Leicester
City Council

MEETING OF THE JOINT MEETING OF THE ADULT SOCIAL CARE SCRUTINY COMMISSION AND THE HEALTH & WELLBEING SCRUTINY COMMISSION

DATE: TUESDAY, 27 JANUARY 2015
TIME: 5:30 pm
PLACE: G.01 Meeting Room 1 - Ground Floor, City Hall, 115 Charles Street, Leicester, LE1 1FZ

Members of the Commission

Councillor Chaplin (Chair)
Councillor Cooke (Vice-Chair)

Councillors Alfonso, Bajaj, Cutkelvin, Dawood, Glover, Grant, Kitterick, Riyait, Sangster, Wann and Willmott

Standing Invitees (Non-voting)

1 Representative of Healthwatch Leicester for each Commission

Members of the Commission are invited to attend the above meeting to consider the items of business listed overleaf.

G. J. Carey
For Monitoring Officer

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Leicester City Council, City Hall, 115 Charles Street, Leicester, LE1 1FZ

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Further information

If you have any queries about any of the above or the business to be discussed, please contact Graham Carey or Julie Harget, Democratic Support on 0116 454 6356/6357 or email graham.carey@leicester.gov.uk or julie.harget@leicester.gov.uk or call in at the City Hall.

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PUBLIC SESSION

AGENDA

1. WELCOME AND INTRODUCTIONS

2. APOLOGIES FOR ABSENCE

3. DECLARATIONS OF INTEREST

Members are asked to declare any interests they may have in the business on the agenda.

4. PETITIONS

The Monitoring Officer to report that a petition has been received from Mr R Ball, on behalf of the Campaign Against NHS Privatisation requesting the Council's Health and Wellbeing Scrutiny Commission to scrutinize the Better Care Together Five Year Plan for Leicester, Leicestershire and Rutland.

Mr Ball has requested to present the petition to the meeting. The petition has 243 signatures and is in the following form:-

"We the undersigned, call upon Leicester City Council's Health and Wellbeing Scrutiny Commission to investigate and scrutinize effectively the Better Care Together Five Year Plan for Leicester, Leicestershire and Rutland which contains plans to cut costs by closing over 400 beds (more than one fifth of all beds) despite a current bed shortage and growing need for health care. While we welcome an expansion of community services, research suggests community services do not necessarily reduce the need for hospital beds and do not lead to a cheaper model of care."

Scrutiny Procedure Rule 9 (a) (ii) (e) states that if a petition is presented at the same Committee meeting at which there is a report on the agenda on the same subject, a Councillor may propose that the petition be considered with the report. Otherwise, the petition will be accepted with debate and referred to the Monitoring Officer for consideration and action as appropriate.

5. QUESTIONS, REPRESENTATIONS, STATEMENTS OF CASE

The Monitoring Officer to report the receipt of any questions, representations and statements of case submitted in accordance with the Council's procedures.

6. CARE QUALITY COMMISSION **Appendix A**

To receive a briefing from the Care Quality Commission on their work in relation to scrutiny.

In particular the CQC have been asked to outline the following:-

- Their work with GP Practices.
- The partnership working arrangements with NHS England.
- An overview of any inspections carried out in Leicester.
- The protocols, if any, for notifying local authority scrutiny functions of planned inspections.

Note: The following documents have been made available since the agenda was originally published.

a) Response to the background questions submitted to the CQC**. Appendix A (Page 1)**

b) Copy of the presentation notes. **Appendix A1 (Page 3)**

7. HEALTHWATCH - UPDATE **Appendix B**

To receive an update on the current arrangements for Healthwatch in the City.

A briefing paper from Voluntary Action Leicester is attached at **Appendix B. (Page 17)**

Note: The following documents have been made available since the agenda was originally published.

A position statement from the former chair and members of the Healthwatch Leicester Board is attached at **Appendix B1 (Page 25)**

A statement from the Director Care Services and Commissioning, Adult Social Care, Leicester City Council is attached at **Appendix B2 (Page 29)**

8. BETTER CARE TOGETHER **Appendix C**

To receive a presentation from Geoff Rowbotham, Interim Programme Director, Better Care Together, and Sue Lock, Managing Director, Leicester City Clinical Commissioning Group on the Better Care Together Programme.

Note: The following documents have been made available since the agenda was originally published.

a) Article in the Leicester Mercury dated 21 January 2015 – **Appendix C (Page 31)**

b) Briefing Note on Better Care Together issued by the Interim Head of Communications and Engagement, Better Care Together on 21 January 2015**. Appendix C1 (Page 33)**

c) Copy of the presentation notes. **Appendix C2 (Page 39)**

9. DEMENTIA STRATEGY **Appendix D**

To receive a presentation on progress against the Implementation Plan for the delivery of the Strategy.

Note: The following document has been made available since the agenda was originally published.

Copy of the presentation notes. **Appendix D (Page 61)**

10. IMPLEMENTING THE CARE ACT 2014 **Appendix E**

To receive a presentation that provides an overview of the key implications of the Care Act 2014 and progress so far in planning for the implementation of the changes. A briefing note for Councillors is attached at **Appendix E (Page 75)** as background information.

Note: The following document has been made available since the agenda was originally published.

Copy of the presentation notes. **Appendix E1 (Page 79)**

11. ANY OTHER URGENT BUSINESS

Appendix A

RESPONSE TO BACKGROUND QUESTIONS SUBMITTED TO THE CQC

1) What work are you doing with GP Practices?

We started inspecting GP practices in April 2014. However, these inspections were pilot inspections to develop and test the methodology. In October 2014 we began to inspect with the new methodology and make formalised judgments about the practice's. Some of those reports have now been published on our WEB site. The judgments are inadequate, requires improvement, good and outstanding. The judgments are made against five domains and populations groups. We have so far had a few outstanding practices across the country and one in in Leicester City.

At the other end of the scale we have those practices that are inadequate overall. These practices will go immediately into special measures.

We are working with the LMC and have developed a good relationship with them. We hold regular meetings and they have shadowed some of our inspections.

2) What partnership working arrangements are there with NHS England?

We have developed very good working relationships with NHSE. We have developed an information sharing protocol with them. We meet regularly with them to at risk sharing meetings with the Area Team and the all the CCG's in Leicestershire and Lincolnshire.

We also attend the quality surveillance group for each county.

We meet and share info across our directorates around local risk that may impact on each other's service groups.

We PMS also have developed an information sharing protocol with the GMC. I also have regular meetings with the GMC liaison officer.

We also meet with Healthwatch.

3) Have any early inspections of social care services been in Leicester? If so, where and what was the outcome?

I am sorry but I cannot provide this information as this work takes place now in another directorate. CQC is split into three separate directorates. Primary Medical Services (PMS), Hospitals and Adult Social Care (ASC). I work in PMS. Yin Naing works in hospitals and will be able to provide information on the hospitals directorates work so far. I will try and get someone or at least some information for you if I can for the meeting.

4) What protocols/examples are there of letting local authority scrutiny functions know of CQC inspections?

I am not aware of any protocol. The CCG's that we are inspecting in for the next quarter are published on our WEB site prior to us visiting. CCG's are written to at the same time the CCG's areas are published. Practices are informed that we will visit two weeks before. Yin will be able to talk about the hospital methodology which is slightly different to PMS.

5) CQC good practice examples of work in other authorities with scrutiny.

We already have meetings set up with Lincolnshire OSC Health both at public OSC meetings and meetings with the chair. We are also going to carry out a development day for the OSC health committee

CQC Hospitals, Adult Social Care and Primary Medical Services.

27 January 2015

Yin Naing – Interim Inspection Manager
Michele Hurst – Inspection Manager
Central Region

Appendix A1

Our purpose and role

Our purpose

We make sure health and social care services provide people with safe, effective, compassionate, high-quality care and we encourage care services to improve

Our role

We monitor, inspect and regulate services to make sure they meet fundamental standards of quality and safety and we publish what we find, including performance ratings to help people choose care

We will be a strong, independent, expert inspectorate that is always on the side of people who use services

The new CQC inspection programme

Larger inspection teams including **specialist inspectors, clinical experts**, and **experts by experience**

We will use **intelligent monitoring** to decide when, where and what to inspect.

Inspections will focus on our **five key questions** about services

KLOEs (key lines of enquiry) as the overall framework for a consistent and comprehensive approach

Strong focus on talking and listening to **staff and patients**

Ratings to help compare services and highlight where care is outstanding, good, requires improvement and inadequate

Quality summit is held with the provider and stakeholders to launch **quality improvement** process for hospitals

Risk summits are also held in PMS

Our key questions

Our focus is on five key questions that ask whether a provider is:

- **Safe?** – people are protected from abuse and avoidable harm
- **Effective?** – people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence
- **Caring?** – staff involve and treat people with compassion, kindness, dignity and respect.
- **Responsive?** – services are organised so that they meet people's needs
- **Well-led?** – the leadership, management and governance of the organisation assure the delivery of high-quality care, supports learning and innovation, and promotes an open and fair culture.

8 Core Services

- In acute hospitals the following 8 core services are always inspected:
    1. Urgent and emergency services
    2. Medical care (including older people's care)
    3. Surgery
    4. Critical care
    5. Maternity and gynaecology
    6. Services for children and young people
    7. End of life care
    8. Outpatients and diagnostic imaging
    - We will also assess other services if there are concerns (e.g. from complaints or from focus groups)
- The inspection team splits into subgroups to review individual areas, but whole team corroboration sessions are vital

Primary Medical Services

In PMS the following population groups are always inspected.

1. Older people
2. People with long term conditions
3. Families, children and young people
4. Working aged people(including those recently retired and students)
5. People whose Circumstances may make them vulnerable
6. People experiencing poor mental health (including people with dementia)
7. To be noted some practices only cater for specific patients for example - Homeless

Inspection teams Hospitals

- Chair – Senior clinician or manager
- Team Leader
- Doctors (senior and junior)
- Nurses (senior and junior)
- AHPs/Managers
- Experts by experience (patients and carers)
- CQC Inspectors
- Analysts

Around 30 people for a DGH more for a multi-site trust or a combined acute/community trust

Inspection teams Primary Medical Services

- Lead Inspector – always present
- GP specialist – always present for comprehensive inspections but not always required for focused inspections
- Practice Nurse Specialist – dependant upon the inspectors judgment
- Practice Manager Specialist - dependant upon the inspectors judgment
- Expert by experience - dependant upon the inspectors judgment
- Pharmacist inspector – provides advice on the data pack prior to inspection and may inspect too if risk is high. Can inspect independently if needed for example a focused inspection.
- Inspection managers – to carry out supervision as part of the ongoing performance management process for the inspectors.

Adult Social care inspection.

Lead Inspector – Always

Specialist inspector – Always

Expert by experience

Pharmacy inspector – where required.

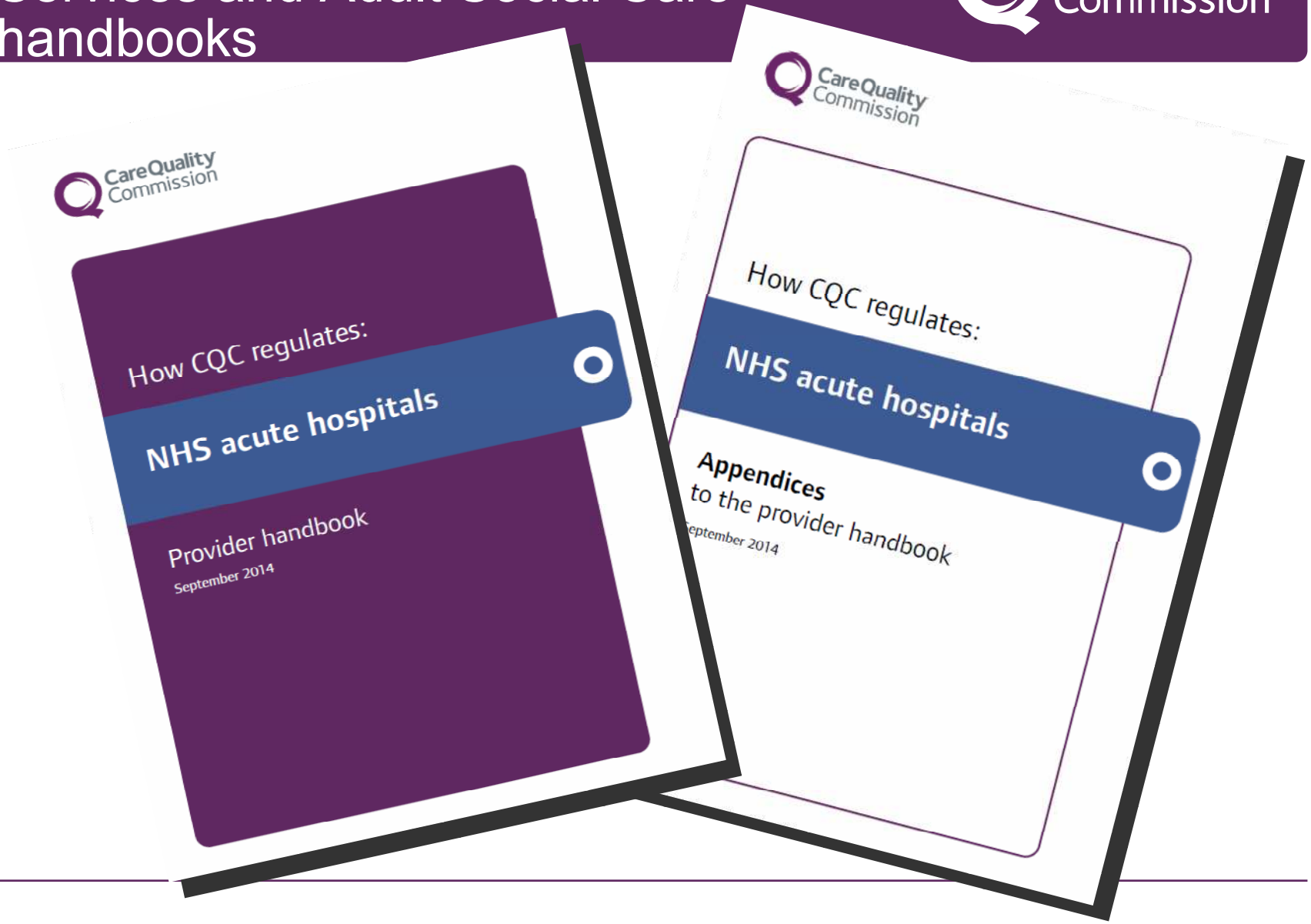
Rating four point scale

Judgement & publication	High level characteristics of each rating level
Outstanding	Innovative, creative, constantly striving to improve, open and transparent
Good	Consistent level of service people have a right to expect, robust arrangements in place for when things do go wrong
Requires Improvement	May have elements of good practice but inconsistent, potential or actual risk, inconsistent responses when things go wrong
Inadequate	Significant harm has or is likely to occur, shortfalls in practice, ineffective or no action taken to put things right or improve

