Leicestershire County Council

Meeting: **Health Overview and Scrutiny Committee**

Date/Time: **Monday, 19 June 2017 at 2.30 pm**

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

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

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

Membership

Mr. P. Bedford CC	Dr. S. Hill CC
Mr. L. Breckon JP CC	Mr T. Parton CC
Mrs. H. J. Fryer CC	Mrs H. L. Richardson CC
Mr. D. A. Gamble CC	Mrs D. Taylor CC
Mrs. A. J. Hack CC	

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

AGENDA

Item		Report by
1.	Appointment of Chairman To note that Mr L Breckon JP CC was nominated as Chairman elect to the Health Overview and Scrutiny Committee at the Annual Meeting of the County Council held on 17 May 2017.	
2.	Election of Deputy Chairman	
3.	Minutes of the meeting held on 1 March 2017	(Pages 5 - 12)
4.	Question Time.	
5.	Questions asked by members under Standing Order 7(3) and 7(5).	
6.	To advise of any other items which the Chairman has decided to take as urgent elsewhere on the agenda.	

7.	Declarations of interest in respect of items on the agenda.		
8.	Declarations of the Party Whip in accordance with Overview and Scrutiny Procedure Rule 16.		
9.	Presentation of Petitions under Standing Order 36.		
10.	Integrated Locality Teams.	Director of Health and Care Integration	(Pages 13 - 44)
11.	East Midlands Ambulance Service Update. A powerpoint presentation is attached	East Midlands Ambulance Service NHS Trust	(Pages 45 - 50)
12.	Staff Training Relating to Discharge.	University Hospitals of Leicester NHS Trust	(Pages 51 - 54)
13.	GP Five Year Forward View Implementation. A powerpoint presentation is attached.	Better Care Together	(Pages 55 - 74)
14.	Sustainability and Transformation Plan Update. There will be a powerpoint presentation for this item.	Better Care Together	
15.	Date of next meeting. The next meeting of the Committee is scheduled to take place on 6 September 2017 at 2.00pm		
16.	Any other items which the Chairman has decided to take as urgent.		

QUESTIONING BY MEMBERS OF OVERVIEW AND SCRUTINY

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

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

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

Key Questions:

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

If it is a new service:

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

If it is a reduction in an existing service:

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

This page is intentionally left blank

Agenda Item 3

Minutes of a meeting of the Health Overview and Scrutiny Committee held at County Hall, Glenfield on Wednesday, 1 March 2017.

PRESENT

Dr. S. Hill CC (in the Chair)

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

In attendance
Dr Satheesh Kumar, Medical Director, Leicestershire Partnership NHS Trust (minute 64 refers)
Dr Peter Miller, Chief Executive, Leicestershire Partnership NHS Trust (minute 64 refers)
Cathy Ellis, Non-Executive Director, Leicestershire Partnership NHS Trust (minute 64 refers)
Andrew Furlong, Medical Director, UHL (minute 65 refers)
Sharron Hotson, Director of Clinical Quality, UHL (minute 65 refers)
Dr Catherine Free, Deputy Medical Director, UHL (minute 66 refers)
Fiona Barber, Healthwatch Leicestershire board member
Kate Allardyce, Performance Team (Leicester & Lincoln) GEM Commissioning Support Unit (minute 69 refers)

57. Minutes of the previous meeting.

The minutes of the meeting held on 23 January 2017 were taken as read, confirmed and signed.

58. Question Time.

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

59. Questions asked by members.

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

60. Urgent Items.

There were no urgent items for consideration.

61. 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 in Item 13: Performance Update as she volunteered for Hermitage FM, a radio station in North West Leicestershire.

Ms. B. 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.

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

There were no declarations of the party whip.

63. Presentation of Petitions.

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

64. Care Quality Commission inspection of Leicestershire Partnership NHS Trust.

The Committee considered a report of Leicestershire Partnership NHS Trust (LPT) which outlined the Care Quality Commission's key findings from their inspections of Leicestershire Partnership Trust in 2015 and 2016 and the Trust's initial response ahead of the production of a full action plan. A copy of the report, marked 'Agenda Item 8', is filed with these minutes.

The Chairman welcomed Dr Satheesh Kumar, Medical Director, Dr Peter Miller, Chief Executive and Cathy Ellis, Non-Executive Director, all from Leicestershire Partnership NHS Trust to the meeting for this item.

Arising from discussions the following points were noted:

(i) In response to a question regarding concerns around staffing levels and skills mix at the Bradgate Unit, reassurance was given that the use of Agency and Bank staff did not impact on patient safety, however it was acknowledged that it could have an impact on staff morale. The staffing issue was recorded on the Risk Register. There were vacancies that needed filling and a recruitment programme was in place. It was noted that Bank staff were on the same terms and conditions as regular staff whereas Agency staff had separate terms and conditions. In response to a question regarding whether the terms and conditions of staff contracts could be improved to encourage staff to remain working for LPT Members were advised that this was unlikely as there was a National Agenda for Change and the terms and conditions had to be in line with this.

(ii) In response to a question regarding how the United Kingdom's changing relationship with the European Union could affect staffing levels, Members were reassured that LPT had approximately 300 staff from European Union countries so the impact would not be significant. However, between LPT and University Hospitals Leicester (UHL) there were 20,000 staff from European Union countries.

(iii) With regard to the Care Quality Commission giving LPT a rating of 'Requires Improvement' in response to the question 'Are services well-led?', Members were reassured that the culture had now changed towards providing more support for

staff. Records were now being kept of the amount of support that had been provided to individual staff members. Members were advised that 65% of staff were getting clinical supervision which was a significant improvement as 18 months previously only 25% were getting clinical supervision. Where it was identified that an inadequate level of support was being provided team managers were being spoken to.

(iv) With regard to concerns raised by the Care Quality Commission that police vehicles were being used to transport patients due to a lack of appropriate transport it was noted that a meeting was to take place with the Chief Constable and the Chief Executive of UHL to discuss the matter. It was also noted that at times there was a lack of bed availability. The Place of Safety was nearing readiness for taking patients however there would still be issues with having the correct number of staff in place and Members were reassured that the levels of staffing support were being looked at. It was noted that the triage car which was staffed by both Police Officers and a mental health practitioner had reduced the need for the Place of Safety.

(v) The issues raised by CQC which could be addressed in a short space of time such as the lack of privacy curtains, fridge temperatures and the lack of a defibrillator at the Community Therapy Unit in Hinckley, had already been dealt with by LPT.

(vi) Work needed to be carried out with partners such as Nottinghamshire Healthcare NHS Trust to improve access to psychology for patients and staff. A psychologist had been appointed to provide support to patients and those working with patients.

(vii) The Child and Adolescent Mental Health Service (CAMHS) Early Help service had not been recommissioned yet as a provider had not come forward. There had been a 20% increase in specialist CAMHS referrals which was not sustainable therefore the early intervention was important. A CAMHS summit would take place in March 2017 to ensure that the Sustainability and Transformation Plan was adequate. There had been an improvement in the waiting times for patients receiving a first CAMHS appointment however there was now a waiting list for patients to start treatment.

(viii) LPT had not been informed of when the Care Quality Commission would be making any further inspections however it was anticipated that the CAMHS services would be inspected again within a year as they had received an ‘Inadequate’ rating, and the rest of LPT was likely to be inspected within 3 years.

RESOLVED:

(a) That the report be noted.

(b) That the actions being taken by LPT to resolve the concerns raised by CQC be welcomed.

65. <u>Care Quality Commission inspection of University Hospitals Leicester.</u>

The Committee considered a report of University Hospitals of Leicester NHS Trust (UHL) which provided an overview of the Care Quality Commission comprehensive inspection of University Hospitals of Leicester in June 2016 and the key findings from the inspection. A copy of the report, marked ‘Agenda Item 9’, is filed with these minutes.

The Chairman welcomed Andrew Furlong, Medical Director, UHL, and Sharron Hotson, Director of Clinical Quality, UHL to the meeting for this item.

In presenting the report the following points were raised:

(i) UHL had conducted a self-assessment and given themselves a rating of 'Requires improvement' therefore they accepted that the rating from the Care Quality Commission which was also 'Requires improvement' was accurate. Whilst the rating from the Care Quality Commission had stayed the same from the previous inspection members were reassured that the culture and leadership at UHL had improved in the intervening period.

(ii) In order to address the concerns raised in the Care Quality Commission report an action plan had been created which was to be shared at a Care Quality Summit. The action plan would be monitored at a bi-monthly forum which reported to the Executive Quality Board.

Arising from discussions the following points were noted:

(i) In order to reduce demand at UHL there needed to be a joined up approach across the NHS in Leicestershire. In particular those issues which did not require hospital treatment needed to be dealt with by GPs. The Sustainability and Transformation Plan attempted to create this integrated environment. The A&E Delivery Board had been looking at ways to encourage patients to attend GP practices rather than hospitals. Walk-in patients were streamed to Urgent Care Centres and encouraged to book appointments at GP Practices.

(ii) In June 2016 conditions had been placed on the licence of UHL, one of which related to the management of sepsis, but those conditions had now been lifted. Members welcomed the improvement in the management of sepsis at UHL.

(iii) UHL had successfully implemented the 'Red to Green initiative' which reduced the amount of days patients were in hospital waiting for treatment or other clinical activity to take place so that they could be discharged sooner. Consultant-led ward rounds had enabled patients to move through the system more quickly. However, improvements needed to be made with regards end of life care and holding meaningful discussions with patients and their family members in order to produce appropriate care plans.

RESOLVED:

(a) That the report be noted.

(b) That the improvements made since the previous Care Quality Commission inspection be welcomed.

66. <u>Emergency Care at Leicester Royal Infirmary.</u>

The Committee considered a report of University Hospitals of Leicester NHS Trust (UHL) which provided an update on Emergency Care at Leicester Royal Infirmary and the planned opening of the new Emergency Department. The Committee also received a presentation which gave an indication of the likely impact of the new Emergency Department on ambulance handovers and flow of patients through the hospital. A copy of

the report marked ‘Agenda Item 10’, and the presentation slides, are filed with these minutes.

The Chairman welcomed Dr Catherine Free, Deputy Medical Director, UHL, to the meeting for this item.

Arising from discussions the following points were noted:

(i) Some new Emergency Departments at other hospitals had experienced a 10% increase in attendance after opening and Members expressed concerns regarding whether UHL would be able to cope with an increased demand after 26 April when the new Department opened. In response it was acknowledged that the new Emergency Department might not resolve all the problems with regard to flow through the hospital however Members were reassured that at previous times of exceptionally high demand UHL had been able to halt elective medical treatment for a 10 day period which had a positive impact on the flow through the Emergency Department.

(ii) The new Emergency Department would have a paediatric short stay unit and Members asked UHL to ensure that the paediatric short stay unit had the facilities and equipment to deal with children of all ages and sizes. The entrance to the paediatric short stay unit would be on the opposite side of the hospital and there would also be changes to the access route to the adult section of the Emergency Department and the ambulance turning circle. Therefore the UHL site map would be redesigned to reflect the changes to the site.

(iii) It was planned that the Emergency Frailty Unit and the Acute Frailty Unit would be co-located as of summer 2018 however in the intervening period the Emergency Frailty Unit would have to be moved elsewhere. Members expressed concerns that this would impact on patient flow within UHL but were reassured that measures were in place to mitigate this problem such as having practitioners with the appropriate skills such as Occupational Therapy deal with frail patients in the Emergency Department to prevent them being required admitting to hospital. In addition the GP Assessment Unit was being kept within Majors.

