County in addressing these issues. The Council is also encouraging people to have seasonal flu vaccination, with free vaccines offered to those considered to be at risk. In relation to excess winter deaths the council is working closely with other agencies to provide advice and support to help people stay warm and healthy in the home. Also encouraging individuals and communities to play there part in checking on family, friends and neighbours and encouraging people to have seasonal flu vaccination. The Warm Homes, Healthy Homes scheme funded by the Council also offers advice.

30. A number of the PHOF indicators were updated in a data release in May 2016 and Appendix 4 summarises the latest position. A number of issues flagged

include take up of the NHS Health Check Programme, completions of drug treatment - non-opiate users, smoking quitters and mental health – excess mortality and suicide rates. In relation to drug treatment - for opiates the completion and non-representation in six months data for the latest quarter 3 is 8.5% which is in the top quartile though below the baseline period. 62.2% are estimated to be in treatment compared with 52% nationally. For non-opiate clients it is 36.2% for completion and non-representation, which is below the national average.

31. Further consideration will be given to actions to tackle these areas as part of the new Health and Wellbeing Strategy and public health service plan development process.

Recommendations

32. The Board is asked to:

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

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

List of Appendices

Appendix 1– Better Care Fund Track Record of Delivery

Appendix 2 – BCF – New Metrics and Targets 2016/17

Appendix 3 – Provider and CCG Dashboard

Appendix 4 – Public Heath Performance Dashboard.

Background papers

University Hospitals Leicester Trust Board meetings can be found at the following link:
http://www.leicestershospitals.nhs.uk/aboutus/our-structure-and-people/board-of-directors/board-meeting-dates/

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APPENDIX 1 - BCF TRACK RECORD OF DELIVERY IN 2015/16

Progress Achieved by the 2015/16 BCF Plan

The Leicestershire BCF Plan is delivered under four themes. The themes are designed to group together related activity/projects so that:

- These are managed and governed effectively within the local integration programme.
- Their contribution and outputs are connected effectively to LLR-wide governance, where applicable.

BCF THEME 1: Unified Prevention Offer	**BCF THEME 2: Long Term Conditions**
• Integration of prevention services in Leicestershire's communities into one consistent wrap-around offer for professionals and services users. • Improved, systematic, targeting, access and coordination of the offer.	• Integrated, proactive case management from multidisciplinary teams for those with complex conditions and/or the over 75s. • Integrated data sharing and records, for risk stratification, care planning and care coordination.
BCF THEME 3: Integrated Urgent Response	**BCF THEME 4: Hospital Discharge and Reablement**
• Integrated, rapid response community and primary care services 24/7 • Working together to avoid unnecessary hospital admissions, supporting people at home wherever possible.	• Safe, timely and effective discharge from hospital, via consistent pathways, reducing length of stay • "Home First" philosophy, focused on reablement and maintaining independence.

Progress by Theme

Implementation of the integration programme in Leicestershire continues at pace. The following table is a summary of our achievements to date:

Unified Prevention Offer ✓ Launched Local Area Coordinators in eight localities to support vulnerable people and extend the availability and uptake of our community based assets. ✓ Implemented the Lightbulb Housing Offer with pilots operating across three localities targeted to improving health and wellbeing. ✓ Redesigning adaptation processes with district council partners and designing a new "housing MOT."	**Integrated, Proactive Care for those with Long Term Conditions** ✓ Rolled out integrated locality working between community nursing and social workers so that they jointly respond and manage their caseloads using shared operational practices and procedures – organised to support both planned care and urgent care cases in each locality. ✓ Adopted NHS number onto 94% of adult social care records.
Integrated Urgent Response ✓ Implemented the frail older people's assessment unit at Loughborough Hospital with 540 people referred and 377 avoided admissions between January to December 2015. ✓ Trained 81% of paramedics in the falls risk assessment tool so that an average of 37% people per month are now not conveyed to hospital; but receive care and support at home instead. ✓ Implemented Night Nursing so that our existing Integrated Crisis Response Service can operate 24/7, with 470 referrals and 437 avoided admissions achieved in the Night Nursing service during 2015. ✓ Piloted seven day services in primary care across both CCGs with evaluation findings informing models and admissions avoidance assumptions for 2016 onwards. ✓ Achieved 1,581 avoided admissions from the above schemes between 1st January 2015 and 31st December 2015, against a target of 2,041.	**Hospital Discharge and Reablement** ✓ High impact interventions prioritised for 2015/16 BCF funding for improving DTOC, which ensured we achieved the DTOC target in Q1 (for the first time since 2011) and sustained good performance throughout 2015/16. ✓ Introduced dedicated housing support to acute and mental health inpatient settings to support hospital discharge, (featured in the HSJ in October). ✓ Redesigned domiciliary care service resulting in business case and joint specification for NHS and LA partners to commission a new service with effect from 2016/17.