How we rate

- Ratings take account of all sources of information:
  - Intelligent monitoring tool
  - Information provided by trust
  - Other data sources
  - Findings from site visits:
    - Direct observations
    - Staff focus groups
    - Patient and public listening events
    - Interviews with key people
- Bottom up approach: each of the 8 core services and population groups are rated on each of the five key questions (safe, effective, caring, responsive, well led).
- Where trusts and practices have more than one location and provide services on different sites we rate these separately.
- We then rate the trust as a whole on the five key questions, with an overall assessment of well-led at trust level.
- We then derive a final overall rating.

NHS acute hospitals Primary Medical Services and Adult Social Care handbooks



- Hospital inspections mental health and general and independent health care
- Primary Medical Services
  - Dental inspections
  - General Practice inspections
  - Health services provided to prisons
  - Youth and Justice inspections
  - Children's safeguarding inspections
  - Thematic inspections
  - Integrated Services inspections
- Adult Social Care
  - Care homes with and without nursing
  - Domiciliary care agencies

- Further information is available at www.cqc.org.uk

Healthwatch Leicester – Briefing Paper from VAL for joint Scrutiny Commission (Adult Social Care and Health) - 27th January 2015.

This briefing paper is designed in response to specific questions asked by the Scrutiny Policy Officer.

Q1 - What resulted in the breakdown with Healthwatch?

There is no breakdown with Healthwatch, the service and 'voice' of Leicester people is still operating. In the last quarter we have:

- Increased Healthwatch Leicester membership by 7% (now there are **1055** Healthwatch Leicester members (up from 752 at the start of Healthwatch Leicester)),
- Completed our first 'Enter and View' report (publication due before the joint scrutiny meeting)
- Launched a report on the Health and Well Being experiences of Leicester's Deaf Community,
- Held a highly successful 'pop up conversation' with the public in Leicester Market just before Christmas.

What has happened is a disagreement over future arrangements with Healthwatch Leicester – specifically whether it should remain as a contract held by VAL (running until end March 2016) or should be handed over by VAL to a newly established body (Healthwatch Leicester Limited).

When the contract was let in 2013, following an open competitive tender, the City Council insisted that VAL change the approach it had originally proposed in its tender. The Council insisted that VAL could not be Healthwatch, and that VAL should agree to a 12 month timetable to set up a separate independent body to deliver Healthwatch Leicester. This VAL reluctantly agreed to – though then we were surprised to then be given a three-year contract to sign by the Council. Despite repeated requests the Council did not disclose how it proposed to contract with a newly established separate body – VAL made it clear that it would not act as a prime contractor with the separate body as a sub contractor.

Although the Council was contracting with VAL to set up and run Healthwatch Leicester it also insisted that VAL take a "…back seat…" in the development of the independent body. VAL appointed Philip Parkinson as interim chair of the Healthwatch Leadership group and he proceeded to set up a committee, establish a Community Interest Company (in December 2013), and recruit a new Board. This process (with background VAL support) did not create an independent body ready to take over Healthwatch Leicester by the original deadline of 1st April 2014 – in the meantime VAL continued to focus on the delivery of an effective Healthwatch service for the people of Leicester. In parallel Healthwatch Leicestershire (using VAL's

original proposed model) was developing fast into an extremely effective voice for patients and service users in the County.

It was made clear in February 2014 that the mechanism the Council wished to use was for VAL to novate the contract to the new body. Novation is commonly used to transfer a contract where a supplier has got into difficulty – this made the VAL Trustee Board uncomfortable as we were not in difficulty in delivering Healthwatch.

On 17th April for the first time the City Council issued a list of requirements to the new chair of Healthwatch Leicester Ltd it was headed "**An independent Healthwatch organisation would need to be able to demonstrate/prove /achieve/provide the following in order for a contract to be appropriately and safely be held by them"** VAL's opinion was that these requirements would be exceedingly difficult and in some cases impossible for the new organisation to meet, as they were in effect the Business Questionnaire requirements for a full tender application.

Six months later (October 2014) the independent Board had completed many of the requirements and received waivers on others such as finance although there was still no identified Treasurer, and there was still no Bank Account. At his point VAL was asked to novate the contact. The VAL Chief Executive wrote a letter to the City Council detailing a range of serious concerns.

It was a VAL Trustee Board decision about whether they should hand over the contract for Healthwatch Leicester they won in open competitive tender. The VAL Trustee Board felt the proposed new arrangements would result in a weaker, less resilient, and less impactful Healthwatch service for Leicester City. VAL felt the City Council was ignoring the evident success of the VAL model for delivery of Healthwatch (as evidenced in Leicestershire). They also felt that the significant advantage for Leicester people of co-location of the Healthwatch Leicester service with the Healthwatch Leicestershire service would be damaged or lost entirely. So even though the post tender agreement with the City Council was to set up a separate body, VAL felt that to do so would be seriously detrimental to the people of Leicester.

VAL was keen for the Healthwatch Leicester Board to continue to work with us – but a number of them have taken the decision to resign.

Q2 – How is Healthwatch work currently being covered?

There are four Board members of Healthwatch Leicester still in place (Helen Child, Gill Brigden, Sue Mason and Brian Wheeler), and plans are underway to recruit new Board members. The staff team are continuing to work hard providing information and signposting to individuals, working with Health and Social Care colleagues on policy and practice development, engagement with the wider community and the **next formal Enter and View** is planned for w/c 21 January 2015 of Rushey Mead Manor Care Home.

The Enter and View team is chaired by Sue Mason, and has the following volunteers as authorised Enter and View representatives Philip Parkinson, Sue Mason, John Bryant, Kim Marshal-Nichols, Pat Hobbs, Michael Gilhooley and Moraig Yates

In partnership with Healthwatch Leicestershire we have planned **one week at UHL** - w/c 26 January 2015 – the departments to be included are:

- Accident & Emergency (A&E)
- Ears, Nose and Throat Department (ENT)
- Ophthalmology Department (Emergency & Clinic)
- Discharge Lounge

Care Quality Commission Inspection at Leicestershire Partnership (9-13 March 2015) – In readiness for the above we will be gathering information from people who use the service by putting out targeted callouts to local residents and networks via:

- Marketing Campaign to community hubs, libraries, schools, Children's Centre, VAL Health & Social Care and CYP Forums; GPs and Community Hospitals, VSC stakeholders, PPGs groups and forums
- Targeted Tweets and Media Releases
- Drop in Clinics at identified City venues where community based services are provided: Braunstone Health & Social Care Centre/Merlyn Vaz Health Centre

Complaints Working Group

The purpose of the Health and Social Care Complaints Task group is to undertake to improve Health and Social Care Complaint handling across Leicester, Leicestershire and surrounding areas for patients and members of the public. It is currently working with UHL on their complaints process, and has established complaints standrads for Better Care Together.

Future plans are to look at:

- Social Care complaints
- Public survey on Complaints working with NHS England

See Appendix at the end of this report for a summary preview of Healthwatch Activities for Quarter 3 2014-15

Further information about the work of Healthwatch Leicester can be found on the Healthwatch Leicester website (http://www.healthwatchleicester.co.uk/) and in the first Healthwatch Leicester Annual Report (http://www.healthwatchleicester.co.uk/resources/healthwatch-leicester-annual-report-201314)

Q3 - Is this work meeting the legal requirement to ensure we have a service such as Healthwatch in the city?

Yes. Leicester has a functioning local Healthwatch service that is required under the *Local Government and Public Involvement in Health Act 2007* – subsection 221(2) as amended by the *Health and Social Care Act 2012* – sub section 182 to:

> **221(2)** The activities for a local authorities area are-
>
> **(a)** promoting and supporting the involvement of local people in the commissioning, the provision and scrutiny of local care services;
> **(b)** enabling local people to monitor for the purposes of their consideration of matters mentioned in subsection (3), and to review for those purposes , the commissioning and provision of local care services;
> **(c)** obtaining the views of local people regarding their needs for, and experiences of, local care services;
> **(d)** making –
> (i) views such as are mentioned in paragraph (c) known, and
> (ii) reports and recommendations about how local care services could or ought to be improved,
> to persons responsible for commissioning, providing, managing or scrutinising local care services and to the Healthwatch England Committee of the Care Quality Commission.
> **(e)** providing advice and information about access to local care services and about choices that may be made with respect to aspects of those services;
> **(f)** reaching views on the matters mentioned in subsection (3) and making those views known to the Healthwatch England Committee of the Care Quality Commission.
> **(g)** making recommendations to that committee to advise the Commission about special reviews or investigations to conduct(or, where the circumstances justify doing so, making such recommendations direct to the Commission);
> **(h)** making recommendations to that committee to publish reports under section 45C(3) of the Health and Social Care Act 2008 about particular matters; and,
> **(i)** giving that committee such assistance as it may require to enable it to carry out its functions effectively, efficiently and economically.
>
> **subsection (3)** The matters referred to in subsection (2)(b) and (f) are:
> (a) the standard of provision of local care services
> (b) whether, and how, local care services could be improved;
> (c) whether, and how, local care services ought to be improved;

The relevant legislation *Health and Social Care Act 2012* and *Local Government and Public Involvement in Health Act 2007* requires that local Healthwatch is **a body corporate and a social enterprise** – both criteria fulfilled by VAL's registered charity status. Specifically subsection 222(2) of the 2007 Act (as amended by the 2012 Act) states:

> **222(2)** The arrangements must be made with a body corporate which-
>
> (a) a social enterprise, and
> (b) satisfies such criteria as may be prescribed by regulations made by the Secretary of State

The regulations (2012) spell out what is defined as a social enterprise (section 35 (1) and (2)) – but these criteria do not apply to a company limited by guarantee registered as a charity in England and Wales (section 35 (3))

The legislation and subsequent regulation (*The NHS Bodies and Local Authorities (Partnership Arrangements, Care Trusts, Public Health and Local Healthwatch) regulations 2012*) also requires Healthwatch **to be independent** of Local Government and Health, specifically subsection 222(3) of the 2007 Act (as amended by the 2012 Act) states:

> **222(3)** None of the following is capable of being a Local Healthwatch Organisation-
>
> (a) a local authority
> (b) a National Health Service Trust
> (c) an NHS Foundation trust
> (d) a Primary Care Trust,or;
> (e) a Strategic Health Authority

The intent of the legislation is that Healthwatch should be independent of the public sector – as VAL is.

Q4 - What are the future plans for Healthwatch?

VAL has advertised for new Healthwatch Board members and aim to have a refreshed Board in place by end March 2015.

VAL will continue to provide the support for a successful Healthwatch Leicester – just as we have successfully supported Healthwatch in the County.

VAL believes the City Council should embrace the successful model for Healthwatch that VAL is delivering in Leicestershire (considered a 'perfectly acceptable' model by Healthwatch England). This provides for an independent Board that gives leadership, strategic direction and lay representation to Healthwatch; backed by VAL employed

Healthwatch Leicester staff members who provide support, expertise and resilience to the service. Healthwatch Leicester will be 'owned' by the Healthwatch Leicester Board and membership and delivered in partnership with VAL (an independent body corporate and social enterprise).

The City Council will be commissioning with an organisation that has a solid track record, history of excellent accountability, and financial resilience.

Kevan Liles
Chief Executive, VAL

16th January 2015.

Summary Update for Q3 (Oct – Dec 2014)

Membership : In Q3 the membership increased by 69 members or 7% increase of the membership, in comparison to an increase of 2.2% in Q2 and an increase of 1.5% in Q1. Key metrics

Quarter	New members	Previous membership total	% Increase
Q1	14	953	1.5%
Q2	21	967	2.2%
Q3	69	986	7%

Signposting : The helpline service operates daily from 10 – 4pm with voice message service for call backs . Key metrics

Activity	Q1	Q2	Q3	Q4	Total
Total Helpline Calls	79	160	134		**373**
Health Issues	18	11	10		**39**
Dental issues	56	147	124		**327**
Social Care Issues	5	2	0		**7**

Involvement with NHS England Local Area Teams

Due to the volume of activity that has taken place through the Helpline, particularly around dentistry queries/issues, we now have regular quarterly meetings with the NHS England Local Area Teams and this meeting also includes Healthwatch Lincolnshire, Lincolnshire PALS and a representative from the NHS England complaints team.

