Leicestershire County Council

Meeting: **Health Overview and Scrutiny Committee**

Date/Time: **Monday, 23 January 2017 at 2.00 pm**

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

Contact: **Mr. E. Walters (0116 305 6016)**

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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.	Minutes of the meeting held on 2 November 2016.		(Pages 5 - 10)
2.	Question Time.		
3.	Questions asked by members under Standing Order 7(3) and 7(5).		
4.	To advise of any other items which the Chairman has decided to take as urgent elsewhere on the agenda.		
5.	Declarations of interest in respect of items on the agenda.		

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

7. Presentation of Petitions under Standing Order 36.

8. Medium Term Financial Strategy - Public Health. (Pages 11 - 22)

9. Summary Care Record and interoperability of I.T. Systems. (Pages 23 - 34)

10. Improving Access to Psychological Therapies update. (Pages 35 - 38)

11. Settings of Care Consultation. (Pages 39 - 64)

12. Substance Misuse Service. (Pages 65 - 70)

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

14. Date of next meeting.

The next meeting of the Committee is scheduled to take place on 1 March 2017 at 2:00pm.

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 1

Minutes of a meeting of the Health Overview and Scrutiny Committee held at County Hall, Glenfield on Wednesday, 2 November 2016.

PRESENT

Dr. S. Hill CC (in the Chair)

Mrs. R. Camamile CC	Mr. D. Jennings 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

In attendance
Mr. E. F. White CC, Cabinet Lead Member for Health
Mike Sandys, Director of Public Health
Tamsin Hooton, Director of Urgent and Emergency Care, West Leicestershire CCG (minute 39 refers).
Matthew Desjardins, Acting Locality Quality Manager, East Midlands Ambulance Service (minute 40 refers).
Dan Webster, Locality Manager, East Midlands Ambulance Service (minute 40 refers).
Kate Allardyce, Performance Team (Leicester & Lincoln) GEM Commissioning Support Unit (minute 42 refers).

32. Minutes of the previous meeting.

The minutes of the meeting held on 14 September 2016 were taken as read, confirmed and signed.

33. Question Time.

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

34. Questions asked by members.

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

35. Urgent Items

There were no urgent items for consideration.

36. Declarations of interest.

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

Dr. T. Eynon CC declared a personal interest in all items on the agenda as a salaried GP and as she volunteered for Radio Carillon, a hospital radio station. She also declared a personal interest in Item 11: Health Performance Update as she had previously worked on Improving Access to Psychological Therapies in Leicestershire in a professional capacity, although she no longer did so.

Ms. Betty Newton CC declared a personal interest in all items on the agenda as she had a relative employed by Leicestershire Partnership NHS Trust and another relative that worked for Leicester Royal Infirmary.

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

There were no declarations of the party whip.

38. Presentation of Petitions.

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

39. Development of Integrated Urgent Care and Winter Planning.

The Committee considered a report of West Leicestershire Clinical Commissioning Group which provided a briefing on the planning process for winter 2016/2017 and an update on Integrated Urgent Care in Leicester, Leicestershire and Rutland. A copy of the report, marked 'Agenda Item 8', 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 the following points were noted:

Winter Planning

(i) Members sought reassurance that consideration would be given to planning for issues which did not arise in winter 2015/16 but which might arise in the future. In response assurance was given that there was the capacity to deal with additional pressures and the following measures were in place:

- Clear plans and protocols for opening 14 escalation beds in Leicestershire Partnership NHS Trust (LPT);
- Accelerating discharges;
- Pacing elective activity over the whole winter period to ensure that there was some capacity in the system which would reduce the risk of planned operations being cancelled;
- Drafting in additional staff and cancelling leave.

(ii) The importance of a good communications plan was highlighted and it was noted that advising the public not to visit Accident and Emergency departments was counterproductive as it only raised awareness of Accident and Emergency facilities. Instead more emphasis would be placed on the quality of the triage process for the Leicester Royal Infirmary Accident and Emergency

Department, as well as the messages professionals gave when dealing with patients both face to face and via the 111 telephone service.

(iii) It was confirmed that whilst the Accident and Emergency Delivery Board wished to fund additional social work capacity and in-reach to hospital to support discharge a source of funding for this had not yet been found.

Integrated Urgent Care

(iv) With regard to a typographical error in the report it was clarified that Integrated primary and community urgent care services for East Leicestershire Clinical Commissioning Group would be procured by 1 October 2017.

(v) Whilst there was a new service model coming into place, there would be no changes to the Crisis Mental Health Team under LPT, though work was taking place to improve the out of hours telephone service.

RESOLVED:

(a) That the changes made as a result of learning from winter 2015/2016 be welcomed;

(b) That the work regarding developing Integrated Urgent Care in Leicester, Leicestershire and Rutland be noted.

40. Leicestershire's Approach to Falls.

The Committee considered a report of the Director of Health and Social Care Integration which provided information on the work to develop a consistent approach to the prevention and treatment of falls in residents over the age of 65 in Leicestershire. The report was requested as a result of a question from Mr. R. Sharp CC at the previous meeting of the Committee, and a copy, marked 'Agenda Item 9', is filed with these minutes.

The Chairman welcomed Andrea Baker, Interim Falls Programme Manager to the meeting for this item, along with two representatives from East Midlands Ambulance Service (EMAS); Matthew Desjardins, Acting Locality Quality Manager, and Dan Webster, Locality Manager.

Arising from discussions the following points were noted:

(i) Consideration was being given to training people in the voluntary sector who went into elderly persons' homes on how to deal with falls. A pilot programme run by the Royal Voluntary Service, entitled 'Move it or Lose it', brought together those who were frail and those who were active and able, and taught them exercises approved by Occupational Therapists involving putting on shoes and socks or reaching up into cupboards. Conversations were taking place to widen this out into sheltered housing and care homes.

(ii) Generally, the target for EMAS to respond to falls was between 20 and 30 minutes, depending on the seriousness of the injuries. This was determined during initial triage of the patient by the call handler. During times of high demand, when life threatening calls had to take priority, a further triage process

took place which took into account whether the patient was alone or accompanied. Calls would then be escalated as necessary and, where further delays were anticipated, monitoring would continue to take place over the phone.

(iii) The paper based Falls Risk Assessment Tool (FRAT) used by paramedics had been successful however the new electronic version (eFRAT) meant that paramedics had a limitless supply of forms to fill in. In future the eFRAT would be used by Leicestershire Fire and Rescue Service when they carried out home safety checks. This formed phase 2 of the scheme which would be in place by the beginning of December. Phase 3 of the scheme, where the eFRAT would be accessible to all people who entered the homes of vulnerable people, such as domiciliary care workers, would commence on 1 April 2017. The aim was to capture all the risks facing a resident during the first visit to their home.

RESOLVED:

(a) That the work being undertaken in connection with the prevention and treatment of falls be supported;

(b) That the information provided regarding the prioritisation of calls to EMAS and the triage process be noted;

(c) That EMAS be asked to investigate further the circumstances of the specific patient referred to by Mr Sharp CC in his question to the Committee on 14 September 2016 and provide an explanation for the delay in attendance by EMAS in that case.

41. Annual Report of the Director of Public Health.

The Committee considered the Annual Report of the Director of Public Health for 2016. The focus of the report was the role of workplace health in improving overall health. A copy of the report is filed with these minutes.

Arising from consideration of the report the following comments were made -

(i) Members were of the view that reviewing the impact of smoking cessation initiatives on an annual basis was too infrequent and requested that reviews take place every 6 months. The Director of Public Health agreed to conduct this review in the timescales requested as part of a wider review of tobacco control.

(ii) Members asked that the Director of Public Health give further consideration to the reasons for sickness absence from work and the way this was dealt with by managers.

(iii) Members requested a more detailed breakdown on the demographics of the people described in the table in Figure 4 of the report as ‘Does Not Want A Job’. It was also suggested that a greater focus be given to those who were unemployed but did want a job as those people should be supported to find employment.

(iv) Members noted the importance of including initiatives to improve health in new housing development schemes and noted that Hinckley and Bosworth Borough Council had submitted a funding bid to the Design Council in connection with this.

(v) Whilst air quality was not one of the indicators for the level of Public Health in Leicestershire its importance was recognised and the Public Health Consultant had designated it as a priority. District Councils could bid for funding to tackle air quality in their geographical areas.

RESOLVED:

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

(b) That the Director of Public Health be asked to report back to the Committee in six months' time regarding the approach to tobacco control including smoking cessation initiatives;

(c) That the comments now made be submitted to the Cabinet for consideration at its meeting on 23 November 2016.

42. Health Performance Update.

The Committee considered a joint report of the Chief Executive of the County Council and Greater East Midlands Commissioning Support Performance Service (GEM), which provided an update of performance at the end of quarter two of 2016-17. A copy of the report marked "Agenda Item 11" is filed with these minutes.

The Committee welcomed Kate Allardyce, Performance Team (Leicester & Lincoln) GEM Commissioning Support Unit to the meeting to present the report.

Arising from discussions the following points were noted:

(i) With regard to Metric 5 – Patient Experience, Members asked for information regarding the sample size of patients who had their satisfaction levels measured. The Lead Analyst for Health and Social Care Integration undertook to find out the answer to this question and report back to Members.

(ii) The target for referral to treatment times was narrowly missed for September 2016. This was the first time the target had been missed since September 2013.

(iii) The information provided in the Leicestershire Mental Health Dashboard was welcomed. Members were of the view that the figures for percentage of IAPT Recovery Rate were positive; however there were concerns about the percentage of people with relevant conditions who were able to access talking therapies in 6 weeks. It was questioned whether GPs were making referrals to talking therapies when appropriate and whether the level of training GPs received on talking therapies was sufficient. Members asked to be provided with further information on the training provided to GPs on Psychological Therapies particularly with regard to Cognitive Behavioural Therapy.

RESOLVED:

(a) That the performance summary, issues identified and actions planned in response to improve performance be noted;

(b) That officers be asked to submit a report on the Access to Psychological Therapies Service to a future meeting of the Committee.

43. Date of next meeting.

RESOLVED:

It was noted that the next meeting of the Committee would be held on 23 January 2016 at 2:00pm.

2.00 - 3.45 pm CHAIRMAN
02 November 2016

Agenda Item 8

Leicestershire County Council

HEALTH OVERVIEW AND SCRUTINY COMMITTEE
23 JANUARY 2017

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

MEDIUM TERM FINANCIAL STRATEGY 2017/18–2020/21

Purpose of Report

1. The purpose of this report is to:

   a) Provide information on the proposed 2017/18 to 2020/21 Medium Term Financial Strategy (MTFS) as it relates to the Public Health Department;

   b) Ask members of the Committee to consider any issues as part of the consultation process, and make any recommendations to the Scrutiny Commission and the Cabinet accordingly.

Policy Framework and Previous Decisions

2. The County Council agreed the current MTFS in February 2016. This was the subject of a comprehensive review and revision in light of the current economic circumstances. The draft MTFS for 2017/18–2020/21 was considered by the Cabinet on 13 December 2016.

Background

3. The MTFS is set out in the report to Cabinet on 13 December 2016, a copy of which has been circulated to all members of the County Council. This report highlights the implications for the Public Health Department.

4. Reports such as this one are being presented to the relevant Overview and Scrutiny Committees. The views of this Committee will be reported to the Scrutiny Commission on 25 January 2017. The Cabinet will consider the results of the scrutiny process on 10 February 2017 before recommending a MTFS, including a budget and capital programme for 2017/18 to the County Council on the 22 February 2017.

