Leicestershire County Council

Meeting: **Health Overview and Scrutiny Committee**

Date/Time: **Wednesday, 5 June 2019 at 2.00 pm**

Location: **Sparkenhoe Committee Room - County Hall**

Contact: **Mr. E. Walters (0116 3052583)**

Email: **Euan.Walters@leics.gov.uk**

Membership

Mr. T. Barkley CC	Dr. S. Hill CC
Mr. D. C. Bill MBE CC	Mr. J. Morgan CC
Dr. R. K. A. Feltham CC	Mrs B. Seaton CC
Mr. T. Gillard CC	Mrs. M. Wright 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.	
2.	Election of Deputy Chairman.	
3.	Minutes of the meeting held on 13 March 2019.	(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.	All Age Mental Health Transformation.	Leicestershire Partnership NHS Trust	(Pages 13 - 48)
11.	QIPP end of financial year.	East Leicestershire and Rutland CCG and West Leicestershire CCG	(Pages 49 - 54)
12.	Primary Care Networks.	East Leicestershire and Rutland CCG and West Leicestershire CCG	(Pages 55 - 60)
13.	Development of a new model for homelessness and housing support.	Director of Public Health	(Pages 61 - 66)

14. Dates of future meetings.

    Future meetings of the Committee are scheduled to take place on the following dates all at 2:00pm:
    11 September 2019;
    13 November 2019;
    15 January 2020;
    4 March 2020;
    3 June 2020;
    9 September 2020;
    11 November 2020.

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

QUESTIONING BY MEMBERS OF OVERVIEW AND SCRUTINY

The ability to ask good, pertinent questions lies at the heart of successful and effective scrutiny. To support members with this, a range of resources, including guides to questioning, are available via the Centre for Public Scrutiny website www.cfps.org.uk.

The following questions have been agreed by Scrutiny members as a good starting point for developing questions:-

- Who was consulted and what were they consulted on? What is the process for and quality of the consultation?
- How have the voices of local people and frontline staff been heard?
- What does success look like?
- What is the history of the service and what will be different this time?
- What happens once the money is spent?
- If the service model is changing, has the previous service model been evaluated?
- What evaluation arrangements are in place – will there be an annual review?

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Agenda Item 3

Minutes of a meeting of the Health Overview and Scrutiny Committee held at County Hall, Glenfield on Wednesday, 13 March 2019.

PRESENT

Dr. R. K. A. Feltham CC (in the Chair)

Mr. D. C. Bill MBE CC	Mr. W. Liquorish JP CC
Mr. J. G. Coxon CC	Mr T. Parton CC
Mrs. A. J. Hack CC	Mrs. J. Richards CC
Dr. S. Hill CC	Mrs. M. Wright CC

In attendance

Micheal Smith, Healthwatch Leicester and Leicestershire.
Paul Gibara, Chief Commissioning and Performance Officer, ELRCCG (minutes 63, 67 and 68 refer).
Dr Dan Barnes, Consultant Thoracic Radiologist, UHL (minute 63 refers).
Sam Leak, Director of Operational Improvement, UHL (minutes 63 and 65 refer).
Mike Ryan Director of Urgent and Emergency Care (Interim), LLR System (minutes 65 and 66 refer).
Nikki Beacher, Head of Adult Services, LPT (minute 65 refers).
Richard Lyne, General Manager, EMAS (minute 65 refers).
Derek Laird, Chief Executive, TASL (minute 66 refers).
Kate Jerram, Operational Manager, TASL (minute 66 refers).
Hayden Newton, Quality Lead, TASL (minute 66 refers).
Ket Chudasama, Director of Performance & Corporate Affairs, West Leicestershire CCG (minutes 67 and 68 refer).
Simon Pizzey, Head of Planning and Strategic Commissioning, ELRCCG (minute 67 refers).
Kate Allardyce, NHS Midlands and Lancashire Commissioning Support Unit (minute 68 refers).

56. Minutes of the previous meeting.

The minutes of the meeting held on 16 January 2019 were taken as read, confirmed and signed.

57. Question Time.

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

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

Mr. D. C. Bill MBE CC asked the following question:

At a previous meeting of this Committee it was agreed that a letter would be sent to the Secretary of State and to NHS England urging support for the £8m programme to re-

organise the Hinckley hospitals. On December 19th it was reported by the CCG that the Secretary of State had allocated this sum to the project and this is of course very good news. It was also reported however that these plans still need to be approved by NHS England and that until this takes place public consultation cannot start.

As time is now moving on can this Committee please agree to press NHS England to approve the plans as submitted by the CCG so that progress can be made?

Dr. R. K. A Feltham CC replied as follows:

NHS England have already approved the strategic outline case for Hinckley and Bosworth Community Services and as such have set aside funding. WLCCG are currently working to refresh and confirm the content of the Pre consultation business case (PCBC) which will require approval of the CCG board and NHS England before consultation can commence. WLCCG are aiming to complete the updated PCBC by June and therefore hope to be able to consult during July – Sept 2019.
Following this consultation, final decisions will be taken by the CCG and will still require approval from the NHS in terms of a further detailed OBC (Outline Business Case) and then an FBC (Full Business Case) - the timelines for these elements are not yet confirmed but it could take up until 2020/21 until full approval to proceed is given. (This is standard in terms of significant capital investment within the NHS, and WLCCG assure that they are doing everything they possibly can to complete the planning as soon as possible without setting unrealistic timescales).

In my view it would not be beneficial for the Committee to write to NHS England again until it has been consulted on the PCBC. County Council officers are in regular contact with officers at WLCCG and are monitoring progress with the business case to ensure that the Health Overview and Scrutiny Committee receives it at the appropriate time.

Mr. D. C. Bill MBE CC asked the following supplementary question:-

Could the local members be kept appraised of progress with Hinckley and Bosworth Community Services?

Dr. R. K. A Feltham CC provided assurance that local members would be kept updated.

59. Urgent items.

There were no urgent items for consideration.

60. 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.

No declarations were made.

61. Declarations of the Party Whip.

There were no declarations of the party whip in accordance with Overview and Scrutiny Procedure Rule 16.

62. Presentation of Petitions.

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

63. Cancer Performance Update.

The Committee considered a report from the Leicester, Leicestershire and Rutland Cancer Programme which provided an update on cancer performance for Leicestershire and highlighted work being undertaken to improve cancer services for patients. A copy of the report, marked 'Agenda Item 8', is filed with these minutes.

The Committee welcomed Paul Gibara, Chief Commissioning and Performance Officer, at ELRCCG along with Dr Dan Barnes, Consultant Thoracic Radiologist, UHL Cancer Centre Clinical Lead, and Sam Leak, Director of Operational Improvement, UHL to the meeting for this item.

Arising from discussions the following points were noted:

(i) In response to concerns raised by members about whether the system had the capacity to meet demand it was acknowledged that changes were required to the way the system operated in order to increase capacity and explained that a transformation programme was underway which would lead to the required changes. Funding from the East Midlands Cancer Alliance had been received which would be used to improve early diagnosis and support those who had been diagnosed with cancer, and there was confidence that additional funding could be obtained which could also be used to increase capacity.

(ii) Members were pleased to note that the LLR Cancer Programme was performing well for early diagnosis in comparison with its peers. However, it was also noted that the performance for cancer screening was deteriorating and NHS England had the responsibility for screening. Reassurance was given that locally CCGs were conducting work to improve the level of communication between GPs and patients regarding the importance of screening and a workshop had been held in this regard. Certain demographics were at a higher risk of cancer than others therefore targeted campaigns took place to encourage people within those demographics to undertake cancer screening. The LLR Cancer Programme made sure it had the additional capacity to deal with the increased demand caused by the targeted campaigns.

(iii) The numbers of 2 week wait referrals from primary care for cancer investigations had increased by 15.9% however the percentage of those patients that were being diagnosed with cancer had remained stable and not increased. NHS England set a target of 3% detection rate for this pathway.

(iv) The Faecal Immunochemical Test (FIT) enabled colorectal cancer to be diagnosed more quickly than other diagnostic methods. Leicester, Leicestershire and Rutland along with Nottinghamshire were the first areas where the FIT was in use and it was expected that it eventually would replace the Fecal Occult Blood Test (FOBT).

RESOLVED:

That the cancer performance for Leicestershire be noted, and the work being undertaken to improve cancer services be supported.

64. Healthwatch Review of Winter Messages.

The Committee considered a report of Healthwatch Leicester and Leicestershire which summarised the results of a review carried out by Healthwatch into the effectiveness of public health messages issued throughout winter 2018/19. A copy of the report, marked 'Agenda Item 9', is filed with these minutes.

The Committee welcomed Micheal Smith, Manager, Healthwatch Leicester and Leicestershire to present this item.

Arising from discussions the following points were noted:

(i) Members stated that it would have been helpful if the Healthwatch report contained details on the ages and places of residence of the participants in the survey. A member also stated that only having one focus group taking place in the County Council area (Loughborough) was insufficient.

(ii) There was some confusion amongst the public around the ages that patients were entitled to receive particular vaccines such as for flu and shingles. Some vaccines were only available for people over the age of 65 and there needed to be better communication around the precise policy that was in place. A member queried whether every GP Practice had the same rules on age or whether it differed across LLR. Officers agreed to ask the Clinical Commissioning Groups to provide a written response to members regarding this query.

(iii) In response to a question from a member, Micheal Smith confirmed that in carrying out the survey Healthwatch had not gained any sense that the public were opposed to vaccinations due to worries that vaccines could cause disorders such as autism.

RESOLVED:

That the results of the review of effectiveness of public health messages issued throughout winter 2018/19 be noted.

65. Urgent and Emergency Care Resilience and Winter 2018/19.

The Committee considered a report of the Leicester, Leicestershire & Rutland (LLR) Health and Social Care System which provided an overview of performance over the 2018/19 winter period across the LLR Urgent and Emergency Care system. A copy of the report, marked 'Agenda Item 10', is filed with these minutes.

The Committee welcomed Mike Ryan Director of Urgent and Emergency Care (Interim), LLR System, along with Sam Leak, Director of Operational Improvement at UHL, Nikki Beacher, Head of Adult Services at LPT and Richard Lyne, General Manager, EMAS to the meeting for this item.

Arising from discussions the following points were noted:

(i) Members were pleased with the marginal improvement in overall performance and particularly welcomed the improvement in some areas for example there were zero 12-hour trolley breaches in A&E. However, it was questioned whether performance would improve the following winter taking into account that 2018/19 was a relatively

mild winter in terms of the weather, and that the population of LLR was continuing to increase. In response to these concerns reassurance was given that LLR had refreshed cold weather and infection control plans for 2018/19 in preparation, and work was being undertaken to address the gap between capacity and demand. Transformational programmes would be implemented in the summer which would ensure that processes were as efficient as possible. The staffing blend on wards was being looked at to ensure the right mix of skills was available and a recruitment drive was taking place in 2019 to address vacancies in nursing and other medical roles.

(ii) The Ambulance Response times had improved though they were still below the national standard. The figures quoted in the report related to the whole of LLR and all areas had seen an improvement, recognising that most of the outliers in terms of response times were in rural areas. As a result of commissioner investment EMAS had increased its staffing levels by 70 and a further 20 new staff were in training and would become part of the active workforce soon.

(iii) In response to a suggestion from a member it was acknowledged that changes could be made to the way the LLR Urgent and Emergency Care System communicated important winter messages to patients such as through greater use of social media, though care would have to be taken to still use methods that would be seen by those that did not access the internet. It was suggested by members that noticeboards at GP Practices needed to be more focused and kept up to date, and also posters and notices needed to be displayed at other venues because not everybody visited their GP Practice regularly.

RESOLVED:

That the improvements to performance over the 2018/19 winter period be welcomed though it be noted that the Committee has concerns whether this improvement in performance can be sustained in future winters.

66. Non Emergency Transport - TASL

The Committee considered a report of the Leicester, Leicestershire & Rutland (LLR) Health and Social Care System regarding the Non-Emergency Patient Transport Service run by Thames Ambulance Service Ltd (TASL) and the Care Quality Commission's inspection report dated 13 February 2019 relating to TASL. A copy of the report, marked 'Agenda Item 11', is filed with these minutes.

