Leicester
City Council

MEETING OF THE HEALTH AND WELLBEING SCRUTINY COMMISSION

DATE: THURSDAY, 5 JULY 2018
TIME: 5:45 pm (please note amended start time)
PLACE: Meeting Room G.01, Ground Floor, City Hall, 115 Charles Street, Leicester, LE1 1FZ

Members of the Commission

Councillor Cutkelvin (Chair)
Councillor Fonseca (Vice-Chair)

Councillors Chaplin, Cleaver, Dr Moore, Pantling, and Dr Sangster.

I unallocated Non-Group place.

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

Standing Invitee (Non-voting)

Representative of Healthwatch Leicester

JHarget

For Monitoring Officer

Officer contacts:
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Leicester City Council, City Hall, 115 Charles Street, Leicester, LE1 1FZ

Information for members of the public

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Further information
If you have any queries about any of the above or the business to be discussed, please contact Julie Harget**, Democratic Support on (0116) 454 6357 or email julie.harget@leicester.gov.uk** or call in at City Hall, 115 Charles Street, Leicester, LE1 1FZ.

For Press Enquiries - please phone the **Communications Unit on 454 4151**

USEFUL ACRONYMS RELATING TO
HEALTH AND WELLBEING SCRUTINY COMMISSION

Acronym	Meaning
AEDB	Accident and Emergency Delivery Board
CAMHS	Children and Adolescents Mental Health Service
CHD	Coronary Heart Disease
CVD	Cardiovascular Disease
CCG LCCCG	Clinical Commissioning Group Leicester City Clinical Commissioning Group
COPD	Chronic Obstructive Pulmonary Disease
CQC	Care Quality Commission
DTOC	Delayed Transfers of Care
ED	Emergency Department
EHC	Emergency Hormonal Contraception
ECMO	Extra Corporeal Membrane Oxygenation
EMAS	East Midlands Ambulance Service
GPAU	General Practitioner Assessment Unit
HALO	Hospital Ambulance Liaison Officer
JSNA	Joint Strategic Needs Assessment
PCT	Primary Care Trust
PICU	Paediatric Intensive Care Unit
PHOF	Public Health Outcomes Framework
RSE	Relationship and Sex Education
STP	Sustainability Transformation Plan
UHL	University Hospitals of Leicester
UEC	Urgent and Emergency Care

PUBLIC SESSION

AGENDA

FIRE / EMERGENCY EVACUATION

If the emergency alarm sounds, you must evacuate the building immediately by the nearest available fire exit and proceed to the area outside the Ramada Encore Hotel on Charles Street as directed by Democratic Services staff. Further instructions will then be given.

1. APOLOGIES FOR ABSENCE

2. DECLARATIONS OF INTEREST

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

3. MINUTES OF PREVIOUS MEETING

The minutes of the meeting held on 7 March 2018 have been circulated and the Commission will be asked to confirm them as a correct record.

4. CHAIR'S ANNOUNCEMENTS AND UPDATE ON PROGRESS WITH MATTERS CONSIDERED AT A PREVIOUS MEETING

5. PETITIONS

The Monitoring Officer to report on the receipt of any petitions submitted in accordance with the Council's procedures.

6. QUESTIONS, REPRESENTATIONS, STATEMENTS OF CASE

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

7. MEMBERSHIP OF THE HEALTH AND WELLBEING SCRUTINY COMMISSION

Members are asked to note the membership of the Commission as detailed on the front of the agenda.

8. DATES OF MEETINGS OF THE HEALTH AND WELLBEING SCRUTINY COMMISSION

Members are asked to note the dates of further meetings of the Health and Wellbeing Scrutiny Commission as detailed below:

23 August 2018
11 October 2018
29 November 2018
15 January 2019
12 March 2019

All meetings will commence at 5.30 pm.

9. TERMS OF REFERENCE — Appendix A (Pages 5 - 6)

Members are asked to note the Terms of Reference for the Health and Wellbeing Scrutiny Commission.

10. INTEGRATED LIFESTYLE SERVICES - CONSULTATION FEEDBACK AND FINAL PROPOSALS — Appendix B (Pages 7 - 18)

The Director of Public Health submits a report that provides consultation feedback and final proposals on the Integrated Lifestyle Services.

Members are asked to:

- Note the themes emerging from public consultation and their impact on the proposed model;
- Note the associated savings to be achieved;
- Note the risks associated with the implementation of this service and proposed mitigations; and
- Feedback comments on the proposed model to the Executive.

Members of the Heritage, Culture, Leisure and Sport Scrutiny Commission have received an invitation to attend and participate in the consideration of this item.

11. LEICESTER ROYAL INFIRMARY (EMERGENCY DEPARTMENT) PHASE TWO — Appendix C (Pages 19 - 24)

The Commission will receive a report which provides an update on Phase Two

of the work to create an Emergency Floor at the Leicester Royal Infirmary. Members are asked to comment on the report as they see fit.

12. REFRESH OF 2017/18 AND 2018/19 OPERATIONAL PLAN FOR LEICESTER CITY CLINICAL COMMISSIONING GROUP **Appendix D (Pages 25 - 164)**

Sarah Prema, Director of Strategy and Implementation and Michelle Iliffe, Director of Finance, will be in attendance to present the Refresh of the 2017/18 and 2018/19 Operational Plan for the Leicester City Clinical Commissioning Group (CCG). NHS organisations are required to produce an Operational Plan as per the planning guidance issued by NHS England in February 2018.

The Scrutiny Commission is asked to note and comment on the Refresh of the Operational Plan.

The national NHS Operational Planning and Contracting Guidance 2017-19 document can be found on the following link:

https://www.england.nhs.uk/wp-content/uploads/2016/09/NHS-operational-planning-guidance-201617-201819.pdf

A refresh of the above NHS Operational Planning Guidance can be found on the following link:

https://www.england.nhs.uk/wp-content/uploads/2018/02/planning-guidance-18-19.pdf

13. UPDATE ON INTEGRATED SEXUAL HEALTH SERVICES

The Director of Public Health will provide Members with an update on the new Integrated Sexual Health Services.

14. WORK PROGRAMME **Appendix E (Pages 165 - 170)**

The Scrutiny Policy Officer submits a document that outlines the Health and Wellbeing Scrutiny Commission's Work Programme for 2018/19. The Commission is asked to consider the Programme and make comments and/or amendments as it considers necessary.

15. ANY OTHER URGENT BUSINESS

For Members to note:

The following are the responses to the questions submitted by Sally Ruane, to the meeting of the Health and Wellbeing Scrutiny Commission held 7 March 2018. The questions were raised under agenda item 6, Questions, Representations and Statement of Case and related to the Sustainability and Transformation Partnership for Leicester, Leicestershire and Rutland and associated issues.

Can the STP leads give any clarity regarding precisely (rather than impressionistically) how an Accountable Care System (ACS) in LLR would differ from current arrangements? What legal basis is there for an ACS?

In April 2018, a number of areas across England will start to operate as an integrated care system (previously known as an Accountable Care system). Many of these new systems, which include areas such as Greater Manchester, Buckinghamshire and Lancashire, are building on the work of the new models programme and Vanguards in their areas. These Vanguards have demonstrated that if you empower local systems to lead change in their community, with some national support to overcome common barriers, real progress can be made.

Areas operating as integrated care systems will be using a population health management approach to redesign services. They will be backed by greater flexibilities and financial incentives. For example, they will receive sustainability funding only if they deliver as a system. These systems will also benefit from a more grown-up regulatory relationship as they take on greater autonomy for managing their own performance.

In Leicester, Leicestershire and Rutland Better Care Together is about creating far greater collaboration and closer working across partners to achieve improvements on the ground to the way services are delivered for patients. This would be through multi-disciplinary teams involving GP practices, community and, social care, mental health and voluntary sector workers, who will work to prevent hospital admissions, reduce patient length of stay in hospital, increase staff satisfaction and improve patient and user experience.

Conversations are ongoing about the local approach to integrated care and no arrangements will be put in place in 2018/19. Partners in health and social care continue to shape integration that will provide better care for people and through Better Care Together we will continue to engage with patients, service users, staff and stakeholders about these future models of care.

What legal basis is there for an ACS?

You may find it useful to visit the following website on Integrated Care System.: https://www.england.nhs.uk/systemchange/integrated-care-systems/

What planning period is being used as the basis for STP proposals and is this adequate?

The STP through Better Care Together is an ongoing iterative process and subject to new and revised guidance and feedback on proposals and plans from NHS England, NHS Improvement and the Department of Health. This is in addition to the feedback that we receive from stakeholders locally.
It will continue to be iterative and all areas of work – whether subject to formal consultation or not – will be included in emerging operational plans at both an organisation and Better Care Together work stream level.

What is the estimated deficit in current acute bed numbers revealed by the winter crisis, black alerts, critical incidents etc and how does this affect the STP?

We do have a deficit in current acute beds. Based on occupancy, speciality and seasonality the gap can vary considerably. The gap is largely due to a growing population. Unprecedented pressures over the winter did contribute to this number.

Through the ongoing acute reconfiguration and the review of community services we will see a revision in bed numbers in Leicester's hospitals. The outcome of these reviews will form proposals for change which will be subject to public consultation.

Within the 2016 draft STP, there was a requirement to make savings to the tune of £29m (rumoured to be higher in the 2018 STP) from the Continuing Healthcare Budget. With City & WL CCGs agreeing a very different Settings of Care Policy from ELR CCG, how will the STP deal with the inequalities that will arise across LLR?

All patients in Leicester, Leicestershire and Rutland are assessed on a case by case basis and regardless of the CCG area that the patient resides in, they will continue to be100% funding based on their health care needs assessed through the Continuing Healthcare Budget.

How can the proposed formal public consultation on acute and maternity reconfiguration be genuine when ITU at the General is planned for closure?

Before any significant changes are made we will be consulting the public in Leicester, Leicestershire and Rutland. Clinicians have told us what they think would be best for the service users and public but we intend to test those assumptions not least with the public but also our senior stakeholders such as the Health Scrutiny and regulatory bodies.

We will only be able to begin formal consultation when we've been through a number of regional and national checkpoints to assess the clinical and financial cases.

Why does the revised STP continue to be withheld from the public? When will it be made available and when will the formal public consultation begin?

After what has been an extremely difficult and challenging winter, we are currently taking stock and reviewing our plans to ensure that they are appropriate and deliverable. We will soon be in a position to provide more information on the next steps.

Any major changes proposed will be subject to formal consultation. That will include acute reconfiguration, maternity services and the community hospital estate. We'll only be able to begin formal consultation when we've been through a number of regional and national checkpoint processes to assess the clinical and financial cases. That's a lengthy process and means we can't put a definitive timescale on consultation just yet. However, the fact that we secured £40m of capital in 2017 gives us confidence that there's still national support for our plans being a priority.

Sue Venables
Head of Communications and Engagement – Better Care Together

SCRUTINY COMMITTEES: TERMS OF REFERENCE

INTRODUCTION

Scrutiny Committees hold the executive and partners to account by reviewing and scrutinising policy and practices. Scrutiny Committees will have regard to the Political Conventions and the Scrutiny Operating Protocols and Handbook in fulfilling their work.

The Overview Select Committee and each Scrutiny Commission will perform the role as set out in Article 8 of the Constitution in relation to the functions set out in its Terms of Reference.

Scrutiny Committees may:-

i. review and scrutinise the decisions made by and performance of the City Mayor, Executive, Committees and Council officers both in relation to individual decisions and over time.

ii. develop policy, generate ideas, review and scrutinise the performance of the Council in relation to its policy objectives, performance targets and/or particular service areas.

iii. question the City Mayor, members of the Executive, committees and Directors about their decisions and performance, whether generally in comparison with service plans and targets over a period of time, or in relation to particular decisions, initiatives or projects.

iv. make recommendations to the City Mayor, Executive, committees and the Council arising from the outcome of the scrutiny process.

v. review and scrutinise the performance of other public bodies in the area and invite reports from them by requesting them to address the Scrutiny Committee and local people about their activities and performance; and

vi. question and gather evidence from any person (with their consent).

- **Annual report:** The Overview Select Committee will report annually to Full Council on its work and make recommendations for future work programmes and amended working methods if appropriate. Scrutiny Commissions / committees will report from time to time as appropriate to Council.

