Date: THURSDAY, 3 APRIL 2014

Time: 9:30 am (**please note change of start time**)

Location: THE COUNCIL CHAMBER - FIRST FLOOR, TOWN HALL, TOWN HALL SQUARE, LEICESTER

HEALTH AND WELLBEING BOARD

Councillors:

Councillor Rory Palmer, Deputy City Mayor (Chair)

Councillor Rita Patel Assistant City Mayor

Councillor Manjula Sood MBE, Assistant City Mayor

City Council Officers:

Deb Watson, Strategic Director, Adult Social Care and Health

Elaine McHale, Interim Strategic Director, Children's Services

Tracie Rees, Director, Care Services and Commissioning, Adult Social Care

NHS Representatives:

Professor Azhar Farooqi, Co-Chair, Leicester City Clinical Commissioning Group

Dr Simon Freeman, Managing Director, Leicester City Clinical Commissioning Group

David Sharp, Director, (Leicestershire and Lincolnshire Area) NHS England

Healthwatch / Other Representatives:

Philip Parkinson, Interim Chair, Healthwatch Leicester

Chief Superintendent, Rob Nixon, Leicester City Basic Command Unit Commander, Leicestershire Police

Members of the Board are summoned to attend the above meeting to consider the items of business listed overleaf.

Members of the public and the press are welcome to attend.

G. J. Carey

For Monitoring Officer

City Mayor healthwatch Leicester Leicestershire Police Protecting our communities NHS Leicester City Clinical Commissioning Group NHS Commissioning Board

INFORMATION FOR MEMBERS OF THE PUBLIC

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You also have the right to see copies of agendas and minutes. Agendas and minutes are available on the Council's website at www.cabinet.leicester.gov.uk or by contacting us as detailed below.

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There are certain occasions when the Council's meetings may need to discuss issues in private session. The reasons for dealing with matters in private session are set down in law.

WHEELCHAIR ACCESS

Meetings are held at the Town Hall. The Meeting rooms are all accessible to wheelchair users. Wheelchair access to the Town Hall is from Horsefair Street (Take the lift to the ground floor and go straight ahead to main reception).

BRAILLE/AUDIO TAPE/TRANSLATION

If there are any particular reports that you would like translating or providing on audio tape, the Democratic Services Officer can organise this for you (production times will depend upon equipment/facility availability).

INDUCTION LOOPS

There are induction loop facilities in meeting rooms. Please speak to the Democratic Services Officer at the meeting if you wish to use this facility or contact them as detailed below.

General Enquiries - if you have any queries about any of the above or the business to be discussed, please contact Graham Carey, Democratic Support on (0116) 454 6356 or email Graham.Carey@leicester.gov.uk or call in at the Town Hall.

Press Enquiries - please phone the Communications Unit on 454 4150

PUBLIC SESSION

AGENDA

NOTE:

This meeting will be webcast live at the following link:-

http://www.leicester.public-i.tv

An archive copy of the webcast will normally be available on the Council's website within 48 hours of the meeting taking place at the following link:-

http://www.leicester.public-i.tv/core/portal/webcasts

2. DECLARATIONS OF INTEREST

Members are asked to declare any interests they may have in the business to be discussed at the meeting.

3. MINUTES OF THE PREVIOUS MEETING **Appendix A Page 1**

The minutes of the previous meeting of the Board held on 30 January 2014 are attached and the Board is asked to confirm them as a correct record.

4. BETTER CARE FUND **Appendix B Page 15**

The Strategic Director Adult Social Care and Health and the Managing Director, Leicester City Clinical Commissioning Group to submit a report including a draft of the Final Plan.

5. JOINT HEALTH AND WELLBEING STRATEGY **Appendix C Page 53**

The Chair of the Integrated Commissioning Board to submit a report providing an update on the implementation of the Joint Health and Wellbeing Strategy.

6. LEICESTER CITY CLINICAL COMMISSIONING GROUP - 2 YEAR PLAN

The Managing Director, Leicester City Clinical Commissioning Group (CCG) to give a presentation providing an overview of Leicester City Clinical Commissioning Group's 2 Year Operational Plan which has to be submitted to NHS England on 4 April 2014.

7. LEICESTER, LEICESTERSHIRE AND RUTLAND 5 YEAR STRATEGY (BETTER CARE TOGETHER) **Appendix D Page 79**

The Programme Director Leicester, Leicestershire and Rutland Five Year Strategy to submit a report on the 5 Year Strategic Plan required to be submitted to NHS England.

8. NHS ENGLAND DRAFT OPERATIONAL PLAN 2014/15 AND EMERGING STRATEGY UPDATE **Appendix E Page 83**

David Sharp, Director, Leicestershire and Lincolnshire Area Team, NHS England, to submit a report on the Draft Operational Plan 2014/15 and Emerging Strategy update.

9. QUALITY PREMIUM REQUIREMENT - INCREASED REPORTING OF MEDICATION INCIDENTS **Appendix F Page 187**

Dawn Leese, Director of Nursing and Quality, Leicester City CCG to submit a report on the Quality Premium Requirement – Increased Reporting of Medication Incidents.

10. PEER CHALLENGE REVIEW FEEDBACK

The Chair to provide a verbal update on the feedback received on the Peer Challenge Review.

11. ANNOUNCEMENTS

Members of the Board to make announcements, if appropriate, on topics of current interest.

12. QUESTIONS FROM MEMBERS OF THE PUBLIC

The Chair to invite questions from members of the public.

13. DATES OF FUTURE MEETINGS

To note that future meetings of the Board will be held on the following dates:-

Thursday 3 July 2014
Thursday 9 October 2014

Meetings of the Board will be held in the Council Chamber, 1st Floor Town Hall, at 10.00am unless stated otherwise on the agenda for the meeting.

Appendix A

Leicester
City Council

Minutes of the Meeting of the
HEALTH AND WELLBEING BOARD

Held: THURSDAY, 30 JANUARY 2014 at 10.00am

Present:

Councillor Rory Palmer (Chair)	–	Deputy City Mayor, Leicester City Council
Professor Azhar Farooqi	–	Co-Chair of the Leicester City Clinical Commissioning Group
Dr Simon Freeman	–	Managing Director, Leicester City Clinical Commissioning Group
Chief Inspector Bill Knopp	–	Leicestershire Police – attending on behalf of Chief Superintendent Rob Nixon
Elaine McHale	–	Interim Strategic Director, Children's Services
Councillor Rita Patel	–	Assistant City Mayor, Adult Social Care
Philip Parkinson	–	Healthwatch Leicester – Interim Chair Healthwatch Leicester
Tracie Rees	–	Director of Care Services and Commissioning, Adult Social Care, Leicester City Council
David Sharp	–	Director, Leicestershire & Lincolnshire Area Team, NHS England
Councillor Manjula Sood	–	Assistant City Mayor (Community Involvement), Leicester City Council
Deb Watson	–	Strategic Director Adult Social Care, Health and Housing, Leicester City Council

Invited attendees

Lorraine Austen	–	Head of Community Health Services, Leicestershire Partnership NHS Trust (LPT) – attending on behalf of Dr Peter Miller, Chief Executive of LPT
Councillor Michael Cooke	–	Chair Leicester City Council Health and Wellbeing Scrutiny Commission
Dr Durairaj Jawahar GP	–	Chair, Millennium Locality, Leicester City Clinical Commissioning Group
Dr Rajesh Kapur GP	–	Locality Chair, Leicester City Central, Leicester City Clinical Commissioning Group
Kate Shields	–	Director of Strategy, University Hospitals of Leicester NHS Trust (UHL) – Attending on behalf of John Adler, Chief Executive of UHL

In attendance

Graham Carey	–	Democratic Services, Leicester City Council
Sue Cavill	–	Head of Customer Communications and Engagement - Greater East Midlands

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42. WELCOME AND INTRODUCTIONS

The Chair welcomed everyone to the meeting and asked Board members and those attending by invitation to introduce themselves.

He also welcomed members of the public and the representatives of the Local Government Association Peer Review Team who were attending to observe the meeting as part of the current Peer Challenge Review.

43. APOLOGIES FOR ABSENCE

Apologies for absence were received from Chief Superintendent Nixon, Leicestershire Police.

Professor Farooqi, Co-Chair Leicester City Clinical Commissioning Group had indicated he would be delayed by another engagement and might arrive late.

44. DECLARATIONS OF INTEREST

Members were asked to declare any interests they might have in the business to be discussed at the meeting.

Councillor Sood declared an Other Disclosable Interest arising from being Chair of the Leicester Council of Faiths and having family members who received social care services.

In accordance with the Council's Code of Conduct, these interests were not considered so significant that they would prejudice Councillor Sood's judgment of the public interest and she was not, therefore, required to withdraw during any discussion involving those items on the agenda.

45. MINUTES OF THE PREVIOUS MEETING

RESOLVED:

that the Minutes of the previous meeting of the Board held on 8 October 2013 be confirmed as a correct record.

46. BETTER CARE FUND

The Managing Director, Leicester City Clinical Commissioning Group and the Strategic Director, Adult Social Care and Health jointly submitted a report on the plan for the Better Care Fund in Leicester City.

The Integration Transformation Fund announced in June 2013 as part of the government's spending round has subsequently been renamed the Better Care Fund (BCF).

The BCF would be a pooled budget of £3.8bn nationally, in part top sliced from NHS budgets in 2015/16, to be spent on health and social care with the aim of driving closer integration, encouraging efficiencies and improving outcomes for patient and service users. The funding would be £23.261m for Leicester and was a combination of new and existing funding streams.

To access the funding it would be necessary to produce and agree a draft local plan by 14 February 2014 detailing how local services would change across health and social care. The local authority and Clinical Commissioning Group must also jointly agree the plan which then has to be signed off by the Board. A further submission of the plan would be required in April 2014.

It was noted that the draft BCF plan submitted with the report would be supplemented with finance templates prior to submission. The plan had been produced within short timescales, as guidance had only been issued shortly before Christmas. Further work to refine the detail of delivering the vision and principles set out in the plan had continued since the Agenda for the meeting had been published and would continue to be developed as the Plan moved towards implementation.

In essence the BCF sought to :-

- Integrate NHS and social care services to keep people well and enable them to stay in the community longer without the need for hospital admissions or long term residential care and thereby promote independence.

- Services would need to be re-shaped and adapted to identify health issues earlier so that intervention measure could be taken to reduce hospital admissions and reduce attendance at A&E departments.

- The funds would be used to extend the scope and capacity of existing services such as the Integrated Crisis Response Service that currently provided a 2 hour response and support from community nurses and/or social care staff for up to 72 hours in urgent situations. The Leicestershire Partnership NHS Trust (LPT) had 10 community service teams aligned to specific GP practices. The Council currently had 3 Social Care Locality Teams and these were being remapped to align with the same 10 areas as the LPT team which will provide better integration with the other health teams working in a locality.

- Four work streams had been identified within the plan to develop and achieve its aims. There were :-

    - Citizen Participation and Empowerment
    - Wider Primary Care, Provided at Scale
    - A Modern Model of Integration
    - Access to Highest Quality Urgent And Emergency Care

- The BCF proposals removed significant funding from the CCG baseline budget for 2015/16 and savings would need to be found elsewhere to compensate for this. For example, emergency admissions to hospital had been held at 2008/09 levels but these would now need to be reduced by a further 15%.

- The GPs' role in developing enhanced services under the proposals would also be vital to achieving the BCF aims, as would the impact upon the acute health services delivered by University Hospitals of Leicester, NHS Trust (UHL).

Kate Shields, Director of Strategy, (UHL) (attending the meeting on behalf of the Trust's Chief Executive) stated that UHL supported the philosophy and principles of the Plan and, having examined the current proposals, UHL believed at this stage, that the changes could be delivered. Health staff would need to be engaged and supported in discussions involving workforce skills and cultural changes to delivering services. UHL felt that monitoring the impact of the changes would be essential through tight performance monitoring during the new contracts to ensuring that services were being maintained at satisfactory and safe levels, and to enable funds to be moved to where they were needed. It was also noted that new approaches to risk sharing would need to be agreed so that increases in community based services properly support decreases in hospital based services.

Lorraine Austen, Head of Community Health Services, Leicestershire Partnership NHS Trust (LPT) (attending on behalf of the Trust's Chief Executive) confirmed that LPT were working closely with social care services to achieve the required co-ordinated and integrated working relationships to deliver the changing services. Additional staff were being recruited within tight timescales to ensure that the extended community services could be delivered.

The effect of the BCF from patient's perspective should be:-

- A significant enhancement of primary care services offered through GPs and made available locally;

- Better care in the community through more joined-up arrangements and more care closer to the patient's home;

- Due to the City's younger age profile, the rapid community response would be targeted at over 60 year olds to reduce hospital admissions. Patients over 60 years old with dementia would also be included, together with 18-59 years olds with 3 or more long term health conditions.

- The success of the proposals would also need the understanding, goodwill and co-operation of the patients themselves as the users of the service, and the transitions required for patients to attend and be supported through primary and community care services rather than acute hospital services would not be without challenges.

- Patients expectations needed to managed and it should be recognised that it may take some time to see the benefits from the new arrangements.

A member of the public also requested that family members and carers should be involved in consultations on Mental Health services as changes in these services could affect their wellbeing as well as those of patients. The Board noted this viewpoint.

Philip Parkinson, on behalf of Healthwatch commented that Healthwatch supported the proposals and the draft plan had been shared with the Healthwatch Board in the previous week. There were many examples of good collaborative working that had taken place and the integrated care proposals were welcomed. He emphasised the need to continue to engage with the many and varied groups involved in health issues in the voluntary and community sector and he welcomed Healthwatch's continued involvement in developing and implementing the proposals.

The Chair invited comments and questions from the public and the following responses were given:-

- The funding for the BCF Plan was a mixture of transfers from existing funds in the health economy and an extra £7.3m investment in new measures. Approximately £11m of these funds were being top sliced from the CCG.

- The CCG budget for 2014/15 was approximately £381m (3.2% increase), which was one of the largest settlements per capita, to reduce the difference between Leicester's health performance indicators compared to the national averages. The budget would rise to approximately £393m in 2015/16 (2.84% increase). However, savings would still need to be found as these increases were still below the underlying rate of inflation in the health economy.

- The concerns over undertaking comprehensive risk assessments on the proposed changes in the delivery of services to ensure quality of care were understood. Not all risks could be identified in advance as some would emerge as the new processes were implemented but these would be addressed at that stage. It should be recognised that some existing services were under pressure and needed to be delivered earlier or in such a way as to provide better care at a cheaper cost.

The Chair thanked everyone for their contribution to the discussions and felt that everyone recognised the risks that were expressed by the public but every organisation represented on the Board was determined to achieve the aims of the BCF proposals and to improve health service delivery to the patient. Further discussions would be held as the Plan progressed in detail and relevant groups were consulted. He also felt Healthwatch would play a major

part in scrutinising the proposals and ensuring patients' views were represented, and the Council's Health and Wellbeing Scrutiny Commission would also have a role in undertaking scrutiny of the process.

RESOLVED:

1) that the Better Care Fund plan be approved for submission to NHS England on 14 February 2014 and that the Chair (Deputy City Mayor), Simon Freeman (Managing Director Leicester City Clinical Commissioning Group) and Andy Keeling (Chief Operating Officer, Leicester City Council) be given delegated authority to make any subsequent amendments and approve the plan for final submission;

2) that a further report on the Better Care Plan including clarity on assurance arrangements be submitted to the next Board meeting in April; and

3) that the appropriate work stream take note of the comments made in relation to communications and engagement and incorporate voluntary and carers organisations within communications and engagement arrangements.

47. URGENT CARE

The Managing Director, Leicester City CCG and Kate Shields, Director of Strategy, University Hospitals of Leicester NHS Trust (UHL) gave a verbal update on Urgent Care.

The Board noted that:-

- The previous poor performance level of the UHL A&E Department had been reported to the Board on previous occasions together with the reasons for this.

- Much work had been undertaken with partners and stakeholders to improve the performance of 'flow-throughs' at the A&E Department and through in-patient processes within UHL

- There had now been a considerable improvement in the performance levels since Christmas and UHL had improved its position from 107th out of 151 acute health trusts to 54th.

- Improvements had been achieved as a result of a wide range of measures including better arrangements for accessing services over week-end periods and 7 day working among more staff than usual at UHL.

- UHL were now achieving the standard of 95% of A&E patients being seen within 4 hours three to four days per week but more work was still required to sustain and improve this performance.

- UHL had introduced a 'super-weekend' initiative to anticipate predicted increased pressures and demands on A&E. Partnership working arrangements had been put in place with local authorities, LPT, CCGs and EMAS to ensure that the anticipated demands could be addressed. As a result of these co-ordinated arrangements the performance level had reached 99% for the 4 'super weekend' days involved. This success needed to be developed further to achieve this level performance on a regular basis. It was noted that system-wide 7 day working is part of the Better Care Fund plans discussed in the previous item.

The Chair concluded that this represented a real test of partnership working arrangements and welcomed the commitment to maintain and improve the performance levels.

RESOLVED:

that the update be noted and that staff in clinical care and social care services be thanked for their contribution to these improvements in performance under difficult circumstances.

48. NHS PLANNING GUIDANCE - EVERYONE COUNTS

The Managing Director, Leicester City Clinical Commissioning Group submitted a report on the NHS Planning Guidance – Everyone Counts for 2014/15 to 2018/19.

The planning guidance for 2014/15 to 2018/19 had been received from NHS England. The guidance entitled "Everyone Counts: Planning for patients 2014/15 to 2018/19" built on the previous planning guidance published in 2012 "Everyone counts: Planning for patients 2013/14". It also reviewed the recommendations from the "Call to Action" paper published in July 2013.

The guidance set out how NHS England proposed that the NHS budget would be invested so as to drive continuous improvement and to make high quality care for all, now and for future generations, into a reality.

The four sections of the guidance was summarised in the report together with the action that were required. The four sections were:-

- Ambitions
- Strategic and Operational Planning Process
- Financial Allocations
- Planning Templates for completion

It was noted that as part of the Strategic and Operational Planning Process, the CCG was required to submit a two year operational plan which must be explicit in dealing with the financial gap including appropriate risk management strategies. This plan has been prepared and circulated to all contributors. The draft plan was required to be prepared by 20 January and submitted by 14

February for further consideration before the final plan was submitted in April together with the first draft of the 5 year Strategic Plan for Leicester, Leicestershire and Rutland. The final submission of the 5 Year Strategic Plan would be in June 2014.

Elaine McHale commented that there was no reference to children in the guidance and Simon Freeman stated that the CCG would be commissioning Special Educational Needs services in 2014/15 and he would discuss this further with her after the meeting.

Philip Parkinson referred to the allocations for Health Tourists and expressed concerns that this would present financial challenges to the CCG as the costs for providing health services to this group fell heavily on the CCG with acute services in their area (i.e. Leicester City). Leicester City CCG could therefore be responsible for providing these services for tourists visiting areas outside of Leicester but which were within the catchment area for treatment at UHL. He was collecting information on the likely impact of this and would be submitting it to NHS England and the government.

Following discussion it was noted that 'Health Tourists' were citizens from outside the EU who travelled to this country and were not registered to receive services from the NHS.

David Sharp commented that the allocation to CCG's for this element of health service provision would not be increased by the Local Area Team even if the proportion of tourists rises. The issues could only be addressed by a national and not a local response.

It was also noted following a question from a member of the public, that the CCG allocation was based upon resident population figures derived from the Office of National Statistics, estimated to be 350,000 for the City in 2015/16.

RESOLVED:

1) that the report be received and the timescale for submission of plans be noted; and

2) that the CCG's 2 Year Operational Plan be provided to the Board after it had been formally submitted on 14 February 2014.

49. NHS ENGLAND COMMISSIONING INTENTIONS

The Director (Leicestershire and Lincolnshire Area) NHS England submitted a report on NHS England's Commissioning Intentions for 2014/15. In addition the Prescribed Specialist Services Commissioning Intentions 2014/15 -2015/16 and NHS Public Health Functions Agreement 2014/15 were also submitted for information.

The report summarised the Commissioning Intentions published by NHS England nationally for the services which it is responsible for commissioning.

NHS England were not producing Area Team specific Commissioning Intentions but were issuing a national set of principles and expectations to deliver equity of access to good quality services for the whole population.

Although Area Teams would not issue their own commissioning intentions, they may issue guidance to providers on local contracting arrangements or operational management.

NHS England's intentions for commissioning specialised services were outlined in the Prescribed Specialist Services Commissioning Intentions 2014/15 - 2015/16 and this document served notice to all providers of specialised services in England and would be supported by further technical guidance to outline which specialised services would be commissioned by NHS England and which would be commissioned by Clinical Commissioning Groups.

The NHS Public Health Functions Agreement 2014/15 set out the agreement between the Secretary of State for Health and NHS England which enabled NHS England to commission certain public health services, such as national immunisation programmes, to drive improvements in public health. The Agreement also set out the outcomes to be achieved and arrangements for funding from the public health budget.

It was noted that there was no requirement to issue Commissioning Intentions for the 4 primary care contractor groups. The regulations governing the relationship between NHS England, pharmacists, dentists and optometrists were regularly reviewed and any amendments would be published on the NHS website. Commissioning Intentions for Health and Justice and Military and Veteran Health had not yet been published but Area Teams would continue to work with all partners across the system to review existing commissioning arrangements.

It was noted that the impact for the City, UHL and LPT would be:-

- 40% of UHL's and LPT's budgets were affected by the proposals;
- NHS England would publish its plan in response to the recently published UK Strategy for Rare Diseases in February 2014.
- There would be a systematic market review for all services to ensure the right capacity is available, consolidating services where appropriate to address clinical or financial sustainability issues.
- The Cancer Drug Fund would continue to be managed as part of the prescribed service single operating model and Trusts needed to have a process in place to ensure that the Cancer Drug Fund application was part of the decision making process so that patients were registered before treatment started.
- The strategic direction in the Guidance would lead to clinical

services being concentrated into fewer sites to achieve clinical safety. This would lead to a much clearer relationship in specialised services between UHL and Nottingham University Hospitals to achieve the objectives of safety, clinical sustainability and financial stability.

- The Guidance predicted that the primary care model would need to be re-organised but did not indicate how at this stage.

The NHS Public Health Functions Agreement 2014/15 set out the relationships and responsibilities of the various national bodies responsible for commissioning services. It also outlined changes to specific programmes and set out clear service specifications and outcome indicators for each programme. It also set out the commitment to transfer children's public health services from pregnancy to age 5 to local authorities from 2015.

During discussion the Board members made the following comments:-

- The voluntary sector and carers played a vital part in the provision of primary care services and needed to be involved in any re-organisation of the primary care model.

- If providers of specialised services became more regionalised, safeguards needed to be in place to ensure that services took account of local demographic and diversity profiles.

- Many of the national performance targets set out in the Public Health Functions Agreement were below those already being achieved in Leicester and the Board would not wish the current levels to be reduced. E.g. MMR vaccinations were at 95.8% compared to 91.2% in the agreement, and the World Health Organisation recommended a level of 95%.

In response, the Director (Leicestershire and Lincolnshire Area) NHS England stated:-

- NHS England would use its local knowledge in commissioning services but although this may be seen as local within the East Midlands it would reflect the local needs that existed in Leicester.

- that whilst some of the floor levels of performance targets were below current delivery levels, it was expected that the current levels would be seen as those to be maintained and there was no intention to reduce these or allow them to deteriorate.

- consultations would be carried with national bodies such as Age UK, Alzheimer's Society etc in relation to commissioning and re-organising service provision and it was recognised that there would also be a need to talk to carers and carers groups about the impact of any changes upon them.

RESOLVED:

1) that the report be noted;

2) that the Board would wish to see the continued delivery services at the current, or increased, levels of performance and not at a decreased level; and

3) that the Council's Health and Wellbeing Scrutiny Commission be requested to monitor the public health agreement performance levels on a quarterly basis and refer to the Health and Wellbeing Board any issues where the performance levels fell below the current or required standard.

50. LEARNING DISABILITY JOINT HEALTH AND SOCIAL CARE SELF ASSESSMENT FRAMEWORK

The Director, Social Care Services and Commissioning submitted a report on the Learning Disability Joint Health and Social Care Self-Assessment Framework (JHSCSAF) submitted in December 2013.

It was noted that the JHSCSAF replaced the 'Valuing People Now' Self-Assessment and the Learning Disability Health Self- Assessment. The current format was developed through extensive consultations between November 2102 and March 2013. All local authorities had been asked to complete the self-assessment working with their local partners including the Clinical Commissioning Groups and the closing date for the submission had been 6 December 2013.

The narrative quality data was divided into three headings (Staying Healthy, Being Safe and Living Well) and had RAG ratings – details of which were contained in the report. There were 27 individual ratings of which 5 were Red, 6 were Amber and 16 were Green. Details of the actions being taken to address the 5 Red ratings were outlined in the report.

RESOLVED:

1) that the Joint Health and Social Care Self-Assessment Framework that was submitted in December 2103 be received; and

2) that the recommendations for future work to ensure the Council along with partner agencies are able to meet their legal responsibilities be supported.

51. ANNOUNCEMENTS

The Chair made the following announcements:-

<u>LGA Peer Challenge</u>

The Chair reminded everyone that the Peer Challenge would take place from 11-14 February 2014. He reminded members of the Board that they had been asked to complete a survey in advance of the review and that the closing date for responding to these was 31 January 2014. He also thanked Board members for making themselves available for interviews and focus groups during the Peer Challenge.

Leicester City Council Budget 2014/15

Consultation was currently being undertaken on the Council's budget proposals for 2014/15 and details of the proposals were available on the Council's website. Healthwatch were thanked for their comments on the proposals.

Leicester Safeguarding Adults Board and Leicester Safeguarding Children Boards

It was noted that both Boards had published their Annual Reports. While these Boards were independent of the Health and Wellbeing Board, their work was clearly of interest to the Board. Copies of both Annual Reports would be circulated to Board members together with contact details for the Safeguarding Adults Board and Safeguarding Children's Board offices so that anyone could make comments directly to Dr D Jones, the independent chair of both Boards.

Members of the Board made the following announcements:-

NHS 111

Dr Freeman reported that the GP's Out of Hours Service in Leicester had gone live with NHS 111 since the last meeting of the Board. The transfer had been relatively trouble free and the service was performing well against the contract targets.

Leicester Type 2 Diabetes Prevention Framework

Professor Farooqi reported that Leicester Food Plan as part of the initiative was still being developed.

Fulfilling Lives – A Better Start

Elaine McHale reported that a 2 day event had been held to identify priorities for the next round of the bid submission, the outcomes of which should be known in June 2014.

Healthwatch Leicester

Philip Parkinson reported that Healthwatch had now appointed Karen Chouhan as the permanent Chair, together with 6 Directors of the Board. He had agreed that he would continue to represent Healthwatch on the Health and Wellbeing Board until the Peer Challenge Review had been completed. It was likely that Ms Chouhan would be attending future Board meetings.

As this was Mr Parkinson's last Board meeting, the Chair expressed thanks and appreciation to him for his service and contributions to the Board.

52. QUESTIONS FROM MEMBERS OF THE PUBLIC

The Chair invited questions from the public and following responses were given:-

Question - Adults with Learning Disabilities

Are Further Education Colleges involved in teaching people with Learning Disabilities and does the Council have any involvement with the Colleges?

Response

The Council worked closely with Leicester College to support students in education with learning difficulties so that the support carried on in the community after they left further education.

Question - Purchase Cost of Health and Social Care Services

What proportion of local health services are purchased at national price levels compared to locally agreed prices?

The CCG paid a mixture of tariffs. The national tariff was paid where these existed but there were also a number of services where a national definition for the provision of the service existed but there was no agreed national tariff for that provision. In these instances local service providers and commissioners negotiated an agreed tariff, which represented approximately one sixth of the CCG's commissioning budget.

The Managing Director of Leicester City Clinical Commissioning Group undertook to provide a written response to the question.

In response to comments from the public, the Chair stated that officers would look at publishing the agenda earlier so that the members of the public and Board had more time to digest the information contained in the reports and that officers would also see if it was possible to provide a simpler summary of some of the extensive NHS publications and reports.

He also asked officers to produce a short 'Jargon Buster' guide to the many acronyms used in the health economy.

53. DATES OF FUTURE MEETINGS

The Board noted that future meetings would be held on the following dates:-

Thursday 3 April 2014

Thursday 3 July 2014
Thursday 9 October 2014

Meetings of the Board would be held in the Tea Room, 1st Floor Town Hall, at 10.00am unless stated that otherwise on the agenda for the meeting.

54. CLOSE OF MEETING

The Chair declared the meeting closed at 11.55 am.

Appendix B

LEICESTER CITY HEALTH AND WELLBEING BOARD
3rd April 2014

Subject:	Better Care Fund
Presented to the Health and Wellbeing Board by:	Dr Simon Freeman, Managing Director, Leicester City CCG Deb Watson, Strategic Director, Adult Social Care, Leicester City Council
Authors:	Rachna Vyas, Head of Strategy & Planning, LCCCG Ruth Lake, Divisional Director, ASC, LCC

EXECUTIVE SUMMARY:

The draft Better Care Fund plan was presented to the Health and Wellbeing Board on 30th January 2014. This was supported and submitted to NHS England and the Local Government Association (LGA) in February.

The plan has been refined, following continued dialogue with health and social stakeholders and with the NHS Local Area Team. A self-assessment of assurance was submitted to NHS England and the LGA (date). Feedback has been given, indicating an assessment of medium risk and medium deliverability. Specific comments were made regarding the alignment of the plan to the wider LLR 5 year Strategic Plan, engagement with the acute sector and with General Practice.

The final draft of the plan is attached, for submission to NHS England and LGA on 4th April 2014. Changes from the 1st draft are highlighted in yellow for ease of reference.

RECOMMENDATIONS:
The Health and Wellbeing Board is requested to:

Make any comments and

Approve the Better Care Fund plan, for submission to NHS England / LGA on 4th April 2014.

Better Care Fund planning template – Part 1

Please note, there are two parts to the template. Part 2 is in Excel and contains metrics and finance. Both parts must be completed as part of your Better Care Fund Submission.

Plans are to be submitted to the relevant NHS England Area Team and Local government representative, as well as copied to: NHSCB.financialperformance@nhs.net

To find your relevant Area Team and local government representative, and for additional support, guidance and contact details, please see the Better Care Fund pages on the NHS England or LGA websites.

1) PLAN DETAILS

a) Summary of Plan

Local Authority	Leicester City Council
Clinical Commissioning Group	Leicester City CCG
Boundary Differences	None
Date agreed at Health and Well-Being Board:	30th January 2014
Date submitted:	14th February 2014

Minimum required value of ITF pooled budget: 2014/15	£14,983,000
2015/16	£23,261,000
Total agreed value of pooled budget: 2014/15	£14,983,000
2015/16	23,261,000

b) Authorisation and signoff

Signed on behalf of NHS Leicester City CCG	
By	Dr Simon Freeman
Position	Managing Director
Date	January 30th 2014
Signed on behalf of Leicester City Council	
By	Andy Keeling
Position	Chief Operating Officer
Date	January 30th 2014
Signed on behalf of the Leicester City Health and Wellbeing Board	
By Chair of Health and Wellbeing Board	Rory Palmer
Position	Deputy City Mayor and Chair of Leicester City Health & Wellbeing Board
Date	January 30th 2014

c) Service provider engagement
Please describe how health and social care providers have been involved in the development of this plan, and the extent to which they are party to it

There is a strong, substantial and successful history of collaborative working across health and social care in Leicester, enabled by robust clinical and political support. This culture of meaningful and effective collaboration has already enabled partners in Leicester to make a real difference, notably through the development of a number of schemes and initiatives aimed at reducing health inequalities in the city.

The clear plan presented in this draft builds upon this existing spirit of collaboration and are part of a wider transformation of the services provided to our population. This links directly into the areas we have identified as priorities for improvement across both mental and physical health, which are:

- Effective, high-quality pre-hospital pathways
- Clinically sound and evidence-based hospital pathways
- Efficient, safe post-hospital pathways.

We have worked closely as one health and social care community on these programmes of work, aiming for systemic change that provides the right level of care at every step of the patient pathway. Full and open engagement with partner organisations has greatly informed the specific schemes detailed in this paper. The plan has also had significant input from other stakeholders, members of the public, patients and carers.

Other organisations we have included in the development of our plan, include General Practitioners across Leicester City, East Leicestershire and Rutland CCG, West Leicestershire CCG, Leicestershire Partnership NHS Trust (LPT), East Midlands Ambulance Services NHS Trust (EMAS), University Hospitals of Leicester NHS Trust (Leicester's Hospitals) and Central Nottingham Community Services (CNCS) our GP Out Of Hours provider. We also ensured we involved Local Authority representatives and teams from adult social care services, and Healthwatch has been a vital partner in our planning so far. As we progress our plan, we also aim to engage with the voluntary sector across Leicester City in respect of specific items of delivery.

d) Patient, service user and public engagement
Please describe how patients, service users and the public have been involved in the development of this plan, and the extent to which they are party to it

Our vision for an effective, high-quality, patient-centred system has been formulated alongside detailed engagement with our local population which has informed the solution from inception through development to completion.

Significant engagement has taken place throughout 2013 around our aims for systemic transformation, and we first introduced the concept of the Better Care Fund at our joint Call to Action event on 3 December 2013.

The event, which was aimed at stakeholders, General Practitioners, patients, carers and members of the public from across the city, presented an outline of the Better Care Fund, its national goals and objectives and tasked attendees with identifying and sharing areas for improvement in health and social care. These responses have been used as a basis to inform all Better Care Fund work streams.

The key themes that emerged from the engagement are the importance of carrying out a full assessment of all of a patient's needs, including health, social care and mental health; integrating care into community settings and putting the wishes of the patient at the centre of decision making; all of which have directly influenced the initiatives in this draft plan.

To commence moving our plan into implementation, a further workshop event is taking place in February 2014. This event will seek to validate the priorities identified and explore how we should measure and pay for 'good' and 'excellent' health and social care through our emerging model of Outcomes-Based Commissioning rather than traditional contracting methods.

As part of our longer-term strategic view, Leicester City patients and public representatives also form part of a Leicester, Leicestershire and Rutland Patient and Public Involvement Group, which is currently chaired by a member of Leicester City Healthwatch. This group has been set up to provide citizens' scrutiny of the five-year strategy plan that is being developed for the Leicester, Leicestershire and Rutland Unit of Planning, known locally as *Better Care Together*, and will carry out a similar role for this plan. We will ensure continuing engagement and active involvement with this group as our plans progress.

e) Related documentation
Please include information/links to any related documents such as the full project plan for the scheme, and documents related to each national condition.

The following list is synopsis of some of the key source documents that have informed this submission.

Document or information title	Synopsis and links
Better Care Together – vision/strategy	The Leicester, Leicestershire and Rutland *Better Care Together* five-year strategic plan, due to be completed by the end of 2013-14, will set out our vision for the form and function of the health and social care economy across Leicester, Leicestershire & Rutland. ***To follow***
Joint Strategic Needs Assessment (JSNA)	Joint local authority and CCG assessments of the health needs of a local population in order to improve the physical and mental health and wellbeing of individuals and

	communities. http://www.leicester.gov.uk/your-council-services/social-care-health/jsna/jsna-reports/
Joint Health & Wellbeing Strategy (JHWS)	The Joint Health and Wellbeing Strategy sets out the priorities and actions which the Health and Wellbeing Board are planning to carry out in the period 2013 to 2016 for Leicester City. http://www.leicester.gov.uk/your-council-services/health-and-wellbeing/health-and-wellbeing-board/joint-health-and-wellbeing-strategy/
Draft CCG Operational Strategy 2014-2016	The Operating Plan sets out the Leicester City Clinical Commissioning Group plan for health care commissioning in 2014/15 and 2015/16. It describes our vision and priorities based upon analysis of public health information and listening to our partners and local people. ***To follow***
A Call to Action: Achieving Parity of Esteem; transformative ideas for commissioners	NHS England has established a Parity of Esteem Programme in order to focus effort and resources on improving clinical services and health outcomes by putting mental health on par with physical health. The Parity of Esteem programme provides ideas on how this can be achieved locally. http://www.england.nhs.uk/wp-content/uploads/2014/02/nhs-parity.pdf

VISION AND SCHEMES

a) Vision for health and care services
Please describe the vision for health and social care services for this community for 2018/19.

- What changes will have been delivered in the pattern and configuration of services over the next five years?
- What difference will this make to patient and service user outcomes?

Our core vision

Our core vision, set out in Leicester's Health and Wellbeing Strategy, remains the same:

"Work together with communities to improve health and reduce inequalities, enabling children, adults and families to enjoy a healthy, safe and fulfilling life".

Our vision for a healthier population goes much further than just ensuring people get the right care from integrated, individual services. We want to create a holistic service delivery mechanism so that every Leicester citizen benefits from a positive experience and better quality of care.

At the core of our vision remains a thorough understanding of our population and the health inequalities it faces, which we will achieve better outcomes in the short and medium term.

Context

Life expectancy for Leicester is below the national average, and the health gap between affluent and more deprived areas within the city is significant. Across areas of the city there can be a difference of more than nine years' life expectancy for men and five years for women. Leicester has a high level of poverty and is ranked 25th worst for deprivation out of 326 local authorities in England in the most recent Index of Deprivation (2010). More than two fifths (41%) of Leicester's population live in the most deprived 20% of areas in England and a further 34% live in the 20-40% most deprived areas.

Although the city has a relatively young population, people suffer both physical and mental ill health and die much younger than the national average. This can be directly linked to the impact of the city's deprivation and made worse by health-related lifestyle factors. The main contributors to early death and the gap in life expectancy in the city are Cardiovascular Disease and Chronic Obstructive Pulmonary Disease. Cancer is also a major cause of death in the city but contributes less to the gap in life expectancy between Leicester and England.

Too often the levels of ill health in the city and the current healthcare model results in an over-reliance on acute care. Long-term conditions are detected late, while primary, community care and social care services are not used to their full potential and services are based around the organisation that is providing the service rather than the needs of the individual patient and their carer(s).

With so many factors influencing the health of the city, such as housing, lifestyle factors

and the environment around us, we recognise the need to shape a new collaborative approach to service delivery which puts the patient and their carer(s) at the centre. We want to deliver seamless services that break down the institutional divide between physical and mental health, primary and secondary care, and health and social care. This approach will be built on strong partnerships between local health and social care agencies and the citizens of Leicester, drawing on all expertise, experience and ideas from across the city.

This means that the drivers of use of acute care in Leicester are complex, related as they are both to frail older people (accepting that we have a relatively lower elderly population relative to total population size) and younger people with multiple morbidities. Our approach and plan therefore by necessity covers both of these issues.

Our approach to the development of our core vision

As part of our application to be an Integration Pioneer, a draft vision was developed and agreed for health and social care services in Leicester as part of the Joint Expression of Interest submitted in June 2013 by Leicester City Council and Leicester City CCG.

As this had been jointly agreed, we have chosen this as the basis for our joint work on the Better Care Fund plan. This has taken into account the recent NHS Planning Guidance (*Everyone Counts: Planning for Patients 2014/15 – 2018/19*) as well as what our population has been telling us is most important to them through our engagement events.

Underpinning our core vision are the five categories of outcomes, as set out in the NHS Outcomes Framework. We will use the Better Care Fund as an enabler towards achieving the outcomes in each domain:

Figure 1: The five categories of outcomes in the NHS Outcomes Framework

Across each of these five categories, the NHS Planning Guidance sets out a further set of 10 specific ambitions. Our Better Care Fund plan is designed to enable us to make

measurable improvement towards these ambitions for the citizens of Leicester City. These are described in Table 1.

Changes in the pattern and configuration of services over the next five years

This plan forms an integral and significant part of the Leicester City CCG 2 Year Operational Plan and is the key driver to achieving transformative change within the Leicester City Health and Social Care economy over the next 2 years. Our core priorities are coordinated with our partner Health and Wellbeing Board areas across Leciesterhisre County and Rutland County, taking into account the differences in need, demography and geography through differing delivery methods.

The changes presented in this plan will form the first 2 years of an overarching move towards a new way of working in recognition of the significant capacity and demand issues faced within the local health and social care economy. By 2018/19, it is recognised that there will be a significant financial gap if we do not change the manner in which services across health and social care are provided. Across Leicester, Leicestershire and Rutland this is being progressed through the 'Better Care Together' 5 Year Strategic Plan, of which the 3 local Better Care Fund Plans form a part of.

We recognise then, that this is simply the start of our collective journey. Over the next five years we will continue to work together through the enablement of the Better Care Fund to build a resilient, efficient and wholly integrated system.

Our vision for integrated care and support in Leicester City is built around the definition of integrated care developed by National Voices:

"I can plan my care with people who work together to understand me and my carer(s), allow me control, and bring together services to achieve the outcomes important to me"

Our early citizen participation strategy has informed the principles that underpin our vision for integrated care. These principles form the basis of our Better Care Fund model and will enable improvements towards the ambitions set out in the NHS Planning Guidance. We have aligned the priority areas of our focus to both the national ambitions and our local principles to ensure that the maximum value is gained from the application of our Better Care Fund. This is summarised in the table below:

Table 1: Priority areas, national ambitions and local principles

10 National Ambitions	Local principle	Local Priority area
Improving health – working together with the Health and Wellbeing Board to ensure the key elements of commissioning for prevention are delivered	Access to preventative services is essential to prevent ill health, avoid deterioration in overall wellbeing and achieve greater independence	Prevention, early detection and improvement of health-related quality of life

Increasing the proportion of older people living independently at home following discharge from hospital	Care should be provided in an integrated way with services organised around the patient and the needs for their carer(s) People should have early diagnosis and timely access to services, particularly when in crisis	Enabling independence following hospital care	
Parity of esteem – ensuring patients with mental health problems don't suffer inequalities		Prevention, early detection and improvement of health-related quality of life	
Securing additional years of life for the people of England with treatable mental and physical health conditions	Services that proactively support people to maintain their health, wellbeing and independence for as long as possible should be provided, receiving care in their home and local community wherever possible	Prevention, early detection and improvement of health-related quality of life	
Improving the health-related quality of life of the 15 million+ people with one or more long-term conditions, including mental health conditions		Prevention, early detection and improvement of health-related quality of life	
Reducing the amount of time people spend avoidably in hospital through better and more integrated care in the community, outside of hospital	Acute hospital emergency admissions to be regarded as an exception by all parts of the system	Reducing the time spent in hospital avoidably	
Making significant progress towards eliminating avoidable deaths in our hospitals caused by problems in care		Reducing the time spent in hospital avoidably	
Reducing health inequalities – ensuring the most vulnerable in our society get better care and better services through integration, in order to get better health outcomes	Tackling the wider or social determinants of health is integral to an approach which puts the patient at the centre of care	Prevention, early detection and improvement of health-related quality of life	

Increasing the number of people with mental and physical health conditions having a positive experience of hospital care	Integration will deliver better outcomes for patients and their carer(s), improves care and patient experience	Reducing the time spent in hospital avoidably
Increasing the number of people with mental and physical health conditions having a positive experience of care outside hospital, in general practice and in the community	Services that proactively support people to maintain their health, wellbeing and independence for as long as possible should be provided, receiving care in their home and local community wherever possible	Prevention, early detection and improvement of health-related quality of life

On the basis of these national ambitions and our local principles, our model for integrated care is based on a menu of services for different scenarios in a patient's life, which will provide support from prevention through to end-of-life care. These have been mapped into priority areas for the Better Care Fund, ensuring pathways of care are changed across our whole system:

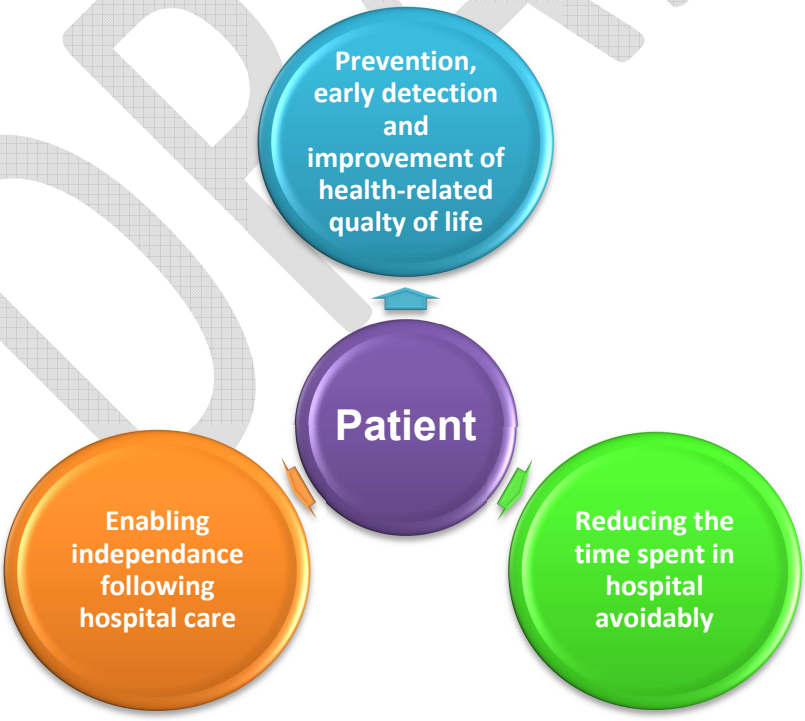

Figure 2: The Leicester City model of integrated care

Schemes under each of these priorities are detailed further in the plan.

In order to ensure the best use of resources, our system integration will be focused on those patient groups likely to derive the most benefit. Data mining has informed this population stratification and fits broadly with what our population has told us, which is:

- Those aged 60 and over
- Those who are 18-59 with three or more health conditions (from a locally defined list of conditions that should be treated out of hospital)
- Those with dementia

For this population, we propose to implement specific services in the following areas:

- Prevention, early detection and improvement of health-related quality of life; services such as risk stratification will target patients at risk of deterioration and hospital admission.
- Services designed to reduce the amount of time people spent avoidably in hospital will prevent those patients in crisis being admitted to hospital; instead they will be treated in their own homes using a better, more integrated community approach, delivered in a holistic fashion.
- Services designed to enable independence following hospital care, such as support to keep patients independent as well as to prevent further avoidable time in hospital where possible.

All three facets of this model are effectively 'wrapped around' the patient in the following manner:

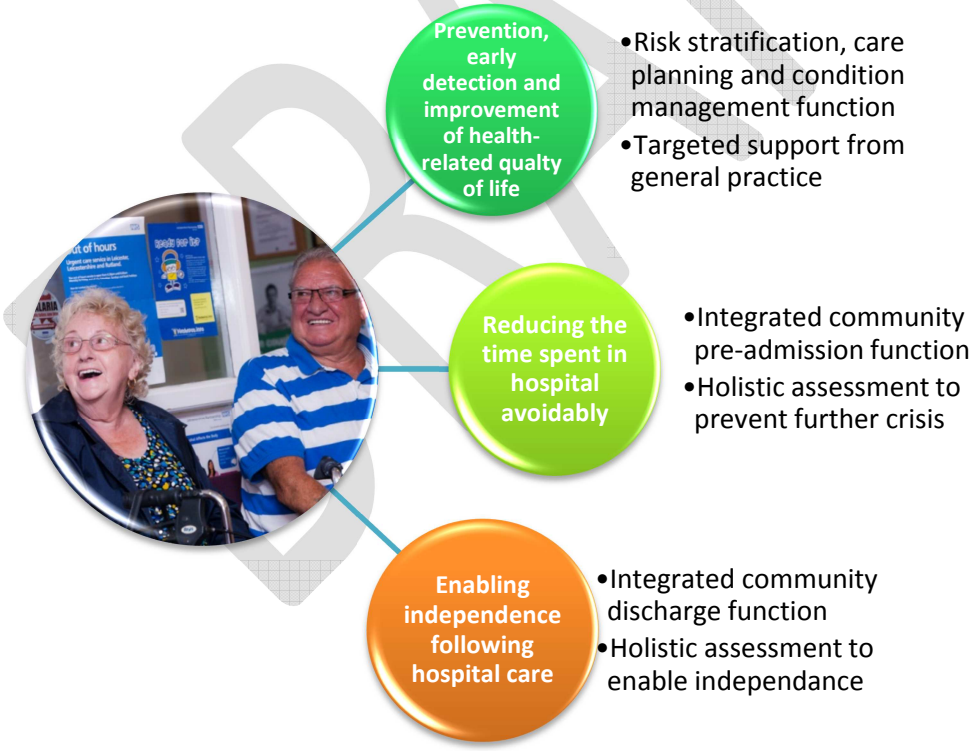

Figure 3: The Leicester City pre- and post-hospital pathway 2014-2016

This integrated model of delivery will enable us to achieve what we set out originally to do: work together with communities to improve health and reduce inequalities, enabling children, adults and families to enjoy a healthy, safe and fulfilling life.

Key enablers of our vision

In practice, our vision for 2015/16 will be enabled by the delivery of the national conditions set out in the Better Care Fund guidance starting in 2014/15. These are described in more detail later in this plan.

We will achieve this improvement through the mobilisation of four transformative work streams, set up as our joint response to the Call to Action issued by NHS England. These will also cover the national conditions underpinning the Better Care Fund:

Table 2: Better Care Fund workstreams

	Work stream	Sub-groups	National condition
1	Citizen participation and empowerment	Listening to patient views	Plans to be jointly agreed
		Delivering better care through the digital revolution	
		Transparency and data sharing	Information sharing/NHS number
2	Wider primary care, provided at scale	Transforming primary care services	
3	A modern model of Integrated Care	Ensuring tailored care for vulnerable and older people	Lead accountable professional
		Care integrated around the patient	Protection of social care
4	Access to the highest quality urgent and emergency care		Seven-day working Implications for the acute sector

Detailed schemes under each of these work streams are described later in the plan.