The Committee welcomed Mike Ryan, Director of Urgent and Emergency Care (Interim), LLR System, Derek Laird, Chief Executive of TASL, Kate Jerram, TASL Operational Manager, and Hayden Newton, Quality lead for TASL to the meeting for this item.

Arising from discussions the following points were noted:

(i) The TASL management team welcomed independent review of the organisation however it was of the view that the timing of the CQC inspection in October 2018 was unfortunate as many initiatives designed to improve performance were not yet imbedded. TASL had challenged the CQC's findings and invited the CQC to conduct a re-inspection of the Non-Emergency Patient Transport Service. The re-inspection was expected to take place in summer 2019 and was likely to include TASL operations in Leicestershire. It was clarified that whilst the results of the CQC

inspection only related to Lincolnshire, the actions to improve performance as set out in the report for the Committee applied to Leicestershire as well.

(ii) Members had concerns that given the emphasis TASL placed on the Lincolnshire part of their operations, including deciding to base their training programme at Grimsby College, it did not give assurance that TASL performance in Leicestershire would be better than that in Lincolnshire. In response to those concerns reassurance was given that the Clinical Commissioning Group operated a quality team which monitored the performance of TASL in Leicestershire, carried out announced and unannounced inspections, took proactive action and ensured that services were safe, standards were met, and that any areas for improvement were addressed.

(iii) In response to a question as to how the patient experience with TASL was monitored, it was explained that a Patient Experience Team had been set up within TASL, the Head of which had recently been recruited. A review and appeal process for complaints had been agreed which included the option of referral to the CCG if the complainant wished to escalate the complaint that far. TASL agreed to provide Committee members with the results of a survey of friends and relatives of patients that used the non-emergency transport service and the analysis of themes and trends. TASL also invited Healthwatch to work with them on measuring and monitoring the patient experience.

(iv) The vehicles used by TASL already contained trackers so the location of the vehicle could be monitored, however new trackers were being installed which would also provide information on the speed of the vehicle and the performance of the driver in relation to safety.

(v) Deep cleaning of the vehicles occurred once every two weeks. During shifts ambulance staff were able, if required, to wipe down the interior of the vehicle and staff were also allocated 20 minutes at the end of the shift to clean the vehicles. If there was not time at the end of the shift to clean the vehicle then staff could notify the manager who would ensure that the vehicle was cleaned the next morning before it was used again.

(vi) The CQC report had identified that not all TASL staff had completed mandatory training so a training programme had been put in place which began in February 2019 and it was expected that by the end of March 2019 all staff would have completed their mandatory training.

RESOLVED:

(a) That the update on the Care Quality Commission's inspection report of TASL be noted with concern, and the actions being taken to address the issues raised in the report be welcomed.

(b) That officers be requested to produce a report for a future Committee meeting on progress with the TASL action plan and the results of any future inspection by the Care Quality Commission.

67. NHS Long Term Plan.

The Committee considered a report of Leicester, Leicestershire and Rutland Clinical Commissioning Groups which set out the key requirements of the NHS Long Term Plan. A copy of the report, marked 'Agenda Item 12', is filed with these minutes.

The Committee welcomed Ket Chudasama, Director of Performance & Corporate Affairs, West Leicestershire CCG, Paul Gibara, Chief Commissioning and Performance Officer at ELRCCG and Simon Pizzey, Head of Planning and Strategic Commissioning, ELRCCG to the meeting.

Arising from discussions the following points were noted:

(i) The NHS Long Term Plan set out firm requirements for how the healthcare system should work and locally plans would have to be made and services would have to be commissioned to deliver those requirements. There was insufficient funding to implement everything the Long Term Plan aimed to achieve therefore decisions would have to be made locally on what would be prioritised and how it would be resourced. Work would be undertaken with Healthwatch to establish what patients' priorities were.

(ii) Members were pleased that it was recognised by the NHS that Leicestershire County Council would be required to play an important role in the implementation of the Long Term Plan locally.

(iii) Members were concerned that the Long Term Plan suggested that some services currently carried out by the Public Health department of the County Council could in future be run by the NHS. It was felt that Public Health in Leicestershire had a good track record with regard to performance.

(iv) Reassurance was given that the Mental Health Investment Standards were within the financial plans submitted to NHS England.

(v) Members welcomed the proposals regarding the introduction of Primary Care Networks (PCNs) and were pleased that the geographical area covered by PCNs would no longer be referred to as 'neighbourhoods' as it was felt that this terminology implied a much smaller area. Concerns were raised by members that the introduction of PCNs would exacerbate staffing shortage problems at GP practices. In response it was confirmed that the Community Service review was looking at staffing issues to support PCNs and it was planned to develop an integrated workforce.

RESOLVED:

(a) That the update on the key requirements of the NHS Long Term Plan be noted;

(b) That officers be requested to produce reports for the Committee at an appropriate time on any specific aspects of the Long Term Plan being implemented in Leicestershire that may be of interest to the Committee.

68. Health Performance Update.

The Committee considered a joint report of the Chief Executive of the County Council and NHS Midlands and Lancashire Commissioning Support Unit, which provided an update of performance to the end of February 2019. A copy of the report, marked 'Agenda Item 13', is filed with these minutes.

The Committee welcomed Kate Allardyce, NHS Midlands and Lancashire Commissioning Support Unit, Ket Chudasama, Director of Performance & Corporate Affairs, West Leicestershire CCG, and Paul Gibara, Chief Commissioning and Performance Officer at ELRCCG to the meeting for this item.

With regard to Delayed Transfers of Care it was confirmed that the plan to bring the Housing Enablement Team into the Integrated Discharge Teams had already been implemented.

RESOLVED:

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

69. Date of next meeting.

RESOLVED:

It was noted that the next meeting of the Committee would be held on 5 June 2019 at 2:00pm.

2.00 - 4.20 pm CHAIRMAN
13 March 2019

All Age Transformation
Transforming our mental health and learning disabilities services

NHS
Leicestershire Partnership
NHS Trust

HEALTH OVERVIEW AND SCRUTINY COMMITTEE: 5 JUNE 2019

REPORT OF LEICESTERSHIRE PARTNERSHIP NHS TRUST

ALL AGE TRANSFORMATION PROGRAMME

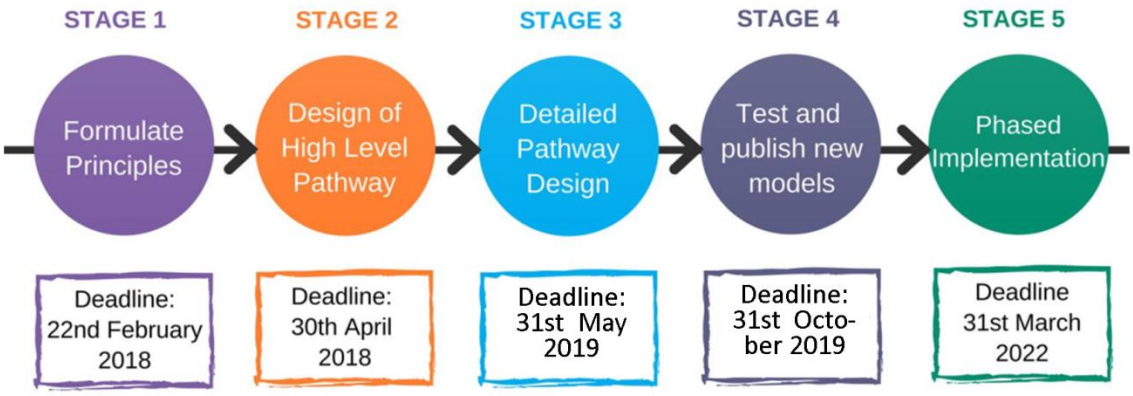
Purpose of report

1. The purpose of this report is to update the Committee on the All Age Transformation Programme which Leicestershire Partnership NHS Trust have been undertaking.

Background

2. The all age transformation programme was initiated by the Sustainability, Transformation partnership in 2017. It was set out to adopt a similar approach to Northumberland, Tyne and Wear Foundation Trust (rated outstanding by the CQC) in undertaking transformational change of Leicestershire Partnership Trust's mental health and learning disabilities services.

3. The programme has been organised over 5 stages depicted below and is coming to the end of stage 3. This staged approach builds the change in layers in recognition of the complexity and extent of change expected.



Design features

4. The design work to date has led to the following design features each one focused on increasing the value added to service users, better utilising staff time to provide that value added input and making the system work better to reduce delays and disruptions in care.

- A common approach to care
- Four broad and distinct specialities (CAMHS, AMH, MHSOP, LD)
- Additional Expertise and Support Process
- Professional lead / care coordinators and 'team around the service user'
- Central Access Point
- All age crisis assessment
- New initial assessment approach for adults, older people and individuals with LD
- New intervention pathways
- Geographically alignment of services
- Peer support workers
- Supporting other needs framework
- Single Integrated Care Plan
- Step-up capacity

5. Workshops have been held in April and May to design the structural changes to services to best meet these key features. This is being pulled together with a detailed analysis of the workforce needed to deliver the key features to form a complete first draft model at the end of May 2019.

Next steps and implementation

6. There are various quality improvement projects that have been running concurrently to the design work, focusing on various elements of CQC findings and service issues. These are focused on undertaken change at pace on areas including environmental improvements, waiting times, adherence to policies and governance. Wherever relevant the immediate changes have been informed by the outputs of the Transformation design whilst being delivered through parallel processes.

7. There are elements of the key features that have started to be implemented which include:
   • the commencement of a training and recruitment programme for peer support workers
   • the commencement of the 'supporting other needs' framework
   • delivery of recovery cafés to increase the focus in clinical practice upon principles of mental health recovery which underpin our new approach to care

8. From June to end of October the wider elements of the design features will be tested for ability to meet demand, viability and affordability. This will be undertaken in conjunction with commissioners and external experts. The model will be revised if necessary. After confirmation of affordability and viability, the proposed changes will be taken forward with further public engagement.

9. At the end of October 2019, any further alterations from the engagement will be made and the model finalised. Implementation will then be undertaken in a phased and careful way to ensure a balance between pace and putting change into practice well.

Circulation under the Local Issues Alert Procedure

Not applicable.

Officer to Contact

John Edwards
Associate Director for Transformation
Leicestershire Partnership NHS Trust
Email: MHLDTransformationteam@leicspart.nhs.uk

Tel: 0116 2255791

List of Appendices

Draft Key design features document.

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Leicestershire Partnership NHS Trust

All Age Transformation
Transforming our mental health and learning disabilities services

Draft – Key Design Features Document

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Introduction

The All Age Transformation Programme was set up in late 2017 with agreement across Leicestershire Partnership NHS Trust (LPT), the Clinical Commissioning Groups (CCGs) other NHS Trusts and local authorities within Leicester Leicestershire and Rutland. It was set up to focus on improving all mental health and learning disabilities services delivered by LPT. While some of these LPT services have been meeting demand and delivering a good quality of care, many consistently struggle with long waiting lists, difficulties in meeting the demand for services and not meeting service user expectations. This has been evident in previous Care Quality Commission (CQC) findings as well as service user and staff surveys.

The approach to the All Age Transformation Programme was inspired by how the outstanding Northumberland, Tyne and Wear NHS Foundation Trust (NTW) approached changing themselves. Their change methodology was adapted to suit LPT's local needs and priorities and the programme was set up to be undertaken over 5 years.