The Scrutiny Committees which have currently been established by the Council in accordance with Article 8 of the Constitution are:

- Overview Select Committee (OSC)
- Adult Social Care Scrutiny Commission

- Children, Young People and Schools Scrutiny Commission
- Economic Development, Transport and Tourism Scrutiny Commission
- Health and Wellbeing Scrutiny Commission
- Heritage, Culture, Leisure and Sport Scrutiny Commission
- Housing Scrutiny Commission
- Neighbourhood Services and Community Involvement Scrutiny Commission

SCRUTINY COMMISSIONS

Scrutiny Commissions **will**:

- Be aligned with the appropriate Executive portfolio.
- Normally undertake overview of Executive work, reviewing items for Executive decision where it chooses.
- Engage in policy development within its remit.
- Normally be attended by the relevant Executive Member, who will be a standing invitee.
- Have their own work programme and will make recommendations to the Executive where appropriate.
- Consider requests by the Executive to carry forward items of work and report to the Executive as appropriate.
- Report on their work to Council from time to time as required.
- Be classed as specific Scrutiny Committees in terms of legislation but will refer cross cutting work to the OSC.
- Consider the training requirements of Members who undertake Scrutiny and seek to secure such training as appropriate.

Appendix B

Health and Wellbeing Scrutiny Commission

Date: 5th July 2018

Title: Integrated Lifestyles Services- Consultation Feedback and final proposals

Lead director: Ruth Tennant

Useful information

- Ward(s) affected: all
- Report author: Ryan Swiers/Jo Atkinson
- Author contact details: ryan.swiers@leciester.gov.uk / jo.atkinson@leicester.gov.uk

0116 4542032

- Report version number: 1

1. Summary

In February this year the Executive approved outline proposal to develop a new integrated lifestyle service following a period of review and a number of earlier papers on these service. These proposals were also shared with an informal meeting for members of the Health and Heritage, Culture, Leisure and Sports Scrutiny Commissions.

This was followed by a period of public consultation which lasted for 8 weeks and was supported by focus groups specifically looking at areas of the proposal which it was felt would benefit from more in-depth insight (weight management, volunteer role and digital services).

The response to the public consultation is detailed in this paper. This response has informed the final proposal for Integrated Lifestyle Services. These proposals have been endorsed by the Executive, pending feedback from Health Scrutiny.

Key themes emerging from the consultation were;

- Support for a shift to integrated lifestyle services with a single booking function
- Support for retaining some specialist staff within this model
- Support for volunteers to be involved in services, as long as sufficient training and support is in place
- Support for greater use of digital services to be developed as long as face to face help continues to be available for people who need it most.

In light of this the proposed new model will;

- Bring staff from a range of existing services (stop smoking service, active lifestyle

City Mayor

scheme, healthy lifestyle hub) together in an integrated team
- Train all staff to deliver brief advice around a range of healthy lifestyles topics but retain subject level expertise
- Development of a comprehensive volunteer training package and recruitment of a co-ordinator post to support this aspect of the service
- Digital services- utilise existing resources such as 'One You' tools and monitor the reach of these services in relation to inequalities

2. Recommendations

- Scrutiny Commission members are asked:
- To note the themes emerging from public consultation and their impact on the proposed model
- To note the associated savings to be achieved
- To note the risks associated with the implementation of this service and proposed mitigations
- To feedback comments on the proposed model to the Executive.

3.

3.1 Background

LIFESTYLE SERVICES – THE CURRENT PICTURE

The city council is currently responsible for a number of lifestyle services (see below) at a total cost of £1.768m in 2017/18. These aim to reduce preventable ill-health in adults, particularly cardio-vascular disease and preventable diabetes, by acting early to support people to make lifestyle changes which will reduce the risk of them going on to develop these conditions.

Since 2015, there have been a number of changes made to our lifestyle services. This has included:
- Focusing weight management on highest risk groups and ceasing funding for Weight Watchers where there is now evidence that people will pay for this themselves.
- Reducing expenditure on smoking, reflecting reductions in demand for the service predominately as a result of increased use of e-cigarettes
- Reducing waiting times and improving retention rates for the Active Lifestyle scheme.

These changes have reduced overall expenditure on these services from £2.2 million in 2016/17 to £1.8 million in 2017/18.

The service review and informal community & stakeholder consultation carried out as part of this review showed:

- Lack of integration and fragmentation between the different lifestyle services
- 'Gold-standard' but high-cost 1-1 support in several of these services
- Lack of on-line or digital provision resulting in high referrals to 1-1 services
- Under-utilisation of other local resources such as existing volunteering schemes, outdoor gyms, community exercise programmes provided by professional sports clubs.
- Potential for improved integration with other council services, particularly adult social care
- Strong support for a single integrated lifestyle where people can tell their story once and which offers an easy point of referral for GPs and other health/ care professionals.
- Continued need for early intervention to reduce high levels of preventable heart

disease, diabetes in working-aged adults in the city, particularly in the most deprived parts of the city
- Significant scope to develop existing lifestyle services to also tackle low level mental health and social isolation
- Under-utilised potential to increase referrals to specialist alcohol treatment services (Turning Point)
- Potential to introduce charging for elements of the service in line with leisure centre pricing.
- Emerging evidence from other parts of the country which have already moved to integrated services of good outcomes

Further changes to lifestyle services are proposed for 2 reasons. Firstly to ensure services are continually improving and the client experience is improved. Secondly in order to meet spending review targets further efficiencies to services are required.

Lifestyle services will contribute £1.35 million towards the current spending review. This level of saving cannot be achieved without significant changes to services and whilst this presents opportunities for greater integration and more innovative working there are inevitably considerable challenges in ensuring services continue to deliver high quality and achieve positive health outcomes.

Proposes changes are part of a broader ongoing piece of work across the division of Public Health and Sports Services to transform services to be focussed on health and wellbeing. This work includes a programme of activities around developing the council's leisure centre offer to improve and modernise leisure services to ensure they are inclusive and well utilised. The integrated lifestyle service will also support work aimed at utilising community assets such as parks, outdoor gyms and walking/cycling to increase physical activity and support positive mental wellbeing.

Consultation has taken place to gain the views of staff and the public on proposals for lifestyle services in order to help refine proposals aimed at improving quality and reducing costs.

3.2 Consultation feedback

171 people completed the consultation (online and paper) over an 8 week period between April and June. The consultation was promoted via citizenspace and the standard council media channels. In addition the CCG, VAL and a wide range of community groups were proactively contacted and encouraged to participate.

It should be noted that whilst 171 people responded to the consultation many questions were answered by low numbers of people. It is not possible to draw conclusions about the representativeness of those who completed the consultation or participated in focus groups. It is also important to note that over 50% of responses came from staff/people in a professional capacity. A breakdown of response rate by question is available.

In addition to the online consultation a number of focus groups were held during the consultation period with a specific focus on exploring the issues of weight management services, the role of digital resources and the involvement of volunteers in a new service. Below is a brief summary of the consultation and focus groups responses;

- Overall support for a shift towards integrated services with responses suggesting this would make services more user friendly
- A single booking system was well received
- There was support for group based sessions with people seeing this as a means of extra support. Whilst most people did not respond to this question (<30%) there was less support for stop smoking services than weight management, diet/physical activity
- A recognition that there was not a 'one size fits all' and that 1:1, group based and online

had a role to play
- The key features affecting sessions included time location and cost. Friendly staff was cited as the biggest factor determining how successful sessions would be
- People expressed a desire for sessions to be offered at evenings and weekends
- A wide range of settings were seen as suitable with leisure centres (61), community centres (41), parks and outdoor (38) spaces being most popular
- Strong support for developing a more extensive walking programme with people suggesting guided and group walks as a good idea
- The increased use of volunteering was generally supported although there were concerns that this should not be used a mean to replace qualified staff
- There were concerns about an integrated service having a generic member of staff and responses were in favour of retaining specialist staff
- Regarding online services there was some concern via the consultation and focus groups about a complete shift to digital services and potential risks of exclusion
- Whilst there were limited responses to questions relating to wider services such as housing and debt management there was generally support for this especially as a signposting function
- Greater use of community assets was also mentioned
- There was a number of comments relating to the role of wider determinants such as takeaways, advertising and sustainable travel

Based on the consultation feedback including areas of concern for those responding, the following considerations will be reflected in the final model for integrated lifestyle services.

- Retention of some specialist staff e.g. specialist smoking advisors but seek to ensure all staff are trained to provide low level brief advice across a range of healthy lifestyle topics
- A move to implement group based sessions gradually whilst investigating their effectiveness locally rather than an immediate shift to default group sessions in all services e.g. stop smoking
- It is not the intention of the new service to make a wholesale shift online but rather to ensure the council is utilising the potential for digital services to support self-care. The new service will ensure that digital services help to effectively manage demand without marginalising those with limited access/capability
- A Leicester-wide lifestyle service will encompass differences in delivery across communities to reflect differing community needs and assets
- Volunteering within the new service will be well supported by a volunteer co-ordinator and training package. Furthermore the nature of volunteering will vary across behaviour change topic, for example volunteers may be more active in a walking programme than stop smoking services
- Digital services will become more prominent in our lifestyle services without replacing a face to face offer. Initially the digital offer will provide a safe and trustworthy source of information on healthy lifestyles with details of accredited apps and resources.
- Digital services will also explore 'light touch' interventions for those with capacity to enable better use of resources. A text reminder service will also be investigated. Any use of digital services will pay due regard to their impact on inequalities.
- Evaluation to consider the effectiveness of changes such as group based sessions and single booking system (available online and by phone) on health outcomes, inequalities, cost effectiveness and customer satisfaction

3.5 Next steps

Public consultation has shown support for proposals to shift lifestyle services towards an integrated model with a single hub function and booking system whilst retaining professional expertise in different topic areas. A single hub and case management system will allow more holistic support for clients and reduce the opportunities for duplication and/or gaps between

services.

An increased role for volunteers and an extended programme of walking will be included as will a shift to support more community based activities including existing sessions and outdoor gyms. As part of a shift to maximise digital services an online platform will bring together safe and reliable health information and existing apps and online support such as the couch to 5k app.

Discussions have taken place with local NHS partners to ensure services are embedded in clinical pathways and health professionals make appropriate referrals. This work will continue to ensure a joined-up approach to supporting healthy lifestyles in Leicester City.

A comprehensive evaluation will accompany the new service to consider the effectiveness of the model overall and the separate elements within in.

Weight management

Feedback in relation to weight management services was broadly similar to that regarding other aspects of the proposed model. Respondents favoured group sessions and recognised that online support could be helpful as could volunteers to support sessions.

Targeted weight management services will continue within the integrated lifestyle service from April 2019 although the provider will continue to be externally commissioned. At present these services are provided via the Diet, Health and Activity in Leicester (DAHL) and Lifestyle, Eating and Activity Programme (LEAP) groups. The consultation has supported the existing view that some groups derive significant benefit from bespoke services above and beyond mainstream weight management programmes.

The proposed new service has a 'go-live' date of April 2019.

4. Financial, legal and other implications

4.1 Financial implications

By 2019/20 the Lifestyle Services will achieve their full savings target although this will require use of reserves for a short period until the plans are fully implemented.

Rohit Rughani
Principal Accountant

4.2 Legal implications

The preferred option is to integrate the Lifestyle services. Under the preferred option – there are no proposed decommissioning but a reduction to some of the services for which a consultation has taken place.

Following consultation, the product of the consultation must be taken into account in the final decision and the responses need to be fed into the decision making process.

In relation to the recommissioning of these services, the design and the running of any procurement should be in accordance and compliance with the Council's Contract Procedure Rules and the Public Contracts Regulations 2015.

Assistance must be sought from and work directly with the Council's procurement team(s) in consultation with legal services to drive the procurement process in compliance with the regulations, internal rules and in order to ensure the desired outcomes are achieved in the

most efficient way.

There is mention of a Digital Offer – this may also require input from IT/Procurement team.

Any reduction to any of the current arrangements should be in accordance with the provisions of the contracts to ensure smooth terminations and in alignment with the proposed procurement of the new Integrated Service.

Previous legal advice has been provided but it is re-iterated that the
the Council must comply with Statutory Best Value Guidance
(https://www.gov.uk/government/publications/consultation-principles-guidance) which means that the where there is an SME organisation (which may be the case in smaller services) then the guidance requires the Council to give 3 months' notice to terminate the current contracts, this is regardless of the contractual provisions.

The implications arising from this report are based on the preferred option as suggested within the report should the option change, legal services will need to be consulted to identify associated legal risks. Ongoing support should be sought from legal services as and when required.

Mannah Begum, Solicitor (Senior) - (Commercial Property and Planning Team
Legal Services)

A number of changes are envisaged in the report which have potential staffing implications.

Where staff are employed by the Council and it is proposed that there will be an organisational review the Council's organisational review policy should be followed.

If there is a decision to out-source any of the services going forward, there is the potential for the TUPE Regulations to apply. The TUPE Regulations are also likely to apply should there be a decision to bring any of the services back in-house.

Further employment legal advice should be sought once a decision on the model for service delivery has been made.

Paul Atreides
Head of Law

4.3 Climate Change and Carbon Reduction implications

A key element of the integrated lifestyle service will be to encourage physical activity and promote walking and cycling which will positively impact on climate change and carbon reduction. Fewer 1:1 sessions is also likely to lead to a reduction in travel, including single occupancy car journeys, for staff and residents

The reduction in 1:1 sessions and greater focus on group sessions, held in local venues, is likely to reduce travel by both clients and council staff, leading to a reduction in city-wide and council carbon emissions.