Service Transformation

5. In the Autumn Statement 2015 the Chancellor announced a 3.9% annual reduction over a 5 year period in Public Health allocations to local authorities. The remaining reductions will be 2.5% in 17/18, and 2.6% in both 18/19 and 19/20. The ring-fence on the grant will continue for 2017/18; future public health funding arrangements could be part of business rates retention scheme but this will be subject to a consultation process.

6. In June 2016 a paper to the Cabinet proposed an Early Help and Prevention (EHAP) Strategy. This would encompass a vision that a comprehensive offer for community based prevention for Leicestershire funded by bringing all the resources together available to local Councils and partners.

7. Public Health will structure its services in line with the Target Operating Model (TOM) aimed at delivering the EHAP Strategy for Leicestershire. The TOM for EHAP services provides:
   - A broad EHAP strategy setting out key priorities across the authority and Leicestershire
   - A focus on EHAP to reduce demand for services
   - A focus on using scarce resources on services that make the biggest impact
   - A focus on the customer/service user
   - Integration that reflects both an emphasis on the services provided by the County Council, rather than by each department, and the integration and co-ordination of services across partner organisations
   - More community involvement in the delivery of appropriate services
   - A streamlined, concentrated and coordinated support service function

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

Proposed Revenue Budget

9. The table below summarises the proposed net 2017/18 revenue budget and provisional budgets for the next three years. The proposed 2017/18 revenue budget is shown in detail in Appendix A. Note that this position is net of public health specific grant giving the negative/low numbers.

	2017/18 £000	**2018/19 £000**	**2019/20 £000**	**2020/21 £000**
Original prior year budget	-2,450	-324	-124	46
Budget Transfers and Adjustments	2,256	0	0	0
Sub total	**-194**	**-324**	**-124**	**-46**
Add proposed growth (Appendix B)	700	700	670	20
Less proposed savings (Appendix B)	-830	-500	-500	-500
Proposed/Provisional net budget	**-324**	**-124**	**46**	**-434**

10. Detailed service budgets have been compiled on the basis of no pay or price inflation, a central contingency will be held which will be allocated to services as necessary.

11. The central contingency also includes provision for an annual 1% increase in the employers' contribution to the Local Government Pension Scheme based upon the 2016 triennial actuarial revaluation of the pension fund.

12. The total gross proposed budget for 2017/18 is £26.5m with contributions from grants, health transfers and service user contributions projected of £26.8m. The proposed net budget for 2017/18 totals -£0.3m and is distributed as follows:

Net Budget 2017/18	£000	%
Public Health Leadership	1,688	6.7%
Sexual Health	4,301	17.0%
NHS Health Check Programme	600	2.4%
Health Protection	180	1.0%
Obesity Programme	656	2.6%
Physical Activity (including contribution to LeicesterShire and Rutland Sport)	1,131	4.5%
Substance Misuse	3,869	15.3%
Smoking and Tobacco	771	3.1%
Children's Public Health 0-19	8,839	35.1%
Public Health Advice	613	2.4%
Public Health Other Commissioned Activity	430	1.7%
Early Help and Prevention Services (transfers from other departments)	2,126	8.4%
Department Total	**25,204**	
Public Health grant	-25,528	
Total Net Budgeted Spend	**-324**	

Other Changes and Transfers

13. Budget transfers totalling a net increase of £2.3m related to the Early Help and Prevention review have been made for the 2017/18 financial year and are now adjusted for in the updated original budget. These transfers relate specifically to budgets for early help and prevention, externally commissioned services held currently within Adults and Communities (£1.5m) and Children and Family Services (£0.8m). Whilst the review takes place these budgets will be held within Public Health.

14. Growth and savings have been categorised in appendix B under the following classification:

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

15. This star rating is included in the descriptions set out for growth and savings below.

16. Savings have also been classified as Transformation or Departmental and highlighted as "Eff" or "SR" dependent on whether the saving is seen as an efficiency or a service reduction or a mixture of both. "Inc" denotes those savings that are funding related or to generate more income.

Growth

17. Growth bids made by the Public Health department are in response to national issues faced by all upper tier local authorities and not internally generated initiatives.

18. Growth over the next four years total £2.1m, including £0.7m in 2017/18. The budget increases are outlined below and summarised in Appendix B.

19. ** G8 Reductions to Public Health specific grant (offsetting savings have been included in this and previous MTFS); £650,000 in 2017/18 rising to £1,960,000 in 2020/21

    The reduction in grant is as a direct result of the Chancellor's Autumn Statement 2015 where an annual average 3.9% reduction over a five year period was announced. The Department of Health (DoH) have now confirmed Leicestershire's 2017/18 allocation as £25.5m a reduction of 2.5% on the 2016/17 level.

20. G9 Integrated Sexual Health Service - increased testing expected as result of new Pre Exposure Prophylaxis (PrEP) treatment for HIV risk groups; £50,000 in 2017/18 rising to £130,000 in 20201/21

    PrEP is a retro-viral drug; tests have suggested that it is effective at reducing the spread of HIV amongst high risk groups. This growth bid at this time only represents the anticipated cost of the increased testing that local authorities would be responsible for under the Health and Social Care Act 2012 related to an introduction of PrEP. The Court of Appeal upheld the decision of the High Court which ruled that NHS England could fund the drug because it was wrong to classify it as preventative. This removed the risk that local authorities would need to fund the cost of the actual drug which could have been as much as £1m in Leicestershire.

Savings

21. Details of proposed savings are set out in Appendix B and total £0.8m in 2017/18 and £2.3m over the next four years in total.

Transformation Savings

22. ** PH1 Review of smoking & tobacco services and contracts; £480,000 in 2017/18

    The new service continues to prioritise the broader tobacco control measures such as support for stopping the trade in illicit tobacco and the healthy schools programme to ensure the next generation do not start smoking. Evidence suggests that tobacco control is the most cost-effective long term measure.

    The stop smoking service has been redesigned to reflect a change in usage (i.e. increased numbers of people self-supporting through the use of e-cigarettes), the use of online technology in service design and a focus on those parts of the population that find it harder to quit. This entailed, during 2016/17, the decommissioning of the universal Stop Smoking Service (£828,000) and associated Nicotine Replacement Therapy (NRT) prescribing (£392,000). In its place an in-house and more targeted cessation service is supported by an element of NRT prescribing, using approaches such as 'quitline' and other electronic media to provide cessation support as a universal 'offer'. This is

alongside a closer working relationship with GP's and pharmacists to delivering an evidence based service and retaining specialist support for vulnerable groups. The £480,000 savings is the last part of a £1,100,000 full year effect saving which was £70,000 above MTFS 2016 target (£1,030,000).

23. PH2 Early Help and Prevention Review - review of externally commissioned prevention services £500,000 in 2018/19 rising to £1,500,000 in 2020/21

The Cabinet approved the Early Help and Prevention (EHAP) Strategy on 17 June 2016.

One of the recommendations proposed that savings were achievable through a close examination of authority wide externally commissioned services. This would be achieved through consistent and tight contract management, reduction in duplication and ensuring authority wide service design and commissioning. The value of the services to be reviewed total £22m, most of which already resides in Public Health, other elements from other departments will be transferred to Public Health to help ensure that they are ring-fenced for this review. Six months into the review, workstreams are on track to deliver the savings identified.

If significant changes to the Strategy and approach for its delivery are proposed, reports will be submitted to the Cabinet and Scrutiny prior to any decision being implemented.

24. PH3 Early Help and Prevention Review - Adults and Communities departmental saving requirement £130,000 in 2017/18

Budgets for two of the contracts, in Adults and Communities, relating to EHAP that transferred to Public Health have existing savings targets associated with them. Mental Health Drop In and Peer Support (£115k) will achieve this saving through a more targeted approach to commissioning. Home Improvement Agency (£15k) will achieve a saving when remaining funding will transfer to Lightbulb whose business model can deliver these services more efficiently.

Departmental

25. * PH4 Review of contracts related to sexual health services; £195,000 in 2017/18

The draft Sexual Health Strategy and sexual health needs assessment sets out the future direction of sexual health services across Leicestershire. The eight priorities for improving sexual health services have led to:

- Better working across commissioners such as the County Council, NHS Clinical Commissioning Groups and NHS England to avoid fragmentation in sexual health commissioning.
- An increased role of primary care in delivering uncomplicated sexual health services.
- A more focussed approach to teenage pregnancy.
- A reduction in opportunistic chlamydia screening and conversion into a full online Sexually Transmitted Infections screening service.
- Increased focus on groups at high risk of poor sexual health, especially men who have sex with men.

The newly implemented approaches to chlamydia screening and STI screening will save in the region of £250,000. The ending of specific contracts for screening aimed at sex workers and reductions in demand led prescribing costs will also contribute approximately £50,000. £195,000 represents the final part of the saving which commenced in 2016/17 and totals £340,000.

26. * PH5 Other Public Health Services; £25,000 in 2017/18

This relates to additional savings made during 2016/17 made when the substance misuse contract was re-procured.

EHAP Savings

27. The MTFS 2016/17 to 2019/20 included an indicative target of £5m for a review of EHAP services. The review took place in late spring 2016 and identified £3m of savings across the authority. The table below provides more details of the savings and which County Council department has the responsibility for achieving the saving. As this is a cross departmental review the savings related to other departments have been taken to the appropriate scrutiny and overview committee.

MTFS Refer-ence	Scheme	Saving Require-ment £000	Department MTFS saving
PH2	Review of externally commissioned prevention services	1,500	Public Health (included above)
CF4	Review of Children's Centre Programme	1,000	Children's & Family Services
CF5	Re-procurement of Contract for Careers Information, Advice & Guidance	340	Children's & Family Services
AC2	Assisted Living Technology	100	Adults & Communities
CE11	Reduced contribution to community capacity building	100	Chief Executive's
	Total	3,040	

28. Progress has been made towards achieving these savings and this is an on-going process. Full business cases for each work stream are currently being developed; these involve considerable service redesign and contract management changes.

Savings Under Development

29. The MTFS is balanced in 2017/18 and shows shortfalls of £2.8m in 2018/19 rising to £23.9m in 2020/21. To help bridge the gap a number of initiatives are under development to generate further savings. Once business cases have been completed savings will be confirmed and included in a future MTFS. Several initiatives will involve the Public Health department, the principle ones are:

- 1 Promoting Independence in the home for high dependency service users
- 2 Commissioning and Procurement
- 3 Digital Services

Other Funding Sources

30. For 2017/18, the following grants and transfers are expected to be received:

- Leicestershire's Public Health Grant for 2017/18 has been confirmed as £25.5m by the DoH.
- Better Care Fund (BCF) - £0.2m for First Contact Plus. The BCF is currently undergoing a refresh for 2017/18 until this process is complete, this funding is not certain. There is considerable pressure on funding in the BCF.

- Rutland County Council - £0.2m relating to part time provision of a Director of Public Health role and provision of commissioning support role.

- University Hospitals of Leicester - £0.1m for the provision of performance and outcome data

Background Papers

- Cabinet : 13 December 2016 – Medium Term Financial Strategy 2017/18 to 2020/21

Circulation under local issues alert procedure

None.

Officers to Contact

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Appendices

Appendix A – Revenue Budget 2017/18
Appendix B – Growth & Savings

Equality and Human Rights Implications

31. Public authorities are required by law to have due regard to the need to:

- Eliminate unlawful discrimination, harassment and victimisation;
- Advance equality of opportunity between people who share protected characteristics and those who do not;
  and
- Foster good relations between people who share protected characteristics and those who do not.