The national conditions will span a number of work streams above. It is recognised that work stream leads will be required to work collaboratively to achieve the measures of success outlined. Expected outputs from the national conditions are explained fully in the section 'National Conditions'.

What will be different in five years?

This programme is purposely aligned with longer-term strategic change across the

Leicester, Leicestershire & Rutland health and social care economy. This is coordinated through the Leicester, Leicestershire and Rutland *Better Care Together* programme and our plans form a part of the Leicester, Leicestershire & Rutland 5 year Strategic Plan. The Strategic Plan will set out the medium term direction for the models of health, care and support services that will need to apply in five years' time across Leicester, Leicestershire and Rutland (the LLR 'unit of planning' footprint) and the steps needed to realise that vision.

At a local level, by joining up our services from the bottom up, as described in later sections of this plan, we will make a fundamental change in both culture and delivery mechanisms within our local health and social care economy.

There will be a significant shift in activity which has traditionally been delivered through the acute sector to a modern model of integrated care, provided at scale in the community. We expect this new model of integrated care to change patient flows to the extent that in five years, we will have seen up to a 15% reduction in the form and function of the acute sector and a significant growth in the services offered in the community.

This transformative change in form and function, while keeping with each organisation's individual responsibilities, will change the landscape of all future commissioning of integrated care models for our city. We will not let traditional boundaries stop us from progressing towards our vision of whole-scale transformational change.

What difference will this make to our patients and their outcomes?

We recognise that our current model of care provides unaffordable and variable quality of care, placing a high demand on the acute sector. Our resources are concentrated on crisis and statutory services, rather than services designed to keep people independent and there is too large a variation in health outcomes across the city.

Typically, our services are not coordinated in a manner which serves our population. There is confusion about when to use services and access is further hampered by a lack of information sharing between and within organisations. This leads to duplication of effort across agencies and leads to a lack of confidence across the system for citizens and professionals working within the system.

This programme will form part of a wider transformative strategy for Leicester City, delivered through both the CCG and the local authority programmes of change and for the Leicester, Leicestershire and Rutland health and social care economy, delivered through the *Better Care Together* programme. However, our Better Care Fund is the key to begin making a difference and improving outcomes for our patients over the next two years.

This programme will move us towards a long-term, high-quality and affordable model of patient care. It will enable our citizens to remain independent for longer, reduce the time spent in hospital avoidably and enable the health-related quality of life for our citizens to be improved.

The commitment detailed in this plan towards transparency and data sharing will enable better health outcomes and improved patient experience by enhancing access to joint records across organisations. This includes access to personalised health care plans for patients at the end of their life or those with long-term conditions.

We will deliver better care through the digital revolution by harnessing technology and applying it to better the services we offer. This includes a truly single point of access for professionals working within our system, an electronic single assessment process to eliminate duplication and use of telehealth to keep our citizens at home and independent.

We will work with our citizens to ensure access to information and guidance through a digital front door, empowering our citizens to self-manage or access the right service at the right time.

We will assume joint responsibility for this programme by co-designing these pathways with all partners within our system. This will both maximise the potential for change and the success in transforming the system.

Inevitably all of these changes will need to see a significantly changed role for General Practice as co-ordinators and potentially integrators of enhanced community services. This role will need to be defined more accurately as implementation of the model proceeds.

b) Aims and objectives

Please describe your overall aims and objectives for integrated care and provide information on how the fund will secure improved outcomes in health and care in your area. Suggested points to cover:

- What are the aims and objectives of your integrated system?
- How will you measure these aims and objectives?
- What measures of health gain will you apply to your population?

The aims and objectives of our integrated system

Our model is focussed on the cohort of people most likely to derive a benefit from integrated ways of working, which we have identified as older people and those with long-term conditions. Our local definition focuses our programme on those aged 60+ and those aged 18-59 with three or more comorbidities.

We will use the Better Care Fund to achieve our aims:

- To design and commission services centred on our patients, public and carers, with our patients, public and carers.
- To empower our population to be both better informed and better manage their own health and wellbeing using a range of traditional and digital media and technology.
- To develop a new model of primary care that provides a more proactive, holistic and responsive community service across physical and mental health, increasing capacity where required.
- To provide a modern model of integrated care with a senior clinician taking responsibility for coordination of care.
- To reduce the amount of time spent in hospital avoidably by our citizens, by focussing on health and social care pathways and services such as housing.
- To ensure that people are kept independent for as long as possible following

hospital care.
- To provide safe, transparent and open data sharing across our system, enabling proactive coordination of care for our citizens.

We have started our journey towards these aims and have committed to achieving our objectives through the following programme of work:

Priority 1: Prevention, early detection and improvement of health-related quality of life
We will achieve this by:
- Increasing the number of people identified as 'at risk' and ensuring they are better able to manage their conditions, including out of hours, thereby reducing demand on statutory social care and health services. This will include both physical and mental health.
- Delivering 'great' experience and improving the quality of life of patients with long term conditions using available technology and patient education programmes, reducing avoidable hospital stays.
- Enabling the use of the NHS number as a primary identifier for all patients, linked to high-quality care plans for our frail elderly patients or those with complex health needs.

Priority 2: Reducing the time spent in hospital avoidably
We will achieve this by:
- Ensuring every person in the cohort experiences coordinated unplanned and planned care from an integrated team, ranging from health to social care to housing and financial services, which responds in a coordinated way to ensure care is delivered in the community and around the individual. This includes increasing capacity in General Practice.
- Reducing the number of avoidable hospital admissions through the provision of rapid community responses, instead of a 999 response. This will focus primarily on those over 60 years of age.

Priority 3: Enabling independence following hospital care
We will achieve this by:
- Ensuring timely hospital discharge via the provision of in-reach (pull) teams to swiftly repatriate people to community based services and maintain independence.
- Increasing the number of patients able to live independently following a hospital stay.

We will achieve these aims and objectives by utilising the resources of the Better Care Fund and harnessing the will of the organisations involved to mobilise the schemes detailed further in this plan.

Each priority will be delivered through the work streams described earlier in this plan, which are summarised below:

	Priority 1: Prevention, early detection & improvement of health related quality of life			**Priority 2:** Reducing the time spent in hospital avoidably		**Priority 3:** Enabling independence following hospital care	
Objectives:	To increase the numbers of people identified as 'at risk' and ensure they are better able to manage their conditions	To deliver 'great' experience and patient focussed condition control using available technology, reducing avoidable hospital stays;	To enable the use of the NHS number as a primary identifier, linked to high quality care plans for our patients with long term conditions	To reduce the number of avoidable hospital admissions through the provision of rapid community responses;	To ensure every person in the cohort experiences coordinated and planned care from an integrated team which responds in a coordinated way to ensure care is delivered in the community and around the individual;	To ensure timely hospital discharge via the provision of in reach (pull) teams to swiftly repatriate people to community based services and maintain independence	To increase the number of patients able to live independently following a hospital stay
Workstream 1: Citizen Participation and empowerment	Increase our offer of assistive technologies						
	Integrating health and social care systems and data around the NHS number						
	Upscale our routine and service user satisfaction surveys						
	Implement traditional and digitally delivered patient education programmes, and integrating our prevention offer through all agencies						
			Integrating our community health 'single point of access' and our local authority 'single point of contact'.				
	Improve our ability to manage and track outcomes for our population						
	Review all existing services provided under our Integrated Commissioning Programme						

	(including those in Section 256 agreements)						
Workstream 2: Wider primary care, provided at scale	Proactive care plans will be drawn up for our target population, specifically focussing on the 60+ and 18-59 with 3 or more comorbidities						
	Invest in preventative services, such as our new Leicester City Lifestyle Hub						
Workstream 3: A modern model of Integrated Care				Commission a Non-Elective team (NET), comprising of traditionally separate teams of health and social care, as one team, providing one service, 24/7.			
					Increase the capacity of the NET team above to be able increase the offer to support patients being discharged home, 7 days a week		
					Create a network of 10 new joint integrated teams covering all of Leicester City, including General Practice		
					Increase the number of these virtual beds through the life of the Better Care Fund, but commission them specifically for our patients in acute mental health services so that they may step down into community facilities		
				Review and then strengthen our reablement offer across both health and social care providers			
Workstream 4: Access to the highest quality urgent and emergency care				Commission one virtual team of 6 local GPs who will respond to 999 calls deemed clinically appropriate 7 days a week between 8am and 10pm			
				Securing community geriatric support for the whole pre-hospital pathway (covering GP team, Non-Elective Team and Planned Intervention Team as described above)			

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Measures of success for these aims and objectives

These aims and objectives will be evaluated by metrics to capture the key measures of the Better Care Fund:

- Reducing delayed transfers of care
- Reducing emergency admissions
- Improving the effectiveness of reablement services
- Reduce admissions to residential and nursing care homes
- Improving patient and experience.

The sixth measure, required to be identified locally, is:

- Estimated diagnosis rate for people with dementia.

Template 2 of this submission details the baselines which have been agreed as part of this plan, with initial trajectories for improvement set. These will be subject to change until formal agreement at the Better Care Fund Programme Board.

Other measures of success

A further measure of success will be the joint use of patient data. This is expected to be live in June 2014 and will be used a marker of success.

In addition, we will be monitoring more detailed key performance indicators as markers of success. These may include, as examples:

- People in top 5% risk identified and managed via a care plan
- Cohort population with integrated care plan / lead professional
- Reduced unplanned admissions to mental health inpatient beds
- People diverted from statutory services
- Length of stay
- People in receipt of assistive technologies
- Falls reduction in the 65+ cohort
- Setting of death

These have been finalised as part of the mobilisation process with baselines and improvement trajectories agreed by 1 April 2014.

Measures of health gain

Long-term health gain measures will include increased life expectancy and healthy life expectancy. As a subset, having health management plans in place will result in reductions in premature mortality for our population.

c) Description of planned changes

Please provide an overview of the schemes and changes covered by your joint work programme, including:

- The key success factors including an outline of processes, end points and time frames for delivery
- How you will ensure other related activity will align, including the JSNA, JHWS, CCG commissioning plan/s and local authority plan/s for social care

Within Leicester City we have agreed jointly to use the opportunities presented by the Better Care Fund to drive a clinically-led, patient-centred transformative change programme. This will harness the collective views, innovations and ideas of many experienced health and social care professionals as well as the views of our patients and carers. The programme is purposely aligned with longer-term strategic planned change in our acute sector, including the plans of Leicester, Leicestershire and Rutland *Better Care Together* programme.

Work stream 1: Citizen participation and empowerment

We will use the Better Care Fund to:

- Commit to integrating health and social care systems and data around the NHS number to ensure that all health and social care staff who need access to the data can access it to provide better holistic care to our population.
- Increase our offer of assistive technologies, particularly for falls and specific conditions such as COPD and hypertension, so that patients feel safe and remain independent and manage their own health proactively.
- Design and implement both traditional and digitally deliverable patient education programmes to empower our patients to manage their conditions better
- Extend our routine patient and service-user satisfaction surveys to include a wider range of services in health and social care to ensure that any service change we implement is increasing patient and service-user satisfaction.
- Begin the process of integrating our community health 'single point of access' and our local authority 'single point of contact'. In 2014/15, we will enable a warm transfer function to enable health and social professionals to easily access services across both health and social care with one phone call. We will review the potential of this virtual integration becoming a real integration during 2014/15.
- Improve our ability to manage and track outcomes for our population, ensuring that every pound spent on the services described above increase outcomes for our target population as well as returns the most value for our patients.

Work stream 2: Wider primary care, provided at scale

We will use the Better Care Fund to:

- Invest an additional £4 per head of population (subject to approval) in GP services to ensure that our older population is cared for proactively by a named GP and has access to relevant services in General Practice
- Specific condition-management plans will be drawn up for our target

population, ensuring that our patients know how to manage their conditions but also know who to call when they feel the need for additional support, other than 999. This will start with our resident care home population and move onto prioritised population segments using our risk stratification model.

- Bring our preventative services together so that they can be accessible to more people, such as through our new Leicester City Lifestyle Hub, empowering people in our target population to access services such as weight management, STOP smoking services, reduction of social isolation and exercise programmes. This will be directly linked to our hugely popular and successful NHS Health Check programme.

Work stream 3: A modern model of integrated care

We will use the Better Care Fund to:

- Commission a Non-Elective Team (NET), bringing together traditionally separate health and social care teams to provide one service, 24 hours a day, seven days a week. This builds on our successful Integrated Crisis Response Service which has recently been nominated for a Local Government Association award for integrated care. These teams will provide care for patients (and carers, where appropriate) in their own homes for up to 72 hours following a crisis call out with the aim of preventing admissions to hospital and promote independence at home. This will cover both physical and mental health and link to services such as housing, handypersons services and assistive technology.
- Increase the capacity of the Non-Elective Team to increase the offer to support patients being discharged home, seven days a week, preventing any delays in any of our hospitals. Ultimately, this will include mental health crisis services.
- Create a network of 10 new Joint Integrated Teams covering all of Leicester City and including General Practice. These teams will offer holistic planned interventions, keeping people independent at home as well as preventing both physical and mental health crises. These teams will refer into all core offers of health and social care services as well actively link with the voluntary sector services in the city.
- Review and then strengthen our reablement offer across both health and social care providers to patients to promote independence and reduce admissions to care homes.
- Invest in the current Intensive Community Support service which discharges patients home into one of 24 virtual beds. We will look to increase the number of these virtual beds through the life of the Better Care Fund, but commission them specifically for our patients in acute mental health services so that they may step down into community facilities.

Work stream 4: Access to the highest quality urgent and emergency care

We will use the Better Care Fund to:

- Commission one virtual team of up to six local GPs who will respond to 999 calls deemed clinically appropriate, seven days a week between 8am and 10pm. These GPs will assess and stabilise the patient and, where clinically appropriate, not-convey the patient the hospital but treat them in their own home. Basic diagnostic equipment will be part of the service, with access to on-call consultants at the

acute site should further consultation be required. If more complex diagnostics are required, the patient will directly access the Emergency Frailty Unit at the Leicester Royal Infirmary and be discharged home, rather than via a base ward.

- Commission community geriatric support for the whole pre-hospital pathway (covering the GP team, Non-Elective Team and Planned Intervention Team) to ensure that our patients are not admitted unnecessarily and equally, are admitted when clinically appropriate.

Other planned activity:

We plan to review all existing services provided under our Integrated Commissioning Programme (including those in Section 256 agreements) to ensure true value is being released by any investments. This includes services covered by:

- ASC Capital Grants
- Disabled Facilities Grant
- Carers Funding
- Reablement funds

In addition, we recognise that the introduction of the Care Bill will have implications for the Better Care Fund in Year 2, specifically concerning funding pressures resulting from care and support reform. As yet, these have not been quantified and will require further collaborative planning.

We will also continue to strengthen the involvement of our vibrant voluntary sector in the City. A workshop specifically with the voluntary sector has been held to ensure that we harness the expertise within the organisations to enable us to achieve our objectives. The recommendations which resulted from the workshop have been incorporated into our planning, with further input planned through 2014/15.

Application of Equality and Diversity principles

We are committed to ensuring that in developing schemes under the Better Care Fund, we will continue to engage with Leicester's diverse communities to design healthcare services that are appropriate and accessible to all. We will pay 'due regard to equality' when making decisions in line with the Equality Act 2010, but, go beyond simple compliance and work towards achieving the highest rating against NHS England's Equality Delivery System and effective delivery of the CCG and Local Authority equality and diversity strategies.

The current schemes have been fully assessed and local Equality leads are part of the Implementation groups for each scheme.

Indicative timeline

Due to the scale of system-wide change required, we have agreed that locally we will not wait until 2015/16 to mobilise. Many of the schemes listed below are happening as part of planned CCG or local authority work programmes during 2014/15 and 2015/16. We will use 2014/15 to test the proposed Better Care Fund models on a larger scale than would normally be enacted. Priorities will be agreed in consultation with our local health and social care partners according to feasibility and return on investment, and with our local population during planned engagement activity.

Actions completed to date:

Q3 2013-14

- Engagement process with our patients, service users and population to agree end-point outcomes began in October 2013.
- Governance structure to ensure all organisations are signed up to the ambition, scale and pace of the Fund was formulated in November 2013.
- Target population for interventions was identified and agreed in November 2013.
- Agreement reached with frontline staff across organisations about what and how to radically change to meet the aims and objectives for our Integrated Care programme in November 2013.
- A high-impact shortlist was developed from qualitative and quantitative intelligence, and developed into outline cases for evaluation in November/December 2013.

Q4 2013-2014

- Detailed activity, finance and workforce implications developed for every scheme under the Better Care Fund programme, including viability of mobilisation timescales, recruitment implications and any procurement implications.
- Further engagement with both patients and service users as well as key stakeholders including Leicester City General Practitioners.
- Approval achieved from all relevant bodies for priority schemes
- Mobilisation of priority schemes begun
- Governance structure agreed and mobilised, with agreed reporting lines and dashboards under further development

Actions planned:

Q1-Q2 2014-15

- Continue Mobilise priority schemes.
- Continue patient and service-user engagement programme.
- Begin Integrated Care Whole Systems programme for data sharing across organisations as Liquid Logic, the new social care IT system, goes live.
- Continue assessment of Outcomes-Based Commissioning model; agree commissioning model and begin commissioning and procurement processes, including detailed system service specification.

Q3-Q4 2014-15

- Begin mobilisation of remaining schemes.

From April 2015

- All schemes to be live, with sufficient monitoring covering activity, outcomes and finance.
- Scope the next stage for the Leicester City Integrated Care pathway.

Our plans, though far-reaching and impactful, form an integral part of the *Better Care Together* programme and align with the overall five-year strategy for the Leicester, Leicestershire and Rutland health and social care economy. Through alignment with this programme, we will ensure no adverse impact is felt in the system as a whole as we implement our plans.

These timescales may change subject to any unforeseen circumstances. However, the

risk of this will be limited by regular briefings to the *Better Care Together* Programme Board.

d) Implications for the acute sector

Set out the implications of the plan on the delivery of NHS services including clearly identifying where any NHS savings will be realised and the risk of the savings not being realised. You must clearly quantify the impact on NHS service delivery targets including in the scenario of the required savings not materialising. The details of this response must be developed with the relevant NHS providers.

The long-term strategic direction of travel for the Leicester, Leicestershire and Rutland health and social care economy has been agreed collectively at the *Better Care Together* Programme Board. The membership of this includes Chief Executives and Lead Clinicians of all agencies across Leicester, Leicestershire and Rutland to ensure that individual organisations' plans, geographically aligned change programmes and all other plans strategically fit together.

The Leicester City Better Care Fund programme will regularly report into the *Better Care Together* programme to ensure that any modelling, in terms of activity reductions or increases, is explicitly understood by all organisations at an executive level as well via individual work streams at ground level.

There is an already established understanding that to achieve the shift of activity from an acute setting into the community will need significant investment in pre-hospital services, in both primary and community care. The Leicester, Leicestershire and Rutland *Better Care Together* five-year strategic plan, due to be completed by the end of 2013-14, will set out our vision for this.

This may include:

- Increasing the community footprint for Leicester, Leicestershire and Rutland
- Improved provision and access to primary care services, including an upskilling of GPs in Leicester City to provide more complex care in the community.
- Downsizing the acute footprint for Leicester, Leicestershire and Rutland

Leicester's Hospitals are currently consulting with their clinical base to assess options for a strategic outline case, looking at options available for the UHL footprint. Leicester, Leicestershire and Rutland CCGs have been an active part of this process and continue to support UHL in this objective.

The schemes detailed in this paper will support any downsizing by significantly reducing activity flowing into Leicester's Hospitals and increasing faster activity flows out. The schemes also enable the requirement set out in the NHS Planning Guidance 2014/15-2018/19 to reduce emergency hospital activity by 15%.

Clinical engagement from Leicester's Hospitals, Leicestershire Partnership Trust and East Midlands Ambulance Service for these schemes has been ongoing through the life of the Better Care Fund and will continue throughout to ensure that the ambitions set out in this paper are owned by the health and social care economy as a whole. We are currently modelling the impact of our schemes in detail, including the impact on estate, workforce and finance across the system.

Since the beginning of 2013/14 UHL have been operating at a financial deficit, which is expected to reach £39.8m by the end of the financial year. UHL has struggled with an unsustainable underlying financial deficit for a number of years, which has been compounded by an escalation in its spending during 2013/14 and some assumptions made by the Trust about income from CCGs and elsewhere which had not been agreed.

Much of UHL's deficit has however been driven by an inability to recruit medical and nursing staff ensuring that this level of support is now at c. £4m per month. Accordingly a reduction in emergency activity at least initially should be mutually beneficial with reductions in income at UHL more than offset by reductions in agency and locum costs and therefore contribute positively to the underlying UHL deficit.

There will inevitably be a point at which further removal of acute work will require UHL to start to reduce resources including physical and human. The scope and pace of this will require further detailed analysis and it is our expectation that there will potentially be a need for transitional support from the 1% transformation fund for UHL during this period.

e) Governance
Please provide details of the arrangements are in place for oversight and governance for progress and outcomes

Shared vision, shared leadership

The delivery of the Better Care Fund builds on a mix of strong existing partnership groups and a new Better Care Fund Implementation Group.

Better Care Fund support function
(Equalities, Finance, Informatics, Governance etc)

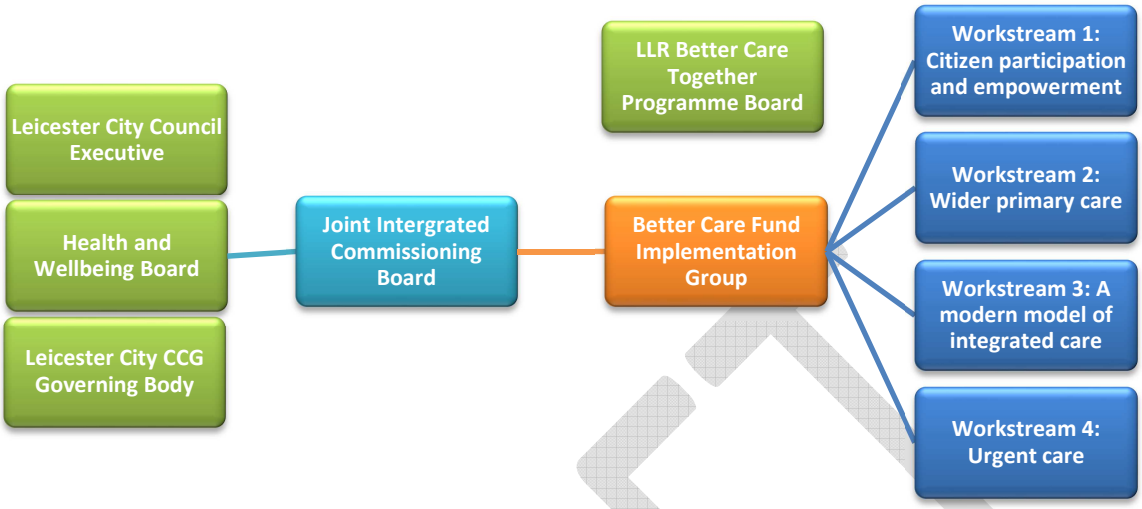


Figure 4: Better Care Fund Programme Structure

The Joint Integrated Commissioning Board consists of executive leaders from the health and social care economy, including the Managing Director of Leicester City CCG, the Director of Adult Social Care, Directors of Finance for the CCG and the local authority as well as clinicians from both the CCG and partner organisations. This Board will oversee the implementation of the Better Care Fund as one of its priority delivery groups.

The delivery of each work stream will be overseen by the Better Care Fund Implementation Group. This will run bi-weekly and be chaired by an Independent Lay member of the CCG. The Implementation Group will be attended by heads of service at both the local authority and partner organisations, and involved teams from relevant functions across the organisations. This will report into the Joint Integrated Commissioning Board for oversight and rapid issue resolution as well as the CCG Performance Executive for active interrogation of the key measures of success outlined above.

Given the collaborative nature of this programme, regular progress reports will also be provided to the LLR *Better Care Together* Programme Board to ensure alignment with the overall strategic direction of travel of the LLR health and social care economy.

Throughout the implementation of the programme, regular checkpoints have been arranged so that key CCG and partner organisation clinicians and elected members can confirm and challenge the overall programme of work.

NATIONAL CONDITIONS

a) Protecting social care services
Please outline your agreed local definition of protecting adult social care services.

Protecting social care services in the Leicester means:

Ensuring that those people with eligible needs within our city **continue to receive the support they require**, in a time of growing demand and budgetary pressures.

Delivering **new approaches to joined up care**, which help people to remain healthy and independent.

By ensuring **proactive interventions to our target population**, to support prevention, self-care and to enable people to tackle the wider determinants of poor health and poor quality of life.

Please explain how local social care services will be protected within your plans.

Funding currently allocated to the Council has been used to enable the local authority to sustain the current level of eligibility criteria and to provide timely assessment, care management and commissioned services to eligible clients. This has also supported the provision of advice, signposting and a range of preventative services to the wider population.

Sustained funding from the Better Care Fund is required to maintain this position, and additional resources will need to be invested in social care to deliver the rapid access services that are required to respond to our agenda to reduce unplanned admissions and admissions to care homes.

A process has been completed which has identified a recommended level of support for social care that both requires Leicester City Council to ensure that it is delivering services in the most cost efficient manner and allows for a fund in 2015/16 with an investment pool equal to the expansion of services needed to meet the required reduction in use of the acute sector.

On the Council side this has seen a projected annual increase in demand for social care against proposed budgets and the profile of cost-efficiency schemes within social care. On the CCG side this has involved an assessment of the numbers and cohorts being impacted in the community, the subsequent sizing of the community teams and therefore the investment needed.

A figure to support social care has now been agreed and will be recommended to the Council executive, CCG Governing Body and Leicester City Health & Wellbeing Board for approval.

b) Seven-day services to support discharge
Please provide evidence of strategic commitment to providing seven-day health and social care services across the local health economy at a joint leadership level (Joint Health and Wellbeing Strategy). Please describe your agreed local plans for implementing seven day services in health and social care to support patients being discharged and prevent unnecessary admissions at weekends.

What we have done so far
There is a local strategic commitment to seven-day working, through the Urgent Care Working Group, in response to the NHS Services Seven Days a Week Forum report. Partners are jointly developing and testing, through 'proof of concept' trials (locally known as 'super-weekends'), seven-day working models based on the recommendations in this report to enable our system to meet the clinical standards as recommended. The first test events ran in January 2014, with all partners across the health and social care system providing weekend service provision.

This builds on the existing enhanced service provision within community health and social care services to facilitate hospital discharge and/or admission avoidance. For example, there are already specific community health and social care services available over the weekend but we recognise that traditionally these have been poorly utilised, both for admissions avoidance and discharge. The test weekends described have proven that a more integrated model of seven-day working across front-line health and social care is vital for a more responsive and patient-centred service.

What we plan to do next
As part of our commitment to deliver seven-day services, we are in the process of agreeing a Service Development and Improvement Plan with our acute and community providers based on our 'proof of concept' trialling. This will be in partnership with the Leicester, Leicestershire and Rutland Urgent Care Working Group.

Our developing Better Care Fund plans include seven-day working (where applicable & feasible) as a standard expectation. For example, the schemes enabled by the Better Care Fund in our plan have all been modelled on a seven-day service expectation. Current mobilisation plans indicate that this will be fully live across the GP First, Non-Elective Team and the Planned Intervention Team in Q2 2014/15 but we expect that some services to expand to seven-day working in Q1 2014/15 where workforce allows across health and social care.

Alongside this, the super-weekends will allow assessment of need within the acute sector to support 7 day working.

c) Data sharing
Please confirm that you are using the NHS Number as the primary identifier for correspondence across all health and care services.

This is currently not in place at Leicester City Council as normal procedure.

If you are not currently using the NHS Number as primary identifier for correspondence please confirm your commitment that this will be in place and when by

What we have done so far
The current IT systems used within social care do not allow for the NHS number to be used as a primary identifier. However, Leicester City Council is committed to doing this and has procured a new social care system to replace their existing systems called Liquid Logic. Liquid Logic will be used within the Council from April 2014 onwards.

What we plan to do next
To ensure that Liquid Logic can use the NHS number as a primary identifier, Leicester City Council have started engagement with HSCIC to ensure appropriate procedures are in place to have access to the NHS number. The Council will apply, as a commissioner, to the HSCIC for the NHS numbers in order to populate the new care system shortly after its live launch. Role based access control will be in place and all staff will be trained to use the NHS number. The NHS number as primary identifier is expected to become standard procedure by June 2014.

All future information sharing agreements between the Council and health partners will include the NHS number as a specific piece of data that is required.

Please confirm that you are committed to adopting systems that are based upon Open APIs (Application Programming Interface) and Open Standards (i.e. secure email standards, interoperability standards (ITK))

Leicester City Council is firmly committed to adopting systems that are based upon Open APIs and Open Standards (i.e. secure email standards, interoperability standards (ITK)). Any new systems that are procured for health and social care will have this as a core requirement. This will allow greater interoperability between systems and allow for greater electronic sharing of information.

The first step in the process has been to procure a new social care system (Liquid Logic). Liquid Logic has the ability to communicate and interoperate with health's IT systems. Once installed, the Council will work with health partners to ensure that information flows between health and social care are carried out electronically, securely and safely by using national standards.

The Council is currently a member of the NHS LLR IM&T Strategy Board. A key objective of this Board is to look at opportunities of sharing and using information better between various organisational systems to improve patient care. Open APIs, Open Standards and ITKs are reviewed as part of any new solution that the Board take forward.

Please confirm that you are committed to ensuring that the appropriate IG Controls will be in place. These will need to cover NHS Standard Contract requirements, IG Toolkit requirements, professional clinical practise and in particular requirements set out in Caldicott 2.

Leicester City Council, Leicestershire Partnership NHS Trust and Leicester's Hospitals are signed up to the Leicestershire information sharing protocol which sets out the minimum standards expected from secure transfer of personal data (e.g. secure email, encryption, pass worded documents, registered post, secure FTP transfer). Newly formed health organisations such as the CCG and Greater East Midlands Commissioning Support Unit (GEM) are currently being invited to sign up.

Where data sharing takes place between these organisations written information sharing agreements are put in place. The county-wide Leicestershire Strategic Information Management Group are currently producing security standards for all partners in the county to adhere to when sharing information based on these standards.

We can confirm that we are committed to ensuring that the appropriate IG Controls will be in place. The existing county-wide information sharing protocol already introduced robust information governance standards across the county and followed Caldicott principles where health data was involved.

An information sharing protocol has been drafted between partners to cover all aspects of information sharing as part of the Better Care Fund. Individual information sharing agreements will be implemented for data sharing relating to the Better Care Fund.

All partners are committed to reviewing their relevant IG policies and fair processing notices to reflect the Caldicott 2 recommendations, and future information sharing agreements will reflect this. Leicester City Council's public health team has attained level 2 of the NHS IG Toolkit.

Leicester City Council last year introduced mandatory online data protection training for all staff, and annual refreshers will be implemented in April 2014. This, combined with the newly procured social care system, will enable Leicester City Council to achieve NHS IG Toolkit Level 2 compliance in its adult's and children's social care services from April 2014 onwards.

The Council has a named Caldicott Guardian within the organisation. The Guardian plays a key role in ensuring that the Council with social services responsibilities and partner organisations satisfy the highest practical standards for handling patient identifiable information. The Guardian actively supports work to enable information sharing where it is appropriate to share, and advises on options for lawful and ethical processing of information.

d) Joint assessment and accountable lead professional
Please confirm that local people at high risk of hospital admission have an agreed accountable lead professional and that health and social care use a joint process to assess risk, plan care and allocate a lead professional. Please specify what proportion of the adult population are identified as at high risk of hospital admission, what approach to risk stratification you have used to identify them, and what proportion of individuals at risk have a joint care plan and accountable professional.

We can confirm that local people at high risk of hospital admission will have an agreed accountable lead professional and that health and social care will use a joint process to assess risk, plan care and allocate a lead professional.

The integrated community team model is the result of discussions with CCG GP leads who have discussed and identified what is required to improve the care delivered to those at most risk of admission. The proposal takes a number of disparate teams, including some non-recurrent pilots – and brings them together into an integrated model that deals with both step-up and step-down caseloads. The teams will be expanded where necessary and, based upon robust evaluation; the effective non-recurrent elements will be funded recurrently. Further discussions are taking place at locality meetings to engage with the wider practice membership. Clearly the central role of the practice as integrators of care will need to be discussed further and supported.

The approach to risk stratification we have used to identify patients at high risk of hospital admission

What we have done so far:

Leicester City CCG has supported practices in using the Adjusted Clinical Groups (ACG) risk predictive software (licenced from Johns Hopkins University in the USA) to risk stratify their registered population and identify those at highest risk of admission to hospital in the next year. We have invested in this to enable our practices to proactively identify patients at high risk of admission and apply a Multi-Disciplinary Team approach to their care.

What we will use the BCF to do next:

We are working with Greater East Midlands Clinical Support Unit and practices to complete this work by the end of April 2014. It is anticipated that by this time all 63 practices across Leicester City will be actively using the Risk Stratification tool to manage their high risk patients.

We have also committed to developing the functionality of this system further, specifically to areas such as medicines management, our care home population and in disease areas associated with frailty.

It is recognised that recorded disease prevalence in some areas is below expected prevalence. 98% of our practices use the SystMone clinical system. We have invested in a clinical system facilitator who supports practices in training, development and the design of clinical templates. This leads to a consistent approach to coding and is helping to increase accurately recorded disease prevalence across the City.

Proportion of the adult population identified as at high risk of hospital admission

What we have done so far:

Using the Adjusted Clinical Groups (ACG) risk predictive software, this is approximately 7,200 people or 2% of the 360,000 residents of the city. We are working with our practices to implement proactive, holistic and responsive services for those patients identified using our RS model.

What we will use the BCF to do next:

The BCF proposal is designed to complement the new DES that is coming into effect in 2014/15, which is focused upon the avoidance of unnecessary admissions in vulnerable people.

Using our local population definition of those aged 60+ or 18-59 with 3 of more comorbidities, a further modelling exercise will take place with practices in July 2014. This will result in a targeted cohort of patients identified as high risk of admission with specific services available to support these patients. In partnership with our General Practices, our 'Planned Intervention Team' will be key to managing both the health related aspects of care required by these patient but also the social care required to manage the patient care in the community and to keep the patient independent. A care navigator will support the clinical lead in identifying the most appropriate service elements for their patient.

What proportions of individuals at risk have a joint care plan and accountable professional

What we have done so far:

Leicester City CCG has a running programme for the provision of high quality, personalised care planning, based upon a SystMone template.

We have, in partnership with NHS England, implemented a Direct Enhanced Service, which incentivises our General Practices to apply the risk stratification system to their population and provide multi-disciplinary assessment and care for those patients identified as being at highest risk.

We have prioritised our frail elderly population, recognising that these patients are at high risk of admission, committing to providing every care home resident in the City with a personalised care plan by March 2014 through a newly commissioned 'Emergency Response Service'. This is a team of GP's who construct care plans for this target population, in partnership with all agencies involved in the patient's care.

By the end of 2013/14, this will result in the following:

1. Approximately 562 personalised care plans for patients at the End of Life
2. Provision of a holistic health and social care assessment, including care planning where required for a further 2100 patients
3. GP led MDT assessment, including care planning where required for a further 800

patients

What we will use the BCF to do next:

As part of our CCG Operating Plan 2014-2016, we have a commitment to ensuring that all patients over 75 registered in Leicester City have a named GP and those at high risk within this cohort will have a joint health and social care plan to enable proactive care management, integrated around the patient.

We will also aim to introduce the same methodology to our target cohort of patients (over 60 years and 18-59 with 3 or more comorbidities); this will involve prioritising our high risk patients from this cohort and provision of a personalised care plan where required. This is a longer term strategic commitment, delivered on a phased basis and driven by the risk predictive scores of the population.

2) RISKS

Please provide details of the most important risks and your plans to mitigate them. This should include risks associated with the impact on NHS service providers

The table below provides an overview of some of the key risks identified through the co-design process to-date. A full risks and mitigations log is being produced in support of our finalised Better Care Fund submission.

Risk	Risk rating	Mitigating Actions
UHL are already in a deficit position; non-delivery of these schemes will effectively push all organisations into deficit	High	Explicit agreement will be made with UHL regarding the expected impact (activity and finance) of this programme.
Poor practice across the urgent care system will effectively render all efforts of this programme null as any activity/finance reductions made will simply be replaced with other activity or changes in coding practice	High	The Better Care Fund Programme Board will work in partnership with both *Better Care Together* and Urgent Care Working Group to ensure delivery of this programme. Much improvement has been seen in 2013-14 and we will commit to working together on further improvements from 2014 onwards.
The shift to integrated working will require a whole scale change in culture and process across numerous organisations. Implications of this shift will be significant for workforce, finance, operations, and clinical governance	High	Clinical and operational credibility will take time to build. Using a bottom-up process of staff engagement on a weekly basis, the initial phases of the schemes will be fluid and take staff feedback into account. As the project progresses, organisational implications will continue to be mitigated at the Programme Board.
The speed at which we are mobilising these new services and systems is rapid.	High	In order to realise the potential of this model in 15/16, it is imperative that this system gains credibility in 14/15 and therefore requires rapid mobilisation. Risks will be mitigated by a resilient Programme Board and delivery sub-structure along with both provider and commissioner organisations releasing staff to mobilise this system safely and
Clinical buy-in, especially from the acute sector, is imperative for success. Historically, this has been a block to success	High	CCG GP leads will form a clinical oversight group, with key clinicians from both acute and non-acute providers to ensure a clinically led process from the outset. The Integrated Care Operational Group will involve clinicians from all organisations from

		the outset to provide a clinically-credible model of care.
The introduction of the Care Bill, currently going through Parliament and expected to receive Royal Assent in 2014, will result in a significant increase in the cost of care provision from April 2016 onwards that is not fully quantifiable currently and will impact the sustainability of current social care funding and plans.	High	The Leicester City Better Care Fund Programme Board recognise this and will collaboratively work towards mitigation of this risk
Capacity within Primary Care, particularly in General Practice, is already stretched. This scheme must complement the schemes already in place.	High	The integrated care pathway for LC will effectively add capacity within primary and community care services. We will work with General Practice to ensure that the pathway agreed is clinically compatible with schemes running in General Practice.

Appendix C

Leicester City Council

LEICESTER CITY HEALTH AND WELLBEING BOARD

3rd APRIL 2014

Subject:	**Update on the Progress of the Joint Health and Wellbeing Strategy**
Presented to the Health and Wellbeing Board by:	**Deb Watson**
Author:	**Adam Archer**

EXECUTIVE SUMMARY:

This report presents information on progress in delivering the Joint Health and Wellbeing Strategy: 'Closing the Gap'. Responsibility for ensuring effective delivery of this strategy has been devolved to the Leicester City Joint Integrated Commissioning Board (JICB).

This is the second bi-annual progress report to the Health and Wellbeing Board. It serves two related purposes: providing assurance that actions identified in the strategy are being delivered and/or flagging up any potential risks to delivery; and, reporting on the performance indicators set out in Annex 2 of the strategy.

This is a high level monitoring report, it acknowledges that both the actions and performance indicators in the strategy are subject to separate monitoring and reporting through the governance arrangements of those partner organisations coming together through the Health and Wellbeing Board.

Progress can be seen in each priority area and there are positive performance trends for at least some of the measures tracking progress in every area. While improvements can be seen against specific measures, it is still very early to judge where the desired impact on the health and wellbeing of the city's residents is being made overall.

RECOMMENDATIONS:
The Health and Wellbeing Board is requested to:

(i) Note progress on the delivery of the Joint Health and Wellbeing Strategy;

(ii) Identify any areas of concern that require further reporting or remedial action from the JICB;

Update on the Progress of the Joint Health and Wellbeing Strategy

Report on behalf of the Leicester City Joint Integrated Commissioning Board

1. Introduction

This report presents information on progress in delivering the Joint Health and Wellbeing Strategy: 'Closing the Gap'.

The strategy aims to reduce health inequalities, delivering against the five strategic priorities:

- Improving outcomes for children and young people
- Reducing premature mortality
- Supporting independence for older people, people with dementia, long term conditions and carers
- Improving mental health and emotional resilience
- Addressing the wider determinants of health through effective use of resources, partnership and community working

For each priority a number of focus areas are identified, and the strategy includes key performance indicators to measure progress. More data is now available to show progress, with direction of travel indications for 22 of the 25 measures now available.

2. Progress on implementing the actions in the Health and Wellbeing Strategy

The overall approach we have taken to monitoring progress against the actions set out on the strategy has been 'light touch' – in order to give a broad overview of progress, and in keeping with the high level and extensive scope of the strategy itself.

Each of the five strategic priorities of the strategy consists of a number of sub-sections. Strategic priorities 1 to 4 contain 15 sub sections, and we have asked contacts for those sub sections to provide a progress statement and RAG rating on each one. For Strategic Priority 5: Focus on the Wider Determinants of Health, there is just one statement for the priority as a whole, to reflect the more enabling and cross-cutting nature of this priority.

Overall, the RAG ratings that contact people gave to the 16 areas were:

Red	Action is at serious risk of not being delivered.	0
Amber	Some risk that actions may not be delivered but this risk will be managed.	6
Green	Good progress is being made and there are no significant problems.	10

The 16 statements of progress, together with RAG ratings are set out at Appendix 1.

Some of the main achievements to support delivery of the outcomes include:

Teenage pregnancy: The new integrated sexual health service commenced on 1st January 2014. The service is currently reviewing its young people's provision with the intention to extend delivery.

Alcohol: A wide range of work has been done to reduce harmful alcohol consumption, including alcohol awareness week, anti-drink-driving campaigns and dry January. There was improved access to drug and alcohol treatment services and a reduction in alcohol related crime.

Cardiovascular disease, respiratory disease and cancer: The target for NHS health checks has been exceeded, and as a result of these checks 2,892 people were identified as having cardiovascular disease, respiratory disease or cancer and a management plan was put in put in place for them.

Dementia: A wide range of initiatives to support people with dementia continues to be put in place, including a memory assessment pathway and an integrated crisis support service. A hospital based network of dementia champions is being recruited and trained.

Carers: Carers in the city are receiving more support, with more receiving personal budgets, information, training and carer's breaks. A Carer's Charter was launched on National Carer's Rights Day, setting out commitments to carers, and the city council introduced a Carer's Employee Group and Carer's Passport to support employees who are carers.

Mental health: In recognition of the problems that people with mental health problems can face in accessing services, the mental health pathway is being re-assessed and the CCG is working with providers to transform the pathway to best meet the needs of patients.

3. Monitoring the key performance indicators in the Health and Wellbeing Strategy

The majority of performance indicators in the strategy are outcome measures. They are designed to provide evidence that the actions identified in the strategy (and indeed the wider efforts of partners under the Board's "call to action") are having the desired impact, or not, as the case may be.

The indicators do not have specific targets, but rather reflect the ambition of the strategy to improve on the current positions for all our priorities.

The baseline position for each indicator is given at Appendix 2, alongside an indication of the direction of travel of performance relative to this baseline. Where possible, a separate indication is given showing direction of travel since the previous update report. More data is available than at the time of the previous update in October 2013. Overall the position remains broadly similar to that reported in October.

As highlighted above, many of these are outcome measures and will show improvement only after the successful completion of actions currently planned and/or being implemented. While improvements can be seen against some specific measures, it is still very early to judge whether the desired improvement "across the piece" is happening.

Measures showing particular improvement relative to the baseline in the Joint Health and Wellbeing Strategy include those monitoring:

Sustaining breastfeeding – Above baseline, up 3.5% in latest quarter

Bowel cancer screening – Up 3.5% on baseline

Older people, aged 65+ admitted on a permanently to residential or nursing care – Rate and number of admissions show continued drop from baseline.

Reablement - Older people supported to live at home following discharge from hospital – Up over 11% on baseline

Over time more data will be available and it will be possible to provide more meaningful reports with increasingly useful trend analysis. In future reports, we intended to add benchmarking of Leicester's position relative to comparable local authorities, where this is possible.

Benchmarking will be against the 15 closest comparator councils from the CIPFA Nearest Neighbours Model. This benchmarking group is used in the Public Health Outcomes Framework and by HSCIC. The membership of the group is shown in Appendix 3.

A summary of the current position on the 25 indicators in the strategy is shown below. The full report on the indicators is set out in ***Appendix 2*** of this report, referencing what action is being taken to address performance against indictors yet to show the desired progress.

Direction of Travel Summary

Part 1: Direction of travel against baselines in the strategy

	Performance has improved from the baseline in the strategy	10
	Performance is similar to the baseline in the strategy	6
	Performance has worsened from the baseline in the strategy	5
	No data has been published since the baseline, or there are data quality issues	4

Part 2: Direction of travel against position in the last update report (October 2013)

	Performance has improved from the position in the last update report	6
	Performance is similar to the position in the last update report	11
	Performance has worsened from the position in the last update report	2
	No data has been published since the previous update report, or there are data quality issues	6

Appendix 1

Implementing the actions in *Closing the Gap: Leicester's Joint Health and Wellbeing Strategy 2013-16*

Progress: March 2014

Strategic Priority 1: Improve outcomes for children and young people

Section	**1.1 Reduce Infant Mortality**
Contacts	Jo Atkinson, Public Health Consultant, Leicester City Council
Leicester's current rate of infant mortality (7/1000) is significantly higher than the national rate. Infant mortality roadshows ran in all 8 neighbourhood areas in 2011/12 aiming to harness the capacity of a range of staff and volunteers to tackle infant mortality. A follow-up event was held in December 2013 with around 60 attendees to showcase projects, share good practice and discuss next steps. On a wider city level, a range of initiatives/ services are in place and being further developed to tackle the risk factors for infant mortality. The infant feeding strategy is being revised, the key aim of which is to improve breastfeeding rates. In November 2013 we achieved Stage 2 of the UNICEF Baby Friendly Initiative which involved interviewing and assessing a wide range of UHL, LPT and children's centre staff about breastfeeding. A maternal obesity service is now operating at a number of venues across the city to support women to minimise excessive weight gain during pregnancy. A social marketing campaign has been running locally aiming to encourage pregnant women to book with a midwife before 12 weeks, an increase in the proportion booking before 12 weeks has been demonstrated	
RATING Green	Good progress is being made and there are no significant problems.

Section	**1.2 Reduce Teenage Pregnancy**
Contacts	Jasmine Murphy, Consultant in Public Health, Leicester City Council
	Liz Rodrigo, Public Health Principal, Leicester City Council
	David Thrussell, Head of Young Peoples Service, Leicester City Council
There has been a small, but not statistically significant rise in under-18 conception rate from 30.0 per 1000 15-19 year olds (2011) to 32.9 per 1000 15-19 year olds in 2012. It is recommended that there is renewed co-ordination of partnership working to rekindle the previous successful approach. **Access to contraception** The new integrated sexual health service commenced on 1st January 2014. The service is currently reviewing its young people's provision with the intention to extend delivery. An additional young people's site has already opened in South Wigston which is serving Leicester students attending colleges in that area. New city centre accommodation is still required for a dedicated young people's sexual health service following the planned relocation in May 2014 of the Connexions Information, Advice and Guidance Service. The Education and Children's Department are completing a transformation programme that involves the redesigning of statutory services for children and young people in	

Leicester based on the child's journey, whilst securing better integration with locality early help services. This is an opportunity for transforming statutory services around the journey children, young people and their families take and will ensure that the child's voice is central to service delivery; whilst leading to improvements in the quality of practice and ultimately outcomes for children, young people and families.

A key intended outcome is to ensure that services are delivered at the right time and place to children and young people through an integrated early help offer to prevent escalation into more complex statutory services. The current remodelling of the Youth Service is providing more targeted support to vulnerable young people; and its closer integration with the Connexions Information, Advice and Guidance Service, aligned with the Troubled Families Programme, will provide a more integrated youth offer including improved access to contraception and sexual health services.

Relationship & Sex Education
The Healthy Schools programme is currently being reviewed and includes RSE.

Educational attainment and raising aspirations.
The educational attainment of young people in Leicester continues to improve.

RATING Amber	Some risk that actions may not be delivered but this risk will be managed.

Section	**1.3 Improve readiness for school at age five**
Contacts	Nicola Bassindale, Early Prevention Service, Leicester City Council

Improving data systems to enable us to identify children at risk of achieving poor outcomes and who have delayed development at an early age, enabling us to target learning support to those who need it most.
Work has continued to progress to improve the quality of data being held on DataNet. This data is readily available for Children's Centre Teachers to access directly in order to pick up trends and identify children at risk of poorer outcomes at Foundation Stage, enabling them to target work with individual children and families and make contact through schools that have a greater proportion of children falling into the bottom 20%. Children's Centre staff continue to provide individual support to children and promote and enable parents to get involved in their child's learning. Learning plans are developed and progress is tracked to evidence the impact of targeted support towards improving outcomes.

Improving our partnership working to improve the quality, quantity and take up of family orientated preventative health and wellbeing initiatives for children living in our most deprived areas.
The integrated model of services delivered through Children's Centres (located in the most deprived areas of the city) enables Leicester City Council and health services to work closely together through formal liaison meetings and day to day working to identify families that may benefit from specific interventions aimed at improving learning and health outcomes. The two year old development check continues to be carried out jointly by health visitors and children's centre staff, enabling issues to be identified earlier and actions planned to address emerging learning or health concerns. Staff working directly with families also pick up on health-related issues and work with partners to develop and target preventative health and wellbeing initiatives to families, focusing on areas such as reducing obesity through healthy eating, improving health and reducing infant mortality through supporting breast feeding and reducing smoking in pregnancy, etc.

