Agenda Item 9

Leicestershire County Council

HEALTH OVERVIEW AND SCRUTINY COMMITTEE: 7 NOVEMBER 2018

REPORT OF THE CHIEF EXECUTIVE AND CCG PERFORMANCE SERVICE

HEALTH PERFORMANCE UPDATE AT END OF OCTOBER 2018

Purpose of Report

1. The purpose of the report is to provide the Committee with an update on health performance in Leicester, Leicestershire and Rutland based on the available data at the end of October 2018.

Background

2. The Committee has, as of recent years, received a joint report on health performance from the County Council's Chief Executive's Department and the CCG Commissioning Support Performance Service. The report aims to provide an overview of performance issues on which the Committee might wish to seek further reports and information, inform discussions and check against other reports coming forward.

NHS Constitution

3. At a national level the health performance reporting model is influenced by the Government's mandate to NHS England. A revised mandate was issued relating to the period 2017-18. There are also a wide range of separate clinical and regulatory standards that apply to individual services and providers. The Public Health Outcomes Framework (PHOF) sets out metrics on which to help assess public health performance and there is a separate framework for other health services. Adult social care outcomes are covered by the Adult Social Care Outcomes Framework (ASCOF).

Changes to Performance Reporting Framework

4. A number of changes have been made to the way performance is reported to the Committee to reflect national NHS constitution changes. The County Council has also developed a new Outcomes Framework which informs reporting. The Health and Wellbeing Board has adopted some changes in its performance reporting processes so that it can have a sharper focus on

individual agency performance and progress. This has been reflected in the dashboards attached to this report. The overall framework will continue to evolve to take account of the above developments as well as any particular areas that the Committee might wish to see included.

5. The following 3 areas therefore form the current basis of reporting to this committee:-
   a. Performance against the key metrics/targets set out in the Better Care Fund plan, in relation to health and care integration;
   b. Clinical Commissioning Group (CCG) performance for both West Leicestershire and East Leicestershire and Rutland CCGs; and
   c. An update on wider Leicestershire public health outcome metrics and performance.