(iv) In response to a question regarding whether there was space in the new Emergency Department for the voluntary sector to dispense help and advice Members were informed that there were no plans of this nature but UHL would give this consideration.

RESOLVED

That the report and accompanying presentation be noted.

67. Healthwatch Work on Discharge.

The Committee considered a report of Healthwatch Leicestershire which presented the findings of their survey on the issue of hospital discharge. A copy of the report, marked ‘Agenda Item 11’, is filed with these minutes.

The Chairman welcomed Fiona Barber, Healthwatch board member, to the meeting for this and other items.

Arising from discussions the following points were noted:

(i) It was important for discharge planning to begin as soon as the patient was admitted to hospital to ensure that all necessary arrangements were in place by the time the patient was ready to leave hospital.

(ii) Approximately 20% of the discharge delays related to patients that required County Council services such as Social Care. These delays could be down to the patient requiring an assessment or a Care Package, or patient choice being a factor such as a preferred Care Home not being available.

(iii) As part of the Sustainability and Transformation Plan the Home First initiative was looking at what the Health and Social Care system needed to improve the transfer of patients from hospital care to home care. A group had been set up which had met twice and a workshop was taking place to discuss a report on Leicestershire by the Emergency Care Improvement Programme who had made recommendations on how the services could be improved. It was intended to implement those recommendations, one of which was to have one discharge team instead of having five different discharge teams across Leicestershire.

(iv) Members raised concerns that a significant proportion of the discharge delays were due to patients having to wait for medication to be provided by the hospital pharmacy.

RESOLVED:

(a) That the report be welcomed.

(b) That officers be asked to submit a further report on Hospital Discharge to the next meeting of the Committee.

68. Better Care Fund Refresh.

The Committee received a report from the Director of Health and Care Integration which provided an overview of progress to refresh and submit the Leicestershire Better Care Fund Plan for 2017/18 – 2018/19. A copy of the report, marked ‘Agenda Item 12’, is filed with these minutes.

In presenting the report the Director of Health and Care Integration raised the following points:

(i) The National Guidance for the Better Care Fund was still outstanding. Along with this Guidance it was expected that figures would be provided for the amount each Local Authority would receive as part of the Disabled Facilities Grant. As these figures had not been provided yet the funding total provided in the report was only indicative.

(ii) The core budget of local authorities and Clinical Commissioning Groups was being spent on the Better Care Fund.

Arising from discussions the following points were noted:

(i) The following services would have changes to their funding arrangements during 2017/18:-

- Two hospital and community based dementia services provided by the voluntary sector were being recommissioned on a Leicester, Leicestershire and Rutland wide basis. The BCF funds associated with these services would be applied to the new arrangements;

- The part of the Lightbulb housing service which was designed to improve the timing of hospital discharge was funded by the Better Care Fund. This service was highly effective and would continue to be funded by the BCF in 2017/178. The funding position would be reviewed for 2018/19 to determine if it would continue to be funded from the BCF or from the Lightbulb service, which would be fully established by this time;

- Clinical Commissioning Groups did not intend the Carers Health and Wellbeing Service to be recommissioned beyond April 2017 as the National Carers Strategy would be implemented at that time.

(ii) Members raised concerns regarding technical problems with the First Contact web based referral form and reassurance was given that consideration would be given to how to resolve these problems.

RESOLVED:

That the contents of the report be noted.

69. 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 three of 2016-17. A copy of the report marked “Agenda Item 13” 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) Members raised concerns regarding the amount of time it took to obtain a GP appointment and were of the view that data on this issue should be logged including the amount of occasions patients were told by a receptionist to call back at a later time. It was noted that the General Practice Survey did cover the issue of GP waiting times.

(ii) With regard to the Public Health and Prevention Indicator entitled Infant Mortality it was clarified that this related to deaths of infants under 1 year old and there was a very small number of these which was why there was little change in the figures.

RESOLVED:

That the performance summary, issues identified and actions planned in response to improve performance be noted.

70. Date of next meeting.

RESOLVED:

It was noted that the next meeting of the Committee would be held on 31 May 2017 at 2:00pm.

2.00 - 4.35 pm CHAIRMAN
01 March 2017

Agenda Item 10

Leicestershire County Council

HEALTH OVERVIEW AND SCRUTINY COMMITTEE: 19 JUNE 2017

REPORT OF THE DIRECTOR OF HEALTH AND CARE INTEGRATION

INTEGRATED LOCALITY TEAMS

Purpose of Report

1. The purpose of this report is to provide an update to the Committee on the development of Integrated Locality Teams in Leicester, Leicestershire and Rutland.

Background

2. The slides attached as Appendix A to this report provide an overview of the Sustainability and Transformation Plan (STP) and its priorities. Integrated Locality Teams is one of the STP workstreams and the second part of the slide deck focuses on the work that has been completed to date in this area.

3. Appendix B to this report is the latest Integrated Localirt Teams bulletin, which focuses on the decisions of the April Programme Board and key pieces of work completed over the last month.

Circulation under local issues alert procedure

None.

Officer to Contact

Cheryl, Director of Health and Care Integration (Joint Appointment)
Tel: 0116 305 4239
E-mail: cheryl.davenport@leics.gov.uk

Appendices

Appendix A – Presentation on Integrated Locality Teams
Appendix B – Integrated Locality Teams May Bulletin

This page is intentionally left blank

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

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

APPENDIX A

Leicestershire County Council's Health Overview and Scrutiny Meeting 19 June, 2017

INTEGRATED LOCALITY TEAMS

Cheryl Davenport
Director of Health and Care Integration
and Louise Young
Programme Manager, Integrated Teams

NHS

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

Content

Part 1 - Overview of the STP and its Priorities

Part 2 - Integrated Locality Teams

What is the STP?

- Health and care ‘place based’ plan for Leicester, Leicestershire & Rutland (LLR) ‘footprint’ (one of 44 nationally)
- Addressing local issues and implementing the NHS 5 Year Forward View to March 2021.
- For more information on the Five Year Forward View see: https://www.england.nhs.uk/wp-content/uploads/2017/03/NEXT-STEPS-ON-THE-NHS-FIVE-YEAR-FORWARD-VIEW.pdf
- STPs make the case for national/external capital investment and access to non-recurrent transformation funding to support national and local priorities
- Locally this is a progression of LLR’s previous *Better Care Together* programme, but with clearer focus on implementing a few key system priorities linked to NHS England’s new models of care
- More information about *Better Care Together* including the STP documents can be found here:
- http://www.bettercareleicester.nhs.uk/ - home page
- http://www.bettercareleicester.nhs.uk/EasysiteWeb/getresource.axd?AssetID=46236 – draft STP
- http://www.bettercareleicester.nhs.uk/Easysiteweb/getresource.axd?AssetID=47665 – STP summary
- The STP document is supported by finance, activity, bed capacity and workforce analysis.

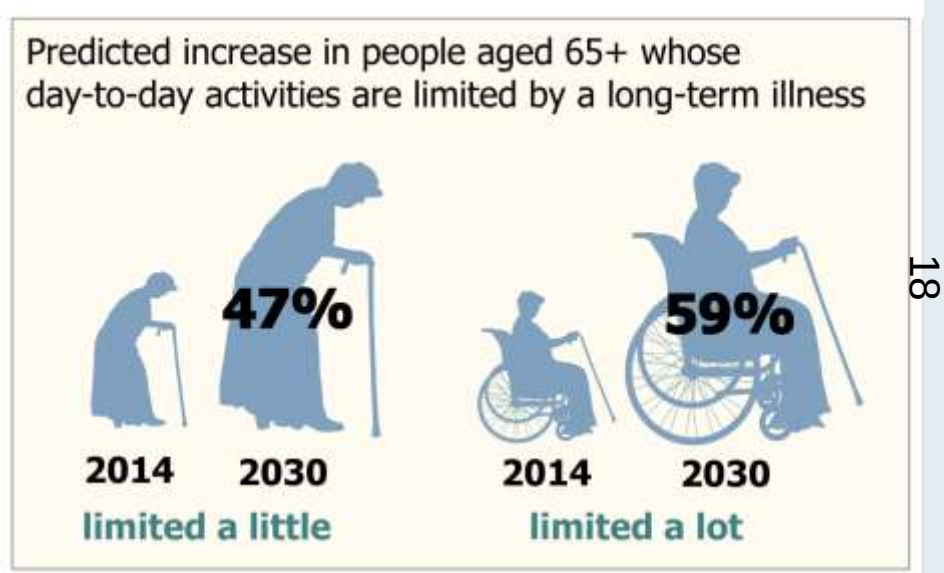
Making us fit for future care

Across Leicester, Leicestershire and Rutland our population is growing

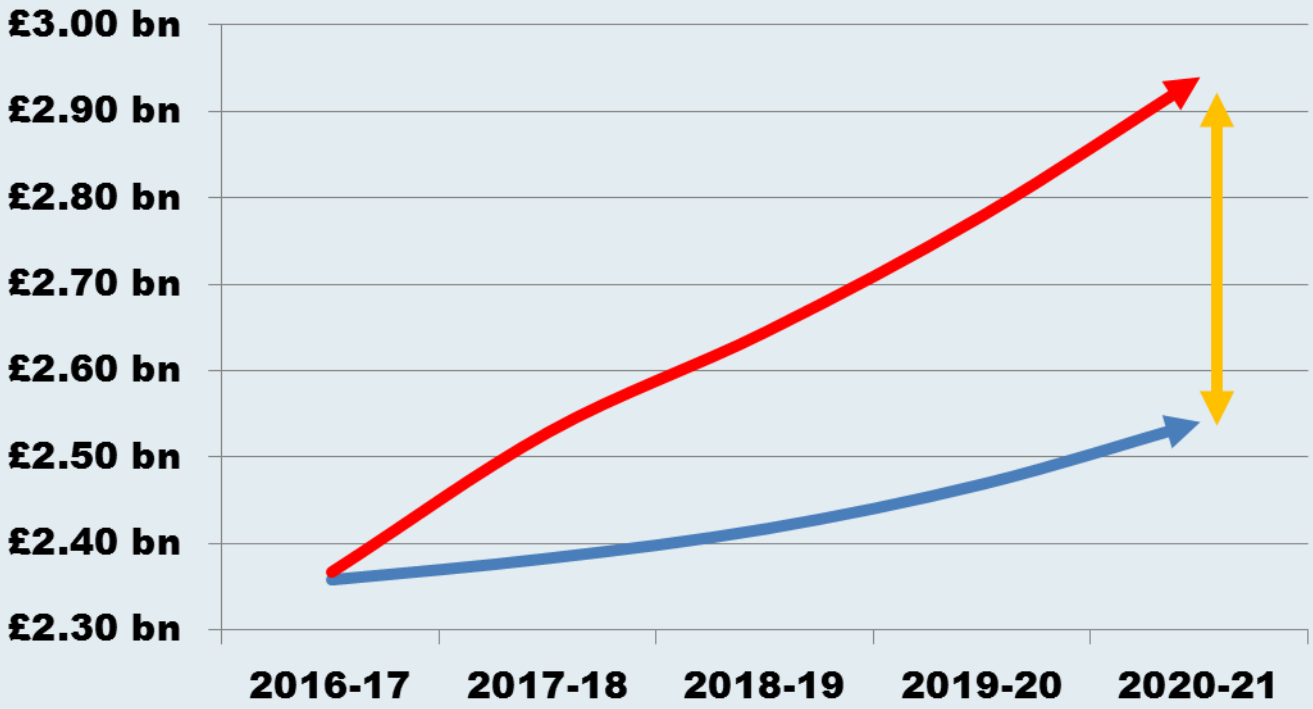
The older population is predicted to increase by 11% in next five years