RATING Green	Good progress is being made and there are no significant problems.

Section	1.4 Promote healthy weight and lifestyles in children and young people
Contacts	Jo Atkinson, Consultant in Public Health, Leicester City Council Steph Dunkley, Public Health Principal, Leicester City Council

- The National Child Measurement Programme published in December 2013 showed significantly high rates of childhood obesity in the city in both reception year and year 6 compared to the national rates.
- The revised Healthy Weight Strategy will be finalised by the end of 2014. Consultation events are planned with stakeholders and service users during spring 2014.
- The Food Routes programme continues to run in primary schools encouraging a whole school approach to healthy eating, including cooking skills courses for children and their families.
- "Cook and eat" programmes to be delivered in early years settings, schools and the wider community will be commissioned during 2014
- The "Playing for health" programme continues to run in the majority of primary schools this academic year led by the professional sports clubs. This offers classes a 5 week multi-skills programme led by sports coaches in curriculum time.
- A new child weight management service - FLiC (Family Lifestyle Clubs) will start to deliver on 1st April 2014, provided by LPT.

RATING Amber	Some risk that actions may not be delivered but this risk will be managed.

Strategic Priority 2: Reduce premature mortality

Section	2.1 Reduce smoking and tobacco use
Contacts	Rod Moore, Public Health, Leicester City Council

Work has also continued to promote smoking cessation with communities, hospitals, primary care, maternity services and other settings. The achievement of quits at 4 weeks is lower than in previous years and a plan is in place to address this. It is thought to reflect a change in approach to quitting brought about by e-cigarettes which is being experienced nationwide. The CCG has recently funded some additional work in strengthening smoking cessation efforts in UHL, which should yield greater numbers of smokers quitting next year. The service continues to make smoking cessation available to younger smokers, though it is finding it less easy to engage with schools on prevention than in previous years. The Step Right Out Campaign to reduce exposure to second hand smoke in homes and cars continues. The independent evaluation has shown that, among the sample consulted, the Step Right Out campaign is achievable for those signing up and motivates the majority of individuals who previously allowed smoking in their home and car, to stick to the pledge to keep them smoke free. The STOP service as a whole will be reviewed in 2014/15.

RATING Amber	Some risk that actions may not be delivered but this risk will be managed.

Section	2.2 Increase physical activity and healthy weight
Contacts	Jo Atkinson, Consultant in Public Health, Leicester City Council Steph Dunkley, Public Health Principal, Leicester City Council

- The revised Healthy Weight Strategy will be finalised by the end of 2014. Consultation events are planned with stakeholders and service users during spring 2014.
- The Healthy Lifestyles Hub continues in 14 GP practices, a roll-out across all practices in the city is planned during 2014/15, in conjunction with the CCG.
- Adult weight management services continue to be provided across the city, particularly targeting those areas and groups with the highest level of need. Consultation on weight management services will take place as part of the revision of the Healthy Weight Strategy. The service will be re-commissioned during 2014.
- "Walking Away from Diabetes" groups are now running in the city aiming using walking as a means of preventing type 2 diabetes.
- The Active Lifestyle Scheme continues to see a high level of demand and now has a waiting list. The service will be reviewed during 2014 in order to manage this demand in the most appropriate way.
- The health trainer service (one to one lifestyle advice) continues to operate in the most disadvantaged areas of the city. The service is being re-commissioned in conjunction with the Healthy Lifestyles Hub during 2014.

RATING Amber	Some risk that actions may not be delivered but this risk will be managed.

Section	2.3 Reduce Harmful Alcohol Consumption
Contacts	Julie O'Boyle, Consultant in Public Health Chief Inspector Donna Tobin-Davies, Leicestershire Police Karly Thompson, Divisional Director East Midlands Ambulance Service Paul Hebborn, Leicestershire Fire and Rescue Service Justine Denton, Leicester City Council Trading Standards Mike Broster, Head of Licensing Leicester City Council Rachna Vyas, Head of Strategy and Planning, Leicester City CCG

- Alcohol awareness campaigns have taken place across the city linked to alcohol awareness week, drink driving and dry January.
- A social marketing campaign in the wards with the highest rates of alcohol related harm asked people "what are you doing tonight" the campaign promoted alternative activities not involving alcohol and encouraged people to consider the number of units they were consuming.
- New recovery focussed drug and alcohol treatment services are providing improved access to treatment for people affected by alcohol misuse.
- Secondary care alcohol liaison workers and primary care alcohol engagement workers are working to reduce the levels of emergency department repeat attendance and hospital admissions.
- Trading standards continue to work to reduce underage sales of alcohol
- Police led initiatives have resulted in a decrease in alcohol related crime including injury due to assault associated with the night time economy.

RATING Green	Good progress is being made and there are no significant problems.

Section	2.4 Improve the identification and clinical management of cardiovascular disease, respiratory disease and cancer
Contacts	Sarah Prema, Leicester City Clinical Commissioning Group (CCG)

- Cardiovascular disease (CVD) and chronic obstructive pulmonary disease (COPD) strategy events were held in November 2013 to identify priorities for the CCG Commissioning Intentions. CVD and COPD continue to be strategic objective areas for the CCG.
- The 5 year strategy across Leicester, Leicestershire and Rutland has also selected CVD, Respiratory and Cancer as priority workstreams. Transformative programmes of work to improve services in these areas will commence in April 2014 covering prevention, treatment and living well with such conditions.
- Between April 2013 and January 2014, 18,985 NHS Health Checks have been undertaken against an Area Team target of 12,400 (by 31st March 2014). Of these 2,892 patients have had conditions detected and a management plan put in place.
- 216 General Practice staff have now received training and development in the management of diabetes through the EDEN project.
- The CCG and Public Health have worked together to upscale the 'Lifestyle referral hub' which will give health professionals a one stop-shop for patients who need lifestyle interventions such as exercise and diet advice. CCG funding has been committed.
- COPD case finding service launched in October 2013 across General Practice and in the community services, with prevalence rates increasing as a result.
- Telehealth and health coaching is supporting 50 patients to manage their conditions better and reduce emergency admissions to hospital. This pilot is due to be increase to 100 patients over the next few months.

RATING Green	Good progress is being made and there are no significant problems.

Strategic Priority 3: Support independence

Section	3.1 People with long term conditions
Contacts	Sarah Prema, Leicester City Clinical Commissioning Group

- 24 'virtual beds' are now live, known as the Intensive Community Support Service to support people coming out of hospital to stay in their own home.
- The CCG has put into place a renewed focus on care planning to enable patients with long term conditions to maintain their condition effectively. This involves care plans for specific groups of patients, such as those identified as high risk of hospital admissions, older people, those with dementia and for those at the end of life
  Our focus on our strategic priority areas (Cardiovascular/Mental Health/Reparatory) continues with projects to detect and manage a range of long term conditions.

RATING Green	Good progress is being made and there are no significant problems.

Section	3.2 Older People
Contacts	Bev White, Leicester City Council
Work is progressing on developing reablement and enablement pathways which will support older people to maintain or regain their independence. Work has begun to develop a Strategy for Older People which will take a holistic approach to the coordination and delivery of culturally appropriate high quality services across health, social care, housing and other relevant organisations. This will also consider how we can increase the participation of older people in neighbourhoods to increase social inclusion and general wellbeing.	
RATING Green	Good progress is being made and there are no significant problems.

Section	3.3 People with Dementia
Contacts	Bev White Leicester City Council
The Joint LLR Dementia Strategy moves into its final year. Achievements include: • A memory assessment pathway has been finalised. • An integrated crisis response service has been developed and is demonstrating considerable success. • A suite of information for carers, people with dementia and professionals has been developed and is about to be distributed. • An information booklet 'Top Tips for diagnosing, supporting and managing the needs of People with Dementia in General Practice' has been distributed to every GP. • The implementation of carers' assessments continues to be a priority. • Work continues to ensure that re-ablement and intermediate care pathways are appropriate for people with dementia and facilitate early discharge. • The provision of appropriate, high quality support services and assistive technology continue to be rolled out. • Awareness of dementia and the availability of services within specific communities is promoted via Memory Cafes and Dementia Friends sessions. • Dementia champions have been recruited, trained and a network developed to ensure that hospital care is of the highest quality; a similar programme for residential and nursing homes is in development. • An event for residential and nursing care providers was held to explore good practice in dementia design and care – 200 delegates attended. • 6 local residential homes are piloting the DoH's Dementia Environment initiative. • Leicester city CCG's diagnosis rate for dementia has increased to almost 56% - target is 66% by 2015 • 49 of 63 GP practices have signed up to the new DES (Directly Enhanced Service) for early diagnosis. • A specialist Discharge to Assess nurse post in UHL is being piloted. • The Quality Assessment Framework for residential care is operational. • Work has begun with housing colleagues to identify pilot projects to improve the support received by people who live in Housing association properties. From 2014, dementia will be a priority in the new NHS 5 Year Strategy and this will be the vehicle for continuing the work.	
RATING Green	Good progress is being made and there are no significant problems.

Section	3.4 Carers
Contacts	Mercy Lett-Charnock, Leicester City Council

- Carers personal budgets are being widely promoted in order to enable carers to access personalised support that meets their needs and 483 additional carers received a personal budget during the year.
- Five voluntary sector providers were awarded monies by the City Council to deliver additional carers breaks and support. Final project reports are due shortly but it is anticipated approximately 450 additional breaks will have been delivered during the year.
- The carers newsletter produced by the City Council has been expanded to reach an additional 850 people during the year. The newsletter is produced specifically for carers to help them access relevant training and services.
- A carer training programme has been developed within the City Council which has delivered training to an additional 200 carers during the last year, to help them undertake their role. In response to specific carer requests training has been delivered on welfare benefit changes, challenging behaviour, direct payments, carers assessments, the decision support tool and autistic spectrum disorder amongst others. We have engaged Gujarati speaking trainers to deliver benefits training as it is a complex area that benefits from a native speaker rather than being translated and carers have welcomed this.
- The City Council and Clinical Commissioning Group launched a Carers Charter on National Carers Rights day, developed by carers from the City, setting out commitments to carers. Displaying of the charters around prominent locations should contribute to raised awareness.
- ASC is working with the National Institute of Adult Continuing Education (NIACE) to look at barriers to older young carers (16-24) accessing education and training opportunities
- The development of a Leicester City Council carer employee group and “carer passport” has been a positive step in supporting our own staff and promoting good practice
- Fifty front line staff have received carer assessment training during the year to help increase the number of assessments done as well as improving understanding of carer issues.
- University Hospitals Leicester has employed a carer champion to improve access to services for carers on discharge from hospital.
- Adult Social Care is part of a newly formed Special Interest Group for carers. Based at De Montfort University, the group is collating existing research around carers and looking into developing research projects based on carer issues, in partnership with practitioners to inform future good practice with an aim to improve services.
- Events for both Carers Week and National Carers Rights Day have been supported by partners and aimed to increase the number of carers identified and of the support available to them.

RATING Green	Good progress is being made and there are no significant problems.

Strategic Priority 4: Improve mental health and emotional resilience

Section	**4.1 Promote the emotional wellbeing of children and young people**
Contacts	Jasmine Murphy, Consultant Public Health, Leicester City Council
	Mark Wheatley, Public Health Principal, Leicester City Council
The Public Health approach continues to focus on strengthening emotional wellbeing in schools and working with specialist services to ensure that there is mental health care provision for children and families in need. Delivering the key message that good emotional, psychological and social health can protect young people. For instance, as key public health and primary care practitioners, school nurses have an important role to play in improving health and tackling the inequalities which underpin the emotional wellbeing of children and young people. The CCG commissions a range of Child and Adolescent Mental Health Services (CAMHS), such as the Children and Families Support Team, primary mental health services, the Leicester City Child Behaviour Intervention Initiative and is currently developing children's IAPT services. CAMHS has a Tiered approach, so that children and young people should be able to gain timely access to the services that they require. There are additional specialist services for issues such as Attention Deficit-Hyperactivity Disorder, Eating Problems and Autism. Leicester City Council has a number Children and Family Centres, which provide services to support families where a child is assessed as being in need as defined by the Children Act 1989. These services include care for children below five years of age on a daily or sessional basis, support for parents on behaviour management, child development and help to build self-esteem.	
RATING Amber	Some risk that actions may not be delivered but this risk will be managed.

Section	**4.2 Address common mental health problems in adults and mitigate the risks of mental health problems in groups who are particularly vulnerable.**
Contacts	Yasmin Surti, Lead commissioner Mental Health, Leicester City Council
	Julie O'Boyle, Consultant in Public Health, Leicester City Council
	Mark Wheatley, Public Health Principal, Leicester City Council
Leicester City Council has signed up to the Time For Change Mental Health Charter and nominated a member champion, Councillor Michael Cooke, but the Mental Health Challenge means that all councillors will seek to influence the full range of services and activities available to improve mental health in Leicester. In Leicester, the Open Mind IAPT (Improving Access to Psychological Therapy) Service is a positive development, delivering psychological therapies where they are needed, in collaboration with local voluntary sector organisations, such as Adhar, Trade and the LGBT centre, to address the stigma of mental health problems in different communities. There have been important local initiatives, such as the Triage Car, in which the Police and Leicestershire Partnership Trust collaborate to provide alternative care and support for someone with a mental health problem. In addition, there is a national Crisis Care	

Concordat which sets out the expected response of mental health services when a person has been taken to a place of safety.

Commissioners are scoping the potential for well-being centres to be developed in the city as a way of improving mental health crisis care.

A key element of the work across LLR under the Better Care Together Strategy development is to develop parity of esteem between mental and physical health problems. People with mental illness are more at risk of premature mortality than the population generally. It is important that mental and physical health care is integrated at every level, with commissioners working to improve standards of physical health care within mental health facilities and primary care, to ensure earlier diagnosis of illnesses.

As a local council championing mental health, Leicester City Council is reflecting a desire for change for those with mental illness and those who support them.

By signing up to the Mental Health Challenge Leicester City Council will support an integrated approach to mental health care, ensuring that mental wellbeing underpins traditional universal services and encouraging the delivery of a broad spectrum of services across the city and where necessary across Leicester, Leicestershire and Rutland and across the region. In doing this Leicester City Council aims to listen to the concerns of people with mental illness and their carers; protect the mental health of children and young people; collaborate in the prevention of mental illness; promote early intervention in mental health and develop personalisation and social care services for people with mental illness.

RATING Green	Good progress is being made and there are no significant problems.

Section	**4.3 Support people with severe and enduring mental health needs**
Contacts	Sarah Prema, Leicester City Clinical Commissioning Group

- The CCG has completed a scoping exercise of mental health services and is currently using this to inform our commissioning intentions.
- The CCG has recognised the requirement to re-assess the mental health pathway and is currently working with our providers to transform this pathway to best suit the needs of our patients. Healthwatch is involved in this piece of work. This will involve specifically looking at services in the areas of the unscheduled acute care mental health pathway, Planned care pathways, complex care, rehabilitation and other specific care pathways.

RATING Green	Good progress is being made and there are no significant problems.

Strategic Priority 5: Focus on the wider determinants of health

Contacts	Sue Cavill, Public Health, Leicester City Council
A presentation has been made to the Children's Trust and the Sports Partnership Board to share with them the agreed Joint Health and Wellbeing Strategy and explore how this can be incorporated into their planning. Additionally, presentations have been made to a number of community groups, including the Forum for Older People, the Deaf and Hard of Hearing Community Feedback Session, a local African-Caribbean group, a Chinese community group and the Zimbabwe Action in Solidarity Leicester Drop-in Centre. These were supported by Healthwatch Leicester. As a result of requests at the Deaf and Hard of Hearing group, Healthwatch organised a follow up session on stopping smoking. The Deputy City Mayor is leading work on further plans to help improve community engagement in implementing the strategy and assessing the equality impacts of decisions.	
RATING Amber	Some risk that actions may not be delivered but this risk will be managed.

	‘Closing the Gap’: Leicester’s Health and Wellbeing Strategy – 2013/16 Indicators					
	Improve outcomes for children and young people					
Indicator	Reporting frequency	**Baseline as published in strategy**	Latest data as at March 2014	Direction of travel vs last report	**Direction of travel vs Baseline**	**Activity supporting performance improvement** For information on activity in support of this measure please see these sections of Appendix 1
Readiness for school at age 5	Annual	11/12 – 64%	12/13 – 27.7% Please see Appendix 3 for technical note	↓	↓	Having investigated the reasons for the significant drop in performance in 2013 we have concluded that an important factor was lack of familiarity with the new assessments used in 2013, and the way moderation was applied. Having reviewed the first year, we have reached a shared view with schools that assessments and moderation probably erred on the side of being overly rigorous, for example, expecting children to demonstrate repeatedly

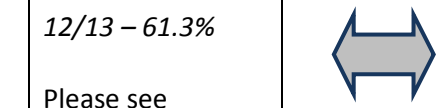
						secure achievement on all or nearly all criteria, rather than a best fit approach. The discussions and work with schools have resulted in a different partnership approach, in which we will work on the assessment process throughout the year. This will help in developing consistency and agreement about interpretation of assessment evidence. Section 1.3
Breastfeeding at 6-8 weeks	Quarterly	11/12 – 54.9%	12/13 – 55.1% 13/14 Q1 –57.9% Q2 – 53.1% **Q3 – 56.5%**			Section 1.1
Smoking in pregnancy Please see Appendix 3 for technical note	Quarterly	11/12 – 12.7%	12/13 - 14.2% 13/14 Q1 – 12.6% **13/14 Q2 – 13.8%**			Section 2.1
Conception rate in under 18 year old girls (per 1000 girls under 18)	Annual	2011 – 30.0	32.9			Section 1.2

Reduce obesity in children under 11 (bring down levels of overweight and obesity to 2000 levels, by 2020)	Annual	Reception: 10/11 – 10.6%	Reception: 11/12 – 11.1% 12/13 – 10.4%			Section 1.4
	Annual	Year 6: 10/11 – 20.6%	Year 6: 11/12- 20.5% 11/12- 21.1%			

	Reduce premature mortality					
Indicator	Reporting frequency	**Baseline**	Latest data	Direction of travel vs last report	**Direction of travel vs Baseline**	**Activity supporting performance improvement** For information on activity in support of this measure please see these sections of Appendix 1
Number of people having NHS Checks Please see Appendix 3 for technical note	Quarterly	11/12 – 8,238	12/13 – 24,048 13/14 Q1 – 7,089 13/14 Q2 – 13,329 **13/14 Q3 – 17,865**			Section 2.4
Smoking cessation: 4 week quit rates	Quarterly	11/12 – 2,806 (1,153 per 100,000 adult pop.)	12/13 – 2,763 13/14 Q1 – 642 13/14 Q2 – 1240 **13/14 Q3 – 1776**			Work has continued to promote smoking cessation with communities, hospitals, primary care, maternity services and others. The achievement of quits at 4

						weeks is lower than in previous years and is thought to reflect a change in approach to quitting brought about in part by e-cigarettes which is being experienced nationwide. A plan is in place to regain momentum. Section 2.1
Reduce smoking prevalence	No regular pattern (Next Survey 2014)	2010 – 26% (Lifestyle survey) 10/11 – 23.4% (Household survey)	-			Section 2.1
Adults participating in recommended levels of physical activity Please see Appendix 3 for technical note	Annual	Oct 10/Oct 11 – 27.8%	Oct 11/Oct 12 – 32.7% Apr 12/Apr 13 – 31.7% **Oct 12/Oct 13 – 30.6%**			Section 2.2
Alcohol-related harm	Annual	11/12 – 6,283 (1,992 per 100,000 pop.)	12/13 – 6,404 (2,038 per 100,000 pop.)			Section 2.3

Uptake of bowel cancer screening in men and women	Annual	11/12 – 43%	12/13 – 46.6%			Sections 2.4 & 3.1
Coverage of cervical screening in women	Annual	11/12 – 74.7%	12/13 73.9%			Sections 2.4 & 3.1
Diabetes: management of blood sugar levels	Annual	11/12 – 62%	12/13 latest 61.8%			Sections 2.4 & 3.1
CHD: management of blood pressure	Annual	11/12 – 88.3%	12/13 - 89.1%			Section 2.4
COPD: Flu vaccination	Annual	11/12 – 92.3%	12/13 - 91.5%			Section 2.4

	Support independence					
Indicator	Reporting frequency	**Baseline**	Latest data	Direction of travel vs last report	**Direction of travel vs Baseline**	**Activity supporting performance improvement** For information on activity in support of this measure please see these sections of Appendix 1
People with Long Term Conditions in control of their condition	Annual	11/12 – 81.24%	*12/13 – 61.3%* Please see Appendix 3 for technical note			New data (2012/13) from the GP Access Survey is available but technical problems persist insofar as we cannot verify the baseline data using the prescribed formula. Section 3.1
Carers receiving needs assessment or review and a specific carers service or advice and information (fmr NI135)	Quarterly	11/12 – 18.8%	12/13 – 26.5% 13/14 Q1 7.6% 13/14 Q2 17.3% **13/14 Q3 25.4%**			Section 3.4

Proportion of older people (65 and over) who are still at home 91 days after discharge from hospital into reablement /rehabilitation services	Quarterly	11/12 – 77.2%	12/13 – 83.8% 13/14 Q1 – 89.5% 13/14 Q2 – 88.8% **13/14 Q3 – 88.6%**			Section 3.2
Older people, aged 65 and over, admitted on a permanent basis in the year to residential or nursing care per 100,000 population	Quarterly (cumulative)	11/12 – 763.20 - revised Feb 2014	12/13 – 735.27 13/14 Q1 141.8 13/14 Q2 354.5 **13/14 Q3 514.7**			Section 3.2
Dementia - Effectiveness of post-diagnosis care in sustaining independence and improving quality of life	N/A	N/A	No Data Please see Appendix 3 for technical note			Section 3.3
Carer-reported quality of life	Biennial (Next survey 14/15)	9/10 – 8.7	12/13 – 7.1			Section 3.4
The proportion of carers who report that they have been included or consulted in discussion about the person they care for.	Biennial (Next survey 14/15)	9/10 – 70%	12/13 – 63.5%			Section 3.4

	Improve mental health and emotional resilience					
Indicator	Reporting frequency	Baseline	Latest data	Direction of travel	**Direction of travel vs Baseline**	**Activity supporting performance improvement** For information on activity in support of this measure please see these sections of Appendix 1
Self-reported well-being - people with a high anxiety score	Annual	11/12 – 41.99%	12/13 – 41.2%			Section 4.2
Proportion of adults in contact with secondary mental health services living independently with or without support	Quarterly	11/12 – 68.1%	12/13 – 32.2% 13/14 Q1 -41.5% 13/14 Q2 -39.3% **13/14 Q3 -40.9%** Please see Appendix 3 for technical note			Section 4.3

Appendix 3 Technical Notes

Production of progress statements for Appendix 1:

To produce each statement, a contact person was identified for each of the areas. That person was asked to liaise with key colleagues to:

- refer to the text of the Joint Health and Wellbeing Strategy for their sub-section;
- report on progress with taking forward the actions in that section, as at September 2013, particularly referring to the bullet points listed under *What we plan to do*;
- make the progress statement short and succinct;
- focus particularly on any key achievements in the context of the strategy or any areas that are on significantly at risk of not being delivered (ie red rated); and
- provide a RAG rating for progress on work in that sub-section.

Reporting frequency for Appendix 2 indictors:

Of the 25 indicators, 2 are reported biennially, 13 annually, 8 quarterly, 1 has no fixed reporting pattern and 1 is a placeholder (not yet being collected).For the biennial and no fixed pattern indicators, there has been no data published since the adoption of the strategy.

Data quality issues and other technical notes on performance indicators

Indicator	Notes
Readiness for school at age 5	A new assessment framework was introduced in 2013. The criteria for reaching a good level of development have changed, and are more demanding. Children have a good level of development if they reach the expected level in all strands of Personal and Social Development, Communication and Language, Physical Development, Literacy and Mathematics. There are now 12 criteria compared to 8. In 2013 only 28% of children in Leicester achieved this measure. However the drop should not be automatically interpreted as a significant difference in the actual level of development reached by the cohorts of 5 year olds. Details of the new assessment process and expectations of moderation were issued late to the LA and schools and settings. This limited the time available for preparatory 'agreement trialling'. Through agreement trialling teachers and others involved in making assessments can debate and reach judgements on best fit assessment levels, especially when trying to assess against a range of criteria and evidence. This is a useful process in training for new assessment systems, and supporting consistent judgements.
Smoking in pregnancy	Performance may be affected by change in data collection methodology in 12/13.
Number of people having NHS Checks	Number of health checks increasing and well ahead of baseline. However rate of increase suggests we are unlikely to improve on 12/13 outturn.

Indicator	Notes
Adults participating in recommended levels of physical activity	Latest results from Active People Survey 7. This figure is for 16 year olds and above and is comparable with previous years.
People with Long Term Conditions in control of their condition	12/13 data based on weighted survey results from GP Access Survey, Dec 2013. *% of respondents to the survey answering either "yes definitely" or "yes to some extent" when asked if they had (In last 6 months), had enough support from local services or organisations to help manage long-term health condition(s)?*
Dementia - Effectiveness of post-diagnosis care in sustaining independence and improving quality of life	Placeholder measure in ASCOF, planned to be effective from 14/15 onwards
Proportion of adults in contact with secondary mental health services living independently with or without support	Data quality issues with this indicator remain outstanding – not possible to make a judgement on direction of travel

Benchmarking:
In future reports it is proposed to include benchmarking against the 15 closest comparator councils from the Chartered Institute of Public Finance and Accountancy (CIPFA) Nearest Neighbours Model. These authorities are:

CIPFA Family authorities group:

E06000032	Luton UA
E08000031	Wolverhampton
E06000018	Nottingham UA
E08000026	Coventry
E08000028	Sandwell
E08000032	Bradford
E06000031	Peterborough UA
E06000008	Blackburn with Darwen UA
E06000010	Kingston upon Hull UA
E06000015	Derby UA
E06000002	Middlesbrough UA
E08000012	Liverpool
E08000004	Oldham
E08000021	Newcastle upon Tyne
E06000039	Slough UA
E06000016	**Leicester UA**

Appendix D

LEICESTER CITY HEALTH AND WELLBEING BOARD
DATE 3rd April 2014

Subject:	Leicester, Leicestershire and Rutland Better Care Together Programme Update
Presented to the Health and Wellbeing Board by:	Geoff Rowbotham, Programme Director
Author:	Geoff Rowbotham, Programme Director

EXECUTIVE SUMMARY:

'Everyone Counts', the NHS planning guidance that was published in December 2013 requires health and social care organisations to develop a 5 year strategy to set direction for the who health and social care system. Two-year plans are also required for 2014/14 and 2015/16, including plans for the use of the newly created pooled budget now known as the Better Care Fund.

In response to the requirement to develop a 5 year strategic plan the Leicester, Leicestershire and Rutland (LLR) Better Care Together Board held a Health and Social Care partner summit on the 29th January 2014.

A shared vision for all partners was agreed and the key actions required supporting the successful delivery of this.

It was agreed through an ongoing consultative approach to develop a proposed integrated Health and Social Care 5 Year Strategy by June 2014 to provide the framework for delivery of the shared vision.

Five priority clinical work streams based on local needs assessments have been identified and agreed for immediate review.

RECOMMENDATIONS:

The Health and Wellbeing Board is requested to: Note the progress made in the last 12 weeks and the proposed key next steps

BETTER HEALTH TOGETHER PROGRAMME

Leicester, Leicestershire and Rutland Health and Social Care

March 2014

PURPOSE

The purpose of this paper is to give an update on the progress made in 2014 by the LLR Better Care Together Programme Board, the actions to date and the immediate next steps for the LLR Better Care Together programme (BCT)

BACKGROUND

'Everyone Counts', the NHS planning guidance that was published in December 2013, required health and social care organisations to develop a 5 year strategy to set direction for the whole health and social care system. Prior to this, NHS and Local Authority partners in Leicester, Leicestershire and Rutland had already established 'Better Care Together' structures as a means of co-ordinating and collaborating on the development of the required 5 year strategic plan. The NHS Planning Guidance also requires the development of two-year plans for 2014/15 and 2015/16, including plans for the use of the newly created pooled budget now known as the Better Care Fund.

1. In response to the requirement to develop a 5 year strategic plan, the LLR Better Care Together Programme Board held a Leicester, Leicestershire and Rutland (LLR) Health and Social care partner summit on 29th January 2014 at the King Power Stadium to agree the approach to the development of an integrated health and Social Care 5 Year Plan. Circa 200 attendees representing partner organisations from health social and the voluntary sectors as well as public and patient/user/carer representatives discussed and agreed :-

    - A joint shared vision for all partners. '*To maximise value for the for the citizens of Leicester, Leicestershire and Rutland (LLR) by improving health and wellbeing outcomes that matter to them, their families and careers in a way that enhances the quality of care at the same time as reducing cost across the public sector to within allocated resources by restructuring the provision of safe, high quality services into the most efficient and effective settings*'

    - Recognising the challenge and step change in thinking required by all partners, it was agreed that plans for the whole health and social care system need to develop together and through consultation by June 2014 a proposed integrated LLR 5 Year Health and Social Care Strategy that delivers this vision

    - To immediately develop proposals around 5 Clinical work streams (Cancer, Cardiovascular disease, Respiratory disease, Dementia, Mental health) that were agreed to be high priority

from both a clinical and financial perspective based on analysis of LLR Commissioning for Value Packs, Joint Strategic Needs Assessments and an impact assessment analysis.

2. The Leicester, Leicestershire and Rutland Health economy has been identified as one of 11 areas that external consultative support would be offered by NHS England the Trust Development Authority and Monitor to support the partners development of a Health and Social Care 5 Year strategic Plan from April 2014

KEY ACTIONS COMPLETED (February –March 2014)

3. Development of the LLR 5 Year Health and Social Care Strategy

- A joint health and social care 'task and finish' group is scoping and completing a draft 'framework document' for agreement by the LLR Better Care Together Board that will form the basis of the development of the strategy plan development in April 2014.

- A second LLR Summit event for Health, Social ,Voluntary Sector Partners and public and patient groups is proposed for 6th May 2014 to share and review progress on the development of the LLR 5 Year Strategy and the Priority work streams

4. Revision of the LLR Better Care Together Programme Governance

- Following a joint LLR Health and Social Care appointment of a Programme Director for the LLR BCT programme in February a review of the governance and programme management has been undertaken in consultation with representatives of key partners and stakeholders.

- A revised programme governance has been proposed and agreed based on ensuring full representation across Health and Social care partners, public and patient groups with appropriate clinical input reporting through the LLR Better Care Together Board to Local Authorities (incl. Health and Well Being Boards) Clinical Commissioning Groups, UHL and LPT Trust Boards and NHS England.

- The revise governance arrangements also recognise the need for the Better Care Fund plans for each Health and Wellbeing Board area to be seen as an integral part of the emerging plans for the whole health and social care system

5. Scoping and Development of the 5 Priority Clinical Work streams

- Between the 4th and 14th February The external consultants Matrix facilitated four Joint workshops, two stakeholder whole day sessions and two group working sessions for each of the 5 priority work streams. Over 200 representatives from the LLR Health, Social, Voluntary sectors supported by a cross section of patient carer representatives

- A final report was reviewed at a summit event for all participants on the 12th March and key next steps agreed. The report and recommendations have been discussed at the March LLR BCT Board and next steps agreed

KEY NEXT STEPS (April-June)

6. The establishment of a LLR Health and Social Care partnership group to develop with the external consultant support a proposed integrated 5 Year Strategy Plan in consultation with and for approval by representatives from Health, Social, Voluntary and public and patient groups.

7. The establishment of the agreed cross partnership programme governance structure underpinned with a supporting Programme Management process to ensure effective and timely approval and performance management.

8. The development and implementation of integrated Health and Social Care Communication & Engagement programmes for both staff and the public across Leicester, Leicestershire and Rutland. Workforce, Estates and Information strategies that support the delivery of the proposed 5 Year Plan service transformation programmes across the LLR partners.

9. A joint LLR Health and Social Care sub group of the LLR BCT Board have agreed to lead the external advertising and appointment process for securing the permanent role of Chair of the LLR Better Care Together Board

Appendix E

LEICESTER CITY HEALTH AND WELLBEING BOARD
3 April 2014

Subject:	**NHS ENGLAND OPERATIONAL PLANS & EMERGING STRATEGY**
Presented to the Health and Wellbeing Board by:	Trish Thompson, Director of Ops & Delivery NHS England (Leicestershire & Lincolnshire Area)
Author:	Peter Huskinson, Director of Commissioning NHS England (Leicestershire & Lincolnshire Area)

EXECUTIVE SUMMARY:
The draft operational plans are being shared with commissioning partners in the 4 health and wellbeing boards and with clinical commissioning groups. Plans have been developed taking account of health needs of the population from resources made available and by canvassing directors of public health in November to identify key strategic issues. It is requested that feedback on the plans is provided during April via Directors of Public Health, to ensure final documents adopted can respond to comments.

BACKGROUND:
A wide range of guidance has been published up to the end of January 2014 to inform operational plans for the next 2 financial years. The core requirements for operational plans are to set out financial and performance goals, and affirm the commissioner's intentions to adopt the priorities set out in planning guidance. Concurrently with the operational planning cycle, a degree of assurance has been sought about development of 5 year strategy including a 'unit of planning' health system plan to which NHS England services contribute.

Full 5 year strategies are not required until June 2014, and are expected to encompass outcome ambitions set with local authority partners for health and care services, with the national strategies for specialised services and primary care yet to be produced to inform local strategies.

No standard format has been required in this planning round, and given the benefit of outlining strategic direction for informing 2 year plans, the Leicestershire and Lincolnshire Area Team have produced this combined document that provides an update on the strategic development of commissioned services, and the health needs to which plans relate, alongside the core operational plan requirements.

A 'plan on a page' summary is provided for the commissioning of primary care and NHS public health services. For specialised services operational plans and summaries are being nationally developed to a single consistent document expected to be made available later this month.

RECOMMENDATIONS:
That the Health and Wellbeing Board be asked to note the contents of the draft plans and to comment on them.

Draft Operational Plan 2014-16 & Emerging Strategy Update

NHS England
(Leicestershire & Lincolnshire)

THE NHS CONSTITUTION
the NHS belongs to us all

NHS England (Leicestershire & Lincolnshire) Operational Plan 2014-16, Emerging Strategic Plans 2014-2019 & Strategy Update

Table of Contents

Foreword

This document sets out proposed plans for services commissioned by NHS England's Leicestershire and Lincolnshire team. It sets out which services we commission, which communities we serve and how these plans compliment the plans and work of other bodies that are responsible for related health and social care services. It provides an overview of relevant aspects of our communities' health needs, & the current state of our healthcare services.

National priorities for healthcare are set by a mandate from the government to NHS England. NHS England has set out its response to achieving those priorities in 'Everyone counts' guidance, & in National commissioning intentions for some services, reflected in these plans.

National regulators govern aspects of how services are commissioned: Monitor sets national prices for many services, and determines rules governing to whom and how contracts to deliver healthcare services may be awarded. Core Quality standards are set out by the Care Quality Commission directly to health and social care providers. The National Institute for Clinical Excellence assesses treatments for clinical and cost effectiveness to recommend which treatments should be made available, & provide guidelines for their use. The contracts with independent contractors who provide primary care (General Practitioners, Optometrists, Pharmacists and Dentists) are nationally negotiated.

Our plans apply locally those national priorities and standards for which we have local responsibility, prioritised within the financial and human resources made available to us, focused on those things that we believe will achieve the greatest impact on health outcomes, given the particular challenges and opportunities we face.

This is the first draft of these plans. The draft reflects early and on-going consultation with other local partners with commissioning responsibilities, and will be further refined as we receive feedback from partners and from regional and national stakeholders. They reflect and will inform related work scheduled for completion after operational plans are concluded, by June 2014: The national primary care strategy and national strategy for specialised services, the Leicestershire & Lincolnshire primary care strategy, and further work on the health system plans for Leicestershire Leicester & Rutland, and Lincolnshire Sustainable Services Review, including outcome ambitions and 'commissioning for prevention' goals.

The NHS at its best is a shared endeavour in pursuit of our vision: "*High quality care for all, now and for future generations*". This purpose is even more important at a time when resources are constrained. It is our intention through these plans to make this vision a reality for the people in our communities who fund, use & work within or in partnership with the NHS.

Peter Huskinson
Director of Commissioning

Executive Summary

NHS England commissioning plans cover primary care, public health services (immunisation, screening and health visiting) and specialised acute and mental health.

For Lincolnshire, Leicester, Leicestershire and Rutland authority areas the key health needs the plans respond to are **life expectancy** below peers in the 2 large county authorities and low in absolute terms in Leicester city, **years of life lost from causes amenable to healthcare** below peers in Leicester city, Lincolnshire and Rutland, and surveyed GP experience below peers in Leicestershire and Lincolnshire, and low in absolute terms in Leicester city, along with poor oral health.

Specialised services has a provider profile of large tertiary trusts (2 acute and 2 mental health providers account for over 70% of spend) as well as some services at 7 other acute and 7 other mental health providers. NHS England are the largest single commissioner of University Hospitals of Leicester NHS Trust, Nottingham University Hospitals NHS Trust, and Nottinghamshire Healthcare NHS Trust.

The key issues for east midlands providers are relatively high Care Quality Commission risk ratings and financial sustainability. Service prices reflect generally good levels of efficiency and more established clinically based access policies now migrated to national consistent policies, making the achievement of further financial savings require more innovative solutions than other regions without this track record.

Commissioning plans implement national commissioning intentions, including plans to converge prices for specialised care where this is outside national tariff, and to make better use of the NHS' national purchasing power for drugs and devices. Of particular importance is the adoption of national clinical service specifications in 2013/14. Providers have areas with time limited permission to become compliant in order to continue to provide services so monitoring action plans in 2014/15 are a key to ensure all patients enjoy consistent standards of care. The national strategy for specialised services is likely to recommend consolidating services to a much smaller number of providers than today, providing improved clinical outcomes through centres of excellence, and a means to achieve 7 day working in a financially sustainable way.

Quality improvement is integral to commissioning plans, and embedded in accountability processes for contracts and via multidisciplinary medical, nursing and primary care contracting review as well as through local and regional Quality Surveillance Groups and close partnership with the Care Quality Commission (CQC). In addition to adopting national Clinical Quality and Innovation (CQUIN) incentive schemes, the area team are working with partners to adopt the chief nursing officer strategy Compassion in Practice (care, compassion, competence, communication, courage and commitment), to further develop learning from complaints, through listening events, and the new data on patient experience available to us from the new year, with priority work plans on healthcare acquired infection, incident reporting, harm free care, and staff satisfaction as levers for change.

Plans also reflect a range of issues specific to the east midlands and to partner commissioners:

1. Addressing the national capacity issues in Child and Adolescent Mental Health (CAMHS) Services through appropriate capacity at each tier. East Midlands has few Tier 3+ services, although some areas now have plans in place to commission them.
2. Aligning capacity across pathways for obesity, weight management and bariatric surgery to ensure patients gain appropriate access to specialist services after first line treatments commissioned by Clinical Commissioning Groups (CCGs) and local authorities have been tried.
3. Provision of appropriate radiotherapy capacity and configuration of related cancer pathways in the South Midlands, reflecting new clinical partnerships between Northampton and Leicester, and Milton Keynes and Oxford.
4. Ensuring the sustainability of HIV services in east midlands providers is not adversely affected by local authority commissioning intentions for sexual health services given the service and workforce dependencies.
5. Appropriate service access to community and inpatient perinatal services following notice given by LPT for a service unable to meet core service standards.
6. Responding to the national review of children's and adult cardiac services
7. The completion of rollout of the East Midlands major trauma network with patients taken to the Major Trauma centre at Nottingham, which will significantly improve survival rates for patients

Specialised service commissioning is adopting a number of innovative interventions including 'NHS Improving Quality' support to providers for establishing 7 day working, internationally proven evidence based clinical decision support systems to improve hospital workflow, beginning in critical care at the 2 largest centres, and a national pilot for hand hygiene technology with promising evidence of reductions in rates of infection.

For public health services, plans build on the excellent progress in becoming the largest national pilot site for the Fluenz vaccination programme for children, making plans for transferring commissioning responsibility for the under 5 health visitor services to local authorities and continuing to expand health visitor and family nurse partnership services to support more families, and the introduction of bowel scoping to the bowel cancer screening programme.

Primary healthcare providers face distinct challenges. For GPs significant variations in patient surveyed satisfaction, major differences in opening hours and ease of access, and services geared around Monday to Friday despite progress in evening and Saturday appointments by some. The national service direction is for wider primary care services provided at scale, recognising the challenge that smaller standalone providers face in dealing with rising population need within constrained financial resources.

Plans for primary care are set out based on a number of ambitions developed through working with professionals and partners, including health watch which will inform the strategy for primary care:

To reduce unjustified variation in quality of services – including working with CCGs to ensure patients with more complex needs benefit from national changes to the GP contract requiring new models of care delivery, and a systematic approach to monitoring quality and addressing outlier practices, and working to tackle capacity issues.

To reduce unjustifiable inequalities in health outcomes and access to services for vulnerable groups, including implementing reviews of enhanced services for dementia, health checks for people with learning disabilities, and alcohol abuse to incorporate assessments for depression and anxiety, working to improve oral health in Leicester city and producing an eye health needs assessment to inform future plans.

To increase citizen participation and empowerment in primary care services, including the friends and family test for GP practices, relaxation of boundaries to extent patient choice of where to register, and full rollout of online booking prescriptions and medical record access, and others.

To improve the quality of life for older people and those with long term conditions though implementing GP contract changes focusing on the 2% of patients at highest risk of unplanned admission

To improve access to primary care services and secondary care dental services including supporting pilot practice groups in the prime minister's challenge fund to deliver new models of access and 7 day working.

To reduce unjustified variation in funding received by providers, and secure the highest quality care and best outcomes for every pound invested. This will involve implementing national contract changes, such as phasing out minimum practice incomes, to ensure resources follow patients, and undertaking a review of all PMS contracts to ensure the higher funding is reflected in higher service standards than GMS practices, and where this is not the case releasing resources to support the strategic development of primary care.

Based on international evidence reviews undertaken for NHS England by Nuffield, a number of care delivery models will be supported, with further work to take place:

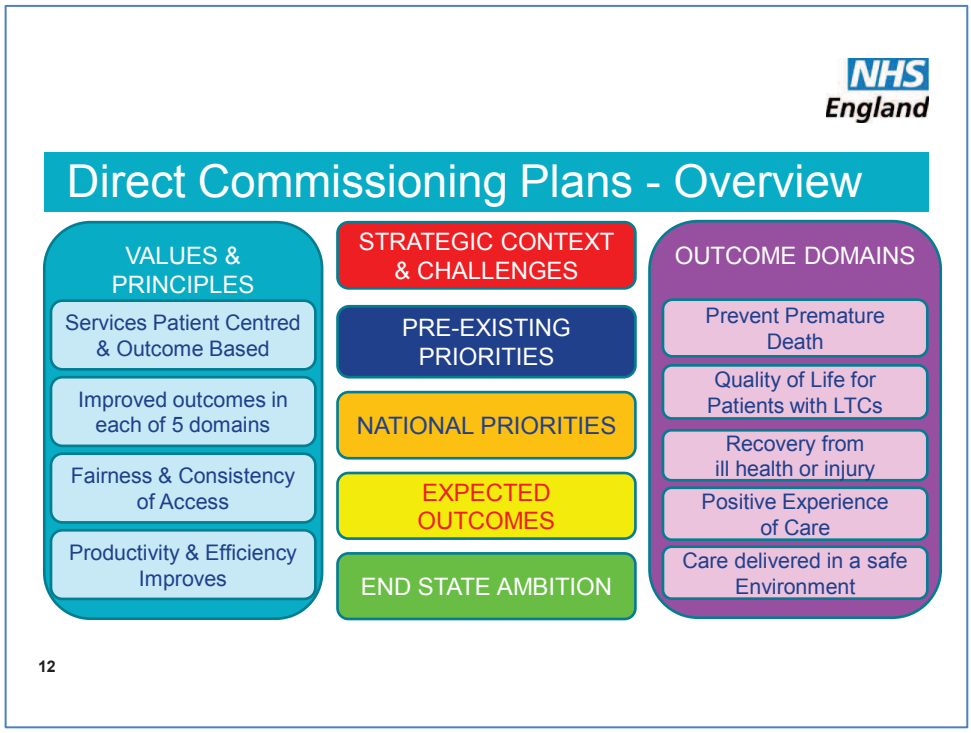
- Integration around specific medical conditions
- Integration across a wide range of conditions in a geography (neighbourhood)
- Colocation and mergers of practices to gain synergies
- Creative use of rural primary care with other public sector and community services
- Federation to manage core services and functions on a shared basis
- Specialist GP services for targeted populations and conditions.

The commissioning plans deliver financially balanced plans in a challenging financial climate whilst responding to a wide range of new ambitions and initiatives set out in 'everyone counts' planning guidance.

Further work with local authority and CCG partners is anticipated using the 'commissioning for prevention' methodology provided nationally to set improvement ambitions jointly with all partners. The area team has prioritised demand management and prevention in its use of monies from emergency care tariffs, and will engage local authority partners in the next months to contribute to refreshing the programme of work in this area.

Overview

Our plans for services sit within a common national framework:



For all services, NHS England's values and principles are that:

- Services should be patient centred and outcome based
- Plans should drive improved outcomes in the five domains set out by government
- Fairness and consistency of access to address health inequalities
- Improvements in productivity and efficiency allow improved quality within available resources

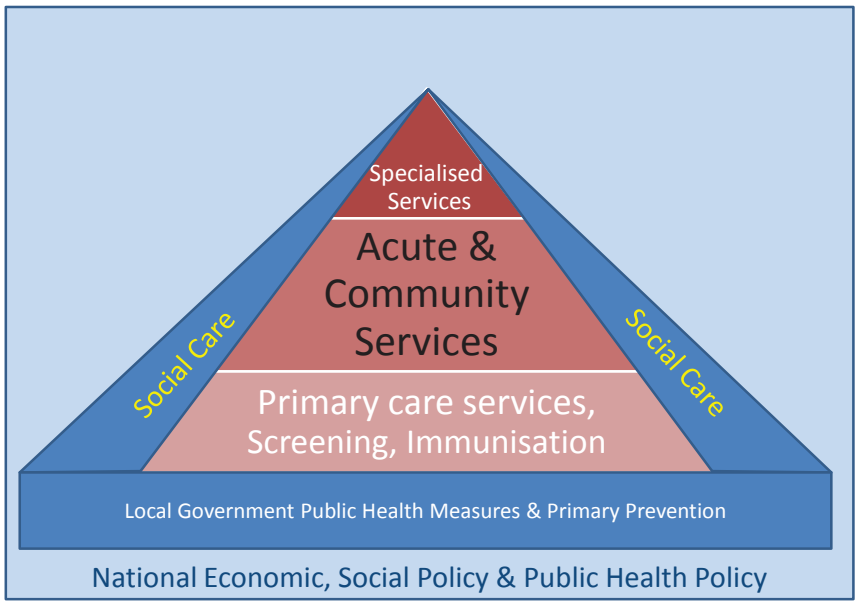
Section one and two set out the strategic context and challenges faced by our population and by providers and commissioners of healthcare. Section three outlines our priorities, the emerging direction for services and the expected outcomes of our plans. Section four focuses on delivery with financial framework for the next two years, and the impact of our change programme for Quality, Innovation, Productivity and Prevention.

Our direct commissioning plans, and those of our CCGs, operate in tandem with a full and active programme of quality improvement led through the NHS England area team and its partners. The outline of the programme is set out in the appendices to these commissioning plans.

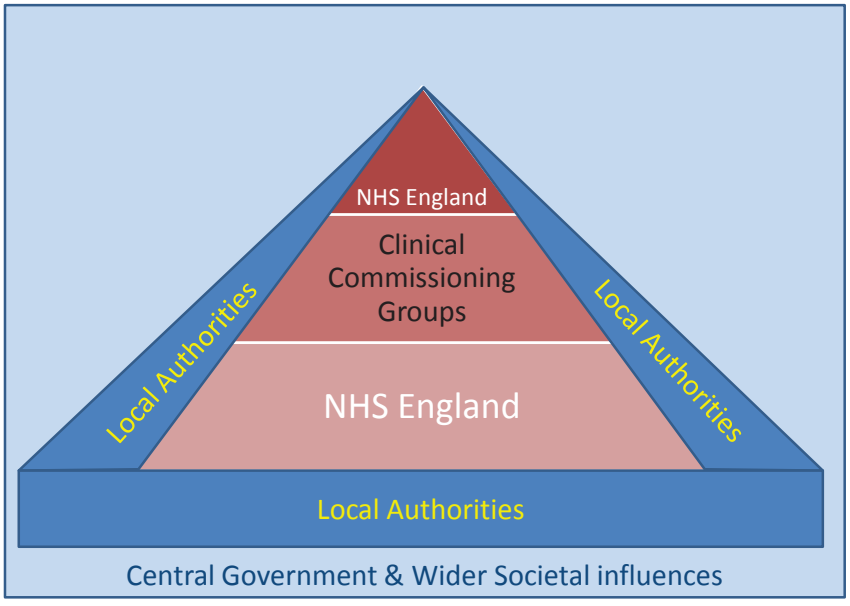
SECTION ONE: NATIONAL AND LOCAL CONTEXT

NHS England's Directly Commissioned Services – An Overview

The NHS in England provides comprehensive healthcare treatment for the whole population for, on average, £34 per person per week, or £1,770 per year. These services, alongside a wide range of other factors, contribute to our life expectancy and the quality of life we live:



A range of public bodies are responsible for these different aspects of care:



At a national level, spend on NHS healthcare in the year ahead is broken down as follows[1]:

NHS Commissioner	Total Spend	Spend Per Person in Population
Specialised Commissioning – NHS England	£13.5bn	£247
Acute and Community Care – CCGs	£64.3bn	£1,179
Primary Care – NHS England	£12.3bn	£225
Immunisation, screening & health Visiting – NHS England	£1.8bn	£33
Other (Better care fund, Health & Justice, National Programmes)	£4.7bn	£86
TOTAL (54.55m People)	**£96.6 bn**	**£1,770**

In Context:

- Two thirds of this money is planned and spent by clinical commissioning groups
- Just under £1 in every £6 is spent on complex and specialised care,
- Around £1 in £8 is spent on Primary Care, and
- Just below £1 in every £50 is spent on NHS Public Health Services (Immunisation, screening & health visiting)

Together the services commissioned by NHS England comprise around £1 in every £4 of spending on the NHS.