Progress with BCF Enablers in 2015

Progress with BCF Enablers in 2015
• Implemented Care and Healthtrak – the new data integration tool for LLR. Care and Healthtrak is now a business as usual tool for measuring the impact of Better Care Together and BCF/integration developments in LLR. • Introduced the safe minimum transfer data set for hospital discharge. • Individual trajectories developed for each of the emergency admissions avoidance schemes with ongoing performance management. • Evaluated the emergency admissions avoidance schemes in conjunction with Loughborough University, Healthwatch Leicestershire and SIMUL8 to inform commissioning intentions for 2016, and with a view to publishing and disseminating our findings and methodology regionally and nationally in 2016. • Emma's story animation published (https://youtu.be/AU8CK-LT3dU) highlighting the approach to emergency admissions avoidance in Leicestershire, featured in the national Better Care Exchange Bulletin. • Social isolation campaign being launched in early 2016. • Integration Stakeholder Bulletins published quarterly featuring our progress and case studies (www.leics.gov.uk/healthwellbeingboardnews#hcibulletins). • Work of the Integration Programme promoted via @leicshwb twitter feed.

Appendix 2 - Better Care Fund Metrics – Targets for 2016/17

The following table explains the definition of each metric, and the rate of improvement we are aiming for in each case.

National Metric (1)	Definition	Trajectory of improvement
Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population	This is a nationally defined metric measuring delivery of the outcome to reduce inappropriate admissions of older people to residential care.	The target for 2016/17 has been set at 630.1 per 100,000 based on the 2015/16 target of 670.4 per 100,000 and a 90% confidence level that the trajectory is decreasing. Current performance is on track to achieve the target for 2015/16. As part of the development of a four year adult social care strategy, detailed analysis of this metric has taken place and the target set accordingly. In 2014/15 there were 710.5 permanent admissions per 100,000 people. In 2015/16 this is likely to reduce to 669.6 per 100,000 people.

National Metric (2)	Definition	Trajectory of improvement
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	This is a nationally defined metric measuring delivery of the outcome to increase the effectiveness of reablement and rehabilitation services whilst ensuring that the number of service users offered the service does not decrease. The aim is therefore to increase the percentage of service users still at home 91 days after discharge.	The target for 2016/17 has been set at 84.2%, based on the expected level of 82.6% being achieved in 2015/16 and a 75% confidence interval that the trajectory is increasing. The lower confidence interval has been chosen to ensure that the target is realistic and achievable. Performance is currently on track to meet the 2015/16 target of 82.0%. As part of the development of a four year adult social care strategy, detailed analysis of this metric has taken place and the target set accordingly. In 2014/15 83.8% of reablement service users were still at home after 91 days. In 2015/16 this is likely to reduce to 82.6%. Due to the introduction of a Help to Live at Home scheme planned for November 2016, a conservative target has been set.

National Metric (3)	Definition	Trajectory of improvement
Delayed transfers of care from hospital per 100,000 population (average per month)	This is a nationally defined metric measuring delivery of the outcome of effective joint working of hospital services (acute, mental health and non-acute) and community-based care in facilitating timely and appropriate transfer from all hospitals for all adults. The aim is therefore to reduce the rate of delayed bed days per 100,000 population.	Recent reductions in delays have focussed on interventions in the acute sector. We have therefore set a target based on reducing the number of days delayed in non-acute settings by 0.5%, while maintaining the rate of days delayed in acute settings at its current low level. The targets are quarterly and are 238.0, 233.3, 215.9, 220.7 for quarters 1 to 4 of 2016/17 respectively. As part of the development of a four year adult social care strategy, detailed analysis of this metric has taken place and the target set accordingly. Substantial improvement in the rate of days delayed has been achieved – the annual rate has dropped from 4,753 per 100,000 in 2014/15 to a probable 2,730 per 100,000 in 2015/16.