Better Care Fund Performance

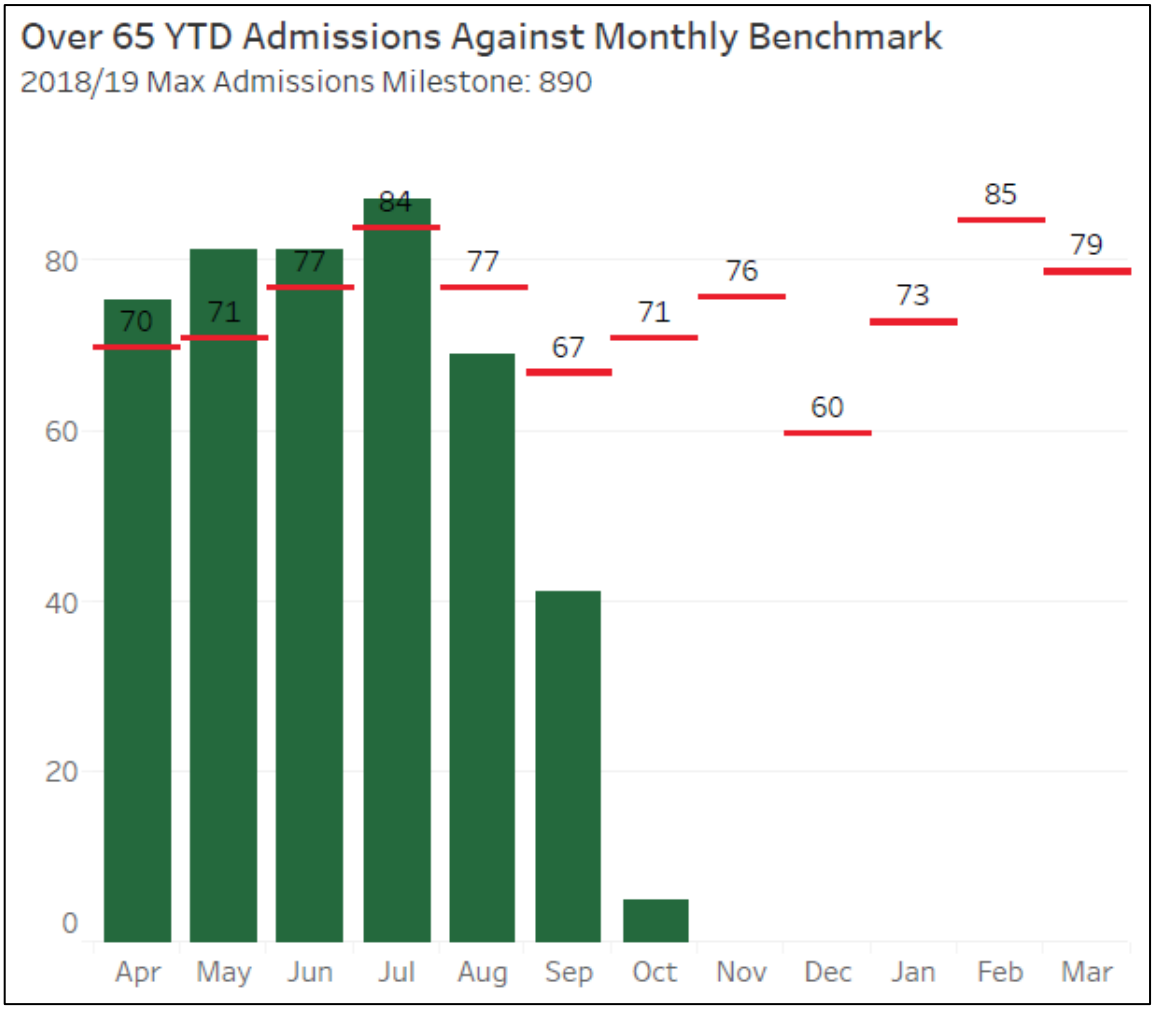
6. BCF planning guidance, released in July 2017, reduced the number of BCF metrics from six to four, removing metric 5 on patient satisfaction, based on the annual GP patient survey, and metric 6 the rate of emergency admissions for injuries due to falls (aged 65+). The guidance contained a requirement for all areas to reduce the number of delayed transfers of care (DToCs).

7. A refresh to the BCF 2017/19 operating guidance was published on 18th July 2018. There is an expectation that the target for delayed transfers of care will be met by the end of September 2018 and this level will be maintained or exceeded thereafter. A review of other BCF outcome metrics has been carried out and these have been updated accordingly.

8. The first wave of Care Quality Commission local system reviews were undertaken during quarter 3 2017/18, which covered 12 areas across England. The second wave of local reviews was published in December. Leicestershire has not been included in this list, which is reflective of the good overall comparative performance – see later sections below.

Metric 1: Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population, per year