Our plans describe NHS England's intentions for Primary Care and NHS Public health Services for the 1.8 million people of Leicester, Leicestershire, Lincoln and Rutland and for all Providers of complex & specialised acute and mental healthcare who are based in the East Midlands, who primarily serve the 4.9 million people in this region, but also some services on a national basis.

Primary care and public health services plans inform the wider population based plans for Leicester Leicestershire & Rutland that all commissioning bodies in the NHS and local authority are developing. The plans for specialised services reflect a national approach to commissioning to ensure nationally consistent access and quality, and complement the local health system population based plans, with all services contributing to the overall outcomes goals the government has set for health and social care.

[1] Source: ONS Population projections, NHS England Allocations working paper 2014

Our Three Commissioning Responsibilities

Direct Commissioning of Specialised Services: Context

In April 2013, NHS England became the sole direct commissioner of all specialised services, with a related budget of some £13.5 Billion (14/15). Specialised services are services which are provided for less common disorders and need to be concentrated in centres of excellence where the highest quality care can be provided – care that is clinically effective, safe and offers a positive experience for patients. It is important that these services are connected to research and teaching.

NHS England is now the sole commissioner of specialised services with a clear responsibility to show leadership in delivering the best outcomes and experience of care for patients. In doing so, NHS England is keen to demonstrate its commitment to working in partnership with patients, the public, clinicians, patient organisations, providers, industry, academia and others, to develop its priorities in the coming years. To support the delivery of this commitment, NHS England is working with the Specialised Healthcare Alliance and Rare Disease UK to develop a national 5 year strategy.

Ten of NHS England's 27 area teams have direct commissioning responsibility for specialised services. They account for over 10 per cent of the overall NHS budget. Area teams are required to implement these national policies at a local level, managing contracts with their providers on behalf of all patients in England.

The Leicestershire, Lincolnshire area team is one of these area teams with commissioning responsibility for commissioning specialised services for the population of England for all providers in the East midlands. This operational plan provides an account of the first two years of the five year strategy from the perspective of the Leicestershire Lincolnshire Area team.

The Strategic direction of NHS England is to deliver quality specialised services for all. This includes ensuring there is access to services for all, the services must be clinically and financially sustainable. To achieve this we are undertaking a systematic and coordinated review of all of the specialised services that we commission. This will involve exploring capacity, capability and access associated with all of the services in the East Midlands. The co-dependency of services and the relationship between those that provide services and commission them is a fundamental to the success of this process. This will inevitable involve adopting new approaches to the delivery of care and the integration of services from both a provider and commissioning perspective. As an Area Team we are working with one of our constituent CCGs (Southern Derbyshire) to pilot one of five national pathfinder projects looking at pathways of care that transcend commissioning boundaries. A project board has been established and project initiation document has been developed in line with the project brief. The focus of the project on commissioning and development of commissioning tools that can be adopted nationally for the management of Acute Kidney Injury.

The systematic and transparent approach to commissioning is underpinned by adhering to a systematic rules based approach. We have adopted a coordinated and constant approach to assessing services against the service specification by ensuring that we have external validation of the process by using members of the regional team, strategic clinical networks and senate as part of this process. Being proactive in ensuring we have a team approach to all aspects of commissioning ensures that maximum use is made of everyone's skills and experience to deliver services which are both clinically and financially sustainable.

All of our commissioning intentions and ambitions are considered within the context of the local healthcare environment. This includes any sustainability reviews being undertaken that are exploring the long-term provision of healthcare over a wide geographical area (Lincolnshire). Well established and programmed peer reviews of cohorts of specialist services (cancer) or service inspections (Keogh or CQC). The impact of changes in the demographics and the dispersal of populations are factors that will need to be considered in implementing nationally set policies and guidance. Local intelligence will come from engagement with the strategic clinical networks and senates, health related charities and user groups. Close cooperation with public health colleagues and the integration of the commissioning function of Public Health England into the organisation will ensure the wider aspects of health care are considered when planning changes to how we commission healthcare. We support Strategic Clinical Networks and Academic Health Science Networks to develop work plans which focus on strategic care models and pathway development for key health needs. This enables integration of care and a shift toward earlier intervention and treatment. The benefit from this work will manifest where there is a direct link to access to specialised care pathways such as in obesity, kidney care and cancer services. Although we will not lose sight of the importance of access, egress, quality and availability of specialised services the team must also be mindful of the financial sustainability of any specialised service that we commission.

A key area for the Area Team is managing its financial risks and for developing the value for money and quality it delivers through its service providers. In order to do this we have an established team of supplier managers and service leads who work together in a matrix to underpin a formal approach to the way that we manage our suppliers. This includes:

- Contract management, negotiation, & where required dispute resolution.
- Co-ordinating the delivery of outcomes and quality including the management of Significant Incidents & commissioning Quality Innovation (CQUIN) schemes.
- Forecasting Demand and Planning Capacity of services
- Production of monthly reporting of performance indicators for service providers
- Financial performance – including carrying out monthly financial review and forecasts, assuring co-ordination with service providers cost base and being accountable to the Head of Finance for accurate financial reporting.
- Maintaining detailed Trust specific business knowledge, including maintaining awareness of providers' service risks.
- Raising and resolving performance issues (e.g. readmission levels, mortality).
- Identifying and managing efficiency programs and targets.
- Supporting the adoption of "best practice" to ensure value for money care processes
- Maintaining high visibility with senior management and clinicians in providers.
- Business Case Review for service developments.
- Benchmarking costs/performance with service specialists

Direct Commissioning of Primary Care: Context

From 1st April 2013, NHS England became the sole commissioner of primary medical, ophthalmic and pharmaceutical services, and all dental services with an associated budget

of £12.6bn. This also included contractor payments, patient registration and primary care support services (Family Health Services).

All 27 Area Teams have direct commissioning responsibility for these services and this is summarised in the table below along with the responsibilities of other commissioners where there is a joint commissioning role.

NHS England Area Team	Related Commissioning
Primary Medical Services Essential and additional primary medical services through GP contracts and nationally commissioned enhanced services. Out of hours primary medical services (where practices have retained the responsibility for providing out-of-hours services. Improving the quality of primary care, access and patient experience.	**CCGs** - Community-based services that go beyond the scope of the GP contract (akin to the current Local Enhanced Services). **CCGs** - Out-of-hours primary medical services (where practices have opted out of providing out-of-hours services under the GP contract). **CCGs** - A duty to support the Area Team to improve the quality of primary medical care.
Pharmaceutical Services Pharmaceutical services provided by community pharmacy contractors (not though a contract but the contractors' terms of service are included in Regulation), dispensing doctors and appliance contractors.	**CCGs** – meeting the costs of prescriptions written by member practices (but not the associated dispensing costs). **Local Authority** – production of the Pharmaceutical Needs Assessment.
General Ophthalmic Services Primary ophthalmic services, NHS sight tests and optical vouchers.	**CCGs** – any other community-based eye care services and secondary care services.
Dental Services All dental services, including primary, community, and secondary care services, plus urgent and emergency dental care.	**Local Authority** – Dental Public Health.

The strategic direction of NHS England is to enable primary care to play a greater role in the move to more integrated out-of-hospital services that deliver better health outcomes and deliver more personalised and proactive care, an excellent patient experience, high standards of quality, and the best possible value for money.

The main challenges for primary care are:

- How can primary care support prevention, care navigation, and case management through an increasingly multidisciplinary approach to service delivery?
- How can primary care reduce expensive unplanned admissions to secondary care and build capacity in the community to deliver integrated out-of-hospital services?
- How can primary care resolve its capacity issues to raise standards and improve consistency?

The Leicestershire and Lincolnshire Area Team's five year strategy aims to address these 'big issues' and deliver our vision for primary care. This includes:

- supporting innovative sustainable models of service delivery, workforce capacity solutions, improved access,
- working through contractual limitations,
- valuing the role of the primary care generalist in providing continuity, coordination and a personal approach, and
- involving patients in our commissioning of services.

The operational plan outlines the first two years of that journey.

Direct Commissioning of Public Health Services: Context

The public health function is responsible for commissioning the 30 services defined in section 7a of the agreement between the Department of Health and NHS England. Twenty six of these relate to national screening programmes and to immunisation programmes. The Public Health England embedded team lead on the commissioning of these services. The remaining four services include health visiting services for those under 5 years, child health records departments, public health services for detained offenders and sexual health referral centres.

Commissioning of all these services requires close working links with other commissioners including:

- CCGs and specialised services commissioners as they commissioning many of the treatment pathways that follow on from screening programmes
- primary care commissioners as much of immunisation is commissioned from primary care as part of the GMS/PMS contract
- local authority commissioners due to the links with school nursing and immunisation services and the transfer of responsibility for commissioning health visiting services that will take place in October 2015.

Whilst the financial value of these services is relatively modest the reach is great with several hundred thousand contacts per year from these services within the population of Leicestershire, Lincolnshire & Rutland

SECTION TWO: OUR CURRENT STATE

Demand for Healthcare - The Health Needs of our Population

Leicester, Leicestershire & Rutland and Lincolnshire

Leicestershire, Lincolnshire and Rutland are the areas whose population is served by our Primary care and Public Health services, geographically amongst the largest footprint served by NHS England's area teams at over 9,500 square km, almost 60% of the east midlands.

The population is diverse with a 40 fold difference in rurality between the 4 local authority areas. The main centres of population are the cities of Leicester and Lincoln with smaller market towns serving the county areas of Leicestershire, Lincolnshire and Rutland in otherwise predominantly rural areas, as well as coastal East Lincolnshire, with a seasonal migrant population. The BME community is under 3% in Lincolnshire and Rutland, 15% in Leicestershire and 49% in Leicester city, with a large South Asian population.

Geographically, Lincolnshire is the third largest county in England and covers an area of 2350 square miles. Leicestershire covers an area of 800 square miles and Rutland is the smallest county in England and covers an area of 152 square miles.

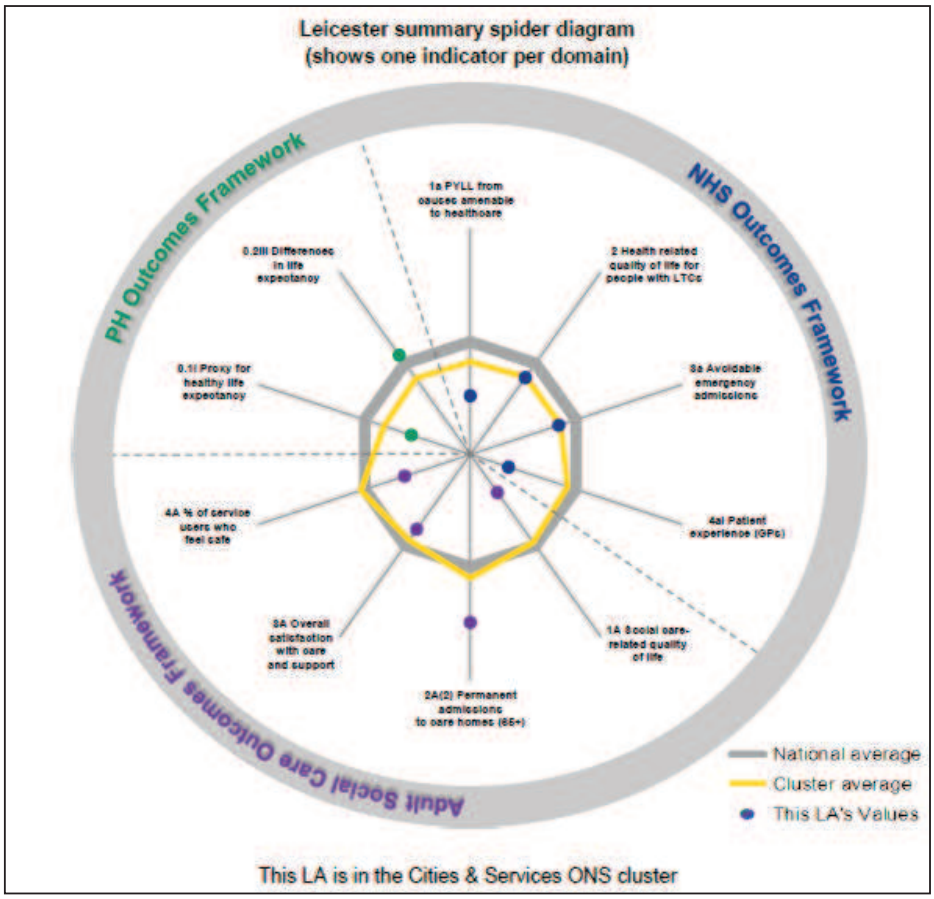
By road, it is approximately 125 miles to travel from the north to south of the area and 140 miles west to east.

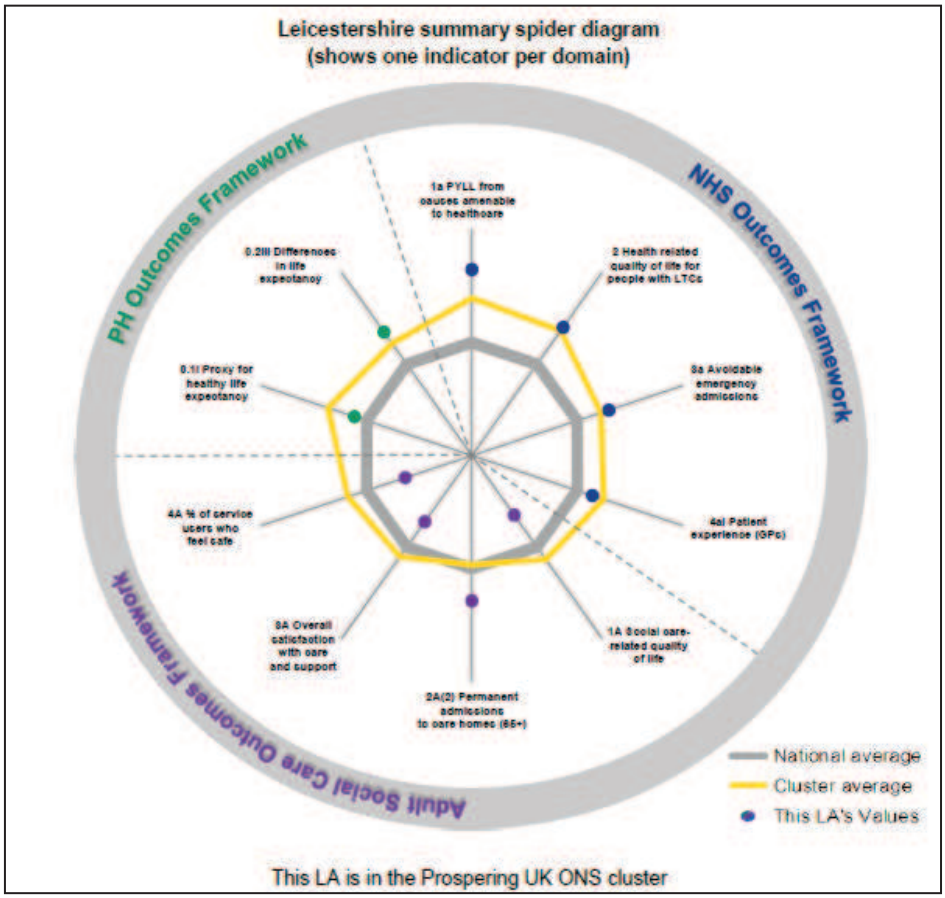
The Leicestershire and Lincolnshire area has a registered population of 1,792,400 with a higher proportion of 0-9 year olds in its population than the England average, a lower proportion of 25-39 year olds in its population than the England average, and a higher proportion of residents aged 60+.

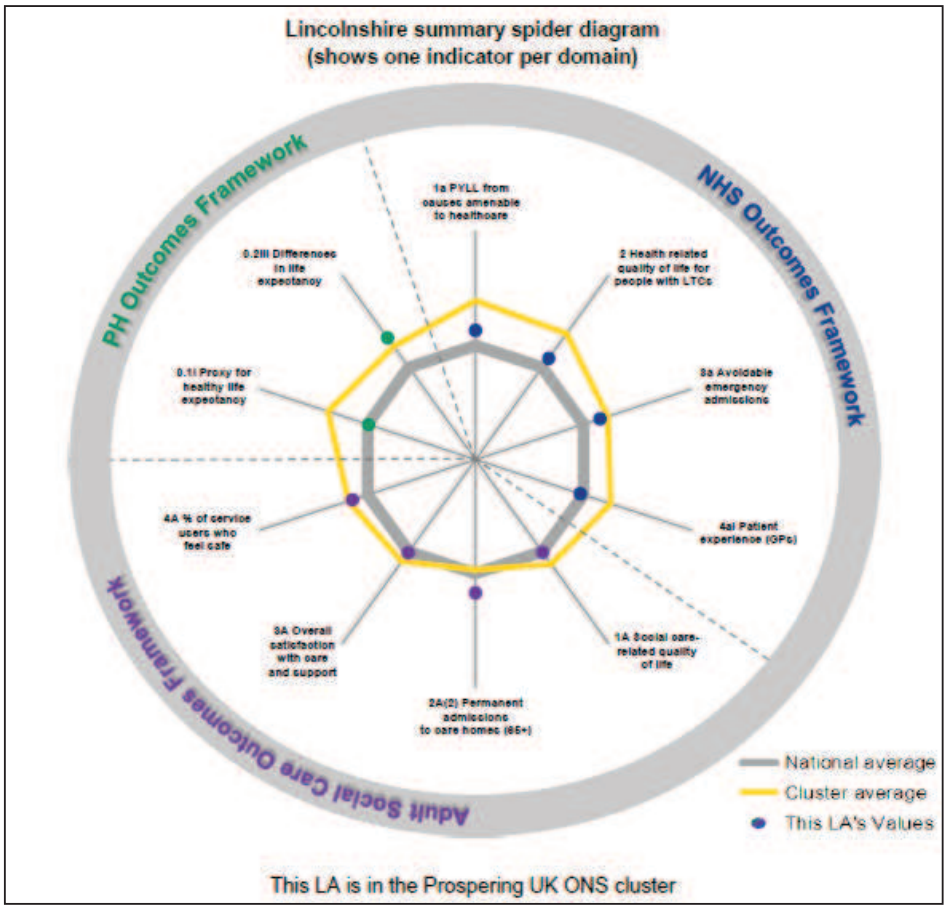
Summary of Health in Leicestershire, Lincolnshire & Rutland

Outcomes benchmarking support packs published by NHS England, Public Health England, The Information Centre and Local Government association identify the existing health and care system performance in Leicestershire, Lincolnshire and Rutland compared to England averages and to similar comparable populations for the outcomes indicators defined by government for health, public health, and social care. The overview of these comparators is shown overleaf. The key health issues identified are:

Leic City	Lincs	Leics	Rutland
Poor Patient surveyed GP Experience	More years of life lost from causes amenable to healthcare than peers	Average Life expectancy below peers	More years of life lost from causes amenable to healthcare than peers
High Years of life lost from causes amendable to healthcare	Health related Quality of life for people with LTC below peers	Patient surveyed GP experience below peers	
Low Average Health Life Expectancy	Patient surveyed GP experience below peers		
	Average Life expectancy below peers		




Leicestershire summary spider diagram
(shows one indicator per domain)
PH Outcomes Framework
NHS Outcomes Framework
Adult Social Care Outcomes Framework
1a PYLL from causes amenable to healthcare
2 Health related quality of life for people with LTCs
3a Avoidable emergency admissions
4al Patient experience (GPs)
1A Social care-related quality of life
2A(2) Permanent admissions to care homes (65+)
3A Overall satisfaction with care and support
4A % of service users who feel safe
0.1i Proxy for healthy life expectancy
0.2iii Differences in life expectancy
National average
Cluster average
This LA's Values
This LA is in the Prospering UK ONS cluster


Lincolnshire summary spider diagram
(shows one indicator per domain)
PH Outcomes Framework
NHS Outcomes Framework
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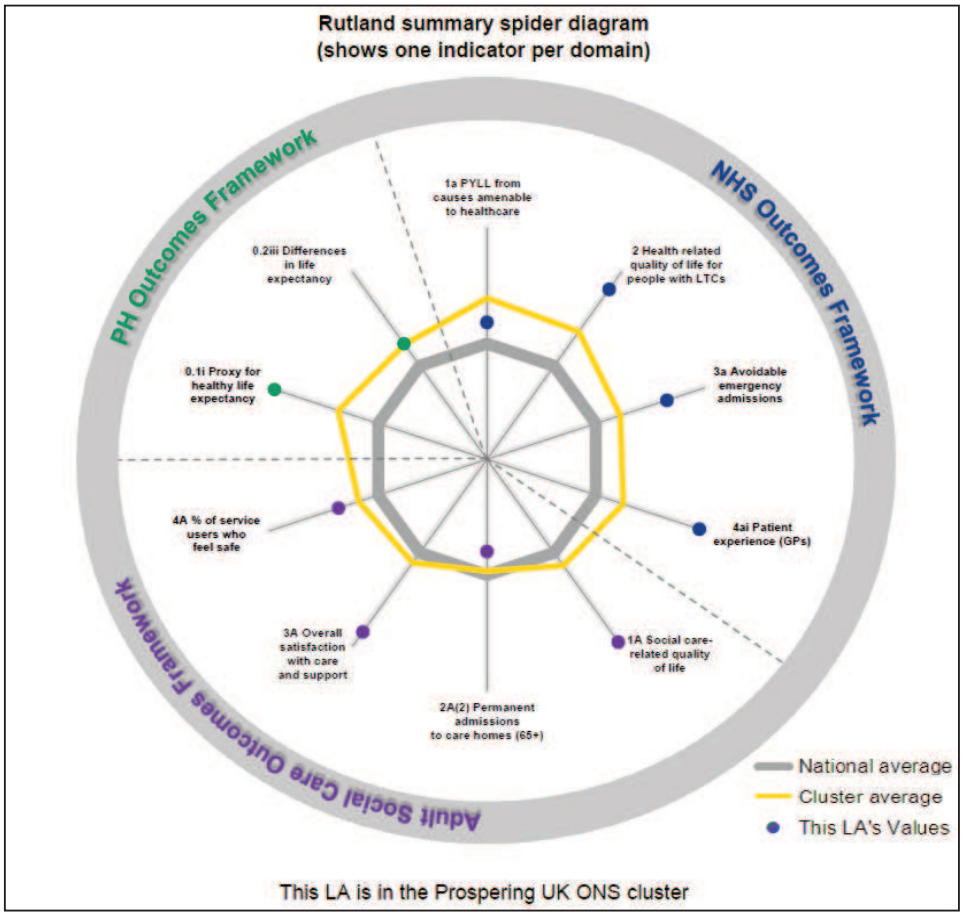
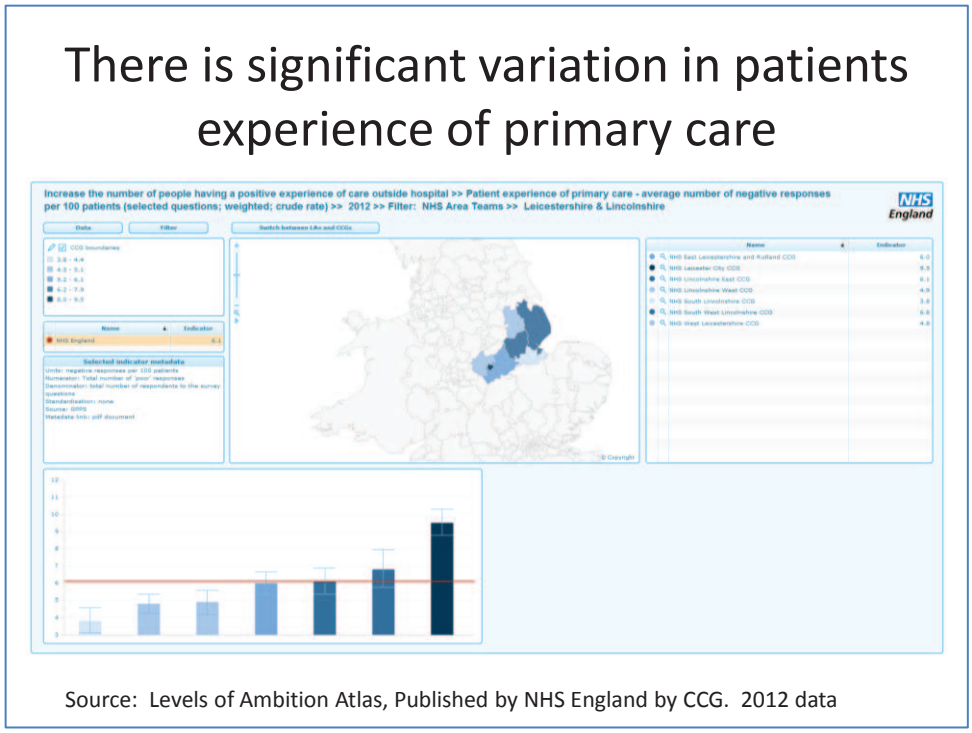


Insights from the Atlas of Variation

The range of issues to be addressed in partnership with the seven CCGs serving Leicestershire and Lincolnshire includes significant variation in the outcomes and experience affected by primary care and public health:



As well as the significant difference in primary care in Leicester city, Lincolnshire South West and Lincolnshire East Appendix 1 highlights greater potential years of life lost in Leicester city and East Lincolnshire, poorer reported quality of life for people with long term conditions in Leicester city, East and west Lincolnshire, and higher levels of avoidable emergency admission in East Lincolnshire. These variances in outcomes help to define the joint agenda between NHS England and CCGs for improving the quality and contribution of primary care services to the wider health and care system.

The East Midlands

Other than national chains of healthcare providers, our commissioned specialised services providers are based in the East Midlands. Our responsibilities are for all patients nationally who use these services; including patients from other regions who choose to use services in the East Midlands. Our providers provide a range of specialised services which address the health needs of the populations they serve. The majority of which will come from the East Midlands catchment. Some specialised services used by the population in the region are not delivered by East Midlands providers; patients from the East Midlands will travel to other providers elsewhere in the UK for those services.

The East Midlands is geographically the fourth largest region in England in terms of area (15,607 sq km) and has a resident population of approximately 4.9 million. The provider landscape includes; two large teaching hospitals for acute care are situated in the region, Nottingham University Hospitals and University Hospitals of Leicester, both of which provide specialised tertiary care. There are seven district general hospitals and five NHS mental health providers which also provide elements of specialised care. Rampton Hospital, which is part of Nottinghamshire Healthcare NHS Trust, the largest Mental Health Trust in the country, is one of three providers of High Secure Psychiatric Services.

The East Midlands has a diverse population with the main centres of population in the cities of Derby, Leicester, Lincoln & Nottingham, & the large town of Northampton. The county areas of Derbyshire, Leicestershire, Lincolnshire, Northamptonshire, Nottinghamshire & Rutland are predominantly rural. Overall, the East Midlands region has the second lowest population density in England. In the cities a substantial proportion of the population is drawn from black & minority ethnic groups & there are high levels of deprivation, as there are in particular areas such as the old mining villages & steel towns. There are particularly low levels of deprivation in some county areas & the average deprivation for the East Midlands is similar to that of England. Increases in births, decreases in deaths, changes in migration & the pattern of UK immigration have all contributed to population growth since 2001.

Summary of Health in the East Midlands

The East Midlands Health Profile 2010, produced by the Association of Public Health Observatories and Department of Health, provides a snapshot of health in the region. It compares East Midlands with other regions and the England average for a range of indicators.

The health of people in the East Midlands is generally close to the England average. However, levels of physical activity in adults, children in Reception year classified as obese and hospital stays for alcohol related harm are all better than the average for England, whilst levels of smoking in pregnancy, breast feeding initiation and infant deaths are all worse.

There are inequalities in health within the East Midlands which are closely associated with deprivation. For example, the health of people in Harborough, Rushcliffe and South Northamptonshire is generally better than both the England average and the East Midlands average, while the health of people in Nottingham, Mansfield and Derby is generally worse.

Death rates from all causes for both males and females have reduced over recent years; however life expectancy for both men and women living in the East Midlands is lower than the England average.

In the East Midlands, levels of people diagnosed with diabetes have increased over the last five years, and are higher than the average for England.

The priorities for the East Midlands are to address health inequalities, tobacco and alcohol use, obesity, physical activity, avoidable injury and death, affordable warmth and the health of children and young people.

The Outcomes benchmarking support packs published by NHS England, Public Health England, The Information Centre and Local Government association identify the existing health and care system performance in the other 6 local authority areas across the east midlands in addition to Leicestershire, Lincolnshire and Rutland. The packs compare to England averages and to similar comparable populations for the outcomes indicators defined by government for health, public health, and social care. The overview of these comparators is shown overleaf. The key health issues identified are:

Notts	Derbyshire	Nottm City	Derby City	Leic City	Lincs	Leics	Rutland	Northants	MK
Differences in life expectancy better than peers but larger than average	Average life expectancy better than peers but below average	Low Average Life expectancy	Low Average Life expectancy	Poor Patient surveyed GP Experience	More years of life lost from causes amenable to healthcare than peers	Average Life expectancy below peers	More years of life lost from causes amenable to healthcare than peers	Differences in life expectancy average, but larger than peers	More years of life lost from causes amenable to healthcare than
Quality of Life for LTC patients better than peers but below average	Quality of Life for LTC patients better than peers but below average	Large differences in life expectancy	Large differences in life expectancy	High Years of life lost from causes amendable to healthcare	Health related Quality of life for people with LTC below peers	Patient surveyed GP experience below peers		More years of life lost from causes amenable to healthcare than peers	Health related Quality of life for people with LTC below peers
		High years of life lost from causes amenable to healthcare		Low Average Health Life Expectancy	Patient surveyed GP experience below peers			More avoidable emergency admissions than peers	Poor Patient surveyed GP Experience
		Poor health related quality of life for people with LTC			Average Life expectancy below peers				

Health Profile Summaries for other East Midlands Authorities are shown in the appendix.

Demographic factors which particularly influence need for services are the age structure, gender, levels of deprivation and ethnicity. Changes in regional demographics will impact on the health care needs and in turn directly influence the type and volume of health services required by a population.

Population Trends

Area Team CCG Breakdown Year on Year ONS Estimates Growth All Ages	2013	2014	2015	2016	2017	2018	2019	2020	2021	9 Year Total
NHS Lincolnshire East CCG	1.4%	1.3%	1.3%	1.3%	1.2%	1.2%	1.2%	1.1%	1.1%	11.7%
NHS Lincolnshire West CCG	0.9%	0.9%	0.8%	0.8%	0.8%	0.8%	0.7%	0.7%	0.7%	7.4%
NHS South West Lincolnshire CCG	1.1%	1.1%	1.1%	1.1%	1.1%	1.0%	1.0%	1.0%	1.0%	10.0%
NHS South Lincolnshire CCG	1.3%	1.3%	1.3%	1.3%	1.3%	1.2%	1.2%	1.2%	1.2%	12.0%
NHS Leicester City CCG	0.5%	0.5%	0.5%	0.5%	0.5%	0.4%	0.4%	0.4%	0.4%	4.2%
NHS East Leicestershire And Rutland CCG	1.0%	0.9%	0.9%	0.9%	0.9%	0.8%	0.8%	0.8%	0.8%	8.1%
NHS West Leicestershire CCG	1.1%	1.0%	1.0%	0.9%	0.8%	0.8%	0.8%	0.7%	0.7%	8.2%
Leics Year on year	0.9%	0.8%	0.8%	0.8%	0.7%	0.7%	0.7%	0.7%	0.6%	6.9%
Lincs Year on year	1.2%	1.2%	1.1%	1.1%	1.1%	1.0%	1.0%	1.0%	1.0%	10.1%
L&L Year on Year	1.0%	1.0%	0.9%	0.9%	0.9%	0.8%	0.8%	0.8%	0.8%	8.2%
Derbyshire And Nottinghamshire Area Team Year on Year	0.7%	0.7%	0.7%	0.7%	0.7%	0.7%	0.6%	0.6%	0.6%	6.3%
Hertfordshire And The South Midlands (E Mids) Year on Year	1.3%	1.3%	1.3%	1.2%	1.2%	1.2%	1.1%	1.1%	1.1%	11.4%
EAST MIDLANDS TOTAL YEAR ON YEAR	1.0%	0.9%	0.9%	0.9%	0.9%	0.8%	0.8%	0.8%	0.8%	8.0%
England Total Year on Year	0.9%	0.9%	0.9%	0.8%	0.8%	0.8%	0.8%	0.8%	0.8%	7.7%

For primary care and public health services, the area team's population served will grow at slightly above the national and east midlands rate. This masks an underlying significant difference between Leicester city which will grow at a significantly lower rate, just over half the regional and national rates of growth, but Lincolnshire as a whole, particularly the east and south of Lincolnshire is forecast to grow at rates significantly above regional and national levels.

For specialised services, the East Midlands population will grow 0.3 percentage points above the national rate over the next 7 years with the South Midlands population growing 50% faster than England as a whole offset by lower growth in Derbyshire & Nottinghamshire with implications for the balance of provider capacity over time, to be factored into the future strategy for specialised services.

Supply of Healthcare – Our Healthcare Providers

Provider Profile – Specialised Services

The Area team hold Acute contracts to the value of circa - £600m (nine providers) and Mental Health contracts to the value of - circa £285m (nine providers):

ACUTE SPECIALISED SERVICES	TYPE	CQC Risk Rating	2013/14 Annual Budget	% of Acute Specialised Budget	Provider Annual Turnover	Specialised Budget as % of Provider Turnover 2012/13
Provider			£m	%	£m	%
Nottingham University Hospitals	NHS Trust	2	228	38%	631	36%
University Hospitals of Leicester	NHS Trust	1	198	33%	649	31%
Derby Hospitals NHS	Foundation Trust	3	55	9%	411	13%
United Lincolnshire Hospitals	NHS Trust	1	42	7%	383	11%
Northampton General Hospital	NHS Trust	1	32	5%	236	13%
Kettering General Hospital T	Foundation Trust	2	19	3%	165	11%
Milton Keynes Hospital	Foundation Trust	3	15	2%	163	9%
Sherwood Forest Hospitals	Foundation Trust	1	10	2%	258	4%
Chesterfield Royal Hospital	Foundation Trust	5	8	1%	178	5%
TOTAL			**607**	**100%**		
SPECIALISED MENTAL HEALTH	**TYPE**		**2013/14 Annual Budget**	**% of Mental Health Specialised budget**	**Provider Annual Turnover**	**Specialised budget as % of Provider Turnover 2012/13**
			£m	%	£m	%
Nottinghamshire Healthcare	Partnership Trust		139	49%	385	36%
St Andrew's Healthcare	Charity		100	35%	169	59%
Northamptonshire Healthcare	Foundation Trust		10	4%	171	6%
Leicestershire Partnership	Partnership Trust		8	3%	235	3%
Raphael Healthcare	Independent		8	3%		
Derbyshire Healthcare	Foundation Trust		5	2%	125	4%
Lincolnshire Partnership	Foundation Trust		4	1%	94	4%
Severe Personality Disorder			6	2%		
The Ansel Group	Independent		4	1%		
Meadow View Hospital (Curate)	Independent		3	1%		
TOTAL			**285**	**100%**		

Within the acute services sector:

- Over 70% of Commissioned spend is with the 2 main tertiary teaching trusts in the region, where NHS England is the largest single commissioner of services at between 30-40% of Total Trust Income

- For the other providers NHS England is only 5-13% of Trust income reflecting a much narrower range of services
- Over 83% of spend is with providers yet to achieve foundation trust status
- Over 85% of spend is at providers in the two highest CQC quality risk ratings
- Financially the 2 NHS Trusts in Leicestershire and Lincolnshire are operating with a large financial deficit (over £70m combined) and three of the five foundation trusts are rated in the highest financial risk rating by Monitor.

This wider context reflects the major priority, working in partnership with CCGs, to achieve financial sustainability and improvements in quality at the whole system level across the majority of acute providers in the East Midlands. The strategy for specialised services will take account of this context

Within the Mental Health Sector, although the spend shows similarly high levels of concentration at the top 2 providers, the drivers are very different:

- More than a third of total spend in this sector, is on one of three national High secure services, which represents 60% of the spend with Nottinghamshire healthcare
- The second largest spend reflects the East Midlands lead for an independent provider with services across 3 regions for which this area team takes a lead role
- The remaining contracts are below £10m in value, with individual case management, rather than high volume treatment, the predominant characteristic of mental health services commissioned.

A key dimension of the profile of providers of specialised healthcare is their current service levels compliance to nationally developed clinical service specifications and policies.

There are currently 359 services identified in the acute services that are currently under consideration for compliance against the service specification. The table below is a summary of the current status with services described in three main categories; **compliant** with the service specification, services not compliant but they have applied for **derogation**[2] and services where only part of the pathway is provided and the service is **provided in partnership**.

Table: Summary of current position of the acute services in the East Midlands current delivery specialist services in accordance with the service specifications

Hospital	Compliant	Derogation	In partnership	TOTAL
Chesterfield Royal Hospital	4		10	**14**
Derby Hospitals	27	3	4	**34**
Kettering General Hospital	6	4	52	**62**
Milton Keynes Foundation Trust	4	4	9	**17**
Northampton General Hospital	23	6	7	**36**
Sherwood Forest Hospitals	4		2	**6**
University Hospitals of Leicester	75	10	2	**87**
United Lincolnshire Hospitals	2	7	5	**14**
Nottingham University Hospitals	68	21	0	**89**
Total	**213**	**55**	**91**	**359**

[2] Derogation is a time-limited conditional agreement to operate at variance to the national specification

Our operational plans set out later in this document outline the intentions for addressing areas of non-compliance with service specifications in line with the emerging strategy for specialised services.

NHS England commissions according to agreed policies and service specifications, which identify where treatments, devices and services are routinely commissioned. Commissioning policies that specify treatment thresholds and criteria act within the NHS contract as 'group prior-approvals' for treatment. In some cases, additional audit may be required with to give prior approval for individual patients by commissioners. Where policies and specifications make clear that treatments, devices and services are not routinely commissioned, or where treatment thresholds and criteria have not been adhered to providers will not receive funding if they initiate these treatments. This ensures, so the money provided to us by the government is available for treatments our population need that do have clear evidence of benefit, in line with NHS England's ethical framework for prioritisation.

Providers are also required to comply with national audit requirements as part of the service specifications. Resulting audit data will be reviewed and used to inform service and quality improvement initiatives as part of on-going contractual monitoring arrangements.

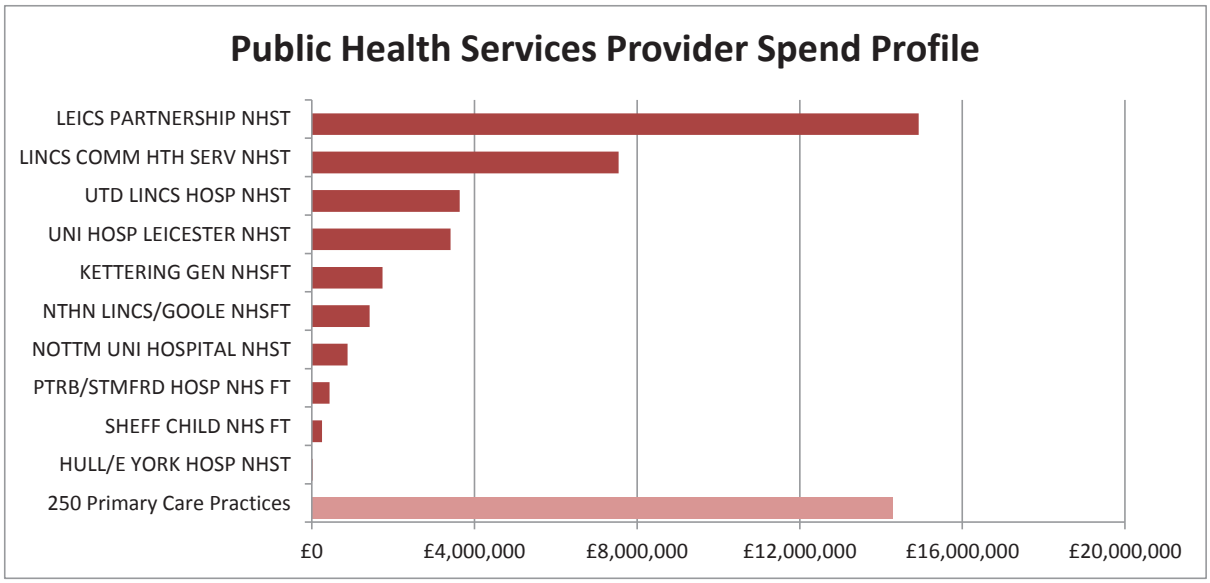
Provider Profile – Public Health Services

PUBLIC HEALTH SERVICES	TYPE	2013/14 Annual Spend	% of Public Health Services Budget	Provider Annual Turnover	L&L Public Health Spend as % of Provider Turnover 2012/13
Provider		£m	%	£m	%
Leicester Partnership Trust	Partnership Trust	14.9	31%	235	6%
Lincolnshire Community Health Services	NHS Trust	7.5	16%	109	7%
United Lincolnshire Hospitals	NHS Trust	3.6	7%	383	1%
University Hospitals of Leicester	NHS Trust	3.4	7%	649	0.5%
Kettering General Hospital	Foundation Trust	1.7	4%	165	1%
North Lincs and Goole Hospitals	Foundation Trust	1.4	3%	285	0.5%
Nottingham University Hospitals	NHS Trust	0.9	2%	631	0.1%
Peterborough & Stamford	Foundation	0.4	1%	219	0.2%
Other Acute		0.3	1%	N/A	N/A
Primary Care Practices	Independent Contractors	14.3	29%	Varies	Varies

Public health services across Leicestershire and Lincolnshire are shown below. The provider base falls into three categories:

- One large provider of community services in each county with spend on child health services though health visitors and family nurse partnerships. These services also provide some immunisation services where not delivered in general practice, and account for just under half (45%) public health services commissioning spend. These services form a relatively small but significant share of provider income.

- Acute services contracts in the area team's geography and neighbouring geographies predominantly screening services. These services comprise a quarter of public health spend but typically represent below 1% of provider turnover.
- Primary care providers, predominantly for immunisation, where the proportion of turnover is higher but overall spend is much less concentrated and geographically decentralised into local communities, spread across over 250 contractors.



The focus for provider development for public health services is at the service level ensuring development in line with national standards and responding to audit visits of national clinical teams.

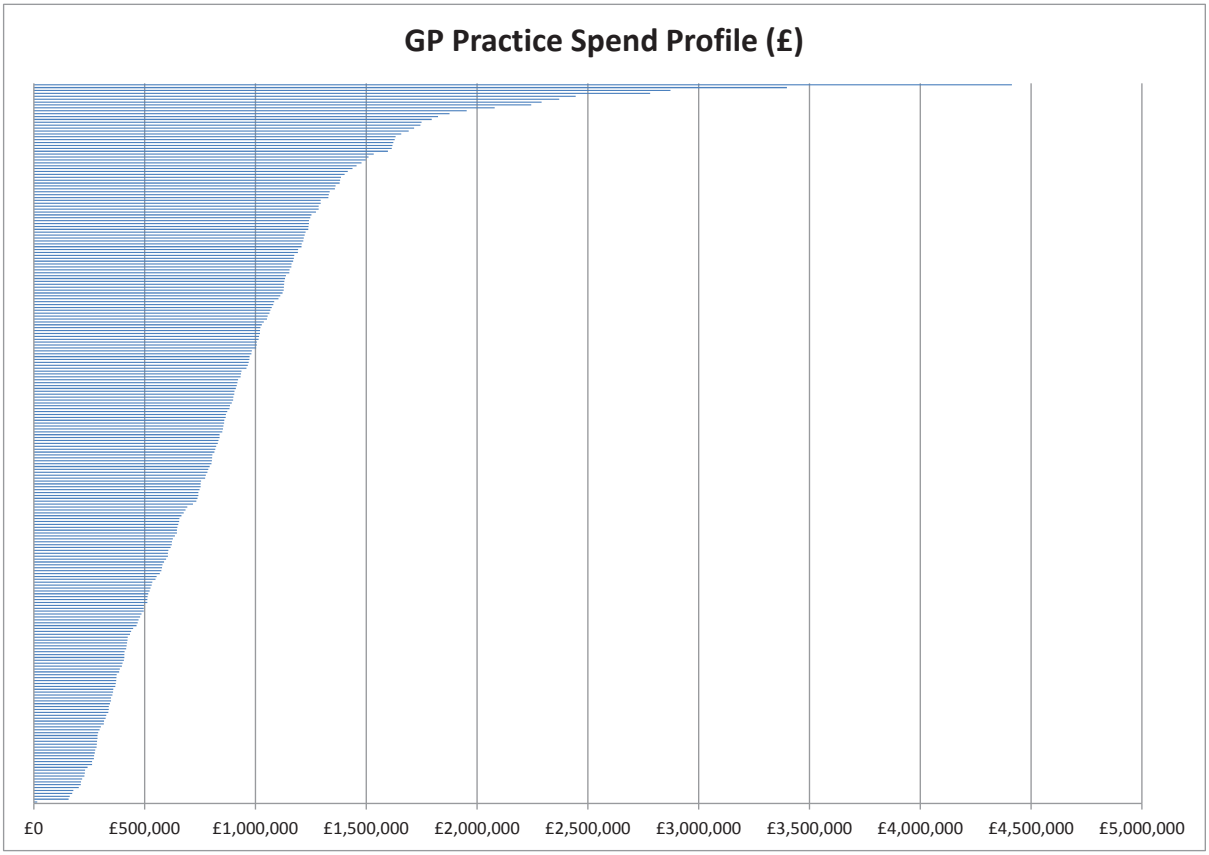
Provider Profile – General Practice

Across Leicestershire and Lincolnshire Primary care services are provided through over 1,100 independent contractors, of which 250 are general practitioner medical services contracts, the balance being primary care dentistry, optometry and pharmacy.

More than nine in ten encounters with the NHS are with Primary healthcare providers. For GP services NHS England represents a single national contracting body, and although practices may be funded by clinical commissioning groups and local authorities for other services, typically well over 95% of practice income will come from NHS England's commissioning of primary care [3]

Commissioning spend with general practice has low levels of concentration with the largest primary care contract accounting for only 2% of NHS England's spend. Within this however, there is considerable variation in the scale of primary care:

[3] Enhanced services vs core services spend set out in the HSCIC report 'Investment in General Practice' 2013



The spread of spend is illustrated below:

Practice Contract	Annual Spend
Upper Decile	£1.60m
Upper Quartile	£1.16m
Median Spend	£0.83m
Lower Quartile	£0.47m
Lower Decile	£0.30m

Strategic plans for primary care acknowledge and respond to the diversity in the scale and size of existing primary care providers, with contracts up to £4.4m per annum from significantly sized organisations, down to small business holders.