National Metric (4)	Definition	Trajectory of improvement
Non-Elective Admissions (General & Acute)	This is a nationally defined metric measuring the reduction in non-elective admissions which can be influenced by effective collaboration across the health and care system. Total non-elective admissions (general and acute) underpin the payment for performance element of the Better Care Fund.	In 2014/15 there were 58,479 non-elective admissions for Leicestershire residents, In 2015/16 it is likely that there will be 59,957. The proposed target for 2016/17 is 726.38 per 100,000 per month, based on a 2.49% reduction on the probable number of non-elective admissions for patients registered with GP practices in Leicestershire for 2015/16 (allowing for population growth). This equates to no more than 58,836 admissions in 2016/17. This assumption has been aligned with final CCG operational plan targets. All existing admission avoidance schemes have been subject to evaluation in 2015/16, and the

		results reflected in the development of a trajectory of 1,517 avoided admissions from these schemes in 2016/17.

National Metric (5)	Definition	Trajectory of improvement
Improved Patient Experience	Selected metric for BCF Plan from national menu: - taken from GP Patient Survey: "In the last 6 months, have you had enough support from local services or organisations to help manage long-term health condition(s)? Please think about all organisations and services, not just health." The metric measures the number of patients giving a response of "Yes, definitely" or "Yes, to some extent" to the above question in the GP Patient Survey in comparison to the total number of responses to the question.	It is proposed to set this target at 63.5% for 2016/17 (data will be released February 2017). This is based on the 2015/16 target (data due for release July 2016) and a 2% increase in the number of positive replies. Current performance of 61.6% (January 2016) is below the England average of 63%.

Local Metric (6)	Definition	Trajectory of Improvement
Injuries due to falls in people aged 65 and over	This is a locally defined metric measuring delivery of the outcome to reduce emergency admissions for injuries due to falls in people aged 65 and over.	It is proposed that this target is set at 1742.9, based on holding the number of admissions for injuries due to falls steady for the 65-79 age group (a reduction in the rate per 100,000 from 678.9 to 664.0) while lowering the rate per 100,000 for the 80+ age group from 7,919.1 to 7,523.1 (this equates to 25 fewer admissions in the year despite the increase in population) The latest published data (2014/15) shows Leicestershire as having a directly standardised rate significantly better than the England average for the whole age 65+ cohort and for the separate 65-79 age group and the 80+ age group.

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APPENDIX 3 — PROVIDER & CCG INDICATORS — March 2015/16