32. Many aspects of the County Council's MTFS may affect service users who have a protected characteristic under equalities legislation. An assessment of the impact of the proposals on the protected groups must be undertaken at a formative stage prior to any final decisions being made. Such assessments will be undertaken in light of the potential impact of proposals and the timing of any proposed changes. Those assessments will be revised as the proposals are developed to ensure decision makers have information to understand the effect of any service change, policy or practice on people who have a protected characteristic.

33. Proposals in relation to savings arising out of a reduction in posts will be subject to the County Council Organisational Change policy which requires an Equality Impact Assessment to be undertaken as part of the action plan.

APPENDIX A

PUBLIC HEALTH DEPARTMENT

REVENUE BUDGET 2017/18

Net Budget 2016/17 £		Employees £	Running Expenses £	Internal Income £	Gross Budget	External Income £	Net Budget £
	PUBLIC HEALTH						
-26,133,955	Public Health Ring-Fenced Grant	0	0	0	0	-25,528,000	-25,528,000
1,700,943	Public Health Leadership	1,512,916	465,173	0	1,978,089	-290,533	1,687,556
4,315,118	Sexual Health	0	4,301,388	0	4,301,388	0	4,301,388
600,000	NHS Health Check programme	0	600,000	0	600,000	0	600,000
190,000	Health Protection	0	180,000	0	180,000	0	180,000
661,600	Obesity Programmes	0	656,000	0	656,000	0	656,000
1,154,757	Physical Activity	0	1,131,451	0	1,131,451	0	1,131,451
4,138,829	Substance Misuse	0	3,869,249	0	3,869,249	0	3,869,249
984,500	Smoking & Tobacco	316,838	454,500	0	771,338	0	771,338
9,307,412	Childrens Public Health 0-19	0	8,839,000	0	8,839,000	0	8,839,000
146,796	Public Health Advice	598,991	219,743	-22,500	796,234	-183,216	613,018
484,000	Public Health Other Commissioned Activity	0	433,400	0	433,400	-3,400	430,000
0	Early Help and Prevention Services	0	2,124,518	0	2,124,518	0	2,124,518
-0	Leicester-Shire and Rutland Sport	854,590	997,081	-1,088,822	762,849	-762,849	0
-2,450,000	**TOTAL PUBLIC HEALTH**	**3,283,335**	**24,271,503**	**-1,111,322**	**26,443,516**	**-26,767,998**	**-324,482**

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Appendix B

	Reference			2017/18 £000	2018/19 £000	2019/20 £000	2020/21 £000
			PUBLIC HEALTH				
			Growth				
			Reduced Income				
**	G8		Reductions to Public Health specific grant(offsetting savings are incluc	650	1,310	1,960	1,960
			Demand & Cost Increases				
	G9		Integrated Sexual Health Service - increased testing expected as result of new Pre Exposure Prophylaxis treatment for HIV risk groups	50	90	110	130
				700	**1,400**	**2,070**	**2,090**
	Reference	Eff/SR/ Income					
			Savings				
			Transformation				
**	PH1	SR	Review of smoking & tobacco services and contracts	-480	-480	-480	-480
	PH2	Eff/SR	Early Help & Prevention Review - review of externally commissioned prevention services		-500	-1,000	-1,500
	PH3	Eff/SR	Early Help & Prevention Review - A&C departmental Saving requirement	-130	-130	-130	-130
				-610	-1,110	-1,610	-2,110
			Departmental				
*	PH4	SR	Review of contracts relating to sexual health services	-195	-195	-195	-195
*	PH5	SR	Other Public Health services	-25	-25	-25	-25
				-220	-220	-220	-220
			TOTAL	**-830**	**-1,330**	**-1,830**	**-2,330**

References used in the following tables

* items unchanged from previous Medium Term Financial Strategy

** items included in the previous Medium Term Financial Strategy which have been amended

Eff - Efficiency saving

SR - Service reduction

Inc - Income

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Agenda Item 9

HEALTH OVERVIEW AND SCRUTINY COMMITTEE: 23 JANUARY 2017

REPORT OF LLR BETTER CARE TOGETHER INFORMATION MANAGEMENT & TECHNOLOGY

SUMMARY CARE RECORD AND CARE PLANNING

Purpose of report

1. The purpose of this report is to update the Health Overview and Scrutiny Committee on the Summary Care Record and Care Planning.

Link to the local Health and Care System

2. This initiative supports the joint health and wellbeing strategy by encouraging the use of patient record sharing to improve the quality of service that patients receive. It is currently not covered by the Better Care Fund. It is a core part of the Information Management & Technology (IM&T) Better Care Together Workstream and it links in with other clinical workstreams such as End of Life. It supports the Sustainability and Transformation Plan by being an integral part of the Local Digital Roadmap. The project will be delivered though the governance of Leicester City CCG and will be linked to the LLR Record Sharing Board.

Policy Framework and Previous Decisions

3. The improvements in digital technology are supported by the Five Year Forward View, Personalised Health and Care 2020.

   The Five Year Forward View makes a commitment that, by 2020, there would be "fully interoperable electronic health records so that patient's records are paperless". This was supported by a Government commitment in Personalised Health and Care 2020 that "all patient and care records will be digital, interoperable and real-time by 2020".

Background

4. Each local area in England was instructed by NHS England to develop a Local Digital Roadmap (LDR) to deliver the Five Year Forward View of ensuring paperless at point of care by 2020 within healthcare settings. The LDR is designed to align with the Sustainability and Transformation Plans (STP). Therefore, within LLR the LDR will support the digital transformation change for the Better Care Together (BCT) Clinical Workstreams. The LDR comprises of a 5 year capabilities plan to ensure digital technology projects are planned in to help deliver the strategy. A key component of the LDR is record sharing and the requirement to have digital care plans for patients who require them.

A number of options were considered with regards to Care Plans led by the BCT End of Life workstream in conjunction with the LLR IM&T Board. It was agreed to move forward with enhancing national technology that is available to all health providers. This has led to the further development of the Summary Care Record (SCR) in the form of Version 2.1. Summary Care Records are currently being used by 98% of GP practices in the country and 100% of GP practices within LLR. All NHS providers have the capability of viewing the SCR. All NHS patients are automatically enrolled within the SCR unless they opt out. Patients are asked for consent prior to access of the SCR data.

Proposals/Options

5. The proposal is to enable SCR Version 2.1 with additional code-sets to the core SCR to all GP practices within LLR. It is envisaged that this work will be completed by March 2017 through funding received by the Estates Transformation and Technology Fund. Further work will need to take place to encourage providers to access the SCR as part of the health care professional workflow.

   SCR is a national system and is available for free. However, there is a cost to implement the solution. Although it has limitations it is found to be the most appropriate and cost effective solution currently available. Other solutions such as wider use of the TPP SystmOne and the Medical Interoperability Gateway (MIG) can help to plug some of the technology gaps that SCR currently has. Organisations with access to TPP SystmOne can have access to the full patient record if the patient originates from a GP practice that has TPP SystmOne. However, if patients are not from a TPP SystmOne practice the MIG can be used to share parts of the GP record.

Consultation/Patient and Public Involvement

6. A patient representative as part of the BCT programme has been part of the discussions to implement SCR as an initial care planning solution. Further communication will be required from GP practices with patients that have Care Plans to ask them for consent to share SCR Version 2.1 data with additional information to core data of the SCR Version 1.

Resource Implications

7. Funding for phase 1 of the project (implementation of SCR V2.1 at GP practices) is funded through the Estates Transformation and Technology Fund. Leicester City CCG will be the lead commissioner on behalf of the three CCG's in LLR.

Circulation under the Local Issues Alert Procedure

None

Officer to Contact

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Appendix

Presentation slides on Summary Care Records use in Care Planning for patients in LLR

Relevant Impact Assessments

Equality and Human Rights Implications

8. Due regard to equality, diversity, community cohesion and human rights in our decision-making process has taken place by NHS Digital on behalf of the NHS regarding the Summary Care Record.

Crime and Disorder Implications

9. *None*

Environmental Implications

10. The Summary Care Record should reduce the amount of paper being used.

Partnership Working and associated issues

11. LLR organisations have worked in partnership for this solution through the LLR IM&T Enablement Group.

Risk Assessment

12. This will form part of the project implementation and covered within the governance of Leicester City CCG.

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APPENDIX

'It's about our life, our health, our care, our family and our community'

Better care together

Leicester, Leicestershire & Rutland health and social care

Summary Care Records (SCR) use in Care Planning for Patients in LLR

Rutland County Council healthwatch Leicester City Council Leicestershire County Council NHS

What is the Summary Care Record?

- National database of core patient data (Version 1):
  - Current medication,
  - Allergies and details of any previous bad reactions to medicines
  - The name, address, date of birth and NHS number of the patient
- Patients can opt out of sharing core patient data, if they do not opt out it is automatically uploaded to the national database
- The SCR is free to use for local organisations
- Information is secure and the patient is asked for consent by the healthcare professional prior to being accessed
- Version 2.1 is an upgrade to core patient data but can allow other read coded data. This can help to create a digital patient **Care Plan**

What are we planning to do?

- Project manage and implement SCR Version 2.1
- Define the dataset that will be used for sharing in SCR Version 2.1 working with Better Care Together Workstream Leads
- Work with GP practices to gain consent to share additional information on SCR Version 2.1 for defined groups of patients
- Ensure that providers view and use information on Version 2.1 at point of care

Current Limitations

- SCR is currently not available in Social Care
- Data can only be updated at the GP practice
- Patients have to opt in to share their record at the GP practice prior to it being available to other services
- Not all health and care professionals currently use SCR

Mitigation

To address the limitations LLR will do the following:

- Maximise the use of MIG technology
- Maximise the use of TPP SystmOne

These are other data sharing methods that will use the same data sets as the SCR but have less limitations

Interoperability

Interoperability is the ability of different IT systems and software applications to communicate, exchange data, and use the information that has been exchanged.

- Currently limited between current suppliers within LLR
- NHS England have defined FHIR (Fast Healthcare Interoperability Resources) as a common set of standards for software companies to use
- MIG provides some interoperability in LLR
- Rollout of data sharing between TPP and EMIS to start in 2017

Better care together
Leicester, Leicestershire & Rutland health and social care

What will it mean for Patients and Professionals

Patients

- Core data can be seen by various care professionals
- Reduces to need to remember what medication you are on
- Reduce the need to have paper copies of the care plan

Improves quality of care

Professionals

- Have electronic access to core patient data to help patient care
- Remove the need to ask the patient what medication they are on or specific questions regarding their care plan

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Agenda Item 10

NHS
East Leicestershire and Rutland
Clinical Commissioning Group

HEALTH OVERVIEW AND SCRUTINY COMMITTEE: 23 JANUARY 2017

REPORT OF EAST LEICESTERSHIRE AND RUTLAND CCG

LEICESTERSHIRE COUNTY AND RUTLAND: IMPROVING ACCESS TO PSYCHOLOGICAL THERAPIES UPDATE REPORT.

Purpose of report

1. The Improving Access to Psychological Therapies (IAPT) programme aims to increase the availability of NICE (National Institute for Health and Care Excellence) recommended psychological treatments for mild to moderate depression and anxiety disorders within NHS commissioned services in England. IAPT offers a realistic and routine first-line treatment, combined where appropriate with medication.

2. This report details performance to date of the Let's Talk Wellbeing IAPT service for West Leicestershire Clinical Commissioning Group and East Leicestershire & Rutland Clinical Commissioning Group.

Policy Framework and Previous Decisions

3. The IAPT programme is consistent with the delivery of the CCG Operational Plans, Better Care Together and Sustainability Transformation Plan.

Background

4. Nottinghamshire Healthcare NHS Foundation Trust (NHCFT) commenced service delivery on 1 April 2014 having replaced Re:Think as the provider of the IAPT service.