Across the duration of the programme the understanding of what to change, the design and ultimate implementation of changes is achieved using several key methodological approaches:

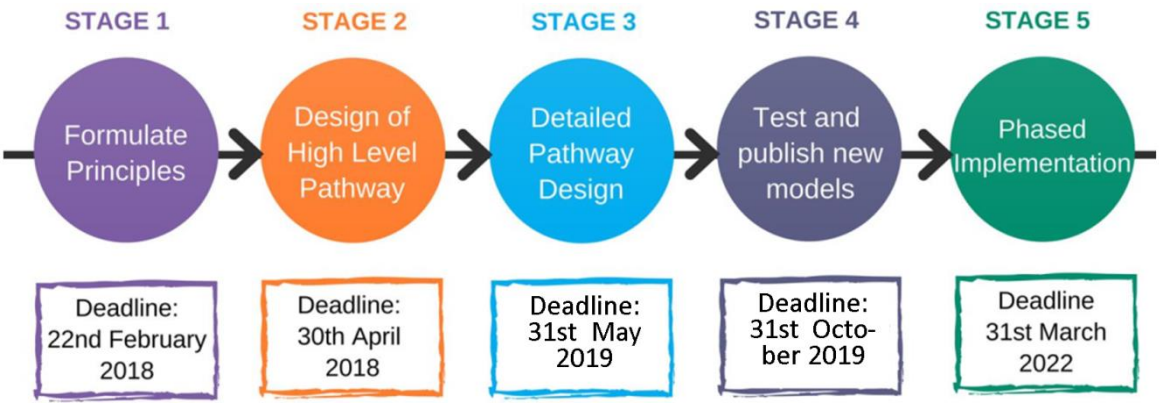
- Co-design — bringing the views of staff, service users, carers and other stakeholders together to understand and design (usually in workshops)
- Data analysis — analysing data and observation to understand where we can improve the areas of the work and ultimately the impact of changes made
- Quality Improvement cycles — when implementing change to use improvement cycles to refine the changes being made and ensure improvement is being achieved

All of the different aspects of the work have been focused primarily upon **Adding Value** to the people that use our services. To help achieve this there is focus on **removing the things that get in the way** of LPT staff adding that value and **improving the processes and systems** to work better for service users.

Adding value – Increasing the things that add value to the people that use our services	**Removing the things getting in the way –** enabling clinicians to have more time to spend with service users and creating a better working life for staff
	Making the processes and systems better – ensuring the best journey experience for service users throughout

Progress so far…

LPT sets out to support a wide diversity of needs through its array of mental health and learning disabilities services. There are too many different services to be able to meaningfully work through all of them in the time that the All Age Transformation Programme has been running. Therefore the programme has been organised into two waves (Wave One and Wave Two). The focus of the programme to date has been on community based services in ***Wave One,*** which has been set out in a series of layers of design leading to a published model and its implementation. These layers are described over 5 stages:



The first stage set out to understand what excellent looks like for staff, service users, carers and stakeholders (such as local authorities, GPs and the voluntary sector). Hundreds of views were received through surveys and workshops. These views were thematically analysed into a set of principles that describe what excellent looks like for how people access services, have their needs assessed, receive treatment and leave services. Follow the link to these principles.

The second stage brought together service users, carers, staff and stakeholders into four week long workshops (access, assessment, treatment and discharge) with many other staff and stakeholders feeding in during each week. Using the principles from stage 1, the attendees developed high level designs of how mental health and learning disabilities could work better. There were over 50 different elements to the designs that came from the four weeks. Follow the following links to those summaries (Access, assessment, treatment, discharge)

The third stage has taken forward the different design elements from stage 2 into many different workshop days (more than 60) with staff, service users, carers and stakeholders focused in creating detailed designs.

What is this document?

This document summarises the **key features** from the end of Stage 3. It has come together from the many months of co-design workshops that have brought together hundreds of LPT staff, service users, carers and stakeholders. It is also been informed from the extensive detailed analysis of LPT service data and hundreds of hours of observing and learning directly of what is working well and what isn't within LPT's mental health and learning disability teams.

The key features will be brought together with a draft workforce model and proposed set of service structures to form a complete draft model at the end of May 2019. See next steps section for more information.

Key Features from Transformation design

This section provides details of all of the key design features that have come out of the Transformation programme to date. The key features of the transformation design to date are described under three sections:

1. Design features and principles that go **across all** mental health and learning disabilities services
2. Specific aspects of design that **require all** mental health and learning disabilities to make changes and work together
3. Specific aspects of design that **effect specific parts** of the mental health and learning disabilities services but not all of them.

These sections are described in turn below.

Section 1: Design features and principles that go across all mental health and learning disabilities services

We will have a common *approach to our care* across all of our mental health and learning disabilities services. We will have *distinct specialties* within our mental health and learning disabilities services that provide specific expertise to groups of service users who, through particular life stages or other reasons, have commonality in their needs. However in recognition that everyone is different and people's needs change over time, we will also work together. We will *share expert knowledge*, collaborate across services, and bring expertise together around each service user. The majority of service users will receive care through *geographically organised teams that are* linked and aligned to the primary care networks (patches of GP practices) to help increase future joint working with GPs and other community services. Service users will always have an individual within LPT's mental health and learning disabilities services *coordinating* the care and support that is offered to them.

Key Feature: Our approach to care

That all LPT mental health and learning disabilities services promote and measure their compliance with the following approach to care:

- We are **Person Centred** in how we support a service user to ensure we meet their individual needs.
- We will help individuals' identify **their Goals** and describe what **Quality of Life** means to them, to shape the treatment and support we offer.
- We **Focus on People's Strengths** in the support we provide and look to build upon their capabilities when planning and delivering treatment and support.
- We will maintain a **Positive Perspective** free of judgement and prejudice and promote wherever possible individuals' making **Choices** and taking **Control.**
- We will help people to **Connect** and strengthen their **Social Networks** to increase the number of people they can turn to when they need support and assist them to develop a social identity.
- We will support people to **Identify** and **Use the Assets** available to them in and around their lives that can help them to stay well.
- We will help individuals to find **Hope**, **Aspirations** and **Motivation** in their health and life journey.
- We will help individuals to **Overcome Stigma** and form a **Positive Sense of Self** and **Identity** and not define themselves by their illness or diagnosis.
- We will support and encourage individuals to identify the things that give them **Meaning and Purpose** in their life.
- We will promote **Empowerment** of individuals to build on their strengths, take personal responsibility and control of their lives.
- We will **Collaborate** with individuals in decisions about their treatment and support.
- We will organise and deliver our services so that they are **Inclusive** and do not unduly exclude anyone.
- We will use **Language** that promotes collaboration, balance in power and creates equal understanding between service user and practitioners.
- We will work with other agencies supporting an individual to **Join Up** support wherever possible.

It is expected that Our Approach to Care will be incorporated into our ongoing quality measurement of services.

Key Feature: Distinct specialties that work together

There will be four broad and distinct specialties within our mental health and learning disabilities services focused on:

- Children's and Young People (CAMHS – Children's & Adolescent Mental Health Services)
- Adults (AMH – Adult Mental Health)
- Older People (MHSOP – Mental Health Services for Older People)
- Learning Disabilities (LD – Learning Disabilities)

The four specialties are designed mainly around life stages and commonality of needs and not by age alone. Each specialty will be made up of staff with specific expertise and training to offer tailored support and interventions. An individual starting an episode of care with our services will be streamed to a particular specialty based on their specific needs through the Central Access Point (described in section 2). All specialties will work together to support service users' individual needs irrespective of which specialty they are initially streamed into. Where individuals require expertise from more than one specialty or team, then this will be provided (described in additional support and expertise key feature).

Service users and carers have described that continuity and coordination of care is important and needed to be maintained wherever workable. However there may be a point or points in their care journey that their needs would overall be better supported within another specialty. In this case, there will then be a transition between specialties that will feel planned and seamless and will:

- be undertaken when it is in the best interests of the service user (determined in conjunction with the service user). This will be mostly informed by the different expertise offered by practitioners in an alternative specialty being more appropriate for the service user's needs.
- see practitioners between different specialties working together alongside the service user (and significant others to the service user) to continue and evolve the individual's care plan.
- not solely occur on an individual's birthday.

Common transition points

The following are common transition points between specialties:

- Children's and young people's specialty will initially[1] focus on childhood and adolescence. Any transition will commonly occur as individuals move into adulthood.

[1] Over the next 5-10 years it is expected that the children and young people's specialty will also focus on young adults as well as childhood and adolescence. This is part of the NHS long-term plan. https://www.england.nhs.uk/long-term-plan/

- A transition to older people specialty will commonly occur when individual's develop dementia and/or have developed both complex physical and mental illness and/or have a mental illness where aging in and of itself is influencing the needs of the individual.

It is expected that all service specifications and criteria will be altered to reflect the above approach.

Key Feature: Continuity and coordination through Professional Lead / Care Coordinator and 'team around the service user'

Continuity and coordination of care is important to service users and needs to be maintained wherever workable. Specialist mental health and learning disabilities services are delivered through multi-disciplinary teams.

Care coordinator / lead professional

Each service user will have a Care Coordinator (also referred to as Lead Professional) who will be part of the multi-disciplinary team (MDT) that is supporting that service user. On the majority occasions this team will be in a specific geographical area (described in geographical patches below). The Care Coordinator / Lead Professional is an individual who takes responsibility of coordinating the care that is provided by LPT and linking, where appropriate, with other services outside of LPT. Where an individual has a high degree of complex needs (as defined by the LPT CPA policy) the Care Coordinator will take on specific duties associated with enhanced CPA.

Team around the service user

The individual service user may require expertise and support that is not routinely part of the local MDT. This may be because there are a few LPT staff with that particular expertise and they need to support several different multi-disciplinary teams at once. These experts will be directly involved in planning and discussions with the local MDT relating to a service user and their individual needs.

This will help to maintain the continuity and coordination of support and be organised to efficiently use the experts' time.

Key Feature: Additional Support and Expertise Process

There will be occasions where the broad specialties and the local MDTs within those specialties do not have all of the expertise and skills to support a service user's individual needs. In such instances the service user's practitioners can seek additional expert support. To support both continuity and resources management there is a ladder of support for the practitioner involved in the service user's care. The level of support required is broadly described in the following basic framework:

• **Transition to another MDT**: (see distinct specialties that work together)	where majority of a service user's care requires expertise and skills that are not available in the local MDT
• **Additional**: (see Team around the service user)	where additional expert support is required to undertake specific tasks / interventions
• **Supported**:	where a practitioner can deliver specific tasks / interventions with the support of another expert
• **Independent**:	where a practitioner can deliver specific tasks / interventions without support

Supported capacity

When a practitioner requires expert support to deliver specific tasks / interventions or assess an individual, they can request expert support from anywhere in the mental health and learning disabilities services (including across the broad specialties). Different levels of support can then be offered to service users as required. The different levels of support are described by the expert (from outside or within Local MDT) to:

- Provide phone advice to practitioner **or**
- Provide case supervision, coaching and support practitioner's planning **or**
- Provide joint (practitioner and additional expert) contacts with the service user for a brief time **or**
- Provide specific interventions jointly with practitioner (where both practitioner and additional expert need to support each other)

Practitioner time will need to be made available to provide supported capacity[2].

[2] Local arrangements will need to be established to ensure that practitioner can access further expertise when required. This can include 'practitioner support slots' in practitioner diaries, electronic tasks and strong directory of different expertise within services. Some practitioners are more likely to provide expert support than others based on their role and these should have more structured arrangements to be accessed and offer support.

Combination of expertise

Combining expertise from across broad specialties to meet individuals' specific needs can occur from the point of access into services (see Central Access Point).

Key Feature: Community teams and geographical alignment

The majority of service users' care will be delivered through geographically aligned local teams. Those geographical patches will be set around groups of GP practices known as Primary Care Networks (PCN). This is to meet the National direction of greater integration between primary and secondary community care and increase joint working across physical, mental health and social care services.

There are likely to be around 26 PCNs in Leicester, Leicestershire and Rutland. Each geographically aligned local team will be organised around three or more of these PCNs. As each broad specialty differs in size, they may need to align to a different number of PCNs to maintain a critical mass of staff in each team. However to support joint working between the specialties they will also need to align well with each other.

The exact geographical alignment of each team will be mapped out after the transformation programme's structural design process in April and May 2019 and when confirmation of the boundaries of the PCNs has been received to LPT.

Geographically Aligned Teams

For each broad specialty it is expected that, wherever possible, the different expertise will be organised into geographically aligned teams. This is to strengthen local MDTs, support diverse service user needs and help teams to understand and manage flow and resources. Small groups of experts are likely to be too small to organise into community teams and will need to work as described in *Team around the service user*.

Section 2: Specific aspects of design that require all mental health and learning disabilities to make changes and work together

We will have a *Central Access Point* that all referrals and individual enquiries for mental health and learning disabilities can be made to. This will be available for health professionals, people involved in our services and people who have a General Practitioner (GP) within Leicester, Leicestershire or Rutland. It will support people's general enquiries and help navigate people to the right help both inside and outside of LPT services. If an individual being referred or referring themselves to the Central Access Point is in *crisis* or has urgent needs then their needs will be assessed promptly at any time of the day across 7 days a week.