		Indicator	Latest Data	Data Period	Trend	DOT	RAG	Indicator	Latest Data	Data Period	Trend	DOT	RAG
UHL	Patient Experience	♦ Friends & Family Test Score - in-patients	**97.0%**	Q4 15/16		↑	G	♦ Friends & Family Test Score - A&E	**96.0%**	Q4 15/16		→	G
		♦ Friends & Family Test Score - Maternity	**95.0%**	Q4 15/16		→	G						
	ED Waiting Times	♦ UHL Emergency Dept. Waiting Time < 4 Hours	**87.0%**	15/16		→	R	♦ 12 Hour Trolley Waits	**0**	15/16	LOW	→	G
		♦ Emergency Dept. Handovers between UHL ED & Ambulance > 30 mins	**20.6%**	15/16	LOW	→	R	♦ Emergency Dept. Handovers between UHL ED & Ambulance > 1 Hour	**12.6%**	15/16	LOW	↓	R
	DTOC	♦ UHL Delayed Transfers of Care - no. of patients as a % of occupied bed days	**1.8%**	15/16	LOW	→	G						
	Hospital Quality	♦ Cancelled Operations - non re-admitted in 28 days	**96.0%**	15/16		→	R	♦ Cancelled operations- Cancelled for a second time	**0**	15/16	LOW	→	G
		♦ Pressure Ulcers (Grade 2)	**89**	15/16	LOW	→	G	♦ Pressure Ulcers (Avoidable Grade 3 & 4)	**34**	15/16	LOW	→	G
		♦ Mixed Sex Accommodation	**No Leics County patients**	15/16	LOW	→	G	♦ Safety Thermometer (% No Harms)	**94.4%**	42430		→	G
		♦ Never Events	**1**	15/16	LOW	→	R	♦ 52 Week waiters (incomplete)	**227**	Dec-15	LOW	↑	R
ALL PROVIDERS	Referral to Treatment	♦ 18 Week Referral to Treatment Incomplete (All Providers) (WLCCG)	**95.0%**	15/16		→	G	♦ 18 Week Referral to Treatment Incomplete (All Providers) (ELRCCG)	**95.0%**	15/16		→	G
	Diagnostic Waiting Time	♦ Diagnostic Waiting Times < 6 weeks (All Providers) (WLCCG)	**95.0%**	15/16		↑	R	♦ Diagnostic Waiting Times < 6 weeks (All Providers) (ELRCCG)	**94.0%**	15/16		↑	R
	Cancer Wait Times	♦ Cancer 2 week wait (WLCCG)	**91.3%**	15/16		↑	A	♦ Cancer 2 week wait (EL&RCCG)	**91.4%**	15/16		→	A
		♦ Cancer 2 week wait Breast symptoms (WLCCG)	**93.1%**	15/16		→	G	♦ Cancer 2 week wait Breast symptoms (EL&RCCG)	**95.0%**	15/16		→	G
		♦ Cancer 31 day (WLCCG)	**95.6%**	15/16		→	G	♦ Cancer 31 day (EL&RCCG)	**96.0%**	15/16		→	G
		♦ Cancer 31 day surgery (WLCCG)	**88.2%**	15/16		↓	R	♦ Cancer 31 day surgery (EL&RCCG)	**86.1%**	15/16		→	R
		♦ Cancer 31 day anti cancer drug (WLCCG)	**99.5%**	15/16		→	G	♦ Cancer 31 day anti cancer drug (EL&RCCG)	**100.0%**	15/16		→	G
		♦ Cancer 31 day radiotherapy (WLCCG)	**94.3%**	15/16		→	G	♦ Cancer 31 day radiotherapy (EL&RCCG)	**96.1%**	15/16		→	G
		♦ Cancer 62 day (WLCCG)	**78.7%**	15/16		→	R	♦ Cancer 62 day (EL&RCCG)	**78.3%**	15/16		→	R
		♦ Cancer 62 day - from screening service (WLCCG)	**89.3%**	15/16		↓	A	♦ Cancer 62 day - from screening service (EL&RCCG)	**86.1%**	15/16		↓	A
		♦ Cancer 62 day - consultant upgrade (WLCCG)	**88.9%**	15/16		→	R	♦ Cancer 62 day - consultant upgrade (EL&RCCG)	**100.0%**	15/16		→	G
		♦ Ambulance Response Times Cat A Red 1 (8 minutes) conditions life threatening & most time critical (WLCCG)	**59.0%**	15/16		→	R	♦ Ambulance Response Times Cat A Red 1 (8 minutes) conditions life threatening & most time critical (ELRCCG)	**56.0%**	15/16		→	R

KEY: Directional Arrows show direction of travel from the previous data reported (↑ = improving performance, ↓ = declining performance, → = no change)

KEY: G - On target or on track to meet target, A - Off target by narrow margin, R - Off target by significant amount