5. Following the award of the contract to Nottinghamshire Healthcare NHS Trust the processes and systems necessary to achieve targets were rolled out. The most significant development was an organisational change of the service to establish a robust management framework, to ensure the service works as efficiently as possible.

Performance Targets

6. IAPT Key Annual Targets:
   - 15% of the prevalent population accessing the service – **not currently being met**
   - 50% of patients move to recovery – **consistently being met**.
   - 75% of people who have completed treatment who waited less than 6 weeks to begin treatment. – **improving currently approx. 71%**

– 95% of people who have completed treatment who waited less than 18 weeks to begin treatment – **consistently being met**

Changes Implemented

7. Alongside the organisational change and recruitment there were a number of strategic approaches to increase efficiency and effectiveness. In summary these were:

1. Increasing performance of all staff
2. Reduction in DNA rates
3. SMS text messaging
4. Self-referral
5. Increase in opt-in rates
6. Introduction of Stress Control Rolling Programme (see paragraph 8 below)
7. Introduction of Silver Cloud (see paragraph 10 below)
8. Modified buildings
9. Organisational Change
10. Introduction of insomnia based referrals and treatment

8. NHCFT increased the expected direct clinical contacts from 20 *planned* hours to 22 *actual* hours. The service also implemented more group treatments, to increase throughput in the service. They successfully created a rolling modular stress control course, allowing patients to access the course at any time rather than having to wait to start a new course.

9. The three bases from which the service operates went through considerable remodelling; the physical changes provided an environment where staff are able to undertake increased telephone work, particularly telephone assessments.

10. The service also introduced Sliver Cloud a social-media-platform with self-help packages which are moderated by clinical staff. This is for use as a step 2 intervention and as a preparation phase for people prior to step 3 high intensity treatments.

11. A major development was to introduce self-referrals across the whole of the county which aimed to increase the number of referrals and improve the quality of the referrals whilst increasing the motivation of the patient for active treatment. Self-referrals will also increase the ease of access to the service by breaking down any unnecessary obstacles and help with reaching hard-to-reach groups.

12. Consistent with the national picture the service has periodically had issues with maintaining staffing levels across the Leicester County and Rutland. This has affected performance intermittently. The Low Intensity (Psychological Wellbeing Practitioner PWP) workforce is fairly transient and suffers from a high turnover of staff due to many of the staff further progressing their career in other areas of psychological therapies. There are very few experienced PWP's within the market place and due to short notice periods many services including Let's Talk Wellbeing also use trainees, and over recruit to this post to try and achieve succession planning. However, trainees do not have full caseloads for some time and are also

risk averse when treating patients, these features can affect moving to recovery targets and waiting times. More recently staffing issues have been kept to a minimum and therefore an emerging issue in 2016/17 has been the need to increase referrals in order to achieve the national targets. In order to address this they worked in collaboration with De Montfort University to develop a curriculum which aims to address some of the recruitment issues experienced with PWP workers. This has provided training places for two cohorts per year (April and September) of up to 50 trainees.

Increasing referrals

13. The service has for some time been looking to increase referrals and self-referrals through various means. The service introduced self-referrals in December 2014 and the apportionment of referrals is now made up of 75% self-referrals and 25% GP referrals through proactive marketing.

14. Some of the initiatives the service has undertaken to increase referrals are:

- Approached 10 large companies within Leicestershire to offer work place stress and anxiety groups
- Modular based stress and anxiety groups within the community
- Attendance at a large number of CCG events
- Regular updates to GP's
- Leaflets within Patient transport vehicles
- Leaflets within GP surgeries and community venues
- Insomnia leaflets within pharmacies
- Increasing the number of referrals via GP contracts (ELRCCG)

15. Other avenues which are currently being explored include working with community staff (nursing and therapists) to help to identify people in the community whether they are patients or carers, who may be suffering with anxiety or depression who would benefit from IAPT. The service is looking to train some of the community staff to help identify anxiety and depression and aid in referrals.

16. The service is also looking to expand the insomnia offering. Although insomnia self-referral leaflets are available within pharmacies the intention is to investigate whether it is possible to place a leaflet within prescriptions for hypnotics, therefore targeting directly those people who may have sleeping issues.

17. The national service model is to extend the offer to people with long term physical conditions, as the evidence indicates significant clinical and public sector benefits. This has led to CCGs looking at ways to integrate IAPT staff into multi-disciplinary teams within physical health settings. This is aimed predominantly at patients with long terms conditions, specifically Chronic Obstructive Pulmonary Disease, Cardiovascular Disease and Dementia. If this is implemented as per national guidance, this will involve increasing staffing levels and potentially treating people in their homes via face to face treatment or Skype/webinars etc.

18. There has recently been an exciting opportunity to further increase awareness and reach of the service. Funding has been agreed to pilot a 6 month community radio

campaign on Hermitage FM radio, if this proves successful there may be an opportunity to expand this pilot to other areas within the county.

19. Work will be undertaken by the provider's communications team and the CCG communications team to develop material for media campaigns, for example rolling adverts on GP televisions screens, twitter, you tube etc. Other options being explored are placing self-referral leaflets in the following locations: Medical schools, Nursing schools, Job Centres, the probation service, courts, 6th form schools and universities.

GP engagement and Training

20. Throughout the provision of the IAPT service by Nottinghamshire Healthcare NSH FT, there has been regular updating of GPs through newsletters, attendance at locality meetings and attendance at formal CCG committees and boards. Although a lot of work has been carried out engaging with GPs it is acknowledged that engagement is needed again, due to some of the initiatives being considered.

21. The service has also attended locality meetings to specifically describe clinical pathways and suitable criteria.

22. In order to reinvigorate GP engagement and to provide potentially training for GPs, especially around the opportunity to refer patients to the insomnia group sessions, how to stop depression, it is proposed that the service attends GP protected learning times (PLT). This had previously been arranged however due to changes in PLT agendas this was never completed.

23. Additionally the service are considering offering GP spirit training subject to funding, the aim across Leicester City, Leicestershire and Rutland (LLCR) would be to use this programme to raise awareness of IAPT and to teach very basic CBT-informed skills to people using self-help materials. The training would be delivered to primary care (including GP's), voluntary sector, employment support and other targeted staff, including those with hard to reach groups and patients with long term conditions. The course will seek to develop knowledge and skills in the application of the 5 Areas Cognitive Behavioural therapy model, including using structured CBT self-help materials with a variety of mental health diagnoses.

Officer to Contact

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Agenda Item 11

East Leicestershire and Rutland Clinical Commissioning Group
Leicester City Clinical Commissioning Group
West Leicestershire Clinical Commissioning Group

HEALTH OVERVIEW AND SCRUTINY COMMITTEE: 23 January 2017

REPORT OF Leicester, Leicestershire and Rutland Clinical Commissioning Groups

Settings of Care Policy Update

Purpose of report

1. The purpose of this paper is to invite comments from the Health Overview and Scrutiny Committee on the draft Settings of Care Policy for the Leicester, Leicestershire and Rutland Clinical Commissioning Groups' (LLR CCGs'). This policy is for the commissioning of services for people who have been assessed as eligible for NHS Continuing Healthcare (CHC) and Personal Health Budgets (PHBs). The policy sets out a common and shared approach to the CCGs' commitments in relation to individual choice and resource allocation.

Background

2. NHS Continuing Healthcare is a package of care which is arranged and funded solely by the NHS for individuals, not in hospital, who have on-going health care needs outside of hospital usually as a result of disability, accident or illness. Patients may receive this care at home, in a care home or a specialist home.

3. Where patients receive care is called "a setting of care." When a person has been assessed as eligible for NHS Continuing Healthcare their care needs are then set out in a care plan and this is then discussed with them and/or their family and carer(s).

4. Personal Health Budgets (PHBs) provide an amount of money to individuals with identified health and wellbeing needs to support care. The care is planned and agreed between individuals, families and their local NHS team.

5. Packages of NHS Continuing Healthcare are subject to a cost-effectiveness test in the same way as all other NHS services. Whilst agreeing a package of care for individuals eligible for CHC funding the CCGs have a statutory duty to consider the available resource. However, in coming to a decision on a package of care to be commissioned for an individual, the CCGs need to ensure clinically appropriate care provision for individuals in a robust way and within the available financial envelope whilst ensuring a quality service is delivered.

6. The purpose of the Settings of Care Policy is therefore to:

   - Define how and when the CCGs will support choice of care setting in relation to clinically appropriate packages of care for individuals within the available financial envelope and to ensure that care is provided equitably across the CCGs

   - Ensure that the clinically assessed care needs of eligible individuals are met in a manner which supports consistent and equitable decisions about the provision of that care regardless of, for example but not limited to, the person's age, condition or disability.

7. As the Settings of Care policy has not been updated since 2011 it is due for review, update and formal adoption and application of the new policy by the CCGs. In addition the policy needs revising to include Personal Health Budgets (PHBs).

8. The key feature of the 2011 Settings of Care policy is the 25% financial threshold which enables CCGs to fund a clinically sustainable package of care, delivered in the individual's setting of choice (e.g. home), where the anticipated cost of that package does not require more than 25% additional funding compared to the cost of equivalent care in an alternative setting. Exceptional circumstances, such as the individual being at the end of their life, are considered in order to enable CCGs to fund packages of care exceeding this financial threshold.

9. LLR CCGs are outliers in relation to both the high number of CHC packages of care and the high cost of those packages. This outlying position is not sustainable for the local health economy and does not arguably demonstrate the most effective use of resources for the local population.

10. In reviewing the policy, the LLR CCGs engaged with people receiving CHC funding, their carers, families and key condition-specific support groups. Members of the HOSC were provided with the outcome of the engagement event at their meeting on 14 September 2016.

Consultation

11. As there are proposed changes to the policy, the LLR CCGs will be formally consulting on those changes to provide further opportunity for people who could be affected (including patients, families and carers) to share their views before any final decision is made.

12. The consultation questions and documents have been approved by all three CCG Governing Bodies and NHS England has provided comments. Although delayed, the consultation commenced on 6 January 2107 and the consultation period is six weeks.

13. All individuals in receipt of fully-funded NHS CHC/PHBs who could be affected by changes to the Settings of Care policy (circa 1,300 people) and their families/those important to them are being given the opportunity to complete and return a survey and participate in an event on the 19th January 2017. Letters have been sent to each individual with a copy of the survey and an invitation to the consultation event. A FREEPOST return address has been provided.

14. The consultation and draft policy are featured on the CCG's website and a media release has been issued inviting members of the public to complete the survey and to attend a consultation event.

15. People also have the opportunity to complete the survey online should they prefer and easy read versions and translations will be available on request.

16. A number of support groups/charities and other identified stakeholders have been invited to comment and attend the event.

17. A telephone number has been provided for anyone with questions or concerns and those needing assistance in completing the form.

18. On conclusion of the consultation, the feedback received will be independently analysed.

Timetable for Decisions

19. On conclusion of the consultation, the feedback will be considered by the LLR CCG and public feedback taken into account.

20. A final decision is scheduled to be made in March 2017 by the LLR CCG Governing Bodies.

Conclusions

21. The Health Overview and Scrutiny Committee are asked to contribute to the consultation and comment on the draft policy documents.

22. The LLR CCGs are committed to listening to the views of the public and to implementing a policy which ensures clinically appropriate, high quality and affordable care provision for individuals.