When an individual's referral (self or through a health professional) for specialist mental health and/or learning disabilities is non-urgent, it will be reviewed within a working day (at least initially on weekdays). If there is a need for further assessment and treatment then an appointment with the right specialty (or combination of specialties) experts will be made there and then.

As part of the assessment phase of a service user's support needs, health professionals will collaborate on developing a care plan (or update one that they had already). This is a *shared plan* between the service and the service user. Any practitioner involved in a service user's care contributes to this one plan. It will also commonly be shared with the service user . This plan will help guide the GP on ways that they can support the service user, both whilst the individual is under the specialist LPT service and also when they leave LPT services. The clearer guidance and improved access arrangements are expected to help people transition between specialist mental health and learning disabilities services to primary care (GPs) easier.

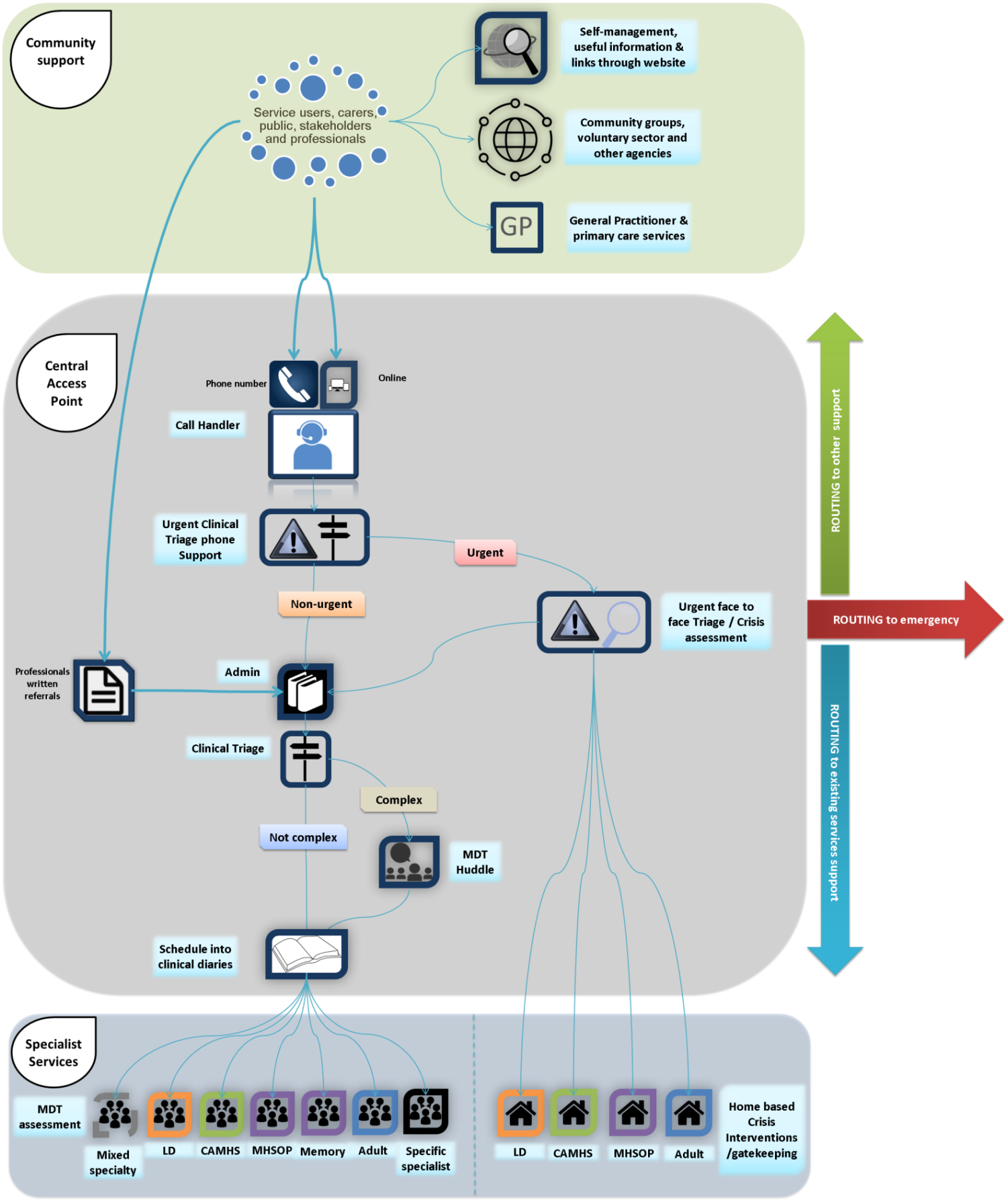
Whilst individuals are receiving specialist services they are likely to have a wide array of other support needs alongside their mental ill health or challenges with their learning disabilities. There will be *improved navigation and connection* offered in our community services with groups, services, procedures and activities that could help their other needs. This will both improve service user's access to support available and release time of professionals to utilise their specialist skills. There will also be individuals who have lived experience of mental health or learning disabilities recruited to teams to support service users' care journey.

Key Feature: Central Access Point for Mental Health and Learning Disabilities

There are several different elements to the Central Access Point. Figure 1 shows the referral and triage process and a detailed description is provided below.

All Age Transformation
Transforming our mental health and learning disabilities services

NHS
Leicestershire Partnership
NHS Trust



Central Point

The Central Access Point will be a central point for:

- All referrals for mental health and learning disabilities[3]
- All mental health crisis referrals
- All phone enquiries (e.g. general, advice, appointment related etc)

When assessments are required the Central Access Point will be aspiring to:

- Undertake urgent assessments within four hours of referral.
- Schedule non-urgent assessments within a working day of referral.

Community Support

There will be information for self-guidance and support available on LPT's website and advertised in different community venues. This is to help people to be aware of what support may be available to them in primary care (such as IAPT) and the community (such as services run in the voluntary sector). There will also be key contact information for them to self-navigate to these resources.

Contacting the Central Access Point

If service users, carers, stakeholders, public or professionals believe that they need to speak to and/or access specialist mental health services they will have initially three ways to do so.

Written referral from professional

Professionals, like GPs, will be able to make a written referral through the electronic system they use or through a letter. This will be received and logged by the Central Access Point Administrative Team and then reviewed by a clinician as part of clinical triage (this is described in more detail under 'clinical triage').

Phone call

Service users, carers, stakeholders, public or professionals will be able to ring the Central Access Point number. This will be answered by a call handler. The call handler determines the nature of the enquiry and some initial information. The call handler will manage the call if the nature of the call is not directly clinical such as general information, appointment changes (that the call handler can amend) or navigation advice. If the nature of the call is clinical then they will direct the call to

[3] There may be an alternative 'Triage and Navigation hub' commissioned specifically for children and adolescence referrals. If in place then processes will need to be established for two access points to seamlessly work together. This could work initially by referrals for CAMHS that are received directly to the Central Access Point being redirected to this new hub and referrals accepted. Any specialist CAMHS referrals agreed at the hub will be routed to the central access point for scheduling appointments.

either the individual's existing clinician (if the caller is known to services) or urgent triage practitioner (this is described in more detail under urgent clinical triage below).

Online enquiry

As an alternative to a phone call, service users, carers, stakeholders, public or professionals will be able to use a secure digital platform to make contact with the Central Access Point. This will be using LPT proven technology (Chat Health) and provide an alternative to phone contact for individuals. The online queries will be managed similarly to the phone call described above. It is recognised that clinical related queries may need to be transferred to phone contact to best support people's needs.

Urgent clinical triage phone support

The urgent clinical triage will be made up of practitioners with skills and knowledge from each of the broad specialties (see distinct specialties that work together key feature). There will be urgent clinical triage available 24 hours a day, 7 days a week. Additional analysis is planned to estimate the shift pattern and the number of practitioners required at given times of the day. The urgent clinical triage practitioner will undertake one or more of the following to support individuals:

- provide telephone advice to inform care and treatment, and advise on a range of clinical issues and/or
- provide telephone support to calm and de-escalate where there are difficult situations and/or
- organise or undertake a face to face triage (this will be undertaken by the same practitioner where achievable) and/or a face to face crisis assessment
- transfer (this can be directly or by tasking depending on practitioner availability) to non-urgent clinical triage to focus on identifying the right non-urgent service to support the individual (see non-urgent clinical triage)

In all instances the person taking the call is focused on ensuring the caller gets the right support for their query.

Urgent face to face triage and/or assessment

If the urgent clinical triage practitioner, in collaboration with the caller/referrer, identifies a need for crisis assessment then this will be organised. Again the practitioner with the right skills and knowledge of the relevant specialty will be allocated for this assessment. It is expected that the service will work towards this being undertaken **within 4 hours** of the initial contact with the Central Access Point.

The urgent clinical triage practitioner may need to see a caller face to face to help identify whether or not they need a crisis assessment and what support to offer. If the individual requires a full crisis assessment then the practitioner will move from triaging to undertaking the assessment.

From the assessment the practitioner with the service user (and carer wherever relevant) will identify the right support for their needs. This could include:

- self-management plan and/or routing to alternative services outside of LPT
- Home based crisis interventions (see Crisis support)
- Non-urgent additional assessment[4]

Admin

The non-urgent written referrals will be organised by the Administrative Team who will provide:

- Initial information gathering to support triage and future assessment
- Book and re-book appointments for service users' initial assessment appointments
- Scheduling and tracking to ensure service users are booked for an appropriate appointment, once they have been triaged and they are not "lost" within the system.

The Administrative Team will help support the clinical triage practitioners and also support the call handlers during periods of high phone traffic.

Clinical triage

The clinical triage clinicians will review every referral received. They will make a decision on the urgency of the referral and stream the referral for urgent assessment if required. If non-urgent they will make a decision on streaming the individual to the most appropriate specialty assessment (*see specialty streams and assessments below*), and/or whether the individuals' needs would be better met through other services or support (*see routing below*). If there is any missing information required to make these decisions the clinical triage clinician (supported by the Administrative Team when appropriate) will seek this information from the referrer or service user/carer.

If the referral is complex then the clinical triage clinician will take the referral to an MDT 'huddle' (which will involve a wider team including medical, therapists etc. and also draw together cross specialty discussions) to help decision making. See MDT huddle section below.

There will be some specific types of referrals which will be supported by very specific clinical triage (such as in-reach older people's team referrals from nursing homes and eating disorder referrals). These referrals will be directed to specific clinical

[4] The additional non-urgent assessment will be looking to build on (rather than repeat) the crisis core assessment with greater depth and/or additional elements. This will be taken into account in scheduling who is to be involved in the non-urgent assessment.

triage clinicians who will review the referral in the same timescale (within a working day). If the case is complex then this will also be taken to MDT huddle.

MDT huddle and Additional Support and Expertise

The clinical triage clinician may not be sure of the best plan for a referral due to complexity or other factors. In these circumstances they can contact specific expertise from the wider services for advice and/or take the referral to a planned MDT huddle (at least daily meeting with input from wider disciplines such as consultant, psychologist, occupational therapists and other professionals scheduled to support the triage clinicians). This meeting will be scheduled to minimise disruption to the wider MDT clinicians' days.

There may be some instances where physical health checks may be required prior to any mental health assessment. The clinical triage clinician would dictate a letter or electronic system task to go to the service user's GP and the service user/carer would be advised to make an appointment with their GP.

Schedule into clinical diaries

If an individual is triaged as requiring an assessment the clinical triage practitioner will provide the details to the Administrative Team including:

- target timescale to be seen
- the specialty stream for the service user
- specific requirements of individuals to be involved in the assessment

The Administrative Team will then agree suitable times with the service user and schedule the assessment directly into clinical diaries.

Specialty Streams and Assessments

If a service user requires further assessment from the clinical triage then they will be streamed into one of the following areas:

- Learning Disabilities (LD)
- Adult Mental Health Services (AMH)
- Children and Adolescence Mental Health Services (CAMHS)
- Mental Health Services for Older People (MHSOP)
- Mental Health Services for Older People (MHSOP) - Memory assessment
- Specialist services (e.g. Eating disorders, Forensic, Nursing home in-reach etc.)[5]
- Mixed specialty

Each stream has differences in either the specialist expertise of the practitioners and/or mix of different disciplines that will normally be involved in the assessment.