APPENDIX 3 PROVIDER & CCG INDICATORS March 2015/16

		Indicator	Latest Data	Data Period	Trend	DOT	RAG	Indicator	Latest Data	Data Period	Trend	DOT	RAG
EMAS	East Midlands Ambulance Service	♦ Ambulance Response Times Cat A Red 2 (8 minutes) conditions life threatening & most time critical, less so than Red 1 (WLCCG)	50.0%	15/16		→	R	♦ Ambulance Response Times Cat A Red 2 (8 minutes) conditions life threatening & most time critical, less so than Red 1 (ELRCCG)	45.0%	15/16		→	R
		♦ Ambulance Response Times Cat A - ambulance arriving at the scene within 19 minutes (WLCCG)	81.0%	15/16		→	R	♦ Ambulance Response Times Cat A - ambulance arriving at the scene within 19 minutes (ELRCCG)	77.0%	15/16		→	R
		♦ Ambulance Response Times Cat A Red 1 (8 minutes) conditions life threatening & most time critical	69.0%	15/16		→	R	♦ Ambulance Response Times Cat A Red 2 (8 minutes) conditions life threatening & most time critical, less so than Red 1	61.0%	15/16		→	R
		♦ Ambulance Response Times Cat A - ambulance arriving at the scene within 19 minutes	87.0%	15/16		→	R						
		♦ Emergency Dept. Ambulance Crew Clear > 30mins	4.0%	15/16	LOW	→	R	♦ Emergency Dept. Ambulance Crew Clear > 60 mins	0.9%	15/16		→	R
IAPT	Mental Health	♦ Psychological Therapies - % of people who enter the service (WLCCG)	14.6%	15/16		→	G	♦ Psychological Therapies - % of people who enter the service (EL&RCCG)	14.0%	15/16	LOW	→	A
		♦ Psychological Therapies- Recovery rate (WLCCG)	51.0%	15/16		↑	G	♦ Psychological Therapies- Recovery rate (EL&RCCG)	55.0%	15/16	LOW	→	G
		♦ Pyschological Therapies - 6 week waits (WLCCG)	45.0%	15/16		↑	R	♦ Pyschological Therapies - 6 week waits (EL&RCCG)	52.0%	15/16		↑	R
		♦ Psychological Therapies- 18 week waits (WLCCG)	95.0%	15/16		→	G	♦ Psychological Therapies- 18 week waits (EL&RCCG)	97.0%	15/16		→	G
LPT	Mental Health	♦ % Delayed Patients (DToC) - Mental Health	6.5%	YTD Mar 16	LOW	↓	G	♦ Occupancy Rate - Mental Health	90.5%	YTD Mar 16		↓	R
		♦ Average Length of Stay - Mental Health	65.1	Mar-16	LOW	↑		♦ Median Length of Stay - Mental Health	26	YTD Mar 16	LOW	↓	
		♦ % of patients under adult mental illness on CPA who were followed up within 7 days of discharge from psychiatric in-patient care (WLCCG)	96.0%	YTD Feb 16		→	G	♦ % of patients under adult mental illness on CPA who were followed up within 7 days of discharge from psychiatric in-patient care (ELRCCG)	96%	YTD Feb 16		→	G
		♦ Early intervention in Psychosis - % newly diagnosed cases against commissioner contract	125.0%	YTD Mar 16		↓	G						
	Community & Other	♦ % Delayed Patients (DToC) - Community	1.0%	YTD Mar 16	LOW	↑	G	♦ Occupancy Rate - Community	91.2%	YTD Mar 16		↑	A
		♦ Average Length of Stay - Community Hospital rehab wards	16.80%	YTD Mar 16	LOW	↓		♦ % Admissions Gate Kept	99.5%	YTD Mar 16		↑	G
		♦ Total number of Home Treatment episodes carried out by Crisis Resolution team year to date	2071	YTD Mar 16		↑	G	♦ Patient experience of community mental health services					
	Quality - Safe Care	♦ Never Events	0	YTD Mar 16	LOW	→	G	♦ Patients safety incidents reporting	8874	YTD Jan 16		↑	
		♦ STEIS - SI actions plans implemented within timescales	96.1%	YTD Mar 16		↑	A	♦ Compliance with hygiene code		YTD Mar 16	LOW		
		♦ MRSA Bacteraemia Cases - Community	0	YTD Mar 16	LOW	→	G	♦ Clostridium Difficile (C Diff) Cases	12	YTD Mar 16	LOW	↓	R

KEY: Directional Arrows show direction of travel from the previous data reported (↑ = improving performance, ↓ = declining performance, → = no change)

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APPENDIX 3 — CCG INDICATORS — March 2015/16