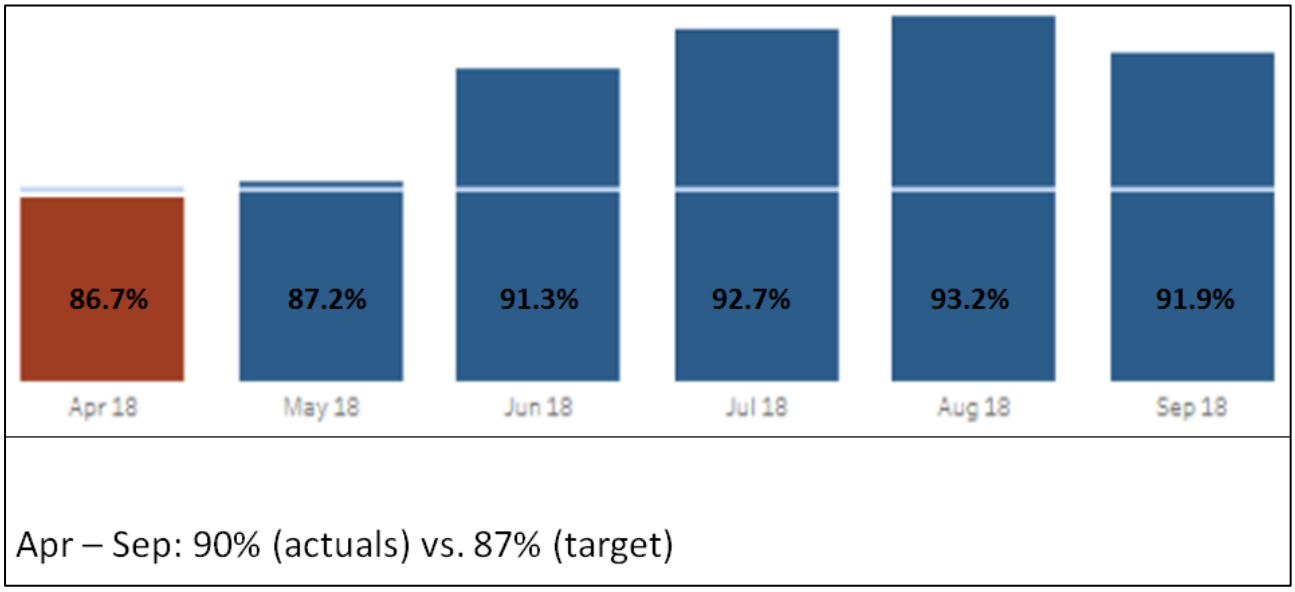
9. Based on permanent admissions between April and September 2018, the current full year forecast is 921 admissions (or 645.6 per 100,000 population). The BCF target for 18/19 is a maximum of 890 admissions. Performance is RAG-rated amber and is statistically similar to the target.



Metric 2: Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services

10. For hospital discharges between Apr and Jun '18, 91.9% of people discharged from hospital into reablement / rehabilitation services were still at home after 91 days. This is above the 18/19 target of 87%. Performance is RAG-rated green and is statistically significantly better than the target.

ASCOF 2B – proportion of older people (65 and over) who are still at home 91 days after discharge from hospital into reablement/rehabilitation services



Metric 3: Delayed transfers of care from hospital per 100,000 population

11. The Government's mandate to the NHS for 2018-19 has set an overall ambition for reducing delays to around 4,000 hospital beds occupied by patients delayed without discharge by September 2018. For Leicestershire this equated to DTOCs not exceeding 7.88 in every 100,000 population per day.

12. For April 2018 to August 2018, there was a monthly average of 970 days delayed for Leicestershire residents, an average monthly rate of 178.47 per 100,000 population against an average monthly target of 241.22. This equates to an average rate of 5.83 days delayed per day per 100,000 population against a target of 7.88. The average breakdown of delayed days between April 2018 and August 2018 are 88.31% attributable to the NHS, 7.36% attributable to social care and 4.33% jointly attributable.

13. The table below highlights full year 2018/19 performance across health and social care sectors.

<u>Leicestershire's DTOC performance – days delayed per day per 100,000 of 18+ population</u>

	NHS Delays	**ASC Delays**	**Joint**	**Total**
Target for FY18/19	**5.50**	**1.25**	**1.13**	**7.88**
Average Performance between April 2018 and August 2018	5.15	0.43	0.25	5.83
Performance at August 2018	6.43	0.52	0.14	7.08

	Days Delayed				Days Delayed per 100,000 population		Days Delayed per 100,000 population per Day	
	NHS	Social care	Joint	Total	Rate	Target	Rate	Target
Apr-18	864	55	66	985	181.20	236.49	6.04	7.88
May-18	727	40	29	796	146.43	244.38	4.72	7.88
Jun-18	745	90	64	899	165.38	236.49	5.51	7.88
Jul-18	865	85	28	978	179.91	244.38	5.80	7.88
Aug-18	1083	87	23	1193	219.46	244.38	7.08	7.88

14. Overall during 2018/19 (April to August), there were 4,851 days lost to delayed transfer of care for Leicestershire residents; a **38% reduction** against the same period in 2017/18. For delayed days specifically attributable to adult social care (ASC) there were 357 days during 2018/19 (April to August) – **a reduction of 71%** against the same period in 2017/18. The breakdown of ASC delays showed that during 2018/19 (April to August) there was a reduction of 60% at University Hospitals of Leicester, 75% at Leicestershire Partnership NHS Trust (LPT) and 63% at hospitals outside of the county against the same period in 2017/18. Leicestershire recent performance is ranked 2nd best out of 16 similar shire authorities.