This has allowed us to have direct access with NHS England to resolve issues and also to discuss in more details some of the issues and concerns raised by patients around all the contracted services provided which cover GPs, Pharmacies and Opticians in addition to the dentists.

Evidence, Insight and Intelligence

- **Deaf Community Report**: Healthwatch Leicester in Partnership with the British Deaf Association and Leicester Deaf Forum had conducted health survey. Report was launched at the event on 24th November involving a wide range of stakeholders.
  - BBC Radio interview the deaf community members and ran the story on 12th Dec 2014.
  - Leicester Mercury article about the report on 12th Dec 2014.
  - Invitation received from the British Society on Mental Health on Deafness to present the finding of the report on their regional meeting on 6th Feb 2015.
  - The findings were also incorporated within the Physical Disability and Sensory Impairment Commissioning Strategy for Adult Social Care in Leicester City.

- Information gathered is going to informed the development of Communication app for Deaf people undertake jointly by LPT, UHL and CCGs
- Steering Group to be established to take the recommendation forward

- **Enter and View visit** – Elderly Care at Hospital in a weekend setting. On 26 October, an Enter and View visit to wards 30 and 31 of Leicester Royal Infirmary by Authorised Reps, lead by Sue Mason. Making observations and speaking to patients, their families and staff on the delivery of care for elderly patients. A draft report has been shared with UHL for factual checking and to give them a right to reply. The report made a number of recommendations from observations made and commended them on aspects of care. The report is to be signed off and published in Q4

Engagement

Activities where HWLC attended events organised by statutory partners and VCS.
Key metrics

Activity	Q1	Q2	Q3	Q4	Total
Engagement events	27	16	14		**57**
Website Traffic					
No. visits	1004	1087	969		**2091**
No. visitors	648	729	690		**1377**

Pop up stall in Leicester Market
As an ongoing part of the public engagement work Healthwatch held a pop-up engagement stall in Leicester Marketplace on December 17th.
Provided, free of charge by Leicester Market, Healthwatch had a gazebo which was situated just outside the indoor market.
Outcomes:

- 104 surveys completed
- 13 case studies captured
- 29 members signed up

Influence and relationship building

- **NHS England** – Supporting the development of NHS Citizen (New Engagement model)– 2 day development workshop Birmingham (October)

- **Development of Mental Health Summit** – Supporting Leicestershire Police and Leicestershire Partnership Trust to plan Summit in Q4.

- **Patient and Public involvement in Research** – Attending multi agency regional workshop (November) linking to East Midlands Academic Health Science Network.

Joint Adult Social Care and Health and Wellbeing Scrutiny Commission

Tuesday 27th January 2015

POSITION STATEMENT from former Chair and members of the Healthwatch Leicester Board

Healthwatch was established under the Health & Social Care Act 2012 as the consumer champion for patients and the public in health and social care replacing the former LINks organisations. Local authorities were charged with bringing Healthwatches into being and in Leicester City following an open, public procurement process Voluntary Action LeicesterShire (VAL) were awarded the contract for three years from 1st April 2013 until 31st March 2016, with the option of a further one or two year extension. At the same time, Leicestershire County Council also awarded the County Healthwatch contract to VAL. (Furthermore, Rutland County Council followed by giving VAL a one year contract to establish Healthwatch Rutland. HW Rutland became independent of VAL on 1st April 2014.)

In March 2013, Philip Parkinson (PP) was asked if he would be prepared to help establish Healthwatch in the City of Leicester and to Chair an interim Leadership Group; he agreed to do so but was immediately confronted with very different views as to the form that Healthwatch should take. There had been a Transition Group led by the City Council during 2012 but it seemed to have petered out between December 2012 and March 2013.

It was quite clear that at least two views emerged, one that VAL could not run Healthwatch in effect as a Sub-committee of its Board and the other that in the spirit of the legislation, Healthwatch should be an independent organisation.

By late summer 2013 however, a point was reached where the position of the City Council was that Healthwatch should become an independent organisation to which end considerable work was undertaken to establish Healthwatch Leicester as a Company limited by guarantee - achieved in November 2012. Full reports were taken to the meetings of the City's Health & Wellbeing Board and to the Leicester Clinical Commissioning Group (CCG) in October 2013 and the membership was kept fully informed through e-bulletins and Newsletters, including personal up-dates from PP as interim Chair.

The intention was to work towards achieving independence by 1st April 2014. Kevan Liles, the CEO of VAL, intimated on several occasions that VAL would not stand in the way of this happening and would in effect work with us to achieve this end. An open, public and transparent recruitment process for a Chair and Directors of Healthwatch was undertaken between October and December 2013;

the panel included Linda Jones, VAL's Chair.

Karen Chouhan (KC) was appointed Chair and succeeded PP.

The Interim Board and the staff team lead by Vandna Gohil succeeded in fulfilling all the expectations of the contract including the KPIs for 2013/14. Throughout the period April 2014 - November 2014, the Healthwatch Chair and Board members were able to make a valuable contribution to the City's Health & Wellbeing Board, it's Health & Adult Social Care Scrutiny Commissions and to various health bodies eg the CCG, NHS England's Quality Surveillance Group. Bringing considerable experience and knowledge they were able to be at the heart of the Better Care Together Programme. One Board member was particularly well informed locally, regionally and nationally with learning disabilities.

A programme of induction was provided for the six newly appointed Directors; unfortunately due to changed personal circumstances two of these had to resign but the three founding Directors - Gill Brigden, Surinder Sharma and PP agreed to stay on to support KC and the new Board. There was some slippage as Directors came to terms with their roles but much productive time was spent in discussing and agreeing a Business Plan for 2014/15.

By June 2014, it was agreed that we needed to hasten the move towards achieving independence; a series of meetings involving the City Council, VAL and the Healthwatch Board were held - monthly in July, August and September. A detailed schedule of everything that would need to be in place to satisfy the City Council of our competency was drawn up. We decided that we needed some assistance to help us and asked David Henson (DH) to do so - he had done a similar job to help establish Healthwatch Rutland. Between July and early September we put together all that was required of us.

DH began to hold regular meetings with staff who appeared to be supportive of our aspirations.

All of this was reported to the three-way meetings. At the July meeting the City Council proposed a Novation Agreement - both VAL and Healthwatch were asked to consider the document BUT at no time was the principle called into question.

In anticipation of achieving a signed Novation in September huge efforts were put in by KC and DH on behalf of, but in conjunction with Board colleagues, to address all the practical tasks necessary for independence - alternative accommodation, a host organization (Age UK), plans for transferring the database and website, opening a bank account etc. These were satisfactorily concluded. Progress was reported to the three-way meetings including the need to carry out certain preparatory work at some initial cost. At no stage was

Healthwatch or the City Council made aware of any misgivings from VAL.

A formal set of recommendations were taken to the public Healthwatch Board meeting on 24th September 2014.

A week later, on 2nd October, KC was advised by the City Council that a letter had been received from VAL saying that they did not feel that the Healthwatch Board had the competences necessary to take on the Healthwatch contract. There was a further letter from the VAL Union representative questioning the lack of consultations with staff about TUPE arrangements. (There were two members of HW staff in the union).

We were advised we would get a copy of the VAL letter but when none had been received KC asked to meet with Kevan Liles; this took place on Monday 13th October with Linda Jones present too. KC was informed that VAL would not agree to a novation of the Healthwatch contract. This was formally confirmed at a further three-way meeting on 3rd November 2014. At this meeting Linda Jones confirmed that VAL would pick up the set up costs that had been incurred in good faith.

The Board of Healthwatch at its meeting on 26th November, then had to make arrangements to overturn the resolutions made on 24th September, apply to Companies House to rescind its Company status and to advise Barclays Bank that it was no longer possible to open an account.

Only one Board member (Sue Mason) felt able to carry on; two resigned immediately upon hearing of the VAL Board's decision (Steph Chapman and Ballu Patel), KC, PP and Surinder Sharma resigned with effect from the 31st December 2014. Helen Child, Vice-Chair, and Gill Brigden offered to remain for a short while to help with whatever transitional arrangements VAL decided to put in place.

KC, PP and SS
January 2015

Joint Meeting of the Adult Social Care Scrutiny Commission and the Health and Wellbeing Scrutiny Commission – 27th January 2015

Healthwatch Update – Leicester City Council's response

The purpose of Healthwatch is to act as the champion for local people, by ensuring that people's health and social care needs are heard, understood and met.

This will be achieved by:

- Listening to people, especially the most vulnerable, to understand their experiences and what matters most to them
- Influencing those who have the power to change services, so that they better meet people's needs now and into the future
- Empowering and informing people to get the most from their health and social care services and encouraging other organisations to do the same
- Championing service improvement across the health and social care systems

The following information provides an overview of the current position relating to Healthwatch Leicester, as requested by the joint scrutiny commission.

The contract for the development of Healthwatch was awarded to VAL in early 2013. The tender highlighted that the development of Heathwatch was still subject to further guidance. The regulations were published after the tender closing date in December 2012. Intially the contract was for a 3 year period, due to the uncertainty around the final guidance.

A number of clarification meetings were held with VAL about the need for an independent Healthwatch body. The Council was clear that an independent body was needed to make decisions about the priorities for Healthwatch Leicester and to influence and champion improvements across the health and care economy in the City.

Confirmation was received on 9th May 2013 that VAL would agree to the transitioning of Healthwatch Leicester into an independent body by 1st April 2014.

Philip Parkinson was appointed as the interim chairperson and was being supported by VAL to create an independent body.

Karen Chouhan was appointed as the permanent chairperson, supported by Philip Parkinson, whilst the independent board was created.

On 28th February 2014 a meeting was held with Philip Parkinson, Keven Liles (VAL) and Council Officers where it was agreed that VAL would agree to novate the contract to the newly formed Healthwatch Leicester Ltd. A target date of 1st October 2014 was agreed.

At the meeting it was agreed that the independent body would need to assure the Council that it was 'fit for purpose' and able to deliver a Healthwatch service for the City. It was agreed that the independent body would need to provide a range of evidence and documents to the Council.

The City Council received correspondence from VAL on 6th October 2014, raising concerns about the capability of the independent body to deliver a Healthwatch service in the City. None of the issues appeared to be unresolvable.

Therefore, a meeting was arranged for 6th November 2014, to discuss the issues and to seek a way forward. However, Linda Jones chairperson of VAL advised that VALs Board would not agree to the novation of the contract.

Following this meeting Karen Chouhan and Philip Parkinson resigned as did a number of other Healthwatch board members.

The provision of a Healthwatch service is a statutory requirement and they have a place on the Health and Wellbeing Board and other key Health and Social Care meetings, where they can raise issues on behalf of the local community. At this time there is a lack of presence from Healthwatch board members.

Contract monitoring information is being provided by VAL, which shows they appear to be delivering to the required performance outcomes. However, concerns relate to the lack of a Healthwatch presence, an inability to raise and influence key issues, which is a major concern, especially with the state of the current health and care economy in the City.

The City Council has met with VAL to discuss the situation and they are aware that they are required to have an independent board in place by 1st June 2015.

Tracie Rees
Director Care Services and Commissioning
Adult Social Care
Leicester City Council

Health shake up plans on track

By Merc_Reporter | Posted: January 21, 2015

By Cathy Buss

Leicester General Hospital; focus on community services

Comments (2)

Plans are on track for the biggest ever shake-up of health services to plug a predicted £400 million annual cash shortfall by 2019, according to officials leading changes.

They believe health organisations across Leicester, Leicestershire and Rutland are now working together to improve care for patients and make services more efficient.

Key areas of the review include urgent care, maternity and newborn services, children's services, learning disability provision, planned care for frail older people and those with long term conditions and mental health services.

The review, known as Better Care Together, is also likely to see hospital services moved to Leicester Royal Infirmary and Glenfield hospital with the Leicester General Hospital site more of a base for community services.

Related content

- Plans for shake up of mental health services to save £10 million
- Health care at home better than being in hospital
- Review as health shake-up to see £400m cash shortfall

Toby Sanders, joint responsible officer for the shake-up, described the past year as “one of hard graft but we have got to a really exciting place.”

Mr Sanders, who is also managing director of the West Leicestershire clinical commissioning group (CCG), said changes to move services out of hospital into the community are already taking place with schemes such as the acute visiting service which assesses patients at home.

He added over the next year he expected one of the biggest changes would come in the way GPs work and with a wider range of service in community hospitals.

Professor Azhar Farooqi, chairman of the Leicester City CCG and clinical lead for the programme, said: “The atmosphere between organisations has changed.

“There is much more collaborative working.

“In the next year we are really going to have to step up activity without any loss in the quality of service.

“This time next year I expect to see more seven day working in primary care and more services provided in the community.”

Members of the Leicester Mercury Patients’ Panel met with key members of the programme board this week.

Eric Charlesworth, chairman of the panel, said: “Better Care Together is a complex process with inherent risks.

“Further information and assurances are being sought on financing, the number of beds required to meet demand, social care evidence of partnership working, all of which need to lead to improved affordable care.