CLINICAL COMMISSIONING GROUP

	Indicator	WL CCG Latest Data	WL CCG Data Period	WL CCG Trend	WL CCG DOT	WL CCG RAG	EL&R CCG Latest Data	EL&R CCG Data Period	EL&R CCG Trend	EL&R CCG DOT	EL&R CCG RAG
DOMAIN 1	♦ 1 year survival from all cancers	68.3	2013		⇧	G	70	2013		⇨	G
	♦ 1 year survival from breast, lung and colorectal cancer	68.4	2011		⇨	G	69.6	2011		⇨	G
	♦ Potential years of life lost (PYLL) from causes considered amenable to healthcare	1764.2	2014	LOW	⇨	A	1978.7	2014	LOW	⇨	R
DOMAIN 2	♦ Unplanned Hospitalisation for chronic ambulatory care sensitive conditions (adults) per 100,000 population	766	15/16	LOW	⇨	R	807	15/16	LOW	⇨	R
	♦ Unplanned Hospitalisation for asthma, diabetes and epilepsy in under 19s per 100,000 population	164	15/16	LOW	⇨	R	168	15/16	LOW	⇨	R
	♦ Health-related quality of life for people with long term conditions	74.6	2014/15		⇨	R	75.5	2014/15		⇨	A
	♦ Estimated diagnosis rate of people with dementia	66.4%	Mar-16		⇧	R	62.0%	15/16		⇧	R
	♦ Proportion of people feeling supported to manage their own condition	62.1%	2014/15		⇨	R	65.1%	2014/15		⇨	R
	♦ Employment of people with long term conditions (difference between England population and people with LTC)	14.5%	Leics July 15 - Sept 15	LOW	⇨	R	14.5%	Leics July 15 - Sept 15	LOW	⇨	R
	♦ Health-related quality of life for carers	0.814	2014/15		⇨	G	0.83	2014/15		⇨	A
	♦ Employment of people with mental illness (difference between England population and people with mental illness)	25.8%	Leics July 15-Sept 15	LOW	⇧	R	25.8%	Leics July 15-Sept 15	LOW	⇧	R
DOMAIN 3	♦ Emergency Admissions for acute conditions that should not usually require hospital admission	1081	15/16	LOW	⇨	R	1113	15/16	LOW	⇨	R
	♦ Rate of emergency admissions within 30 days of discharge	1508	15/16	LOW	⇨	R	1631	15/16	LOW	⇨	R
	♦ Emergency Admissions for children with Lower Respiratory Tract Infections (LRTI) per 100,000 population	219	15/16	LOW	⇨	R	254	15/16	LOW	⇨	R
DOMAIN 4	♦ Overall experience of NHS Dental Service	86.0%	Jan-Sept 15		⇨	G	87.0%	Jan-Sept 15		⇧	G
	♦ Access to GP Services	73.0%	Jan-Sept 15		⇨	R	71.0%	Jan-Sept 15		⇩	R
	♦ Access to NHS Dental Services	95.0%	Jan-Sept 15		⇨	G	93.0%	Jan-Sept 15		⇨	R
DOMAIN 5	♦ Incidence of health associated infection MRSA	0	15/16	LOW	⇨	G	0	15/16	LOW	⇨	G
	♦ Incidence of health associated infection CDIFF	105	15/16	LOW	⇨	R	79	15/16	LOW	⇩	R
PRIMARY CARE	♦ Satisfaction with the quality of consultation at a GP Practice	435	Jan-Sept 15		⇧	G	435	Jan-Sept 15		⇩	R
	♦ Satisfaction with the overall care received at Surgery	85.0%	Jan-Sept 15		⇨	G	84.0%	Jan-Sept 15		⇨	R