15. Nationally there were 145,600 total delayed days in August 2018, of which 94,900 were in acute care. This is a decrease from August 2017, where there were 180,300 total delayed days, of which 115,900 were in acute care. The 145,600 total delayed days in August 2018 is equivalent to 4,697 daily DTOC beds. This compares to 4,516 in July 2018 and 5,816 in August 2017. Both the NHS and Social Care sectors have seen reductions in the volume of delayed transfers of care in the last year. 61.3% of all delays in August 2018 were attributable to the NHS, 31.3% were attributable to Social Care and the remaining 7.4% were attributable to both NHS and Social Care. The proportion of delays attributable to Social Care has decreased over the last year to 31.3%.

16. Despite not meeting the national target for 2017/18, local health and care partners across LLR have worked tirelessly to deliver significant, measureable improvements to transfers out of hospital and reduce DTOCs. There has been a system-wide approach across partners, which the BCF contributes towards and significant levels of BCF and Improved BCF funding allocated to supporting managing transfers of care.

17. The reduction in the number of delayed beds days is attributed to a concentrated effort from all partners to reduce DTOC's. This includes Leicestershire Partnership NHS Trust restructuring staffing to focus on complex patients with a long length of stay, focusing matrons on wards to look at census data directly and reviewing all end to end processes to improve patient flow.

18. Within University Hospitals Leicester (UHL) the development of the Integrated Discharge Team (IDT) and utilising the Red2Green process, which looks at patient delays on a daily basis, has positively impacted on delays. Across partners two Multi- Agency discharge events were held over two weekly periods (December and January) to look at all delayed patients using escalation calls for all partner involvement. This included transport providers, adult social care and housing.

Summary of DTOC Actions Taken

19. A detailed joint action plan is in progress to further maintain and improve the delayed transfers of care position. The following paragraphs provide an update on actions since the last report.

20. The redesign of discharge pathway 2 (home with new support) and pathway 3 (complex transfers – unable to go straight home) led by Home First is due to take place. This will include agreeing and implementing an LLR-wide model for Discharge to Assess and reablement.

21. The development of trusted assessment between staff across the hospital and with services providing Home First community services and with care home providers, both for new and existing resident transfers is to be progressed.

22. There are plans to bring the Housing Enablement Team into the Integrated Discharge Teams (IDT), and increases in resources to support IDT presence at the front door are to take place. The discharge hub environment usage is to be reviewed to ensure that all those who need to work together to pursue complex discharges are able to do so, not just those specifically identified as IDT members or those working on a limited number of wards.

23. Opportunities are to be explored for all adult social care staff facilitating discharges to have access to NHS systems to share information about patients' requirements. Combining the IDT with red2green and (possibly the flow coordinators) would allow a wider resource to be focused on similar issues and responses e.g. being eyes and ears for each other's requirements, challenging decisions and progress in the same way.

24. The actions taken also include:
    - A review of the effectiveness of the continuing healthcare end to end process implemented within Community and Community Hospitals.
    - A phased implementation of the continuing healthcare end to end process for UHL with an assessor for Midlands and Lancashire CSU commencing in March to support the Complex Discharge Team.

Metric 4: Total non-elective admissions into hospital (general and acute), per 100,000 population, per month

25. Secondary User Statistics data for April 2018 – August 2018 shows 28,194 non-elective admissions. 48% of these were for older adults aged 65+. This translates to an average rate of 816.86 admissions per 100,000 population, per month against a target of 836.69. The 2018/19 target was set based on the 2017/18 – 2018/19 operating plans submitted jointly by LLR CCGs on 23rd December 2016 with a refresh being provided in 2018/19. In 2017/18 Leicestershire was ranked 24th out of 32 counties on emergency admissions (65+) per 100k population.

26. The overall performance on emergency admissions continues to be challenging for the whole of LLR, but is rated as **green.** The new model of urgent care, which the BCF contributes towards, was commissioned with effect from April 2017 across LLR. However, the rate of admissions for Leicestershire has not reduced during 2017/18 and 2018/19. A change in the Children's Assessment pathway came into effect from 16th July 2018. Prior to this, on average, 6% of NEA's was a result of the pathway not being in-acted.