Officer to Contact

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List of Appendices

Appendix 1 – Consultation documents
Appendix 2 – Draft Settings of Care Policy

East Leicestershire and Rutland Clinical Commissioning Group
Leicester City Clinical Commissioning Group
West Leicestershire Clinical Commissioning Group

Have your say on Settings of Care policy

Your three local Clinical Commissioning Groups are inviting you to have your say on the Settings of Care policy which ensures clinically appropriate, high quality and affordable care provision for individuals who are eligible for NHS Continuing Healthcare (CHC) funding.

A 'setting of care' is the location where a patient receives a package of care arranged and funded solely by the NHS for a person aged 18 and over, to meet physical and/or mental health needs which have arisen as a result of disability, accident or illness. It is based on the patient's clinical needs and safety.

When a person has been assessed as eligible for CHC funding their care needs are set out in a care plan and this is then discussed with them and/or their family and carer(s).

The Settings of Care policy is used to guide the CCGs in deciding the limit of additional funding for providing care in an individual's preferred setting and includes criteria which ensure that individual clinical circumstances are taken into account.

What you need to know and do

We are inviting you to take part in a public consultation by answering a few questions on proposed changes to the policy. You may have taken part in our previous survey during the summer, which we looked at carefully, before reviewing the policy and proposing some changes. We are now urging you to comment on the proposed changes before a decision is made. Changes to the policy could mean

changes to the care you receive in future, so it is important that you have your say.

Why the policy needs to change

The current policy is outdated and doesn't reflect developments such as Personal Health Budgets, a new scheme that provides an amount of money to support a patient's identified healthcare and wellbeing needs.

Sometimes, a patient's preferred setting of care (e.g. at home) can cost more than the same level of care in a different setting. If the CCGs spend more money in some cases for a patient's preferred choice, this can reduce the overall amount of funding available to care for all patients. We fund more CHC packages of care and of higher costs than most other areas in the country - in 2015/16 we spent £73.5 million.

Fairer and sustainable Continuing Healthcare

Our current position is not sustainable for the local health economy and does not demonstrate that we are spending money in the best way for you and other patients. We have a set budget that has to cover the healthcare needs of all local people. We also

have to make decisions fairly and ensure that all those eligible for CHC have equal access to healthcare funding.

The proposed changes

Based on feedback from the survey, we are proposing:

- **A reduction to the current 25% spending limit** - the current policy allows the CCGs to spend up to 25% more than the most cost effective option to provide care in a setting of a patient's choice. We are proposing two options for you to consider.
- **The introduction of clearer exceptionality criteria** - such as someone at the very end of their life.
- **The implementation of guidelines to reduce clinical risk** - 24-hour care from a registered nurse would only be provided in a nursing home and hospital level care would only be provided in a specialist unit.
- **Use of registered care settings** - we will try to offer and place patients with preferred care providers. If their choice is not available, to meet reasonable assessed care needs, we may place people with an alternative care provider who meets the requirements.

Your voice counts

Your views matter to us and we consider them carefully when making decisions. We invited you to take part in a survey during the summer:

- Most people felt it was important that there was consistency of care and that care was delivered in a clinically safe and appropriate environment.
- Most people felt that the affordability of care to the NHS was important in some way.
- Almost everyone thought that it was important that patients and/or their families had a choice in their setting of care.
- Most people agreed that end of life care was an exceptional circumstance.

You can view the full findings of the survey here.

How the changes could affect you

Once the policy has been refreshed and approved, any changes would be applied at the patients' next annual review or, in the case of new patients, at the point people are determined eligible for Continuing Healthcare funding.

Patients who receive packages of care funded by the Local Authority will not be affected by the Settings of Care policy review.

What next?

Please answer the consultation questions and return to the FREEPOST address below:

Freepost NHS QUESTIONNAIRE RESPONSES
Settings of Care LLR

Alternatively, you can take part by answering the questions online:

www.surveymonkey.com/r/SettingsofCare2017

By telephone: 0116 295 3405

By email:

listening@eastleicestershireandrutlandccg.nhs.uk

Or by attending our consultation event at: **Leicester Racecourse, Oadby, Leicester, LE2 4AL on Thursday 19 January between 10am and 12pm.**

You can also contact us if you would like this information in another language or if you have another specific request.

Please detach and return this form by Monday 20 February 2017 to:

Freepost NHS QUESTIONNAIRE RESPONSES

Settings of Care LLR

1. Firstly, please tell us by ticking the box(es) that apply, if you are:

☐ An individual receiving CHC funded care

☐ A carer for an individual receiving CHC funded care

☐ A family member of/someone important to an individual receiving CHC funded care

☐ A representative from a patient or carer support group

☐ A member of staff involved in caring for an individual receiving CHC

☐ A member of the public Other, please specify ……..

2. Please tell us which of the following options being considered by the LLR CCGs you prefer. (Please tick one option)

☐ **Option One** - spending no more than the most cost effective setting to care for an individual in their preferred setting

☐ **Option Two** – spending up to an additional 10% to care for an individual in their preferred setting compared to the cost of the same level of care in the most cost effective setting

3. The exceptionality criteria we are proposing is care for a patient at the end of their life. Is there anything else you think should be considered as an exceptional circumstance? Please explain in the box below.

4. Sometimes the care provider and/or the setting might need to change for an individual for a number of reasons. If the CCG deems that a provider is not providing care of an acceptable standard, patients will be moved as soon as possible to ensure their safety.

Please select one of the following options to indicate the minimum notice period you think the CCG should give to in relation to changes to their setting of care, where a move does not compromise the quality of service provided: (Please tick one option)

☐ Seven days' notice to the individual

☐ Two weeks' notice to the individual

☐ One month's notice to the individual

5. How satisfied are you with the way this consultation is being run?

- ☐ Very satisfied
- ☐ Satisfied
- ☐ Neither satisfied or dissatisfied
- ☐ Dissatisfied
- ☐ Very dissatisfied

Equalities monitoring

We recognise and actively promote the benefits of diversity and we are committed to treating everyone with dignity and respect regardless of age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex (gender) or sexual orientation. To ensure that our services are designed for the population we serve, we would like you to complete the short monitoring section below. The information provided will only be used for the purpose it has been collected for and will not be passed on to any third parties.

6. Please state the first letters and numbers of your postcode, e.g., LE1. ☐

7. What is your gender?

☐ Male ☐ Female ☐ Transgender ☐ Prefer not to say

8. What is your age?

☐ Under 16 ☐ 16-24 ☐ 25-34 ☐ 35-59 ☐ 60-74 ☐ 75+ ☐ Prefer not to say

9. What is your ethnic group?

- ☐ Asian or Asian British
- ☐ Black or Black British
- ☐ Chinese
- ☐ Mixed dual heritage
- ☐ White or White British
- ☐ Gypsy/Romany/Irish traveller
- ☐ Arab
- ☐ Other (please specify) ……
- ☐ Prefer not to say

10. Do you consider yourself to have a disability?

☐ Yes ☐ No ☐ Prefer not to say

11. What is your sexual orientation?

☐ Bisexual ☐ Heterosexual/straight ☐ Gay ☐ Lesbian ☐ Prefer not to say

☐ Other (please state) ……..

12. What is your religion and belief?

☐ No religion ☐ Baha'i

☐ Buddhist ☐ Christian (including Church of England, Catholic, Protestant and all other Christian denominations)

☐ Hindu ☐ Jain

☐ Jewish ☐ Muslim

☐ Sikh

☐ Other (please specify)……

☐ Prefer not to say

Thank you for helping us with this consultation.

Please return this form by Monday 20 February, 2016 to the address on the top of this form.

We can provide versions of this document in other languages and formats such as Braille and large print on request. Please contact the Engagement and Involvement department, telephone **0116 295 4183.**

Somali
Waxaan ku siin karnaa bug-yarahaan oo ku qoran luqado iyo habab kale sida farta indhoolaha Braille iyo daabacad far waa-wayn markii aad soo codsato. Fadlan la soo xiriir qaybta Ka-qaybgalka iyo Dhex-gelidda, lambarka telefoonka waa 0116 295 4183.

Polish
Jeżeli chcieliby Państwo otrzymać kopię niniejszej ulotki w tłumaczeniu na język obcy lub w innym formacie, np. w alfabecie Braille'a lub w powiększonym druku, prosimy skontaktować się telefonicznie z zespołem ds. zaangażowania (Engagement and Involvement) pod numerem telefonu 0116 295 4183.

Cantonese
如有要求，我們可以將本宣傳手册用其他語言或格式顯示，如盲文或大號字體。 請致電我們的“參與部門” (Engagement and Involvement Department) 0116 295 4183.

Gujarati
અમે આ ચોપાનિયાનું ભાષાંતરો બીજી ભાષાઓમાં અને શૈલીઓમાં જેમ કે બ્રેઇમાં અને વિનંતી કરવાથી મોટા અક્ષરોમાં છાપેલા પૂરાં પાડી શકીએ છીએ. ઇંગેજમન્ટ અને ઇન્વોલ્વમન્ટ વિભાગનો ટેલિફોન 0116 295 4183 દ્વારા સંપર્ક કરો.

Hindi
हम आपको यह परचा दूसरी भाषाएँ में और ब्रेल एवं बडे अक्षरो जैसी रूपरेखा में निवेदन करने पर प्राप्य कर सकते है। कृपया कर के इनगेज्मन्ट और इन्वाल्वमन्ट विभाग में टॅलिफॉन द्वारा 0116 295 4183 पर संपर्क कीजिए।

Urdu
ہم درخواست کرنے پرلیفلیٹ کے اس ترجمے کو دیگر زبانوں اورصورتوں مثال کے طورپربریل اور بڑے حروف میں بھی فراہم کرسکتے ہیں۔ براہ کرم اس ٹیلی فون نمبر0116 295 4183 پراینگیجمنٹ اینڈ اینوالومنٹ ڈیپارٹمنٹ کے ساتھہ رابطہ قائم کریں۔

Arabic
يمكننا تقديم نسخ من هذه النشرة بلغات أخرى وصيغ مثل برايل والطباعة الكبيرة في الطلب. يرجى الاتصال انخراط وإشراك وزارة، والهاتف

Appendix 2 – Draft Settings of Care Policy

Leicester City Clinical Commissioning Group
West Leicestershire Clinical Commissioning Group
East Leicestershire and Rutland Clinical Commissioning Group

DRAFT Settings of Care Policy

Contents

NHS Continuing Healthcare and Personal Health Budgets

1. Introduction

This policy describes the way in which the three Clinical Commissioning Groups (CCGs) of Leicester, Leicestershire and Rutland (LLR) who are East Leicestershire and Rutland CCG, Leicester City CCG and West Leicestershire CCG, will plan and commission services for people who have been assessed as eligible for an episode of fully funded NHS Continuing Healthcare (CHC) and agree the level of a Personal Health Budget (PHB).

CHC is a package of care (PoC) or placement arranged and funded solely by the NHS for a person aged 18 and over to meet physical and/or mental health needs which have arisen as a result of disability, accident or illness. A PHB is an amount of money to support an individual's identified healthcare and wellbeing needs, planned and agreed between the individual, or their representative, and the local NHS team.

The CCGs have developed this policy to help inform a common and shared understanding of CCG commitments in relation to individual choice and resource allocation.

As per the National Framework for NHS Continuing Healthcare, the process of assessment and decision-making should be person-centred. This means placing the individual, their perception of their support needs, and their preferred models of support at the heart of the assessment and care-planning process. When deciding on how their needs are met, the individual's wishes and expectations of how and where the care is delivered, and how their personal information is shared, should be documented and taken into account, along with the risks of different types of provision and fairness of access to resources.