The clinical triage clinician/MDT huddle will identify any additional disciplines that are needed to support an individual's assessment based on their particular needs. The mixed specialty stream will be used where a mixture of specialist expertise is required from across the broad specialties (e.g. MHSOP, AMH, CAMHS, LD) to undertake an assessment together. See assessment key feature below for more information.

Routing

At any point during any element of the Central Access Point there will be a consideration of possible routing of the service user to other advice and support. This can include:

- Routing a service user/referrer to the emergency services (e.g. police, ambulance) if at any point there are concerns that an individual requires immediate service support
- Routing a service user/referrer to advice and support provided by external agency (including IAPT, voluntary sector, GP, community groups, website etc.) where this meets their specific needs better than LPT's specialist mental health and learning disabilities services
- Routing a service user/referrer to existing clinical team when known to services. Where there are clinical concerns or queries the existing clinical team will most likely be best placed to support the service user/referrer. Therefore the individual will be routed to the existing clinical team unless the urgency of the need required support sooner than the existing team can respond to. In those circumstances the urgent clinical triage will support the individual with liaison with the existing team wherever possible.

Key Feature: Crisis support

The urgent/crisis triage and assessment of the service user's needs is described in the Central Access Point key feature. The different specialty expertise that provides the urgent triage and crisis assessments will also deliver broad specialty specific home-based crisis interventions.

Home-based Crisis Interventions

There will be different home-based crisis interventions delivered by each broad specialty to best match the support offered to the presenting needs of the service user and their carers. The different specialties will work together where required to ensure that individual needs can be supported where needs require a combination of specialty expertise and interventions.

Facilitated Early Discharge Planning

An aspect of the crisis support services is in facilitating earlier discharge from specialist mental health inpatient settings. The model for facilitated discharge within adult services is currently under design in Wave 2. See next steps.

Increased local support within community services

There will be community 'step up' support offered within community services (initially described in adult services – see community step up) that is expected to reduce demand for ad-hoc crisis support for adults receiving community services.

Key Feature: Single Integrated Care Plan

There will be a single integrated care plan for each individual that uses LPT's specialist mental health and learning disabilities services. This plan will, wherever possible, be collaboratively created between the service user and the practitioners involved in their care and support. Any practitioner, team or service involved with the service user will contribute to this one plan. Within the plan there will be:

- Service user and carer goals
- Safety and crisis plan
- Wider advanced directives
- Care plan (including expectations on other external practitioners involved with the service user such as their GP)

The plan will be provided to the service user and where appropriate their carer. It will use language and have content that they understand and is meaningful to them. It will also reinforce our approach to care. It will be used as a key and consistent tool for communicating with GPs to help them support the service user.

Key Feature: Peer support workers

There will be a programme of preparing, training and equipping current or previous service users with knowledge, skills and confidence to become peer support workers. There will be peer support worker roles introduced across all the core community teams, with recruitment planned for the initial cohort to commence at the autumn of 2019. There will be a central support structure, ongoing supervision and specific safeguards for the health of individuals recruited into the roles.

The peer support workers will integrate within each wider team and become part of a mix of different skills within each area. They will have a distinct role of utilising their lived experience, sharing personal experiences to build trust and develop a sense of mutuality in a service user's journey. They will focus on building on service user's

strengths, promote increased self-management, engagement in services and connection with community activities amongst wider support and team tasks. They will also have an important role in supporting their wider team in continually improving their care delivery approaches to best support service users using experience insight.

Based on other mental health organisation experiences and published studies, the involvement of peer support workers in our teams will be expected to have multiple benefits. This includes releasing clinical time within a team, help improve service user experience, reduce likelihood of admission to hospital for some and help service user's to be ready for transition out of specialist services earlier. In many instances, based on the service user's circumstances, the peer support workers will focus on the wider family as well as the service user. This can include supporting connection and communication between specialties (where different individuals are involved in different members of a family unit).

Key Feature: Supporting Other Needs

Alongside mental health or learning disability related needs, individuals involved in services can commonly require support for a variety of other needs. These *other needs* can include areas such as benefits, housing, loneliness and isolation, addiction, relationships, healthy lifestyles and general community activity.

Supporting these other needs is a significant component of what mental health and learning disability practitioners do but the systems, processes, support and information to help them is often patchy. There will therefore be:

- Framework for Supporting Other Needs - three levels of support: Advice and information, needing help, needing more help.
- A clear and easily navigable system of guidance, services and activities to meet individual needs
- A helpline for staff to get advice, guidance and information
- Capacity in teams for helping individuals access support for other needs

Framework for supporting other needs

There will always need to be flexibility to support individual's other needs. There will be a broad framework to help organise the way we go about supporting these other needs. This will have three levels:

Category	Individual…	Expected actions
• **Advice and information**:	Understands their other support needs Is confident to address them.	• Provide information and contacts • Record in integrated care plan
• **Needing help**:	Needs help to identify and understand their other support needs Requires some assistance to identify support and make contact.	• Explore other support needs and coaching • Discuss options and help decision making on right support • Provide assistance on making contact with support service / group / activity • Record in integrated care plan
• **Needing more help**:	Needs help to identify and understand their other support needs Needs more help and assistance to locate and access support.	• Explore other support needs and coaching • Discuss options and help decision making on right support • Provide assistance on making contact with support service / group / activity • Organise or provide support to the individual to access support service / group / activity • Record in integrated care plan

'Supporting Other Needs' System: A clear and navigable system of guidance, services and activities

There will be a managed database of the wider community services, activities, groups and guidance available to individuals that use our services. This will provide:

- high quality and accurate information on support available to service users
- an efficient way to search and locate information based on an individual service users need

It will be developed in conjunction with the other 'social prescribing' databases that exist currently to ensure consistency of information and increase likelihood of being up to date. It will be managed through a new central Community Knowledge Officer, who will throughout be continually updating and adding to the database.

This will be available for service users' to self-navigate and for LPT staff to use.

Community Knowledge Service: A helpline for staff to get advice, guidance and information

If staff cannot find a suitable service to support a service user's other needs through the Supporting Other Needs system (or their local knowledge) then they will be able to ring a helpline. The helpline will be able to:

- support a staff member to find their information on the system (and learn about better ways to organise the system to make it easier for people to find the information)
- take the staff query and explore whether suitable services exist to meet the need. They will then provide the details to the staff member and update the 'Supporting Other Needs' system. If they cannot identify a suitable service then they will log an unmet need (which will then be provided to commissioners to inform future decision making)
- support a team to identify any roles (e.g. Local area coordinators, local social prescribing facilitators) in their area that can help support a service user getting access to advice, guidance and information.

Capacity in teams to help individuals access support

Individuals needing help and more help (see above framework), may require time and assistance in completing forms, identifying what might help their other needs and accessing services. There will be capacity identified both within the teams and around teams that could provide this support for individuals. Within a team there will be support workers and peer support workers that can help the wider clinical team provide some direct assistance (see peer support workers) to service users and their carers. A network of other support will also be created around each team of key roles in each area that can provide additional support to individuals. This network is likely to include volunteers, local area coordinators, local social prescribing facilitators and targeted local voluntary sector and charity workers. Teams will be supported in identifying and building these networks through a new Community Knowledge Officer role.

Section 3: Specific aspects of design that effect specific parts of the mental health and learning disabilities services but not all of them

From the Central Access Point the Administrative Team will schedule adults, older people and individuals with LD directly into appointments with the combination of practitioners that are viewed to best assess the individuals' needs. The *assessment* will be scheduled to efficiently bring together the support of different practitioners and

increase the likelihood of a good experience for service users. At this initial assessment the service user and practitioners will collaborate to formulate a good initial care plan. For adults and older people this will include a selection of interventions informed by new *intervention pathways*. These pathways describe the likely phases of treatment for individuals with specific mental health conditions and a range of interventions that could help the service users' depending on their specific needs. Alongside informing care, simplified pathways will be used to explain to service users and carers their likely journey through our services. This is expected to improve their understanding of what is likely to happen for them and be better informed in their collaboration around their care choices.

There will be times when service users will become unwell and require increased contact with practitioners in the community. Within adult and older people community teams there will be specific *'step up'* practitioners who have flexibility to add support to a service user's existing care team when needed. This will help support service user's through periods of increased need and risk without practitioners cancelling appointments with other service users.

Key Feature: Structured assessment

There will be a new approach to initial assessment for adults, older people and individuals with LD.

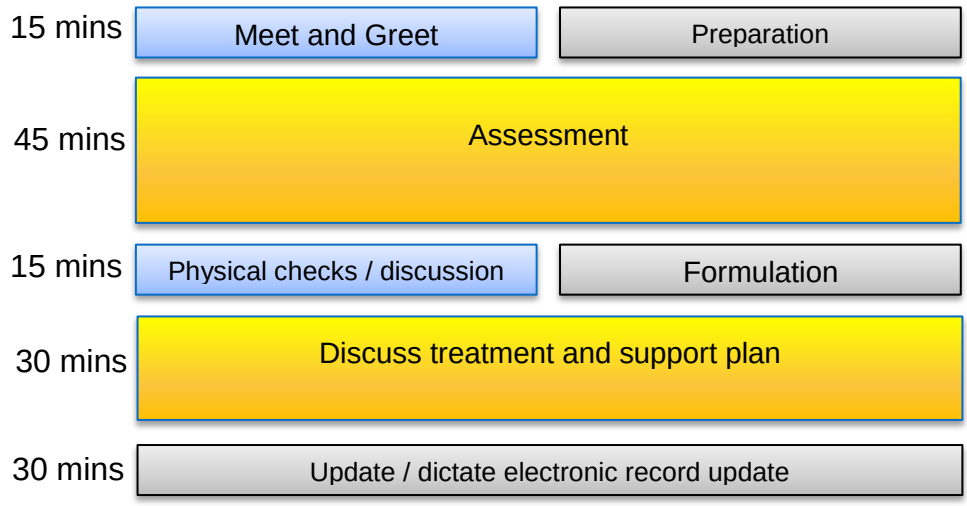
At the Central Access Point, a service user will be streamed into the most appropriate broad specialty for assessment (see specialty streams). At the Central Access Point, the clinical triage clinicians will determine the broad specialty that a service user should be streamed to and how quickly they should be assessed. They will also determine which specific disciplines (including where there needs to be additional expertise from a different specialty) need to be involved in the assessment. The assessment will be scheduled directly into clinical diaries and could be for home or clinic based contact. The service user will remain under the Central Access Point until the assessment has taken place to avoid the individual becoming lost in the system. The assessment will occur within the geographically aligned team that the service user has been streamed to.

The service user will be provided information explaining what to expect from their appointment when it is scheduled at the Central Access Point. This is intended to make sure they feel that there are no surprises in the assessment and can prepare themselves. They will also be provided with a form that they can use to generate any specific concerns, questions and queries that the can be addressed in the appointment.

For a clinic based contact, the service user will have a support worker meeting and greeting them. At the same time, the assessing practitioner will have time to prepare

well. The practitioner will then undertake a core assessment. The service user will then have time for physical checks and further discussion (e.g. on other support needs) whilst the assessing practitioner undertakes formulation. The assessing practitioner will be able to do this with the support of a senior practitioner, where required, to support the assessing practitioner think about their formulation and thoughts on treatment. The assessing practitioner and, if required, senior practitioner then both meet with the service user and carer to collaborate on developing a treatment and support plan that best suits the service user's needs. There is then allotted time for the assessor to dictate and record the assessment.

The following diagram and table describe how this is expected to work where a community nurse and consultant are required for the assessment (depending on the need of the service user this could be a combination of different practitioners). Please note: the timescales in the diagram represent a hypothetical example only.



Action:	Tasks:	By: (staff member)	Time allocated:
Meet & Greet	Meet service user, explain the format of the assessment, complete paperwork	Support worker	15mins prior to appointment starting
Preparation	Reading notes, familiarisation with referral & patient history	Nurse	15mins prior to appointment starting
Assessment	Complete assessment tasks	Nurse	45mins
Formulation	Discussion between nurse & consultant to formulate and agree treatment plan. Phone call to other clinicians	Nurse / Consultant	15mins
Physical checks/ further discussion	Physical checks as required. Discussion with support worker about other support needs/ social prescribing	Healthcare Support Worker/ Peer Support Worker	15mins
Discuss treatment & support plan	Clinician/s, service users and carers discuss and agree initial treatment & support plan	Nurse / Consultant	30mins
Update Electronic Patient Record	Clinician/s update the electronic patient record and perform other admin tasks regarding the assessment (e.g. contacts)	Nurse	30mins

This structured approach will be adapted for home-based assessments which can include joint visits or phone call slots allocated with senior practitioners, as required.