In addition, a key element of the integrated lifestyle service will be to encourage physical activity and to promote walking and cycling. This may lead to some clients adopting these active travel options for regular journeys previously made by car or bus – again contributing to reduced city-wide carbon emissions.

Duncan Bell, Senior Environmental Consultant.

4.4 Equality Implications

When making decisions, the Council must comply with the Public Sector Equality Duty (PSED) (Equality Act 2010) by paying due regard, when carrying out their functions, to the need to eliminate unlawful discrimination, advance equality of opportunity and foster good relations between people who share a 'protected characteristic' and those who do not.

In doing so, the council must consider the possible impact on those who are likely to be affected by the recommendation and their protected characteristics.

Protected groups under the Equality Act 2010 are age, disability, gender re-assignment, pregnancy and maternity, marriage and civil partnership, race, religion or belief, sex and sexual orientation.

The report outlines proposals to bring existing lifestyle services together into one integrated service.

The key changes which are likely to have an impact on those who use the services are potential changes to the time and location of sessions, a shift towards group sessions as opposed to 1-1s and the provision of a digital platform. An Equality Impact Assessment has been commenced to explore the impacts of the proposal in greater detail. The initial assessment of the potential equalities impacts has identified that the changes may have a disproportionate negative impact on particular protected characteristic groups such as age, disability, race, pregnancy and maternity and gender reassignment. It has been identified that this disproportionate negative impact can be reduced or removed my maintaining face to face, 1-1 and phone provision for those who require it.

Although mitigating actions have been identified, there are some benefits gained from group work and online provision in terms of peer support, socialisation and ease of access which should be accessible to and inclusive of people with protected characteristics. The ways in which group sessions and the digital platform can be made as accessible and inclusive as possible, will require consideration throughout the future development of the proposals. In particular, engagement with service user groups will be key to ensuring that the digital offer is accessible.

The equality impact assessment, consultation results, further engagement with service users and equality monitoring information should continue to be used in the decision making process, in the further development of the proposals and their implementation and in order to identify any unexpected equalities implications which arise and mitigate for these.
The implications arising from this report are based on the preferred option. Should the option change, the equalities implications of the alternative proposal will need to be considered. Ongoing support should be sought from the equalities team as and when required.

The report also suggests that implementing the proposals will require an organisational review of certain services. Where staff are employed by the Council and it is proposed that there will be an organisational review, the Council's organisational review policy should be followed in order to ensure that equalities implications of the review are fully taken into account.

Appendix A- Consultation feedback

171 people completed the consultation (online and paper) over the 8 week period. It should be noted that whilst 171 people responded to the consultation many questions were answered by low numbers of people. The breakdown of response rate by question is available in the summary report attached as appendix A. Over 50% of responses came from staff or people in a professional capacity. Below is a brief summary of the responses received;

We are looking to have one team providing the whole range of lifestyle services rather than having separate services. What are your views on this? (72 people answered this question)

- Overall there was support for this proposal with responders noting that this was a good idea and would make services more user friendly
- Comments showed that people appreciated that unhealthy behaviours often clustered and having an integrated service would help in these cases although it was also mentioned that tackling multiple behaviours can be problematic
- There were concerns about creating a generic staff member to tackle all unhealthy behaviours and the risks of losing subject expertise with people stressing the need for specialist staff to be retained
- A single booking system was seen as a positive step
- There were concerns about a new service losing a degree of personalisation that currently exists in separate services
- It was also noted that a new service should offer greater flexibility in terms of appointment times/days/venues

Greater use of online booking/support, apps, phone/text support in relation to stop smoking services and diet/physical activity and weight management services

- There was some support for all of the above in the 3 services listed although there were very limited responses to these questions (84% did not answer)

Healthy Lifestyle Apps used previously

- Only a small number of responders indicated that they had used a website/app to improve their health with couch to 5k being the most commonly cited (53% did not answer)

Group based support for stop smoking services and diet/physical activity and weight management services

- 70% of responders did not answer this question. 86 individuals did with 11 saying they would attend stop smoking support in a group, 35 would attend group based weight management and 40 would attend diet/physical activity sessions offered in a group.
- The key things people mentioned were about group sessions was that access should be good and a range of times should be offered
- Comments were generally positive about the benefits of group sessions although some people were clear that they would not attend these sessions
- Cost, time and location were mentioned but friendly staff was the most common response in terms of what would be important about these services

Features that would make services more appealing

- Good accessibility
- Face to face sessions
- Evening and weekend sessions
- Friendly staff
- No/low cost

Greater use of online services

- There was limited support for this with concerns expressed about the risks of some people being excluded (>70% did not answer this question)

Which of these might you attend to increase your physical activity / lose weight?

- There was support for a wide range of activities including home based, running and outdoor gyms, yoga/pilates with the most popular being walking (35), swimming (40) and exercise classes (40)

Where would you most like to access physical activity sessions?

- A wide range of settings was given with leisure centres (61), community centres (41), parks and outdoor spaces (38) being most popular

Where would you most like to access stop smoking sessions?

- Very limited responses (23%) but some support for health centres and community centres

Walking is a free and simple way for many people to improve their health and wellbeing. Do you have any thoughts on how we could encourage people to walk more?

- There was strong support for this with a range of positive comments
- Group walks and guided walks were especially popular
- Walks to work, lunchtime walks and walks with pets were also mentioned
- Having a range of times and venues for walks was important
- Having details on walks and routes available via apps/website was also mentioned

Would you be interested in attending healthy lifestyles sessions where you could bring a friend or family member?

- There was some support (49) for this option with people suggesting that extra support can be helpful

Greater use of local volunteers to help others improve their health

- Respondents were generally supportive of this and it was seen as a good idea
- It was a clear message however that volunteers should be well trained and supported
- There was also a view that this should support and not replace the role of the health professional

Other comments

- Limited additional comments but some consistency existed such as the need to ensure sessions are run in the evenings and the role of cycling be embraced as part of encouraging healthy lifestyles
- Greater use of community assets was also mentioned

- There was a number of comments relating to the role of wider determinants such as takeaways, advertising and sustainable travel

Do you think we should provide advice and guidance on where people can get help with things such as housing, debt management, etc? - wider advice support

- 57% of people did not answer this question. Of those that did there was generally support with some concerns raised. Comments suggested this should mainly be about signposting. 2 people said no.

3.3 Focus group feedback

5 Focus groups were held over a 3 week period. In total approximately 70 people were involved in these groups which comprised current and former service users along with general members of the public. Specific sessions were held for members of the South Asian population and for adults with learning difficulties. The sessions were led by 2 members of the public health team who used a broad question template to act as a guide and both independently recorded responses which were triangulated shortly after the sessions. Focus groups were not recorded in an effort to encourage participants to speak candidly and as such the notes taken were reflected back to the group during and afterwards to ensure what had been captured was a fair and accurate record of the discussion.

Whilst the discussions in the various groups were understandably different there was a considerable degree of consistency in responses. As such the key themes which emerged are shown below and where this was not consistent across the groups this is also shown.

- Overall proposal to shift to an integrated team
    - Generally a positive response to a shift towards greater integration
    - Consistent concerns about the risk of diluting professional expertise if a generic health advisor was the end goal
    - Supportive of a single team being responsible for appointment booking and having a named contact who had oversight of their journey
    - It was suggested in all of the focus groups that whilst a Leicester wide service was relevant there should be a more local offer to reflect the different needs/assets of various communities/wards

- What matters most to you about lifestyle services
    - The things that came out of all groups was the importance of the staff involved; they must be knowledgeable, empathetic and above all friendly
    - Access was also cited as a major factor with all groups suggesting that having services available in a range of settings at various times was important

- Weight Management
    - A strong feeling that group sessions were the preferred method of delivery. A recognition that some people may prefer 1:1 sessions but overwhelmingly it was felt that the benefits of a group were significant when addressing this issue.
    - The expertise of qualified staff was felt to be very important. Service users cited commercial services they had used where the advice and resources provided was at a lower level
    - The application of information in practical advice was felt to be vital e.g. advice on reading food labels
    - It was acknowledged that a service which had a specific focus on the South Asian diet and was tailored towards this audience had several benefits comparted to a generic offer
    - Service users felt that the most beneficial change the council could make to the service would be to offer it for longer

    - The groups explained that they agreed there was a place for greater support to be offered at distance either via phone or a digital channel but that this could not replace the face to face element for them

- Digital Services
    - There was a recognition in all groups that the internet was somewhere most people initially looked for advice/info on healthy lifestyles but that there were challenges in knowing which information was safe and trustworthy
    - In light of the above the was support for a single website for lifestyle service which would provide reliable information
    - Significant concern in all groups but especially when talking to adults with learning difficulties about a shift from face to face services to online. All groups were worried that as a means of saving money the council would be gradually putting all existing services online
    - Concerns also around access and the IT literacy in all groups but again especially when talking top adults with learning difficulties
    - All groups expressed concerns about a 'council' website; explaining that they felt it would not be as appealing, functional or accessible as more commercial sites. Examples were given about current council services online and issues service users had faced with them
    - There was a clear message that any digital platform should be available in a range of languages and feature lots of images with information kept clear and concise
    - Text reminders were felt to be a useful service
    - Online services have a role in long term maintenance of behaviour change through the use of online groups/forums
    - The 'maps' function was seen as useful with the ability to search by postcode and get easy access directions mentioned as a positive
    - Some attendees mentioned that they would likely access a website on a smartphone rather than PC and so anything offered on line needed to operate well via this medium
    - The 'chat' function received both positive and negative feedback
    - Online groups were felt to have a place especially when exiting face to face services as part of a tapered reduction in support

- The role of volunteering in lifestyle services
    - A positive response to increased use of community centres, groups and greater role for local health champions
    - There was however much concern over the role volunteers would play with all groups. It was a very clear message that people felt there was a role for volunteers but this should be in support not replacement of a qualified health professional
    - Ensuring sufficient training and support was in place for volunteers was highlighted as crucial
    - Volunteers and peer mentors were seen as having particular use at entry and exit point of services
    - Issues around reliability and accountability were also flagged when using volunteers to 'deliver' sessions
    - It was recognised that volunteers may be more appropriate in some aspects of an integrated service than others e.g. walking groups

18

NHS
University Hospitals of Leicester
NHS Trust

Report to: Leicester City Health and Wellbeing Scrutiny Commission

5 July 2018

Emergency Floor Phase 2 – Leicester Royal Infirmary

In June, we came to the end of our four year journey to create an Emergency Floor for our patients. The first part of the Floor saw the new Emergency Department (ED) open in April last year, and we have now completed the move of all of our five acute assessment units right next door thus creating the Emergency Floor.

We wanted to design an Emergency Floor to meet the needs of the patients that we serve. Given that a large number of our patients are frail and elderly, often with dementia, it was crucial that we designed a "frailty friendly" floor to enable us to deliver better patient care. We looked at other hospitals here and across the world, drawing on research, expertise and best practice to create the right environment. This new floor enables us to change and improve the way we deliver tailored care to our individual patients.

We have worked with Age UK, Vista and with academics that have experience of designing hospitals for improving healthcare outcomes to ensure that our facilities meet the needs of all of our patients. The design includes rubber flooring in the department rather than vinyl, which can be difficult to walk on, purpose-built mental health rooms where patients will be protected from harm whilst they are assessed and treated and the ability to provide more privacy and dignity to patients as they are treated.

A map of the new area is enclosed. Having the assessment units so close to the ED means that the flow for patients will be much quicker, and medical teams from across the patient pathway will work closer together to ensure the patients get the right care, in the right place, first time.

Phase 2 of the Emergency Floor opened to patients on 3 June, when all of our assessment units relocated from their current locations across the hospital site, to right next door to the Emergency Department. Assessment units are where patients are assessed, diagnosed and immediate acute medical treatment is started for up to 72 hours. Patients either then move to a main ward in the hospital, or are discharged home.

Our acute assessment units are as follows:

- **Emergency Decision Unit (EDU)** – This unit is run by our ED team. Patients in this unit are transferred from ED to continue their treatment, and often stay up to 24 hours. The mental health team are also based in this unit.
- **Acute Medical Unit (AMU)** – Clinicians on this unit will assess, diagnose and start treatment for medical patients, for up to 72 hours.