Long term illnesses are also increasing

This leads to a greater demand for health and care services



Identifying the health and care financial gap



The money context

- We currently spend c£1.6bn on NHS services across LLR
- By the end of the STP 5 year plan this will *increase* to c£1.8bn
- But, demand and demographic growth plus the cost of delivering services and new treatments will outstrip these increased resources by c£342m across the local NHS and a further c£57m across the local authorities
- The STP is not about 'cuts' but it is about choices in how we spend public money
- The approach we are taking to this is a 'placed based budget' one that looks across organisations at the 'LLR pound'
- And which focuses on new ways of working and models of care that manage demand and are more efficient

The ‘triple aim’ gaps the LLR STP will address

Health and wellbeing outcomes gap

- Lifestyle and Prevention
- Outcome and Inequalities (e.g. people’s health outcomes not being determined by where they live, reducing variation in outcomes)
- Mental Health Parity of Esteem (mental health services on an equal footing with other parts of health and care)

Care and quality gap

- Emergency Care Pathway (A&E and ambulance handover delays)
- General Practice (variation and resilience)
- Clinical workforce supply (ensuring we have the staff in place we need to deliver our plans)

Finance and efficiency gap

- Provider systems and processes (internal efficiency)
- Estates configuration (how we collectively make best use our buildings)
- Back office functions (shared services to improve the efficiency of the LLR pound)

Overall STP Philosophy – Home First

We believe that being at home with support is the best place for many people to stay well and manage their conditions or illnesses.

In practical terms this means everyone should ask:

“Why is this patient not at home?” or

“How best can we keep them at home?”

We call this principle “Home First”

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

LLR STP Priority Areas

1. **New Models of Care** focussed on prevention and moderation of demand growth – e.g. Home First, Integrated Locality Teams, Urgent Care, Planned Care, Resilient General Practice
2. **Service Configuration** to ensure clinical and financial sustainability – how services are planned and delivered across acute, community and mental health hospital sites in the future
3. **Redesign of Care Pathways** to delivered improved outcomes for patients and deliver core services and quality standards
4. **Operational Efficiencies** – e.g Review of 'Back office' functions, medicines optimisation, estate utilisation
5. **Getting the Enablers Right** - IMT (digital roadmap), workforce, estates, joint commissioning.

NHS

The journey through care for patients

Patient managing their own conditions and preventing illness through healthier living **Prevention Work stream**

GP practice co-ordinates care **General Practice Programme**

“Federations” of GPs working together to deliver enhanced care and diagnostics **General Practice work Programme**

Community based care with support from local teams **Integrated Teams and Home First Programmes**

Care when you need urgent medical attention **Urgent Care Programme**

The Changes Being Introduced in Community Settings

Commissioners, GPs, GP Practice Federations, Social Care, Acute and Community Services are collaborating to introduce a new model of care focussing on 4 key areas:

1) **Increasing prevention and self management**
2) **Developing accessible and responsive unscheduled primary and community care**
3) **Developing extended primary and community teams**
4) **Securing specialist support in non acute settings**

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

LLR Integrated Teams: Programme Structure

Rutland County Council healthwatch Leicester City Council Leicestershire County Council NHS

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

Who will benefit from integrated locality teams?

PHASE 1 = 3 cohorts of people:

- ❑ **Adults with 5 or more chronic conditions**
- ❑ **All adults with a 'frailty' marker, regardless of age but related to impaired function**
- ❑ **Adults whose secondary care costs are predicted to cost three or more times the average cost over the next twelve months**

(inc. people transitioning to end of life care, intensive specialist community or residential care.

In the future the whole population will benefit from integrated locality teams

Rutland County Council · healthwatch · Leicester City Council · Leicestershire County Council · NHS

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

What's the ask?

- Develop a deep understanding of the needs of the three groups of service users, across organisational boundaries and data sets.
- Identify how care and support varies, why it varies, and how these differences can be addressed.
- Define new ways of working and support staff to change their practice.
- Undertake some initial tests of new ways of working.
- Plan how the new ways of working can be rolled out across all eleven localities during 2017/18.

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

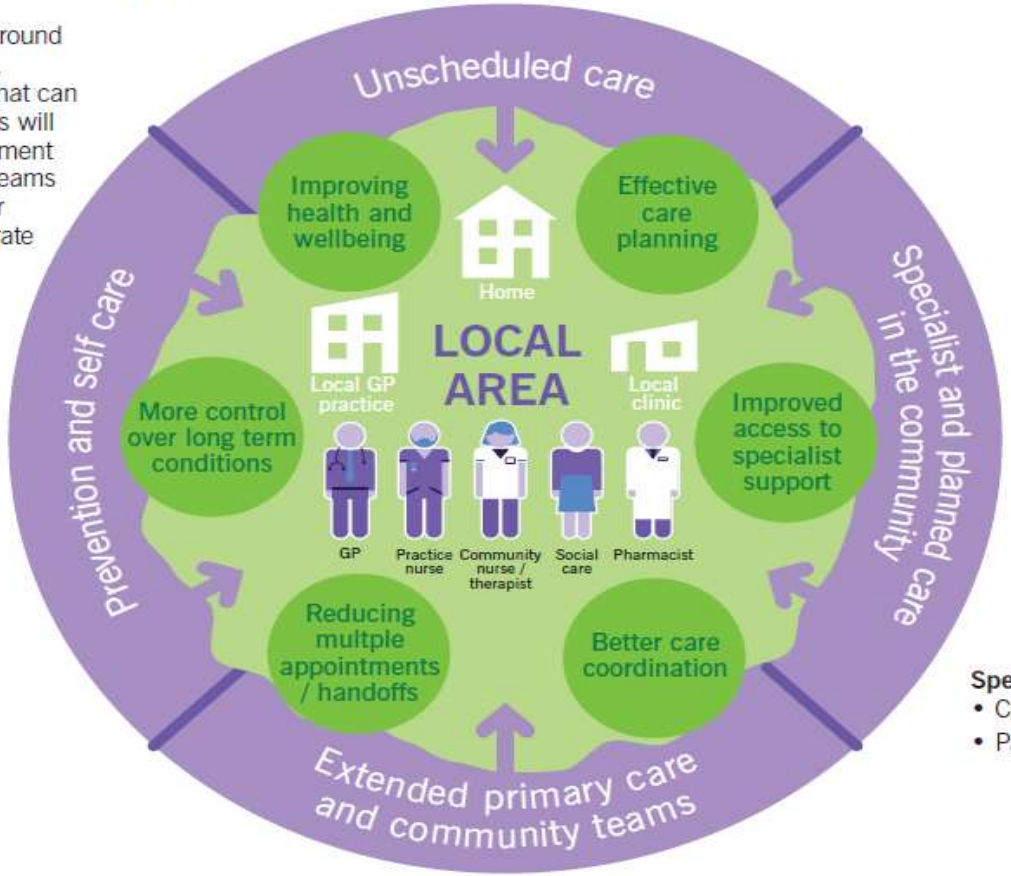
Your Integrated Locality Teams (Leicester, Leicestershire and Rutland)

A new innovative approach to joint working in your community

Our model of integration wraps around the patient and their GP practice, extending the care and support that can be offered in the community. This will be delivered through the development of new multidisciplinary locality teams who will be jointly responsible for patient care and initially concentrate on specific groups of patients.

Cohorts:
The specific groups of patients who will initially benefit from this model in Leicester, Leicestershire and Rutland from April 2017 are:

- Adults with five or more chronic conditions
- People with a frailty marker regardless of age (impaired function)
- Adults whose acute care costs are predicted to be three times the average over the next 12 months



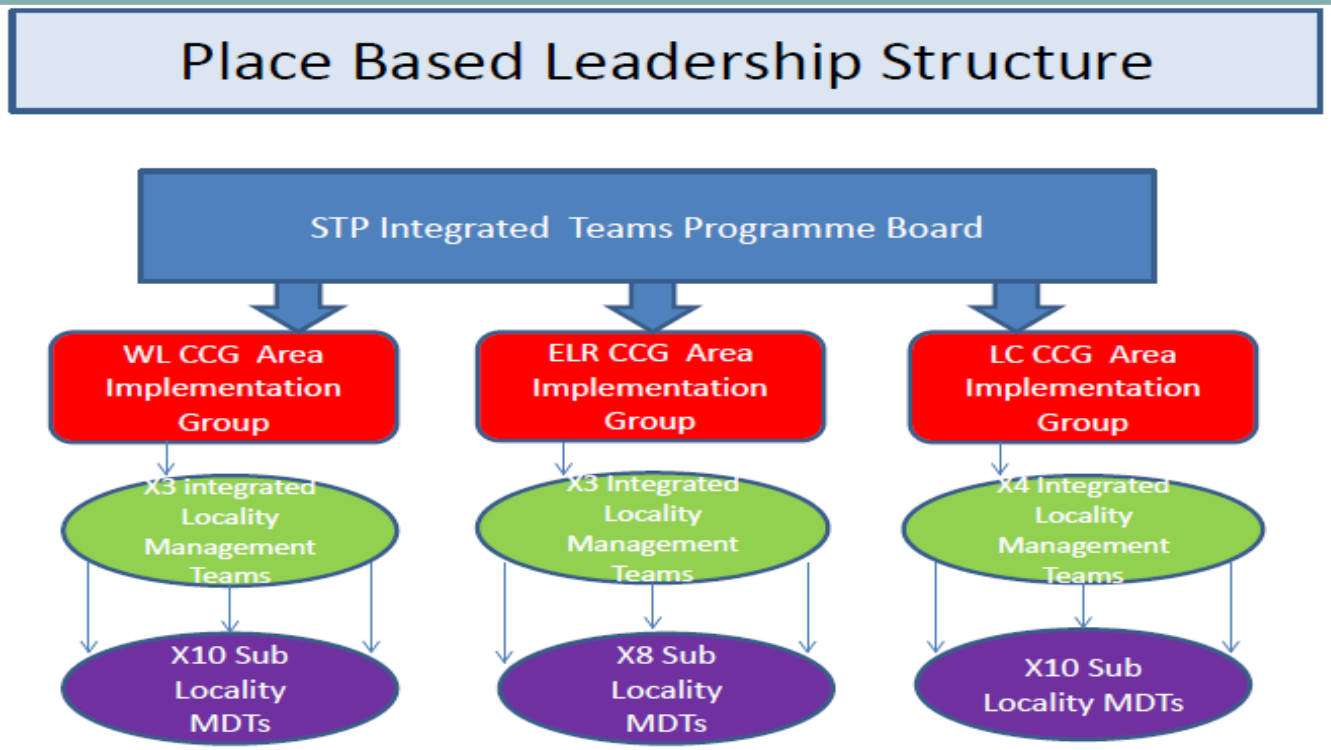
LLR System Benefits

- Reducing the number of permanent admissions to residential care
- Supporting people to recover and be reabled at home - enabling people to stay in their home for longer
- Reducing the number of bed days and delayed transfers from hospital
- Reducing emergency admissions and readmissions
- Reducing falls
- Intergrating data

Specialist support examples:

- Community psychiatric services
- Palliative care services

Integrated Teams Implementation Approach



Integrated Locality Teams and Sub Locality Structure

WLCCG Integrated Teams Locality and Sub Locality Structure

North West Leics
103,878

WEIR
Ashby Med Centre
Ashby Surgery
Measham
Ibstock
40,658

WIGGINS
Long Lane
Hugglescote
Markfield
28,381

MURRAY
Castle Donington
Broom Leys
Manor House
Hepplewhite (Whitwick)
Lewis (Whitwick)
Whitwick Surgery
34,839

Hinckley & Bosworth
114,696

BROWNLEE
Centre Surgery
Barwell & Hollycroft
The Maples
Castle Mead
37,798

FARAH
Heath Lane
Newbold Verdon
Desford
Groby
Ratby
35,688

STOREY
Orchard
Stoney Stanton
Burbage
Station View
41,210

South Charnwood
76,942

AINSLIE
Mahavir
Anstey
Thurmaston
Silverdale
Greengate
Birstall
37,994

HOY
Quorn
Cottage Surgery
Banks Surgery
Highgate Surgery
Charnwood
Alpine House
Barrow
38,948

North Charnwood
83,666

ENNIS
Bridge Street
Park View
Pinfold
Woodbrook
L'boro University
50,330

RUTHERFORD
Forest House
Dishley Grange
Rosebery Street
Field Street
33,336

ELRCCG Integrated Teams Locality and Sub Locality Structure

Melton & Rutland
101,606

Syston & Melton
Jubilee
County
Latham House
Long Clawson
64,859

Rutland
Empingham
Oakham
Market Overton
Uppingham
36,747

Oadby & Wigston
55,006

Oadby
Severn
Croft
Rosemead Drive
Central
25,845

Wigston
Bushloe
Wigston
South Wigston
29,161

Blaby & Lutterworth
106,688

South Blaby &
Lutterworth
Enderby
Northfield
Hazelmere
Narborough
Countesthorpe
Limes
Lutterworth
Wycliffe
67,817

North Blaby
Kingsway
Forest House
Glenfield
38,871

Market Harborough
59,260

Market Harborough
Husbands Bosworth
Market Harborough
27,849

South East
Billesdon
Two Shires
Kibworth
31,411

LCCCG Integrated Teams Locality and Sub Locality Structure

North West
109,154

BRAUNSTONE HSCC
Hockley Farm
Merridale
25,672

BELGRAVE
Beaumont Lodge
The Practice Beaumont Leys
Westcotes HC (Dr Lawrence)
Groby Road MC
Heatherbrook Surgery
Manor Park MC
47,950

WESTCOTES
Briton Street Surgery
Fosse MC
The Parks
Westcotes 1
Westcotes 2
Oakmeadow Surgery
Fosse Family Practice
Westcotes HC (Dr Hazeldine)
35,532

South
90,056

MERIDIAN
De Montfort University
Walnut Street MC
Clarendon Park MC
Victoria Park HC
52,730

PASLEY ROAD
Aylestone Med Centre
Surgery @ Aylestone
Saffron Health
The Hedges MC
Pasley Road (Dr Singh)
Pasley Road HC
(Dr Khong)
37,326

Central
124,203

ST PETERS
Community Health Centre
Highfields Surgery
Highfields MC
Al-Waqas
Shefa Medical Practice
Dr Mansingh, St Peters
37,578

MERLYN VAZ
East Park MC
The Charnwood Practice
East Leicester MP
Dr Kapur, Melbourne Rd
St Matthews MC
36,236

RUSHEY MEAD
Canon St
Spinney Hill MC
Evington MC
Dr Kapur Brandon St
Brandon St Surgery
(pooled list)
Belgrave Surgery
Broadhurst Surgery
50,389

North East
65,702

SPRINGFIELD ROAD
Ar-Razi
Asquith Surgery
Downing Drive
St Elizabeth's
Willowbrook
The Willows
35,822

UPPINGHAM ROAD
Sayeed Med Centre
Johnson MP
Humberstone MP
The Practice Rushey Mead
Rushey Mead HC
29,880

Leicestershire County Council · Rutland County Council · NHS Leicester City Clinical Commissioning Group · NHS East Leicestershire and Rutland Clinical Commissioning Group · NHS West Leicestershire Clinical Commissioning Group · Leicestershire Partnership NHS · University Hospitals of Leicester NHS · East Midlands Ambulance Service NHS · NHS England

ELCCG Integrated Locality Teams and Sub Locality Structure

Melton & Rutland
101,606

SYSTON & MELTON
Jubilee
County
Latham House
Long Clawson
64,859

RUTLAND
Empingham
Oakham
Market Overton
Uppingham
36,747

Blaby & Lutterworth
106,688

SOUTH BLABY & LUTTERWORTH
Enderby
Northfield
Hazelmere
Narborough
Countesthorpe
Limes
Lutterworth
Wycliffe
67,817

NORTH BLABY
Kingsway
Forest House
Glenfield
38,871

Oadby & Wigston
55,006

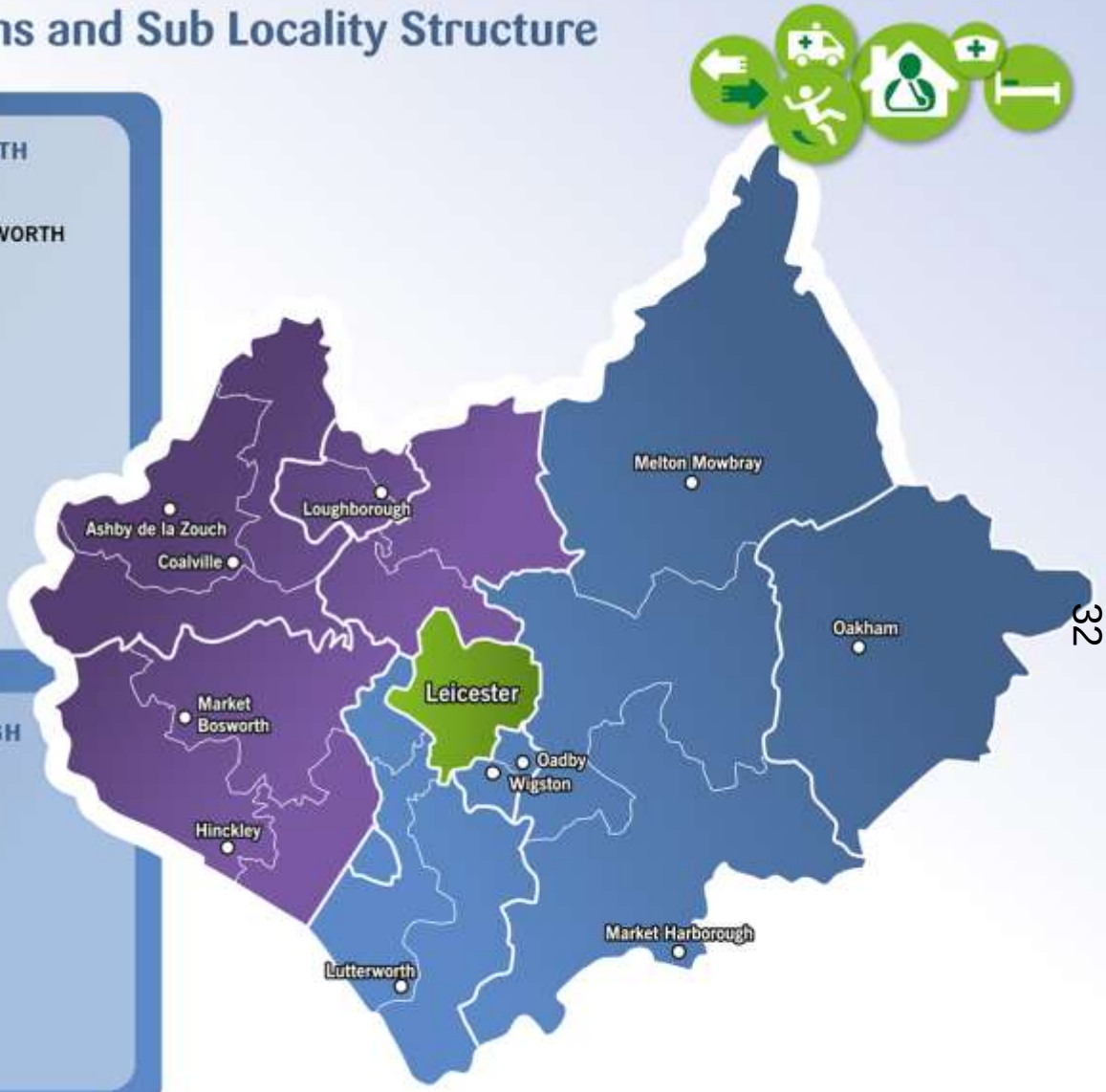
OADBY
Severn
Croft
Rosemead Drive
Central
25,845

WIGSTON
Bushloe
Wigston
South Wigston
29,161

Market Harborough
59,260

MARKET HARBOROUGH
Husbands Bosworth
Market Harborough
27,849

SOUTH EAST
Billesdon
Two Shires
Kibworth
31,411



WLCCG Integrated Locality Teams and Sub Locality Structure

North West Leics
103,878

WEIR
Ashby Med Centre
Ashby Surgery
Measham
Ibstock
40,658

WIGGINS
Long Lane
Hugglescote
Markfield
28,381

MURRAY
Castle Donington
Broom Leys
Manor House
Hepplewhite (Whitwick)
Lewis (Whitwick)
Whitwick Surgery
34,839

North Charnwood
83,666

ENNIS
Bridge Street
Park View
Pinfold
Woodbrook
L'boro University
50,330

RUTHERFORD
Forest House
Dishley Grange
Rosebery Street
Field Street
33,336

Hinckley & Bosworth
114,696

BROWNLEE
Centre Surgery
Barwell & Hollycroft
The Maples
Castle Mead
37,798

FARAH
Heath Lane
Newbold Verdon
Desford
Groby
Ratby
35,688

STOREY
Orchard
Stoney Stanton
Burbage
Station View
41,210

South Charnwood 76,942

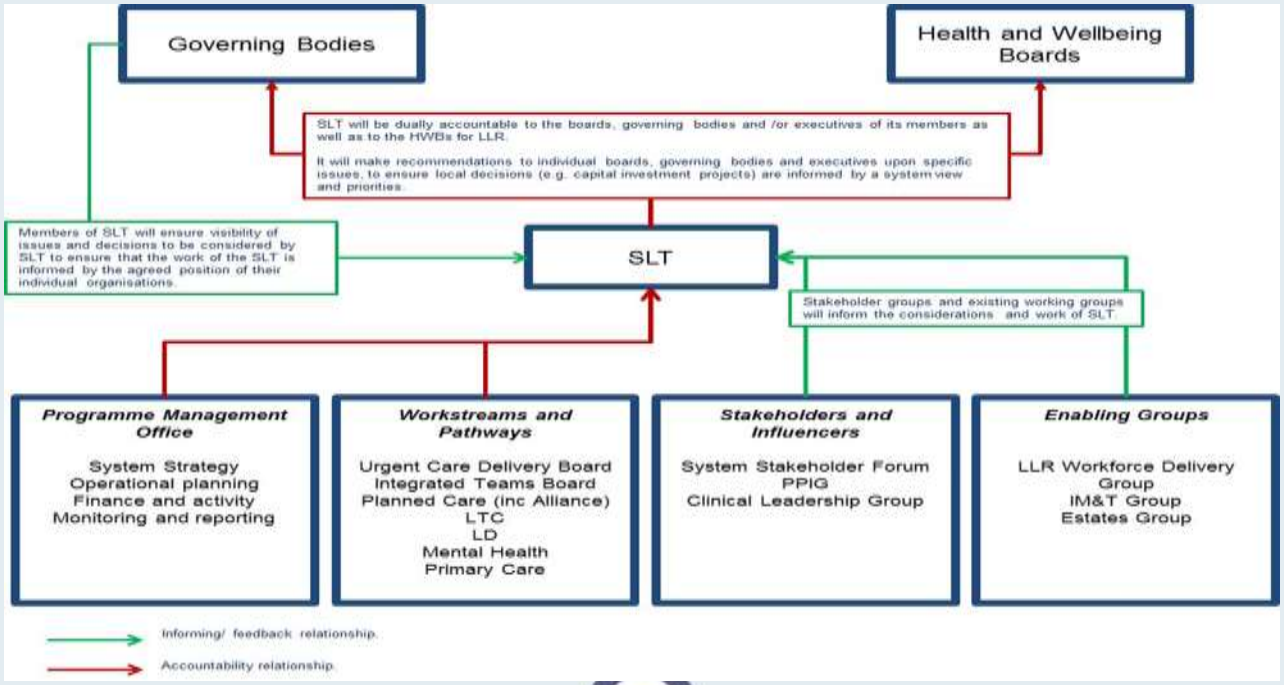
AINSLIE
Mahavir
Anstey
Thurmaston
Silverdale
Greengate
Birstall
37,994