Patient Experience of General Practice

GP Patient Survey Results – General Practice

Satisfaction with Accessing Primary Care	NHS EAST LEICESTERSHIRE AND RUTLAND CCG		NHS LEICESTER CITY CCG		NHS LINCOLNSHIRE EAST CCG		NHS LINCOLNSHIRE WEST CCG		NHS SOUTH LINCOLNSHIRE CCG		NHS SOUTH WEST LINCOLNSHIRE CCG		NHS WEST LEICESTERSHIRE CCG	
	%age	No. red outliers	%age	No. red outliers	%age	No. red outliers	%age	No. red outliers	%age	No. red outliers	%age	No. red outliers	%age	No. red outliers
Accessing GP Services	75	45	72	70	74	38	76	39	78	8	77	16	76	61
Making an Appointment	85	26	84	41	85	19	87	17	89	3	90	8	88	14
Opening Hours	80	18	82	15	82	11	83	6	85	1	82	5	82	15
Average of All Three/sum of outliers	80	89	79	126	80	68	82	62	84	12	83	29	82	90
Satisfaction with the Quality of Consultation at the GP Practice	%age	No. red outliers	%age	No. red outliers	%age	No. red outliers	%age	No. red outliers	%age	No. red outliers	%age	No. red outliers	%age	No. red outliers
Seeing a Doctor	89	27	83	118	86	44	89	25	90	7	90	15	88	49
Seeing a Nurse	90	9	87	29	91	4	92	3	92	2	92	0	89	40
Average of both/sum of outliers	90	36	85	147	89	48	91	28	91	9	91	15	89	89
Satisfaction with the overall care received at the surgery	%age	No. red outliers	%age	No. red outliers	%age	No. red outliers	%age	No. red outliers	%age	No. red outliers	%age	No. red outliers	%age	No. red outliers
Overall Experience	84	19	77	42	81	16	84	10	88	3	86	7	85	18

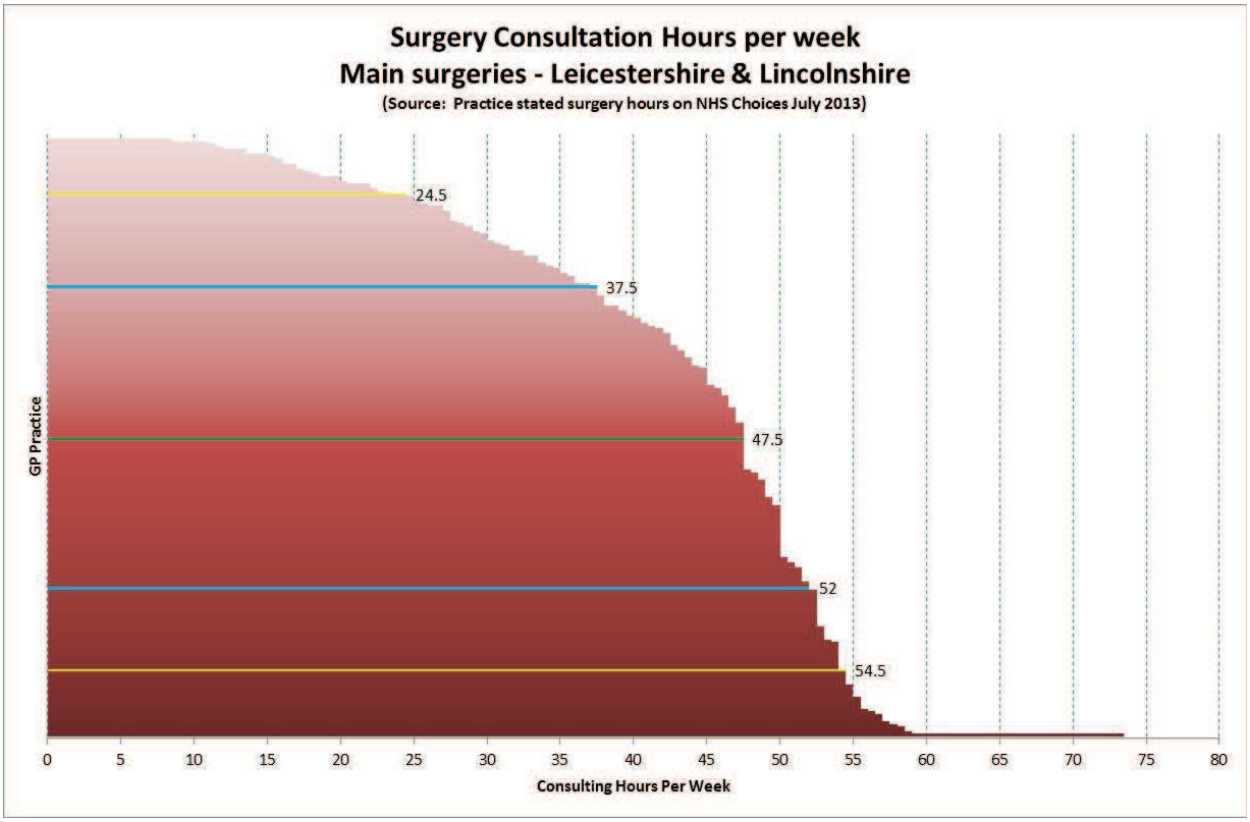
Work to improve quality is a joint responsibility of NHS England and Clinical commissioning groups. The table above illustrates that even where overall satisfaction rates are good across an area there are practices who are adverse outliers. This informs our priorities set out later in this plan taken forward with the relevant CCG.

	Analysis of number of outliers					
CCG	**Practices with no outliers**	**1<5**	**6<10**	**11<15**	**16<21**	**Total no of practices**
NHS EAST LEICESTERSHIRE & RUTLAND CCG	11	10	6	4	3	34
NHS LEICESTER CITY CCG	13	27	7	10	7	64
NHS LINCOLNSHIRE EAST CCG	6	11	10	2	1	30
NHS LINCOLNSHIRE WEST CCG	11	18	8	1	0	38
NHS SOUTH LINCOLNSHIRE CCG	6	7	2	0	0	15
NHS SOUTH WEST LINCOLNSHIRE CCG	8	8	0	2	1	19
NHS WEST LEICESTERSHIRE CCG	13	19	16	2	0	50

Red Outliers - indicate where the practice score for a particular question is significantly worse compared to the national average (i.e. where confidence intervals for the practice and the national average do not overlap).

Ease of Access to GP practices

In addition to patient surveyed perception of the opening hours and ease of making an appointment, local analysis has been undertaken highlighting the significant differences in the degree to which a GP consultation is available at times that are convenient to all:



Whilst a quarter of practices provide more than 52 hours per week in which to book appointments, a quarter of our practices offer fewer than 37.5 hours, and one in ten less than 25 hours per week.

The distribution of opening hours illustrates times when our population are less likely to be able to secure a routine GP appointment, depending on the practice they are registered with.

Specific opening hours are not a condition of national GMS contracts held by GPs although meeting the reasonable needs of patients is required. As general practice is supported to make a greater contribution to the health and care system, the availability of services at times convenient to all, together with the cost effective use of premises and workforce in primary care, is a key consideration.

We will continue to work with our CCG colleagues to drive improvement in patient experience of general practice. This will be informed further by the results from the Friends & Family Test, which states in general practice in December 2014.

Leicestershire and Lincolnshire Area

% Area Open for GP-Routine Appointments (Main & Branches)

Commencing	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
06:00	0%	0%	0%	0%	0%	0%	0%
06:30	0%	0%	0%	0%	0%	0%	0%
07:00	2%	1%	1%	2%	0%	1%	0%
07:30	5%	6%	4%	6%	3%	1%	0%
08:00	31%	31%	33%	30%	30%	4%	0%
08:30	78%	76%	77%	77%	77%	7%	1%
09:00	98%	97%	97%	98%	97%	9%	1%
09:30	100%	99%	99%	100%	99%	8%	1%
10:00	100%	99%	99%	100%	99%	9%	1%
10:30	97%	96%	96%	96%	96%	7%	1%
11:00	89%	89%	89%	89%	89%	5%	0%
11:30	77%	78%	76%	75%	75%	3%	0%
12:00	63%	65%	61%	61%	62%	2%	0%
12:30	49%	50%	47%	47%	49%	2%	0%
13:00	43%	42%	40%	39%	41%	1%	0%
13:30	43%	42%	39%	38%	41%	1%	0%
14:00	58%	55%	53%	49%	57%	1%	0%
14:30	65%	61%	59%	54%	63%	1%	0%
15:00	73%	69%	65%	59%	71%	1%	0%
15:30	85%	78%	73%	65%	80%	0%	0%
16:00	96%	92%	84%	75%	93%	0%	0%
16:30	97%	93%	85%	76%	95%	0%	0%
17:00	94%	93%	84%	73%	93%	0%	0%
17:30	86%	84%	78%	68%	84%	0%	0%
18:00	64%	62%	59%	52%	62%	0%	0%
18:30	36%	32%	33%	27%	28%	0%	0%
19:00	18%	12%	10%	5%	5%	0%	0%
19:30	15%	9%	9%	3%	2%	0%	0%
20:00	11%	5%	7%	2%	1%	0%	0%
20:30	3%	2%	2%	1%	1%	0%	0%
21:00	2%	0%	1%	1%	0%	0%	0%
21:30	0%	0%	0%	0%	0%	0%	0%
22:00	0%	0%	0%	0%	0%	0%	0%

% of Practice sites offering routine GP appointments

Key:

Darker Green = High number of practices
Yellow = Medium number of practices
Orange = Low number of practices
Darker Red = Minimum number of practices

(Source: Practice Declared Surgery Hours. NHS Choices July 2013)

i. Effectiveness

General Practice - Primary Care Web Tool

The Assurance Management Framework for Primary Medical Services introduces high level indicators supported by outcome standards which are a set of measurable indicators for general practice. The aim is to inform practices and commissioners on a range of measures that are evidence based, outcome focused and are appropriate measures to use for any practice.

Clinical effectiveness and patient experience is assured through a nationally consistent approach using 2 tools: The General Practice Outcome Standards (GPOS) and the General Practice High Level Indicators (GPHLI).

The General Practice High Level Indicators (GPHLI) form part of the assurance management framework for primary medical services and the indicators present a minimum level of service and outcomes that patients can expect from general practice. Indicators have been grouped across the NHS Outcomes Framework domains and will change and evolve over time. The purpose of the tool is to generate the start of a discussion between Area Teams and practices so that they can understand the reasons behind variation, be that warranted or unwarranted, and where necessary to support practices to make improvements

or changes. Examples of the indicators are emergency asthma admissions per 100 patients on the disease register and emergency diabetes admissions per 100 patients on the disease register both of which sit under Domain 2 of the NHS Outcomes Framework.
Across the Leicestershire and Lincolnshire area we have 26 outliers against the GPHLI.

The General Practice Outcome Standards (GPOS) have been provided to support quality improvement; they can be used for peer review and benchmarking and also to provide a consistent platform for Area Teams and CCGs to identify areas for quality improvement. The outcome standards are not process based indicators and therefore represent a good measure of practice achievement; they represent the basics patients should expect to receive from general practice. The outcome standards also represent a benchmark for how a practice is doing over time compared to other practices in a similar context. The benchmarked data will help us to understand whether variation is fair or unwarranted. However, individual outcome standards should not be viewed in isolation, these need to be triangulated with other information, such as GPHLIs, hospital activity data, and patient complaints, in order to identify areas of unwarranted variation and monitor improvement. Examples of the outcome standards are satisfaction with the quality of consultation at the GP practice and satisfaction with accessing primary care both of which sit under Domain 4 of the NHS Outcomes Framework.
Across the Leicestershire and Lincolnshire area we have 41 outliers against the GPOS.

Provider Profile – Dentistry

Provider Profile – Dentistry

Dental Service Provider	Type	Total Number	Total Contract Value	Average (£Thousand)
General Dental Services (GDS) Providers	Independent Contractor (Sole/Partnership)	140	£33.2m	£237
General Dental Services (GDS) Providers	Body Corporate	60	£22.7m	£378
Personal Dental Services (PDS) Providers	Independent Contractor (Sole/Partnership)	36	£7.4 m	£205
Personal Dental Services (PDS) Providers	Body Corporate	15	£4.0 m	£267
Personal Dental Services Plus (PDS Plus) Providers	Independent Contractor (Sole/Partnership)	4	£0.6 m	£141
Personal Dental Services Plus (PDS Plus) Providers	Body Corporate	10	£4.9 m	£490
General Dental Services Provider GDS (Pilot contract)	Body Corporate	1	£0.8 m	£774
General Dental Services Provider GDS (Pilot contract)	Independent Contractor (Sole/Partnership)	1	£0.5 m	£529
Total		**267**	**£74.2 m**	**£278**

Primary Dental Services Commissioning
Since April 2006, the following contracting routes have been available to enable the commissioning of primary dental services:
• General Dental Services contracts (GDS)
• Personal Dental Service contracts (PDS) which includes non -mandatory services such as orthodontic services and sedation services.
PDS Plus Contracts area variation of the PDS contract and include KP's (quality metrics) that reward the delivery of good oral health and care pathway and improved access.

GDS contracts and PDS agreements
GDS contracts are nationally negotiated contracts and PDS agreements are negotiated locally but are underpinned by national regulations. The main differences between GDS and PDS are that GDS contracts are not time limited (PDS agreements are) and that PDS can apply to non-mandatory services (eg orthodontic only practices).
Community or Salaried Dental Services are directly commissioned using the PDS contract framework and generally provide services for vulnerable and hard to reach groups.

Primary dental services comprise:
Essential services
Every GDS practice is required to provide a full range of general dental services (mandatory services) plus any agreed non -mandatory services. PDS may also include mandatory services and a mix of additional locally negotiated services, but can also be agreed for solely non-mandatory services (i.e. with no general dental services).
Community or Salaried Dental Services are as defined locally.
All GDS providers and PDS contractors with a mandatory service agreement are expected to provide a full range of primary care dental services to all their NHS patients based on clinical need (limited only by their ability to clinically provide the intervention).

Additional services
All GDS and PDS practices can contract or agree to provide additional services with the commissioner.

General Dental Services Provider GDS (Pilot contract)
Dental Pilots have been established to test new ways of working in order to inform a new national contract.

Locally our primary care dental contracts are split as follows:
GDS contracts = 76%
PDS agreements = 18%
PDS Plus agreements = 5%
Dental Pilots = 1%

NHS England will be the sole NHS commissioner with dental practices, but the key characteristic of this contractor group is that under 60% of primary care dentistry is commissioned and funded through the NHS with private healthcare (self-funded, and insurance and corporate benefit based) comprising over 40%.

GP Patient Survey Results – General Dental Practice

March 2013 data from the GPPS results show 83% Positive Experience for Leicestershire & Lincolnshire, which when benchmarked to other Area Teams in the region, puts us at the lowest level of positive experience but we are not statistically significantly different to the national position.
From the most recent data available from e-reporting (Sept 2013), the % of patients satisfied with the treatment received was 92.3% (national % = 92.5%, regional % = 92.7%).
When looking at the number of unique patients seen in the last 24 months, there is a slight improvement compared to the previous year (ranked 4th in the region). However there has been a drop in the activity commissioned when compared to last year.

Quality and Access - General Dental Practice

The drivers for NHS dental services for us are high quality dental services, improved access, patient centred services, appropriate referrals into secondary care and prevention focus through 'Delivery Better Oral Health' and our operational plan.

Community and Acute Dental Services

Whilst Local Authorities have a central role to play in oral health promotion, NHS England area team commissions all steps in dental pathways, with contracts with community and acute services for more complex care. The provider profile for spend on these services is:

COMMUNITY AND ACUTE ORAL HEALTHCARE SERVICES	TYPE	2013/14 Annual Spend	% of Secondary Dental Services Budget	Provider Annual Turnover	L&L Public Health Spend as % of Provider Turnover 2012/13
Provider		£m	%	£m	%
University Hospitals of Leicester	NHS Trust	5.6	32%	649	0.9%
United Lincolnshire Hospitals	NHS Trust	5.4	31%	383	1.4%
Derbyshire Community Health Services (in Leicestershire)	NHS Trust	3.3	19%	198	2%
Lincolnshire Community Health Services	NHS Trust	1.7	10%	109	2%
Peterborough & Stamford	Foundation	0.9	5%	219	0.2%
Kettering General Hospital T	Foundation Trust	0.2	1%	165	0.1%
Derby Hospitals	Foundation Trust	0.2	1%	285	<0.1%
Nottingham University Hospitals	NHS Trust	0.2	1%	631	<0.1%

For all providers, these services constitute a very small share of turnover. The supply base segments into three groups:

- Two Acute Dentistry in-area contracts, 63% of spend
- Two Community Dental services (DCHS serves Leicestershire), 29% of spend
- Small contracts for out of county acute dentistry flows 8% of spend

Acute contracts are predominantly funded through nationally set prices (Payment by Results) with demand and capacity management to maintain NHS constitution rights to treatment within 18 weeks a key focus. Community provider dentistry contracts are more varied reflecting models to improve access for populations with specific needs.

Provider Profile - General Ophthalmic Services

Provider Profile – General Ophthalmic Services

Ophthalmic Service Provider	Type	Number	13/14 Contract Value
Mandatory Services Contracts	Independent Contractor (Sole/Partnership)	67	
Mandatory Services Contracts	Body Corporate	129	
Total Mandatory Contracts		196	
Additional Services Contracts	Independent Contractor (Sole/Partnership)	38	
Additional Services Contracts	Body Corporate	67	
Total Additional Services Contracts		105	
Total Optometry Contracts		**301**	**£18m**

The primary characteristic of provider profiles for Ophthalmic services is a mature retail market with an even split between larger chain and independent outlets. NHS commissioned spend is based on nationally negotiated services and prices, and represents less than £1 in every £5 of provider income, the vast majority being private spending on eye care.

Provider Profile - Community Pharmacy

Provider Profile – Pharmaceutical Services

Pharmaceutical Service Provider	Type	Number	13/14 Spend (Forecast)
Community Pharmacy	Independent Contractor (Sole/Partnership)	151	£52.6m
Community Pharmacy	Multiple/Chain	195	
Dispensing Practices	Independent Contractor (Sole/Partnership)	84	£13.2m [4]
Total Providers		**430**	**£65.8m**

The Community Pharmacy Contractual Framework was introduced in April 2005.

[4] Professional fees associated with dispensing costs

The contractual framework for community pharmacies has three different elements:

1. **Essential Services** – the following list of services must be provided by all contractors:

    - The dispensing of medicines
    - The dispensing of appliances
    - Repeat dispensing
    - Clinical governance
    - Public health (promotion of healthy lifestyles)
    - Signposting and
    - Support for self –care

2. **Advanced Services** – these services can be provided by all contractors if they have met the accreditation requirements and are providing ALL essential services. There are two advanced services:

    - Medicine Use Reviews
    - New Medicines Service

Both essential and advanced services are commissioned by NHS England.

3. **Locally commissioned services** (previously known as enhanced services) – these are commissioned to meet local health care needs and are commissioned by CCGs or Local Authorities. They can include services such as smoking cessation, provision of emergency hormonal contraception, and minor ailment services.

Dispensing doctors provide the following services to patients:

- The dispensing of medicines
- The dispensing of appliances.

These services are funded by NHS England.

Community Pharmacy can make an important contribution to the provision and delivery of integrated services for patients. For example, the hospitals discharge process. There is a risk that commissioners do not see the potential of community pharmacy and this valuable resource may be overlooked. Our plans are designed to ensure that the risk of community pharmacy is optimised. Generally hours of availability of community pharmacies extend into the evenings and weekends. In addition, across the area, there are 36 pharmacies that open for 100 hours per week.

Like ophthalmic services NHS commissioned spend on community pharmacy is a relatively small part (£1 in every £6) of the large £14.5bn industry, the main dynamics being the competition between the supermarket, national chain and independent providers, with over the counter medicines and diversified retail playing a large role. The services commissioned by NHS England fund prescription medicine dispensing, medicines use reviews with potential for a wider range of primary healthcare services to be delivered by pharmacists as an alternative primary care local facility with wide opening hours.

Summary

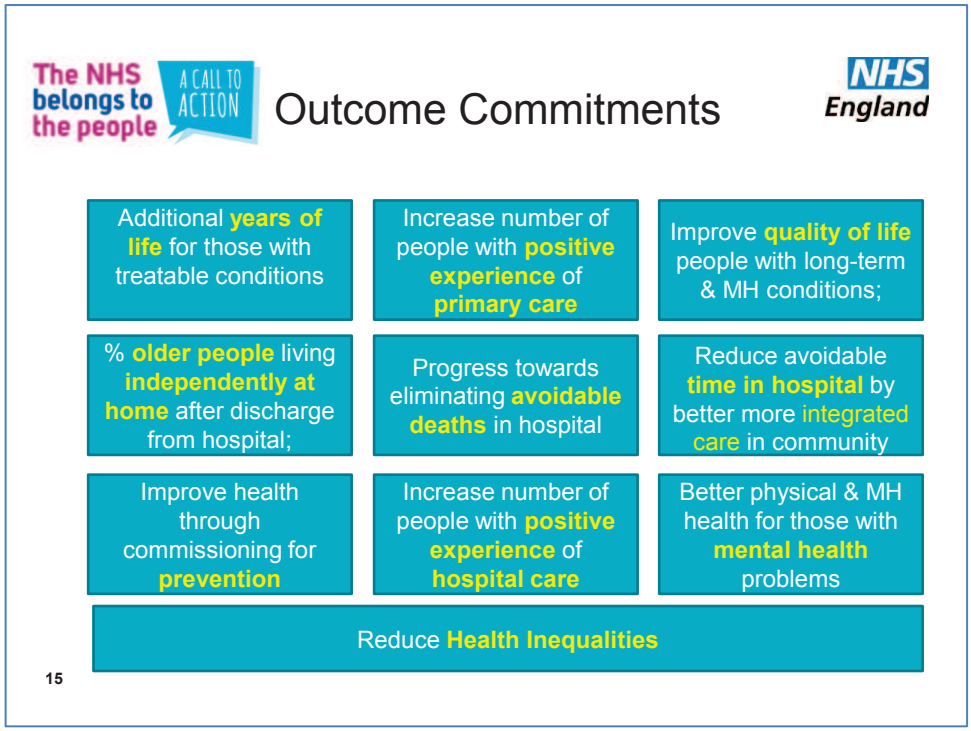
Our plans and future strategy for the three commissioning responsibilities reflect the health needs and priorities of the communities we serve, but the key issues, and the nature of healthcare provider services varies greatly between primary care, public health service and specialised commissioning. A ‘one size fits all’ approach would not be effective. The next section sets out our Ambitions and plans in light of these different challenges.

SECTION THREE: OUR AMBITIONS AND PLANS

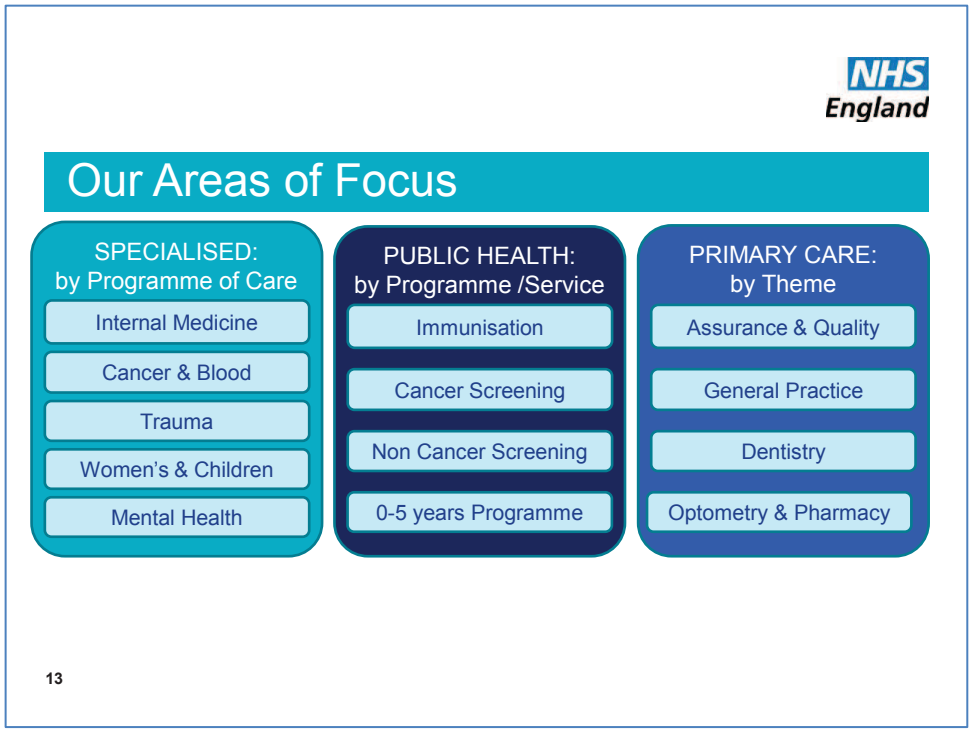
Values and Principles:

- Services Patient Centred and Outcome Based
- Improved outcomes in each of the 5 domains
- Fairness and Consistency of Access
- Productivity and Efficiency Improves

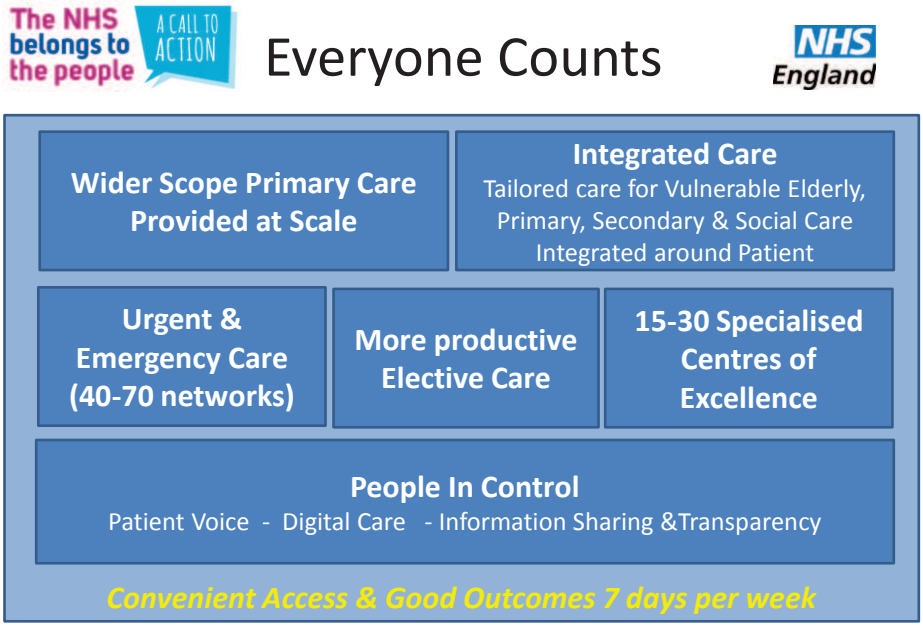
These will be underpinned by the delivery of the goals set out within Everyone Counts. Published in December 2013, Everyone counts: Planning for patients 2014/15 to 2018/19 sets out proposals to make the NHS England vision and purpose "High quality care for all, now and for future generations" a reality. The ten goals set out in the guidance include:



Our ambition and actions to address these ten goals and ensure delivery across the five domains and seven outcome measures of the NHS Outcomes Framework are set out in summary below, for each of our three commissioning responsibilities.



Within this section below, for each of our commissioning responsibilities we also set out the direction for service development, in particular how our strategy responds to the emerging national direction for services set out in 'everyone counts' and the national review of Emergency and Urgent Care:



In some cases initiatives are managed as projects with the aim of a measurable improvement in Quality, in Innovation, in Productivity, or in Prevention. These projects are referred to as QIPP and help free up financial resources to commit to strategic priorities and to remain within allocated budgets.

Specialised Services – Our Ambitions and Plans

Our ambition and actions to address these ten goals and ensure delivery across the five domains and seven outcome measures of the NHS Outcomes Framework are set out in summary within the following tables split between the mental health programme of care, and the 4 programmes of care delivered through acute services:

Table: Delivering Everyone Counts - Specialised Mental Health Services Objectives

Goals	Key actions/features
Secure **additional years of life** for people with treatable mental & physical health conditions	**"Plans to reduce 20yr gap in life expectancy for people with severe mental illness"** For our services this is most applicable to people with psychotic illness and the long term effects of psychotropic medication and poor access to physical healthcare. • Specialised commissioners introduced a CQUIN in 2011 in high secure and 2013 for all other specialised mental health services targeted at improving physical healthcare. This will be built on in 2014/15 and in future years. • We have been working closely with the nursing and quality team to examine any Serious Incidents/deaths in specialised services which may relate to poor access to physical healthcare and will build on this and any lessons learnt going forward. • Contracted requirements are to ensure continued improvement of healthy lifestyles for staff and patients.
Improve **health-related quality of life** for 15 million people with MH & Long Term conditions	• Ensuring services are effective and of high quality through service user feedback and service visits provides assurance that health related quality of life is maximised for service users. • Ensuring that the CQUIN for 13/14 physical health care is rolled into the quality schedule of the contract and will built upon in future years. • Patients have access to education and training opportunities whilst an inpatient to improve the options available to them on discharge.
Reduce **avoidable time in hospital** through better, more integrated care in community	**"Identification and support for young people with mental health problems"** • NHS England took on responsibility for commissioning Tier 4 CAMHS in April 2013. There is currently a national review of CAMHS tier 4 taking place which will report March/April. We will need to build in to the plan implementing the findings of the review. • Locally we need to commit to continued funding of the 2 CAMHS case managers who are ensuring appropriate, efficient and effective care pathways into and out of Tier 4 services and are starting to work with East Midlands providers to improve the quality of services and patient experience. • Case managers actively engage with patients and clinical teams to ensure patients are in the right place at the right time for treatment and that delayed discharges are avoided. • CAMHS patients are reviewed regularly and case managers actively work with partner agencies to ensure that care pathways and discharge plans are effective to reduce length of stays and avoidable delays.

Goals	Key actions/features
	• Introduction of shared pathway into specialised services, providers asked to implement a recovery approach which includes identifying the most appropriate recovery tools for their populations, drawing upon a range of recovery resources and which supports service users to engage directly in identifying outcomes, care planning and the CPA process, E.g. Recovery Star, My Shared Pathway Resource Books, Care Index, and Wrap.
Increasing number of people having a **positive experience** of **Hospital** care	• We have been working closely with the nursing and quality team to examine any Serious Incidents/deaths in specialised services which may relate to poor access to physical healthcare and will build on this and any lessons learnt going forward. • Service visits and interviews with service users to gain direct service user feedback and take actions with the provider to improve positive experiences in hospital. • CQUIN for innovation introduced into specialised services to enhance patient choice and experience for example CPA for CAMHS and Adults, which in future years will be established as common practice. • Case managers actively engage with patients and clinical teams to ensure patients are in the right place at the right time for treatment and that delayed discharges are avoided.

Goals	Key actions/features
Increasing number of people having a **positive experience** of **GP & community** care	• All patients in secure hospitals will have an annual health check, this is a contractual requirement and was measured as part of the 'My Shared pathway' CQUIN • In addition all patients with a learning disability will be offered an annual health check that meets the criteria of the Cardiff health check tool • That patients in secure hospitals will have access to healthcare equal to that which they would receive via a GP and commissioned by CCGs • The area team will continue to implement a comprehensive response to the winterbourne view findings: ✓ Quarterly data collection process will provide detail to the Leicestershire and Lincolnshire Area on the number of adults and young people with Learning Disabilities and/or Autism in secure hospitals hosted in the Leicestershire and Lincolnshire Area. ✓ Our case managers will continue to work with providers to ensure all patients who are detained and in secure services in the East Midlands have robust care plans in place and that discharge planning commences as possible; ensuring patients with a learning disabilities and/or autism do not remain in secure hospital care any longer than is clinically appropriate. ✓ Our case managers monitor the CPA process to ensure each patient identified as being fit for discharge are proceeding though their treatment and discharge pathway in a timely and appropriate way. ✓ Our case managers regularly meet and liaise with our area CCG colleagues and the patient care co-ordinators to monitor the patient's discharge pathway. ✓ As a net importer of patients from other areas into our large services providers, such as St Andrews Healthcare, we work closely with the other Area Teams. A number of these patients will be identified as needing to transition to lower security or to community settings by the local Area Teams and CCGs and we will continue to work with our partners to move patients on to appropriate services. ✓ Area Team will link in with CCG and Local Authority strategic planning and reporting on Winterbourne View Review, Autism Strategy, Learning Disability Self-Assessment Framework (LD SAF) and Joint Strategic Assessment Needs(JSNA)
Make progress in eliminating **avoidable deaths in hospital** caused by problems in care	• Serious incident investigation and quality management via Area Team Quality and Nursing Directorate. • Suicide prevention is a contract requirement and hospitals are required to not using non-collapsible rails in patient areas. • Annual ligature audit is required in all services. • Specialised commissioners introduced a CQUIN in 2011 in high secure and 2013 for all other specialised mental health services targeted at improving physical healthcare. This will be built on in 2014/15 and in future years.

Goals	Key actions/features
Reducing health **inequalities**	• All commissioned services are required to have Equity of Access, Equality and Non-Discrimination policies. • Access to services it through a nationally agreed access assessment process to ensure patients access the right services at the right time for the right treatment. • Guidance for the transfer of prisoners to hospital for treatment. • Case managers and quality reviews in hospitals will check that 'reasonable measures' are taken by providers to ensure a patient's needs are met across the all elements covered by the Equality Act. • The CAMHS Tier 4 review will look at location and access of provision, which will then inform commissioners future location planning. • Commissioners will also work with Clinical Reference Groups to look at specialised service provision such a perinatal inpatient services to ensure that location of future commissioned services takes into account location and access.
Parity of Esteem: Equal focus on **improvements in Mental Health** & on physical outcomes for people with MH problems	The approach to achieving parity of esteem for mental health includes: • Review the % of the specialised budget this year that is mental health and commit to at least maintaining it, if not increasing which is probably warranted across some of the new services we have taken on recently. • Patient length of stay is being monitored to compare parity in services and outcomes. • Working with providers to ensure that not only are mental health services are compliant with minimum services specification requirements but that they meet high quality standards. This may require additional investment as East Midlands prices are at the lower end of national provision. • We have among the most price efficient MH services in the country which has been confirmed during the 10 Area Team benchmarking exercises. • The Area Team will contribute and support to national procurement exercises being planned for mental health services to ensure that the services commissioned represent high quality and value for money. Our parity of esteem is reflected by: • A small number of services that are lower than the national average and where this has a negative impact on the ability for the provider to deliver the national service specifications, the Area Team will work with the provider to address this, providing parity of esteem for patients closer to home and supporting the stabilisation of high quality service delivery. • Size of provider, capacity, quality of service and outcomes are considered when negotiating contracts to ensure there is local and national parity. • Provider stabilisation, capacity and demand at local and national levels are also incorporated into contract negotiations. • The 10 Area Teams managing mental health services work closely to ensure that providers across the country are treated and managed consistently.

Table 2 Delivering Everyone Counts - Specialised Acute Services Objectives

Goals	Key actions/features
Secure **additional years of life** for people with treatable mental & physical health conditions Preventing people from dying prematurely	A comprehensive review of all specialised services against the service specification will ensure that care is centred around centres of excellence and this should increase the efficacy of health care in the EM. Given that 2 major providers deliver 70% of the specialist services in the region it is likely that there will be a concentration of expertise in these areas. Effective use of a Major Trauma system with a coordinated approach between MTC, trauma units and the ambulance service should prevent unnecessary deaths, increase both life years in real terms and in quality terms. The use of a coordinated approach to rehabilitation across the EM will also assist with the above. The development of a rehabilitation network is in its infancy but work associated with increasing wellbeing, early return to work and achieving better measurable rehabilitation outcomes will see improvements in this area. A coordinated approach which includes assessing all formally designated services delivering specialised rehabilitation, a review of the activity using the UKROC data and support for the development of a clinical network charged with developing rehabilitation across the East Midlands will add quality years to the lives of patients. Implementation of Specialised Services Policies, CQUINS and QIPP schemes aim to achieve increased services quality and improved patient experience and better outcomes.
Improve **health-related quality of life** for 15 million people with MH & Long Term conditions	Use of the medical intelligence from the review of all services providing specialist services using the service specification coupled with a complete assessment against the activity in these centres and the population distribution in the EM we will be able to develop a long term strategy to ensure access to specialist care is available for all. This is particular important for patients with long-term conditions when access to care spans the spectrum from intensive inpatient care and also specialist care in the home or close to their home. Cooperation with clinical networks, CCGs, relevant charities and local authorities will ensure there is a comprehensive "network" of care for patients with long-term conditions. Support for the principle of providing specialist care throughout the whole pathway (in patient and the community) by making effective use of support workers and specialist nurses / therapists will provide a supportive platform for this cohort of patients and their families. Examples of this are the current support for support workers / nurses / therapists to span both the inpatient aspect of specialist care an care in the community can be found in a number of specialist areas including: HIV, burns and plastics, cancer, Teenager and Young Adults services, Long Term Ventilation and neurological conditions. There are plans to work with acute providers to expand this mode of care across more specialist areas. This initiative will be supported on the basis that it can reduce hospital admissions, promote early discharge and improve patient care. Ensuring that appropriate the CQUINs for 14/15 accurately reflect improvements in this area also acts as a stimulus to promoting quality. The intention is to ensure the quality schedule of the contract is managed robustly.

Goals	Key actions/features
Reduce **avoidable time in hospital** through better, more integrated care in community	**"Identification and support for initiatives that ensure that the whole pathway for specialised services is provided for by adopting an integrated approach to the delivery of specialised services that spans both the acute care and primary care environment"** Identifying specialist services that are commissioned to provide or it is beneficial to provide services using a model that reaches out into the community will both reduce hospital admissions and provide a more integrated service. The intention is where appropriate to support providers to provide specialist posts that bridge the gap between the acute and community environment. Examples of this are the current support for support workers / nurses / therapists to span both the inpatient aspect of specialist care and care in the community can be found in a number of specialist areas including: HIV, burns and plastics, cancer, Teenager and Young Adults services, Long Term Ventilation and neurological conditions. There are plans to work with acute providers to expand this mode of care across more specialist areas. This initiative will be supported on the basis that it can reduce hospital admissions, promote early discharge and improve patient care.
Increase % **older people living independently** following hospital **discharge**	Better rehabilitation services, specialist community support and case management will address this issue (as above). This is all covered by the philosophy of providing an integrated model of working for specialised services.
Increasing number of people having a **positive experience** of **Hospital** care	We have been working closely with the nursing and quality team to examine any Serious Incidents/deaths in specialised services which may relate to the timely access to specialised services. Some qualitative data is available regarding the enhanced patient experience of operating a specialist outreach service (burns service outreach team). The intention is to continue to evaluate this form of initiative. There is work underway to do a joint evaluation of specialist nursing teams delivering burns care in the community. This will be undertaken jointly by members of the service specialist team and the burns outreach team. Providers of specialised services will be compliant with the requirement to seek patient feedback using the Friends and Family test and provide feedback to commissioners on progress.
Make progress in eliminating **avoidable deaths in hospital** caused by problems in care	Serious incident investigation and quality management via Area Team Quality and Nursing Directorate. Audit of major trauma data, increased numbers of unexpected survivors as a result of implementation of major trauma system. Region wide peer review / mortality and morbidity meetings to peer review clinical outcomes (Burns Audit, Major Trauma, Cancer

Goals	Key actions/features
Improve health through **commissioning for prevention** and every contact counts	• Support for the implementation of a rehabilitation network and endorsing initiatives that promote wellbeing may have a positive effect on prevention. • Support for enhanced Long Term Ventilation team and Long Term Conditions (such as neurological conditions) will help to prevent avoidable events that require hospital admission or episodes of sub optimal health. E.g. Neuromuscular Dystrophy
Reducing health **inequalities**	• The use of the service specifications and a comprehensive review of all services will provide the medical intelligence to undertake a review of all specialised services against the population served. This will ensure there is a matrix of specialised services that is accessible to all. This work will take 2 to 5 years to complete but is part of a long term strategy to ensure that the right specialists services are in the right place to ensure there is equality of access for all patients in the EM. This will help address any issues associated with health inequality.
Parity of Esteem	For acute services parity of esteem relates both to the delivery of improvements in mental health services, and focusing with providers of physical health care, on differences in relative outcomes for those in receipt of mental health services. • As the availability of data improves through national developments such as care.data we will explore with CCG and CSU partners the opportunities to provide improved insights for our providers of acute care to target services where outcome differentials are significant and not attributable to presenting differences in health status.

Specialised Services - Service Development

Commissioning for prevention

The partnership challenge to achieve financial sustainability of services is well illustrated in specialised healthcare. Research indicates that year on year growth in spend for specialised services has been on average 4% higher than for other sectors of care over the last ten years, partly due to the availability of new technologies and drugs but also due to growth in underlying health needs. The key levers to address this rise relate to wider prevention and early intervention commissioned through local authorities and clinical commissioning groups – for example interventions to address alcohol use, exercise, smoking, and diet through local authority led public sector partnerships, and the effective management of chronic kidney disease in primary care will both have an impact on rates of growth for renal dialysis and transplant. By the time patients present with a need for high cost specialist interventions the opportunity to intervene at lower cost has been lost.

We will work with our partners within the ten Health and Wellbeing Boards, utilising the 5 steps recommended in the 'Commissioning for prevention' report to address key service risks and improve health outcomes in our region:

1. Analyse key health problems
2. Prioritise & set common goals
3. Identify high-impact programmes

4. Plan resources
5. Measure & experiment

National Issues being addressed by all Specialised Commissioners:

- Continued variation in access
- Sustainability of some services
- Achieving compliance with full service specifications and supporting reconfiguration where this is not a realistic prospect
- Financial affordability
- Supporting new models for commissioning to promote integrated care
- National reviews of capacity and service models including radiotherapy, cardiac surgery, Tier 4 CAMHS and liver transplant services
- Development of remaining service specifications and clinical policies
- Development of national procurement arrangements and key priority areas
- Financial benchmarking and development of standardised prices

Key issues for East Midlands services by programme of care

Programme of Care: Internal Medicine

Obesity/ Bariatric surgery

Implementation of the Clinical Commissioning Policy for Complex and Specialised Obesity Surgery

The Area Team is working with CCGs and Local Authorities to develop a co-ordinated plan to achieve a safe managed transition to the new national commissioning policy. This aims to keep the capacity of services at each stage of the pathway in balance. Including benchmarking and a flow model that will help identify required inputs at each level of service. Pathways will be agreed across commissioners and patients will receive a seamless service so that patients who may benefit from potentially lifesaving surgery are be identified after they have completed Tier-3 weight management and referred in a timely manner for specialised surgery. The pathway should include long term Public Health initiatives which impact on behaviour and reduce demand for specialised surgery.

Programme of Care: Blood and Cancer

Radiotherapy Review

From 1 April 2013 NHS England became the commissioners of radiotherapy services for England as a prescribed service, enabling strategic decisions about service needs and clinical pathways across geographical boundaries to be made. Locally, decisions in relation to radiotherapy delivery partner at Milton Keynes and relationships with NGH and OUH on cancer pathways require the involvement of the Area Team and network in advising on

appropriate options for consideration in the light of the sustainability of services. An option appraisal has been completed and recommendations are being developed pending further activity and outcomes modelling and national guidance.

HIV Services

There are risks to the sustainability of HIV/GUM services in some East Midlands Providers due to the re procurement of Sexual Health Services by Local Authorities- Risk of segregation of services and introduction of private sector providers. In addition emerging cost pressure of the introduction of new service tariffs for HIV services (year of care).

Programme of Care: Mental Health

Perinatal Mental Health

A provider - Leicestershire Partnership Trust (LPT) has given notice to NHS England that it cannot comply with the service specification, necessary quality standards or invest the finances required to bring the current service up to standard. NHS England has been liaising with LPT and the CCG's regarding the way forward and the need to ensure that the pathway to Inpatient Perinatal beds is clear and widely known by all stakeholders to ensure that women receiving effective treatment and admission when identified as appropriate by the Community Perinatal Service.

Since NHS England has developed a national service specification to ensure that all Perinatal Inpatient Units across the country are of the same standard and deliver the same quality and standard of care, the East Midlands CCG's and Perinatal Quality Network are working together to write a regional service specification for Community Perinatal Services. This will also ensure that all areas of the East Midlands are working towards a Gold Standard service for pregnant women and mothers with mental health problems. And no matter where a woman may become ill the quality and standard of support she receives will not depend upon the area, county or postcode where she resides or receives her treatment.

Programme of Care: Women and Children's Services

Paediatric congenital cardiac Services

A new national review has been established to consider the whole lifetime pathway of care for people with congenital heart disease (CHD). This aims to:

- Secure best outcomes for patients
- Tackle variation
- Deliver great patient experience

University Hospitals Leicester is one of the providers currently providing paediatric congenital cardiac surgery. They are currently providing monthly returns on the transition dashboard which is being implemented nationally. CRGs are developing national commissioning products including service specifications incorporating new standards of care. Upon the outcome of the review the Area Team will be required to support

implementation of an action plan to deliver the recommendations. This may involve the decommissioning /reconfiguration of current service models in the region.

Strategic Ambition to build a sustainable coordinated approach to the provision of specialised services in the East Midlands

Addressing Services not yet at national service specification standards

The assessment of all specialised services against the service specifications developed by the Clinical Reference Groups will inform this strategic direction of travel and ensure that there is a robust platform on which we can develop a plan to deliver commission specialised services in a manner that improves quality, access and efficiency. Throughout the process of reviewing all specialised services in the East Midlands there has been good engagement with the providers and both the strategic and operational delivery networks. This has ensured that historic knowledge and current medical intelligence from a variety of sources has been taken into consideration when measuring compliance of the services against the specification.

There are currently 359 services identified in the acute services that are currently under consideration for compliance against the service specification. The table in section two provides a summary of the current status with services described in three main categories; **compliant** with the service specification, services not compliant but they have applied for **derogation** and services where only part of the pathway is provided and the service is **provided in partnership**.

The two major hospitals providing specialised services in the region Leicester and Nottingham have 87 and 89 specialised services respectively. This supports the intention, set out below, to concentrate specialised services in centres of excellence with some 15 to 30 such centres being viable in England (NHS England, 2013a). This process will become part of the current contract round and form the basis of planning of service provision in the future. NUH have the most services undergoing the derogation process (21). The principle deficits identified are associated with gaps in resources (staffing or infrastructure) to meet all of the service specification. The level of clinical risk associated with the derogation plans have been reviewed with regards to the providers continuing to provide these services.

Specialised services concentrated in centres of excellence

NHS England now develops specialised service policies and service specifications nationally. These specify the services patients can expect to receive and where they will be provided, they also set out what high cost treatments NHS England will or won't routinely fund.

Strategic Direction of travel outlined in 'Everyone counts' is for Specialised services to be consolidated in fewer providers**,** linked to Academic Health Science Networks, utilising service specifications, policy and national procurement where required.

For the purpose of planning it is understood that consolidation of specialised services is expected and that this will be to the most capable provider where issues of quality or affordability are unresolvable. Approximately 60% of specialised services are already provided in fewer than 30 centres. We would therefore expect that most specialised services, which are by their nature often rare and complex, should be provided in relatively

few centres, although there are of course, exceptions. As part of NHS England's work on the 5-year strategy they will be looking at the evidence base for greater consolidation of services at both service and provider level.

Our Aspirations for partnering East Midlands commissioners & providers to deliver this change:

- The provider landscape is redesigned in partnership with providers and CCGs in line with local whole system change programmes. The new provider landscape is:
    - Best for patients overall health and outcomes (CCG population and commissioned provider population) - Reducing the no of years of life lost for treatable conditions
    - Local citizens will be included in all aspects of service change resulting from the consolidation of services
    - Best for the economic climate – model ensures Value for money and better use of resources
    - There is oversight and assurance of CCG plans to ensure overlap and integration is managed – we have agreed future mechanisms for engagement and partnership working.
    - Prime contracting models are in place for networked care delivering in partnership with tight clinical governance across providers (80% of services within programmes of care).

In order to ensure that NHS funded care is appropriately placed, we will agree plans and work together with providers and CCG commissioners, to ensure that all elements of the care pathway are aligned and reflect local strategic reviews (e.g. Better Care Together programme for Leicestershire & Rutland, and Lincolnshire Sustainable Services Review).

The on-going work across the East Midlands will secure consistent levels of quality and efficiency, as the team works with regional providers to ensure compliance to national service specifications. This, together with a programme of redesign to ensure our providers can deliver services in line with the most efficient peers has the potential to identify further services that are not clinically sustainable to national standards at efficient levels of spend

These services, together with services which cannot meet national standards for structural reasons (e.g. undertaking insufficient cases per year, or serving a population catchment insufficient to maintain standalone services) or services unable to make the transition to seven day consistent outcomes on a standalone basis will be the focus of strategic change.

Subject to the approval of regulators we will look favourably on clinical joint ventures between the 2 main tertiary providers to create the opportunity for clinicians to drive the consolidation and collaboration agenda, respecting patient's opportunities to exercise choice in neighbouring services at the point of tertiary referral and publishing outcomes relative to others to ensure such choices are well informed and lead to greater volumes of treatment at services achieving better outcomes.

Where there are benefits significant economies of scale which achieve better clinical outcomes or financial sustainability we will encourage providers to consider consolidation of

sites and more centralised access to services, whilst preserving access locally where these gains are not significant.

Principal Deliverables that underpin the strategy for improving the provision of specialised care

Deliverable	Description
Seven day services	We will engage with NHS IQ to model and plan the potential for 7 day working across our provider footprint ensuring that this reflects clinical quality requirements within national service specifications and the available affordability envelope. This will link with ambitions to consolidate specialised services within a reduced provider footprint which will require the redesign and modernisation of services and associated patient pathways.
Highest Quality Urgent and Emergency Care	In the East Midlands the major trauma network will be completed by April 14 which will cover the whole of the region and be centred on the Major Trauma Centre (MTC) located within Nottingham University Hospital NHS Trust. Development of a comprehensive major trauma network and system has involved the MTC working with other providers of emergency care in local Accident and Emergency Departments, the East Midlands Ambulance Service and the Major Trauma Network. Because trauma and urgent care spans the commissioning responsibilities of both CCGs and specialised commissioners a number of the services will have to be commissioned in a manner that involves working in partnership. Major trauma is commissioned by NHS England and falls under the remit of those responsible for specialised services with other Emergency Medicine services being the responsibility of CCGs. One of the challenges is the traditional boundaries of the clinical networks which are not aligned with all of the services commissioned in the East Midlands. To develop a truly integrated system for urgent and emergency care commissioners (specialised and non-specialised), clinicians (primary and secondary care), clinical networks and the ambulance services will have to work in partnership.
Research and Innovation	As part of the redesign of the specialised provider landscape we will actively encourage providers to seek research opportunities. This will be supported through local commissioning decisions where possible and linked to Academic Health Science networks.
Access and utilisation of reliable and robust medical intelligence	Joint working between commissioners and providers to implement system wide processes to monitor bed utilisation will help all those involved in health care to develop a strategic plan which is robust, defensible and delivers quality care. The use of Utilisation Reviews has been incorporated into the CQUIN process to incentivise healthcare providers to embrace this technology. In addition to influencing lasting organisational change associated with bed utilisation there are also plans to influence clinical practise by encouraging the use of new technologies to reduce hospital acquired infection. This is seen as a priority across all clinical areas.