- **Acute Care Bays (ACB)** – This unit looks after patients with critical medical conditions. Patients can be on this unit for a short time to stabilise their condition, or for a longer period for acute medical care.
- **Emergency Frailty Unit (EFU)** – Led by geriatricians, the team here specialise in treating older people for up to 24 hours. Patients here are often discharged home without a need for a further hospital stay. The multi-disciplinary team, known as the Frailty Emergency Squad, are based here; the squad, made up of a doctor, advanced nurse practioner, pharmacist, therapist and primary care coordinator, review patients and work to get them home as swiftly as possible. The squad also in-reach into ED to see those patients that can be looked after swiftly and discharged without need to come further into the hospital.
- **Acute Frailty Unit (AFU)** – This unit specialises in treating older people for up to 72 hours. Patients in this unit are often transferred to a ward either in the hospital or in the community for further care and treatment.

Attached to AFU is Memory Lane. Gratefully paid for by the RVS charity, Memory Lane offers a safe space for patients with dementia to sit and interact with meaningful activity coordinators, and take part in activities that help them remain calm whilst in hospital. The Lane includes a small café, where, with support from volunteers, patients will be able to have a cup of tea and cake in a café setting. Therapy assessments will also be carried out in this area.

As part of the planning for moving to the new units, the teams have developed new ways of working to improve patient experience and make the patient pathway more efficient. The units will benefit from earlier senior doctor input into a patients care; increased focus on frailty at the front door of the ED; and having more acute medical consultants working in ED, concentrating on those patients that can be discharged quickly or transferred directly to another area of the hospital for treatment.

Performance update

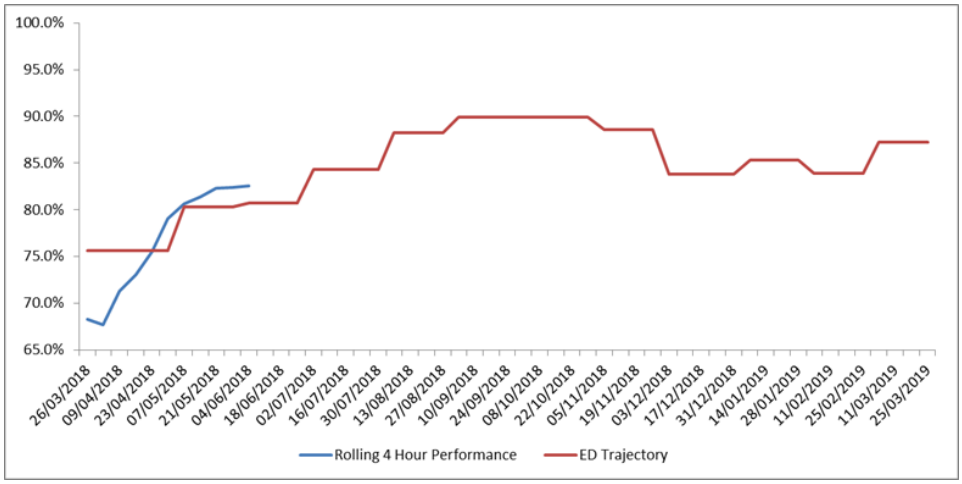
In May, we saw some of the best ambulance handover performance at the Trust for a number of years; and we were the best in the region with an average handover time below 15 minutes. This follows targeted and sustained work by the Emergency Department (ED) clinical and management teams, to ensure procedures are followed in a timely manner for each ambulance that arrives on site.

From April 1, UHL sub-contracted the running and development of the assessment area and primary care stream to Derbyshire Health United (DHU). Following some issues at the outset of the contract period where rota gaps – of both GPs and Advanced Nurse Practitioners – were not filled to the required levels, there has been much work by the team over the last 2 months to improve this. We are now seeing an improved and consistent fill rate of the rota.

Some gaps do however remain, and we continue to meet daily with DHU to address this, to ensure we are able to run an effective primary care service for our patients.

Following a challenging and extended winter, performance against the emergency 4 hour standard has improved in recent weeks. As a Trust, we are currently ahead of the trajectory target set by NHS Improvement for June, with performance currently at 84.2% vs the target of 81%. This follows considerable effort by staff from the front to the back door of the hospital, ensuring patients flow efficiently from arrival to discharge.

The graph below shows our performance against trajectory year to date.



Summary:

The opening of Phase two of Leicester's Emergency Department brings to an end the 4 year project to create a fit for purpose (and fit for the future) 'frailty friendly' ED for the citizens of Leicester, Leicestershire and Rutland. At the same time work continues with other health partners, Public Health and adult social care to fundamentally change the care pathways for frail and multi-morbid patients to ensure that only those patients who need to attend hospital actually end up there.

Acute Medical Unit

Acute Frailty Unit and dementia corridor – Memory Lane

Emergency Floor - phase one and phase two

Refresh of 2017/18 and 2018/19 Operational Plan for Leicester City Clinical Commissioning Group

Background

1. The CCGs in Leicester, Leicestershire and Rutland are responsible for planning and improving healthcare services on behalf of our communities. We face an ever increasing demand for services locally and in 2018/19 are experiencing our toughest financial position yet.

2. NHS organisations are required to produce an Operational Plan as per the planning guidance issued by NHS England in February 2018. The Operational Plan for 2018/19 takes account of updates to national NHS England planning guidance, and sets out the expectations for both providers and commissioners in the forthcoming period. The refreshed operational plan for the CCG's in Leicester, Leicestershire and Rutland is attached as Appendix 1.

3. The refreshed plan includes details of the health priorities, timescales and milestones for delivery, as well as a summary of the activity, finance, performance and Quality, Innovation Productivity and Prevention (QIPP) plans for the year. The plan for LLR was submitted to and approved by NHS England in March 2018.

4. The key requirements from the NHS Planning Guidance are detailed in this paper, although the full document can be viewed at: https://www.england.nhs.uk/wp-content/uploads/2018/02/planning-guidance-18-19.pdf.

Key requirements of the revised planning guidance for 2018/19

5. It should be noted that 2018/19 is a refresh only and represents the second year of agreed two year plans and contracts. Therefore the expectation was for an update on the 2017-19 Operational Plan and contract variations, not new negotiated contracts.

6. National growth figures for activity were applied to outturns for 2017/18 in order to determine the activity plan for 2018/19. There are different growth rates applied to different areas of NHS acute activity and the individual growth rates are detailed on page 11 of Appendix 1. The application of these growth rates is designed to ensure that commissioners purchase sufficient activity to meet the needs of their system.

7. The national expectation is that the majority of providers will meet the 4 hour target for A&E of 95% by the end of March 2019, with aggregate performance reaching 90% by September 2018. Locally our trajectories to deliver this are set out on page 25 of Appendix 1.

8. There is a focus on continuing to reduce delayed transfers of care (DTOC), ensuring the system delivers the standard of no more than 3.5% of beds occupied by DTOC patients. Locally we are doing well against this standard and, in particular, social care delays are well below target.

9. There is also a focus on reducing the number of long stay in-patients in hospital and recent communication has been sent to both health and social care organisations asking for work to be done to reduce the number of "stranded" patients (those in hospital for more than 7 days) and "super stranded" patients (those in hospital for more than 21 days).

10. There is also a national focus on moderating the demand for emergency and elective care. Our plans to address this are set out in the Operational Plan. Specifically this focuses on delivery of Planned Care (page 16 of the plan), urgent and emergency care (page 20), development and delivery of Integrated Teams (page 28), and implementation of a Home First model (page 56).

11. Although the Referral to Treatment time target of 18 weeks is still in place a new metric has been introduced to measure elective performance. This is to ensure that the number of patients on "incomplete pathways" – often referred to as waiting list times – is no more at the end of March 2019 than at the end of March 2018. Our local trajectories for both measures are detailed on page 17 of the plan at appendix 1.

12. There is an expectation that systems, through their Sustainability and Transformation Partnerships, will continue to take an increasingly prominent role in planning and managing system-wide efforts to improve services. Work is ongoing through our System Leadership Team (of which Leicester City Council is an active partner) to drive this work forward.

13. The CCG has a range of performance targets that it needs to deliver. This is in line with previous years and the full set of these indicators is set out in pages 84-128 of Appendix 1.

Local actions to deliver national priorities

14. Our local actions to deliver the national priorities are set out in the Operational Plan (appendix 1) and details of the national deliverables are detailed in Annex 1 of the *Refreshing NHS Plans for 2018/19* document. Specifics include:

    - Mental Health (page 44 of Appendix 1): we have met the investment requirement – which means that we must invest in mental health services at a faster rate than our overall programme funding – and there is a plan to deliver a further increase in access to IAPT services.
    - Cancer (page 62): we plan to deliver all cancer targets within 2018/19. We are implementing nationally agreed pathways for lung, prostrate and colorectal cancers; rolling out a new test for bowel cancer; and commissioning recovery packages.
    - Primary Care (page 58): we continue to work to improve access and sustainability of primary care in the city. We have already opened our extended hours hubs, while we have a number of initiatives to attract and retain primary care workforce. We have also invested in primary care to support them to become more sustainable and a number of practices have received funding to improve their premises.
    - Urgent and Emergency Care (page 20): we continue to work with UHL and the wider system to improve performance of the 4 hour target, including alternatives to attendance and admission, flow within the hospital and actions to improve discharge and reduce DTOCs. We have introduced clinical navigation into the NHS 111 system to ensure only those that need to are sent to A&E are. Ambulance handover times have been a challenge across LLR (although city performance is better), and as such additional financial resources have been provided to East Midlands Ambulance Service to enable them to meet these standards.

- Transforming care for people with Learning Disabilities (page 72): we are continuing to develop plans to support people in the community and reduce inappropriate hospital stays.
- Maternity (page 69): we are working towards delivering the national ambition in "savings Babies Lives" care bundle to reduce stillbirths, neonatal deaths and brain injury by 20% in 2020 and 50% in 2030. The current baseline is 73 neonatal deaths, and we plan to reduce this by 2 in the first year followed by 3 each subsequent year.

Key financial assumptions for development of 2018/19 Operational Plan

15. The key financial assumptions used in developing Leicester City Clinical Commissioning Group refreshed Operational Plan for 2018/19 mirror the national requirements.

16. The CCG allocations for 2018/19 total £512.415m. The Programme (service provision) allocation for is £449.169m. This includes growth at 2.82%. Further one off allocations total £260k.

17. Our Primary Care Co-Commissioning funding is £52.819m, including growth at 2.72%. The separate GP Access allocation of £2.427m has remained the same value as 2017/18.

18. The CCG running cost allowance has reduced to £7.740m from £7.752m in 2017/18. This is the budget for running the organisation and is separate to allocations for service provision

19. Expenditure, prior to efficiencies, totals £530.470m. Therefore the efficiency gap – QIPP – for 2018/19 is £18.055m. This equates to 3.52% QIPP against the CCG allocations. Details of the individual QIPP schemes can be found in pages 129-132 of Appendix 1.

20. The financial plan for 2018/19 includes the national contingency reserve requirement of 0.5%; mental health investment standard target 2.8%; requirement to plan for in year financial balance and to continue to deliver the control total surplus of £12.388m.

Quality, Innovation, Productivity and Prevention – delivery and assurance

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

22. The CCG's QIPP targets are around 3.5% of the CCG budgets – which is considered to be average or slightly below average by comparison to CCGs nationally – but still present significant challenges.

23. The CCG has a strong track record of financial management and we believe many of our plans will make a positive difference to people's lives - by improving care, preventing debilitating illnesses and making the best use of public resources. Inevitably however, with the tough financial situation we face, we continue to have to make difficult decisions.

24. The CCGs follow a rigorous process in delivery of our QIPP plans from initial planning stages through to eventual implementation.

25. Our processes have strong clinical leadership and involve:
    - quality assurance
    - impact and sustainability assessments
    - evaluation
    - consideration of service user feedback.

26. Our processes also include public and patient involvement in service redesign and in our decision making regarding significant changes to service, in line with our statutory duties.

27. The schemes listed in the supporting documents are the areas where we believe there is potential to do things differently to improve quality and make efficiency savings.

28. Work is underway on the majority of schemes and we will be in a position later in the year to give more detailed information on changes and how we have considered and mitigated potential impact on our patients.

29. Further QIPP schemes will be developed and implemented during the financial year to ensure delivery of the required QIPP targets.

Recommendation

The Health and Wellbeing Scrutiny Commission is asked to:

NOTE the Leicester City Clinical Commissioning Groups Refresh of 2017/18 and 2018/19

Appendix D2

LEICESTER, LEICESTERSHIRE AND RUTLAND CLINICAL COMMISSIONING GROUPS OPERATIONAL PLAN

Refresh of 2017/18 and 2018/19 Operational Plan

NHS East Leicestershire and Rutland Clinical Commissioning Group

NHS Leicester City Clinical Commissioning Group

NHS West Leicestershire Clinical Commissioning Group

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Foreword

Our organisations commission and provide health and care services for over a million people in Leicester, Leicestershire and Rutland. Every day our services support people to stay healthy and lead independent lives. When people are ill our services are there for them, their carers and families. Over the next five years, the services we are accountable for will need to adapt and transform in order to ensure that they remain clinically and financially sustainable. How we will do this is set out in our Leicester, Leicestershire and Rutland Sustainability and Transformation Partnership (STP) plan.