APPENDIX 4 — PUBLIC HEALTH AND PREVENTION INDICATORS — March 2015/16

		Indicator	Latest Data	Data Period	Trend	DOT	RAG	Indicator	Latest Data	Data Period	Trend	DOT	RAG
PUBLIC HEALTH	PH12	Slope index of inequality in life expectancy at birth (Males) (Leics) (PHOF 0.2iii)	**6.20**	2012-14	LOW	→	A	% of adults classified as overweight or obese (Leics) (PHOF 2.12)	**64.7%**	2012-14	LOW	→	A
	PH13	Slope index of inequality in life expectancy at birth (Females) (Leics) (PHOF 0.2iii)	**5.00**	2012-14	LOW	→	A	% successful completion of drug treatment - opiate users (PHOF 2.15i)	**9.3%***	2014		↑	G
	PH14	Life expectancy at birth (Males) (Leics) (PHOF 0.1ii)	**80.50**	2012-14		↑	G	% successful completion of drug treatment - non-opiate users (PHOF 2.15ii)	**40.2%***	2014		→	R
	PH15	Life expectancy at birth(Females) (Leics) (PHOF 0.1ii)	**84.00**	2012-14		↓	G	Admissions to hospital for alcohol related causes (rate per 100,000) (Leics) (PHOF 2.18)	**596**	2014/15	LOW	↓	A
	PH16	Take up of the NHS Health Check Programme – by those eligible (2.22iv)	**46.6%**	2014/15		→	R	Chlamydia diagnoses (rate per 100,000 15-24 year olds) (Leics) (PHOF 3.02ii)	**1616**	2014		↓	A
	PH17	Under 75 mortality rate from all cardiovascular diseases (Persons per 100,000) (Leics) (PHOF 4.04i)	**64.00**	2012-14	LOW	→	G	People presenting with HIV at a late stage of infection - % of presentations (Leics) (PHOF 3.04)	**40.5%**	2012-14	LOW	↓	G
	PH18	Under 75 mortality rate from respiratory disease (Persons per 100,000) (Leics) (PHOF 4.07i)	**23.30**	2012-14	LOW	→	G	Under 18 conceptions (rate per 1,000) (Leics) (PHOF 2.04)	**18.50**	2013	LOW	↑	G
	PH19	Under 75 mortality rate from cancer (Persons per 100,000) (Leics) (PHOF 4.05i)	**128.40**	2012-14	LOW	→	G	Prevalence of smoking among persons aged 18 years and over (Leics) (PHOF 2.14)	**17.0%**	2014	LOW	→	A
	PH56	Under 75 mortality rate from all liver disease (Persons per 100,000) (Leics) (PHOF 4.06i)	**13.50**	2012/14	LOW	→	G	Number of self-reported 4 week smoking quitters (Leics)	**2637**	Q1 -Q4 2015/16		↑	R
	PH20	% of eligible women screened - breast cancer (Leics) (PHOF 2.20i)	**83.5%**	2015		→	G	% of women smoking at time of delivery (Leics) (PHOF 2.03)	**10.3%***	2014/15	LOW	→	G
	PH21	% of eligible women screened - cervical cancer (Leics) (PHOF 2.20ii)	**77.9%**	2015		→	G						
PHYSICAL HEALTH	PH42	% of physically active children - participation in more than 3hrs a week of community sport only	**42.5%**	2014/15		↓	G	% of physically inactive adults (Leics) (PHOF 2.13ii)	**24.8%**	2014	LOW	→	G
	PH47	% of physically active children - participation in more than 3hrs a week of curriculum sport only	**53.4%**	2014/15		↓	G	% of adults participating in one or more sports a week for 30 minutes or more (Leics)	**38.0%**	Oct 14 - Sep 15		→	G
	PH32	% of physically active adults (PHOF 2.13i)	**59.9%**	2014		→	G						
CYP HEALTH	PH35	% of mothers initiating breastfeeding (PHOF 2.02i)	**74.4%**	2014/15		→	A	% of children with excess weight - 4-5 year olds (Leics) (PHOF 2.06i)	**20.3%**	2014/15	LOW	↑	G
	PH36	% of mothers breastfeeding at 6-8 weeks (PHOF 2.02ii)	**47.2%**	2014/15		↑	G	% of children with excess weight - 10-11 year olds (Leics) (PHOF 2.06ii)	**30.0%**	2014/15	LOW	↑	G
	PH37	% children aged 5 years with one or more decayed, missing or filled teeth (PHOF 4.02)	**0.95**	2011-12	LOW		A	Infant Mortality (PHOF 4.01)	**3.60**	2011-13	LOW	→	A
MENTAL HEALTH	PH4	Excess under 75 mortality rate in adults with serious mental illness (Leics) (PHOF 4.09)	**437.1**	2013/14		↓	R	Suicide rate (Persons) (PHOF 4.10)	**8.6**	2012-14		→	R

*: Value for Leicestershire and Rutland combined.

KEY: Directional Arrows show direction of travel from the previous data reported (↑ = improving performance, ↓ = declining performance, → = no change)

KEY: G - On target or on track to meet target, A - Off target by narrow margin, R - Off target by significant amount