Health and Care Interface Dashboard

27. In relation to benchmarking overall performance the Department of Health and the Ministry of Housing, Communities and Local Government have developed a health and care interface performance dashboard. This brings together a range of metrics in relation to the interface between the NHS and Adult Social Care. An updated version of the NHS-Social Care Interface Dashboard has recently been issued based on 6 key metrics of performance including emergency admissions, length of stay, delayed days, reablement and discharges at weekends. Out of 150 areas Leicestershire is ranked 41st and rank 2nd in its nearest neighbour group.

CCG Performance Dashboards - Appendix 1 and 2

28. NHS England's CCG Improvement and Assessment Framework (IAF) was introduced in 2016/17, it aligns key objectives and priorities and informs the way NHS England manages relationships with CCGs. For 2017/18 NHS England refreshed the IAF to replace the existing assurance process. An IAF for 2018/19 has yet to be released.

29. This framework provides a greater focus on assisting improvement alongside statutory assessment functions and is based on 4 areas of assurance for each CCG; Better Health, Sustainability, Leadership and Better Care. The full dashboards, as published in July 18 by NHS England, showing CCG

performance across all 4 domains, are reported in Appendix 1 (ELR) and Appendix 2 (WL).

30. The following table provides an explanation to each indicator 'at risk' where ELRCCG or WLCCG are RAG-rated as red. More up-to-date data has been provided in the table where available. Details of local actions in place in relation to these 'at risk' metrics are also shown.

Metric 'at risk' as per October 18 IAF and explanation of metric	**Most recent local data**	**Local actions in place / supporting information**
Antimicrobial resistance (AMR): Broad spectrum prescribing The purpose of this indicator is to encourage an improvement in appropriate antibiotic prescribing in primary care, in particular broad spectrum antibiotics.	**National Target <10%** **ELR** YTD July 18 - 10.4%	9 ELR practices are above the target, however all practices have mandatory audits to complete on antibiotic prescribing. One of these is a c.diff audit which relates to this indicator. Practices are expected to embed learning to their prescribing of these broad spectrum antibiotics, raise awareness amongst prescribers about local antimicrobial guidelines and highlight prescribing as part of the audit. As part of the 5year AMR strategy there have been other antimicrobial initiatives. This includes a drive to reduce inappropriate prescribing of antimicrobials and raising the awareness of schemes like 'not treating cold and flus with antibiotics' which has been successful in reducing our overall antimicrobial prescribing.
Cancer 62 days of referral to treatment The indicator is a core delivery indicator that spans the whole pathway from referral to first treatment covering the length of time from urgent GP referral, first outpatient appointment, decision to treat and finally first definitive treatment. Shorter waiting times can help to ease patient anxiety and, at best, can lead to earlier diagnosis, quicker treatment, a lower risk of complications, an enhanced patient experience and improved cancer outcomes.	**National Target >85%** UHL have stated this metric should be achieved from December 2018. **Latest Performance** **ELR** (All Providers); April 18 – Aug 18 78% (354 referrals out of 451 treated within 62days) **WL** (All Providers); April 18 – Aug 18 77% (397 referrals out of 517 treated within 62days) **UHL** (All patients); April 18 – Aug 18 76% (902 referrals out of 1192 treated within 62days)	The number of patients waiting on the 62 day backlog in early October was the lowest since April 2018 at UHL. Actions to support the Intensive Support Team recommendations are now incorporated into the Recovery Action Plan. Additional capacity at Derby (robotic) and the Alliance (non-cancer activity) being used. Sheffield Consultants meeting with the UHL Gynaecology service in early October to scope out any opportunities to do things differently and to discuss the Sheffield model. Weekly cancer calls between UHL and CCG continue to be in place. Demand and capacity modelling to be undertaken in a number of services such as Breast and Oncology. Quarterly 62-day thematic reviews are undertaken and presented to the Cancer