The latest version of our STP plan sets out the actions that we will need to take in order to balance the various pressures of continued growth in patient demand from an ageing and growing population, a requirement to recover and maintain delivery against national access and quality standards and how we will ensure financial sustainability across Leicester, Leicestershire and Rutland.

Our STP builds on the work of our Better Care Together programme, the plans of which were already well advanced and articulated in many areas. Our two year Operational Plan has been updated for 2018/19 and sets out how Leicester City CCG; East Leicestershire and Rutland CCG; and West Leicestershire CCG will work together with provider and local authority partners to deliver the priorities set out in the STP plan for the next year.

The financial challenge facing the NHS nationally over the next five years is well recognised. In LLR we are no different, with all CCGs significantly financially challenged, and in order to achieve system and organisational financial control totals over the next year considerable transformational change will be required.

To achieve this we need to work together as a system while at the same time ensuring a tight grip on each CCG's financial position. As part of this the three CCGs are discussing a proposal to move towards a single Accountable Officer and single Management Team across the three CCGs.

Our Governance arrangements to support the delivery of both transformational change and QIPP are set out in this plan, (page 13).

Our arrangements for engaging and communicating with patients, carers, stakeholders such as Healthwatch and the wider public are also outlined throughout this plan and their insights will be integral to ensuring that services are patient-centred.

Our drive is to deliver high quality care and as a result of the actions set out in our STP plan and this Operational Plan we would expect by 2021/22 that:

- Patients will have more of their care provided in the community by integrated teams with the GP practice as the foundation of care.
- Patients will only go to acute hospitals when they are acutely ill or for a planned procedure that cannot be done in a community setting.
- More people will be encouraged to lead healthy lifestyles to prevent the onset of long term conditions.
- Screening and early detection programmes will enable more people to be diagnosed early to enable improved management of disease and to reduce burden.
- Professionals will have access to a shared record to improve the quality and outcome of patient care.
- General Practitioners will increasingly use their skills to support the most complex patients and routine care will be delivered by other professionals.
- General Practice will be increasingly working in networks to improve resilience and capacity.
- The system will be in financial balance and be achieving its performance standards

Sue Lock **Managing Director** **LC CCG**	**Karen English** **Managing Director** **ELR CCG**	**Toby Sanders** **Managing Director** **WL CCG**

Challenges

The challenges that LLR face are detailed in our STP plan where we have undertaken an analysis to identify solutions, against the three gaps of health and wellbeing; care and quality and finance and efficiency. Many of these solutions require implementation in the next year and as such form part of our Operational Plan for 2018/19.

A summary of these gaps and challenges are set out below.

NHS Constitutional Standard Performance

As a system there are a number of NHS Constitutional and access standards where performance remains below expectation. The areas are:

- A&E 4 hour target
- Cancer waiting times
- IAPT Referral and Recovery Targets
- Referral to Treatment (RTT)

The plans to address this under performance are part of the key action section, pages 16-82 of this Operational Plan.

There will be an ongoing focus to ensure delivery of the 2018/19 referral to treatment operational standard – to ensure that we do not have any more patients on incomplete pathways at March 2019 than we do at March 2018. Performance trajectories for 2018/19 are detailed in Appendix 2.

Health and Wellbeing

There is variation in health outcomes across LLR (including life expectancy), much of which is related to the "social determinants of health" – i.e. the broad social and economic circumstances that together influence health. Acknowledging these health inequalities, our solutions to address life style factors, early detection of ill-health and ongoing management of long term conditions are being progressed through workstreams including Long Term Conditions, Self-Care and Prevention, and Cancer.

Care and Quality

We have identified that we need to make improvements across a number of areas which are addressed in this Operational Plan including improving independence; ensuring primary care is more resilient; improving outcomes for mental health and continuing to work with providers that are rated as Required Improvement by the CQC.

Finance and Efficiency

In order to achieve system and organisational financial balance in 2018/19 there is a significant QIPP requirement. The key actions within this plan set out how this will be delivered.

Getting contracting right to enable delivery of the STP

There is a commitment across the CCGs and main providers within LLR to seek to change the "terms of trade" in order to align more effectively the incentives across all parts of the system. By changing our "terms of trade" we want to focus on value through considering costs, efficiency and effectiveness.

Developing a new contract model represents a significant development in the way provider and commissioner organisations interact, so for 2018/19 we have agreed contractual arrangements with UHL on a Payment by Results basis, and a block value arrangement with LPT. However, we continue to work with our providers to develop the new contracting arrangements, with a view to enacting a new model within the 2019/20 contract.

We consider this as the first step in changing the way our system operates. In subsequent years we would want to move to a system that has a single control total with risk and gain share arrangements, working together to deliver system solutions.

Quality

The aim of Leicester, Leicestershire and Rutland Clinical Commissioning Groups (LLR CCG's) is to commission high quality, safe and effective health services that meet the needs of our people; to ensure that the right services are commissioned for patients to be seen at the right time, in the right place by the right professional. In relation to quality we encompass the three equally important parts that include: Care that is safe, Care that is clinically effective and Care that provides a positive experience for people. Our focus is on the following areas.

Patient Experience: The patient, carer and service user voice is heard using a range of methodologies. Insight is gathered either through established patient groups and outreach work or through specific engagement programmes relating to service redesign or in relation to proposed changes to services. This feedback includes:

- Experience Led Commissioning (ELC) to co-design and co-produce services and inform new services.
- Receive and review monthly complaints reports and review quarterly patient experience reports to identify areas for improvement by providers.
- Monitor the contractual requirement in respect of Duty of Candour for all Patient Safety Incidents where there has been moderate or severe harm.
- Undertake as part of the NHS Standard contract and quality requirement regular quality visits to our provider organisations that will include review of patient experience utilising our CCG Patient Leaders.
- Use markers of patient experience within general practice such as national patient experience survey and NHS Choices to triangulate data and inform actions for improvement.
- Work collaboratively with our Healthwatch organisations via the Enter and View visits to gain an understanding of patient experience and actions for improvement.

Patient Safety: Ensure a commitment to improve collaboration to multi-agency working across health and social care to address patient safety concerns for patient safety incidents and a patient safety culture across all our providers of services. In addition we will:

- Via the Learning Lessons to Improve Care (LLtIC) work to ensure system wide clinical leadership across the health community to lead and drive safety, support the patient and staff engagement, listening and action, continue the drive for effective care across interfaces between providers of health services, focus on transforming emergency care in our wards, hospitals and communities, and transforming End of Life Care (EoL).
- Monitor Serious Incidents from our providers to identify any safety concerns or harms in light of the current system issues and pressures on our local urgent care system that includes in particular the LRI Emergency Department and EMAS provider.
- Participate in the annual publication of findings from reviews of deaths including the annual publication of avoidable death rates and actions to reduce deaths related to problems in healthcare.

Infection Prevention and Control: Work in partnership with infection prevention teams across the local health economy to implement established measures and develop innovative methods to ensure the incidence of healthcare associated infection is reduced to achieve the best outcomes for our population and keep them safe. We will:

- Focus on antimicrobial prescribing across our range of providers and compliance with the LLR antimicrobial resistance strategy.
- Review investigations into incidents of C-Difficile and MRSA to ensure that learning is incorporated into business as usual and changes made to practice.
- Continue to work towards a zero tolerance ambition of MRSA bloodstream infections.
- Work with our colleagues across public health, primary and secondary care, and social care on reducing key infections such as community acquired pneumonia, urinary tract infections and sepsis.
- Provide a focus for improvements in the recognition, management and reduction in HCAIs.
- Ensure training and education in infection prevention and control, and medicine optimisation via support of our Care Home Pharmacist to reduce incidents of HCAI's.
- Ensure antibiotic stewardship lead across each CCG.
- Ensure all providers implement the Sepsis guidelines and tools to ensure early identification and management.

Safeguarding: The LLR Chief Nurses will be supported with their statutory duties in safeguarding by Designated Nurses, a Designated Doctor and the LLR CCG Hosted Safeguarding Team. In 2018/19 our safeguarding priorities will include:

- Assurance that there are a range of services in place to safeguard children and adults, evaluated by the CCG's using suite of monitoring tools supported by audit.
- Assurance via regulated inspections e.g. CQC.
- Working with providers to ensure that we have multi-agency collaboration and communication in place.
- Ensuring the performance monitoring of the safeguarding vulnerable people element of the NHS Contract (SC32 Safeguarding, including PREVENT) is delivered by health provider organisations.
- Supporting the Safeguarding Children and Adult Board programme groups and work streams (supporting the delivery of LLR Children and Adult Boards Business Plans).
- Support patients subject to DoLS and CoP requirements.

Workforce and Organisational Development: The LLR CCG's will continue to drive a new generation within the health and social care workforce to work across organisational boundaries, and with a greater focus on out of hospital service and integrated working. In response to workforce challenges we will:

- Establish a clear baseline of our current workforce and undertake workforce modelling and capacity planning. Getting the detail right by reviewing and refining the skill mix of teams to better understand the types of work that needs to be done in new settings to better enable, people to move around the system quickly efficiently and effectively.
- Implement the LLR General Practice Nurse Recruitment and Retention Strategy Pre-Registration Nurse Placement, Return to Practice Scheme, Rotational Placements, Developing Advanced Nurse Practitioner role, and Assistant Practitioner (HCA) role and Nurse Associate Role and their development facilitated by the LLR Training Hubs led by General Practice.
- Provide an annual General Practice Nursing Conference.
- Demonstrate nurse leadership in the STP via the new nursing framework:

'Leading on Change, adding Value,' with focus on: health and wellbeing, care and quality and funding and efficiency.

- Promote System Workforce development (UHL and LPT work), Piloting the New Nurse associate role, to include HCA from General Practice.
- Support training for General Practice Nurses.
- Develop a recruitment microsite to bring all health and care vacancies together and create marketing campaigns promoting LLR as a great place to live, learn work and play with the aim of increasing staff retention and recruitment across all clinical roles.

Research and Innovation: LLR CCGs will meet its statutory responsibilities to promote research and innovation, to use research evidence and to follow policy with respect to excess treatment costs for non-commercial research studies. The participation of local patients in funded research will be supported through an R&D Office, which hosts a service for the three Leicester, Leicestershire and Rutland (LLR) CCGs. We will work closely with the regional Clinical Research Network (CRN) to support study delivery in primary care. All East Midlands NHS R&D Leads meet regularly to discuss research progress across the region, resolve any common issues and share national developments involving the Health Research Authority and NHS England.

Primary Care Quality: We have adopted a holistic approach to monitoring quality in Primary Care; which has been designed to develop an environment where learning from both success and adverse events can be shared with the aim of continually striving to improve the quality and experience of healthcare for both patients and our Primary Care workforce. A key area of learning has been from our General Practice that have been in Special Measures following CQC reviews, and where we have developed support and programmes to ensure practices understand and develop robust clinical governance, systems and process to demonstrate services that are well led and of high quality. We will:

- Promote and Support the 'Supporting Vulnerable Practices programme that will offer insight to human factors and driving improvement through leadership and positive culture for quality improvement.
- Utilise our governance arrangements that are in place within each CCG for Information Sharing with NHSE to enable a systematic process for the determination of risk in General Practice relating to quality and safety.
- Reward our practices via the Quality and Outcome Framework (QOF) for the provision of 'quality of care' and helps to standardise improvements in the delivery of clinical care.
- Utilise our Primary Care Quality Dashboards: that provide a high level view of an individual practice in terms of quality and safety.
- Utilise our clinical leads for General Practice both medical and nursing to drive and champion continuous quality improvement and clinical governance in General Practice.

Contract Quality Assurance: In 2018/19 and as part of the LLR STP we will lead on and drive continuous quality improvement in our new and emerging service developments and at the same time maintain our robust quality monitoring and assurance processes of our existing services to ensure provision of high quality services across LLR. We will:

- via the Commissioning for Quality and Innovation (CQUIN) Payment Framework: drive quality improvement that focuses on system working, and integration and deliver

the requirements of the planning guidance.

- via the Contract Quality Review process ensure robust monitoring of all provider organisations via the Quality Schedules to ensure compliance with essential standards of care and quality focusing on particular: Safer Staffing and staffing shortages, waiting delays in the urgent care services, waiting list delays in UHL and Pressure Ulcer care.
- undertake both announced and unannounced Quality Visits of all our provider organisation to ensure direct sight of patient care and patient experience.
- support organisations to improve in the event that they are subject to CQC special measures.

Urgent Care

- Support the urgent care activities for physical and mental health to reduce pressure across the system ensuring that patients and services remain safe.