Public Health Services – Our Ambitions and Plans

The function of the public health team within the Area Team is to implement the content of the section 7a agreement. Currently this contains 30 specifications; 14 immunisation programmes, 12 screening programmes and four other programmes the largest of which is the public health services for under 5s, predominantly health visiting and family nurse partnerships.

Aligning priorities to anticipated changes to section 7a agreement

The content of the section 7a will change over time. The three major changes that are already known are:

1 Roll out of the Fluenz programme (intranasal flu vaccine) to all 2-16 year olds
2 The transfer of the commissioning responsibility for public health services for the under 5s to local authorities. This is likely to take place in October 2015.
3 The introduction of bowel scoping as part of the bowel cancer screening programme. This will see sigmoidoscopy offered to everyone at the age of 55 years.

Other potential changes to the section 7a agreement the possible introduction of a meningococcal B vaccine in to the childhood immunisation schedule, additions to the new born screening programme with tests for other rare conditions using the blood spot sample at 3 days, and possibly a move to using HPV testing as the primary test in cervical screening. The introduction of other new immunisation or screening programmes within a 5 year timescale is quite conceivable.

Changes to provider landscape for public health services

There are two main drivers that might affect the provider landscape over a five year period:

1 Decisions at national level as to the ideal size of a provider of screening services. For example there is a desire to see larger grading units for diabetic eye screening services. This may see work being brought together at an East Midlands or even larger level. Conversely, the current arrangement that sees Kettering as the lead bowel cancer screening provider for Leicestershire and Northamptonshire is currently being split up as the national team has decreed that the unit is too large for efficient operation.

2 Any requirement to go out to tender may significantly change the provider landscape for screening services. If independent providers become involved in the screening services the processes for referring in to the programmes and for the onward referral to treatment services are likely to become more complicated, as will the necessary fail safe systems.

The Fluenz programme is sufficiently large that it may change the way that immunisation services are provided. Currently in Leicestershire and Lincolnshire only HPV vaccine is given

through schools. The move to providing Fluenz through schools may dictate the need to establish a robust immunisation service for schools in both areas. It may then make sense to move the teenage booster for Td/IPV and the new teenage booster for meningitis C from general practice in to schools. This would require investment.

Demography / prevalence

Both screening and immunisation services are population based services and are therefore sensitive to demographic changes. The Knowledge and Information Team (KIT) in the PHE Centre have been asked to take on the work for the East Midlands of modelling the impact of demographic changes for all screening and immunisation services. This will include taking account of the predicted changes in prevalence of diabetes in different geographical areas. There will also be the option to look at sensitivity analyses around uptake of services as this is the other principal driver of resource use.

Core business over the next next five years

The core business for the next five years will be to ensure efficient, effective and equitable service provision informed by patient experience. This will be include targeted actions in support of the following themes:

Quality	• To ensure that screening programmes meet the minimum acceptable targets at the earliest opportunity and to strive to meet the achievable targets over this time. • To comply with the recommendations following regional QA visits • To meet new recommendations from national programmes including amendments to section 7a service specifications • To ensure childhood immunisation programmes move towards 95% uptake for all programmes.
Productive Efficiency	• To ensure that services are provided at costs that are at least not higher than the median price for the service nationally
Allocative efficiency	• To ensure that resources within the public health ring fence are allocated to services in the most appropriate way resulting in all services being fairly resourced and able to generate maximal health benefit.
Equity	• To undertake equity audits and act on the outcomes to ensure that services are accessed by, and provide benefit to, all parts of society according to need.
Patient experience	• To find innovative and effective ways to gather patient views about service provision and to involve patients in the design and evaluation of services.
Governance	• To ensure a managed process for the transfer of commissioning responsibility for public health services for children under 5 years from the Area Team to upper tier local authorities • To ensure that all programmes are subject to good governance procedures and processes.

Public Health Services - Two Year Plan Priorities

The Development programme over the next 2 years is outlined below:

The services that are commissioned by the AT under the section 7a agreement are specific and clearly defined. This plan therefore focusses on each service rather than looking at overarching themes such as the ten goals or six themes.

Immunisation services

Routine childhood immunisation

In Leicestershire we will strive to maintain existing good performance with a focus on the practices that are performing least well.

In Lincolnshire performance compares unfavourably with peer “PCT” areas (the only unit of comparison available). A work stream is in place to improve all aspects of the patient pathway, including the child health information service involvement, to ensure that accurate and timely information is available that will be used to drive up performance.

Meningitis C teenage booster

For 2014 this will be given in general practice. During 2014/15 work will be undertaken to establish a new commissioning arrangement from April 2015 in line with national guidance. This links to work around the Fluenz programme as there may be benefit in concentrating all teenage immunisations through a school based service.

New Meningitis C catch up for university entrants

The detail of this catch-up has yet to be announced. It is assumed that this will be a GP provided service but the contractual mechanism for this is not yet clear. It is assumed that new money will be available for this catch-up programme.

HPV vaccination

In Leicestershire and in Leicester City the target of 90% has been achieved in 2012/13. For the City this was the first time the target has been achieved so the aim is to maintain this excellent performance.

In Lincolnshire the performance was slightly below the target at 88%. Work is in hand to improve this rate with an expectation that 90% will be achieved for dose three in 2014 and beyond.

Seasonal flu

Performance across the Area Team for those over 65 is likely to be slightly under the 75% target for 2013/14. It is difficult to know what else to put in place to try to improve uptake further. For those at risk under 65 the aim is to immunise more individuals each year. The target of 75% for this group is unattainable due to the methodology of data collection, hence the focus on numbers of individuals immunised.

In addition to the normal cohorts general practices have immunised >40% of all 2 and 3 year olds with Fluenz in 2013/14. The aim will be to increase this percentage on an annual basis and to add in the 4 year old cohort from 2014.

Pneumococcal vaccine

There is reference to a change to the adult pneumococcal programme. The details of this are not known but we are confident that we can implement any change.

Fluenz programme in schools

Leicestershire ran the largest pilot of Fluenz in primary schools in 2013. In 2014 the aspiration is to extend the primary school pilot to cover the whole of the LLR primary school population as well as offering the vaccine to years 7 and 8 in secondary schools. This is dependent on national funding being available. In 2015 we will at least match whatever the national plan is for this programme which has yet to be announced.

Lincolnshire in 2014 will offer the vaccine to all years 7 and 8 in secondary schools. In 2015 we will follow whatever the national plan is for this programme which has yet to be announced.

Neonatal hepatitis B

We will establish revised pathways of care to ensure that all at risk babies receive hep B vaccination in line with national policy and that an appropriate failsafe process is in place involving CHIS to ensure that no children fall through the net. We will also initiate the blood spot test at one year.

Screening Services

Bench marking

For screening services that are not based on a national funding formula we will continue with our benchmarking work to ensure that we are achieving value for money from the services that we commission.

Breast cancer screening

Leicestershire:

We will implement the pathway for high risk women in line with NICE guidance. We will maintain the good level of uptake that this service has traditionally secured.

Lincolnshire

We will implement the pathway for high risk women in line with NICE guidance. We will ensure that the service becomes fully digital at the earliest opportunity. We will work with the trust to ensure that they can deliver a robust and effective service based on effective team working.

Cervical cancer screening

We will commission HPV testing as part of the cervical screening programme. We will look to stop the decline in uptake of cervical screening particularly in younger women.

Bowel cancer screening

We will establish University Hospitals of Leicester NHS Trust as an independent bowel cancer screening unit. We will support the trust to participate in wave two of implementation of the bowel scope extension of the bowel screening programme.

We will ensure that United Lincolnshire Hospitals NHS Trust can provide this service in fully accredited facilities. We will support their aspiration to be in phase two of implementing the bowel scope programme.

Diabetic eye screening programme

We will implement the new pathway for surveillance. We will work with both providers to look at better ways of contracting for this service, potentially building on the local tariff developed in Nottingham and Derbyshire Area Team.

Abdominal aortic aneurysm screening

We will take on the commissioning and contracting responsibility from the national team for the site in Lincolnshire and will continue to support the site in Leicestershire.

Antenatal and Newborn screening

We will implement the fail safe programme for the new born blood spot programme.

We will support trusts to implement the SMART system for managing the NIPE programme.

Child health information system

We will ensure that the local Child Health Information Systems are in accordance with the national service specification by the end of March 2015 and will work with our providers to address any issue they may have in attaining the required standards.

Child & Family Health Services

Health visiting for under 5s

We will commission such that in each area they will reach the nationally required trajectory for health visiting numbers. We will also ensure that the rest of the skill mix of the teams is appropriNGHate given the rapid expansion in qualified health visitor numbers.

We will work jointly with colleagues from local authorities to manage the transfer of commissioning from NHS England to local authorities to take effect whenever that transfer is confirmed.

Family nurse partnership

We will commission the required expansion of the nationally agreed increase in the number of FNP places which include the introduction of a new site in Lincolnshire and the continued support of the existing site in Leicester City.

We will work jointly with colleagues from local authorities to manage the transfer of commissioning from NHS England to local authorities to take effect whenever that transfer is confirmed.

Primary Care Services – Our Ambitions and Plans

Local Ambition One (Quality)

To **reduce unjustified variation in the quality** of the services received by patients.
Key outcomes:

- a high quality workforce, optimising the skill mix across all primary care service providers to ensure the right people, with the right skills, are in the right place at the right time ;
- modern models of integrated working designed around the patient, recognising the expanded role of general practice in co-ordinating and delivering personalised care and the potential role of others such as community pharmacy.;
- Optimising the new GMS contract changes, in partnership with CCGs, to deliver more proactive care for people with more complex needs and promoting consistently high standards of quality;
- Improved patient experience.

Improvement interventions

We will establish more robust mechanisms for triangulating data and information to improve our understanding of the quality of the service provided by primary care. We will develop robust quality and performance assurance frameworks for primary care to ensure that there is a consistent approach to managing unwarranted variation in quality.

Implementing the GMS Contract changes for 14/15 – the range of changes to the GMS contract seek to enable integration, new ways of working, and proactive care that is 'wrapped around' patients, particularly those with complex needs; this supports local CCG plans for managing multi morbidity through integrated neighbourhood teams.
The new enhanced service for reducing unplanned hospital admissions will again support CCG plans and by working together and giving consistent messages we can ensure that there is no duplication of effort or confusion for general practice and we can improve patient experience and outcomes.

Working with CCGs to address capacity issues in Primary Care and secure a high quality workforce. As a starting point we need to understand our GP workforce and identify the gaps. During the next 12 months we are planning to undertake a GP recruitment initiative in partnership with CCG's.

For dental service providers we are looking to better use of resources, IMOS pathway (awaited) and Orthodontic Framework.

Local Ambition Two (Outcomes)

To reduce **unjustifiable inequalities** in health outcomes and access to services
Key outcomes:

- commissioning across pathways (e.g. LD, homeless etc)
- federated models of delivery across independent contractors
- modern models of integrated working designed around the patient

Improvement interventions
GMS contract changes 14/15
Implementing other nationally negotiated changes which include:

- A review of the enhanced service for Diagnosis and Care for People with Dementia;
- A review of the enhanced service for Annual Health Checks for People with Learning Disabilities
- A review of the enhanced service for Alcohol Abuse, to incorporate additional assessment for depression and anxiety.

Improving oral health
Partnership working with Leicester City Council to deliver the Oral Health Promotion Strategy (2014-2017) for pre-school children. Five year old children in Leicester have the highest experience of dental decay observed in England. The aim of the strategy is to support co-ordinated activity across Leicester City to improve oral health, reduce oral health inequalities

and lay solid foundations for good oral health throughout life. The ambition is for a 10% increase in the proportion of 5 year olds in Leicester with no signs of dental disease by 2019. We will jointly explore different models of service provision, direct access to dental therapists etc, and ensure access is equitable.

The Leicestershire, Leicester City and Lincolnshire Oral Health Needs Assessment is being produced and this is expected to be completed by June 2014.

Eye health
The Eye Health Needs Assessment (gap analysis) is being produced for our area and will be overseen by the Eye Health LPN.

Improve access to and uptake of GOS sight testing for vulnerable groups and at risks groups, for example the homeless. This proposal will be implemented through the Eye Health LPN task and finish group in 2014/15.

Local Ambition Three (Patient Services): To increase citizen participation and empowerment and ensure that they are at the centre of our planning.

Key outcomes:

- Improved access to the right services in a timely manner through better information
- Greater access to NHS Choices
- Choice of GP practice
- Greater involvement of patients in service design and commissioning.
- Friends and family test implemented

Improvement Intervention

GMS contract changes 14/15
The Friends and family test will be a contractual requirement for GP practices from December 2014. Practices will be able to develop a second question and we are encouraging practice to discuss this with their CCG and the Area Team. The Friends and family test has already been piloted in Lincolnshire. This is expected to be introduced for other primary care providers by March 2015.
From October 2014, all GP practices will be able to register patients from outside their boundary area without a duty to provide home visits.
From April 2014 it will be a contractual requirement for GP practices to promote and offer patients the opportunity to book appointments, order repeat prescriptions and gain access to medical records on line.
The patient participation enhanced service will be reviewed so that this is greater innovation in how practices seek and act on patient feedback, including the views of patients with mental health needs.
Patient Engagement and Empowerment
Introduction of patient stories which engage patients, relatives, and carers in ways that use their knowledge and experience to directly influence future service provision. This has

commenced in January 2014 within the Lincolnshire Salaried Dental Service. It is the intention to develop this approach and roll it out.
Establish a 'People Bank' where citizens and organisations can register an interest in participation opportunities. Commissioners can also use it to identify interested people for engagement activities.
Hold a local 'listening event' to understand how patients want to participate in the management of their care and how they wish to participate in the commissioning process itself.
Good links with Healthwatch have already been established and we want to strengthen this further in 2014/15 through the primary care meeting structure and the development and implementation of the primary care strategy.
Patient involvement in the planned procurements for 2014/15.
Review Area Team structures and processes to ensure that the local need, local voice and shared decision making with patient representatives are incorporated at every stage of the commissioning cycle from design to delivery to contract monitoring.

Local Ambition Four (Patient Services): To improve the quality of life for older patients and those patients with one or more Long Term Condition.

Key outcomes:

- Commissioning for outcomes
- Wider primary care, provided at scale
- Modern models of integrated working designed around the patient

Improvement Intervention

GMS contract changes 14/15
Implementing nationally negotiated changes for general practice that support more personalised care for older people and those with complex needs.

There will be a new enhanced service to improve services for patients with complex health and care needs and reduce avoidable emergency admissions. The resources released from the QOF quality and productivity domain (100 points) and the risk stratification DES (which will cease with effect from 31st March 2104) will fund the new enhanced service. Given the level of funding associated with the new enhanced service, the expectation is that the majority of practices will sign up to provide this service.
The key elements of the scheme are intended to reduce unplanned admissions, for example proactive care management of at least 2% of patients with complex needs and at the high risk of emergency admissions.

As part of a commitment to more personalised care for patients with long-term conditions, all patients aged 75 and over will have a named, accountable GP with overall responsibility for their care. This will be a contractual duty from 1st April 2014 and any new patients will be notified within 21 days and existing patients notified by June 2014.

These changes will be reflected in PMS contracts once underpinning legislative changes and guidance are in place. These changes will also be reflected in all our local newly procured APMS contracts as a minimum.

We are working with CCGs to ensure that the funding available to support practice plans that improve the quality of care for older people, complement the above core contract changes.

The Eye Health LPN will establish a task and finish group in 2014/15 to take forward Falls Prevention with the aim to reduce avoidable emergency admissions.

Now that the Pharmacy LPN and Eye Health LPN have been established we will be strengthening links with CCGs to improve patient pathways.

Implementing the GMS Contract changes for 14/15 – the range of changes to the GMS contract seek to enable integration, new ways of working, and proactive care that is 'wrapped around' patients, particularly those with complex needs; this supports local CCG plans for managing multi morbidity through integrated neighbourhood teams.
The new enhanced service for reducing unplanned hospital admissions will again support CCG plans and by working together and giving consistent messages we can ensure that there is no duplication of effort or confusion for general practice and we can improve patient experience and outcomes.

Local Ambition Five (Access):To improve access to primary care services & secondary care dental services.

Key outcomes:

- Annual improvement in patient experience of access to services
- Pilot(s) in place for testing new ways of working for general practice

Improvement Intervention

PM Challenge Fund: Improving Access to General Practice

This national scheme is seeking bids for a 2 year pilot to test out innovative models of service delivery, such as federated models, new ways of working that improve access, and make better use of email and phone consultations.

Local Service Reviews

Align the local primary care strategy with the Lincolnshire Sustainable Services Review and the LLR Better Care Together Programme to ensure that there is a 'fit' with local approaches to new models of service delivery and integrated patient care packages.

Access to dental services

The Leicestershire, Leicester City and Lincolnshire Oral Health Needs Assessment is being produced and this is expected to be completed by June 2014. This will provide
Access to dental services – dental look at the % of patients seen
Secondary care pathway development across primary, community, and secondary care dental services. Currently prioritising minor oral surgery and orthodontics (awaiting national pathways) and restorative dentistry, which requires a local review due to differences in the referral criteria applied across the area.

Service reconfiguration project for the Leicestershire Salaried Dental Service, including a review of dental out of hours services and Dental Access Centres. The project was established late in 13/14 and will be taken forward in 2014/15

Access to sight testing
Improve access to and uptake of GOS sight testing for vulnerable groups and at risks groups, for example the homeless. This proposal will be implemented through the Eye Health LPN task and finish group in 2014/15.

Local Ambition 6 (Delivering Value): To reduce unjustified variation in funding levels received by providers and secure the highest quality of care and the best outcomes for every pound invested.

Key outcomes:

- better use of estate from which primary care services are delivered (quality of premises and value for money)
- Delivery of financial plan and associated QIPP schemes
- Redirection of resources to primary care services aligned to strategic direction for scale, scope and integrated care.

Improvement Interventions

Encouraging the adoption of new models of primary and integrated care

A key priority for NHS England is to implement the new arrangements for GP practices to deliver tailored and co-ordinated care for older people and those with complex needs, in partnership with CCGs.

We will support wider primary care delivered in conjunction with social care, community services and formerly acute services where CCG plans support this. This may mean embedding NHS England GP practice contracts in wider arrangements, and jointly commissioning providers of a wider range of integrated care, as a practical way to support tangible delivery aligned to the purpose of the Better Care Fund.

We will support, enabled by a regional and national programme of Primary Care Development, 6 potential care delivery models relevant to local needs and aspirations:

1. Integration around related services for a specific medical condition or group of conditions, in line with the intentions of Leicestershire CCGs.

2. Integration across a wide range of conditions around a specific geography, as reflected in Lincolnshire sustainable services review priority for neighbourhood teams

3. Colocation & merger of practices where it allows improvements in premises in a more cost effective way than standalone development, whilst preserving a level of choice.

4. Creative use of primary care with other public sector and community services in more rural locations

5. Support for practices to bring core services and functions together and manage them jointly on a shared basis such as through federation agreements, whilst preserving individual contractual arrangements for patients.

6. Exploration of the use and expansion of specialist GP services for targeted populations, where evidence suggests clustering patients with specific conditions or needs with others achieves better outcomes than dispersed in small numbers within general contracts.

Except where there are no other alternatives, it is expected these arrangements will take priority in any resource allocation decisions over standalone developments. Further dialogue with commissioning partners and local representative committees will take place to more fully articulate the range of models we will provide support to, as part of the implementation plans for the primary care strategy currently under development

GMS Contract changes 14/15

All area teams in NHS England are implementing the nationally agreed phase out of Minimum practice income guarantee (MPIG) funding for GP practices from 1st April 2014 with a pace of change of 7 years. Funding will be recycled into global sum payments so that funding is more fairly matched to number of patients and key determinants of practice workload.
Local impact for practices – we have 6 'outlier' practices (nationally there are 98) which will lose the largest amount of funding per patient. We will need to discuss possible options with those practices: this could include federation or networking, merging with another practice, other cost-efficiency improvements within the practice, or other commissioning/contracting solutions.

PMS reviews
Impact for practices (assessed on the same basis as GMS) – we have 8 'outlier' practices. We will review all practices, starting with the 8 'outlier' practices, and the resources released will support QIPP delivery. Where possible these resources will be targeted towards our strategic aims for primary care, such as wider primary care provided at scale, supporting new models of care (federation, networks, and neighbourhood teams) and better more convenient access. This will involve joint working with our CCGs, particularly in supporting local urgent and emergency care networks and reducing avoidable emergency admissions. Implement equitable funding mechanisms with an agreed pace of change; with a part year effect in Year 1 to accommodate a reasonable notice period of change.

Local 'premium' for Leicestershire practices (from PCT fairer funding exercise).

We will Implement equitable funding mechanisms with an agreed pace of change in consultation with Local Medical Committees (LMCs), practices and CCGs recognising a managed process is needed. Again released resources will be targeted to strategic aims.

Premises utilisation/Rent abatement policy

We will implement the rent abatement policy for GP practices (which means where practices host wider services they attract a share of the premises rent). This will ensure that the true costs of wider primary and community services are reflected. We will implement this in a staged way for existing services, ensuring finances are aligned between commissioners, and there are no unintended consequences. All new services delivered in practice will be costed taking account of rent costs due.

Time limited contracts
We will review the time limited contracts and where appropriate re-procure services, which is already underway. Design and commission services in partnership with local communities, so that we secure value for money, improve health outcomes and offer new models of care.

Sustainability
Delivery of financial plan and associated QIPP schemes to address the local financial gap for primary care and secondary care dental services. Detailed QIPP plans will be made available as they are further developed.

We need to address workforce capacity and resilience in order to sustain the large-scale shift to community-based patient care and new models of integrated working. In partnership with CCGs and Local Education and Training Boards we aim to have a workforce that can deliver personalised and cost effective care; two key elements are

- An expanded, skilled, resilient and flexible workforce working within integrated teams.
- Academic and quality-improvement activity plus a positive learning climate embedded in primary care.

Governance Overview
Within NHS England, the AT Change Programme Board and Primary Care Strategy Group will oversee the delivery of the improvement interventions reporting to the Area Team executive, and with national line of sight through Primary Care Oversight Group as required.

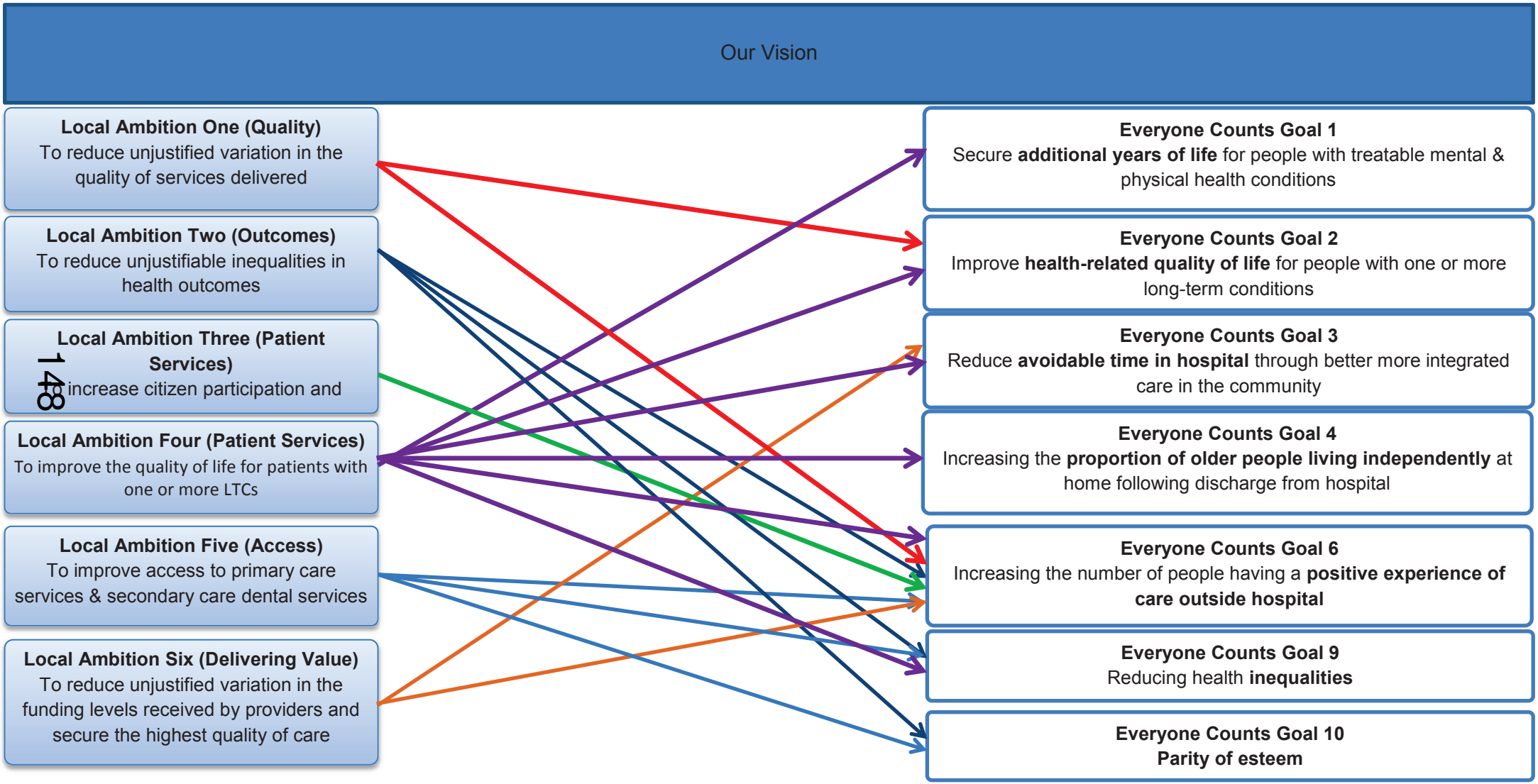
- On-going dialogue with CCGs on progress, recognising our shared agenda
- Membership of the Lincolnshire Sustainable Services Review Steering Board and LLR Better Care Together Programme Board and relevant delivery groups to ensure alignment
- Quarterly updates to the 4 health and wellbeing boards

Key values and principles

- Common core offer of high quality patient centred primary care
- Continuous improvement in health outcomes across the domains
- Patient experience and clinical leadership driving the commissioning agenda
- Maximise value by securing the highest quality of care and the best outcomes for every pound invested

The diagram (overleaf) maps primary care operational plans to ‘everyone counts’ guidance:

Primary Care Services – Everyone Counts

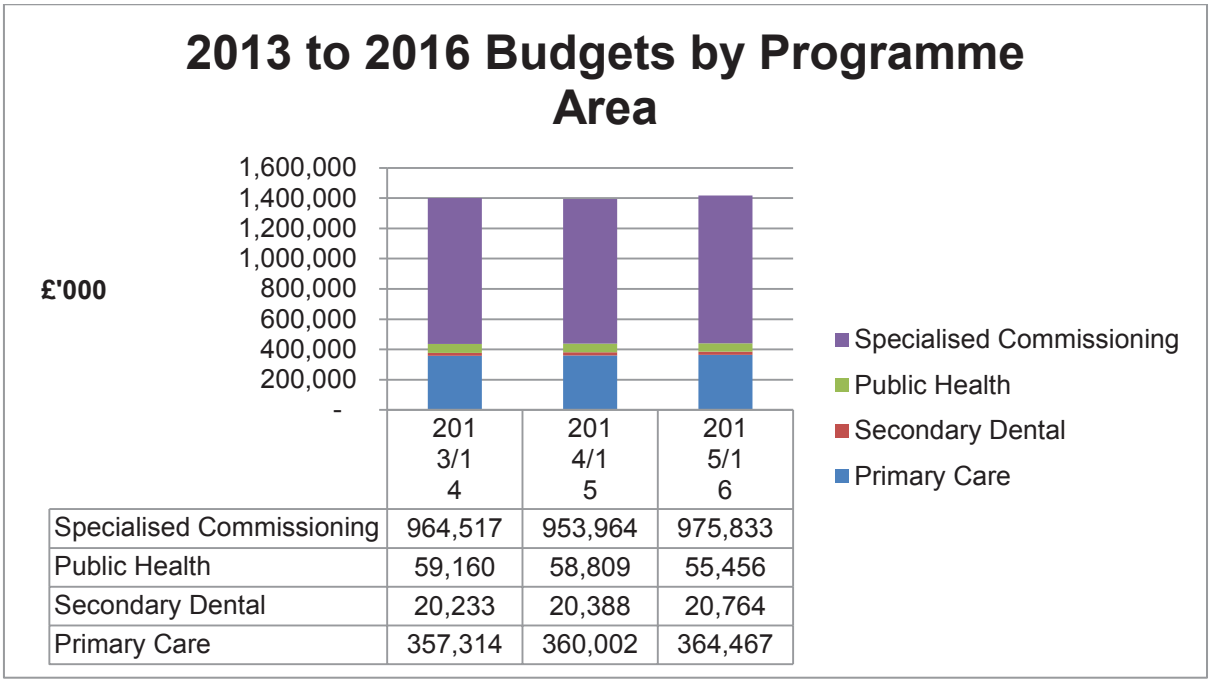


SECTION FOUR: FINANCE, PERFORMANCE, AND DELIVERY

Draft Financial Plans – Financial Commentary

Introduction

Leicestershire & Lincolnshire Area Team has a budget of £1.4bn, as shown in the graph below. This financial commentary is intended to highlight the changes assumed with the budgets below from 2013/14 to 2015/16, and the outcomes as a result of those changes.



	2013/14	2014/15	2015/16
Specialised Commissioning	964,517	953,964	975,833
Public Health	59,160	58,809	55,456
Secondary Dental	20,233	20,388	20,764
Primary Care	357,314	360,002	364,467

Plans have been developed in detail for 2014/15 and 2015/16. Financial plans have been populated for 2016/17 to 2018/19 however these reflect continuation of basic assumptions for allocations and costs in line with 2014 to 2016. Strategic plans are to be developed for the plan submission required in March.

The plans have been developed in line with commissioning plans, and reflect the current development of operational planning, and currently available information.

Requirements

Table 1 shows a list of the key business rules for Direct Commissioning. In summary these are in line with 2013/14 apart from the requirement of specialised commissioning to deliver a 1% surplus, and ensure a headroom reserve is placed aside, where in 13/14 this was used in lieu of growth.

The other major change is the increase of the headroom from 2% to 2.5% in 2014/15. This then returns to 2% in 2015/16 onwards. A minimum of 1% of the headroom should be used for transformation.

All areas are expected to maintain a 0.5% contingency for in year pressures.

Although the requirement is for a 1% surplus, the requirement for 2014/15 is that the current agreed forecast surplus in 2013/14 is the required surplus for 2014/15. Reductions to surplus can be made in 2015/16 to meet the 'financial cliff edge'.

The 1% surplus from 2013/14 has been confirmed will be carried forward from 2013/14 in Primary Care, and secondary Dental. The forms currently allow all surplus/deficits to impact on 2014/15, which has an impact for Specialised Commissioning as it is currently forecasting to be £4.6m overspent. In line with national discussions on specialist commissioning it has been assumed that this pressure will be met centrally.

Table 1. Business rules for 2014/15 and 2015/16

	2014/15			2015/16		
Commissioned Area	Surplus	Contingency	Headroom	Surplus	Contingency	Headroom
Specialised Commissioning	1.0%	0.5%	2.5%	1.0%	0.5%	2.0%
Primary care	1.0%	0.5%	2.5%	1.0%	0.5%	2.0%
Public Health	0.0%	0.5%	0.0%	0.0%	0.5%	0.0%
Secondary Dental	1.0%	0.5%	2.5%	1.0%	0.5%	2.0%

Allocations

Allocation changes are summarised in table 2. Specialised commissioning received an uplift of 4.3%. This was designed to allow specialised commissioners to meet in year pressures from 2013/14 and reflecting the evidence about relative pace of growth in healthcare need for complex services such as new high cost drugs being made available.

Primary care increases for the Leicestershire and Lincolnshire Area are 2.2% in 2014/15. This is weighted taking into account forecast population changes, and unmet need. This increase is also applied to Secondary Dental, which nationally is considered as part of the primary care allocation.

The public health growth in allocation is being retained nationally. The intention is to allocate the growth based upon the outcome of the plans. As a result it's expected with the investment requirements in public health that the financial plans will be overspent pending agreed transfers.

For technical reasons financial plans templates in 2014/15 and onwards allow for no anticipated allocations. This means where recurrent allocations haven't been included with the national allocation notified for the plans the position this causes a pressure in the position. These have been notified to the central team and amount to £1.831m within

Primary care. £1.41m of this relates to agreed infrastructure allocation corrections with Leicestershire CCGs.

Table 2. 2014/15 to 2015/16 Recurrent Allocations

	Specialised Commissioning		Public Health		Secondary Dental		Primary Care	
	2014/15 £000	2015/16 £000	2014/15 £000	2015/16 £000	2014/15 £000	2015/16 £000	2014/15 £000	2015/16 £000
Total Recurrent Notified Allocation	953,964	1,011,679	58,809	58,693	20,190	20,560	356,130	362,680

Key Assumptions

Below is a list of the key assumptions made within the financial plans.

Specialised

4% Tariff efficiency will be applied in full to health care providers, apart from primary care providers.

2.8% Tariff Increase – Different from national at 2.7%, which reflects local view that the impact will not reflect in the same proportions as anticipated nationally.

Demographic growth at 0.82% - determined by projections on local ONS data.

Non-demographic growth of 4.6% - This relates to drugs and device increases and other service growth.

Coding and Counting issues expected to cost around £6m (where providers can increase charges for care delivered according to national rules where improved coding results in extra activity being billed).

Convergence costs over 13/14 of £12.4m reflecting additional eligibility for treatment under new national clinical policies

A separate ring fenced fund for demand management and prevention for specialised services as a result of the national tariff for emergency care, with £4m planned in line with 2013/14.

Cancer Drugs Fund allocations and costs are removed for 14/15 onwards as funding held centrally by NHS England.

Public Health

Contracts change in line with national assumptions i.e. 4% tariff efficiency 2.7% price increase

Demographic Growth at 0.82%

Secondary Dental

Contracts change in line with national assumptions i.e. 4% tariff efficiency 2.7% price increase

Demographic Growth at 0.82%

Primary care

Inflation applied in line with previous year's impact at 1.25% on GPs.

Demographic Growth at 0.82% or GP demographics are in line with national assumptions, 1.3% and 1.2% for 14/15 and 15/16 respectively.

GP IT allocation and costs are excluded from the position.

Where not population based, no increase has been assumed, in line with previous experience on Primary care.

Investments

Increases to costs over the assumptions already highlighted are listed within recurrent investments sheets (those which are required from the baseline), and non-recurrent investments (those that utilise the 'headroom'). A summary of those investments are contained within table 3.

Table 3. 2014/15 Recurrent and Non-Recurrent Investments

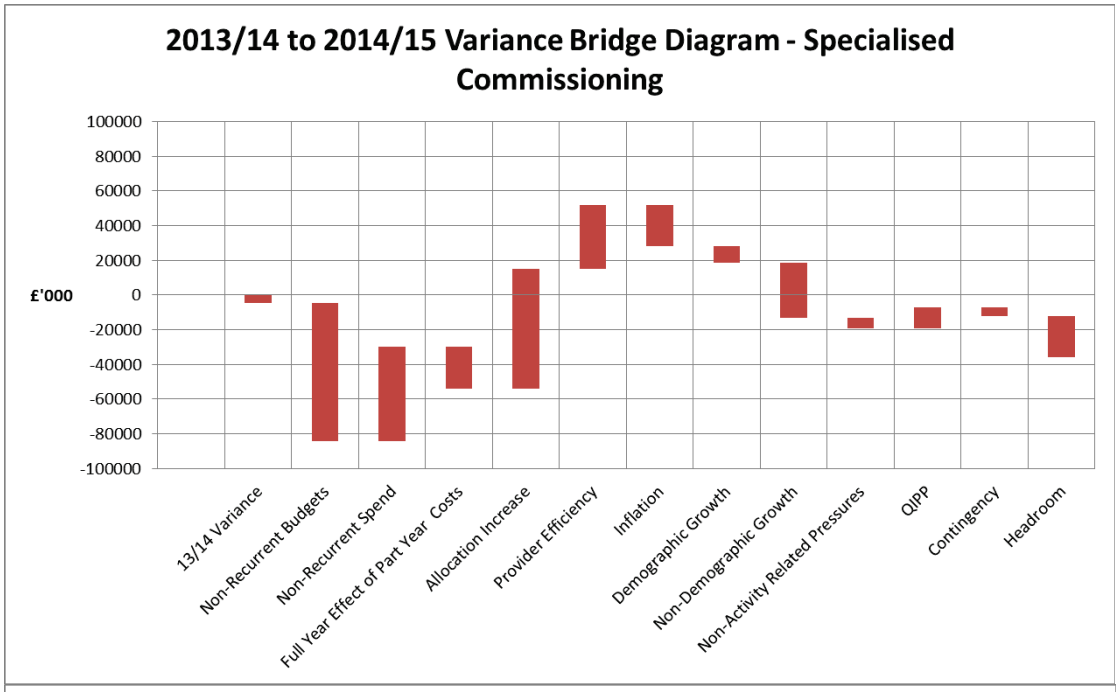
Programme Area	Recurrent £'000	Non-Recurrent £'000
Specialised Commissioning	0	23849
Public Health	5992	0
Secondary Dental	0	506
Primary Care	11887	4591
Total	**17879**	**28946**

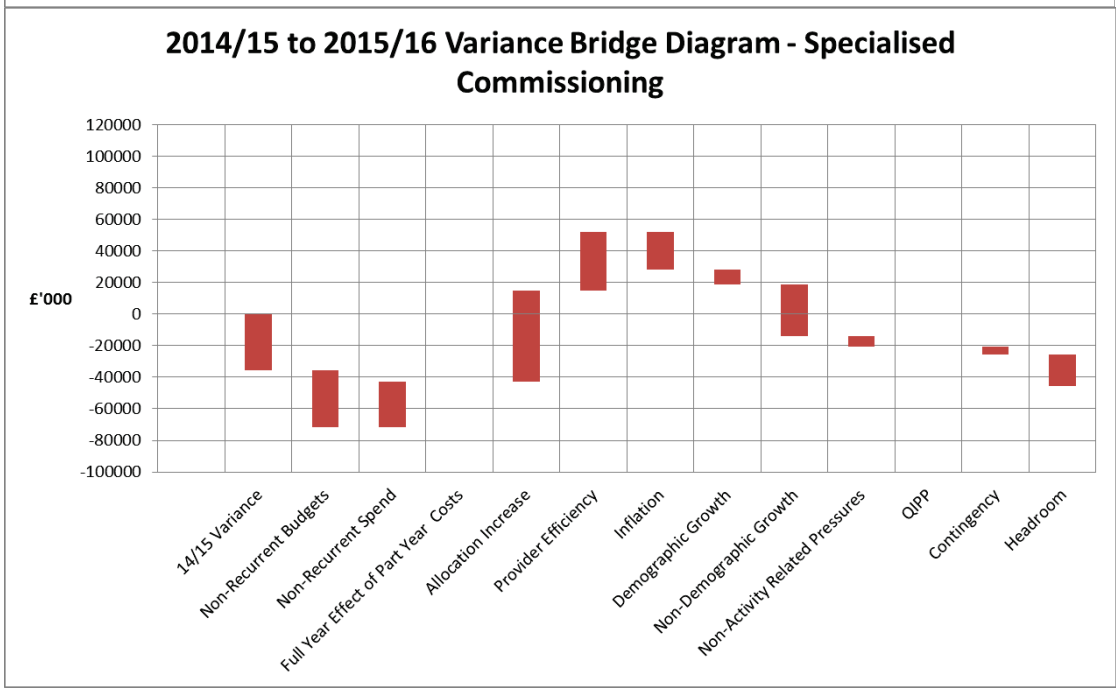
GP IT is excluded from resource and expenditure from 2014/15 onwards as it is being transferred to CCGs.

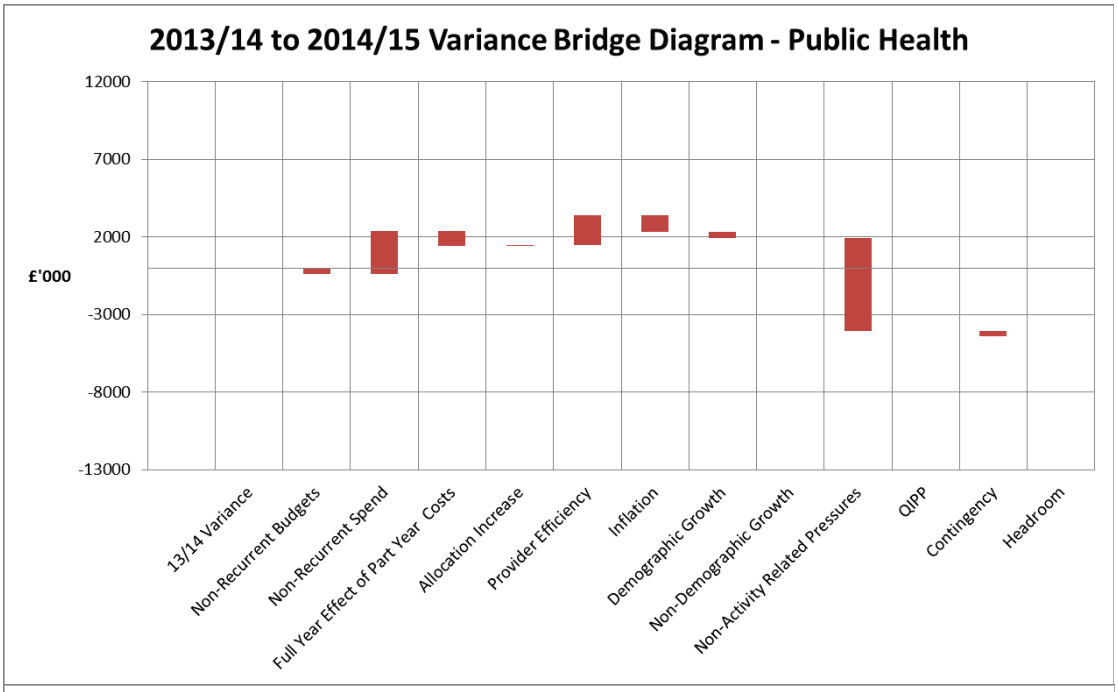
Detailed financial plans are assured through the NHS England regional office, a summary of which will be made available following finalisation.

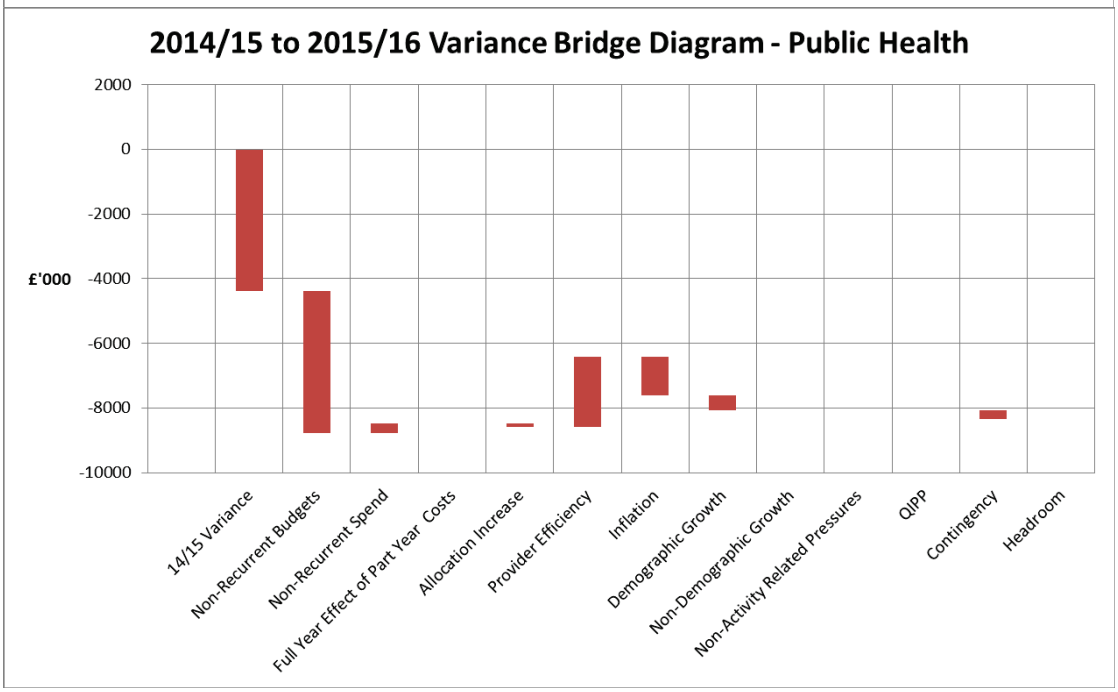
Bridge Diagrams

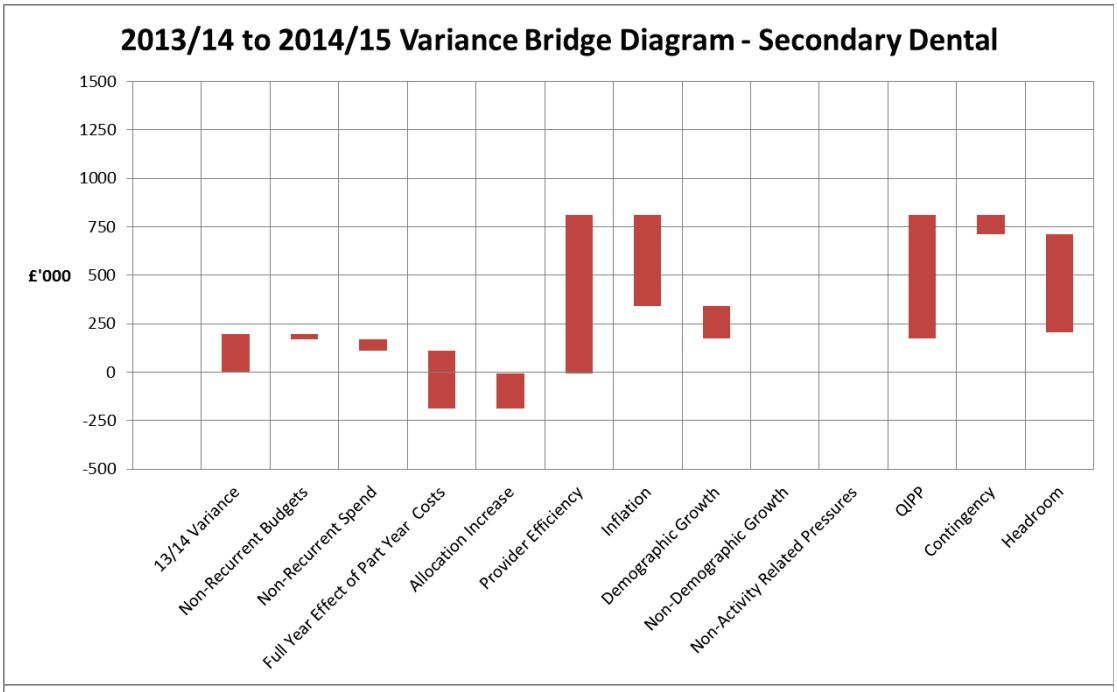
Below are bridge diagrams highlighting key movements within the financial plans from 2013/14 forecast outturn to 2015/16.