“There must be effective scrutiny by the public and authorities to challenge or confirm and understand the proposals.”

BRIEFING NOTE ON BETTER CARE TOGETHER

FROM THE Interim Head of Communications and Engagement

To all Senior Stakeholders

Tomorrow (22 January 2105) is Better Care Together's first Partnership Board meeting in public at the Peepul Centre. Ahead of that, I wanted to share a briefing with you including latest developments about the programme.

Senior Stakeholder briefing

I am pleased to attach below the latest briefing about Better Care Together, the five year transformation programme for health and social care in Leicester, Leicestershire and Rutland, launched in late June 2014.

Introduction: The context and vision for Better Care Together

As the Chief Executive of NHS England said recently when he set out his five year forward view,

"Our values haven't changed, but our world has. So the NHS needs to adapt to take advantage of the opportunities that science and technology offer patients, carers and those who serve them. But it also needs to evolve to meet new challenges: we live longer, with complex health issues, sometimes of our own making… we need to take a longer view…"

Local health and social services are under increasing pressure because more people than ever before require our help. In part, this should be welcomed because people are living longer as a result of the improvements in health and social care which have taken place over the last twenty years.

Locally we have some brilliant services which would be the envy of many other health economies, but there are also things which do not work well for people and their families. We have world class diabetes and heart services, but we also struggle with some of the basics like access to GP appointments, A&E overcrowding, and above all, gaps between different parts of the NHS and social services. This often means that people spend too long waiting for things to happen or struggle to find their way around the different services.

Better Care Together was created to address these issues, specifically the over reliance on acute hospitals; the changing needs of an older and often sicker population, austerity and the public's desire to have more services available in their local communities.

Our 5 year vision for a local health and social care service is one which "*Supports you and your community through every stage of life".*

We want to create communities and services which…

- Support children and parents so they have the very best start in life

- Help people stay well in mind and body throughout their life
- Know patient's histories to help anticipate and plan for their health needs
- Care for the most vulnerable and the most frail citizens
- Are there when it matters most and especially in a crisis
- Help support people and their loved ones when life comes to an end.

The very best start in life: From what mums have told us we know that they want more choice about where they give birth and the reassurance that there is specialist expertise close by if anything should go wrong. So, we will be looking at how we can support expectant mothers to have their babies at home; how we can give mums the option of a midwife-led birth and how we can better support new families in the first year of having a baby. We also understand that older children and young people sometimes require services which are different to adults, so we will plan for services which are available in the community and which look after our young people's state of mind as well as their physical health.

Helping people stay well in mind and body: Everyone knows that prevention is better than cure, but we still spend most of our time and money treating illness. We all need to focus more on wellness. In future we want local people to have the best education and support to stay healthy regardless of their age or background. This means more time and effort spent on training and educating people to overcome issues which will affect their health and wellbeing… so, whether it's support to eat more healthily, lose weight, drink less, stop smoking or get active… we want to help people to do the right thing.

Knowing people's history and planning for their needs: Often a crisis like a fall for an older person or a worsening of an existing illness is predictable, yet for too many people the result is a hospital visit.

In future we are going to work with those patients and their carers who we know are at risk to make sure that they have personal care plans completely focused on them and their needs. And we will make more services which have traditionally been based in the City hospitals, available in the community. This will mean that a spell in hospital becomes the exception in all but the most complex situations.

Caring for the most vulnerable and frail: We know that there are more older people living locally than ever before, and whilst many are enjoying healthy and independent lives, for some old age is lonely and beset by health problems. We know that people want to live independently, preferably in their own homes for as long as possible and we will support them to do this. We will make sure we know who the most vulnerable people are and give them the most support. We will work with carers, and especially those who are looking after people with dementia, to make sure that they get the help they need. And we will respond to calls for help from the most vulnerable quickly to avoid them reaching the point where a stay in hospital is the only option.

Be here when it matters and especially in a crisis: A lot of our plans are about avoiding a health crisis by getting the right services to people more quickly, but even then some people will still become poorly. When they do our community crisis response teams will be there quickly. They will discuss the options with people and where possible organise specialist teams to care for people in their own homes or a care/nursing home rather than hospital. If a trip to hospital is required then from the winter of 2016 patients will be looked after in the UK's only purpose built 'frailty friendly' A&E. And when it is time for them to go home we will make sure that all the services they need to continue to live independently, are in place.

When life comes to an end: It happens to us all and yet it is a subject which patients, doctors and nurses sometimes struggle to talk about. Most people at the end of life would prefer to die at home with friends and family around them, but they need support to make that choice and support in their last days for them to have the best death possible. We will make sure that doctors, nurses and other professionals are properly trained to have these difficult conversations and carers, and that patient's wishes are honoured at the end of their life.

Latest Progress: The Strategic Outline Case

As we move from vision to plans, each clinical work stream, (e.g. maternity / end of life care / Frail Older people) in Better Care Together is working with doctors, nurses, managers, patients and stakeholders to consider what the best clinical solutions are.

Some of this more detailed thinking has been captured and presented in the draft Strategic Outline Case, (SOC).

The SOC is an important milestone in the development of the Better Care Together programme and though it is by no means 'the plan' it does set out the scale of our ambitions. The draft SOC will be reviewed and hopefully endorsed by both the NHS Trust Development Authority and NHS England… in that sense it should give us the support to develop the plans in more detail and ultimately where appropriate consult with the public and stakeholders on those plans.

The SOC has been endorsed by all health and social care bodies in Leicester, Leicestershire and Rutland. So, throughout November and December the SOC has been to all three Health & Wellbeing Boards, to the three CCGs and two main provider Trusts for comment and approval. This was finally approved in its draft form on 22 December and was sent as a draft to NHS England and the NHS Trust Development Authority for their views.

The draft SOC on Finance:

An important element of the SOC was a detailed financial prediction which looked at what would happen if the local NHS and social care did nothing to address issues of demand and available resources.

The analysis showed that the health economy in Leicester, Leicestershire and Rutland receives £1.8bn per year to commission and provide health services. And

the ‘do nothing’ approach would see a financial gap in the Leicester, Leicestershire and Rutland health economy of £390million by 2019.

There is also continuing funding pressures on all three Local Authorities and there needs to be further work to evaluate the costs of adult social care as more service users and cared for in their communities.

However if BCT cross system initiatives, aligned and linked to organisation savings initiatives, deliver according to the initial plans, then the economy as a whole would deliver a £1.9m health economy surplus in year five.

The strategic outline case also makes the case for additional support in order to reconfigure services. In other words to get from where we are now to where we want to be will require additional funding, for example to ‘double run’ services in *both* the acute hospital and in the community until the services in the community are well established.

Alongside this there is the ongoing requirement for capital funding. For Leicester’s hospitals this amounts to £320m over 5 years to support the likes of the new Accident and Emergency Department at the Royal Infirmary and the investment required to consolidate acute care on to two, rather than three sites, (see below).

The SOC on hospital reconfiguration and Beds:

Leicester’s hospitals headline strategy is to become smaller and more specialised as fewer people are required to come into hospital and more services shift to the community. As described in June last year this means that all acute services (i.e. the specialist and emergency work) will move to the Royal and the Glenfield Hospitals. This will mean a different future for the General Hospital as an ‘integrated health and social care campus’.

At the same time there will be a steady transfer of beds from the acute hospitals into the community. In essence the principle is that as we create more responsive services in the community for people like the frail elderly, there will be a greater need for beds closer to home or at home than there is in hospital.

This is clearly the ‘holy grail’ for healthcare, not only does it lead to better outcomes it is also substantially more cost effective to prevent or at least have alternatives to hospital admission… but we know there needs to be a ‘safety net’… if for whatever reason, admissions do not decrease in line with bed transfers. As such an important principle in the SOC is that beds will not substantially reduce in the acute hospitals until alternative and proven services are available in the community.

Other Developments:

It is important to stress that whilst Better Care Together represents the whole health and social care system 5 year plan, we are not waiting for the final agreement, support and consultation on the plan to get cracking on some of the obvious improvements.

Improvements in community care:
So, already patients and service users in Leicester city, Leicestershire and Rutland are benefitting from £63 million from Better Care Fund projects.

In Leicester, over £23million will be used to improve care closer to home for those who are aged 60 years of age and above, younger adults with three or more health conditions and anyone with dementia.

Most of the schemes in the Leicester City plan are already live. For example:
The unscheduled care team is providing 72 hours of support for increasing numbers of frail and older people in their own homes.

The Clinical Response Team is building up to full capacity so that it can attend referrals from GPs, care homes and 999, where a patient is at risk of a hospital admission. Whilst new 'Care Navigators' are supporting patients at home with a holistic view of both their health and social care needs.

Leicestershire County service users will benefit from £38million with GPs, community nurses, and social services working together in Leicestershire' communities to provide better care, closer to home avoiding admissions to hospital, with services targeted primarily to older people, vulnerable people, those with long term conditions and their carers .

The County's integrated crisis response service is already providing 72 hours of support for people in their own homes when care needs escalate, a new rapid assessment service for older people launched in October, a community falls response, being delivered in partnership with East Midlands Ambulance service, will be in place in time for the winter period, and the county's clinical commissioning groups are testing out how elements of GP service can operate across a seven day period. All of this work will ultimately reduce the demand on our local hospitals.
And in Rutland £2.2million will be providing residents with the right care, in the right place, at the right time, by creating new community services and managing a reduction in emergency admissions to hospitals.

Changes to Intensive Care
Leicester currently has 3 intensive care units, (ITUs), one at each hospital. However the service and clinical teams are spread too thinly across the three. So whilst demand for ITU grows at the Royal and the Glenfield, it has diminished at the General. Over the last few years this has meant that recruiting clinical staff to the ITU at the General has been problematic because new young intensivists want to practice in big, busy units.

The clinical teams have told us that it is time to bite the bullet and that the only way to make sure that ITU at the Royal and the Glenfield is capable of dealing with demand is to shift beds and expertise from the General, (in line with the strategy to have two, rather than three acute hospitals), and invest in two 'super ITUs' at the other hospitals. This therefore is the plan and though it is part of the overall strategy for Better Care Together, it is likely to be something that needs to be executed sooner rather than later, (within 12 months).

Gateway Review

Finally we wanted to share the results of the recent 'Gateway Review' of Better Care Together. Gateway Reviews are Whitehall's way of assessing whether major projects like BCT are going to deliver what they set out to do.
Over a period of four days, the Office of Government Commerce (OGC) reviewed Better Care Together. It interviewed 37 individuals from across the Leicester, Leicestershire and Rutland health and social care system, mainly face to face. These included clinicians, GPs, senior local authority representatives and patient and public involvement representatives.

The full report is available but one of the key quotes was:
"Significant progress has been made by this community over the last six months largely due to effective leadership by the joint Senior Responsible Officers and support from [the] Programme Office…we commend this leadership. Many influential stakeholders remarked on how there had been more joint progress across the community in the last six months than the previous ten years."

We wanted to share this with you not out of pride, rather in recognition that as you have told us previously; fundamental change to the health and social care system across Leicester, Leicestershire and Rutland has been talked about for too long and it is high time we actually did something. The Gateway Review recognised that with the right leaders locally and the enthusiasm of clinicians and stakeholders, we are now starting to make meaningful inroads into creating a health and social care system which is genuinely better for local people.

We recognise that this briefing is substantially longer than we would like or you would ideally want to read, however, it does accurately reflect that there is a lot of really positive work going on at the moment.

In the meantime thank you for your continued support and interest in the work of Better Care Together.