Patient Care

- Work with commissioning support unit to ensure high quality services for patients requiring continuing healthcare and SEND.
- Lead Care and Treatment Reviews to ensure effective implementation of the Transforming Care agenda, working to reduce inpatient capacity by March 2019 to 10 – 15.

Quality Improvement

We have committed to a system-wide approach to quality improvement which is clinically driven by the LLR Clinical Leadership Group in order to achieve the ambitious aims of the STP. Work to build quality improvement and leadership capacity and capability across the system is supported by the East Midlands Leadership Academy and members of the Health Foundation's 'Q Community'; an improvement community of health and care professionals across the LLR system designed to encourage the sharing of ideas, enhancing of skills and collaboration to make health and care better.

Improvements will be led by system experts, skilled in quality improvement methodology who, through the clear articulation of expected outcomes for our patients and service users, will lead change underpinned by sound evidence gathered though a variety of sources including quality visits, data collected to understand variation and engaging the right people at the right time.

Finance

This section outlines the financial plans for West Leicestershire CCG, East Leicestershire and Rutland CCG and Leicester City CCG for the financial year 2018/19. It outlines the context within which the plans have been produced and also provides specific details on plans for investments and savings. It provides confirmation that the CCGs intend to deliver financially against key NHS England requirements. The submission on the 30th April shows an in year balanced plan for all three CCG's.

Overall, since the (Leicester, Leicestershire and Rutland) LLR CCGs operate within limited financial budgets, they have a duty to ensure that allocated funds are spent on efficient and effective health care services for the population ensuring value for money and appropriate use of NHS funds.

Context

All of the health and social care organisations in LLR face financial challenge, as demand and demographic growth for services out-strip the increased resources available year on year.

Without developing new ways of working the impact of increased demand creates a financial gap for health and social care across LLR of £387.5m by 2021/22.

The LLR system has been aware of this continuing demand and resource gap for some years and has produced a 5 year Sustainability and Transformation Partnership Plan, the final version of which is due to be published in Spring 2018. The CCGs' 2018/19 financial plans represent the detailed plans for year 3 of the STP plan.

The Financial Plan

In line with NHS England requirements for 2018/19, the CCGs plan to deliver against all business rules:

- Delivery of a break even position in year.
- Holding an uncommitted contingency of 0.5%
- Remain within Running Cost Allocation
- Delivery of the Mental Health Investment Standard, ensuring planned Mental Health resources grow in line with CCG allocations
- Delivery of significant QIPP savings to fund required investment.
- Funding of activity growth as per NHS England minimum levels.

Financial Plan Summary 2018/19	**LC CCG (£'000)**	**WL CCG (£'000)**	**ELR CCG (£'000)**
Recurrent Baseline Growth	12,338	12,262	10,320
Co-Commissioning Growth	1,399	933	577
Reduction in running costs allocation	-12	-4	-10
Allocations made recurrent	344	-961	-1071
Non recurrent allocations	260	321	221
NET CHANGE IN FUNDING	**14,329**	**12,551**	**10,037**
Recurrent Impact from 2017/18	7,129	7,397	1,595
Demographic Growth	2,871	3,131	2,047
Non Demographic	12,370	12,201	10,530
Inflation	9,435	8,150	7,362
Efficiency	-6,600	-6,383	-5,419
Net QIPP	-18,055	-20,495	-19,645
Cost Pressures	3,415	4,684	10,180
Increase/(Decrease) in surplus	0	0	0
Investments:			
Other	1,202	1,425	848
Replacement of Contingency Reserve	2,562	2,441	2,539
NET CHANGE IN EXPENDITURE	**14,329**	**12,551**	**10,037**

Quality, Innovation, Productivity and Prevention (QIPP)

In 2017/18 the LLR CCGs planned, implemented and delivered a number of QIPP schemes. These were designed to change various elements of care pathways in order to improve either quality of care, productivity or prevention. A number of the schemes were designed to change services in such a way that funds could be moved from one care setting to another or from one service to another and in so doing, delivering increased volume and or quality of care for the same cost. The full list of QIPP schemes agreed for 2018/19 is contained in Appendix 3.

Our financial modelling for 2018/19 requires an unprecedented level of QIPP savings to be delivered across LLR CCGs to support financial stability across the system. Many of the QIPP schemes are intended to involve service transformation such as New Models of Care, Service Configuration and Re-designed Pathways. There are also a number of transactional QIPP schemes expected to improve efficiency and value for money.

QIPP projects have been developed in partnership across LLR as part of the STP and planning process and have undergone a confirm and challenge process to ensure they are clinically safe, move the CCG towards its goals and have been developed in conjunction with the local clinicians.

During the year further work will be undertaken across LLR to identify new schemes to mitigate any risk of shortfall in delivery.

Investments

Due to the financial challenge faced by the CCGs there is little funding available for investments during 2018/19. The majority of investments will be spent in the following 4 areas:

- To reinstate the 0.5% contingency reserve to manage risk during the financial year.
- To achieve the General Practice 5 Year Forward View
- To support the delivery of QIPP savings
- To achieve mental health parity of esteem and make suitable transformation of Mental Health services

Other assumptions

The LLR CCGs' financial plans are aligned with latest planning guidance received from NHS England and others, specifically including the following:

- Tariff Inflation is applied at a net level of 0.1%.
- Increases in tariff relating to CNST charges have been incorporated into the plan.
- Whilst BCF plans for 2018/19 are in the final stages of agreement, all CCGs have assumed the minimum level of funding will be fully spent.
- CHC Non demographic Growth has been based on historic levels of growth pre-QIPP.
- Acute growth has been calculated to account for demographic changes.
- Non-demographic growth is also factored into these plans to reflect the ageing population and the impact this has on healthcare required.

Risks and Mitigations

The major financial risk is the delivery of QIPP at the targeted level across LLR CCGs. Mitigation against this and other financial risks within the plan is as follows:

- A 0.5% Contingency will be set aside to guard against adverse risks
- Further QIPP schemes will be developed and implemented during the financial years to ensure delivery of the required position.

Risks and mitigations to delivery of the Operational Plan are contained in Appendix 4.

Activity

LLR CCG 2018/19 activity plans have been developed by considering trends from2014/15 to the current year to date. Trends have been established by CCG, by speciality, by Point of Delivery (POD) and by UHL and non-UHL providers. Each POD and speciality has been plotted and manually reviewed to identify any step changes, for example pathway or coding changes. Where a step change has occurred, only activity post the change has been used in establishing trends.

An alignment has then taken place between each CCG's growth trends, UHL growth assumptions and the national planning guidance assumptions. Where CCGs have modelled growth rates (net of QIPP) at variance from the national assumptions, each CCG has undertaken a validation process to determine the level of growth to be applied to their plan. As a minimum, all LLR CCGs have adopted the national percentage growth assumptions for each POD, net of QIPP.

The final growth figures applied are detailed in the following tables. Full plans are attached as Appendix 5.

Leicester City CCG

POD	Plan	Growth
GP Referrals	73,510	0.8%
Other Referrals	40,709	4.6%
1st OP New	98,234	6.4%
Follow UP OP	176,013	5.1%
Day Cases	33,521	5.8%
Elective Admissions	4,978	1.0%
Non Elective (0 LOS)	15,282	5.6%
Non Elective (+1 LOS)	27,329	0.9%
A&E Attendances	143,363	1.1%

West Leicestershire CCG

POD	Plan	Growth
GP Referrals	79,782	0.8%
Other Referrals	45,658	4.6%
1st OP New	104,733	6.4%
Follow UP OP	195,875	4.1%
Day Cases	46,336	7.0%
Elective Admissions	6,509	0.3%
Non Elective (0 LOS)	11,311	5.6%
Non Elective (+1 LOS)	27,273	3.2%
A&E Attendances	124,017	1.1%

East Leicestershire and Rutland CCG

POD	Plan	Growth
GP Referrals	71,406	0.8%
Other Referrals	37,151	4.6%
1st OP New	98,467	6.4%
Follow UP OP	176,284	4.1%
Day Cases	40,569	4.2%
Elective Admissions	6,473	0.3%
Non Elective (0 LOS)	9,614	5.6%
Non Elective (+1 LOS)	23,611	0.9%
A&E Attendances	121,427	1.1%

Key Actions

The key actions set out in this Operational Plan are designed to deliver:

- The STP plan solutions to close the financial, health and well- being and quality gap;
- Address the Nine Must Dos in the Planning Guidance; and
- The Constitutional and Operational targets.

We are working collaboratively across the three CCGs and our two main providers in development of this Operational Plan. Therefore the majority of the key actions set out in this section of the plan are LLR wide and as such all three CCGs and providers are working together to implement and deliver these.

For each key action we have developed a high level Project Document which sets out a scheme overview and key actions; baseline activity and trajectories (where this is appropriate); investment required; savings to be achieved; activity changes; and a high level implementation plan. Each key action is detailed in a Project Document at the end of this Plan, pages 16 to 82.

The key actions have been through a confirm and challenge session to ensure the robustness of the plans. The majority have detailed project plans and or business cases in place.

The focus now is to concentrate on the implementation and delivery of the key actions. Each of the key actions has a lead CCG and it will be their responsibility to implement and deliver on behalf of all three CCGs and the LLR system.

To support this each key action has a Chief Executive/Accountable Officer lead; an Executive SRO; a clinical lead(s) and an implementation manager. More information on our governance can be found later in this plan, page 13. We have programme management arrangements in place to support delivery and provide information to partners on progress.

In addition at a system level the System Leadership Team (SLT) made up of Chief Executives/Managing Directors from across the health sector together with clinical leaders from the NHS organisations and very senior representation from Local Authorities will oversee delivery of the STP plan solutions. Each STP workstream has an SLT sponsor.

At a CCG level the delivery of the QIPP schemes set out in this Operational Plan will be overseen by the LLR QIPP Delivery Board which is made up of Executives from each CCG. East Leicestershire and Rutland CCG co-ordinate the overall QIPP programme on behalf of the three CCGs.

The following table gives an overview of how the key actions map to the STP solutions and the Nine Must Dos. Further information on how our plans map to the Nine Must Dos can be found in Appendix 1.

Key Action	STP	Must Do
Planned Care		
Urgent Care		
Integrated Teams		
Medicines Optimisation		
CHC		
Adult Mental Health		
Community Services Review		
CCG Efficiencies		
Home First		
Primary Care		
Cancer		
Children Mental Health		
Children's, maternity, neonates		
Learning Disabilities		
Self-Care and Prevention		
Acute Reconfiguration		
IM&T		

Governance

To deliver the plans set out in this Operational Plan the following governance arrangements are in place. Some of these arrangements will change should the three CCGs move towards a single management team but the level of assurance requirement will remain the same.

At a system level:

- The overall delivery of the STP plan will be overseen by a Senior Leadership Team made up of Chief Executives from providers; CCG Managing Directors; very senior representation from local authorities; and a clinical lead from each of the NHS organisations to provide robust clinical oversight and scrutiny.
- Each member of SLT has a sponsor role to a number of key schemes set out in this Operational Plan. They are responsible for the overall delivery of their schemes supported by a Senior Responsible Officer and Implementation Leads.
- Regular updates on the three CCGs' progress against this Operational Plan will be provided to the GP board member lead forums. This will facilitate clinical oversight to ensure the programme remains clinically relevant and that progress is maintained.

At a scheme level each has:

- A member of the System Leadership Team (SLT) having responsibility for overall delivery (for key schemes).
- An Executive Senior Responsible Officer to ensure delivery.
- For clinical workstreams there is a lead clinician and in some schemes such as Urgent Care there are clinical leads from primary and acute.
- An implementation manager to oversee the day to day implementation of the scheme.
- A group that oversees the development and implementation of each scheme.

We have programme management arrangements in place and they monitor progress of delivery and report this to the System Leadership Team and the LLR QIPP Group.

At CCG Implementation level:

- Each CCG has a lead area of responsibility on behalf of the three CCGs and is responsible for delivering the LLR schemes that relate to that area. Where there is a risk to delivery then escalation will take place through the programme management arrangements already described to the System Leadership Team.
- A LLR CCG QIPP Group meets on a fortnightly basis to monitor progress against QIPP schemes and to take corrective action where necessary or escalate to the Managing Directors' Meeting. This group is made up of Executives from the three CCGs.
- Each organisation has processes in place to assure delivery, which feeds into the monthly LLR QIPP meeting through a confirm and challenge approach.
- Once a month QIPP delivery is discussed at the Managing Directors' meeting to ensure corrective action can be taken quickly if needed.
- An LLR QIPP tracker is in place which is used to monitor progress both by individual organisations and the LLR QIPP group.

Evolving our governance arrangements

As we move towards more system-based delivery of solutions, our governance arrangements will need to change. Proposals are currently being considered on how we can move our current governance arrangements around delivery from organisational based to

system based. We are also looking at our Programme Management Office arrangements to see if these need strengthening.