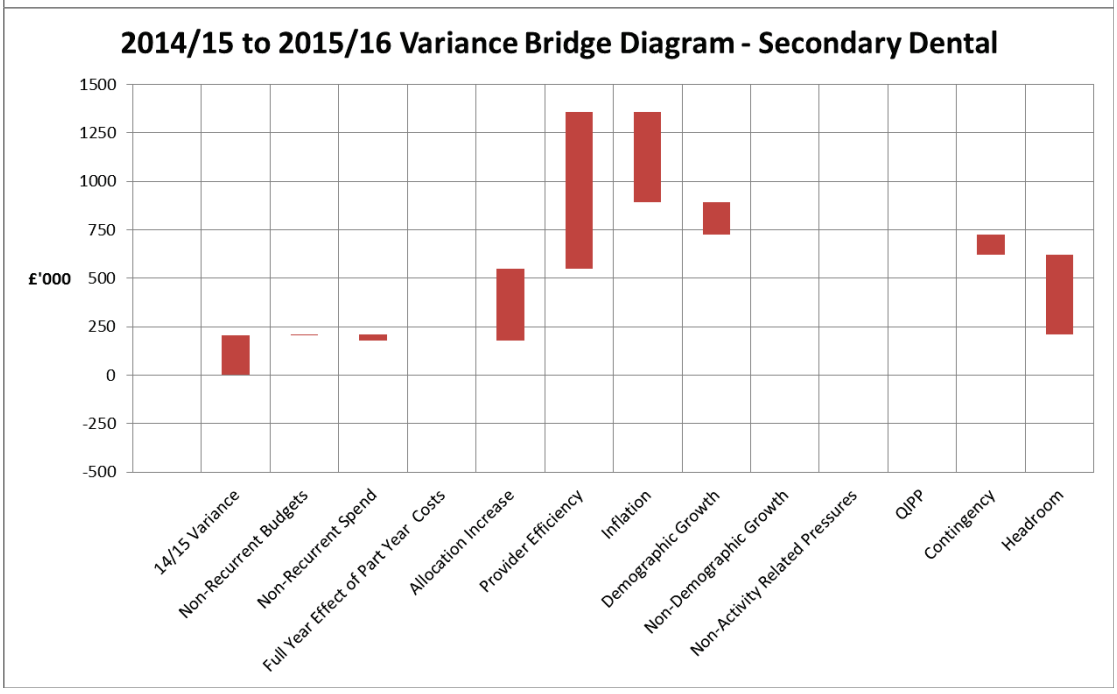


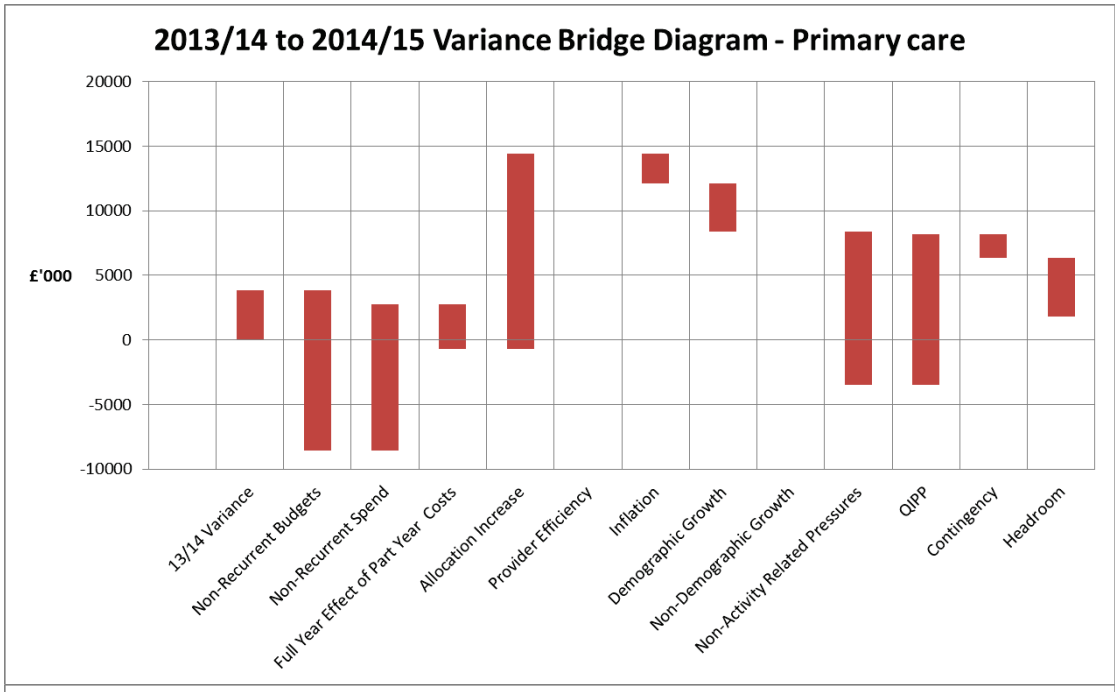



2013/14 to 2014/15 Variance Bridge Diagram - Public Health
12000
7000
2000
£'000
-3000
-8000
-13000
13/14 Variance
Non-Recurrent Budgets
Non-Recurrent Spend
Full Year Effect of Part Year Costs
Allocation Increase
Provider Efficiency
Inflation
Demographic Growth
Non-Demographic Growth
Non-Activity Related Pressures
QIPP
Contingency
Headroom


2014/15 to 2015/16 Variance Bridge Diagram - Public Health
2000
0
-2000
£'000
-4000
-6000
-8000
-10000
14/15 Variance
Non-Recurrent Budgets
Non-Recurrent Spend
Full Year Effect of Part Year Costs
Allocation Increase
Provider Efficiency
Inflation
Demographic Growth
Non-Demographic Growth
Non-Activity Related Pressures
QIPP
Contingency
Headroom


2013/14 to 2014/15 Variance Bridge Diagram - Secondary Dental
£'000
1500
1250
1000
750
500
250
0
-250
-500
13/14 Variance
Non-Recurrent Budgets
Non-Recurrent Spend
Full Year Effect of Part Year Costs
Allocation Increase
Provider Efficiency
Inflation
Demographic Growth
Non-Demographic Growth
Non-Activity Related Pressures
QIPP
Contingency
Headroom


2014/15 to 2015/16 Variance Bridge Diagram - Secondary Dental
£'000
1500
1250
1000
750
500
250
0
-250
-500
14/15 Variance
Non-Recurrent Budgets
Non-Recurrent Spend
Full Year Effect of Part Year Costs
Allocation Increase
Provider Efficiency
Inflation
Demographic Growth
Non-Demographic Growth
Non-Activity Related Pressures
QIPP
Contingency
Headroom


2013/14 to 2014/15 Variance Bridge Diagram - Primary care
£'000
20000
15000
10000
5000
0
-5000
-10000
13/14 Variance
Non-Recurrent Budgets
Non-Recurrent Spend
Full Year Effect of Part Year Costs
Allocation Increase
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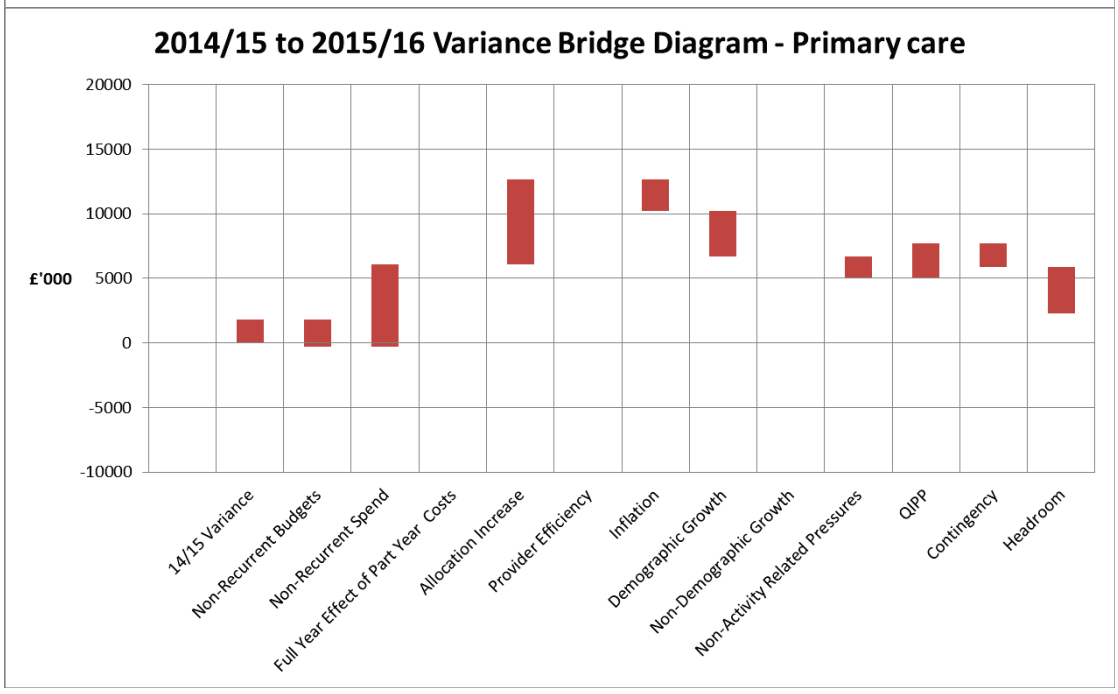
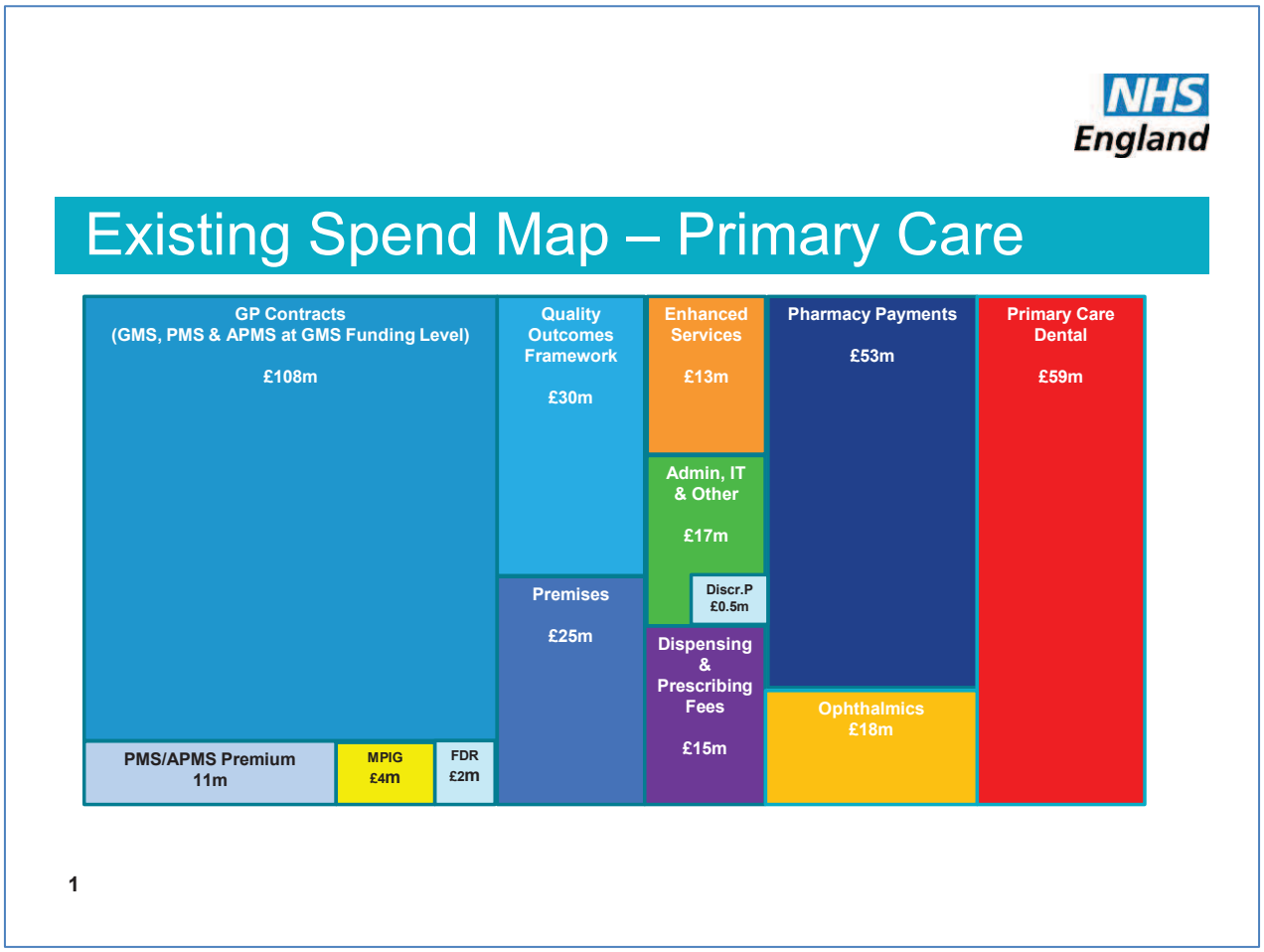
Demographic Growth
Non-Demographic Growth
Non-Activity Related Pressures
QIPP
Contingency
Headroom


2014/15 to 2015/16 Variance Bridge Diagram - Primary care
£'000
20000
15000
10000
5000
0
-5000
-10000
14/15 Variance
Non-Recurrent Budgets
Non-Recurrent Spend
Full Year Effect of Part Year Costs
Allocation Increase
Provider Efficiency
Inflation
Demographic Growth
Non-Demographic Growth
Non-Activity Related Pressures
QIPP
Contingency
Headroom

Financial Mapping for Direct Commissioning to inform QIPP Goals

The Charts below show the relative sizes of areas of spend within each direct commissioning budget, grouping together areas of spend in relation to the potential levers for change. In some cases there is scope for local action, and other areas are set by national policy.

Primary Care Financial Mapping



For each area of spend it is potentially possible, at national for some services or at local level for others to address the quantity of service commissioned, or the price/ level of payment for that service. Each spend area has specific contstraints:

GP contracts are funded to the level within GMS on a per registered patient basis at £108m. It is possible to reduce the number of registered patients through cleansing the GP registered list to ensure those who have left the area have been removed, but once this is being done annually and is reflected in the baseline spend levels, the spend in this area is not subject to local determination as the GMS spend per patient is nationally negotiated, and local population demographics will drive the level of patients registered.

PMS/APMS contract premiums are an example of funding per patient above GMS funded levels either to provide enhanced service levels to target groups with specific health needs (e.g. homeless people) or for more stretching quality KPIs. This is an area in which local action e.g. through a contract review may impact the number of practices receiving such payments, the conditions for payment, or the level of payment.

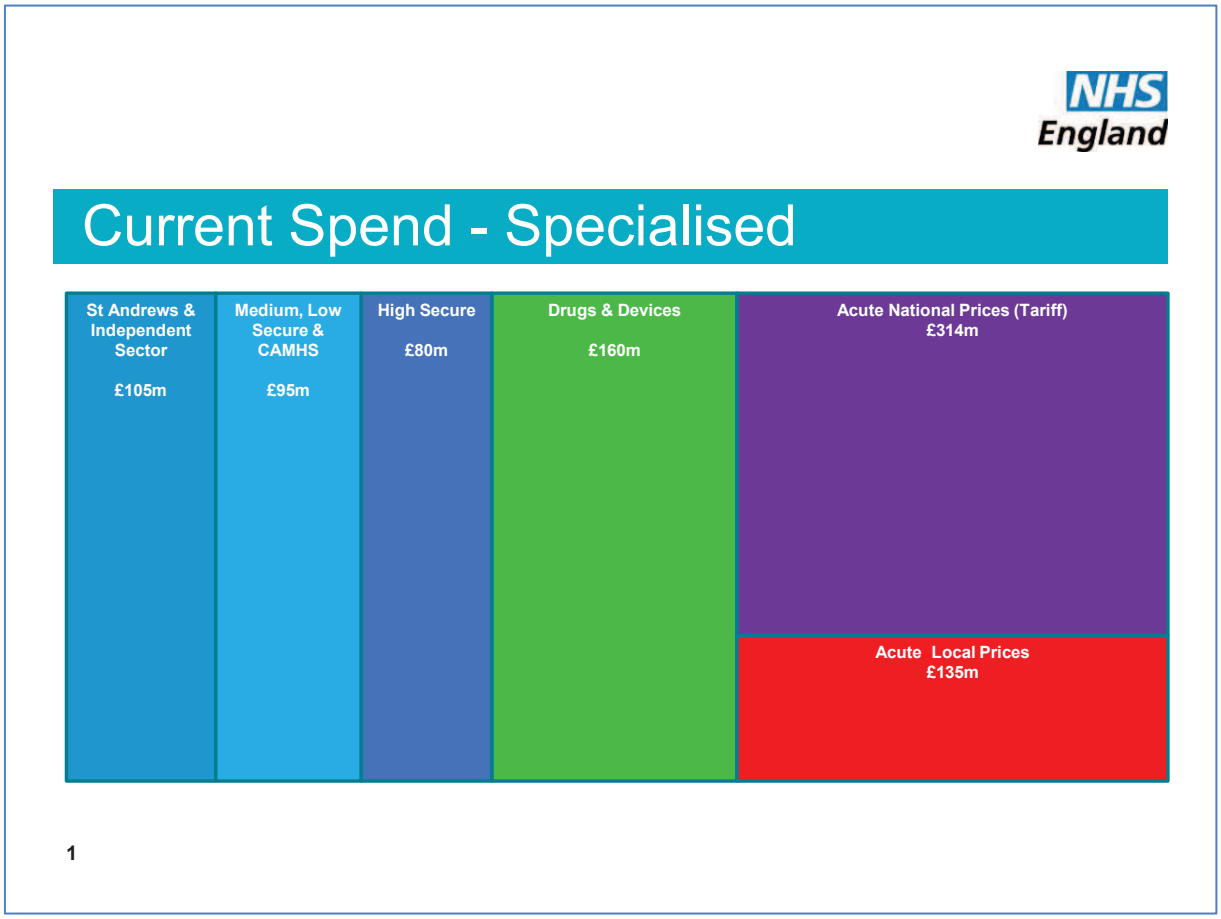
National and Directed Enhanced Services are areas where, once on-going payment verification is in place, uptake of services is determined by the choices of practices, with payment at nationally negotiated levels.

The benefit of financial mapping is to ensure informed dialogue in the setting of financial improvement plans. For primary care services this is particularly challenging, as the areas with local levers and discretion.

Setting a top down 3% Improvement target across the full £357m primary care budget requires year on year recurrent savings of £10.7m.

Our QIPP plans will be reviewed to address the gap against nationally set requirements based on setting bottom up % change for each area of spend and holding dialogue with regional and national teams to be assured goals are stretching but realistic and achievable without destabilising provider viability, or undermining strategic aims for the future role of primary care.

Specialised Commissioning Financial Mapping



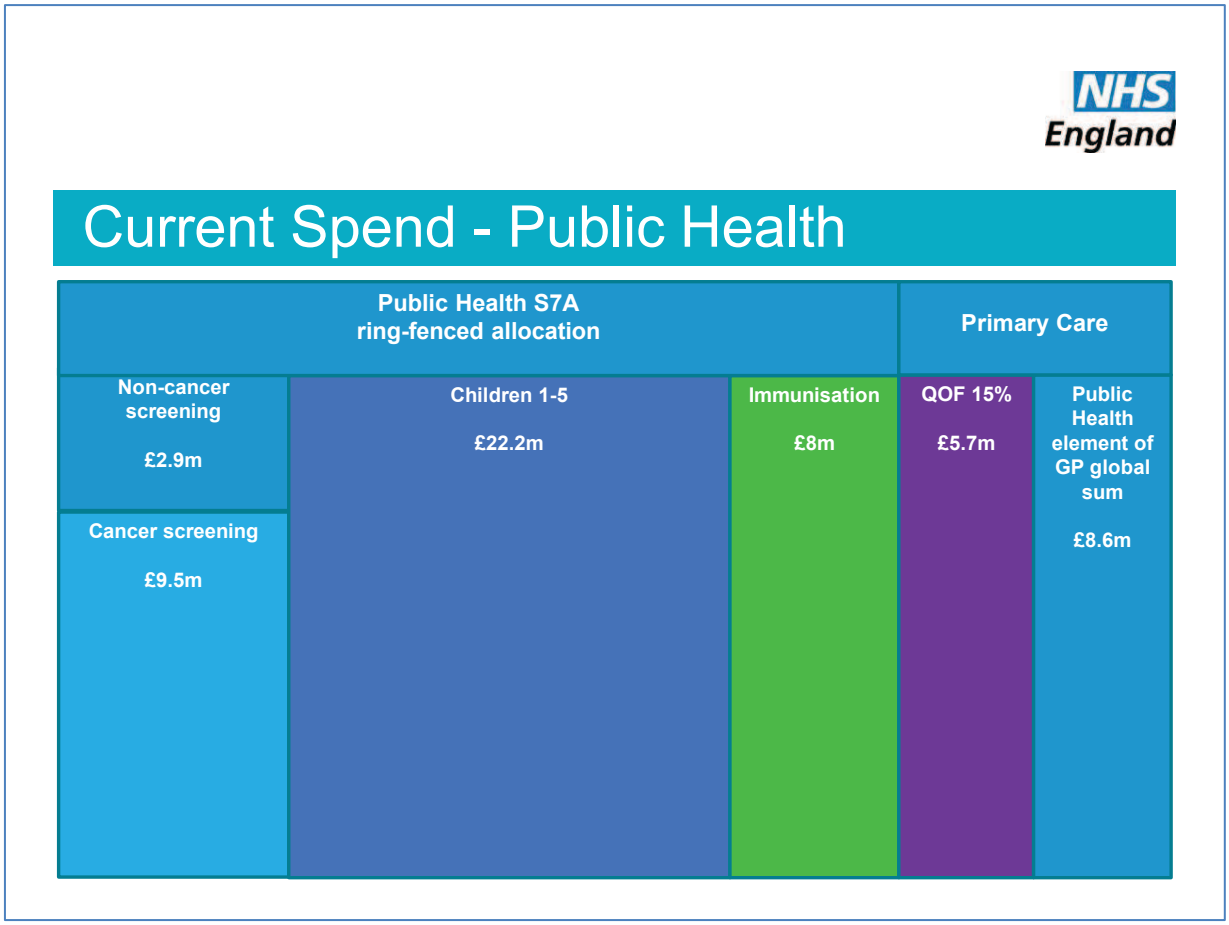
For specialised services the mental health spend profile is heavily influenced by High secure and national independent sector mental health responsibilities where placement levels are not in the control of the area team. The QIPP initiatives planned for medium, low secure, and CAMHS amount to around 2% of baseline spend in those areas.

For the 4 acute programmes of care, there are three distinct areas with different levers. A stretching cost improvement for high cost drugs and devices, on top of cost growth avoidance initiatives, of almost 7% of baseline spend, has robust local plans in place.

For the acute services paid at national tariff it is not possible to negotiate prices so areas of focus relate to reducing treatment volumes through clinical threshold auditing. Previous national benchmarks suggest levels of use by the east midlands population are low so the impact of clinical policies in aligning historic practice to current evidence will be less significant. Areas of bed day based spend through clinical utilisation review is an additional area where improvements are expected over a 1-3 year period of sustained change.

For acute services at local prices some price negotiation is possible. Many east midlands services are already at or below best quartile cost based prices, which reduces the scope to negotiate further reductions without impact on quality but there are exceptions to this, which inform contracting goals.

Public Health Financial Mapping

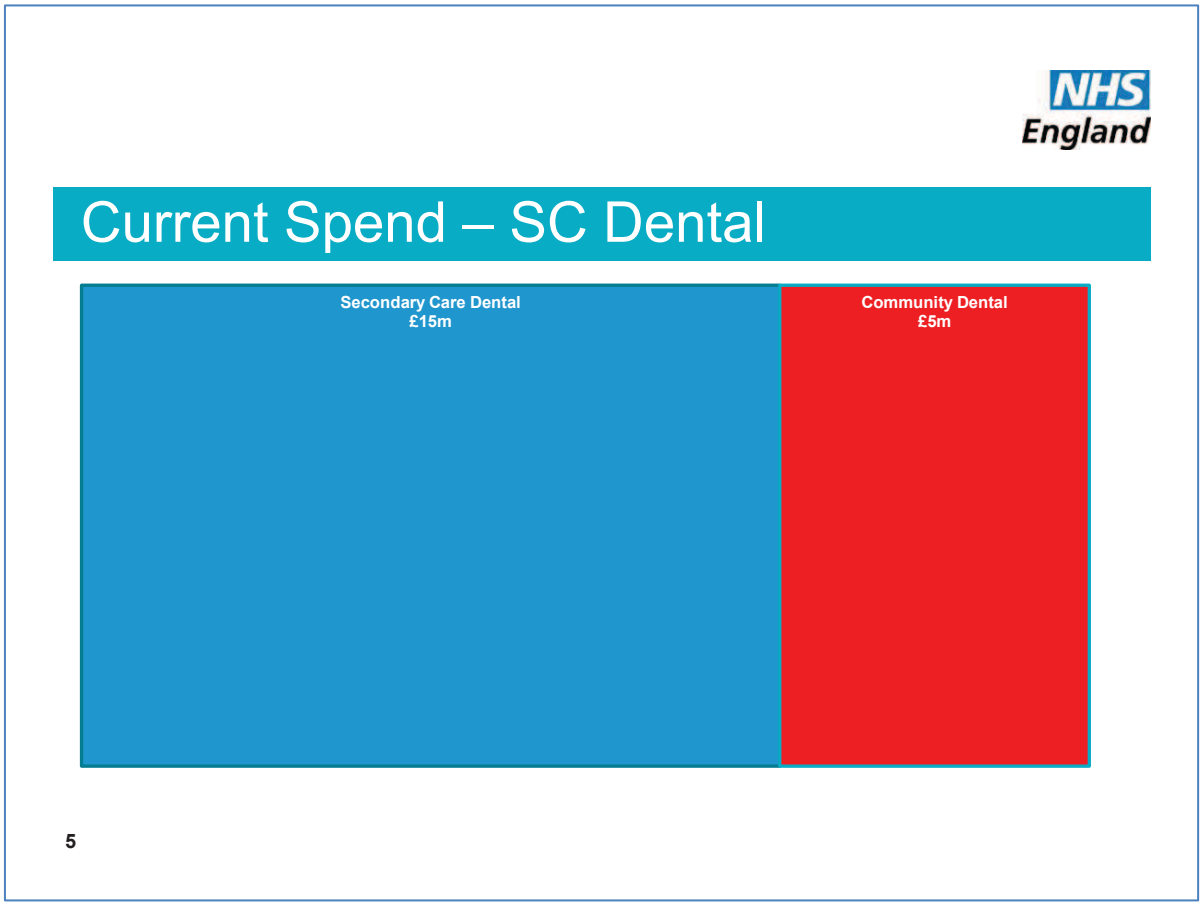


The three distinct areas (screening, child health, and immunisation) are subject to different dynamics. For QOF and global sum prices are nationally set, and constraining the level of achievement would be counter to the health outcome aims of commissioners. Immunisations are similarly paid at a 'going' rate to GP practices with links to patient registered list to maintain records a significant benefit of retaining a GP model where possible.

The major area of spend is on child health. This is subject to mandated targets for resource inputs (national targeted number of health visitors and family nurse partners employed) and agenda for change national pay scales. Efficiency can, in this area of spend, only come from reductions in the corporate overhead on services or in limited cases by changes to skill mix, although the nature of national targets allow limited flexibility.

The QIPP programme for public health is necessarily most focussed on screening services. Again whilst it is neither possible nor desirable to reduce quantity of screening activity (greater reach to populations is a positive health gain) there is opportunity to work with providers whose unit costs are not yet at the levels of the most efficient services, and to ensure service economies of scale are realised to support the commissioning of the national developments planned.

Secondary Dental Financial Mapping



Acute dental spend uses nationally set prices, with opportunities for productivity (reduced follow ups) and reductions in referrals through better primary care management, but beyond

this treatment volumes need to keep pace with referrals in order to meet NHS constitution rights of patients to be treated within 18 weeks of referral. The more significant area is community dental services where locally negotiated prices and service models are informing the work of the commissioning team to improve value.

Performance and Delivery - Specialised Services

All specialised services treatment must meet the standards in the NHS constitution, but the key performance measures are at trust wide levels, rather than split between specialised and non-specialised services, so no performance trajectories have been requested for operational plans.

Key areas of delivery, alongside the service development agenda are the management and effective governance of contracts, and the managed uptake of drugs and devices in line with best evidence and value.

Individual Funding Request and Cancer Drugs Fund (IFR/CDF)

The Area Team is also responsible for the establishment of a region-wide Individual Funding Request and Cancer Drugs Fund process hosted in the Leicestershire & Lincolnshire Area Team. Effective systems and processes have been established to administer the CDF and the IFR process and the team is working well. Cancer Drugs Fund budget is £50,248

PbR Excluded Drugs

During 14/15 we plan to achieve the following:

- Work with Provider Trusts and CCGs to repatriate post-transplant prescribing of renal immunosuppressant medication
- Work with Providers and CCGs to repatriate prescribing of inhaled antibacterials prescribed for Cystic Fibrosis
- Ensure there is a consistent understanding and application across East Midlands Provider Trusts of chemotherapy associated costs (procurement costs and supplementary medicines)
- Agree schemes with Providers so that the benefits associated with more efficient use of medicines not reimbursed through national prices are shared. We aim to agree 5 new schemes in 14/15 and 5 new schemes in 15/16

Effective procurement of high cost drugs
The Area Team is an active member of the national procurement framework for excluded drugs and devices and will continue to be an active contributor to the work plans of the Regional Pharmacy collaborative. Both of these mechanisms will ensure consistent pricing of high cost drugs and best value to the NHS.

NICE appraisal
Drugs as detailed in the current NHS England excluded drug list will be commissioned in line with NHS England commissioning policies and NICE Technology Appraisals (TA). NICE approved drugs recommended within a NICE Technology Appraisal that are excluded from tariff will be automatically funded from day 90 of its publication. Some approved drugs and devices may be funded before this time at the discretion of NHS England.

Sharing the benefits associated with more efficient use of medicines not reimbursed through national prices

Because acquisition costs of medicines not reimbursed through national prices are reimbursed by commissioners, there may be little incentive for a provider to maximise the cost-effectiveness of these treatments, particularly where providers have to make decisions on prioritisation of their resources or if improvements in cost-effectiveness require the commitment of additional resources. The AT will incentivise provider trusts to ensure maximum value for money from medicines excluded from the national tariff. This will be done through clear, up-front agreements on the share of financial savings with both commissioners and providers and according to the principles described in national NHS England guidance.

Budget setting and reporting
Budgets for excluded drugs will be set on an annual basis. This will be based on the provider's assessment of need through horizon scanning, and agreed through a 'confirm and challenge' meeting with the provider. Analysis of monthly reports of Trust activity against budget will be undertaken, and questions on performance will be raised when necessary.

Post- transplant immunosuppressants and inhaled antibiotics for cystic fibrosis
All post-transplant immunosuppressants and inhaled antibiotics for cystic fibrosis will be commissioned directly from Trusts by April 2016. The AT will work with Trusts and CCGs to ensure that prescribing of these drugs are safely repatriated from primary care to secondary care.

Homecare
The AT will work with Trusts to ensure that the recommendations identified in the Hackett Report are implemented effectively. The AT will work with Providers to ensure that Homecare services are safe and effective and make best use of NHS resources.

Chemotherapy
NHS England commissioning intentions states that only those drugs which are defined as a priority within a recognised chemotherapy regimen will be funded as part of the pass through arrangements. It does not include drugs which are provided for symptoms that arise post chemotherapy (e.g. antiemetics, unless given to all patients as part of the standard regimen) and it does not include longer-term use of non-chemotherapeutic agents such as bisphosphonates. In addition, hormone therapies, unless specifically identified as excluded by the national Payment by Results team or by agreement with NHS England, are considered in tariff.

The AT will work with Trusts to ensure that supportive medicines for chemotherapy are dealt with in a consistent manner across the East Midlands and will work towards a consistent national mechanism of payment.

Procurement costs related to chemotherapy will be agreed in line with national principles and the AT will work with colleagues nationally to develop a consistent mechanism of payment.

Performance and Delivery – Public Health Services

Public health measures performance trajectories based on the outlined plans are stated overleaf. These are subject to further refinement.

			UJNIFY Target	Current Achievement				
				Q1	Q2			
				Unless alt. period specified		14-15	15-16	2018/19
E.F.1	Population Vaccination Coverage – Dtap / IPV / Hib (1 year old)		>=94.7%	97.1	96.9	97.5	97.5	97.5
E.F.2	Population Vaccination Coverage – MenC (1 year old)		93.9%	96.7%	95.6	97.5	97.5	97.5
E.F.3	Population Vaccination Coverage – PCV (1 year old)		94.2%	97.0%	96.9	97.5	97.5	97.5
E.F.4	Population Vaccination Coverage – Dtap / IPV / Hib (2 years old)		96.1%	98.1%	98	98	98	98
E.F.5	Population Vaccination Coverage – PCV Booster (2 years old)		91.5%	95.6%	95.8	96	96	96
E.F.6	Population Vaccination Coverage – Hib / MenC Booster (2 years old)		92.3%	95.8%	95.9	96	96	96
E.F.7	Population Vaccination Coverage – MMR for One Dose (2 years old)		91.2%	95.2%	95.4	96	96	96
E.F.8	Population Vaccination Coverage – MMR for One Dose (5 years old)		92.9%	96.2%	96.3	97	97	97
E.F.9	Population Vaccination Coverage – MMR for Two Doses (5 years old)		86.0%	92.0%	91.3	93	94	95
E.F.10	Population vaccination coverage - Hib / MenC booster (5 years old)		88.6%	94.6%	94	95	95	96
E.F.11	Population Vaccination Coverage - Hepatitis B (1 year old)		tbc					
E.F.12	Population Vaccination Coverage - Hepatitis B (2 years old)		tbc					
E.F.13	Population Vaccination Coverage - HPV		86.8%			90	90	90
E.F.14	Population Vaccination Coverage - PPV		68.3%	69%		69	70	71
E.F.15	Population Vaccination Coverage - Flu (aged 65+)		73.4%	72.0%		74	75	75
E.F.16	Population Vaccination Coverage - Flu (at risk individuals)		51.3%	47.4%		51	55	60
E.F.17	Percentage of Pregnant Women eligible for Infectious Disease Screening who are tested for HIV, leading to a Conclusive Result		98.1%	99.0%	99.23%	99	99	99
E.F.18	Percentage of Women Booked for Antenatal Care, as reported by Maternity Services, who have a Screening Test for Syphilis, Hepatitis B and Susceptibility to Rubella leading to a Conclusive Result		tbc	not available	not available			
E.F.19	Percentage of Pregnant Women eligible for Antenatal Sickle Cell and Thalassaemia Screening for whom a Conclusive Screening Result is available at the Day of Report		98.0%	99.3%	99.1%	99	99	99
E.F.20	Percentage of Babies Registered within the Local Authority area both at Birth and at the Time of Report who are Eligible for Newborn Blood Spot Screening and have a Conclusive Result Recorded on the Child Health Information System within an Effective Timeframe		92.3%	87.1%	71.2%			
E.F.21	Percentage of Babies Eligible for Newborn Hearing Screening for whom the Screening Process is Complete within 4 Weeks Corrected Age (hospital programmes – well babies, all programmes – NICU babies) or 5 Weeks Corrected Age (community programmes – well babies)		97.5%	99.3%	99.1%	99	99	99
E.F.22	Percentage of Babies Eligible for the Newborn Physical Examination who were Tested within 72 hours of Birth		tbc		98.27%	98	99	99
E.F.23	Percentage of those offered Screening for Diabetic Eye Screening who attend a Digital Screening Event		80.2%		To Dec across AT =62%	82	83	84
E.F.24	Abdominal Aortic Aneurysm (AAA) KPI		-					
E.F.25	Breast Cancer Screening Coverage - Percentage of Eligible Women Screened Adequately within the Previous 3 Years on 31st March		76.9%		82%	82	82	83
E.F.26	Cervical Cancer Screening Coverage - Percentage of Eligible Women Screened Adequately within the Previous 3.5 or 5.5 Years (according to age) on 31st March		75.3%		80% 2012-13	80	80	80
E.F.27	Bowel Cancer Screening - Uptake and Coverage over 2.5 Years		55.8%			57	58	60
E.F.28	Number of FTE Health Visitors		tbc-improvement					

Performance and Delivery – Primary Care Services

Primary Care performance trajectories based on the outlined plans are stated overleaf. These are subject to further refinement and subject to a degree of inherent uncertainty due to the nature of the measures.

ANNEX D: PRIMARY CARE MEASURE	Reference number	Area team to complete	Target / trajectory guidance	2013/14	2014/15	2015/16	Comment (1 line Rationale for how change will be achieved)
Medical							
Patient satisfaction							
Satisfaction with the quality of consultation at the GP practice	ED1	YES	Annual improvement	611	615	619	Year on year reduction in the number of practices with red outliers (25% reduction).Review the practices that have more than 10 red outliers, triangulate with other measures in GPOS and GPHLI and in partnership with CCGs and their local balanced scorecard,as part of the assurance framework process. Agree action plan and timeframes for improvement.
Satisfaction with the overall care received at the surgery	ED2	YES	Annual improvement	166	168	170	Year on year reduction in the number of practices with red outliers (25% reduction).Review the practices that have more than 10 red outliers, triangulate with other measures in GPOS and GPHLI and in partnership with CCGs and their local balanced scorecard,as part of the assurance framework process.Agree action plan and timeframes for improvement.
Satisfaction with accessing primary care	ED3	YES	Annual improvement	252	254	256	Year on year reduction in the number of practices with red outliers (25% reduction).When looking at the availability of routine appointments, we intend to address the lack of availability during core hours and aim to ensure that access to extended hours is offered and available to patients. Improvement in the number of consultation hours available per week. This should improve patient satisfaction with GP opening hours and the convenience of opening times.
Referrals							
Proportion of new cancer cases referred using 2 week wait pathway	ED4	NO	None as area team not to complete				
Vaccinations							
Flu vaccinations – at risk coverage	ED5	YES	At or above 51.3%				
Mental health							
Identifying the prevalence of depression compared to estimated model	ED6	YES	The guidance quoted on GPOS gives an aim to reduce the outliers from level 1 and level 2 outliers - so I'd suggest reducing the number of outliers in the area and plans to tackle the level 2 outlieing practices	Trigger level 2 = 5 practices Trigger level 1 = 10	Reduce trigger level 2 practices from 5 to 3	Reduce trigger level 1 practices from 10 to 5	Target those that are at trigger level 2 in 14/15 (triangulating with other measures) and agree action plans with timescales for improvement. Review those practices that are at trigger level 1 in 15/16 and target those practices that have are 'approaching review ' under GPOS. Again agree action plans with timescale for improvement.
Dental							
Access							
% Patients seen – 24 month measure	ED7	YES	Exceeding the % of patients seen in 2012/13	55%	54%	54%	We have remained at the 55% level throughout 13/14. In 13/14 we clawedback under performance, we did not commission any additional activity (either recurrently or non recurrently), and we renegotiated contracts to reduce the level of recurrent under performance, hence in 14/15 we are likely to see the % level drop. There may be some positive impact from the monitoring of recall intervals but this is difficult to quantify. We are not planning to commission additional UDAs in 14/15 hence the % is likely to remain at 54%.
Activity							
Number of course of treatments per 100,000 population	ED8	YES	None in guidance - assume planning numbers rather than an improvement	2,779,098 UDAs contracted	2,779,098 UDAs contracted	2,779,098 UDAs contracted	This is based on the number of UDAs commissioned (Dec 2013 positio) rather than courses of treatment. This will remain the same for 14/15 & 15/16 because we are not planning to commission additional activity at this time.
Patient experience							
GPPS % Positive experience	ED9	YES	None given but based on Medical patient satisfaction assume an annual improvement	83%	83%	83%	If positive experience is based on questions relating to access improvement above 83% is unlikely; on the basis that patients may not wish to travel to where dental access is available and we are not planning to commissioned additional activity. Initiatives to impeove access relate more to the shift from secondary care to community based services.
General Ophthalmic Services							
Activity							
Total number of sight tests/per 100,000 population	ED10	YES	None - assume planning numbers rather than an increase	28096	28808	29520	waiting for guidance
Quality and Innovation							
%of tints per voucher	ED11	YES	None - assume planning numbers rather than an increase	not available	not available	not available	waiting for guidance
% of repairs per voucher and % of replacements per voucher	ED12	YES	None - assume planning numbers rather than an increase	not available	not available	not available	waiting for guidance
% of prisms per voucher	ED13	YES	None - assume planning numbers rather than an increase	not available	not available	not available	waiting for guidance

APPENDICES

Appendix 1: Primary Care Summary – Regional Plan on a Page Format

Appendix 2: Public Health Summary – Regional Plan on a Page Format

See following pages

Note: Specialised Operating Plan – National format

The Specialised Operating Plan contains key elements of this document and is available as a separate standalone publication. The Operating plan contains further detail of the financial element of QIPP plans assessed against national opportunities.

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Leicestershire & Lincolnshire

Primary Care 5 year Strategic Plan on a Page

Our Vision

To have in place a **strong and effective primary care** that delivers high **quality and responsive services** to patients, that fulfils its pivotal role in improving the **health outcomes** of our population whilst **containing costs**, and hence makes a vital contribution to a **high-performing** and **sustainable well integrated** healthcare system.

Local Ambition One (Quality)
To reduce unjustified variation in the quality of services delivered

Local Ambition Two (Outcomes)
To reduce unjustifiable inequalities in health outcomes

Delivered through intervention

- Working with CCGs to address capacity issues in Primary Care and secure a high quality workforce
- Developing robust quality and performance assurance frameworks for primary care to ensure that there is a consistent approach to managing unwarranted variation in quality
- Supporting wider primary care in conjunction with social care, community services and acute services where this is supported by CCG plans

Local Ambition Three (Patient Services)
To increase citizen participation and empowerment

Local Ambition Four (Patient Services)
To improve the quality of life for patients with one or more LTCs

Delivered through intervention

- Review Area Team structures and processes to ensure that the local need, local voice and shared decision making with patient representatives are incorporated at every stage of the commissioning cycle from design to delivery to contract monitoring
- Implementing nationally negotiated changes for general practice that support more personalised care for older people and those with complex needs in partnership with CCGs.

Local Ambition Five (Access)
To improve access to primary care services & secondary care dental services

Local Ambition Six (Delivering Value)
To replace unjustified variation in the funding levels received by providers with strategic investment in new models of primary care

Delivered through intervention

- Provide support to PM's Challenge Fund pilot bids to improve access
- Align the local primary care strategy with the Lincolnshire Sustainable Services Review and the LLR Better Care Together Programme to ensure that there is a 'fit' with local approaches to new models of service delivery and integrated patient care packages
- Implement equitable funding mechanisms with an appropriate pace of change
- Implement QIPP schemes

Overseen through the following governance arrangements

- The AT Change Programme Board and Primary Care Strategy Group will oversee delivery
- On-going dialogue with CCGs & Health and Wellbeing boards on progress, recognising our shared agenda
- Better care Together & LSSR Partnership boards

Sustainability Goals

- Delivery of financial plan & QIPP schemes
- Delivery of the local ambitions
- Academic and quality-improvement activity and a positive learning climate embedded in primary care
- An expanded, skilled, resilient and flexible workforce working within integrated teams

Key Values and Principles

- Common core offer of high quality patient centred primary care
- Continuous improvement in health outcomes across the domains
- Patient experience and clinical leadership driving the commissioning agenda
- Maximise value by securing the highest quality of care and the best outcomes for every pound invested

Leicestershire & Lincolnshire **Area** Team, Public Health Commissioning

VISION: High Quality Care for all, now and future generations.

The Dept. of Health, NHS England share the vision of working in partnership to achieve the benefits of the Section 7A agreement for the people of England.
We maintain a shared commitment to protect and improve the public's health. (from S7Agreement)

System Objective One
Ensure the effective commissioning of Section 7A Agreement public health services, utilising innovative and extended service models to deliver best quality, highly skilled provision
****

System Objective Two
Seek to increase the pace of change for full implementation of the national S7A specifications, leading to a standardised offer for service users
****

System Objective Three
Reduce the range of variation in local performance seeking to consistently achieve highest practicable performance across all programmes
****

System Objective Four
Drive continuous improvement through on going service review/design and outcome monitoring, to ensure highest quality, best value public health S7A services for our population
****

System Objective Five
Work with key partners and HWB to optimise opportunities to reduce health inequalities, improve health and achieve better outcomes through best use of resources including development of integrated service
****

System Objective Six
Ensure that the views of service users, parents, cares etc. are sought and taken into account when planning and improving services
****

2014/15

- Work with providers to further develop processes regarding listening to the patient voice, client involvement in service evaluation and future commissioning of S7A services
- Increase HV workforce to meet trajectory of 363 WTE by 31/03/15
- Through joint working with providers & LETB ensure access to training modules to support full delivery of HCP
- Maximise capacity of FNP places available in Leicester City and introduce a new site in Lincolnshire
- Develop safe & robust co-produced transition plans, 0-5 years services working collaboratively with Local Authority
- Work with GPs and child health records department in Lincolnshire to improve routine childhood vaccination uptake
- Implement the meningitis C catch up programme for university entrants
- Establish revised pathways for newborm children requiring hepatitis B vaccination
- Bench mark all screening service providers to ensure good value for money is being achieved
- Commission high risk breast screening in line with Breast Screening Programme (BSP) guidance across the Area Team
- Monitor the safety and effectiveness of the new in-house and EMPATH for UHL laboratory provision of the IDSP programme following repatriation from NGHT to local maternity providers
- Support UHL and ULHT to be part of phase two of the bowel scope implmentation
- Review models of the delivery of all teenage vaccines in line with national guidance & parallel to childhood flu
- Identification and Implementation of PH related QIPP programmes
- Ensure implementation of the national fail safe programme for new born blood spot screening
- Support trusts to implement the SMART system for managing the NIPE programme

2015/16

- Review revised Section 7A Agreement and implement any national changes as required
- Work with providers to maintain and further develop patient & public involvement
- Progress and complete robust transfer to Local Authority responsibility commissioning of 0-5 years services (Oct 2015)
- Review, refinement and continuation of screening and immunisation 2014-15 intentions
- Continue roll out of childhood flu vaccination programme
- Identification and implementation of PH related QIPP programmes

2016/19

- Review Section 7 A Agreement and implement any national changes as required
- Maintain and improve against all PH S7A outcome measures in line with national requirements
- Ensure safe on going provision of high quality CHIS/CHRD services, and implement any nationally identified reporting mechanisms following any national changes to S7A
- Review and further align provider based patient experience and involvement processes

Overseen through the following governance arrangements

- Area Team Direct Commissioning Team Meeting
- Area Team Executive Meeting
- Change Programme Board
- Programme Board arrangements (all programmes)
- DPH led Health Protection Boards
- FNP Advisory group & National Unit
- Integrated childrens commissioning Groups/Childrens board (Joint LA/CCG/AT)

Trust

Measured using the following success criteria

- Number of FTE Health Visitors, achievement of roll out HCP
- Population vaccination coverage programme specific (S7A)
- Breast cancer coverage % screened adequately previous 3 yrs
- Cervical cancer coverage % screened adequately previous 3.5 or 5.5 yrs (age dependent)
- Bowel cancer uptake & coverage
- AAA screening, KPI
- % offered Diabetic eye screening who attend
- Ante natal & new-born screening, specific measure in line with each programme requirement (S7A)

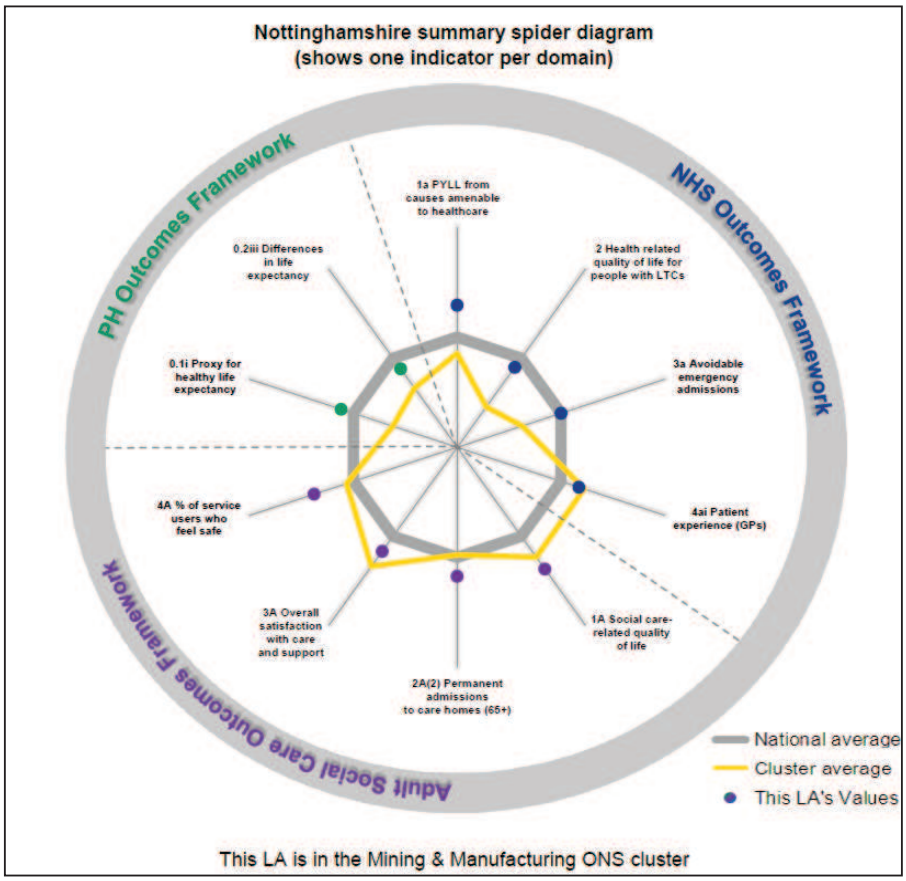
System values and principles (DN: Taken from NHS Constitution)

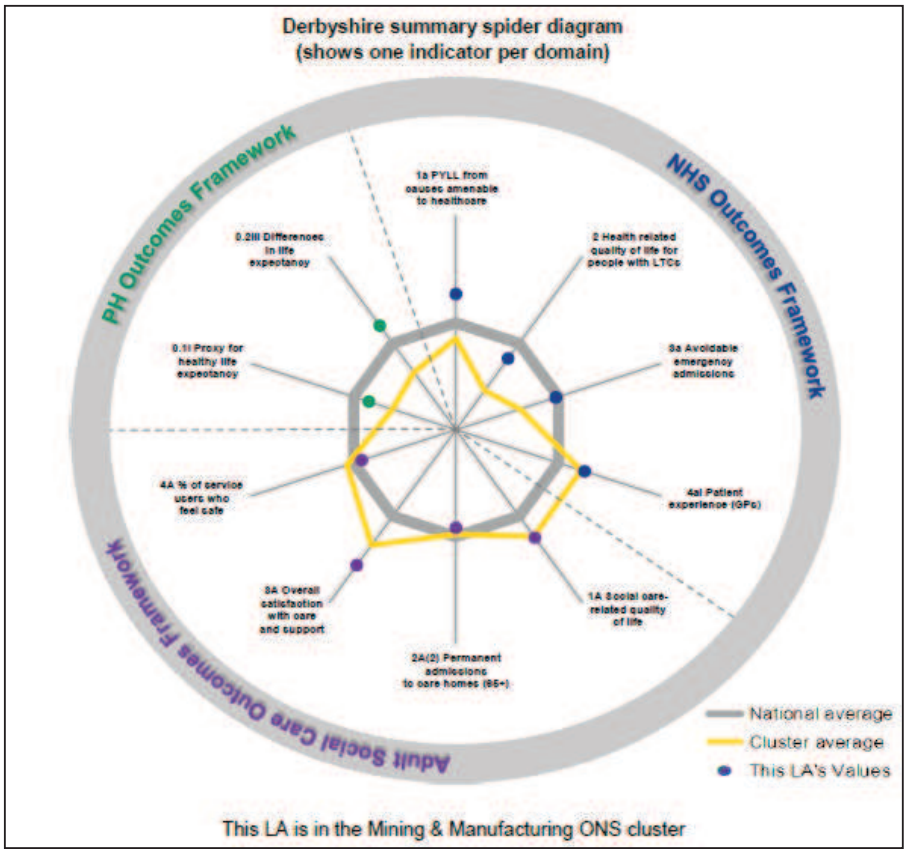
- Respect, consent, dignity, confidentiality
- Working together for patients
- Quality of Care and Environment
- The right to receive immunisation under the National Immunisation programmes
- The NHS will provide screening programmes as recommended by the National Screening Committee