HOY
Quorn
Cottage Surgery
Banks Surgery
Highgate Surgery
Charnwood
Alpine House
Barrow
38,948

How is implementation progressing in LLR?

- We have taken learning from other parts of the country to inform how to deliver this in LLR
- Integrated teams are in place across LLR, led jointly by adult social care, GPs, and LPT.
- District Councils are being encouraged to join their local team(s) as key partners
- Other services planned for community settings are being built around these teams
- Integrated teams are starting to test new ways of working (test beds) during 2017
- An approach to measuring the impact of integrated teams has been developed which includes measuring patient experience, improvements in care coordination, and monitoring that specific aspects of clinical care and support have been offered and put into place
- Regular stakeholder bulletins are available – see example with your papers

STP Governance Arrangements



This page is intentionally left blank

Integrated Locality Teams

Leicester, Leicestershire and Rutland

APPENDIX B

LLR Integrated Teams Programme Board Bulletin No. 4: May 2017

Welcome to the fourth edition of the Leicester, Leicestershire and Rutland (LLR) Integrated Locality Teams bulletin. This edition focuses on the decisions of the April Programme Board and key pieces of work completed over the last month.

Development of Integrated Locality Teams – how to guide

The 'how to guide' is currently being distributed through Integrated Locality Teams and GP practices.

Further work is continuing to develop the specific information needed by individual professionals e.g. concentrating on the roles/requirements of GPs, social care staff and community health service staff. This will also be shaped by the work in test beds across LLR.

Summary Care Record (SCR 2.1) and Integrated Care Planning

The Programme Board received an update from Clare Sherman (IM&T Lead - Leics City CCG) on Summary Care Records.

The three CCGs have successfully bid for funding under the Estates Technology Transformation Fund (ETTF). This will enable the delivery of shared records across LLR between health and social care colleagues.

The first stage is the implementation of the new Summary Care Record functionality (SCRv2.1) - this functionality allows additional information to be added to a patient's Summary Care Record, once patient consent is obtained.

A related piece of work is the new 'Integrated Care Plan' template which will allow clinicians to record consent and enter additional information for key areas such as Long Term Conditions and End of Life.

It is anticipated this work will allow faster access to information, along with quicker diagnosis and treatment for patients.

The programme will be completed in three phases:

Phase 1 - SCR 2.1 is being rolled out across LLR GP practices
- All SystmOne practice training will be completed by the end of April 2017
- EMIS practice training to be completed by mid-May 2017

Phase 2 - Provider services and secondary care - focuses on providers viewing the data captured by practices through the most appropriate tool

Phase 3 – Adult Social Care – the information shared will not allow for read and write functionality, but will enable colleagues to be able to view – this will be helpful for the work of ILT's

Test beds

The Programme Board were updated on the test bed proposals received and informed that some great ideas had been received.

The ILT test bed proposals will be signed off and monitored by each CCG's governance implementation group – the Programme Board will not approve these. Progress of the approved test beds will be monitored through reports at future Programme Boards.

Approved test beds	Scope	ILT/ CCG	Objectives
One Home One Practice and wrap around services for Care Homes	The focus cohort will be care home patients across both Oadby and Wigston. There is the potential for improvements in wrap around services and also an opportunity to explore a One Home One Practice model in Oadby. The aim of the project is as a locality to explore the adopting of a one home one GP practice model where feasible. In addition the team will look at the wrap around services in support of the care home and how the various teams can work smarter to improve not only the care given but also the working practices for the teams.	Oadby and Wigston - ELRCCG	The objective of the test bed is to understand and significantly improve the structure and access to health and social care services wrapped around care home patients. To restructure registration of care home patients to match one care home to one practice across the locality with the aim of standardising GP capacity for care home patients and approach to care plan management.
MDT working	The focus cohort will be care home patients across both Oadby and Wigston. There is the potential for improvements in MDT working. The aim of the project is as a locality, and initially as a locality team, to look at MDT working and how to integrate and facilitate care homes in MDT practice.	Oadby and Wigston – ELRCCG	The objective of the test bed is to understand and significantly improve the engagement and implementation in MDT working.
Wellness Advisors	The focus for this test bed will be patients who have registered or walk-in access to Rutland GP practices. The project will provide access to non-clinical help and advice / support services for these patients. The aim of the project is to test the model of embedded staff within a GP practice who provide help and support to patients who are in need of support but not necessarily of a clinical nature.	Rutland - ELRCCG	The objective of the test bed is to provide access to help and advice / support services for registered patients within GP practice.
Teleconference/ video conference MDT	The test bed will test primary care based Multi-disciplinary Team (MDT) meetings for risk stratified red/amber End of Life patients under the care of South Blaby practices. The focus cohorts will be: • Green, Amber and Red EoL patients • 3-5 patients monthly who community nurses are concerned about	Blaby and Lutterworth – ELRCCG	The objective is to improve attendance at complex care planning MDT meetings across the sub-locality, improving engagement in End of Life care planning, proactive care planning reviews and crisis management. These planned activities will enable other aspects of the EoL and Urgent Care system.

Structured intervention programme for high risk ILT patients	All practices in N&EL, Central and N&W HNN. The focus cohort will be high risk patients from within the Integrated Locality Teams cohort. Each Practice will be given an allocated number of such patients to proactively call in for care planning and discussion at MDT meetings during the course of the year. The components of this scheme are: *1.* Registration of the PIC GP patients on clinical system and flagging with a code as the intervention group. *2.* Discussion of patient's case at MDT *3.* Proactive invitation to patient (and carer if relevant) to attend for two proactively planned 20 minute appointments during the year for the purpose of care planning and self-management education discussions. *4.* Potential referral to one or more community services such as social care or mental health services or the lifestyle hub depending on the individual's goals.	• North & East Leicester – LCCCG • Central – LCCCG • North West - LCCCG	The objective of the test bed is to: • Create a template to be used on S1 to allow practices to deliver a structured programme of care • Deliver a personalised care plan for each patient on the scheme – a copy to be given to the patient and a copy stored in the clinical record for viewing by relevant personnel • Reduction in emergency attendances and admissions in the intervention group compared to CCG average and to patients previous utilisation • Reduction in average number of medicines prescribed in the intervention group compared to CCG average for this age group
Face to face MDT	The scope of this test bed is to test face to face MDTs through co-ordinating MDTs in practices in the two sub localities in N&EL.	North & East Leicester - LCCCG	The objective of the test bed is to develop an ILT by having face to face MDTs in practices to enhance patient care and prevent unnecessary admissions.
Proposal to test dedicated pharmacy team support for care homes	The focus will be selected Care Homes in NEL HNN. Selection will be based on intelligence from LC CCG Nursing Quality team or City Council Care Home Quality and Contracts Team. The plan is eventually to get to all Care Homes. The focus cohort will be high–risk patients living in identified intervention care homes identified via pharmacist reviews of care records. The second focus cohort will be all care home residents in selected care homes.	North East Leicester - LCCCG	The objective of the test bed is to: • Reduce medicines waste (and therefore cost and potential patient harm) in selected care homes • Reduce burden of polypharmacy in selected patients • Improve prescribing , dispensing and storage of medicines practice
Face to face MDTs	All practices in South HNN. The focus cohorts will be: • PIC GP patients • ILT cohort –	South Leicester – LCCCG	The objective of the test bed is through the South Integrated Teams Programme general practices, social care, acute and community teams will work with commissioners to introduce a new model of care focussing on four key areas:

	- Frailty - Having five or more chronic conditions - Predicted to spend three or more times the average in secondary care • Patients where intervention from ASC and LPT will be valuable • Likewise ASC/ LPT to identify patients who could value GP intervention The test bed will be coordinated through the two sub localities in South – *Meridian* and *Pasley Road*		1. Increasing prevention and self-management 2. Developing accessible and responsive unscheduled primary and community care 3. Developing extended primary and community teams 4. Securing specialist support in non-acute settings
Co-ordination of community care for frail patients discharged from UHL and Loughborough hospitals	The focus cohorts will be: • People with a frailty marker regardless of age • Adults with five or more long term conditions • Adults whose acute care costs are predicted to be three times the average over the next twelve months The project will involve introducing a Hospital Discharge Community Care Co-ordinator and a standard operating procedure to work to. Capacity will be created from existing LPT resources at the appropriate grade.	Charnwood - WLCCG	The objective of the test bed is to: • Develop co-ordinated care for the identified cohort of patients, post discharge from hospital. • Have joined up care for the patients, with clear lines of communication between GP, adult social care, community health and therapy teams. • Explore opportunities and benefits for new ways of working across a multi-disciplinary workforce.
Multidisciplinary 'Best Practice' working across three sub localities in Hinckley and Bosworth	The project will involve testing the benefits of holding quarterly 'Best Practice' meetings with health and social care to discuss case studies, to learn lessons, celebrate what's going well, share service updates and best practice. The focus cohorts will be patients/ service users who fall into a minimum of one of the three cohort's i.e. 1. People with a frailty marker regardless of age 2. Adults with five or more long term conditions 3. Adults whose acute care costs are predicted to be three times the average over the next twelve months	Hinckley and Bosworth - WLCCG	The objective of the test bed is to: • Understand the benefits of holding sub-locality MDTs • Understand what information is most helpful to share • Understand the best ways of sharing information across teams • Determine who needs to be part of a sub-locality MDT