If the service user requires further assessment time then this will be offered which could include involvement of other practitioners (e.g. if a need is identified that requires alternative expertise to help assess). This would be scheduled directly from the local team.

Key Feature: Intervention Pathways

There will be intervention pathways across all mental health and learning disabilities. There are existing pathways that have been developed within Learning Disabilities and Children's and Adolescence Mental Health Services over time. There will now be additional new pathways, focusing predominantly on adult and older people with mental health illness. The pathways are designed to increase consistency of the treatment offered across teams and support the service user in being better informed around their likely journey with the services.

New intervention pathways

The new intervention pathways include:

- Attention Deficit Hyperactivity Disorder (ADHD)
- Autism Spectrum Disorder (ASD)
- Anxiety
- Bipolar disorder
- Depression
- Eating Disorders
- Personality Difficulties and Complex Trauma
- Psychosis

Each of these pathways can be viewed through following the embedded links above. There is a guide to the best way to read the pathways available here and an FAQ also available.

Work has also commenced to develop pathways for:

- Dementia
- Complex physical and mental health related illnesses

How pathways will be used

The new intervention pathways represent the way that we want to offer treatment to individuals presenting with specific conditions. They do not represent a proscriptive guide on how treatment should be undertaken and do not limit clinical judgment. As flexibility is required to ensure the treatment offered is developed in collaboration with the service user to best meet their individual needs. The pathways therefore represent the typical interventions that may be offered and the likely journey of a service user between them. Service users are not expected to use every part of a single pathway and may access parts of multiple pathways at the same time. It is recognised that individual service users may have multiple needs and diagnoses. The pathways will also support the ongoing planning of services in a way that can deliver best practice and evidence-based care that can be locally afforded. The pathways are therefore expected to be iteratively developed to keep up to date with best practice, changes to the wider system and the resources available.

Implementation of the pathways

The pathways are currently in draft form. They will not be finalised and/or implemented until the testing phase (Stage 4) of *Wave one* of the transformation programme has been completed (*see next steps*). Depending on the resources available and the total cost of the new model, the interventions in the pathways may need to be refined. After this point, the pathways will be expected to be reviewed on a regular basis to adjust to best practice, wider system and resource changes.

Key Feature: Community step up support

For community teams in adult and older people specialties there will be ‘step up’ capacity (LD services will continue to have outreach team support). This ‘step up’ capacity will:

- be located within local community teams
- be made up of practitioners who do not have a routine caseload and therefore have availability and flexibility to provide additional contact and support for service users when required
- work with service users’ existing care team to plan, coordinate and deliver additional support to service user’s when needed
- provide temporary additional support

‘Step up’ support will be considered if a service user’s needs change and they require a temporary increase in the frequency of support beyond what they have been receiving. The service user’s practitioners will have other service users that they will be routinely in contact with. The additional ‘step up’ support will allow these

contacts to continue whilst providing the increased support to the service user. The service user's existing care team will remain involved in the individual's care as before but with the additional help offered by the 'step up' practitioners. The 'step up' practitioners will also be involved in the care team's routine supervision and care management discussions whilst they are offering support to the service user.

When the temporary need has been resolved, the 'step up' practitioners will stop being involved in that specific service user's care. This will allow them to maintain flexibility and capacity to support other service user's if they need additional support.

Reasons to involve 'step up'

A service user's existing care team would consider involvement of their local 'step up' practitioners if a service user's needs required a temporary increase in support over and above the support that they could provide. This could include:

- Deterioration or relapse in a service user's mental health
- Increased risk of a service user harming themselves or others
- Carer burnout, carer resilience has been reduced or there is a breakdown in a care package
- Service user not engaging in services and is at 'high risk' of harming self or others
- Significant clinician or carer concerns

When will 'step up' support be provided

'Step up' practitioners will be able to provide support 7 days a week in daytime. They will be able to provide frequent contact (up to daily) for service users and carers as required for a temporary period (expected to be not more than 6 weeks). The 'step up' practitioners alongside the existing care team will establish contingency plans for if service users or carers need support out of hours (evening and night). This will commonly be the provision of telephone support through the crisis team (accessed through the Central Access Point).

What support will the 'Step up' practitioners provide

The 'step up' practitioners will provide an array of different interventions through phone and face to face contact, these include:

- Counselling
- Medication management and compliance
- Diet / eating support
- Sleeping advice and education
- Intensive psycho-education
- Supporting individual with other support needs
- Carer support
- Investigating safeguarding concerns

- Linking with other agencies

They will operate as part of the wider multi-disciplinary care team for the service user and will involve experts from the team where required in the support that they offer.

What are reasons not to involve 'step up' practitioners

'Step up' practitioners would not routinely be drawn into a service user's care in the following scenarios:

- If reported escalated needs of service user have not been assessed
- If a service user is not open to the service
- If the risks are assessed as 'too high' for the support that 'step up' can offer
- If increasing contacts or involving other practitioners is at odds with a service user's care plan or not felt by the care team to be helpful
- If 'step up' practitioner support has previously been tried and not worked (and the circumstances are not significantly different this time)
- If 'step up' is being used to compensate for planned and routine support not being done as expected

At what point will the 'step up' practitioners end their involvement in care

'Step up' practitioners are intended to provide temporary additional support to an existing care approach. They are envisaged to not provide support beyond 6 weeks and in many instances provide shorter periods of contact. The scenarios where the additional 'step up' support would stop include:

- When the service user has returned back to their baseline state (point prior to 'step up' involvement)
- When care package is in place (if care package was the main reason for 'step up' support)
- When specific issues or risks (that led to 'step up' support) are manageable for the individual or carer
- If the service user is developing dependency upon the additional 'step up' support that is unhelpful for their overall recovery/care journey
- If the service user wants to reduce the input they receive

Next Steps

A complete draft model from Wave One design will be produced for the end of May 2019. This will include:

The key design features	Described in this document
A draft workforce model	A detailed analysis has been undertaken alongside the co-design workshops. This is being used to develop a draft workforce model, which will provide a description of the staff estimated to be required to deliver these changed ways of working. A draft workforce model will be completed by the end of May 2019.
Proposed service structures	There is a process across April and May 2019 for LPT staff to look at the best ways to alter teams and service structures to help deliver these design features. Following an option appraisal on May 15 and May 23 to determine the best and safest workforce model and structure, there will be a preferred set of service structures described.

There will then be a period of testing and further engagement to have confidence that Wave One changes will be affordable, meet expected demand and deliver additional value (quality) to services users. This is expected to take until summer 2019 and there will be opportunities to trial changes across this period. The Wave One design will then be complete and a plan will be formed about how and when the changes will be put in place. The changes will then be made in phases (bit by bit) to make sure each change is working, learn and refine changes in practice and the right staff are in place. This will continue for the next two years until 2022.

Wave Two design and improvement work will start by June 2019 and work alongside the Wave One changes that all mental health and learning disabilities services are developing together. Wave Two will be made up of several different transformation and improvement schemes that each have a specific focus and build on existing improvement projects. The different focused areas of change within Wave Two are still to be mapped out but are likely to include severe and moderate Learning Disabilities (LD) pathways, core 24 (hospital based liaison services), children and young people services (CAMHS) and dementia services.

In most cases these are areas where there is existing improvement work planned or being undertaken. As part of Wave Two there will be some additional support offered to these projects from the All Age Transformation Programme team and a greater alignment of all the improvement work together. This is intended to build upon these existing improvement projects rather than replace or disrupt them. Each scheme will be expected to use co-design (involvement of service users, carers, staff

and stakeholders) and data to identify improvements and make changes incrementally (bit by bit) as they progress.

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Agenda Item 11

NHS
West Leicestershire
Clinical Commissioning Group

HEALTH OVERVIEW AND SCRUTINY COMMITTEE: 5th JUNE 2019

REPORT OF NHS WEST LEICESTERSHIRE CCG AND NHS EAST LEICESTERSHIRE AND RUTLAND CCG

QUALITY, INNOVATION, PRODUCTIVITY AND PREVENTION PROGRAMME 2018/19 AND 2019/20 PLAN

Purpose of report

1. The purpose of this report is to:

   a. Provide an update on the 2018/19 Quality, Innovation, Productivity and Prevention (QIPP) programme for NHS West Leicestershire CCG (WL CCG) and NHS East Leicestershire and Rutland CCG (ELR CCG).

   b. Outline the planned 2019/20 QIPP programme for NHS West Leicestershire CCG (WL CCG) and NHS East Leicestershire and Rutland CCG (ELR CCG).

Background

2. Nationally the NHS has a QIPP programme which is a response to national efficiency savings that are required as demand for healthcare services continues to grow. QIPP programmes are used to continually review and evaluate the quality, efficiency and effectiveness of healthcare services while identifying unnecessary expenditure

3. The CCGs have significant ambitions and aims for service transformation to meet increase population and healthcare needs and ensure delivery on national priorities. There is also significant growth in the activity levels of healthcare commissioned due to increased patient demand. In order to ensure these planned investments and growth areas are adequately resourced, the CCGs are faced with significant QIPP challenges of £40.145m in 2018/19 and £49.020m in 2019/20.

4. Many of the QIPP schemes involve service transformation such as new models of care, service reconfiguration and re-designed clinical pathways. There are also transactional QIPP schemes expected to improve efficiency and value for money.

5. A report was provided to the HOSC in September providing an update on progress made in regard to CCG QIPP savings schemes in 2018/19 and the expected financial outturn. Information was also provided in relation to the quality processes in place for all QIPP schemes to ensure CCGs effectively comply with statutory duties.

2018/19 QIPP Delivery

6. QIPP is monitored internally within the CCGs with the support of a Leicester, Leicestershire and Rutland, (LLR) wide Project Management Office, (PMO). Senior Responsible Officers are in place for each QIPP scheme who are responsible for the development and implementation of plans alongside clinical leads supported by

finance, contracting and other support staff. Monitoring and escalation takes place at the QIPP Assurance Group (QAG), which is an executive level LLR meeting which meets twice monthly. Formally the outcome of PMO and QAG processes is reported into the Collaborative Commissioning Board and also individual CCG formal committees on a monthly basis.

7. The final month 12 position has confirmed QIPP achievement for both Leicestershire County CCGs of £39.184m against the annual plan of £40.145m as shown in tables 1 and 2 below:

TABLE 1 - Summary Performance by CCG

CCG	YTD Plan (£'000)	YTD Actuals (£'000)	YTD Variance (£'000)	Annual Plan (£'000)	Forecast Outturn (£'000)	Annual Variance (£'000)	Annual variance %
ELR	(19,647)	(19,709)	(62)	(19,647)	(19,709)	(62)	0%
WL	(20,498)	(19,475)	1,023	(20,498)	(19,475)	1,023	-5%
Grand Total	**(40,145)**	**(39,184)**	**961**	**(40,145)**	**(39,184)**	**961**	**-2%**

TABLE 2 - Summary Performance by Programme Area

Programme Area	YTD Plan (£'000)	YTD Actuals (£'000)	YTD Variance (£'000)	Annual Plan (£'000)	Forecast Outturn (£'000)	Annual Variance (£'000)	Annual variance %
CHC	(4,337)	(6,138)	(1,801)	(4,337)	(6,138)	(1,801)	42%
Community	(3,154)	(1,107)	2,047	(3,154)	(1,107)	2,047	-65%
CommunityServices Redesign	(885)	(112)	773	(885)	(112)	773	-87%
Contracting	(3,442)	(1,697)	1,745	(3,442)	(1,697)	1,745	-51%
Corporate	(2,158)	(1,380)	778	(2,158)	(1,380)	778	-36%
Finance	(3,094)	(8,487)	(5,393)	(3,094)	(8,487)	(5,393)	174%
Integrated Teams workstream	(1,304)	395	1,699	(1,304)	395	1,699	-130%
Medicine Management	(7,243)	(8,643)	(1,400)	(7,243)	(8,643)	(1,400)	19%
Mental Health/LD	(3,813)	(3,539)	274	(3,813)	(3,539)	274	-7%
Planned Care Workstream	(4,283)	(1,398)	2,885	(4,283)	(1,398)	2,885	-67%
Primary Care	(4,597)	(5,285)	(688)	(4,597)	(5,285)	(688)	15%
Urgent Care Workstream	(1,835)	(1,792)	43	(1,835)	(1,792)	43	-2%
Grand Total	**(40,145)**	**(39,184)**	**961**	**(40,145)**	**(39,184)**	**961**	**-2%**

8. As can be seen above, ELR CCG over achieved their annual plan by £0.062m while WL CCG under delivered by £1.023m. The main reason for the difference in delivery was due to ELR CCG delivering £3.5m QIPP savings in relation to a prescribing target of £3m, while WL CCG delivered £2.5m of prescribing savings.