Stuart Baird
Interim Head of Communications and Engagement
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Better care **together**

Leicester, Leicestershire & Rutland health and social care

A five year plan for Health and Care across Leicester, Leicestershire and Rutland

2014-2019

Update – January 2015

Adult Social Care and Health and Wellbeing Scrutiny Commission

More information at:

www.bettercareleicester.nhs.uk

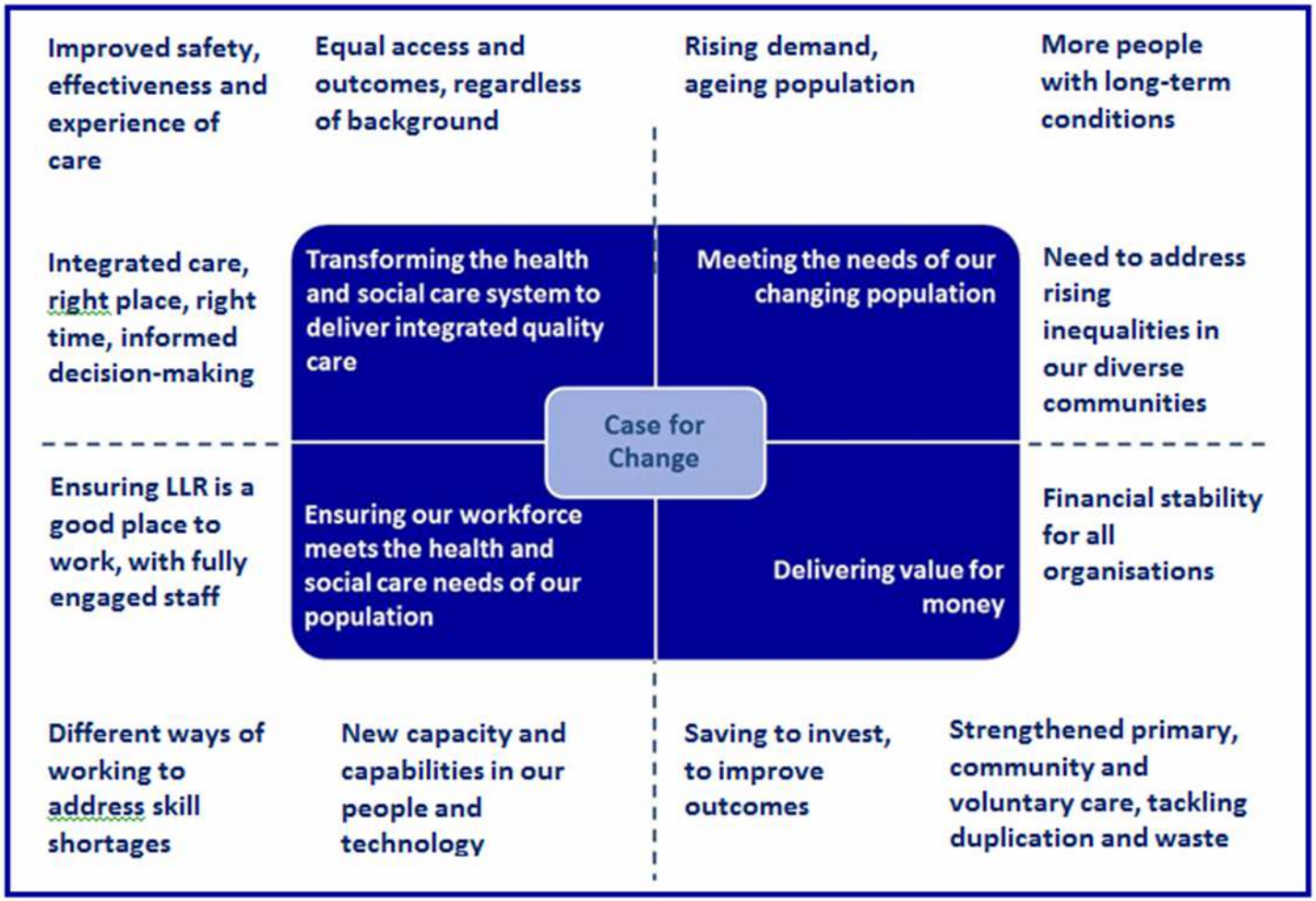

THE STORY
SO FAR

Vision ‘NHS and Social Care service that supports you and your community through every stage of life’

- Meeting the clinical and social care case for service change for Leicester, Leicestershire and Rutland
- Closing a potential health financial gap of £400m
- Addressing historic local issues ie meeting the differing needs of our communities
- Working in partnership across the health and social care system
- Moving at sufficient pace ie translating plans into delivery and implementation

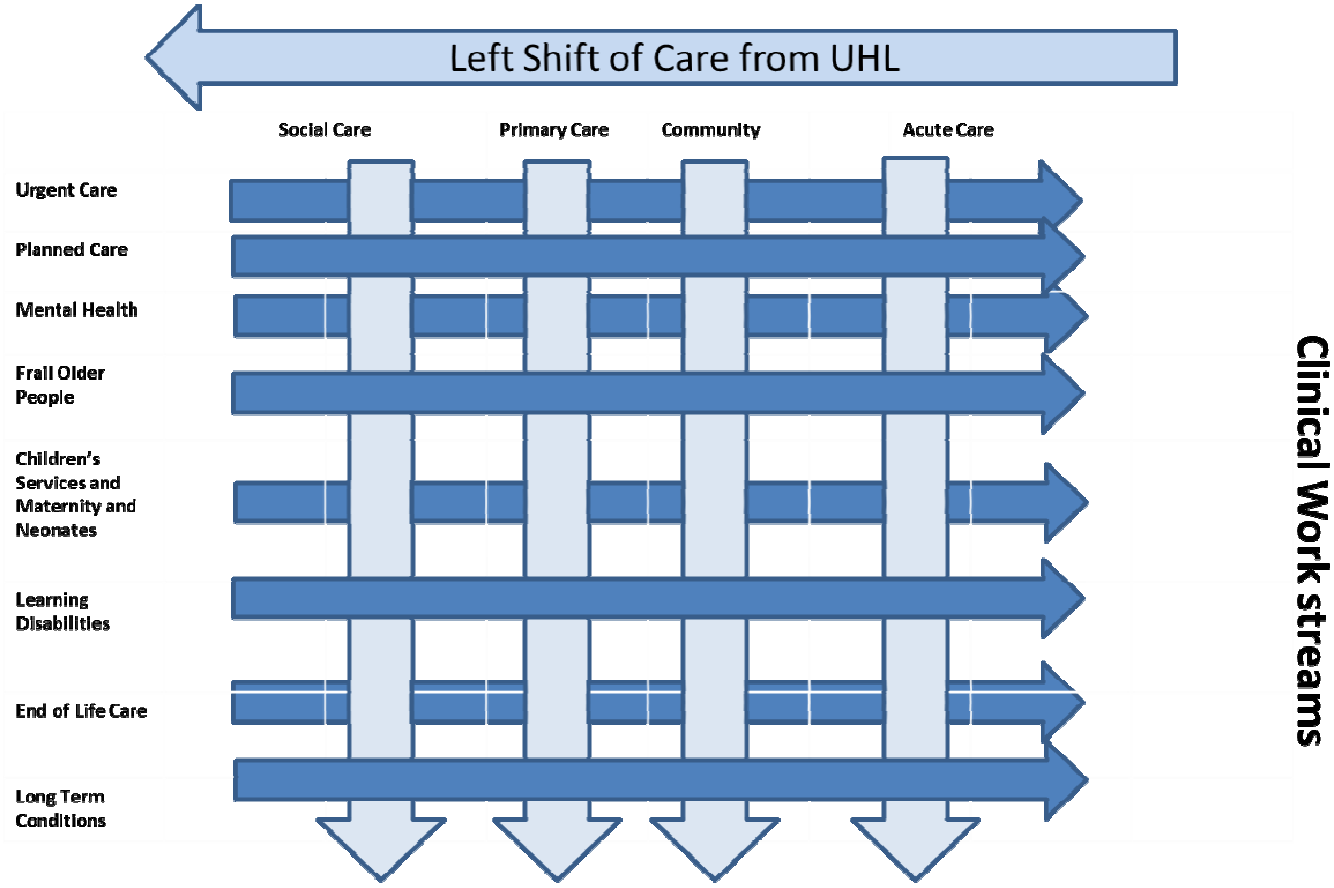
We have a draft plan. We have increased confidence in delivery. We are addressing known risks to the quality of our plan and to our ability to deliver

A vision and plan built around the clinical and social care case for change



A framework for developing our service change

The Better Care Together Programme sets out plans for eight clinical workstreams, and within four different care settings



Developed into proposed Clinical pathway work streams

Each of eight clinical pathway work streams has worked to the same format of describing our existing service, the interventions we intend to make and the resulting outcomes.

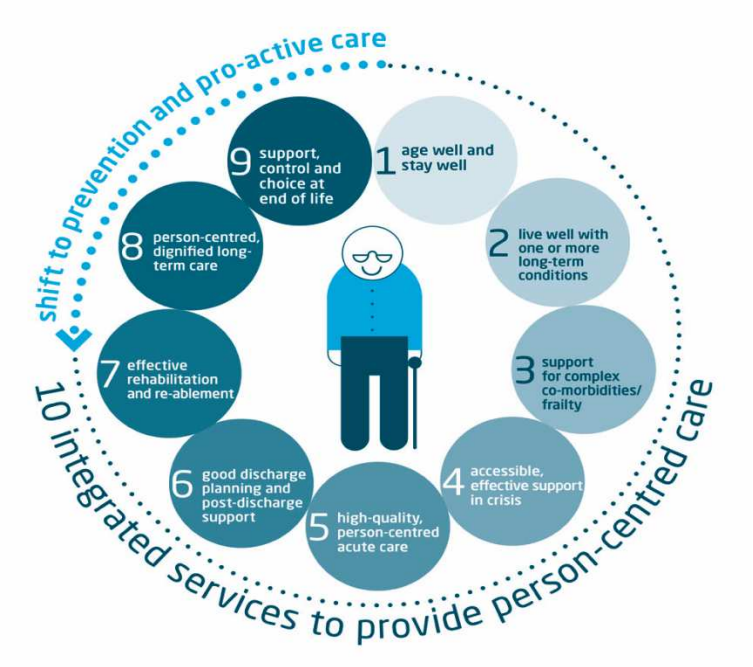
URGENT CARE (ACCIDENT AND EMERGENCY)

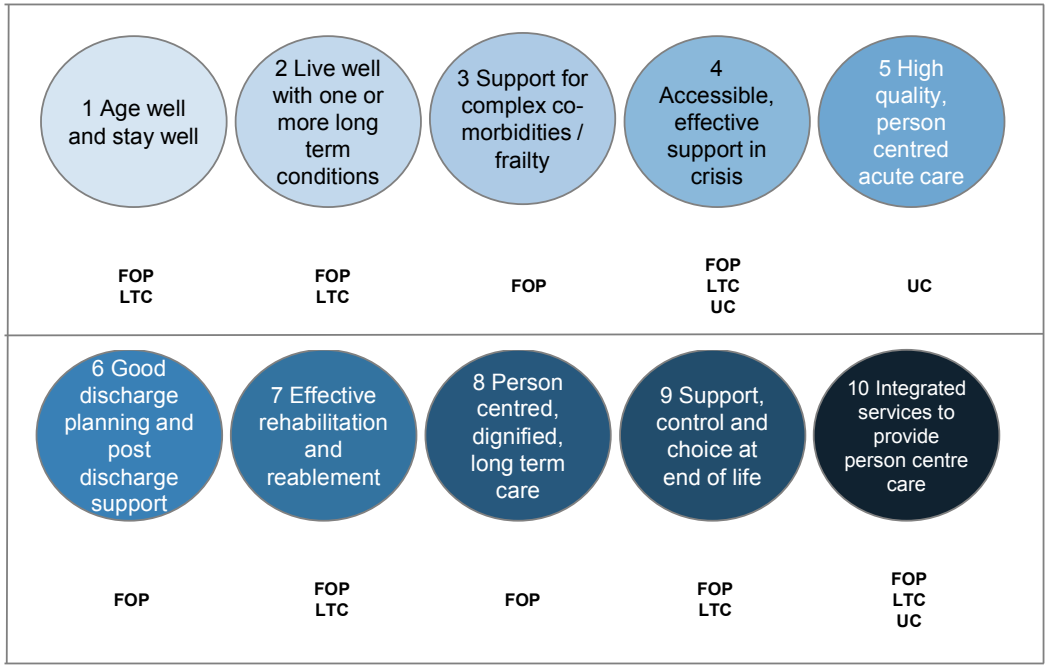
Our existing service	What are we going to do	Our outcomes in 5 Years
Difficulty achieving **national standards** - *we need to make sure we deliver to our 4 hour targets*	Help people to choose right and look after themselves when appropriate	More people being treated in the **right place**
Setting is **crowded** and uncomfortable - *we need to improve the urgent care environment*	Support more patients to be seen and treated by the ambulance service	Better **patient experience**
Complex and **different depending on where you live** in LLR - *where is it best for me to go when I'm ill*	Targeting support to those who need it through cases management	**Simpler system** for people to understand
Lack of **connection** in community services - *we need to deliver joined up services*	Develop more services to support people at home or in the community	Reduction in **admissions** for chronic diseases
	Make urgent care services across LLR consistent	**Less time** spent in hospital
	Support A&E to be as effective as possible	**National targets** being met with 4 hours targets consistently met
	Next 5 years ---------- →	

That are built on best practice and have the patient at the centre

The urgent care, frail older people and long-term conditions workstreams used the Kings Funds' Ten Components of Care to frame service transformation

Urgent care example…





In summary what have we achieved so far?

First Phase- 'Developing the Plan' through to 'Discussion and Review'

Through the support of Leicester, Leicestershire and Rutland (LLR) NHS and Social care partners, clinical and patient representatives

1. The engagement of clinicians, patient and voluntary representative groups in developing the proposals

2. A BCT five year strategic plan approved by all health and Local authority organisations which describes our shared plans to reform health and social care services across LLR;

3. A strategic outline case (SOC), published in December 2014, which sets out the financial case for the BCT programme as being the preferred way forward to deliver the plans set out in the five year strategic plan.

4. A BCT Partnership Board and Clinical Leadership Group with supporting programs representing Health and Social care partners , public and patient representative groups

5. External reviews supporting the approach ie Health and Wellbeing Boards, Clinical Senate, NHS England, Office of Government Commerce

6. Delivering early service reconfiguration patient benefits

A recent patient story by introducing the Crisis Response team for 2014/16 – Frail Older People work stream.

Two scenario's of a 78 year calling 999 with back pain, feverish and lethargic. Here is his pathway before and after the revised pathway

Usual patient pathway:

EMAS responds within 30 mins

Transport patient to hospital

Patient in ED for 4 hours

What actually happened via the revised pathway:

999 call at 6.45pm. CPT GP responds within 20 mins

Assessed and treated at home. Referred to Urgent Care Triage for holistic assessment

Unscheduled Care Team responded within 2 hours, provided 72 hours of care

Patient discharged from care with full independence. GP informed.

A patient story under development through the Planned Care work stream 2015/16

Patient present at GP/ Optometrist with problem with their eye

Usual patient pathway:

GP refers patients to eyes specialist out patient unit in UHL

Patient waits weeks for appointment to see eye specialist

Patient attends A&E as an emergency.