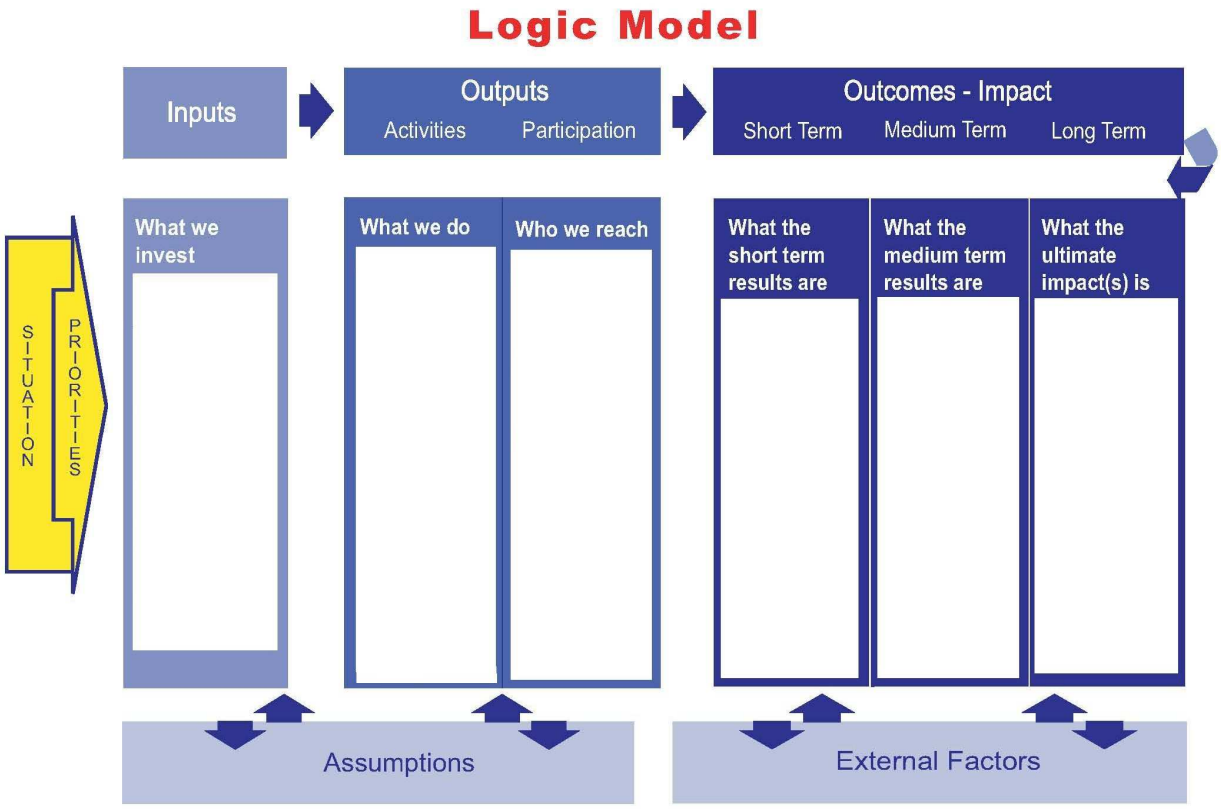
Practice pharmacist completing medication reviews for care home residents	The test bed will be tested with one GP practice and one care home in the first instance and use the learning to expand the PDSA to further care homes if successful. The focus cohort will be care home residents who fall into a minimum of one of the three cohort's i.e. 1. People with a frailty marker regardless of age 2. Adults with five or more long term conditions 3. Adults whose acute care costs are predicted to be three times the average over the next twelve months	Hinckley and Bosworth – WLCCG	The objective of the test bed is to test the feasibility of a practice pharmacist undertaking medication reviews for residents in a care home.
Locality multi-disciplinary networking	Locality level multi-disciplinary networking to involve all ILT care partners. The scheduled monthly NWL Federated Locality Meetings will be re-structured with one hour of the meeting being dedicated to Integrated Teams to offer an opportunity for networking and improvement. Feedback from all multi-disciplinary partners indicated that the most useful part of previous "MDT meetings" and larger group discussions was that they enabled communication and relationship building which, in turn, highlighted and spread good practice and enhanced understanding of what services and/or interventions were available – all improving patient outcomes and experience.	North West Leicestershire - WLCCG	The objective of the test bed is to: • Improve and focus communications and working relationships between all ILT care partners • Increase awareness and understanding of care partners across all ILT care partners • Generate inclusively agreed ideas/topics for further test bed PDSAs

Logic Model

A logic model has been developed to describe the Integrated Locality Team programme's inputs, outputs, outcomes, assumptions and interdependencies.

Logic models are a useful, graphical, way to summarise the relationships between the different components of a programme. They help to explain the 'theory of change' or in other words, how the 'intervention' will lead to the intended outcomes.

Logic models come in many shapes and sizes - below is an example logic model template. It is a live document/framework and will be updated as we learn more from the pilot teams



Each test bed will be asked to develop its own logic model to enable the programme to monitor the interventions and outcomes, and take a consistent approach to overall programme performance.

QIPP

Gill Killbery provided an update to the Programme Board on the QIPP savings. An STP level review of the QIPP is currently being completed – an updated QIPP for ILT's will be presented to the next Programme Board.

Memorandum of Understanding (MoU)

A draft MoU has been developed to help facilitate the work of ILT's. The Programme Board have been asked to review and comment on the document. Programme board will consider all feedback received at the May Board. The outcome will inform a paper to SLT in due course.

Implementation Plan

An implementation plan has been finalised at LLR level for the Integrated Locality Team's programme, which details key milestones across 2017/18. This is also designed to help inform the development of local implementation plans across each CCG footprint.

For more information about the development of Integrated Locality Teams in LLR visit our webpages:

www.healthandcareleicestershire.co.uk/health-and-care-integration/integrated-locality-teams/

To find out about the local arrangements and work in progress in your area please contact the relevant CCG implementation lead in the first instance:

- **West Leicestershire** (Charnwood, NW Leicestershire and Hinckley and Bosworth) – Arlene.Neville@westleicestershireccg.nhs.uk
- **East Leicestershire and Rutland** (Melton/Rutland/Harborough, Oadby and Wigston, Blaby and Lutterworth) - Paula.Vaughan@EastLeicestershireandRutlandccg.nhs.uk
- **Leicester City** – Rachana.Vyas@leicestercityccg.nhs.uk

If you have any feedback about this edition of the bulletin, or suggestions for future bulletins, please contact our communications lead sally.kilbourne@leics.gov.uk.

This page is intentionally left blank

Ambulance Response Programme

NHS
East Midlands Ambulance Service
NHS Trust

Presented by : Will Legge

ARP Objectives

East Midlands Ambulance Service NHS Trust

- Timely response to patients with life-threatening conditions (CATEGORY 1)
- Right clinical resources to meet the needs of patients
- Reducing multiple dispatches - EMAS currently 1.28 reds & 1.1 Green 1 & 2
- Reducing the number of diverts
- Increasing Hear and Treat – less codes in ARP highlighted as suitable for H&T
- Increasing See and Treat
- Improve availability of transporting resource

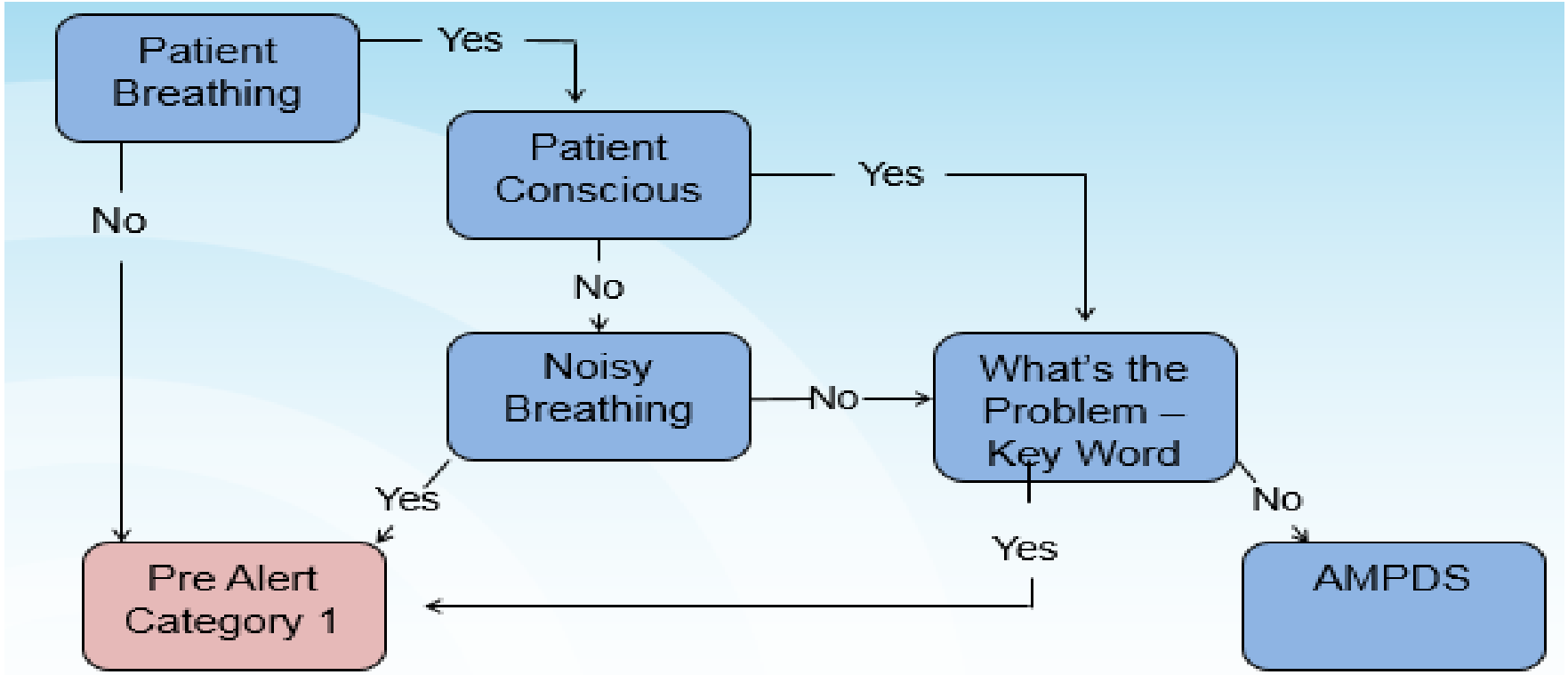
ARP Responses

East Midlands Ambulance Service NHS Trust

Standard	% of activity (ORH Modelling)	Av number of responses per day (based on 1808 responses)
Category 1	7%	127
Category 2	53%	958
Category 3	35%	633
Category 4	5%	90

What triggers a Pre Alert Category 1

East Midlands Ambulance Service NHS Trust



Demand and Capacity review

East Midlands Ambulance Service NHS Trust

- The objective of the review was to access and make recommendations on future resourcing required across the operations and call handling functions for EMAS.
- The study should be undertaken in relation to the Sustainability and Transformational Partnership (STP) ambitions and constitutional performance standards for a period up to and including March 2019.

This page is intentionally left blank

Agenda Item 12

HEALTH OVERVIEW AND SCRUTINY COMMITTEE: 19 JUNE 2017

REPORT OF UNIVERSITY HOSPITALS NHS TRUST

STAFF TRAINING RELATING TO DISCHARGE

Introduction

1. This paper provides a further update to the report presented to the Leicestershire Health and Wellbeing Board in March 2017 in response to 'The Lived Experience of Hospital Discharge Report' and serves to outline plans in relation to staff training relating to Hospital Discharge.

Background

2. Healthwatch Leicestershire undertook a qualitative and quantitative survey with patients, staff and carers about their experiences of hospital discharge between September and December 2016 as part of their programme of work to highlight the views of health and social care service users about their experience that local services offer. 'The Lived Experience of Hospital Discharge Report' highlighted five key recommendations for improvement. The University Hospitals of Leicester (UHL) NHS Trust welcomed the report as it provided a timely and helpful insight into the discharge processes within its hospitals.