9. At an overall LLR system level (including Leicester City CCG), £58.652m QIPP savings were delivered during 2018/19, exceeding the overall QIPP target of £58.200m by £0.452m.

10. A Lessons Learned exercise has been undertaken by the LLR PMO and the findings presented to the CCGs' Joint Management Team. This exercise analysed delivery of QIPP over the course of the year versus planned delivery, identified trends in delivery and non-delivery and undertook some Root Cause Analysis in order to understand the factors that impact on delivery.

11. The key findings of this exercise were:

    a. Although the forecast QIPP delivery varied during the financial year, the PMO assured value was consistent and accurate, demonstrating itself to be a powerful indicatory tool of delivery and risk.

    b. QIPP delivery was heavily reliant on financial/budgetary schemes. Transformational schemes failed to deliver due to unrealistic profiling and unrealistic scope of projects.

    c. There was a lack of consistent finance support across schemes.

12. In response to these findings, the following actions have/will be been undertaken to support delivery of QIPP in 2019/20:

    a. Specific finance support has been allocated to each QIPP scheme.

    b. Decision making needs to be stronger in relation to projects which are 'off track' and remedial actions put in place sooner.

    c. The PMO assured value has proven to be a powerful indicatory tool which can be used by Senior Management effectively to aid decisions.

    d. The PMO to provide additional project management support to project teams as required.

2019/20 QIPP Plan

13. Locally, WL CCG, ELR CCG and Leicester City CCG (LC CCG) have worked together collaboratively to agree the 2019/20 QIPP plan to ensure no duplication and alignment with CCG strategic priorities and operational plans.

14. Project Initiation Documents (PIDs) and business cases were completed as part of the 2019/20 planning round which were subject to a formal confirm and challenge process both financially and clinically. Each scheme has an identified SRO (executive lead), Clinical Lead, Project Lead and dedicated Finance Support.

15. Tables 3 and 4 below summarises the QIPP (Net) requirements for each of the CCGs during 2019/20.

Table 3: Summary of Net QIPP Requirements

	ELR CCG	WL CCG	COUNTY TOTAL
	£'000	£'000	£'000
Identified QIPP	(20,354)	(17,428)	(37,782)
Unidentified QIPP	(6,289)	(4,949)	(11,238)
Total QIPP Requirement	**(26,642)**	**(22,378)**	**(49,020)**

Table 4: QIPP Schemes by Area of Spend

Area of Spend	ELR CCG (£'000)	WL CCG (£'000)
Commissioning System Admin	(938)	(20)
Community Healthcare	(1,294)	(904)
Continuing Healthcare Strategic Improvement Programme	(2,514)	(2,462)
Discharge Programme	(414)	(538)
Elective Care	(2,641)	(2,569)
Emergency Care	(3,647)	(4,023)
Mental Health	(978)	(1,062)
Optimising the Use of Medicines	(5,130)	(5,137)
Primary Care	(2,799)	(713)
Unidentified	(6,289)	(4,949)
Grand Total	**(26,642)**	**(22,378)**

16. Many of the QIPP schemes will involve service transformation such as new models of care, service reconfiguration and re-designed clinical pathways. There are also a number of transactional QIPP schemes expected to improved efficiency and value for money.

2019/20 WL and ELR CCG QIPP Challenge

17. The QIPP targets for ELR CGG and WL CCG are 6.0% and 4.3% respectively, both of which present significant challenges.

18. The 2019/20 QIPP plans are designed to address inefficiencies across the system to ensure that CCGs meet constitutional requirements and deliver on activity and finance plans whilst supporting system transformation and pathway redesign across LLR in line with our strategic priorities.

19. The CCGs follow a rigorous process in delivery of our QIPP plans from initial planning stages through to eventual implementation. Our processes have strong clinical leadership and involved quality assurance, impact and sustainability assessments, evaluation and consideration of service user feedback.

20. Successful delivery of the QIPP targets present significant challenges. As shown above, ELR CCG and WL CCG currently have an element of unidentified QIPP within their financial plans amounting to £6.289m and £4.949m respectively. Work is being undertaken to identify further schemes/stretch existing schemes in order to mitigate risk and ensure delivery.

21. A System Sustainability Group (SSG) has been developed which is chaired by the Director of Finance at LPT and includes both Providers and CCGs. The purpose of this group is to maximise delivery of existing schemes and develop new efficiency opportunities.

22. Cross organisation working within the planning and PMO functions will be undertaken to consider additional options for efficiency savings. This will require the co-ordination of input from and to the STP work streams, LPT directorates and UHL CMGS.

Conclusions

23. The CCGs are facing significant financial challenges and must ensure that every pound we spend brings maximum benefit and quality care to our patients while local services continue to meet required needs.

24. The CCGs have rigorous processes in place to ensure we are spending money wisely and to ensure we continue to delivery high quality care in a cost effective way, now and in the future.

25. QIPP schemes amounting to £37.782m have been identified at both County and CCG level which vary in terms of development. There remains an element of unidentified QIPP in relation to ELR CCG (£6.289m) and WL CCG (£4.949m).

26. The delivery of QIPP targets will be challenging and to mitigate risk, further QIPP schemes will be developed and implemented during the financial year to ensure delivery.

Background papers

Officer to Contact

Spencer Gay, Chief Finance Officer, WL CCG
Tel: 01509 567754
E-mail: spencer.gay@westleicestershireccg.nhs.uk

Donna Enoux, Chief Finance Officer, ELR CCG
Tel: 0116 2956227
E-mail: @eastleicestershireandrutlandccg.nhs.uk

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A partnership between:
East Leicestershire and Rutland CCG
West Leicestershire CCG

HEALTH OVERVIEW AND SCRUTINY COMMITTEE: 5 JUNE 2019

REPORT OF EAST LEICESTERSHIRE AND RUTLAND CCG AND WEST LEICESTERSHIRE CCG

DEVELOPMENT OF PRIMARY CARE NETWORKS ACROSS LEICESTER, LEICESTERSHIRE AND RUTLAND

Purpose of report

1. The purpose of this report is to update the Health Overview and Scrutiny Committee with the progress of Primary Care Network (PCN) development across Leicester, Leicestershire and Rutland (LLR). The report will give a description of PCNs, their purpose and role and explain the progress that has been made towards forming PCNs across LLR.

Background

Description of Primary Care Networks

2. A Primary Care Network is a group of GP practices that agree to work together with other practices in their local area to provide the care patients need, in better ways. By working together, it is expected they will be able to make resources go further and care for patients more creatively.
3. Each PCN will look after between 30,000 and 50,000 patients, but there may be some with more or less patients than that.
4. GP practices will remain independent. Patients will continue to be registered at their existing GP practice and it will still be the main point of contact for their care.
5. GP practices will work with other health, social care and voluntary sector professionals to plan and join up patients' care. These wider teams will include pharmacists, district nurses and specialists who care for certain types of conditions or groups of patients with particular needs.
6. PCNs will launch on 1 July 2019 and over time are expected to bring a number of benefits for patients:
    - Joined up services - everyone knows previous interactions;
    - Access to a wider range of professionals and diagnostics in the community - in a single appointment;

- Different ways of getting advice and treatment, including digital, telephone based and physical services, matched to their individual needs;
- Shorter waiting times and convenient appointments;
- Greater patient involvement in decisions about their care;
- Increased focus on prevention and personalised care.

7. Each primary care network will decide how it will provide care for its patients. For example, sometimes a health professional may work for a particular practice or will support patients in all practices in the PCN. There may also be times when a patient will receive their appointment at one of the other practices in the network – particularly if they have a non-urgent need or that practice specialises in an area of care they need.
8. A much wider team of health professionals is increasingly becoming involved in patients' care in GP practices. Through Primary Care Networks there will be more clinical pharmacists, physiotherapists, physician associates, community paramedics and social prescribing link workers.

Why Primary Care Networks are being created

9. Primary Care Networks are part of NHS England's Long Term Plan, published in January 2019. They have been put in place to improve and extend the range of care that is available in the community and join up the care that is provided from different organisations.

Role of PCNs in an Integrated Care System

10. In its Long Term Plan, NHS England made a commitment to deliver Integrated Care Systems (ICS) by April 2021. This means more collaborative system working between GP practices, health partners, social care, voluntary sector and local authorities. The purpose of an ICS is to build capability in the system and improve services at three levels:

    - System
    - Place
    - Neighbourhood (locality/network level)

11. PCNs will become the basis for neighbourhoods, defined populations and geographies, around which integrated care between local hospitals and local authorities, primary care, community health and the third sector, can be planned and delivered.

12. PCNs will be expected to play a significant role at all levels of the ICS:

    - Primary care networks will deliver integrated services to people in 'neighbourhoods', as the foundation of an effective health system;

- In ‘places’ (Local Authority boundaries), primary care will interact with hospitals and local authorities, working together to meet the population’s needs (in some systems, federations could operate at the ‘place’ level to support primary care networks);
- At the system level (LLR), primary care as a provider will increasingly participate in system decision making. Networks create an opportunity for primary care to have a greater voice in both the design and delivery of ‘place’ based care with hospitals and local authorities, than may have been feasible historically in arrangement of individual separate practices.

13. The Clinical Directors of PCNs will play a critical role in shaping and supporting the ICS and ensuring GP practices are fully engaged in implementing the Long Term Plan. Through PCNs, practices will play an even greater part in the wider system than they have previously.

LLR PCN Development and Timetables

14. Primary Care Networks need to be established by 1 July 2019. The clinical commissioning groups have been supporting GP practices to form into PCNs and are in the final stages of agreeing them.

15. If they have been agreed before the Health Overview and Scrutiny Committee on 5 June, information will be provided either verbally or in writing on the day. If they have not been finalised, a separate briefing will be provided to the Committee at a later date.

16. PCN development has been supported by both CCGs and the Leicestershire and Rutland Local Medical Committee. GP Federations across both CCGs have also played a facilitative role, with particular focus on administration of some of the key PCN formation processes (e.g. election/appointment of PCN Accountable Clinical Director posts).

PCN funding

17. Much of the future of PCNs is yet undefined. By 2023/24, NHS England will make £891 million available to Primary Care. By 2023/24 this equates to a settlement of £726,000 new annual funding for a PCN with an average-weighted population of 50,000.

18. It is known that PCNs will receive new funding in three ways through a ‘Network Contract’:

    - **Five new roles:** PCNs will each receive funding to put in place five roles: clinical pharmacist, social prescribing link worker, community paramedic, physiotherapist and physician associate. The scheme extends gradually. This reflects available supply and funding:

- in 2019 it starts with clinical pharmacists and social prescribing link workers only;
- in 2020 physician associates and first contact physiotherapists are added; and
- in 2021 it also includes first contact community paramedics.

- **Seven key priority areas:** Funding to carry out services in the seven key areas: structured medications review and optimisation, enhanced health in care homes, anticipatory care requirements for complex patients, personalised care, supporting early cancer diagnosis, CVD prevention and diagnosis, tackling neighbourhood inequalities.
- **New shared savings scheme:** PCNs are also expected to be able to benefit from a new 'shared savings' scheme resulting from system-wide efficiencies. For example, reducing avoidable A&E attendances, admissions and delayed discharge, streamlining patient pathways to reduce avoidable outpatient visits and preventing over-medication through pharmacist reviews.