What actually happened via the revised pathway:

Optometrist/GP attends PEARS Scheme to gain accreditation to treat patient.

Optometrist/GP delivers treatment to patient.

Patient discharged!!

Optometrist/GP attends course every 3 years for on going accreditation

Reductions of A&E attendances by 2000 per year!!

A proposed patient story for Long Term Conditions work stream 2016/17.

Usual patient pathway:

Story one: Patient presents at hospital with Breathing Problems

- Patient admitted into hospital for specialist review
- Specialist advise patient on a course of self management treatment for COPD condition
- Patient leaves hospital after 10 days

What actually happened via the revised pathway:

Story two: Patient attends GP surgery and is risk assessed

- GP advises patient to attend an out patient clinic to complete self management course.
- Specialist Respiratory nurse advises on a structured approach to self management
- Patients confident raised. Now has more skills to deal with management of condition
- Patient has better quality of life !! & Less A&E admissions .

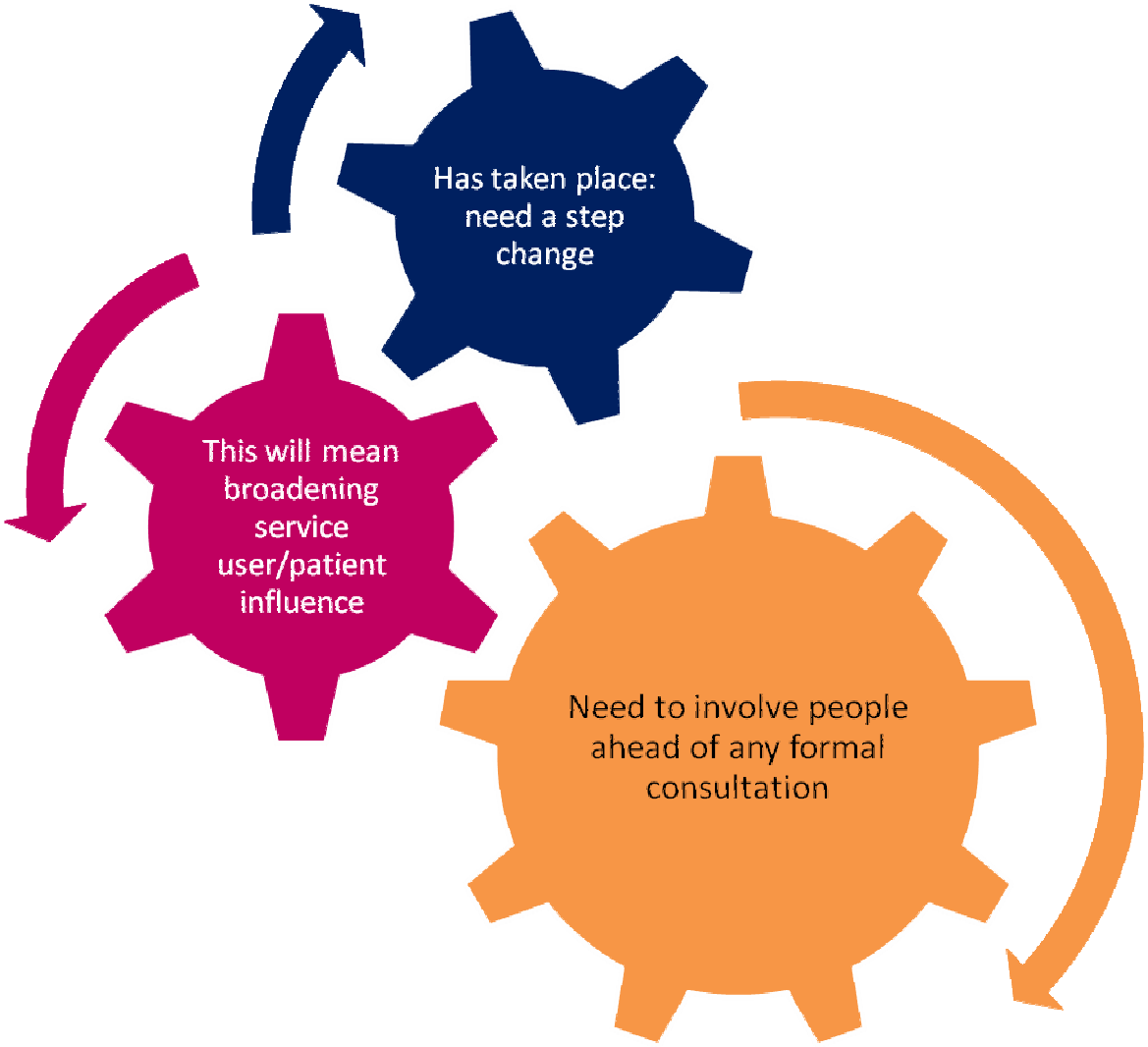

THE NEXT
STEPS

Service Reconfiguration – Implementation Commencing February 2015

Supporting work underway

- Social care -integration/alignment of services started
- Primary care- Review of services being approved
- Improving Quality of Care- End of Life Care, Learning Lessons programs established
- Workforce - New Roles, Recruitment and Cultural change programs commenced
- Quality and Risk assurance- Ongoing external reviews ie Safeguarding Boards, Clinical Senate.
- Voluntary Sector – Joint Engagement event April 2015

Engagement so far



Patient and Public Involvement and Communication and Engagement Workshop: feedback

Honest narrative about challenges

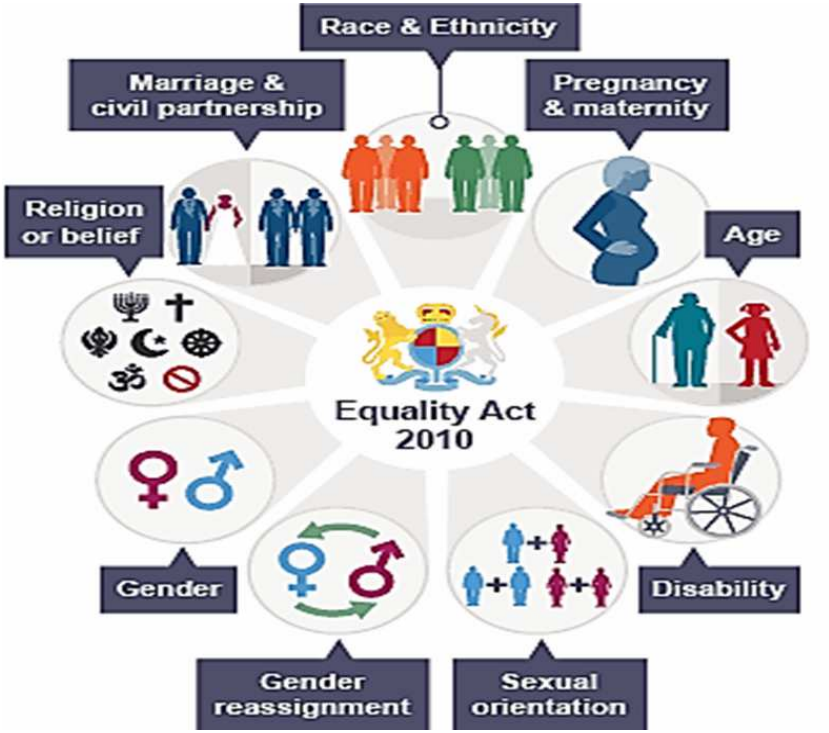
Greater diversity more work with ethnic minority/hard to reach groups

Welcome the open approach to Public and Patient involvement

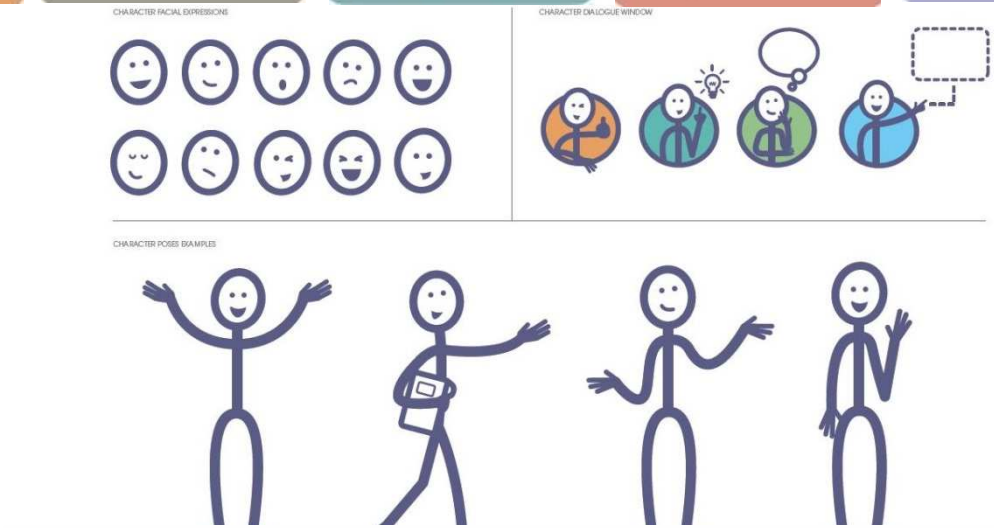
Widen the Ambassadors clinical/patients role

more outreach work needed, go out to communities and voluntary groups rather than host event where they would have to attend. Outreach not events

Wider awareness raising being planned with health watch groups Feb/March 2015



New public led creative designs narrative being launched February 2015



BCT Film → Updated Website → New documents

In development

Consultation process plan under development – February to May 2015

- Work stream agrees an engagement and consultation plan using **'intent form'**.
- Plans submitted to **Implementation** and **communications and engagement groups** – these are checked against legal and equality considerations
- Task and Finish – Review consultation plans
- Plans submitted **to Partner Boards, Partnership Board, HWBB,OSCs,**
- Task and Finish – Review consultation(s) groups
- Plans are implemented
- Results of consultation have **an independent analysis ie NHSE, OGC**

What methods should be used?

Multi layered approach

- Public & Patient Groups
- Healthwatch
- Voluntary & Community sector
- Outreach ie Local companies
- Coat tailing ie Council Tax bills
- Events & Meeting

Engagement – Use what is known to work

- Youtube
- Blogs
- Social media
- Connectors & messengers ie ambassadors

Experiment with others

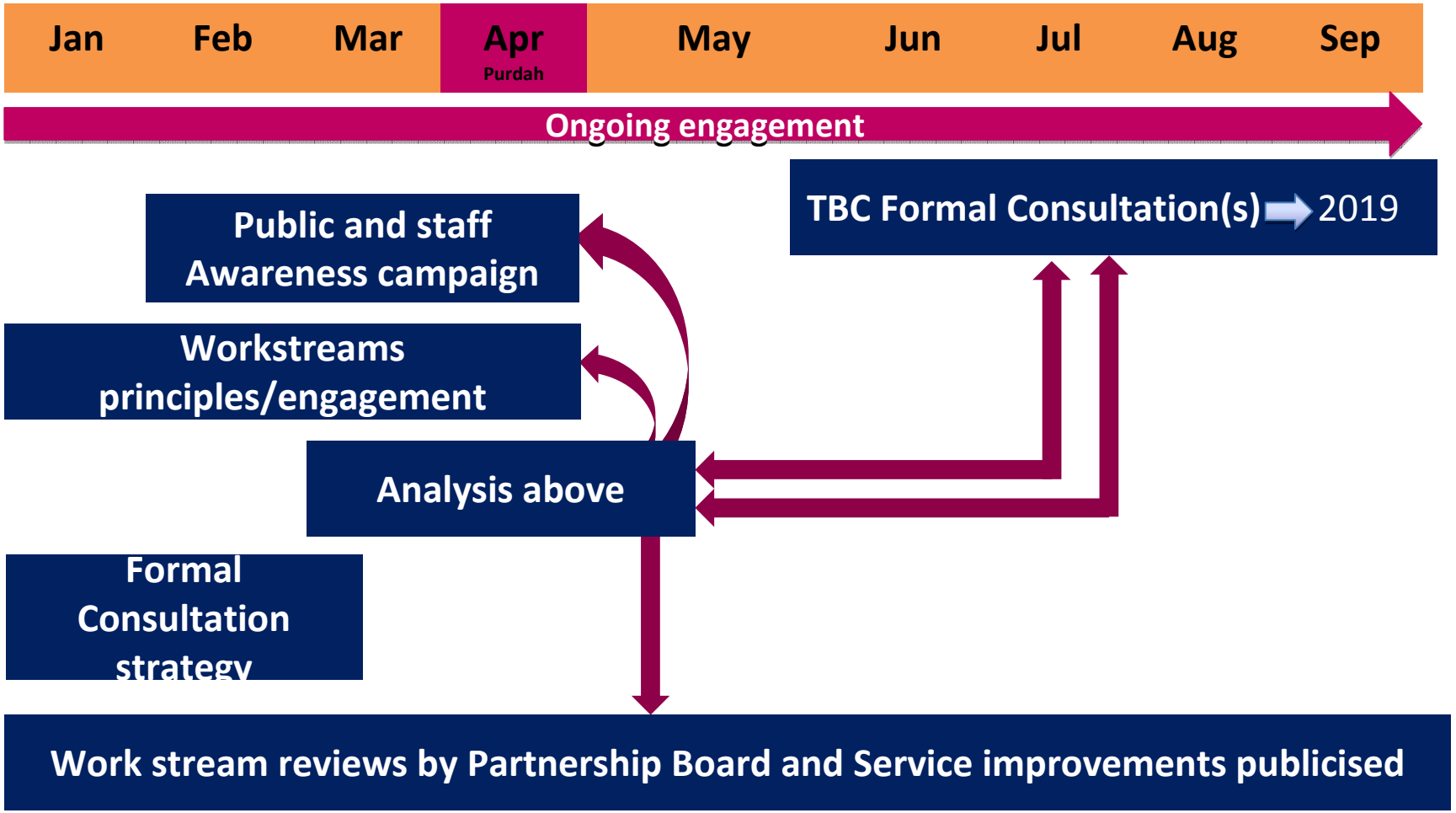
Right message

Right audience

Right time

Campaign Development

Timeline


Jan
Feb
Mar
Apr
Purdah
May
Jun
Jul
Aug
Sep
Ongoing engagement
TBC Formal Consultation(s)
2019
Public and staff Awareness campaign
Workstreams principles/engagement
Analysis above
Formal Consultation strategy
Work stream reviews by Partnership Board and Service improvements publicised