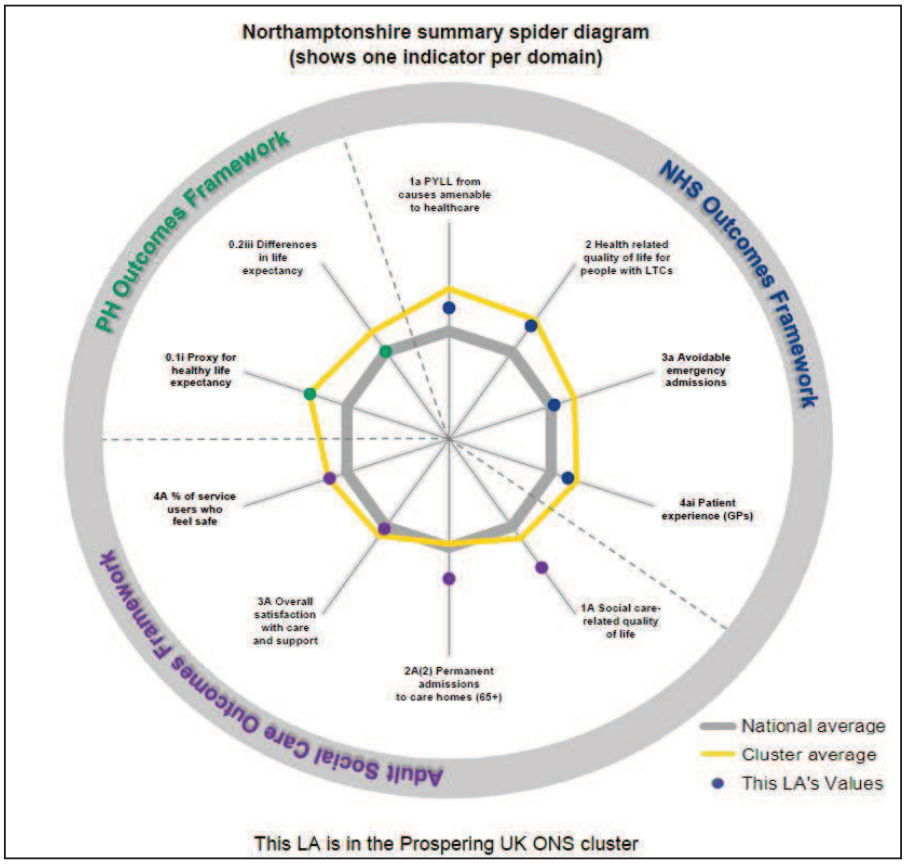
ADDITIONAL

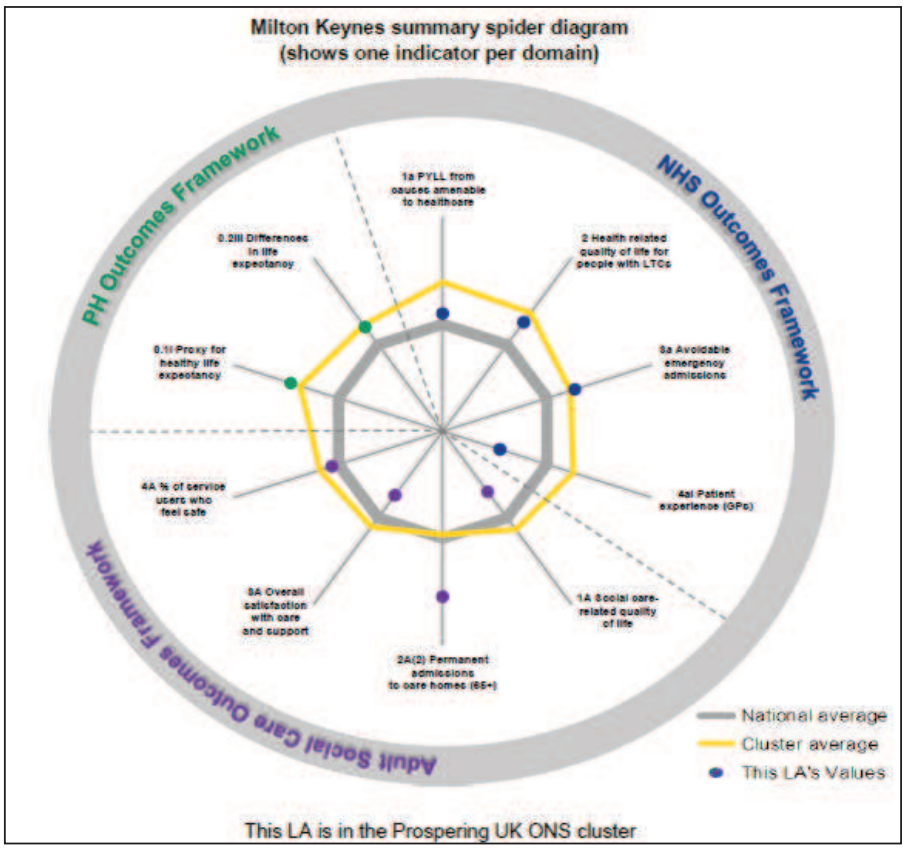
- PHE Code of Conduct and Values and Behaviours https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/206902/Read-the-code-of-conduct-for-PHE-staff.pdf

Appendix 3: Health Profile Summaries for East Midlands Authorities






Northamptonshire summary spider diagram
(shows one indicator per domain)
PH Outcomes Framework
NHS Outcomes Framework
Adult Social Care Outcomes Framework
1a PYLL from causes amenable to healthcare
2 Health related quality of life for people with LTCs
3a Avoidable emergency admissions
4ai Patient experience (GPs)
1A Social care-related quality of life
2A(2) Permanent admissions to care homes (65+)
3A Overall satisfaction with care and support
4A % of service users who feel safe
0.1i Proxy for healthy life expectancy
0.2iii Differences in life expectancy
National average
Cluster average
This LA's Values
This LA is in the Prospering UK ONS cluster


Milton Keynes summary spider diagram
(shows one indicator per domain)
PH Outcomes Framework
NHS Outcomes Framework
Adult Social Care Outcomes Framework
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National average
Cluster average
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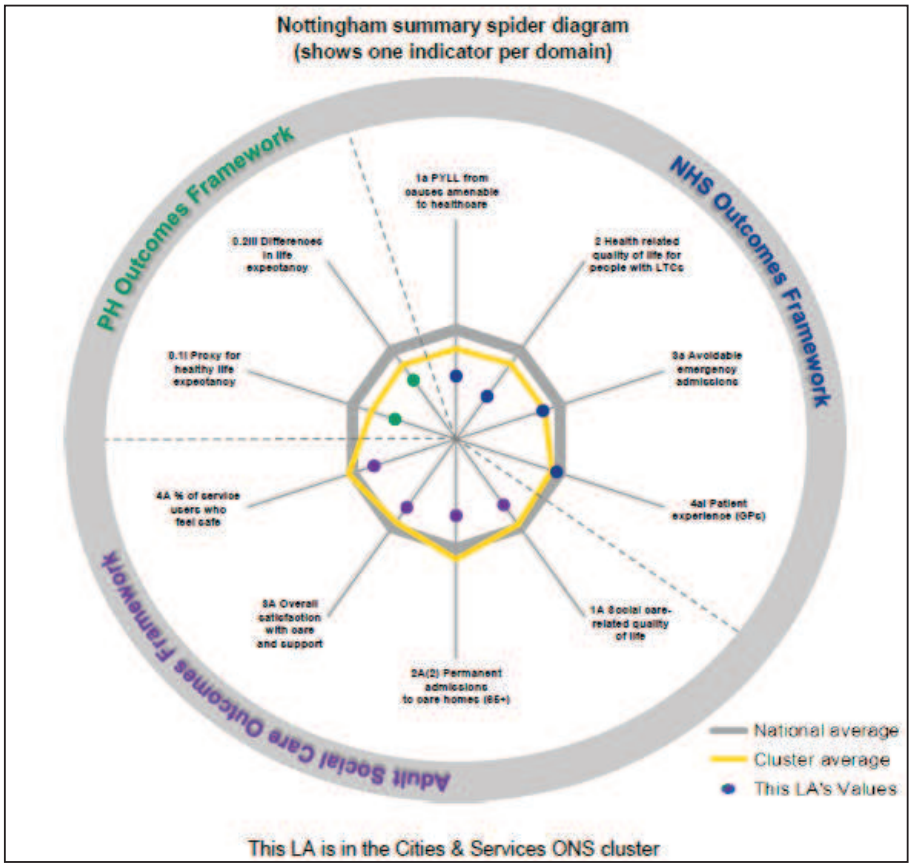
This LA is in the Prospering UK ONS cluster


Nottingham summary spider diagram
(shows one indicator per domain)
PH Outcomes Framework
NHS Outcomes Framework
Adult Social Care Outcomes Framework
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2 Health related quality of life for people with LTCs
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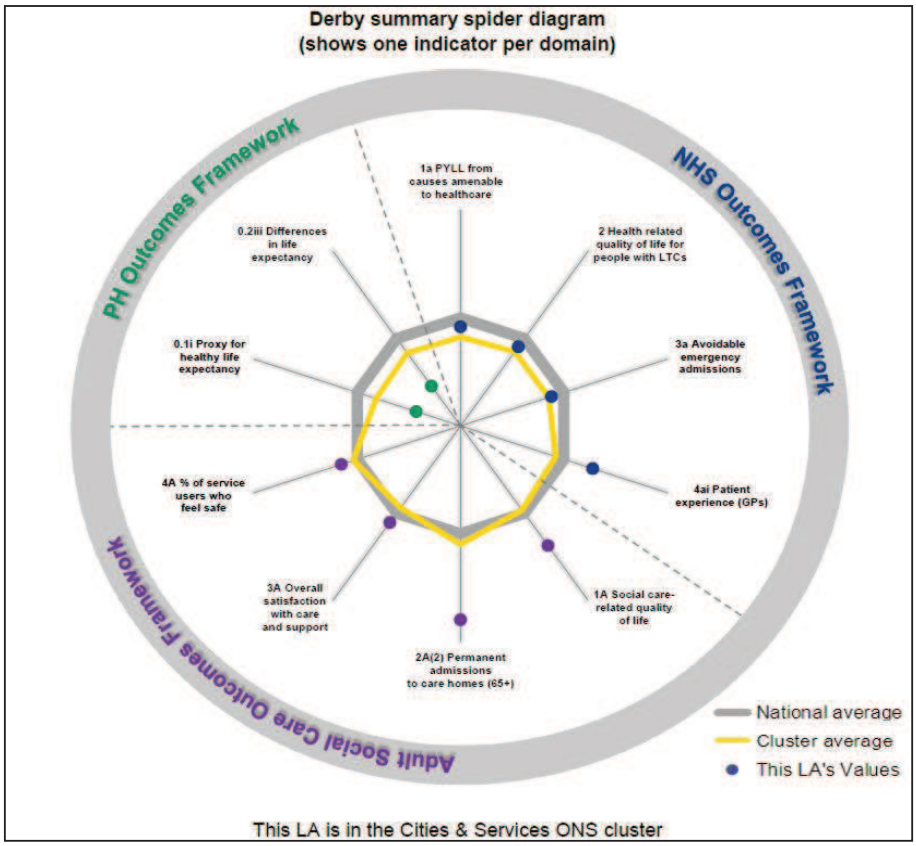
0.2iii Differences in life expectancy
National average
Cluster average
This LA's Values
This LA is in the Cities & Services ONS cluster


Derby summary spider diagram
(shows one indicator per domain)
PH Outcomes Framework
NHS Outcomes Framework
Adult Social Care Outcomes Framework
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2 Health related quality of life for people with LTCs
3a Avoidable emergency admissions
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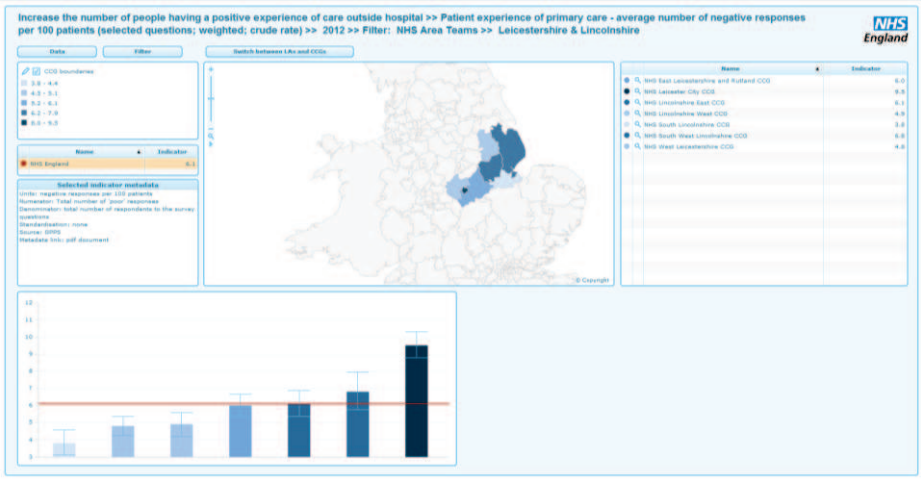
4A % of service users who feel safe
0.1i Proxy for healthy life expectancy
0.2iii Differences in life expectancy
National average
Cluster average
This LA's Values
This LA is in the Cities & Services ONS cluster

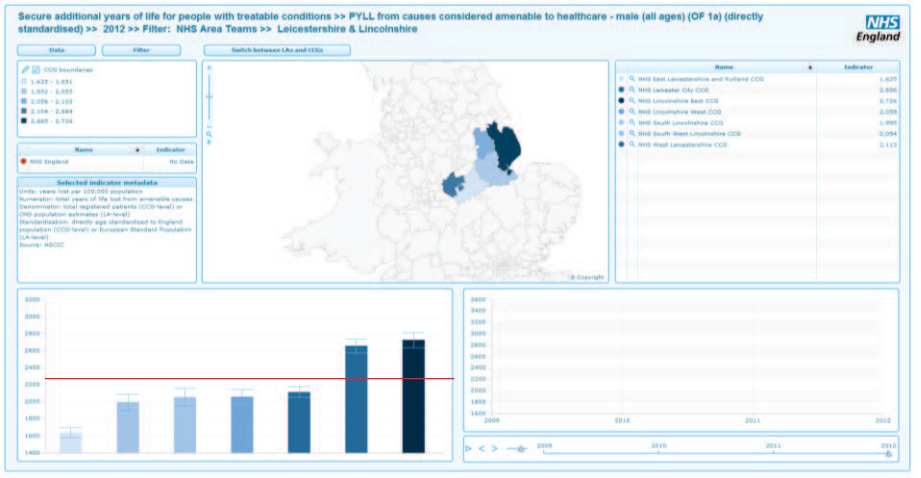
Appendix 4: Levels of Ambition Atlas Extracts

There is significant variation in patients experience of primary care



Source: Levels of Ambition Atlas, Published by NHS England by CCG. 2012 data

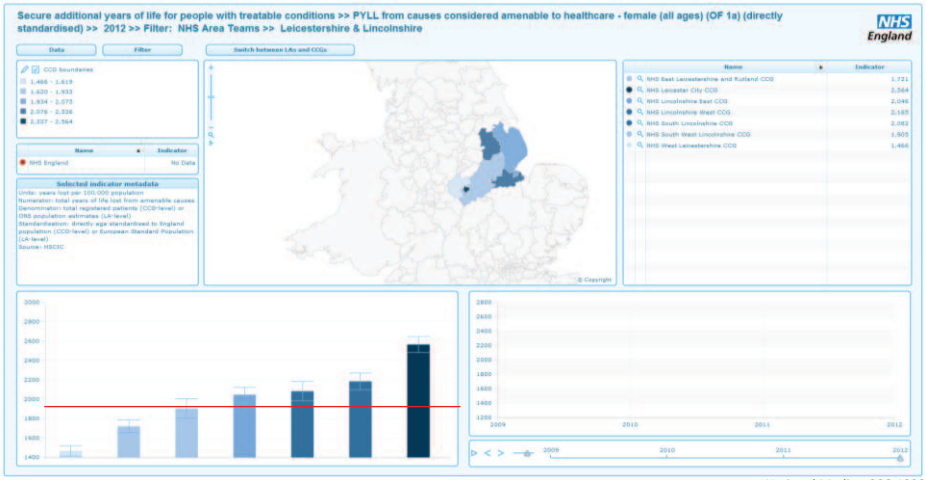
East Lincolnshire & Leicester City Potential Years of Life Lost: Males



National Median CCG 2251

Source: Levels of Ambition Atlas, Published by NHS England by CCG. 2012 data

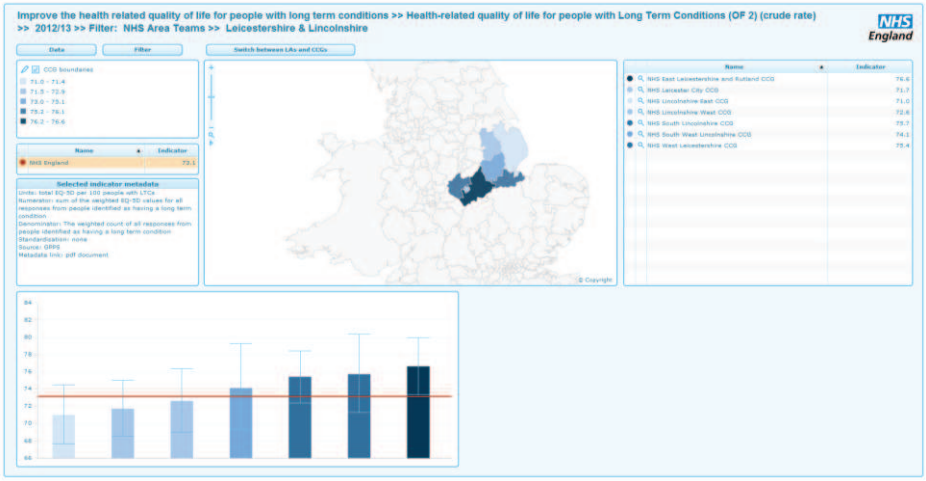
Leicester City, South & West Lincolnshire: Potential Years of Life Lost: Females



National Median CCG 1938

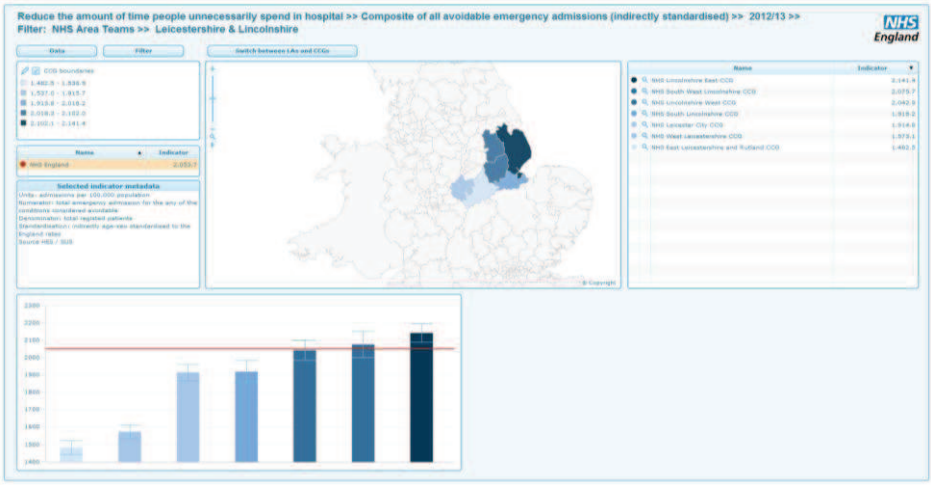
Source: Levels of Ambition Atlas, Published by NHS England by CCG. 2012 data

Variable Quality of Life for people with LTC



Source: Levels of Ambition Atlas, Published by NHS England by CCG. 2012 data

Avoidable Emergency Admissions



Source: Levels of Ambition Atlas, Published by NHS England by CCG. 2012/13 data

Appendix 5: Quality and Safety Plans

Introduction

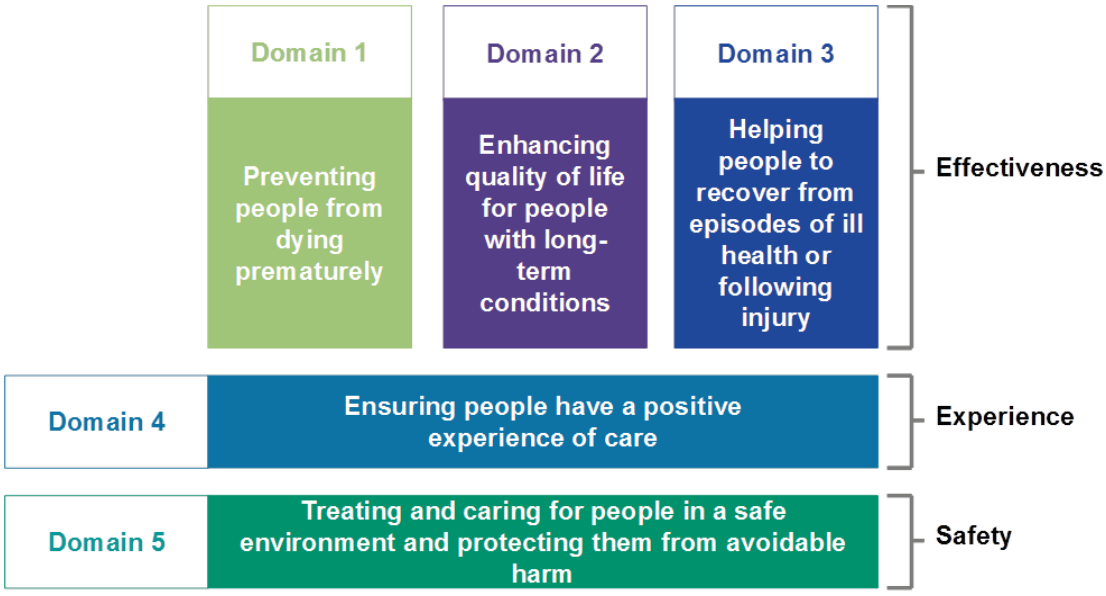
NHS England's mission is to secure **high quality care for all – now and for future generations.**

The NHS should support everyone to have greater control of their health and wellbeing, and to live longer, healthier lives by offering high quality health and care services that are compassionate, inclusive and constantly improving

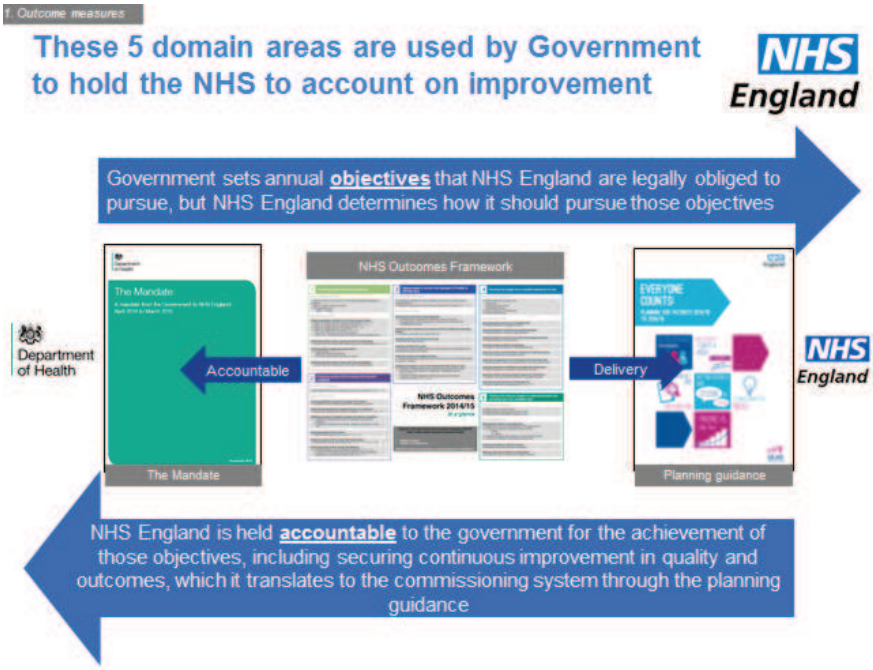
The single common definition of quality encompasses three equally important parts:

- Care that is **clinically effective**- not just in the eyes of clinicians but in the eyes of patients themselves;
- Care that is **safe**; and,
- Care that provides as positive an **experience** for patients as possible

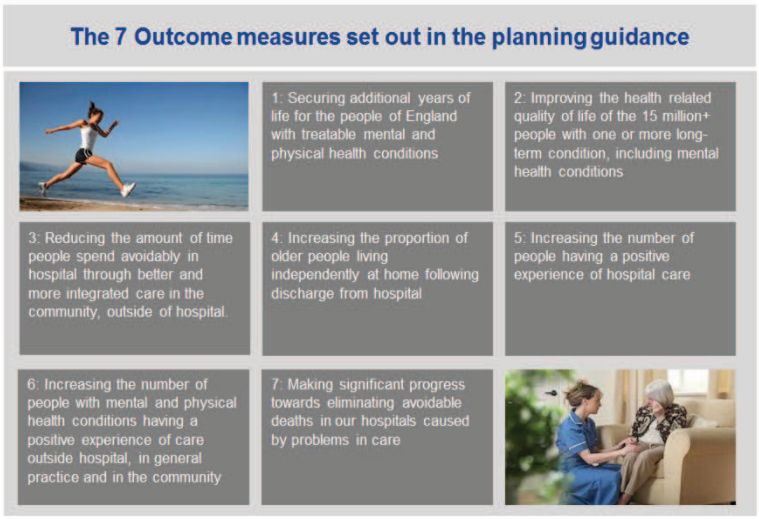
At a national level, the **NHS Outcomes Framework** has been developed. This framework provides us with a way of measuring the actual outcomes we are achieving for the population of England.



Further information on High Quality Care for all and the NHS Outcomes Framework: http://www.england.nhs.uk/about/imp-our-mission



NHS England's planning guidance 'Everyone Counts: Planning for patients 2014/15 to 2018/19' sets out NHS England's clear commitment to an outcomes based approach and CCG's together with NHS England Area Teams are expected to jointly set levels of ambition against seven overarching outcomes.



A full version of our planning guide can be found at: http://www.england.nhs.uk/wp-content/uploads/2013/12/5yr-strat-plann-guid-wa.pdf

2. Compassion in practice

The CNO strategy describes the **6 C's**

- ***C**are*;
- ***C**ompassion*;
- ***C**ompetence*;
- ***C**ommunication*;
- ***C**ourage*; and,
- ***C**ommitment*,

The 6C's have been developed to support a culture where patients and service users will have the best possible care.

These 6C's are not just for nurses and midwives but should underpin values and behaviours of all our staff. As such the CNO strategy underpins a significant proportion of the elements of our quality work with CCGs, and directly commissioned services.

- During the next two years we will establish a baseline to better understand how the ethos of the Nursing and midwifery strategy can be embedded into Primary Care and Specialised Services.

- We will ensure local provider plans are delivering against the six action areas associated with the 6 C's:

  - **Action area one:** Helping people to stay independent, maximise well-being and improving health outcomes
  - **Action area two:** Working with people to provide a positive experience of care
  - **Action area three:** Delivering high quality care and measuring the impact
  - **Action area four:** Building and strengthening leadership
  - **Action area five:** Ensuring we have the right staff, with the right skills, in the right place
  - **Action area six:** Supporting positive staff experience

We will work closely with our CCG colleagues to monitor the impact of compassion in practice across our local health service providers.

For more information about Compassion in Practice please visit: http://www.england.nhs.uk/nursingvision/

2. Learning from national reports

A number of recent high profile reports (Report of the Mid Staffordshire NHS Public Enquiry, by Robert Francis QC [2013]; Winterbourne View [DH, 2012]; Review into the quality of care and treatment provided by 14 hospital trust in England, by Professor Sir Bruce Keogh KBE [2013]; and Improving the Safety of Patients in England, National Advisory Group on the Safety of Patients in England [2013]), have identified that vulnerable people were not provided with basic standards of care and that their fundamental rights to dignity were not respected.

- We will utilise the messages from these, and subsequent national reports and investigations, to identify and set key deliverable targets for quality and patient safety. In particular we will ensure we commission services to deliver the requirements of the Winterbourne Concordat.

- A key target will be to develop 'listening events' with vulnerable group's e.g. patients with a Learning Difficulty and Carers.

- Further to this we will engage with local healthwatch organisations and NHS partners to promote a culture of learning from complaints and PALs services, and encourage our local population to use the complaints route without fear of retribution, to help identify areas for improvement.

- We will endeavour to better understand the public satisfaction levels with our complaints service. The benefits of this will provide us with the opportunity to include thematic analysis into our quality reviews of directly commissioned services.

3. Patient Experience

Patient Experience is a key priority area for NHS England and has been outlined in:

- Domain 4 of the NHS Outcomes Framework: Ensuring that patients have a positive experience of care;
- Action area two of the Compassion in Practice strategy: Working with people to provide a positive experience of care; and,
- NHS England's 5 year planning guidance[5] under ambitions 5 & 6

Patient Experience

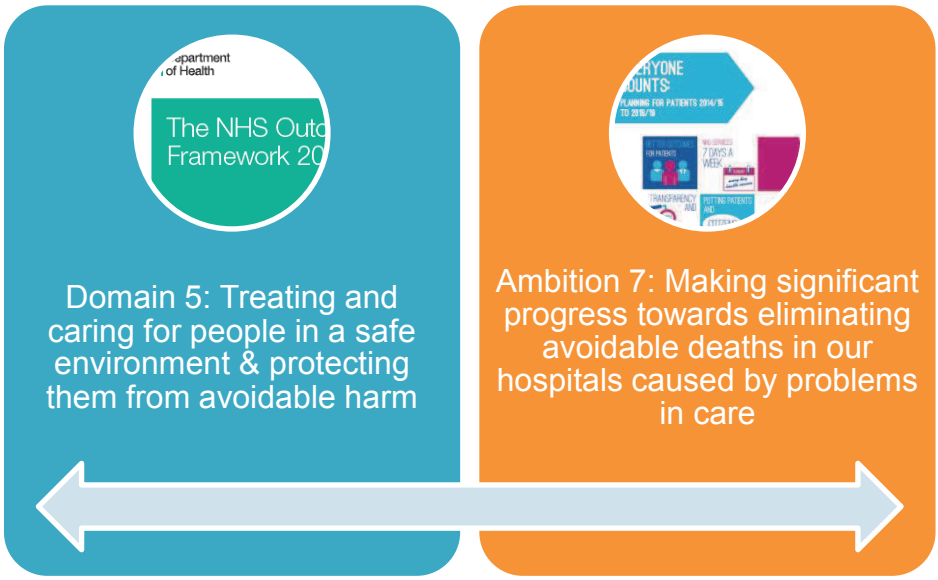
[5] Everyone Counts: Planning for patients 2014/15 to 2018/19, available at: http://www.england.nhs.uk/wp-content/uploads/2013/12/5yr-strat-plann-guid-wa.pdf

- We will continue to work with our CCG commissioning colleagues to drive improvement in patient experience of hospital care.
- We will support the roll-out of the Friends & Family Test across Primary Care starting in General Practice.
- We will collaboratively develop local systems to drive improved patient empowerment, linking to the national drivers 'Patients in control' and 'Personal health budgets'.
- We will improve partnership working with our local healthwatch establishments to enable lessons to be shared and provide scrutiny to our complaints process
- We will establish more robust mechanisms of triangulating data and information in order to improve our understanding of the available information. This improved data set and understanding will then be used to support our local delivery plans.

4. Patient Safety

Domain 5 of the NHS Outcomes Framework has been developed to measure a reduction in avoidable harm. Ambition 7 of NHS England's 5 year planning guide also focusses on patient safety.

Patient Safety



Healthcare Acquired Infections:

- We will take a whole health community approach to reducing healthcare acquired infections (HCAI) and continue to support our CCG colleagues to deliver improvements.

- We will ensure that CCGs and provider organisations are supported to analyse the underlying causes of HCAI and utilise this information to develop robust action plans to meet stringent targets for reducing Clostridium Difficile infections and MRSA bacteraemias.

Incident Reporting: Nationally and locally we recognise incident reporting from primary care is low. Across the Leicestershire & Lincolnshire area the rate of incidents reported from Primary Care per 100,000 population is 3.05 compared to 646 across all NHS sectors nationally.

- We will actively promote incident reporting across primary care through a structured education and training programme to increase incident reporting from Primary Care.

Harm Free Care: The NHS Safety Thermometer is a local improvement tool for measuring, monitoring, and analysing patient harms and 'harm free' care.

'Harmfree'care
A new mindset in patient safety improvement

- Through systematic monitoring and analysis of the NHS safety thermometer data, and continuous work with our CCG colleagues, we aim to reduce avoidable harm from pressure ulcers; falls; urinary tract infections (UTI) and venous thromboembolism.

Local analysis suggests the priority for our community health service providers should be in relation to a reduction in pressure ulcers. For our acute providers focus should be on a reduction in pressure ulcers and, patients with a catheter and a UTI.

- Through collaboration with our CCG partners we will ensure the relevant priority areas are included within the local Commissioning for Quality and Innovation (CQUIN) schemes for 2014/15, as described in the NHS England CQUIN guidance 2014/15 document, published in December 2013.

The full CQUIN guidance can be found at: http://www.england.nhs.uk/wp-content/uploads/2013/12/cquin-guid-1415.pdf

Serious Incident Management: We will work with our CCG and provider colleagues to ensure the NHS Commissioning Board Serious Incident Framework (2013) is adhered to.

- We will undertake systematic analysis of themes and trends of all serious incidents reported to NHS England Leicestershire & Lincolnshire Area Team to ensure to ensure robust investigations have been undertaken and that appropriate lessons have been learnt.

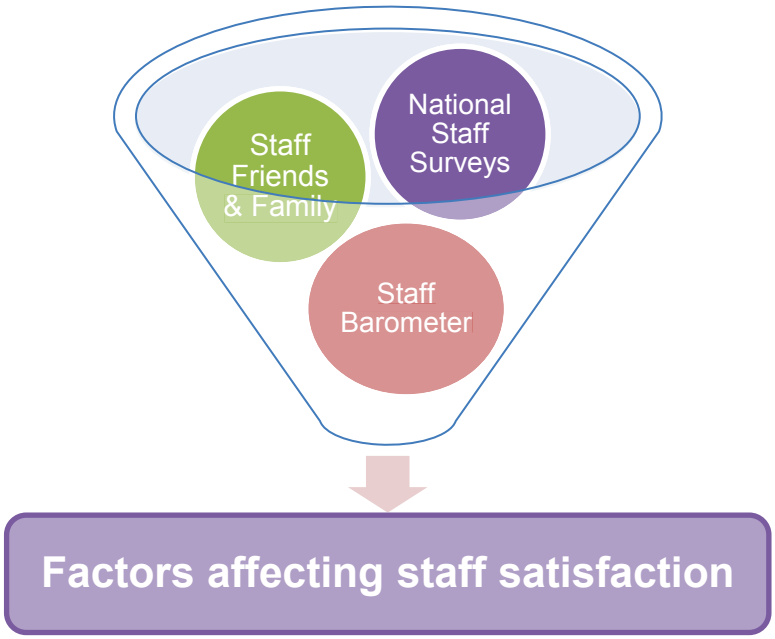
  This analysis will also be used to identify areas of patient safety for further scrutiny or improvement and will be used to support our local delivery plans.

- We will introduce a regular mechanism for disseminating lessons learnt across the health community, as appropriate, to ensure that others can learn the lessons and prevent a recurrence of the same event happening elsewhere.

5. Staff satisfaction

Action area six from the 6C's relates to supporting positive staff experience. Staff opinions, about their place of work, will continue to be collected via the annual staff surveys.

- We will undertake to analyse the outputs from these surveys to understand the factors affecting staff satisfaction in the local health economy and how staff satisfaction benchmarks against others.



- We will work with our CCG colleagues to ensure the new Staff Friends & Family Test is rolled out as per the NHS England CQUIN guidance 2014/15 document, published in December 2013.

- We will continue to promote the uptake of the NHS England staff barometer and co-ordinate the information to improve our local staff satisfaction.

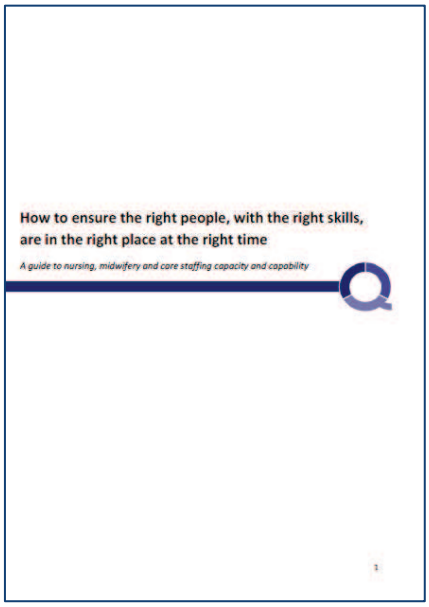
6. Safeguarding

- We will continue to support the strategic vision and direction of safeguarding across Leicestershire & Lincolnshire through pro-active engagement and attendance at all of the local safeguarding boards.
- We will ensure that all our staff undertakes safeguarding training, which is commensurate with their roles and responsibilities.

- We will develop the role of the 'Named GP' locally to support primary care professionals in the operational delivery of safeguarding the local population.

- We will work with the CCG's to utilise messages from Serious Case Reviews and Domestic Homicide reviews, as well as the wider learning sourced from the safeguarding boards learning and development frameworks, to improve practice standards.

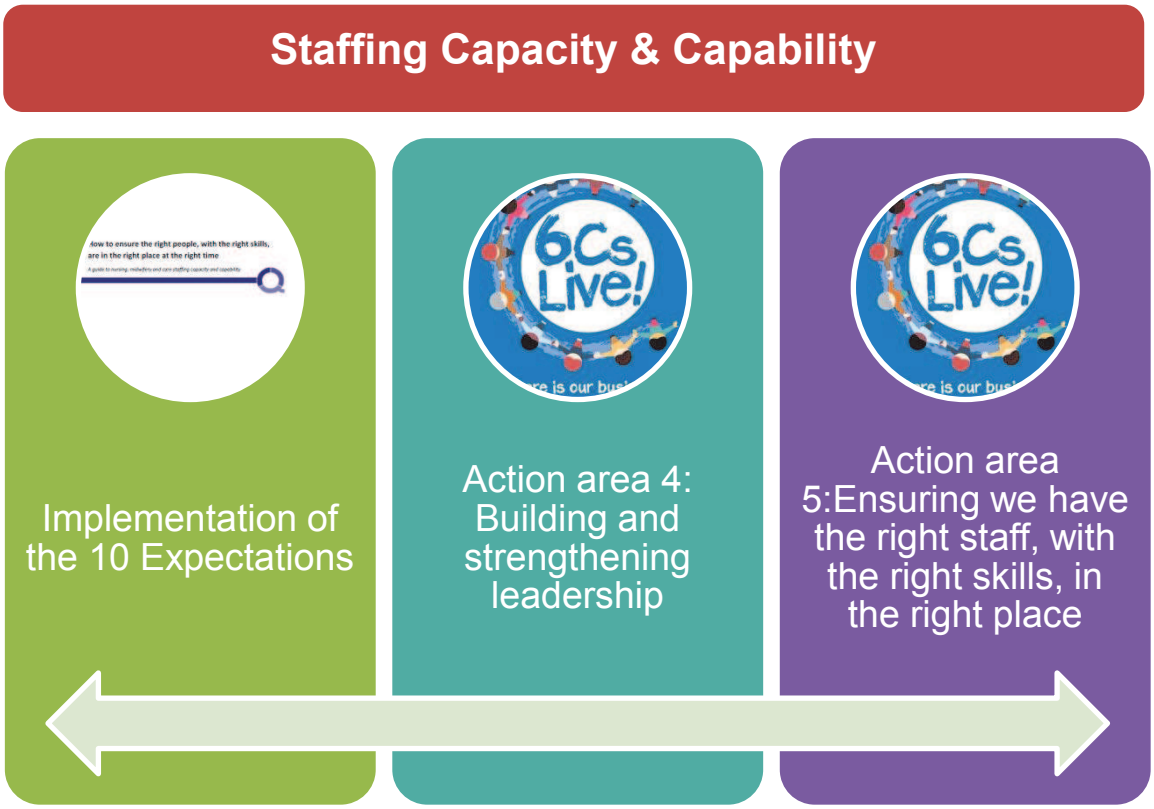
7. Staffing Capacity & Capability



The National Quality Board report: How to ensure the right people, with the right skills, are in the right place at the right time, *A guide to nursing, midwifery and care staffing capacity and capability* [2013] identified 10 expectations. The expectation is that all organisations are meeting these requirements currently, or taking active steps to ensure they do in the very near future.

- We will work with our internal, CCG and provider colleagues to ensure that the 10 expectations identified in the report have been implemented appropriately.

- We will link this work to Action areas 4 and 5 of the 6C's to ensure strong leadership and ensuring we have the right staff, with the right skills, in the right place.



- We will proactively support the development and implementation of a robust revalidation and appraisal system that is congruent with the NMC guidance for nurse revalidation.

- Individual practitioner concerns will be managed in a fair and open system that promotes learning and improvement and NHS England Clinical Teams will continue to actively contribute to the local governance arrangements relating to individual practitioners.

8. Quality Assurance Framework

- We will develop robust Quality Assurance Frameworks for all services directly commissioned by the Area Team, ensuring they offer the best possible outcomes for patients.

- We will set clear specifications for monitoring and assuring quality in the service contract and ensure patient and other stakeholder views are considered.

- We will maintain and improve the existing partnership relationships with local and regional Quality Surveillance Group members.

- We will ensure the local Quality Surveillance Group continues to provide constructive challenge and scrutiny of our local providers by systematically bringing together different parts of the health and care economy to routinely and methodically share information and intelligence about quality. The QSG will continue to:

    - Present information, including soft intelligence gathered through a variety of methods
    - Provide a forum, supported and facilitated by NHS England, for local health and care economies to work openly and honestly together to ensure quality across the system
    - Ensure a shared view of risks to quality through sharing intelligence
    - Acting as an early warning mechanism of risk about poor quality, and
    - Provide opportunities to coordinate actions to drive improvement whilst respecting statutory responsibilities of and on-going operational liaison between organisations

Document Version History

File	Notes
140210 Strategic & Operational plans LL Draft v1	Initial draft
140210 Strategic & Operational plans LL Draft v2i	Incorporating changes from initial regional NHS England review
140303 Strategic & Operational plans LL Draft v2j	Section completion primary care provider profiles. Explanatory notes for some technical terms. Truncation of technical financial commentary. Separation of draft QIPP projects to supplementary document for further development. Addition of Executive Summary and Document version history.
140305 Strategic & Operational plans LL Draft v2k	Amended to remove abbreviations for specific healthcare provider

Appendix F

LEICESTER CITY HEALTH AND WELLBEING BOARD
3 APRIL 2014

Subject:	Quality Premium requirement – Increased reporting of medication incidents
Presented to the Health and Wellbeing Board by:	Dawn Leese, Director of Nursing and Quality LCCCG
Author:	Dawn Leese, Director of Nursing and Quality LCCCG

EXECUTIVE SUMMARY:

The purpose of this paper is to make the Health and Wellbeing Board aware of the details specifically relating to the quality premium indicator relating to the increased level of reporting of medication errors and the proposed approach for 2014/15.

RECOMMENDATIONS:

The Health and Wellbeing Board is requested to:

- Note the quality premium requirement for CCGs in 2014/15.
- Approve the target increases and approach.

Quality Premium requirement – Increased reporting of medication incidents

Introduction/Background

The 'quality premium' (NHSE December 13, available at: http://www.england.nhs.uk/wp-content/uploads/2014/01/qual-prem-guid-21.pdf) is intended to reward clinical commissioning groups (CCGs) for improvements in the quality of the services that they commission and for associated improvements in health outcomes and reducing inequalities.

The quality premium is paid to CCGs in 2015/16 – to reflect the quality of the health services commissioned by them in 2014/15 – will be based on six measures that cover a combination of national and local priorities. These are:

- reducing potential years of lives lost through causes considered amenable to healthcare and addressing locally agreed priorities for reducing premature mortality (15 per cent of quality premium);
- improving access to psychological therapies (15 per cent of quality premium);
- reducing avoidable emergency admissions (25 per cent of quality premium);
- addressing issues identified in the 2013/14 Friends and Family Test (FFT), supporting roll out of FFT in 2014/15 and showing improvement in a locally selected patient experience indicator (15 per cent of quality premium);
- improving the reporting of medication-related safety incidents based on a locally selected measure (15 per cent of quality premium);
- a further local measure that should be based on local priorities such as those identified in joint health and wellbeing strategies (15 per cent of quality premium).

NHS England has sought to design the quality premium to ensure that it:

- Rewards CCGs for improved outcomes from the services they commission against the main objectives of the NHS Outcomes Framework and the CCG Outcomes Indicator Set, i.e. reducing premature mortality, enhancing quality of life for people with long-term conditions, helping recovery after acute illness or injury, improving patient experience, and ensuring patient safety;
- Sets broad overarching objectives as far as possible, leaving CCGs to determine with health and wellbeing partners what specific local priorities they will need to pursue to achieve improvements in these areas; promotes reductions in health inequalities and recognises the different starting points of CCGs: all of the measures except avoidable emergency admissions include the ability for CCGs and local partners to set either partially or fully the level of improvement to be achieved,
- Further promotes local priority-setting by highlighting the importance of local approaches reflecting joint health and wellbeing strategies;
- Underlines the importance of maintaining patients' rights and pledges under the NHS Constitution.

The purpose of this paper is to make the Health and Wellbeing Board aware of the details and approach, specifically relating to the indicator relating to increased levels of reporting of medication errors.

The Quality Premium Guidance states that:

A CCG will earn this portion of the quality premium if:

- it agrees a specified increased level of reporting of medication errors from specified local providers for the period between Q4, 2013/14 and Q4, 2014/15; and
- these providers achieve the specified increase.

The local measure may include improved levels of reporting from primary care.

The measure should be agreed by the CCG with its local Health and Wellbeing Board and the NHS England area team.

Where the same provider is a local provider for more than one CCG, those CCGs may wish to jointly agree an increased level of reporting with that provider.

Proposed approach for 2014

The Health and Wellbeing Board are requested to agree the following approach:

- Increased reporting by UHL and LPT by **15% overall**. We have not included other providers or primary care at this stage as this was felt to be too complex for year 1 of this indicator.
- These proposed increases (once approved by MDs) will be shared with the Area team and HWBB for agreement during March / April by the individual CCGs
- These will be monitored via the Clinical Quality Review Group for each of the providers. The quality schedules for the UHL and LPT will include a ¼ and final reporting in relation to progress with achieving the agreed increases. This will allow CCGs to evidence progress and achievement of this target.

The narrative related to those increases and rational for them is as follows:

The proactive reporting of medication incidents is a positive step in developing a positive safety culture. Increased reporting should be encouraged to aid learning and allow actions to be taken to prevent future events and patient harm. Provider organisations will not be in the same starting place when agreeing this indicator and for this reason we have agreed a different

1. **UHL**

   In the UHL 2014/15 contract there are two specific indicators which will support delivery across this requirement:

   Quality Schedule indicator:

Indicator: Increased reporting of medication errors, and continued reporting of medication errors causing moderate or serious harm and 10 x drug errors resulting in harm.

Threshold: Increase in numbers of medication errors from reported 13/14 baseline and evidence of learning from medication errors and actions being taken to improve

CQUIN:
Medication Safety Thermometer - Implementation of the Medication Safety Thermometer Steps 1 and 2 as part of the National Pilot Programme.

Indicator: The Medication Safety Thermometer focuses on Medication Reconciliation, Allergy Status, Medication Omission, and Identifying harm from high risk medicines in line with Domain 5 of the NHS Outcomes Framework.

This will be implemented across all wards in UHL through 2014/15.

2. LPT

LPT have agreed in principle to a 15% increase over the agreed period (Q4, 2013/14 and Q4, 2014/15). This is based on a current reporting rate of around 600 incidents per year. Having analysed current reporting it was felt that with focussed support, education and effective feedback, then reporting could be improved in a number of areas:

- District nursing services
- Community hospitals services
- Mental Health Services for Older People Wards
- Mental health services

There are already well established mechanisms for reporting medications related incidents and this will be utilised to enable the sharing of achievement with this improvement trajectory with commissioners.

Recommendations and Next steps

The Health and Wellbeing Board is requested to:

- Agree the request for approval of the target increases and approach.