		Board.
A&E admission, transfer, discharge within 4 hours A&E waiting times form part of the NHS Constitution. This measure aims to encourage providers to improve health outcomes and patient experience of A&E. The standard relates to patients being admitted, transferred or discharged within 4 hours of their arrival at an A&E department. The national ambition in 18/19 is to achieve above 90% in September 2018, and that the majority of providers are achieving the 95% standard for the month of March 2019	**<u>18/19 National Target >90% in September 18, and 95% in March 19</u>** **UHL** % All UHL+UCC < 4Hrs – April – Oct 18 85% **UHL ED only** April – Oct 18 80% (104,762 patients admitted, transferred or discharged within 4hrs out of 131,543 total patients) **5 LLR Urgent Care Centres only** April – Oct 18 98% (50,903 patients seen within 4hrs out of 51,728)	This indicator measures the flow through the UEC (Urgent & Emergency Care) system. Indicator development work is taking place as part of the UEC agenda and therefore new national measures are likely to emerge to better reflect the transformed UEC system for inclusion in the framework. Primary challenges to the 4hr standard delivery are largely affiliated with the slow pace and differentials between admission/discharge profiles. The theme of a high number of patients waiting for medical beds, with a significant variability in discharges for medicine, continues as in previous months. Capacity issues contributed to a number of elective cancellations throughout the month. Primary care front door processes continue to be reviewed and a new process has been put in place by Derbyshire Health United (DHU). However, front door performance continues to vary. There has been an improvement in filling the number of rota gaps and UHL and DHU continue to work closely to monitor the impact of the new processes.
18 week Referral To Treatment (RTT) The NHS Constitution sets out that patients can expect to start consultant-led treatment within a maximum of 18 weeks from referral for non-urgent conditions if they want this and it is clinically appropriate. 18/19 National Target >92% of patients to start treatment with 18weeks from referral In 18/19 the national ambition is also that the Waiting List should be sustained at March 2018 levels in March 2019.	**Latest Performance** **ELR (All Providers)** Sept 18 – 87% 20,661 patients waiting at the end of March 18 21,600 patients waiting at the end of September 18. **WL (All Providers)** Sept 18 – 86% 23,384 patients waiting at the end of March 18 23,603 patients waiting at the end of September 18 **UHL (All Patients)** UHL are not expecting to meet the national standard of 92% in 18/19. Sept 18 – 85% 64,751 patients waiting at the end of March 18. 65,574 patients waiting at the end of September 18.	There was an approximate 3% decrease in the number of patients on the backlog from the last reporting period. Future performance is predicted to be at risk due to competing demands with emergency and cancer performance, delays due to diagnostic performance and reduced levels of patient transfers to the Independent Sector. A trajectory has been agreed by the Trust and NHSImprovement (NHSI) to meet the planning guidance, which is on track this month. The levels of transfer to the independent sector have increased in August, as the method of contacting patients was changed due to difficulties in previous months in contacting patients. Action plans have been agreed with all specialities with performance below 92% and a waiting list greater than 50. It has been agreed that UHL will now also transfer patients to the independent sector at the point of referral which should increase the number of patients choosing to transfer. The theatre productivity programme should increase productivity ensuring capacity is fully utilised and reduce cancellations.

Areas of Improvement

31. There are several areas which are worth commenting on, that have improved in 18/19, these are;
    - Dementia Diagnosis – ELR and WL CCG's continue to achieve the national standard that over 67% of the expected number of dementia patients now have a dementia diagnosis within primary care.
    - Cancer - Percentage of patients receiving first definitive treatment within one month of a cancer diagnosis has achieved the 96% target during most months in 2018.
    - Delayed transfers of care - levels remain within tolerance levels at UHL, with particular low levels in May – July.
    - IAPT Recovery – The national target relating to the percentage of people who are assessed as 'moving to recovery' continues to be achieved for ELR & WL patients.
    - At the end of July, August & September there were no patients waiting longer than 52 weeks for treatment at UHL.