Engagement, Involvement and Consultation

Engagement has been integral to the STP process and the associated Better Care Together Programme (BCT). A wide variety of stakeholders have been involved ranging from statutory bodies, elected officials, local authorities, the voluntary and community sector, right through to patient and public groups.

During spring of 2015, a large scale public campaign was launched across LLR which explained the current position of health and social care services in the area, and ensured that the priorities of the local communities and other stakeholders, matched the direction of travel of the BCT programme. Over 1000 responses were received, and a population reach of over 375,000 was achieved through various engagement techniques. The data was used to inform our Draft STP plan published in November 2016.

Following the publication of the Draft LLR STP plan in November 2016 further engagement took place with the public and our stakeholders. This resulted in 11,929 interactions over a variety of media including events; focused group events; and digital and social media. We also received feedback on our Draft Plan from NHS England. All of this feedback from this engagement has been used to inform the development our final STP.

In addition, individual Better Care Together work streams have also undertake extensive engagement with carers, patients and staff over the last three years which has supported the redesign of services.

Engagement in 2018/19

This year there are a number of schemes, both generally and within our STP that require engagement and involvement with patients, service users, carers and staff to understand their experiences of the care they receive and what matters most to them. A number of schemes previously engaged on are now at a stage of co-production with staff and patients. In addition, there are a number of transformational schemes within our STP that require formal consultation.

Topics for engagement and involvement are:

- New low value and not routinely funded treatments;
- Integrated Locality Teams in East Leicestershire and Rutland and Leicester City;
- Activities within the GP Forward View including extended hours;
- Changes and improvements within individual GP practices;
- Community services review;
- Review of local short break (respite) for carers of people with a learning disability.

We move to a stage of co-producing the following services (that have previously been engaged on) with patients and service users:

- Integrated Locality Teams in West Leicestershire;
- End of Life;
- Cardiorespiratory services;
- Falls services.

There are a number of key transformational schemes that we will be working towards consultation on during 2018/19; however the likelihood of consultation in 2018/19 is limited, with the possible exception of the configuration of community services in Hinckley. The timing of the consultation will be dependent on the approvals process of either NHS England, NHS Improvement and the Department of Health or for some initiatives all three. Whilst going through the

approvals process we will engage further on these programmes of work.

- Reconfigure hospitals to move all acute clinical services onto two sites: Leicester Royal Infirmary and Glenfield Hospital. Retain some non-acute health services on the site of Leicester General Hospital (LGH).
- Remodel maternity services to create a new maternity hospital at the Leicester Royal Infirmary and subject to the outcome of the consultation, a midwife-led unit at the Leicester General Hospital will be considered. Close the birthing unit at St Mary's, Melton Mowbray.

Reconfigure community hospitals, which will involve closing the Feilding Palmer Hospital in Lutterworth and Hinckley and District Hospital.

Timescale for formal consultation

An STP update is due to be published in June/July 2018. This will enable:

- Engagement to take place on the overall proposals set out in the STP; and
- A continuation towards formal consultation to be undertaken.

Action	Date
Formal approval of STP update by Boards	June/July 2018
Publish STP update	June/July 2018
Engagement of wider STP starts	May 2018
Commence engagement for community services review	June/July 2018
Commence further engagement on acute reconfiguration	July 2018
Consider responses from engagement	From Autumn 2018
Patient and insights to influence proposals from	Autumn 2018

Scheme: Planned Care	**Nine Must Do**		**STP Priority**	**√**	**GIRFT**	**√**	**MOO**	**√**	**RightCare**	**√**	**Other**		

Scheme Description - Reducing demand for New Outpatient Appointments: Driving down secondary care demand for new outpatients referrals by 20% through the use of referral management tools:

- **Standard Referral Forms:** in 2017/18 200 pathways have been developed and launched onto the PRISM system this will enable, together with the national programme for electronic referrals which is due to go live in April 2018, all GP planned care referrals to UHL to be made electronically to a prescribed format which is designed to ensure that referrals are of a good quality first time and meet the relevant criteria. In 2018/19 LLR will support the increased usage of PRISM by GPs through our primary care incentive schemes.
- **Advice and Guidance:** in 2017/18 27 specialities have launched an Advice and Guidance (A&G) service for GPs that has resulted in 80% of those referrals to A&G not requiring an outpatient appointment. In 2018/19 LLR will support the increased usage of this service by GPs through our primary care incentive schemes.
- **Peer to Peer review of referrals**: in 2018/19 LLR will continue through primary care incentive schemes to ensure that GP referrals, except 2 week waits, are peer reviewed prior to referral to secondary care.
- **Agreed Referral Protocols**: in 2017/18 work has been done to review LLR's Low Value and Not Routinely Funded treatment policies, this has resulted in a number of treatment policies being updated and 70 new treatments identified that could be added to the protocol. In Quarter 1 of 2018/19 engagement will take place on the proposals for introducing new treatments to the protocol to ensure changes are influenced by patient voices with a view of implementation into acute contracts in Quarter 2 2018/19 with impact from Quarter 3 onwards.
- **Prior Approval**: to support the Agreed Referral Protocol work a pilot is underway to identify the need and benefit of introducing a prior approval process to treatments within the Low Value Treatment Policy. Should this be successful the plan would be to introduce a Prior Approval Process on the other treatment policies from Quarter 1 and the new ones from Quarter 3 2018/19.
- **Triage hubs:** by the end of Quarter 1 of 2018/19, triage functions for MSK, Rheumatology, and Pain will be operational; Ophthalmology will go live in Quarter 2 2018/19; and Gastroenterology, Dermatology and ENT will go live Quarter 3 2018/19.

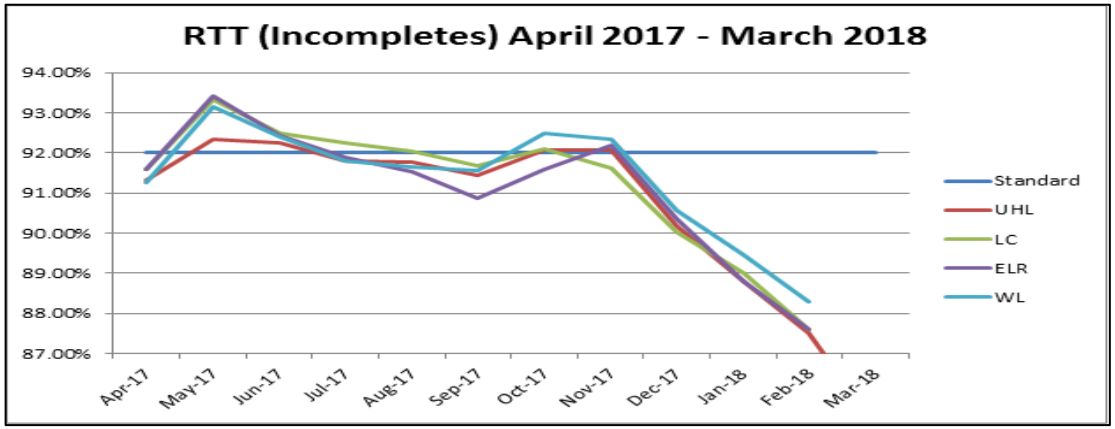
Transforming Planned Care: Ensuring cost effective planned care pathways by:

- **Full pathway reviews**: will be undertaken, over the next two years, in the following areas to enable the removal of duplication and inefficiencies and to integrate services where it makes sense to do so including the use of shared care – Gastroenterology; Ophthalmology; Cardiology; Dermatology; Urology; ENT; Respiratory; General Surgery; Clinical Haematology; Neurology; Gynaecology; Sleep; Physiotherapy; and diagnostics. This will include reducing outpatient follow ups by reducing clinical variation, removing unnecessary follow-ups, using virtual clinics, non face to face appointments and through open access referrals; reducing DNA and cancelled appointments; improving theatre utilisation to deliver the agreed average case per list; clinic utilisation above 95% and efficiencies of system wide scheduling; ensuring that procedures are undertaken in the most cost effective setting using the information provided through the Step Down Surgery Programme and BADS and maximising the use of the LLR Alliance; improving length of stay for patients; and wherever possible taking out premium rates.
- **Redesign of audiology:** to ensure a pathway approach to treatment and costs.
- **Redesign diagnostics**: to ensure that procedures are undertaken in the most appropriate setting.

- **Shared Care**: review LLR's shared care arrangements to increase the uptake of shared care within the primary care setting either via individual GP practices or through collaborative arrangements – this will be part of the full pathway review work.
- **Repatriation of out of area:** independent work and general income schemes back into the LLR system.
- **MSK Physiotherapy**: fully implement a new integrated pathway which commenced in Quarter 4 2017/18.

Baseline Positon and Trajectory

- RTT performance in 2017/18 is shown in the graph below, with the operational standard of 92% of incomplete waits within 18 weeks achieved in four months during 2017/18. The standard was not achieved from December 2017 to March 2018 as an effect of the elective pause which took place between December 2017 and January 2018, and the winter pressures ongoing throughout Quarter 4.



The un-validated performance for LLR CCGs in March 2018 is four 52 week incomplete pathways, with a trajectory of zero > 52 week incomplete pathways for 2018/19.

RTT 2018/19

Month	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
Trajectory	85.5%	86.6%	87.6%	88.6%	89.5%	90.2%	90.9%	91.5%	89.7%	88.3%	90.5%	92.0%

The elective pause in January 2018 and ongoing pressures into February and March 2018 have significantly impacted on the RTT incompletes, resulting in an increased number of patients on UHL incomplete RTT list with a corresponding increase in people waiting over 18 weeks. The current trajectory assumes that the 2018/19 refreshed planning guidance will be achieved, and furthermore, the 2017/18 operational standard of 92% incompletes will be achieved by March 2019.

To support the delivery of the RTT target:

- UHL will continue to work on internal efficiencies in theatres, waiting list management, skill mixing and also consultant recruitment.
- The shift of activity into the Alliance continues, with potential for activity to shift to the Provider Company Ltd. (PCL) of the Alliance following the transfer of the AQP

contracts.

- Commissioners are working to ensure best flexible use of available capacity across the STP footprint through the 2018/19 contract plans including Independent Sector providers alongside UHL, the Alliance and Out of County providers.
- The transformation and demand schemes detailed will also support delivery.

High Level Plan

Key Actions	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018	Sept 2018	Oct 2018	Nov 2018	Dec 2018	Jan 2019	Feb 2019	Mar 2019
Drive up the usage of PRISM and Advice and Guidance in primary care												
Peer to Peer Reviews in primary care												
Undertake engagement on new low value and not routinely funded treatments												
Implementation of new low value and not routinely funded treatments												
Assessment of Prior Approval Process Pilot												
Triage development for Ophthalmology												
Triage development for Gastro; Dermatology and ENT												
Phase one pathway reviews												
• Review pathway												
• Implement pathway												
• Delivery												
Phase two pathway reviews												
• Review pathway												
• Implement pathway												
• Delivery												
Audiology												
• Determination of route to implement new pathway												
• Implement new pathway												
Diagnostics												
• Develop proposals and approvals												
• Implementation												
MSK Integrated Physiotherapy												

Gross Savings

	City	East	West	Total
Demand Management 1st	144,075	470,000	292,936	**907,011**
Demand Management Follow Ups	86,694	263,000	149,865	**499,559**
Low Value Treatments	39,951	64,789	64,789	**169,529**
Pathway Redesign	638,209	264,000	535,383	**1,437,592**
Audiology	47,913	0	47,913	**95,826**
MSK Physiotherapy	292,059	212,821	292,059	**796,939**
Physiotherapy	32,297	0	32,297	**64,594**
Diagnostics	239,437	0	239,437	**478,874**
Totals	**1,520,635**	**1,274,610**	**1,654,679**	**4,449,924**

Investment

	City	East	West	Total
Planned Care Pay and Non Pay	191,973	191,973	191,973	**575,919**
IT Investment	56,667	56,667	56,667	**170,001**
Total	**248,640**	**248,640**	**248,640**	**745,920**

Net Savings

	City	East	West	Total
Gross Savings (all schemes)	1,769,276	1,567,640	1,903,329	**5,240,245**
Investment (all schemes)	-248,640	-248,640	-248,640	**-745,920**
Total Net Savings	**1,520,636**	**1,319,000**	**1,654,689**	**4,494,325**

Activity Changes

	City	East	West	Total
New Outpatient	-1,198	-1,011	-1,758	**-3,967**
Follow Ups	-1,187	-1,282	-2,115	**-4,584**
Electives	-15	0	-20	**-35**

Scheme: Urgent Care	**Nine Must Do**	√	**STP Priority**	√	**GIRFT**		**MOO**		**RightCare**		**Other**		