The CCGs' responsibility to commission CHC services derives ultimately from s3 National Health Service Act 2006. This places a duty on the CCGs to arrange for the provision, to such extent as it considers necessary to meet the reasonable requirements of the persons for whom it is responsible, of:

- [non-hospital] accommodation for the purpose of any service provided under the Act;
- medical and nursing services; and
- such other services or facilities for the prevention of illness, the care of persons suffering from illness and the after-care of persons who have suffered from illness as it considers are appropriate as part of the health service.

The CCGs are also under a statutory duty to break even financially (s223H).

Accordingly, while the CCGs will endeavour to respect the individual's preferences in commissioning CHC services, CCGs are obliged to take into account the cost of services, as well as the clinical risks inherent therein, when planning how to meet assessed needs and making an offer of a package of such services, in order to ensure that the best use is made of the limited resources available.

The CCGs will commission care to meet clinically assessed care need in an appropriate way. These packages of care are also subject to a cost-effectiveness test, in the same way as all other NHS services are. In deciding what an appropriate PoC is for eligible individuals, the CCGs have a statutory duty to consider the overall resource available to them to provide services to all the patients for whom they are responsible. In coming to a decision on the PoC for a particular individual, the CCGs need to ensure they are commissioning clinically appropriate and sustainable care within the available financial envelope, so ensuring that a high quality service is delivered while financial governance is maintained.

It is recognised that a PoC in an individual's own home, or alternative forms of supported living, are often bespoke in nature and thus can often be considerably more costly than the delivery of an equivalent PoC for an individual in an alternative setting (e.g. a care home). The CCGs are obliged by law to seek to balance the realisation of patient choice with the need to work within the financial allocations provided. This policy seeks to assist the CCGs to do this in a rational and practical manner.

2. Scope

This policy applies to:

- all CCG staff who are required to make decisions about the level of packages of care for individuals that are eligible for an episode of fully funded NHS CHC or a PHB
- any staff across the health economy who are contracted to determine eligibility or broker placements under the terms of the NHS national standard contract or a service level agreement
- all adults aged 18 years and over who are eligible for funding of an episode of fully funded NHS CHC or a PHB
- individuals and/or their representative(s) who request a PoC that could be provided in a more cost-effective alternative setting and still meet the individual's clinically assessed care needs in a clinically safe and appropriate manner.

3. Purpose, Aims and Principles

The Purpose

The purpose of this policy is to:

- define how and when the CCGs will support choice of care setting in relation to clinically appropriate packages of care for individuals within the available financial envelope and ensure that care is provided equitably across the CCGs
- ensure that the clinically assessed care needs of eligible individuals are met in a manner which supports consistent and equitable decisions about the provision of that care regardless of, for example but not limited to, the person's age, condition or disability.

The intentions of this policy are to:

- inform robust, fair and consistent commissioning decisions by the CCGs
- ensure that there is consistency in the local area in the packages of care that individuals are offered

- ensure the CCGs achieve value for money in the purchasing of packages of care for individuals
- facilitate effective partnership working between healthcare providers, NHS bodies and the Local Authorities (LAs) in the area
- promote individual choice as far as is reasonably possible.

The Aims

This policy aims to assist the CCGs to:

- provide guidance for those staff who are designing the PoC with the eligible individual, so that all parties understand that the cost of the POC provided must be proportionate for similar levels of care need regardless of the setting in which the PoC is provided, whilst meeting all of the individual's clinically assessed and eligible health and associated social care needs
- take account of the wishes expressed by individuals and their representatives when making decisions as to the settings of packages of care to be offered
- promote the individual's independence and to support individuals to take reasonable risks whilst ensuring that care provided is clinically safe, including through the use of a PHB, taking into consideration the factors set out below:

    - the individual's safety
    - the individual's choice and preference
    - ensuring services are of sufficient quality
    - the individual's right to respect for their personal family and private life, free from unwarranted state interference
    - ensuring services are culturally sensitive
    - ensuring services are personalised to meet individual clinically assessed care need
    - best use of resources for the population of the CCGs.

- make decisions about a clinically appropriate PoC in a fair and cost-effective way, within the available financial envelope
- understand the CCG's legal responsibilities in commissioning a PoC that meets the clinically assessed care needs of the individual
- meet the responsibilities set out in the law and guidance listed in Appendix B

The Principles

The principles of this policy are:

a. The CCGs understand that many individuals with complex medical conditions wish to remain in their own homes and to continue to live with their families/those important to them with a PoC to aid them to do this.
b. Similarly, the CCGs accept that many individuals might prefer other care options including other forms of supported living or registered care homes.
c. Where an individual or their family/those important to them expresses such a desire, the CCG will investigate whether it is clinically feasible to provide a sustainable PoC for the individual that is consistent with their preferences.
d. The CCGs need to act fairly to balance the resources spent on an individual patient with those available to fund services to other patients and the wider health economy.

e. In an attempt to balance the different interests (available resources vs meeting the desire for bespoke services at home or in an alternative setting), the CCGs are prepared to support a clinically sustainable PoC which keeps an individual in their preferred setting of care, where the anticipated cost to the CCG is not more than TBC% above the anticipated cost of the provision of a broadly similar PoC to be delivered in an appropriate alternative setting. This TBC% financial threshold limit will be applied consistently to every PoC across the three CCGs unless exceptional circumstances apply as defined in section 12 below.
f. Where an individual lacks capacity and a best interest decision has to be made, it will be made in accordance with the financial threshold limit outlined in (e) above.
g. Exceptionality as identified in the policy will be determined on a case by case basis.

4. Mental Capacity and Representation

Where there is reason to believe that an individual may lack the capacity to make a decision relating to the provision of (or change to) their PoC and/or accommodation, a Mental Capacity Assessment (MCA) must be undertaken. If the assessment confirms that the individual lacks the relevant capacity, a 'best interest decision' should be undertaken in accordance with the Mental Capacity Act 2005 and the related Code of Practice. Where appropriate, the CCG will appoint an Independent Mental Capacity Advocate (IMCA) to support the individual in decision making in accordance with the 2005 Act.

In some circumstances in advance of losing capacity, the individual may have given another person formal authority to make a decision on their behalf once capacity is lost. Where the CCG is made aware of this, and a best interest decision is required in respect of an offered PoC, it will ask to see the original or a certified copy of one of the following documents:

- A Lasting Power of Attorney which has been registered with the Office of the Public Guardian. This could be a Health and Welfare Lasting Power of Attorney and/or a Property and Financial Affairs Lasting Power of Attorney depending on the circumstances under discussion.
- An Enduring Power of Attorney which has been registered with the Office of the Public Guardian.
- An order of the Court of Protection appointing the representative as Deputy and the order enables them to decide on the PoC or accommodation of the individual.
- An order from the Court of Protection, in respect of the PoC or accommodation of the individual.

Where one of the above documents is provided to the CCG, it will decide how to involve the bearer in any best interest decisions. The CCG will make this decision in accordance with the Mental Capacity Act Code of Practice referenced in Appendix B.

5. Equality, inclusion and human rights

5.1 Equality commitment statement

LLR CCGs aim to design and implement policy documents that meet the diverse needs of our services, population and workforce, seeking to ensure that none are placed at a disadvantage by comparison with others. We take into account current statutory duties, including those enshrined in the Equality Act 2010 and the Human Rights Act 1998, and we promote equal opportunities for all.

This document has been designed to ensure that no-one receives less favourable treatment due to their personal circumstances i.e. their age, disability, sex (gender), gender reassignment, sexual orientation, marriage and civil partnership, race, religion or belief, pregnancy and maternity. This has been considered in the purpose of this policy which includes ensuring that the clinically assessed care needs of eligible individuals are met in a manner which supports consistent and equitable decisions about the provision of that care regardless of, for example but not limited to, the person's age, condition or disability (section 3, page 4).

5.2 Public Sector Equality Duty

This policy has been reviewed in relation to compliance with the Public Sector Equality Duty (PSED) set out in the Equality Act 2010, to have due regard to the need to eliminate discrimination, harassment, victimisation and other prohibited conduct; to advance equality of opportunity; and to foster good relations between those who share a relevant protected characteristic and those who do not.
The protected characteristics of individuals will be considered in the application of this policy with packages of care minimising disadvantages suffered by eligible individuals due to their protected characteristics and encouraging eligible individuals with protected characteristics to participate in public life wherever possible. For example, but not limited to, enabling an individual to continue to parent their dependent children and enabling an individual to continue to practice their religion/belief.

The National Constitutional duty for the CCGs to protect and promote Human Rights for every individual has been considered in this policy as below:

- The principles of this policy includes the CCGs understanding that many individuals with complex medical conditions wish to remain in their own homes and to continue to live with their families/those important to them with a PoC to aid them to do this (section 3, page 5).

- The CCGs must consider commissioning on a case by case basis, via a specific purchase, for an individual to be located near specific places in the local community and/or in a place that enables family/those important to them to visit easily. This might be a relevant consideration where the CCGs' preferred available care homes are not within a reasonable travelling distance. This would enable the individual to be accommodated in their preferred area despite the fact that the anticipated cost to the CCG may be up to TBC% more than the available CCG-preferred accommodation (based on CCG agreed standard rates for equivalent levels of care need). Such requests must be guided by the factors set out in section 12 of this policy. The individual must also understand that where such an arrangement has been agreed this arrangement will be subject to regular review and may change (section 6.1.1, page 8).

6. Identification of Care Provision

Where an individual is eligible for an episode of fully funded NHS CHC or a PHB, the CCG will commission the PoC that meets the individual's clinically assessed care needs. In other words, the CCG will fund a PoC that is needed to meet the individual's care requirements. This may or may not be in the individual's preferred setting of care.

6.1 The role of the CCGs

The CCGs must:

- seek to take into account any reasonable request from the individual and their representative(s) in making the decision about the PoC, subject to the factors set out in sections 3 and 12 of this policy
- endeavour to offer a reasonable choice of available, preferred providers to the individual
- where the individual wishes to receive their care from an alternative provider, the CCG will consider this preference, subject to it satisfying the following criteria:

    - the individual's preferred care setting is considered by the CCG to be suitable in relation to the individual's care needs as assessed by the CCG
    - the cost of making arrangements for the individual at their preferred care setting would not require the CCG to pay more than they would usually expect to pay having regard to the individual's clinically assessed care needs (and having regard to the average cost of the packages of care offered by the CCG and rejected by the individual)
    - the individual's preferred care setting is available
    - the preferred care setting is able to provide the required care to the individual subject to the CCG's usual terms and conditions, having regard to the nature of the care setting for such an individual in receipt of an episode of fully funded NHS CHC or a PHB
- take account of the wishes expressed by individuals and their representative(s) when making decisions as to the setting of care to be offered to individuals.

6.1.1 The CCG and Registered Care Settings

Where care is to be provided in a registered care setting (i.e. one that provides accommodation, such as a nursing home, residential home and some supported living schemes), the CCGs will only place individuals with providers which are:

a. registered with the Care Quality Commission (CQC – or any successor) as providing the appropriate form of care to meet the individual's clinically assessed care needs; and
b. not subject to an embargo by the CCGs or LAs, including the host CCG or LA if the provider is not located in LLR
c. contracted to the LLR CCGs to provide nursing care at the standard rate. (Note: Contracted providers are also eligible for the Commissioning for Quality and Innovation [CQUIN] quality premium, subject to achieving the required quality standards);
d. contracted to the CCGs to provide care at an enhanced rate, where the CCGs determine that enhanced care is required.

The CCGs must:

- consider providing a placement in a registered care setting not contracted to the CCGs in exceptional circumstances. This will only be approved when the provider complies with paragraphs **a** and **b** above.