3. This paper focuses on recommendation 3 from the report; Training:

   'There should be an improved schedule and a consistent approach to staff training relating to discharge. This training should have an element of multi-disciplinary and multi-agency focus'.

Current Situation

4. There is currently no system wide training for hospital discharge across Leicester, Leicestershire and Rutland (LLR). A multidisciplinary discharge training project group has been meeting since August 2016 and has made the following recommendations:

   - Support the principle of 'essential to role' training in this area of patient care
   - Support the implementation of a training programme and ensure staff are released.
   - Demonstrate role modelling behaviours from leaders (Band 7/6 Staff) through attending the first run of training.

- Support additional resources required from communication teams to generate ‘key messages’ on a regular basis to refresh knowledge.

5. These recommendations were presented to the UHL Emergency Quality Care Steering Group in April 2017, where the recommendations were agreed in principle.

6. The frail older people’s accredited training module includes a day on discharge training and the preceptorship programme has a two hour session on safe effective discharge although it is recognised that small numbers attend. Other unplanned training occurs on an individual or ward based level.

7. Leicestershire Partnership NHS Trust has an e-learning package and information specific for new starters already in development.

8. The UHL Hospital Discharge Policy and ‘Good Practice in Discharge Planning’ Guidelines are available to staff via the hospital intranet.

9. New ways of working have been explored with the introduction of ward-based discharge co-ordinators (Trainee Assistant Practitioners: discharge) to some ward areas with plans to further develop this role.

10. Primary care co-ordinators work with teams within the hospital to in-reach and identify patients who are likely to require support on discharge.

New ways of working

11. We are already working hard with our health and social care partners to improve our urgent and emergency pathways through a number of high impact actions that aim to improve the patient pathway through improved working and integration. Progress against these actions is monitored by the Leicester, Leicestershire and Rutland Accident and Emergency Delivery Board.

12. We are working with the NHS Emergency Care Improvement Partnership (ECIP) to review our models of care and identify further opportunities for development. We have started our programme of rolling out the ‘SAFER’ patient flow bundle and the ‘Red and Green days’ approach which aim to reduce both the internal and external delays in a patient’s journey.

13. In July 2017 we are planning to launch an Integrated Discharge Team (IDT) that will operate at the ‘front door’ (Emergency Department and assessment units) and the ‘back door’ inpatient wards (specialist medicine, orthopaedic and oncology). The IDT will be comprised of health and social care staff. Each of the wards will have a ‘discharge specialist’ from the IDT available daily at the morning board rounds to coach and support timely and effective discharge, focussing on the principles of right person, right place, first time.

.

14. Within the IDT there will be an identified lead for co-ordinating and delivering on training who will plan with our health and social care partners a training programme that is essential to role and meets the recommendations set out from the original discharge training project group. The aim being that all staff involved in discharge will have a competency-based passport which will endorse their knowledge and skills on the discharge pathways

Conclusion

15. We recognise that we have a significant amount of work to undertake to achieve a fully sustained and transformed urgent and emergency care system but the continued focus internally and externally with our health and social care partners will ensure that discharge and in particular training of our staff in discharge practices remains a key area of improvement.

Recommendation

16. The Health Overview and Scrutiny Committee are invited to receive this report and note:
    - The actions the Trust and our partners are undertaking to improve the discharge pathway for our patients.
    - The Trust's plans to introduce an Integrated Discharge Team on 1st July 2017 with a specific lead for staff training on discharge.

Background Papers

Healthwatch Report – the Lived Experiences of Hospital Discharge – http://ow.ly/GEhz30cqT5J

Response from UHL submitted to the Health and Wellbeing Board on 16 March 2017 - http://ow.ly/MsXU30cqSZs

Officer to contact

Gill Staton, Head of Nursing

This page is intentionally left blank

DRAFT

Sustainability and Transformation Partnership Implementation plan

STP Workstream	**Primary Care**
SLT Lead	Karen English
SRO	Tim Sacks

Version 3/ 7.06.17

17. Primary care

Deliverable (National milestone date)	Key actions (Action owner)	Delivery milestone											
		2017/18				2018/19				2019/20		2020/21	
		Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	H1	H2	H1	H2
National 1 - 50% of the public have access to evening and weekend GP appointments by March 2018; and 100% by March 2019	An integrated service that provides at least 45 minutes of GP services per 1000 patients in evenings and weekends (Paula Vaughan, Julia Corey, David Muir)				X				X				
	A clinical triage hub to enhance the NHS 111 service. (Paula Vaughan, Rachana Vyas, David Muir)		X										
	An integrated home visiting service available 24/7 for urgent and Complex patients (Paula Vaughan, Rachana Vyas, David Muir)	X											

17. Primary care

Deliverable (National milestone date)	Key actions (Action owner)	Delivery milestone											
		2017/18				2018/19				2019/20		2020/21	
		Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	H1	H2	H1	H2
National 2 - Increase the number of clinical pharmacists working in GP surgeries to over 900 by March 2018; and to over 1300 by March 2019	Complete bids for funding to employ pharmacists within General Practice as part of the national Clinical Pharmacists in General Practice Programme Wave 1 & 2 to increase the numbers of clinical pharmacists working in primary care. (Lesley Gant, Gill Stead)	X											
	Increase clinical pharmacists in general practice through national and local funding. (Lesley Gant, Gill Stead, John Nicholls)	X			X								
	Coordinate bids for funding to employ pharmacists within General Practice across LLR as part of Wave 3 of the national funding programme, Clinical Pharmacists within General practice to increase the numbers of clinical pharmacists working in primary care , (Lesley Gant, Gill Stead, John Nicholls)		X										

17. Primary care

Deliverable (National milestone date)	Key actions (Action owner)	Delivery milestone											
		2017/18				2018/19				2019/20		2020/21	
		Q 1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	H1	H2	H1	H2
National 3 - 800 mental health therapists placed in primary care by March 2018; and over 1500 by March 2019	Increase number of trainee university placements for psychological therapists. (Simon Baker)			X		X		X					
	Develop alternative and robust recruitment plans / offerings. (Simon Baker)			X									
	Develop with provider robust retention approach / plans. (Simon Baker)			X									

17. Primary care

Deliverable (National milestone date)	Key actions (Action owner)	Delivery milestone											
		2017/18				2018/19				2019/20		2020/21	
		Q 1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	H1	H2	H1	H2
National 4 - Invest in an additional 800 infrastructure projects for primary care (2019)	ETTF Cohort 1 - Business case Completion and ongoing due diligence to ensure value for money and adherence to required timescale. (Amanda Anderson)	X											
	ETTF Cohort 2 - work with NHSE to support development of the business case for the 10 schemes in cohort 2. Estate condition survey information to support the decision making for investment using the national) ETTF Process. Numbers in progress across LLR (Amanda Anderson)			X									
	ETTF Cohort 3 - Work with scheme identified as cohort 3 to review funding and prioritise need in line with previous CCG processes. (Amanda Anderson)						X						

17. Primary care

Deliverable (National milestone date)	Key actions (Action owner)	Delivery milestone											
		2017/18				2018/19				2019/20		2020/21	
		Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	H1	H2	H1	H2
National 5 - Use of funding incentives - including for extra staff and premises - to support the process of practices working together in hubs or networks 2017-2019	EL CCG Funding to support groups of General Practices to come together in line with the proposed new care models. (Tim Sacks)	X	X	X	X	X	X	X	X				
	WL CCG outcome based federation level QIPP scheme. closely aligned to our strategic priorities which include the sustainability of general practice primary care at scale. (Ian Potter)	X	X	X	X	X	X	X	X				
	LC CCG - through the four city Health Needs Neighbourhoods (HNNs) which encompass all of LC CCG practices. Consider transformational opportunities of practices working together to free-up capacity and enable resources to be redirected to the areas of greatest need. (Richard Morris)	X	X	X	X	X	X	X	X				

17. Primary care

Deliverable (National milestone date)	Key actions (Action owner)	Delivery milestone											
		2017/18				2018/19				2019/20		2020/21	
		Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	H1	H2	H1	H2
Local deliverable 1 – Workforce. International recruitment, workforce mapping, care navigators.	Develop plan for an International Recruitment Programme undertaking a Co-ordinated international recruitment drive for clinical skills across LLR in line with the national programme. (Clare Sherman)			X									
	Map the future workforce needs inline with the proposed new models of care in General Practice (Tim Sacks)			X									
	Active Signposting and Correspondence Management Training to upskill admin staff and release GP time (Ian Potter)	X		X	X								
	Produce a comprehensive baseline of current workforce numbers and skills in General Practice to show current and projected workforce gaps and to map future supply of trainees, informing reporting tool development.(Tim Sacks)			X									

17. Primary care

Deliverable (National milestone date)	Key actions (Action owner)	Delivery milestone											
		2017/18				2018/19				2019/20		2020/21	
		Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	H1	H2	H1	H2
Local deliverable 2 – Workload. Transferring care safely. (Rebecca Perry)	Clinical Integration group in place across LLR	X											
	Development of new common reporting pathways for both operational and quality concerns.		X										
Local deliverable 3 – Workload. Ten high Impact Actions. (Ian Potter)	Ten high impact actions launch event and rollout of supported cohorts		X										
Local deliverable 4 – Models & Contracts. Linking directly with the three clinical work streams for Complex, non-complex and Planned care within the STP GP Programme Board to asses, analyse and model:	Modelling delivery of complex / non-complex pathways Intro details			X									
	Develop new ways of joint working / contracting to deliver sustainable models		X										
	Development of a toolkit for practices.		X										

17. Primary care

Deliverable (National milestone date)	Key actions (Action owner)	Delivery milestone											
		2017/18				2018/19				2019/20		2020/21	
		Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	H1	H2	H1	H2
Local deliverable 5 – Communications and Engagement. Communications plan and Vision.	Formulation and agree single vision for all LLR parties and Stakeholders for STP and Public. (Tim Sacks)	X											
	Communications plan completion (Richard Morris)			X									
Local deliverable 6 – IM&T. Online consultations and single platform interoperable systems	Online General Practice Consultation Software Systems, development of online consultation systems with a view to improving access and making the best use of clinical time (Clare Sherman)			X									
	Support practices to migrate as part of the local transition towards a footprint wide clinical system estate towards a single interoperable platform inline with GPSoC.(Clare Sherman)				X								

17. Primary care

Deliverable (National milestone date)	Key actions (Action owner)	Delivery milestone											
		2017/18				2018/19				2019/20		2020/21	
		Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	H1	H2	H1	H2
Local deliverable 7 – Finance. Transformation and models of funding	Agree financial plan for core general Practice for next 5 years (Tim Sacks)		X										
	Agree and align discretionary funding (Tim Sacks)	X											
	Agree and align incentives and transformational funds (Tim Sacks)	X											