19. In addition, two existing funding streams will transfer to PCNs in the future: extended access services and community-based services.

20. Full details relating to PCN funding is still to be published.

Patient engagement

21. During the summer of 2018, NHS England carried out a programme of engagement on the Long Term Plan, of which Primary Care Networks are a part.

22. The PCNs are being developed under very tight timescales. PCNs are expected to have engaged with their constituent Patient Participation Groups during their development to ensure patient views were taken into account.

23. The clinical commissioning groups in Leicester, Leicestershire and Rutland are embarking on a programme of engagement about the local primary care networks in June 2019, when they have been agreed. In February and April 2019 BBC Radio Leicester and BBC East Midlands featured Primary Care Networks and the range of health professionals that will be involved in patients' care.

24. Before making any changes to services, GP practices and primary care networks will be expected to engage with their patients. All GP practices should have a Patient Participation Group and they will continue to be involved in the running of the practice and the Primary Care Network going forward.

Next steps

25. The clinical commissioning groups are continuing to work with GP practices to finalise the development of the PCNs. Following this the CCGs will commence engagement and communication with local patients and stakeholders in June 2019 to

help them understand the changes and how they may be affected.

26. During 2019/20 the clinical commissioning groups will continue to support the PCNS as they develop and as more detail becomes available about what will be required in the future.

Background papers

NHS Long Term Plan – https://www.longtermplan.nhs.uk/

Officer to Contact

Name and Job Title: Tim Sacks, Chief Operating Officer
Telephone: 0116 295 3413
Email: tim.sacks@eastleicestershireandrutland.ccg.nhs.uk

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Agenda Item 13

Leicestershire County Council

HEALTH OVERVIEW AND SCRUTINY COMMITTEE: 5th JUNE 2019

DEVELOPMENT OF A NEW MODEL FOR HOMELESSNESS AND HOUSING SUPPORT

REPORT OF DIRECTOR OF PUBLIC HEALTH

Purpose of report

1. The purpose of this report is to advise the Health Overview and Scrutiny Committee on the consultation to develop a new model for homelessness and housing support.

Policy Framework and Previous Decisions

2. In September 2014, the Cabinet considered the outcome of the strategic review of the Adults and Communities Department's secondary prevention services and authorised the Director of Adults and Communities to implement the proposed prevention offer for Homelessness Support establishing the current service.

3. In June 2016, the Cabinet considered the outcome of an independent review of Early Help and Prevention (EHAP) services and approved the EHAP Strategy arising from that review. The proposed new model for homelessness and housing support is within the scope of this Strategy and will form part of the prevention offer in Leicestershire as set out in the Target Operating Model for prevention in the EHAP review.

4. In April 2018 commissioning responsibility for the service was transferred from the Department for Adults and Communities to Public Health, along with a revised MTFS savings target of £200,000 to be achieved by April 2020.

5. The Council does not bear the statutory responsibility for homelessness support. That responsibility lies with district councils under the Homelessness Act 2002 and latterly the Homelessness Reduction Act (HRA), which came into effect from 3 April 2018 and which places a new duty to prevent and relieve homelessness regardless of priority. The Council does however have a duty under the Act to assist the district councils with formulating their strategies and to take these into account when formulating its social service function.

6. In November 2018, the Cabinet approved the public health department's request to consult on a new model for Homelessness and Housing Support Service for Leicestershire.

Background

7. Being homeless has significant negative impacts on both physical and mental health. The average age of death for those who are rough sleeping or resident in homeless accommodation is 47 for men and 43 for women, therefore, the health of the homeless is a priority area for public health.

8. In 2014, 80% of homeless people in England reported that they had mental health disorders, with 45% having been diagnosed with a mental health condition.

9. The most prevalent health problems among homeless individuals are substance misuse (62.5%), and 42.6% report having both substance misuse and mental health issues. Given that these problems are causally linked with homelessness, they add significantly more costs to homelessness due to the need for health and social care support.

10. District councils have responsibility, under the Homelessness Act 2002 and latterly the Homelessness Reduction Act (HRA) 2017, to prevent and relieve homelessness regardless of priority. The HRA introduced measures whereby all eligible people who are found to be homeless or threatened with homelessness are entitled to more tailored support from the housing authority, regardless of priority need, intentionality, and local connection. The housing authority, in our local case, is the district council. The key duties are:
    a. Local housing authorities must assess anyone who is found to be homeless or threatened with homelessness and where appropriate, support the individual or family to develop a personalised housing plan.
    b. Under the prevention duty, local housing authorities must take 'reasonable steps' to help people avoid becoming homeless, with reference to their personal plan. This could mean, for example, supporting them to either stay in their accommodation or helping them find somewhere to live. The intention behind this duty is to help households before they reach a housing crisis situation.
    c. Under the relief duty, local housing authorities must take 'reasonable steps' to help the applicant into accommodation, with reference to their personal plan. This could be, for example, the provision of a rent deposit or debt advice. Where accommodation is provided, the housing authority must be satisfied that the accommodation will be available for at least six months.

Proposals/Options

11. It is proposed that a future service model provides for those at risk of homelessness who require more intensive support with contributory health and social issues (for example substance misuse, mental health disorders, domestic abuse or sexual violence), where community centred support might help prevent people becoming homeless.

12. This would move away from the current more general housing support service. The new model will work with families at risk of homelessness as well as single people.

13. We are proposing a model that would support:
    a. Individuals and families at potential risk of homelessness but not 'covered' by the HRA 2017 duties (outside the 56 days 'window' for homelessness prevention

support) with contributory health and social issues (for example substance misuse, mental health disorders, domestic abuse or sexual violence).

b. District councils who are providing housing support to individuals and families at risk of homelessness and 'covered' by the HRA 2017 duties (within 56 day 'window' for homelessness prevention support) with more intensive community based support around defined contributory health and social issues such as alcohol, drugs, mental health, domestic violence, sexual violence as well as housing related support.

c. Individuals and families at the end of the 56 days 'window' of homelessness prevention support where ongoing support may enable them to avoid becoming at risk of homelessness again.

14. To deliver this proposed model of support, we are suggesting:

a. Building the capability of all First Contact Plus staff and local area coordinators to be able to identify and provide advice for issues known to be linked to an increased risk of homelessness. This could include tenancy issues, debt management, neighbourhood disputes, alcohol and drug addiction and family breakdown.
    i. Additional training to ensure these frontline staff members feel competent to spot and respond to contributory health and social issues would be delivered by new specialist homelessness prevention coordinators.

b. Using the First Contact Plus service as a central referral hub for accessing advice and support relevant to issues linked to an increased risk of homelessness.
    i. Individuals, families, professionals and partner agencies can access self-help information, advice and guidance online and over the phone.
    ii. Self-referral or professional referrals can be made to the First Contact Plus service and staff would then facilitate an assessment of need and, where appropriate, provide onward signposting to homelessness prevention support services (including to housing teams at District Councils) or referral to other County Council services- tailored to the individual's needs [1].

c. Utilising the existing cadre of local area coordinators to work across priority patches in Leicestershire and tackle the contributory health and social issues (for example substance misuse, mental health disorders, domestic abuse or sexual violence) that increase the risk of homelessness.
    i. Coordinators would identify individuals and families to prioritise support to through introductions via other agencies or individuals.

[1] Leicestershire County Council commissions a range of services, across all departments, to support individuals' wellbeing and prevent homelessness. Examples include Mental Health Reablement, Local Area Coordination service (LAC), Supporting Leicestershire Families (SLF) team and First contact plus (including benefit maximisation and priority visiting offered through the Department for Work and Pensions). This is not an exhaustive list.

ii. Local area coordinators would receive additional mentoring and support from new specialist homelessness prevention coordinators to discuss complex cases.

d. Enhancing existing community-based interventions and statutory provision of housing support by District Councils through the recruitment of specialist homelessness prevention coordinators.
   i. Access to targeted information and enhanced support (for a smaller group of people who are within the 56 day 'window' for homelessness prevention support) could be accessed via referral from District Council housing teams (or their HRA provider). This would be enabled through regular direct contact between specialist coordinators and/ or through District Council teams making a professional referral via the First Contact plus service.
   ii. New specialist prevention coordinators would collectively cover Leicestershire whilst having close working relationships with District Council housing officers in their patch.

Consultation

15. Following the Cabinet's approval in November 2018, a targeted consultation exercise was planned and is taking place for 12 weeks between May and August 2019.

16. The consultation will seek the views of district councils, the current provider, Nottingham Community Housing Association (and its sub-contracted providers), the wider voluntary and community sector, CCGs and health service providers, and the current service providers for substance misuse and mental health services. This will be achieved through an event aimed at these partners and professionals on the 10 June 2019 at County Hall and collating views from an online questionnaire.

17. The consultation will seek the views of existing and previous housing support users. This will be achieved via focus group events on the 31 May 2019 at Loughborough Town Hall, Loughborough and 7 June at the Salvation Army, Wigston. Additionally, views will be collated from an online questionnaire. Respondents are also being given the option to complete this survey by hand if preferred.

18. The outcomes of the consultation will help inform the final model which will be presented to the Cabinet for approval in October of 2019.

19. The consultation can be accessed via the following link: https://www.leicestershire.gov.uk/have-your-say/current-consultations/homelessness-prevention-support

Resource Implications

20. The new model for homelessness and housing support is expected to achieve savings of £200,000 per annum which would contribute to the Medium Term Financial Strategy (MTFS) savings target. The total remaining budget for this service will be £300,000 per annum.

21. As part of the service remodel, it is likely that TUPE (Transfer of Undertakings (Protection of Employment) Regulations 1981) will apply. The purpose of TUPE is to protect employment rights when employees transfer from one business to another, which may be the case with the new delivery model. Further work is required to identify potential redundancy costs.

22. The Director of Corporate Resources and the Director of Law and Governance have advised on the consultation.

Timetable for Decisions

23. The consultation results will be reported to the Council's Cabinet during Autumn 2019.

24. If Cabinet decides to go ahead with the proposed service, further engagement with current providers would take place as part of the transition to the new service.

25. A new service is expected to be in place by 1st April 2020.

Conclusions

26. The report has been submitted to provide an update on the development of a new model for homelessness and housing support. The Committee is asked to note the contents and are invited to comment on the proposals.

Background papers

27. Report to the Cabinet on 17 June 2016 - Early Help and Prevention Review and Strategy
http://politics.leics.gov.uk/ieListDocuments.aspx?CId=135&MId=4603&Ver=4

28. Report to the Cabinet on 23 November 2018- Development of a new model for homelessness and housing support
http://politics.leics.gov.uk/documents/s142331/Housing%20Homelessness%20Cabinet%20Report%20Nov%202018%20v0.7%20final.pdf

Circulation under the Local Issues Alert Procedure

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Mrs. M. E. Newton CC
Mr. M. J. Hunt CC
Mr. T. Parton CC
Mr. G. A. Boulter CC
Mr. M. H. Charlesworth CC
Mrs. L. Broadley CC
Mr. D.A. Gamble CC
Mr. J. Kaufman CC

This report will be circulated to all Members of the County Council via the Members' Digest .

Equality and Human Rights Implications

29. The Equality Act 2010 imposes a duty on the local authority when making decisions to exercise due regard to the need to eliminate unlawful discrimination, advance equality of opportunity and foster good relations between people who have a protected characteristic and those who do not. An Equality and Human Rights Impact Assessment (EHRIA) report will be completed in relation to the impact of any change to service model. This will be informed by the outcomes of the consultation and will be presented to the Cabinet alongside the consultation outcomes to assist the Cabinet with the exercise of its Public Sector Equality Duty under the Equality Act 2010.

30. An EHRIA screening assessment has been carried out, which concludes that although the proposals are likely to have an impact on individuals or groups associated with several of the 'protected characteristics', at this stage the direction and size of the impact is unknown and so a full EHRIA is required.

31. The EHRIA screening has been used to inform the consultation exercise, for example in targeting the cohorts and representative groups who should be involved.

32. A full EHRIA will be completed when the feedback from the consultation has been collated.

Officers to Contact

Mike Sandys, Director of Public Health
Tel. 0116 305 4239
Email: mike.sandys@leics.gov.uk

Rob Howard, Consultant in Public Health
Tel: 0116 305 4256
Email: rob.howard@leics.gov.uk