- approve requests for a preferred setting of care, where reasonably possible, provided that the criteria set out at sections 3 and 12 of this policy are satisfied.
- where a care home that was not originally offered is requested by the individual, consider accepting the individual's preferred setting of care providing it complies with the criteria set out in sections 6.1 and 12 of this policy.
- consider commissioning on a case by case basis, via a specific purchase, for an individual to be located near specific places in the local community and/or in a place that enables family/those important to them to visit easily. This might be a relevant consideration where the CCGs' preferred available care homes are not within a reasonable travelling distance[1]. This would enable the individual to be accommodated in their preferred area despite the fact that the anticipated cost to the CCG may be up to TBC% more than the available CCG-preferred accommodation (based on CCG agreed standard rates for equivalent levels of care need). Such requests must be guided by the factors set out in section 12 of this policy. The individual must also understand that where such an arrangement has been agreed this arrangement will be subject to regular review and may change.
- bear in mind that if an individual or their representative(s) exercise individual choice and prefer a care home in another area, the CCG must consider placing the individual there, subject to the factors in sections 3, 6.1 and 12.

6.1.2 The CCG and preferred provider placements

To assist the CCGs in achieving consistent, equitable packages of care, the CCGs will endeavour to offer and place individuals with preferred providers. These are those providers that have undergone a procurement exercise with the CCG.

Where a preferred provider is not available to meet the individual's clinically assessed care needs, the CCG may make a specific purchase and place the individual with another care provider who meets the individual's care needs. Where such an arrangement has been agreed the CCG reserves the right to move the individual to a suitable preferred provider when capacity becomes available, where this will provide better value for money to the CCG. For example, if an individual has a specific care need which cannot be met in the available preferred accommodation, the CCG will need to specifically commission accommodation for the individual, potentially through an individually negotiated agreement. The CCG should notify the individual and/or their representative that they may be moved should a suitable preferred provider subsequently have capacity. In such circumstances, the CCG will give a minimum of TBC notice to the individual.

Though all reasonable requests from individuals and their representative(s) will be considered, the CCG is not obliged to accept requests from individuals for specific care providers which have not been classed as preferred providers.

Where the CCG deems that a provider is not providing care of an acceptable standard, the CCG reserves the right to move the individual to an alternative provider.

The CCGs contract with different providers to meet the care needs of different service users. Where an individual's assessed care needs change, the CCG may offer a PoC with

[1] Reasonable travelling distance will be based on a case by case assessment of an individual's circumstances, and must take into account factors such as ability of family/those important to the individual to visit, which may include consideration of public transport links and mobility of the family/those important to the individual in question.

a different provider. In such circumstances, the CCG will give a minimum of TBC notice to the individual.

6.1.3 The CCG and domiciliary care providers

The CCGs acknowledge that:

- the provision of domiciliary care for an individual requiring care across the 24 hour period is likely to be more costly than care provided to that same individual in a residential or nursing home placement. However, the anticipated cost to the CCG **must not be** more than TBC% above the anticipated cost of the provision of a broadly similar PoC to be delivered in an appropriate alternative setting unless exceptional circumstances apply as defined in section 12 below.
- many individuals with complex healthcare needs wish to remain in their own homes, with support provided in that setting. Where an individual or their representative(s) express such a desire, the CCG will investigate to determine whether providing a PoC in the home is clinically and financially sustainable.
- where the CCG decides to offer domiciliary care to an individual, the individual's home becomes the care providers' place of work. Employee safety is an important consideration in domiciliary packages of care. The individual's home must be a reasonably safe environment in which to work and deliver care to the individual. The cleanliness of the environment, and the nature of interactions between the individual, family/those important to them/carer and the employee are just two examples of factors to be taken into account in considering whether the setting is safe or not.

Where domiciliary care is to be provided, the CCGs will:

- benchmark the cost of a PoC against the cost of a suitable PoC in a registered care setting that will meet the clinically assessed care needs of the individual
- when an individual expresses the preference to receive care at home, set the cost of domiciliary care provision at no more than TBC% above the anticipated cost of the provision of a broadly similar PoC in an appropriate registered care setting
- ask family members/those important to the individual if they are willing and able to supplement support and, if they agree, the CCGs will assume that family members/those important to the individual will provide the agreed level of support when designing any domiciliary care package. However, no pressure should be applied on them to offer such support as family members/those important to the individual are under no legal obligation to offer care

6.1.4 The CCG and preferred providers

Though all reasonable requests from individuals and their representative(s) will be considered, the CCG is not obliged to accept requests from individuals for specific care providers which have not been classed as preferred providers.

Where the CCG deems that a provider is not providing care of an acceptable standard, the CCG reserves the right to move the individual to an alternative provider.

The CCGs contract with different providers to meet the assessed care needs of different individuals. Where an individual's needs change, the CCG may offer a PoC with a different provider.

A PHB may be provided to an individual in a registered or a non-registered setting of care. It may cover all or part of the care needed by the individual. It may only be used to pay for care agreed as part of a PoC by the CCG.

6.2 The CCG and Personal Health Budgets

Since October 2014, all individuals eligible for CHC and children eligible for Continuing Care have had a "Right to Have" a PHB, save to the extent that this is not appropriate or is otherwise precluded by the statutory framework. In line with the 2015/16 Five Year Forward View, the CCGs have made a commitment to expand their 'local offer' to more patients with complex needs. Where the CCG decides to offer an individual a PHB, it will benchmark the cost of such a PoC against alternative packages of care.

The requirements for PHBs are laid down in the CCGs' PHB Policy:

6.3 The role of the Care Co-ordinator

The individual's Care Co-ordinator will effect the following:

- discussion of the proposed PoC with the individual and their representative(s) (where the individual gives consent for such a discussion or where the individual lacks capacity) including how and where the care and support may be provided.
- identification of different options for packages of care and securing an indication as to which PoC and/or setting of care is preferred by the individual.
- preparation of a written care plan that must clearly identify and articulate the clinical outcomes that the individual wishes to achieve and what actions need to take place to seek to enable those health improvements to be realised.
- using an agreed NHS Funding Request Form, set out the details of the requested PoC and any associated information. The form must be completed in full for every proposed PoC.

7 Availability of care provision

To enable individuals to *receive* the correct PoC promptly, they must be *offered* care as soon as possible. If an individual's first choice from the CCGs' preferred provider range is not available, they will be offered another CCG preferred provider to ensure provision as soon as possible. The CCGs will offer packages of care from preferred providers before any others, unless exceptional circumstances apply as detailed in section 12 below.

If the individual requests a setting of care that is currently unavailable and/or is unwilling to accept the CCG's offer of a PoC, there are several options available to the CCGs:

- Temporary placement of the individual with an alternative care provider until the CCG's preferred provider is available. For example, an alternative home care provider, alternative care home, respite care or a community bed
- The individual may choose to go to their own or a relative's home without the assessed PoC until the preferred setting/care provider is available. The terms set out in section 9 of this policy will apply. The individual will, however, retain the right subsequently to change their mind and accept the PoC offered by the CCG. If the individual does not

have mental capacity to make this decision, the CCG will exercise its duties under the Mental Capacity Act 2005 to ensure that a best interests decision is made.

- If it has been agreed with the individual that the clinically assessed care needs can best be met through a care home placement, the CCG may choose to provide home care until the preferred care home is available, but cost implications to the CCG must be considered when identifying the level of a PoC to be provided. This will be in accordance with sections 3 and 12 of this policy.

Where the CCG provides an individual with a PoC that is more expensive than the standard cost due to, either unavailability in the market, or the inability of the CCG to commission at the standard cost, the additional cost will be funded by the CCG. Where such an arrangement has been agreed, the CCG reserves the right to move the individual to a suitable preferred provider when one becomes available where this will provide better value for money to the CCG. The CCG must notify the individual, and/or their representative(s), that their provision may be moved should a preferred provider subsequently have capacity. In such circumstances, the CCG will give a minimum of TBC notice to the individual.

If an individual's representative(s) are delaying placement in a care home due to non-availability of a preferred care home provider, and the individual does not have the mental capacity to make a decision themselves, the CCG will have recourse to the Vulnerable Adults Policy, local safeguarding procedures and the Mental Capacity Act 2005, as appropriate.

If the individual is in an acute healthcare setting, they must move to the most appropriate setting of care as soon as they are medically fit for discharge, even if their preferred setting/care provider is not available. The individual's preference must be considered in line with sections 3 and 12 of this policy, when the CCG is deciding which PoC to offer to them. Where the individual's preferred setting is not available, but an alternative setting that will meet their clinically assessed care needs is available, they must move and cannot remain in an acute healthcare setting once they are medically stable.

8 Acceptance of care provision

An individual is not obliged to accept an episode of fully funded NHS CHC. Once an individual is eligible and offered a PoC and they choose not to accept this, the CCG must (in appropriate cases) take reasonable steps to make the individual aware that the LA does not assume responsibility to provide care to the individual. The CCG will work with the individual to help them understand their available options and facilitate access to appropriate advocacy support. As appropriate, the CCG will have recourse to the Vulnerable Adults Policy, local safeguarding procedures and the Mental Capacity Act 2005.

9 Withdrawal of care provision

The NHS discharges its duty to individuals by making an offer of a suitable PoC to individuals whether they choose to accept the offer or not. The following are examples of how this can work in practice:

- The CCG offers to discharge its duty by providing a PoC for an individual in one or more appropriate care settings, irrespective of whether this is the individual's preferred setting, and that offer is rejected by the individual.

- The CCG offers to discharge its duty to an individual who, to date, has had a PoC in their own home by moving the individual to one or more appropriate care homes (since the costs of providing such care may be significantly less than providing care for an isolated individual in their own home) but that offer of a care home is rejected by the individual.

Either of the above circumstances may lead to a decision to withdraw services from the individual. The CCG will have recourse to the Vulnerable Adults Policy, local safeguarding procedures and the Mental Capacity Act, as appropriate.

Where an individual exercises their right to refuse, the CCG will ask the individual or their representative(s) to sign a written statement confirming that they are choosing not to accept the offer of a PoC.

It may be appropriate for the CCG to withdraw a PoC where the situation presents a risk of danger or violence to, or harassment of, the care staff who are delivering the PoC.

The CCG may also withdraw a PoC where the clinical risks become too high. This can be identified through, or independently of, the review process. Where the clinical risk has become too high in a home setting, the CCG may choose to offer a PoC in a care home setting.

10 Disputes

An individual may dispute a decision by the CCG in relation the PoC offered. Such disputes will be dealt with through the CCG's complaints procedure. If the complaint cannot be resolved locally the individual or their representative can apply to the Health Service Ombudsman.

Leicester City CCG:

East Leicestershire and Rutland CCG:

West Leicestershire CCG:

11 Continuing Healthcare review

A case review should be undertaken no later than three months after the initial eligibility decision, in order to reassess the individual's care needs and eligibility for an episode of fully funded NHS CHC, and to ensure that the individual's clinically assessed care needs are being met. Reviews should take place annually thereafter, as a minimum. The CHC review may identify an adjusted, decreased or increased care need.

If the review demonstrates that the individual's condition has improved to an extent that they no longer meet the eligibility criteria for CHC, the CCG is obliged to cease funding, whether the PoC is delivered in a home or care home setting. In these circumstances, the individual will be informed and where appropriate the Local Authority (LA) will also be informed.

Where an individual remains eligible and is receiving a PoC in their home setting, the CCG will consider the ability of the PoC to be delivered in the home setting, and also the cost effectiveness of this PoC in accordance with sections 3 and 12 of this policy.

Where the individual remains eligible and is accommodated in a care home setting, the CCG will ensure that the care home is able and suitable to deliver this adjusted or decreased care need.

Where the care home is unable to meet this adjusted care need, the CCG will accommodate the individual in accordance with sections 3 and 12 of this policy.