Questions &
Comments

PRESENTATION ON THE DEMENTIA STRATEGY

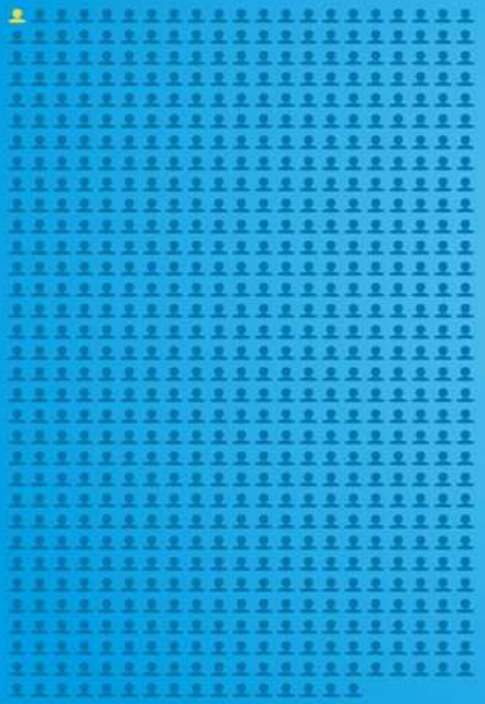
JOINT ADULT SOCIAL CARE AND HEALTH AND WELLBEING SCRUTINY COMMISSION - JANUARY 2015

NATIONAL AND REGIONAL INFORMATION OF INTEREST


850,000 people live with dementia in the UK
...if we don't take action this number is predicted to rise to over two million by 2051.
850,000
2015
1,142,677
...more than the entire population of Birmingham, the UK's second largest city.
2025
2,092,945
...more than the entire population of Liverpool, Manchester and Birmingham combined.
2051
Alzheimer's Society (2014a).
Dementia UK: second edition. London: Alzheimer's Society.
Alzheimer's Society
Leading the fight against dementia

The risk of dementia increases with age

1 in 688 people
under 65 have dementia.

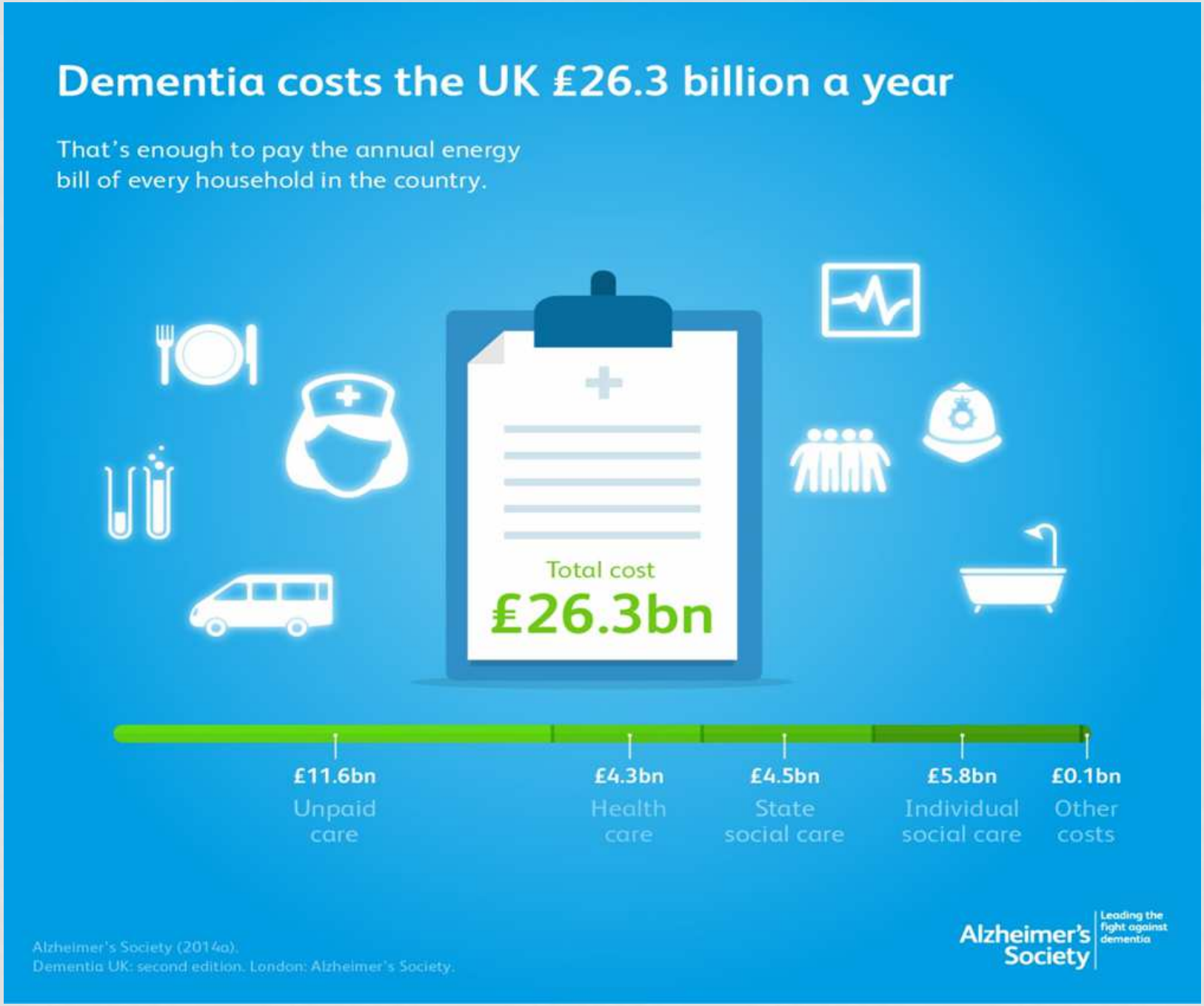


1 in 14 people
over 65 have dementia.

1 in 6 people
over 80 have dementia.

Alzheimer's Society (2014a).
Dementia UK: second edition. London: Alzheimer's Society. Based on 2013 figures

Alzheimer's Society | Leading the fight against dementia


Dementia costs the UK £26.3 billion a year
That's enough to pay the annual energy bill of every household in the country.
Total cost
£26.3bn
£11.6bn
Unpaid care
£4.3bn
Health care
£4.5bn
State social care
£5.8bn
Individual social care
£0.1bn
Other costs
Alzheimer's Society (2014a).
Dementia UK: second edition. London: Alzheimer's Society.
Alzheimer's Society
Leading the fight against dementia

UPDATE ON THE PROGRESS OF LLR JOINT DEMENTIA STRATEGY

DEMENTIA - ACHIEVEMENTS

- A memory assessment pathway has been developed from primary to secondary care and back into the community
- Respite care and response to crises are available through adult social care
- Carers receive information on dementia in primary and secondary care, via Dementia Care Advisors, the voluntary sector and from other services such as memory cafes, dementia activity groups
- Reablement and intermediate care pathways are being developed with input from staff working with people with dementia
- The memory pathway – Primary Care – Secondary Care (Memory Clinic) – Dementia Care Advisor is well established but the shared care protocol is not yet agreed
- Due to the successful increase in dementia diagnosis, the Dementia Care Advisor service is working to capacity. A service review has identified several options to resolve this, pending further refinement through the Better Care Together dementia workstream

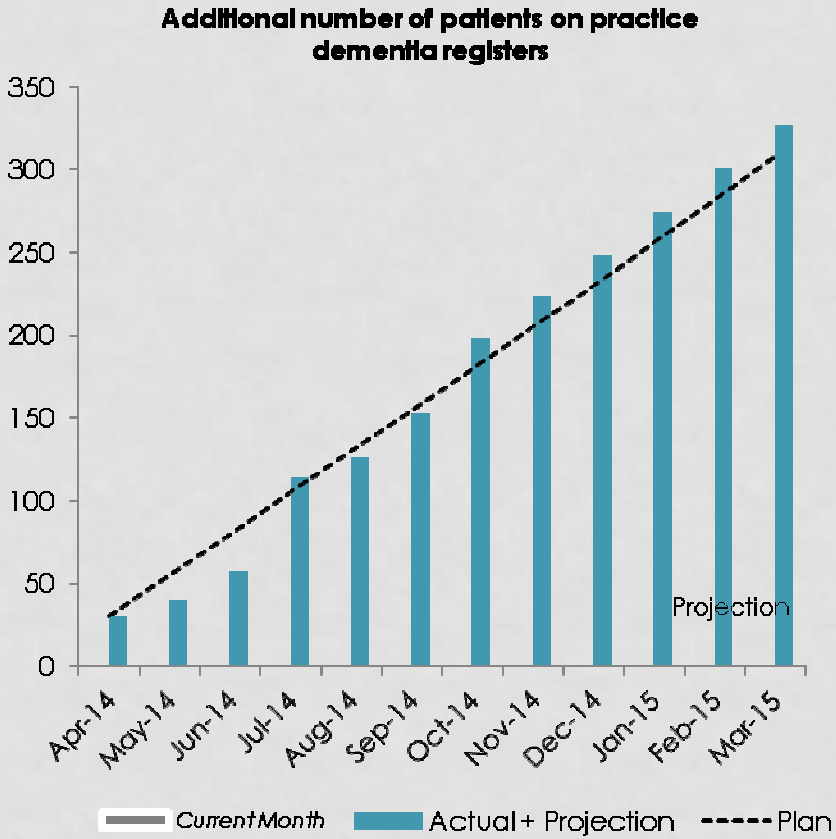
DEMENTIA - ACHIEVEMENTS

- People with dementia are supported to live independently and safely within their own homes through, for example, outcome focused domiciliary support, assistive technology and access to community services via Dementia Care Advisors – this supports the reduction of inappropriate hospital admissions
- Awareness of dementia and the availability of services continues to be raised through events such as Dementia Awareness week which was launched at the Shree Hindu Mandir Temple and Dementia Friends sessions which have been delivered locally to nearly 1000 people
- A Quality Assessment Framework is used to monitor the quality of care in residential and nursing homes – a dementia specific QAF will be developed – the East Midland Clinical Strategic Network is looking at a set of standards

DEMENTIA – WORK IN PROGRESS

- Better Care Together
  - Workstream under the Frail Older People priority of Better Care Together
  - Data gathering now
- NHS Monies allocated for continuation of Hospital Liaison Scheme
- Appointment of Project Lead awaited
- Regular liaison with BCT lead to raise awareness of pressures to inform development and resource allocation
- Potential project to explore the reasons for under representation of BME communities in dementia services

DEMENTIA - OBJECTIVES



- **Objective:**

Increase the number of patients on dementia register as % of the LCCCG Prevalence Rate to 67% (national average is 48%)

- **Current position:**

On target to exceed this target. If current trend is maintained, the CCG will achieve 72% by year-end

- **Other actions:**

Dementia awareness sessions have now been provided for approximately 350 practice/CCG staff

Dementia diagnosis now forms part of GP practice locality meeting agendas.

Following the excellent feedback from the Dementia Awareness Week launch event the CCG are looking at planning a series of 'mini-dementia roadshows' in partnership with the City Council.