ENT and Ophthalmology wait times - *the information provided is for UHL only.*

32. Patients referred to the ENT service are on average seen within 11 weeks (20-25% are discharged at the first appointment), and follow-ups at 20 weeks. All patients are seen in order of clinical urgency and then in date order. The information also encompasses patient choice where patient initiated delays extend the patients' wait to be seen and patients who do not attend, which are around 10% for the service. An average of 9.27% of first appointments are not utilised due to DNA's over the past 12 months. DNA's for a follow up appointment are slightly lower at 7.5% for the last 12 months.

33. Unfortunately, there are times where some patients wait longer than UHL would want and what is set nationally as an appropriate waiting time standard, however, a waiting time of 6 months is not typical for the service. The service has recently employed a new Consultant which has increased the capacity. Although there has been additional consultant capacity, the service has seen a 9% increase in GP referrals, so the additional demand has outstripped the capacity available. UHL are working with CCG commissioners and planned care on managing patient demand.

34. The ophthalmology service typically sees patients within 9 weeks and patients receive a follow-up on average 3 weeks later if required. For patients requiring long term follow ups after treatment has commenced, 97% are booked within 6 months of when clinically indicated. The CCGs are working on a project called High Impact Interventions which is looking at improving the management of glaucoma and other long term eye conditions.

35. ENT and ophthalmology are areas that the CCG are working with providers to redesign elements of the services to improve the patient journey. This is expected to also have a positive impact on waiting times over time.

Public Health Outcomes Performance – Appendix 4

36. Appendix 4 sets out current performance against a range of outcomes set in the performance framework for public health. The Framework contains 39 indicators related to public health priorities and delivery. The dashboard sets out, in relation to each indicator, the statistical significance compared to the overall England position or relevant service benchmark where appropriate. A rag rating of 'green' shows those that are performing better than the England value or benchmark and 'red' worse than England value or benchmark.

37. Analysis 4 shows that of the comparable indicators, 18 are green, 12 amber and 2 reds. There are 7 indicators that are not suitable for comparison or have no national data.

38. Of the 18 green indicators, the following indicators, under 18 conceptions, new sexually transmitted infections and smoking status at time of delivery have shown significant improvement over the last few years. There are no significant changes for child excess weight in 4-5 year olds and for child excess weight in 10-11 years. However, the recently published data for 2017/18 shows a significant decline (worsening) compared to the previous year in the excess weight indicators for both 4-5 year olds and 10-11 year olds in Leicestershire. Preliminary investigations suggest this is due to a data quality issue. More information will be presented in the next HOSC dashboard once the data has been published as part of the Public Health Outcomes Framework (PHOF).

39. Breast cancer screening coverage and cervical cancer screening coverage has shown a significant declining (worsening) performance over the last five years. This declining trend, for both indicators, is witnessed nationally.

40. Of the 12 indicators that are amber, the proportion of five year old children free from dental decay in Leicestershire for 2016/17 has significantly increased. There are no significant changes for successful completion of drug treatment for non-opiate users. Successful completion of drug treatment for opiate users has shown a trend of worsening performance.

41. The two red indicators include – chlamydia detection rate which shows Leicestershire has declined to be worse than the benchmark goal and is ranked 4th out of 16 of the CIPFA nearest neighbours (1 being the best); Take up of

NHS health checks for the time period 2013/14-2017/18, Leicestershire is ranked 13th out of 16.

42. Further work is underway to progress improvement across the range of indicator areas. Further consideration will be given to actions to tackle these areas as part of Health and Wellbeing Strategy implementation and the public health service plan development process.

43. HIV late diagnosis (%) for 2015-17 for Leicestershire has no value presented as the data is supressed due to disclosure issues. Breastfeeding initiation and breastfeeding prevalence at 6-8 weeks for Leicestershire has no value presented due to data quality reasons. Self-reported wellbeing – people with a low worthwhile score for 2016/17 for Leicestershire has no value due to number of cases being too small.

44. Leicestershire and Rutland have combined values for the following three indicators - smoking status at time of delivery, successful completion of drug treatment (opiate users) and successful completion of drug treatment (non-opiate users).

List of Appendices

Appendix 1 and 2 – CCG Performance Dashboards
Appendix 3 – BCF Performance Metrics and NHS-Care Interface Dashboard
Appendix 4 – Public Heath Performance Dashboard

Background papers

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

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