Where there is a decreased care need, the CCG will consider the cost effectiveness of the PoC to be delivered in the current care home setting, and may move the individual to a suitable alternative care provider in accordance with sections 3 and 12 of this policy. In such circumstances, the CCG will give a minimum of TBC notice to the individual.

12 Exceptional Circumstances

The CCGs are required to achieve financial balance each year and therefore have a statutory duty to support a clinically sustainable PoC funded by the NHS which keeps an individual in their preferred setting of care, where the anticipated cost to the CCG is not more than TBC% above the anticipated cost of the provision of a broadly similar PoC to be delivered in an appropriate alternative setting.

The CCGs' policy is that the High Risk and Complex Care Panel should consider requests for CHC funding where the anticipated cost to the CCG is more than TBC% above the cost of a broadly similar PoC to be delivered in an alternative setting.

12.1 Exceptional circumstances criteria

In exceptional circumstances, the CCGs will be prepared to consider funding provision where the anticipated cost to the CCG is more than TBC% above the cost of a broadly similar PoC to be delivered in an alternative setting. Exceptional circumstances will be considered on a case by case basis. Please see below an indication of the exceptional circumstances:

- An End of Life Care patient – a person with a rapidly deteriorating condition and entering a terminal phase who may need CHC funding to enable their assessed care needs to be urgently met (e.g. to enable them to go home to die or to provide appropriate end of life support to be put in place either in their own home or in a care setting).
-

Please note that, due to the clinical risk of providing the following level of care in a home setting, it should be presumed that this should not be delivered in an individual's own home:

- 24 hour care from a registered nurse. This clinical need would normally be provided in a nursing home
- hospital level care. This clinical need would normally be provided within a specialist unit

12.2 Demonstrating exceptional circumstances

a. The requesting clinician is required to present a full report to the High Risk and Complex Care panel using the NHS Funding Request Form which sets out a

comprehensive and balanced clinical picture of the history and present state of the individual's medical condition, the nature of the PoC requested and the anticipated benefits of the care requested.

b. The panel shall determine, based upon the evidence provided to the panel, whether individual exceptional clinical and/or operational circumstances have been demonstrated for the patient. The evidence to show that, for the individual patient, the proposed PoC is likely to be clinically effective may be part of the case that the patient's individual clinical and/or operational circumstances are considered to be exceptional.

c. In determining whether a clinician is able to demonstrate that a patient has individual exceptional circumstances the panel shall compare the individual to other patients with the same presenting medical condition at the same stage of progression.

13 Fast track applications

Care provision for individuals assessed using the Fast Track Pathway Tool for NHS CHC will be subject to the same principles as set out in sections 3 and 12 of this policy.

14 High Risk and Complex Care Panel

Following agreement that an individual meets the eligibility criteria for CHC or a PHB and a PoC has been identified that makes up an ongoing care plan, cases are referred (where applicable) to the LLR CCGs' High Risk and Complex Care Panel to consider requests for NHS funding. The panel considers:

- a specific PoC
- correct application of the Settings of Care Policy
- the risks inherent in the design of the proposed support/care plan for service users taking up a PHB

The panel has two distinct functions to consider:

i. risk associated with care plans
ii. complex care placements and their cost effectiveness

Appendix A – Definitions

Accommodation: In the context of CHC, accommodation relates to an appropriately registered care setting or the individual's own home.

Care Co-ordinator: Care Co-ordinator refers to the person who coordinates the assessment and care planning process. Care Co-ordinators are usually the central point of contact with the individual.

Care provision: Care provision takes two main forms:

- Care provided in an individual's own home and referred to in this document as 'home care' or 'domiciliary care'.
- Care provided in an appropriately registered care setting (such as a nursing home or a residential home) and referred to in this document as 'registered care setting' or 'care home'.

CHC: CHC is used in this policy as an abbreviation for NHS Continuing Healthcare which is a package of care arranged and funded solely by the NHS for a person aged 18 and over to meet physical or mental health care needs which have arisen as a result of disability, accident or illness.

Individual: In the context of this policy the individual is the service user that has been assessed and found eligible for CHC.

Personal Health Budget; an amount of money to support identified healthcare and wellbeing needs, planned and agreed between an individual or their representative, and the local NHS team.

Representative(s): Representative(s) refers to the person(s) whom it is appropriate for the CCGs to consult about and involve in decisions about the provision of CHC/PHB to the individual. The individual receiving healthcare may elect to have representative(s) act with them or on their behalf, or there may be representative(s), formally or informally appointed or chosen, where the individual does not have the mental capacity to make independent decisions relating to the CHC eligibility process or the proposed package of care.

Representatives may be legal representatives, individual advocates, family/those important to the individual, or other people who are interested in the individual's wellbeing.

Where the individual has capacity, they must give consent for any representative to act on their behalf.

A person who has formally been appointed as an Attorney or Deputy has defined responsibilities for the individual. The extent of these responsibilities will vary according to the nature of their appointment.

Local Authority: Local Authority refers to Leicester City Council, Leicestershire County Council or Rutland County Council.

CCG: CCG refers to NHS Leicester City, East Leicestershire and Rutland, or West Leicestershire Clinical Commissioning Group.

Provider: Provider refers to the organisation that provides a package of care to the individual.

Preferred providers: These providers have been assessed and accepted onto the Any Qualified Provider framework by the CCG as being able to fulfil the CHC requirements of defined categories of individuals at an agreed cost.

Appendix B – Legal Sources

- Human Rights Act 1998
- Mental Capacity Act 2005 Code of Practice
- National Health Service Income Generation - Best practice: Revised guidance on income generation in the NHS (1 February 2006)
- National Health Service Act 2006 (as amended)
- Guidance on NHS patients who wish to pay for additional private care (May 2009)
- Equality Act 2010
- The National Health Service Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012 (as amended)
- The National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care - November 2012 (revised)
- Who Pays? Determining responsibility for payments to providers (August 2013)
- Care Act 2014
- NHS Constitution for England 2015

Leicestershire County Council

HEALTH OVERVIEW AND SCRUTINY COMMITTEE: 23rd JAN 2017

REPORT OF DIRECTOR OF PUBLIC HEALTH

COMMUNITY SUBSTANCE MISUSE TREATMENT SERVICES

Purpose of report

1. The purpose of this report is to provide scrutiny members with an update on community substance misuse treatment services following the re-procurement that took place in 2016.

Policy Framework and Previous Decisions

2. A report has previously been presented to the Health Overview and Scrutiny Committee in September 2015 where the committee were consulted on the proposed model and the procurement timescales to ensure the new contract was in place by 1st July 2016.

Background

3. Following a period of redesign and procurement, Turning Point, a national social enterprise providing specialist substance misuse services, were awarded the contract to provide an integrated substance misuse treatment service across Leicestershire and Leicester City. The contract commenced on 1st July 2016 and combines adult and young person's community based services including those within the criminal justice service, and HMP Leicester. Whilst there is a single provider, Leicestershire County Council and Leicester City have separate contracts with Turning Point.

4. The Turning Point contract runs for 4 years with an option to extend for an additional 12 months. Commissioning partners include, Leicestershire County Council, Leicester City Council, Office of the Police and Crime Commissioner (OPCC), and NHS England. This partnership is underpinned by a Partnership Agreement.

5. Key elements of the new service include;

- Equity of access across county and city from a hub and spoke model with one Co-ordinated Single Intake System (CSIS)
- Clinically safe and effective services
- Reducing harm and building sustainable recovery

Progress to Date

6. On award of the contract in February, Turning Point and commissioning partners commenced the Implementation Phase in readiness for the contract going live on 1st

July. This was a critical and challenging time, that required the bringing together of six existing service providers across Leicestershire and Leicester City into one service provider. For Turning Point this included receiving staff from multiple services, reviewing and consolidating various premises options, and timely data transfer within Information Governance protocols and security, whilst ensuring safe continuity of care for clients transferring.

7. The service successfully opened on 1st July 2016 with limited disruption to service users. Turning Point were able to take over the existing service hub in Coalville and opened a new hub in Loughborough. Co-location with other services/authorities had been negotiated in Harborough, Hinckley, and Melton and initially all existing satellite venues across the county continued to be used. These are currently being reviewed for suitability. A new central city centre hub opened in September 2016.

8. In December 2016 a launch event was held at the city centre hub in Eldon Street. This was very well attended, and included an opportunity for visitors to find out more about the interventions and services provided by Turning Point in Leicestershire. The event was attended by Lord Victor Adebowale (Turning Point Chief Executive), and Mr. E. F. White CC.

9. The Mobilisation Phase from 1st July has ensured that all service users were safely transferred and their treatment continued, and Turning Point continues to receive new referrals. Current service provision includes;

- Single referral point/number;
- Information and advice;
- Assessment;
- Psychosocial interventions;
- Counselling;
- Harm reduction services;
- Clinical services including substitute prescribing and detoxification;
- Peer mentoring support;
- Groupwork programmes;
- Mutual Aid/recovery support.

10. The service model includes separate and specific provision for young people and young adults, and also ensures reaching out to the most vulnerable and less visible members of our community. This requires Turning Point to establish operational protocols with key services to promote information sharing and joint working.

11. To ensure the effective delivery of the service a governance structure has been put in place. This includes monthly Contract Management Meetings held jointly (LCC and Leicester City) with Turning Point, and quarterly meetings that include other commissioning partners. In addition, a Strategic Board including commissioning partners and other relevant partners (National Probation Service, Police) meets every 6 months providing a broader strategic overview.

12. Key performance indicators have been agreed and Turning Point provided the first quarterly update (July- Sept) in November for discussion at the Contract Management Meeting. As anticipated, there have been teething problems with data uploads and data quality. These issues have been resolved between the Public

Health England (PHE) National Drug/Alcohol Treatment Monitoring System (ND/ATMS), and Turning Point, and commissioners will follow up to ensure future performance reports are more robust. However, local data and feedback has been positive and commissioners are reassured of delivery of a good quality service and progress to date.

13. Now core services are in place, priorities for the coming months include ensuring protocols and care-pathways are in place with broader stakeholders, and finalising additional management performance data.

Resource Implications

14. The overall annual contract value is £8,423,736, of which the Leicestershire contribution is £3,365,201. This contribution is funded from the Public Health Grant.

Conclusions

15. The procurement and implementation of the new contract for substance misuse treatment services ensured the successful continuation of service provision. Turning Point have managed the transfer well and commissioners are reassured by progress to date.

Background papers

Report to Health Overview + Scrutiny Committee on 9th September 2015
Report to Cabinet on 11th September 2015

Circulation under the Local Issues Alert Procedure

None

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List of Appendices

Appendix 1 – Turning point Leicestershire Contact Details

Relevant Impact Assessments

Equality and Human Rights Implications

16. An EHRIA has been completed for the substance misuse procurement.

Crime and Disorder Implications

17. Individuals treated for and supported to recover from substance misuse are less likely to reoffend and/or behave anti-socially. This will impact positively on crime and disorder.

Appendix 1

Turning Point Leicestershire – for referrals, and more information

Phone – 0330 303 6000

Online – www.wellbeing.turning-point.co.uk/leicestershire

Email – LLreferrals@turning-point.co.uk

Hubs –

Loughborough – 55-56 Woodgate, Loughborough, LE11 2TG

Coalville – 42 High Street, Coalville, LE67 3EE

City Centre – 2 Eldon Street, Leicester, LE1 3QL

Young People/Young Adult Hub – 165 Granby Street, Leicester, LE1 6FE

For details of additional community/satellite venues sites across the County contact Turning Point.
Self- referrals accepted.

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