CHALLENGES

- Increase in diagnosis whilst positive means more people needing support from
  - Dementia Care Advisors
    - Service just had a light review by ASC commissioners, highly valued but severe capacity issues
  - Community support services
    - No additional money – same services – more people
  - Secondary care
    - Additional referrals from primary care = longer waiting times
  - Primary care
    - Lack of shared care protocol = patients retained in secondary care
    - BCT will help with this
  - Carers services
    - No additional money – same services – more people
- Need to be clear about partner's responsibilities re funding and provision

DIAGNOSIS OF DEMENTIA IN LEICESTER ACCORDING TO WARD AREA

Ward name	Registered resident population	No. with Dementia	Est Prev of Dementia	DEM_UCL	DEM_LCL	Signif-icance cw Leicester	Signif-icance cw England
Abbey	15,948	48	0.30%	0.22%	0.39%	lower	lower
Aylestone	11,736	80	0.68%	0.54%	0.83%	higher	
Beaumont Leys	17,751	58	0.33%	0.24%	0.41%	lower	lower
Belgrave	13,085	41	0.32%	0.22%	0.41%	lower	lower
Braunstone Park and Fowley Fields	19,788	142	0.72%	0.60%	0.84%	higher	higher
Castle	25,758	52	0.19%	0.14%	0.25%	lower	lower
Charnwood	15,075	66	0.41%	0.31%	0.51%		lower
Coleman	15,719	65	0.39%	0.29%	0.48%		lower
Evington	11,875	88	0.70%	0.55%	0.85%	higher	
Eyres Monsel	12,599	95	0.75%	0.60%	0.90%	higher	higher
Fosse	13,576	68	0.50%	0.38%	0.62%		
Freemen	12,999	78	0.60%	0.48%	0.73%		
Humberstone and Hamilton	20,299	114	0.55%	0.45%	0.65%		
Knighton	18,220	124	0.68%	0.55%	0.80%	higher	
Latimer	15,351	41	0.27%	0.18%	0.35%	lower	lower
New Parks	18,754	94	0.50%	0.40%	0.60%		
Rushey Mead	17,502	84	0.48%	0.38%	0.58%		
Spinney Hills	28,608	81	0.29%	0.22%	0.35%	lower	lower
Stoneygate	23,125	67	0.29%	0.22%	0.35%	lower	lower
Thurncourt	11,039	90	0.81%	0.65%	0.98%	higher	higher
Westcotes	13,802	51	0.37%	0.27%	0.47%		lower
Western Park	10,898	58	0.53%	0.39%	0.67%		
Leicester	366,502	1,681	0.46%	0.44%	0.48%		lower
England	55,012,096	318,669	0.57%	0.57%	0.57%		
Leicester	378,433	1,745	0.46%	0.44%	0.48%		

Significantly higher than Leicester

Significantly lower than Leicester

DIAGNOSIS OF DEMENTIA IN LEICESTER ACCORDING TO ETHNICITY

Ethnic Category	Freq of dementia diagnosis (QOF)	Proportion	Lower	Upper	>65 in Leicester (Census)	Leicester Proportion
White/White British	1,172	78.8	76.7	80.8	26,035	70.0
Asian/Asian British	250	16.8	15.0	18.8	9,557	25.7
Black/Black British	44	3.0	2.2	3.9	1,115	3.0
Mixed	8	0.5	0.3	1.1	224	0.6
Other	13	1.1	0.7	1.7	285	0.8
Not recorded	383	100.2				
	1,870				37,216	

DEMENTIA - SUMMARY

- The LLR Joint Dementia Strategy finished in 2014.
- Dementia is identified as a priority in the Better Care Together Strategy.
- Awaiting Project Lead to drive forward
- Local Diagnosis rate is well above the national average.
- Memory Pathway is well established with supporting services but all under pressure
- Health & Well Being Strategy monitors delivery of the LLR Strategy
  - Indicator – number of people accessing community services

Care Act 2014
Briefing For Councillors November 2014

Care Act 2014	This is a very important piece of legislation, which will transform the practice of adult social work and care in England when it is implemented in April 2015. **It received Royal Assent on 14 May 2014** and the **final regulations were published on the 23 October 2014.** **The Care Act:** • Will apply from April 2015. • Is a new law about care and support for Adults in England. • Brings all the different laws on care and support together to make one new law instead. • Says what people mainly over 18, who need care and support should be able to get. • says what council's will have to do and gives clear guidance about the law.
Why does it matter?	The Care Act means: • The council will need to work in different ways, which means a cultural change for staff and partners. Social workers will be required to actively support people to choose, control and manage their own care. • People who need care and support will need to think differently about how the council and their partners can help them make their lives better, and remain independent as long as possible. • The council will need to make changes to IT systems. • Councils must think about education, training and work when they look at a person's care and support needs. • Services like Health, Housing, Children's Services, employment and training and the police will need to co-operate with the council and work much closer together. • Adults Social Care will need to work with Children's Services before children are 18, to help children and their carers' plan for the future and the support they might need as an adult, this may include training or/and employment. All these changes means there will be major impacts on the council's costs and on the workforce.
What are the Key changes	<u>General responsibilities</u> • **Well-being**: councils must always consider how to give people the care and support to make their lives better in all decisions regarding an individual's care and support needs. • **Prevention and reduce**: councils must think about services that stop problems before they start, or stop them getting worse as early as possible. • **Joining up care and support**: new duties on councils to join up care and

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support with health and housing (**Better Care Fund)**

- **Information advice service for everyone**: councils must give information and advice to everyone who wants it, not just people who have their care and support paid for by the council. This now also includes independent financial advice to help people understand what support they'll need to help them better plan for the future. The council will need to provide information on how the system operates in their area, the choice and types of care and support, how to access care and support, how to access independent financial advice on care issues, and how to raise issues of concern.

Assessing needs

- **Carers rights to assessments**: For the first time carers have rights to assessments and eligibility for services from local authorities. All council's will follow the same criteria.
- **Independent advocacy**: for people who find it very difficult to be involved at any stage of their assessment or care planning, and there is no-one else to speak for them then the council must find them an independent advocate.
- **A new national eligibility threshold**: There is a new national eligibility criteria for adults who need care and support, which is similar to the council's current 'critical and substantial' threshold and so is not expected to lead to greater numbers of people being eligible. All local authorities will have the same rules to follow. Adults and carers who are not eligible for care and support will have to have written advice on 'what can be done to meet or stop them getting worst.

Funding and charging

- **Limit on how much a person will have to pay:** If people have enough money they will need to pay for their care and support, however, from April 2016 there will be limit or cap on how much a person will have to pay during their lifetime for their care and support. The Care Act Introduces a £72,000 cap on lifetime costs of care**.** There will be a lower limit for people of working age who develop care needs before retirement age (details are still being worked out). A zero cap for people aged 18 who are eligible; they will receive free care and support to meet those needs for the rest of their lives. The Government is considering extending this to 25.
- An increase to £118,000 on the upper threshold for receiving means tested support.
- **Universal deferred payment scheme**: People who need residential care and own their own home may not have to sell their home to pay for their care straight away. They can make an agreement with the council.
- **Gives new rights to self-funders** – people who pay for their own care and support and have eligible needs must be given an independent personal

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budget, which tells them the amount of money that the council has worked out it will cost to arrange the necessary care and support. The council must also give them an Individual care account to keep a record of how much they have spent on their care and support and inform them when they reach their limit or cap.

Moving to a different area

- **If a person wants to move to a new area:** the council will have to, for the first time, inform the relevant council in the area the person wants to move to. The new council will have to carry on meeting the person's needs straight away until such time as they are able to review the person's needs.

Keeping adults safe

- **Safeguarding:** For the first time there is a law telling councils what to do to help keep adults safe from abuse or neglect. The council already has a Safeguarding Board, however, this is now a statutory requirement.

Transition from Children Services

- Sets out a new range of duties to support transitions from children's to adults services **including carers of children and young people.** It will aim to support independence and help them gain training and employment. There are Significant links with the Children's and Families Act 2014 - See SEND Code of practice 0-25 years

Choice of high quality providers

- **A new duty requiring local authorities to promote the diversity and quality of local services**; councils must make sure there are lots of different care and support services in their area, so that there is a range of high quality providers in all areas allowing people to make the best choice to satisfy their own needs and preferences. This should be provided for all residents including self-funders and direct payment recipients.

  In ensuring this variety of services, council's must have regard to the importance of enabling carers or people with care needs who wish to participate in work, education or training to do so.

Market Oversight and provider failure

- Introduces a **new regime to oversee the financial stability of the most hard to replace care providers,** and ensure that care will not be interrupted if providers fail.
- The **CQC** has published guidance on the new system for regulation and inspection of adult social care services in England, which will be rolled out from October 1.

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	• Sets out Ofsted-style ratings for hospitals and care homes so that patients and the public can compare organisations or services in a fair and balanced way and make informed choices about where to go. • Makes it a criminal offence for health and care providers to supply or publish false or misleading information Delegation of local authority functions • This allows local authorities to authorise a person to exercise certain functions on its behalf and could pave the way for external organisations to provide support assessment and support planning functions
When will the changes come into effect?	The majority of the new duties and responsibilities of the Care Act will come into effect in **April 2015** and the major **financial reforms** i.e. Cap on Care costs, duty to provide care accounts and duty to provide independent personal budgets in **April 2016.**
Final Regulations and Guidance	Following consultation in June 2014 the final statutory guidance and regulations were released on 23 October 2014.
Further details for councillors	If you need further information about any of the Care Act please contact Gwen Doswell, Programme Manager Transformation, Tel: 0116 4542302 gwen.doswell@leicester.gov.uk. To help Councillors deal with constituent enquiries, Councillors will be sent briefings on the Care Act between now and 1 April 2015.
Further Information	Care Act 2014 http://www.legislation.gov.uk/ukpga/2014/23/contents/enacted The Department of Health has produced 19 Fact sheets at : https://www.gov.uk/government/publications/care-act-2014-part-1-factsheets Government response to draft regulations and guidance 23 October 2014 NHS Choices – Social Care Services directory The Children's and Families Act 2014: Code of practice: https://www.gov.uk/government/publications/send-code-of-practice-0-to-25
Progress by Leicester City Council	Leicester City Council is preparing for the changes planned from April 2015 and has set up a programme board to oversee implementation and compliance. The work of the programme is co-ordinated by Gwen Doswell, Programme Manager to ensure that change is aligned across the department's major change programmes.
councillors briefing was produced by	Adult Social Care, Transformation Team, Bosworth House, Tel: 0116 454 2302 Email: gwen.doswell@leicester.gov.uk 20 November 2014

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JOINT Health and Adult Social Care Scrutiny Commission meeting "Implementing the Care Act 2014"

27th January 2015

Care Act 2014

Leicester City Council

Purpose of the Act

* **The Care Act 2014 is intended to achieve 4 things-**
  - Create the primary legislation needed to enact the recommendations in the White Paper *Reforming Care and Support: Caring for our future*
  - Implement the recommendations on reforming the funding of care and support (Dilnot)
  - Meet the recommendations of the Law Commission report on modernising Adult Social Care legislation
  - Enact elements of the government's response to the Mid- Staffordshire NHS Foundation Trust Public Enquiry (Francis)

Key Milestones

* Oct 2014 - Final Statutory Guidance released (for changes that come in on 1st April 2015)
* Oct 2014 - Final funding allocations from Government
* Oct 2014 - CQC implement new regulation & inspection system including ratings
* April 2015 – Care Act Provisions in Force (excl funding reform)
* April 2016 - Care Act Provisions in Force (incl funding reform)

Care Act 2014 – General Responsibilities

1. Explicit requirement to consider people' s well-being when commissioning services

2. Focus on preventing, reducing and delaying care and support needs

3. Need to join up care and support with health and housing via the Better Care Together Programme

4. A requirement to provide Information, Advice and Guidance, including independent financial advice relating to paying for care

Care Act 2014

Leicester City Council

Care Act 2014 – Assessing Needs

From 1st April 2015

1. Carers will have the right to assessments

2. The provision of independent advocacy to help people to exercise their rights to social care

3. Introduction of a national eligibility threshold

4. New duties in respect of prisoners rights to social care

Eligibility

* The variable threshold introduced under FACS will be replaced by a national threshold that councils must comply with

* New national criteria is intended to be equivalent to “substantial”

Care Act 2014 – Other

From 1st April 2015

1. Statutory requirement for a new Adult Safeguarding Board

2. New Care Quality Commission inspection and rating regime (started October 2014)

3. Transitions – link to Children's and Families Act 2014 – support 0 to 25 years

4. Delegation of local authority functions

5. Market oversight and provider failure

6. Market shaping

7. Universal deferred payment scheme

Care Act 2014 – Funding and Charging

From April 2016

1. A cap on lifetime costs of care (proposed at £72,000 for people 65years and over)

2. Introduction of Individual Care Accounts

3. Increase to means test threshold to £118,000

Care Act 2014

Leicester City Council

Increased Demand

*__Self-funders:__ increase in numbers seeking needs assessments and financial assessments to start Care Account - estimate for Leicester 2015/16 – **1009**

*__Carers:__ Significant increase for carers' assessments and young carers assessments (estimated for Leicester **3949** over 18yrs old)

Care Act 2014

Leicester City Council

Challenges to Implementing the Care Act 2014

* Understanding the nature of change and increased demand
* Training the workforce
* Communicating with the right people at the right time
* Financial modelling for the funding changes in April 2016
* Changes to the IT system

Care Act – National and Local Public Information Campaign

National (02/02/15-23/03/15)

1. **Radio Advertising** (Gold, Smoth East Midland radio stations, Gem 106 (02 Feb to 15 March)

2. **Door Drop Leaflets** (23,074 households) Covering 11 wards (17-28 Feb) : -
-LE4 6 (Latimer, Belgrave and Rushey Mead)
-LE4 7 (Rushey Mead and Belgrave)
-LE5 2 (Thurncourt, Hamilton and Evington
-LE5 5 (Evington, Spinney Hills and Stoneygate

3. **GP Waiting Rooms** (16 Feb – 15 March) Screen information and leaflets

4. **National Media editorials** (16 Feb – 15 March)

Local (30/01/15 - 17/02/2015)

- **Letter** to existing care and support users and carers
- **Letter to all ward councillors** where door drop leaflets are being delivered
- **Councillors Care Act Briefing** Jan/Feb (30 January 2015)
- www.leicester.gov.uk/careact
- **Information screen at City Hall**
- **Voluntary and Community/ Groups/Providers/Leicester CCG/UHL**
    - Leaflets (electronic)
    - Links to websites
    - Article in newsletters
- **Link** (February 2015)