17. Primary Care - Outcomes

Work Area	Outcome Descriptor	Baseline	Target	Current Position
National 1 - Access	An integrated service that provides at least 45 minutes of GP services per 1000 patients in evenings and weekends	ELR CCG 24/7 LLR Home Visiting Extended Hours DES. Extended Primary Care through Minor Injuries CBS. Extended Urgent Primary Care through 4 UC centre. LC CCG Extended hours CBS and 4 Primary Care Hubs within LC CCG WL CCG Integrated Community urgent Care Service from Apr 17.	50% of the public have access to evening and weekend GP appointments by March 2018; and 100% by March 2019 50% of the public have access to evening and weekend GP appointments by March 2018; and 100% by March 2019. Appointments to be bookable via 111 and practices to support primary care sustainability UC service elements to be fully integrated and underpinned by Clinical Navigation, enabling proactive clinical handover to the right service at the right time.	LC CCG 30 mins per patient – 45 mins per patient – Appointments bookable – compliant ELR CCG 30 mins per patient – compliant 45 mins per patient – compliant Appointments bookable – uncompliant WL CCG 30 mins per patient – compliant 45 mins per patient – compliant Appointments bookable – uncompliant in regard to GP bookable appointments (subject of test beds through 17/18)

17. Primary Care - Outcomes

Work Area	Outcome Descriptor	Baseline	Target	Current Position
National 2 - Clinical Pharmacists	To have a clinical pharmacist available for every practice through either the national funded clinical pharmacist in primary care programme or through local CGG funding.	All ELR CCG practices have been funded for clinical pharmacist input. LC CCG wave 1 pilot, Across Leicester federation practices have access to 6.5 (whole time equivalent) pharmacist support. WL CCG – Successful wave 1 joint federation bid. Awaiting final approval from NHS E once payment and KPIs have been decided by NHS E.	Every practice to have an aligned clinical pharmacist Successful wave 3 bid across LLR	ELR CCG funded positions with practices for pharmacy support in every practice. LC CCG successful wave1 bid. Pharmacy support available to 9 practices within Across Leicester federation. WL CCG – Successful wave 1 joint federation bid. Awaiting final approval from NHS E to proceed. Original bid has been reduced to 5 pharmacists and 1 8a in line with the criteria and federation are in consultation with practices around the alignment of the reduced offer.

17. Primary Care - Outcomes

Work Area	Outcome Descriptor	Baseline	Target	Current Position
National 3 -Mental Health	NHS Five Year Forward View requires by 2020/21 at least 25% of people with common mental health conditions access services each year. Maintaining quality standards of 75% of people access treatment within six weeks, 95% within 18 weeks; and at least 50% achieve recovery across the adult age group.	16/17 Mandated national target of 15% of people accessing the service with common mental health conditions.	by 2020/21 at least 25% of people with common mental health conditions access services each year.	Developing recruitment plan in order to ensure adequate workers to achieve the target. Developing a marketing strategy to increase referrals Coordinating with STP integrated teams and community nursing / therapy.
National 4- Infrastructure - ETTF	Estates strategy ensuring fit for purpose premises and ability to deliver new models Estates investment from national ETTF programme Improvement to existing estate infrastructure or development of new estate. Providing a safer and a more efficient environment for patient care.	Practices requiring improvement identified and prioritised utilising RAG rating model.	Maximise opportunity for Estates investment in line with national ETTF programme Further develop estates strategy ensuring fit for purpose premises and ability to deliver new models of care in line with STP strategy	Successful bids submitted to the national ETTF programme. Cohort 1 developments are complete and cohort 2 (10 practices) underway including 2 new builds.

17. Primary Care - Outcomes

Work Area	Outcome Descriptor	Baseline	Target	Current Position
National 5 - Transformation	ELR CCG Successful transition by groups of practices to a new model of delivery of care for their patient Populations. This will include joint working for back office and administration duties, joint clinical services to improve access and outcomes and dependent on patient need, Geography, estate and scale of services delivered, the potential for merged practices, larger partnerships, community interest companies all to support a more sustainable long term model of General Practice A Fully financially sustainable Federation supporting and providing services across ELR WL CCG Targeted investment to support an outcome based federation level QIPP scheme. A fundamental shift from previous practice level schemes closely aligned to our strategic priorities which including: the sustainability of general practice, primary care at scale, addressing unwarranted variation; supporting clinical behavioural change and assisting the CCG achieve financial sustainability. Delivered at a federation level the scheme focuses on: efficiency and integrated teams, embedding processes to support delivery and maintaining / reducing activity levels in prescribing and non elective admissions	Each CCG has allocated an equal split of £1.50 per registered patient in 2017/18 and 2018/19 and has been accounted for through existing resource aligned to each operational financial plan.	Identified new models of care and services at scale. Supported implementation through federation channels. Support practices to explore different contract options Ensure resilient models are supported, avoid replicating the same models	ELR CCG £175K for federation in17/18. £325K available for practice bids. Balance in 2018/19 WL CCG £575k £575k to support outcome based federation level QIPP scheme LC CCG £582K available to support services at scale and to further develop federations.

17. Primary Care - Outcomes

Work Area	Outcome Descriptor	Baseline	Target	Current Position
National 5 - Transformation	LC CCG Groups of practices successfully collaborating to provide services at scale, with delivery of appropriate new models of care to patients. LC CCG federation(s)supported to bring about the development of 'at scale' solutions within practices	Each CCG has allocated an equal split of £1.50 per registered patient in 2017/18 and 2018/19 and has been accounted for through existing resource aligned to each operational financial plan.	Identified new models of care and services at scale. Supported implementation through federation channels. Support practices to explore different contract options Ensure resilient models are supported, avoid replicating the same models	ELR CCG £175K for federation in17/18. £325K available for practice bids. WL CCG £575k £575k to support outcome based federation level QIPP scheme LC CCG £582K available to support services at scale and to further develop federations.

17. Primary Care - Outcomes

Work Area	Outcome Descriptor	Baseline	Target	Current Position
Local 1 – <u>WORKFORCE</u>	<u>International Recruitment</u> International recruitment plan in place across LLR with participating practices included in the bidding process. EU GPs in LLR practices by 18/19	Currently no international recruitment plan in place across LLR..	Recruitment programme bid to be submitted by Sep 17. EU GPs to be in Practices by 18/19.	LLR exploring learning from Lincoln pilot. Project Manager funding identified through LWAG to progress.
	<u>Baseline- New Models of Care</u> Understanding through a new quarterly enhanced practice workforce return the scale of necessary recruitment by clinical group and the future training needs to deliver new models of care. Through HEEM / WFP funded study, Rural, Urban and sub urban groupings of practices will model the future staffing need and skill mix for future needs for a sustainable new Model.	HEE quarterly data set.	New detailed LLR returns on workforce metrics	Map the future workforce needs in line with the proposed new models of care in General Practice
	<u>Active sign posting</u> Through effective use of allocated resources build up the knowledge, skills and capacity of practices to develop innovative approaches to active signposting and document management releasing GP time.	Successful LLR bid to 'Releasing Time to Care' programme securing NHS England support to deliver LLR programme covering GPIP, Fundamental of Quality Improvement and Collaborative Leaning in Action events.	Through the provision of local training build the knowledge, skills and capacity of general practice to deliver initiatives to free up GP time.	Engagement event held on 9th February, 2 Collaborative Learning in Action (CLAP) events delivered, 3rd scheduled for July focused on active signposting and social prescribing. 4 day CLAP course scheduled for October 2017. 2 Day Fundamentals of Quality Improvement Programme taking place.

17. Primary Care - Outcomes

Work Area	Outcome Descriptor	Baseline	Target	Current Position
	<u>Baseline</u> Baseline identified of current workforce, highlighting risks of retirement and inequity of access for patients and informed development of new reporting tool for quicker access to more bespoke results to inform future workforce supply needs.	Currently using the primary care web tool for submissions. Results not available in a timely manner.	Identified risks to current workforce and upcoming gaps through retirement. New tool developed and available for practice use.	Final comments from CCGs on Enhanced Workforce Data Set questionnaire received. Final version of questionnaire put together incorporating feedback and sent to HEE to begin building the tool.
Local 2 - <u>WORKLOAD</u>	<u>Transferring care safely</u> Improve clinician and patient experience Improve patient safety including prescribing and medicine usage reduce un-necessary hand overs And follow up appointments (primary and secondary care). Reduce un-necessary or duplicate out-patient/consultant lead care referrals release primary and acute care capacity Development of new common reporting pathways for both operational and quality concerns.	Survey undertaken. Gave evidence for important areas to address – medication, investigations referrals. Identified that the current system does not serve patients GPs, or consultants well with patient caught between interfaces for tests, referrals, follow up or treatment including prescribing	New simple rules for transferred care Develop better IT solutions Agree principles to ensure agreed method of working together between sectors Systems to keep up with integrated working, discharge process, diagnostic hubs .	Guide book co-designed by Task & Finish Group with input from across LLR at final draft stage. Mechanism for sharing Guidebook in form of PRISM agreed. Review of the most effective way of raising urgent risk issues eg telephone hotline in UHL undertaken and GP concerns line to be implemented. Agreement for a similar process to be agreed in community.

17. Primary Care - Outcomes

Work Area	Outcome Descriptor	Baseline	Target	Current Position
	10 High Impact Actions Collaborative learning in action programme for practices, targeting HIAs 1) active signposting & 8) Social prescribing. Agreed with NHS England, structure and content of offer to practices. Key learning outcomes agreed across LLR.	Evaluation of showcase event.	Collaborative learning in action programme for 15 - 25 practices, targeting HIAs 1) active signposting & 8) Social prescribing.	High Impact Action event held on 09.02.17 in partnership with NHS England sustainable improvement team.
Local 4 – MODELS AND CONTRACTS	Toolkit for practices for models of care linked to Complex, non-complex and Planned care within the STP GP Programme Board to assist ways of joint working / contracting to deliver sustainable models.	Joint working undertaken through federation working on bespoke projects	Defined models and tool kit available to assist practices and federations All practices working formally or informally together to deliver new models of care for patients	Federations formed and delivering care or supporting practices to deliver new models of care for larger patient groups Examples of mergers, large partnerships and informal joint working across LLR
Local 5 – COMMUNICATION AND ENGAGEMENT	Local GP5FV vision defined and communicated. Communications plan in place	Visionary event to define the vision and inform the plan	Communications plan in place and engagement with all stakeholder and patient groups to develop care models rolled out	Wide scale engagement on the GP5YFV and STP plans Visioning event planned for 27th

17. Primary Care - Outcomes

Work Area	Outcome Descriptor	Baseline	Target	Current Position
Local 6 – IM&T	<u>Online Consultation</u> Pilot online General Practice Consultation Systems in 3 areas during 2017/18 as part of a range of initiatives to improve access and make best use of clinical time to identify the appropriate IT solution for LLR in line with national guidance once available. Increased efficiency and productivity . Potential reduction in face to face consultations Increased use of technology to support improved access	Practices currently do not offer any e consultation solutions	Online pilots operational within LLR practices	Scoping work of potential online systems is being developed and will be adapted once national guidance is available
	<u>Interoperability</u> A single interoperable platform inline with GPSoC across LLR.	Two GP Clinical Systems across LLR. Number of practices migrated from Emis Web to SystmOne in 16/17 = 12	LLR CCG demographic areas to move to a single interoperable platform. Aim for 10 migrations in 17/18 - dependant on GPSoC	WL CCG SystmOne = 30 Emis Web = 18 ELR CCG SystmOne = 19 Emis Web = 12 2 additional GP Services on SystmOne. LC CCG SystmOne = 58 Emis Web = 1
Local 7 - Finance, transformation and models of funding	Financial Plan agreed for core general practice for the next 5 years. Alignment of discretionary funding and alignment of incentives and transformational funds.	Agreed funding plan for 5 years.	Funding Plan agreed. Transformational and discretionary funding aligned.	Funding plan agreed and funding streams being identified.

This page is intentionally left blank