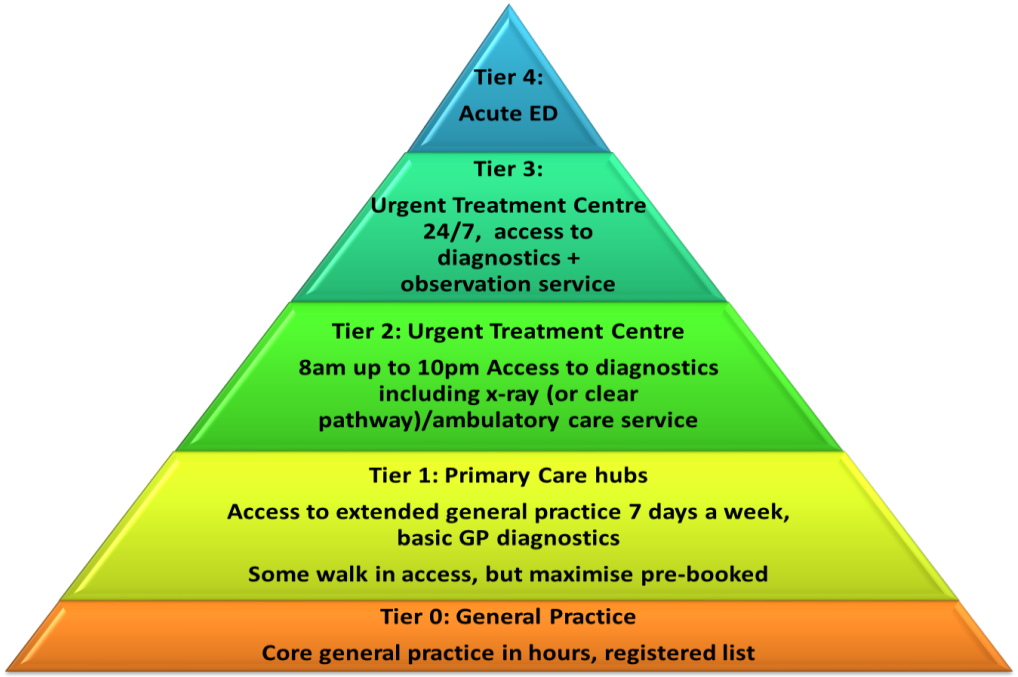
Scheme Description

Our vision is to create a health and care system that provides responsive, accessible person-centred services as close to home as possible. It will be a model in which services will wrap care around the individual, promoting self-care and independence, enhancing recovery and reablement, through integrated health and social care services that exploit innovation and promote care in the right setting at the right time. In this way, we anticipate we can better manage patients with long term and complex conditions and we can reduce the demand on the Emergency Department at acute hospitals and ambulance services. To do this, we have taken forward a significant redesign of community urgent care services in LLR, to deliver services accessible 24 hours per day, seven days a week in community and hospital settings. Enhanced clinical assessment and navigation is a central part of the new integrated urgent care offer, reducing demand on ambulances and acute emergency services.

Progress we have made in 2017/2018: We have redesigned community urgent care services to deliver consistent, integrated urgent care 24/7, reducing duplication through functional integration. Services are organised on a 'tiers of care model', integrating extended primary care and out of hours care, as shown in the diagram to the right. The key changes we delivered in 2017/2018 included:

- Delivery of clinical navigation through the LLR navigation hub – an IUC CAS model supporting NHS 111. 49% of patients now speak to a clinician after calling NHS 111. Clinicians in the hub have access to the primary care record and SCR2
- Progress made on information sharing, interoperability and direct booking. NHS 111 and the navigation hub can book into all LLR urgent care services. We have begun to enable direct booking to GP practices and build direct booking links from the LRI ED to urgent care services, including into City hubs
- Mobilisation of a redesigned 24/7 home visiting service, incorporating out of hours visiting, acute visiting service and night nursing
- Commissioned new UCC and primary care hub services in WLCCG and City CCG, delivering extended primary care access alongside urgent care services, with appointments bookable through NHS111
- Introduced a 'single front door' model at the LRI ED, which streams patients to the right service, including an integrated primary care service within ED
- Implemented an integrated discharge team at UHL
- Built a predictive modelling tool to support operational response to surges in demand and improve capacity planning
- Piloted 14 discharge to assess beds.

A communications, engagement and marketing strategy developed and supported by organisations within the health system will be implemented to support urgent and emergency care response, promote self-care and the new urgent care model.



What we plan to do in 2018/2019

We have three key objectives to improve the urgent care system in LLR:

1. To improve access to out of hospital services in order to reduce demand on acute services, the Emergency Department and ambulances.
2. To improve hospital operational processes in order to improve the delivery of national targets, and to reduce patient delays.
3. To improve patient and carer experience of discharge by improving discharge processes across the system and reducing delayed transfers of care.

These objectives are reflected in the structure of the Urgent and Emergency Care programme plan, which has three main strands of work, inflow, flow and discharge. Our plans within each key area are described in more detail below. Our aim is to strengthen primary care to reduce the presentation of patients into urgent and emergency care, while at the same time strengthening the provision of out of hours and urgent care in the community. Crucial to the success of the system is adequate urgent care provision in the community (i.e. both staff and facilities) and an effective navigation system to ensure patients are directed to the appropriate place for their care.

Managing demand for emergency care services (Inflow): Key plans for 2018/2018 are:

Expansion of Clinical Navigation: following the successful implementation of the LLR Clinical Navigation Hub (CNH) during 2017/18 we plan to re-commission and expand the model, increasing the volume of cases receiving clinical triage by at least 5% for ED triage and to achieve 75% coverage of 'green' ambulance triage. We will also be increasing the range of conditions passed for clinical assessment, and include referrals to Adult Mental Health crisis services, following the successful implementation of direct transfer of CAMHS patients and non-crisis mental health. The navigation hub has access to SCR2, and we will build on the 'passporting scheme' developed in 2017/18 to increase targeted, proactive care planning by GPs for at risk patients, so that care plans are available to clinicians in the CNH.

We will use Experience Led Commissioning research and high impact improvements that support better outcomes for people who use urgent care services to continue to co-produce the Clinical Navigation Hub.

Introduce 111 online: complete our options appraisal of available tools, and, working with co-commissioners of NHS 111, implement the preferred solution so that there is coverage of NHS111 across LLR by December 2018.

Improving direct booking for patients across the urgent care system: building on the progress made already, during 2018/2019 direct booking will be extended in scope, including booking of in-hours appointments with GP practices and will enable the direct booking of Urgent Treatment Centres (UTC) and extended primary care appointments from the ED front door at LRI.

Reducing ambulance conveyance: implementation of dedicated resource to manage frequent callers with EMAS – EMAS have 110 frequent callers that make more than 5 calls per month. Through having a dedicated call resource as part of the Clinical Assessment and Triage – EMAs can effectively redirect these patients and reduce the conveyance to these callers.

Redesign telephone advice for health care professionals: focussing on providing dedicated consultant support to GPs to reduce emergency admissions and ED attendances for acute medicine, geriatrics and paediatrics, and opening professional advice to EMAS crews in order for them to access clinical advice which would help reduce conveyance to ED.

Implementation of telemedicine within clinical navigation: provide remote support to residents of care homes and their carers through a video link into the LLR CNH, with the aim of reducing ambulance conveyances, attendances to A&E, admissions into hospital and reducing the pressure on the home visiting service.

Complete the designation of UTCs: including developing the capability for electronic prescribing, and further develop the local LLR diagnostic offer in line with the national Specification. Three LLR services are being considered for designation as UTCs in 2018, Loughborough, Oadby and Merlyn Vaz.

Progress the redesign of urgent care services in ELR: following engagement with the public, begin the re-procurement of ELR Urgent Care Centres to deliver extended primary care services and urgent care at least 8am to 8pm, aiming for consistency with the tiers of care model described above.

Mainstreaming of the Mental Health Triage Car: as part of the Winter Escalation the MH Triage Care has been implemented within LLR. The plan is to continue beyond March 2018 and roll out.

LRI Front Door: implementation of effective Primary Care Streaming – UHL have procured a Primary Care Partner to deliver this, which will commence in April 2018 and will implement the newly procured Primary care streaming, integrated with out of hours appointments when other urgent care services are closed overnight. Embed re-direction to community services, UTCs and primary care, with patients given a booked appointment where appropriate.

Increase and Improve Ambulatory Pathways outside of UHL: within the LLR UEC Workstream we have identified three key Ambulatory pathways that can be developed outside of secondary Care in order to divert patients away from ED. Based on presentation at EDU/EFU – 20% of patients with pain, sprains and head complaints that arrive in ED are discharged without any investigations or treatment. Significant amount of this activity is generated by patients who end up with a disposition from NHS 111 to ED. Work is under way to develop Ambulatory Pathways with NHS 111, LLR CNH and UTCs to divert these patients safely from an ED disposition to clinical assessment by the CNH/UTC. Current QIPP assumptions are that 40% of the current ED activity related to this can be deflected from ED.

Liaison Psychiatry: during 2016/17 work was undertaken to improve liaison psychiatry within the ED. We are aiming to meet the NHS service standard for the provision of psychiatric teams in in-patient wards and emergency departments (known as Core 24) by 2020/21. A study of existing services identified the need for improvements, including mental health ward cover. Although LLR was unsuccessful in becoming a wave one site for Core 24, we will bid to become a wave two site in 2018. An all-age place of safety assessment unit opened in June 2017. CAMHS crisis referral direct from NHS 111 went live in August 2017.

Improve ambulance response times: we are developing enhanced services for ambulatory assessment in community settings with rapid access to diagnostics to support assessment and avoid unnecessary attendance at hospital. EMAS began piloting the Ambulance Response Programme (ARP) in July 2017 and we will work with the lead commissioner and NHSE to monitor and improve the response to patients. The EMAS Clinical Assessment Team (CAT) service will begin to integrate with the LLR clinical

navigation service in 2018, developing a consistent response to clinical assessment and non-conveyance and enabling EMAS to view patient records and directly book into LLR services.

Improving patient flow within hospital, to deliver national targets and reduce delays (Flow):

LLR has historically been challenged urgent care system, in relation to ED flow and delivery of the key national target that patients should be admitted or discharged within 4 hours of attending ED. Support has been made available to UHL via NHS Improvement and ECIP, and there is a comprehensive recovery plan to improve ED waiting times in 2018/2019. Plans include:

ED Flow: there are a number of actions which will be progressed to improve flow through ED and reduce patient delays, particularly for patients who do not require an admission. Actions include:

- Optimising streaming and assessment processes - delivering rapid flow through ED to manage demand, with front door streaming and flow co-ordinators. Implementation of planned inter-professional standards for UHL and an enhanced response from clinical specialties to ED, including monitoring and performance management of standards. Developing standard operating procedures for rapid assessment from ED to wards across UHL.
- Improving ED staffing and skills mix through undertaking workforce modelling for consultants ensuring skills mix provides adequate cover for evenings/nights.
- Ensuring 7 days a week availability of beds for emergency admissions
- Redesign of the LRI 'hot floor' and ambulatory pathways i.e. AMU, EDU to assist with streaming and flow, with a focus on admission avoidance
- Ensuring that there are robust staffing plans in place for winter and bank holidays.

SAFER: is a practical tool to reduce delays for patients in adult inpatient wards that has been shown to improve the flow of patients through hospital. It includes, aiming to discharge patients in the morning and move others from assessment units to wards before midday, among other measures. We will continue to roll out this approach across all wards in UHL and LPT over 2018/19 – supported by seven day discharge capabilities. Actions include:

- Maximising the use of Nerve Centre for all e-beds medical handover, board rounds and escalation of care
- Ensuring senior clinicians attend board rounds to ensure timely discharges to free up beds for ED admissions
- Increasing discharge planning the day before, and early writing of TTOs and discharge letters by clinical staff.

Embedding Red to Green across LLR: Red to Green is an initiate that support the SAFER flow bundles by asking clinicians to actively consider what the next step a patient is waiting for and eliminate time spent on process delays rather than clinical care. R2G is already in place on UHL and LPT wards, but it will be further embedded by the following actions:

- Implementation of a visual management system to assist in the identification of wasted time in a patient's journey, focussing on reducing delays for stranded and super stranded patients
- Develop educational tools to support staff with Red to Green processes and reporting
- Maximise the benefit of implementation of the medical step down ward
- Ensure interface with transport supports timely discharges and NEPTS capacity meets demand.

Predictive Modelling: we have developed a real-time demand and activity model to improve management of operational resource and capacity and enable longer term planning. The predictive modelling tool is now in live testing and is being used by UHL to develop responsive plans to surges in demand. In 2018/2019 we will deliver training on use of the model to key operational staff, and undertake an evaluation of the effectiveness of the tool.

Improving discharge processes to improve patient experience and reduce patient delays (Discharge). Our key priorities for improving discharge are:

Delivery of DTOC action plan: linking with the three BCFs across LLR. We have made some good progress on reducing DTOC rates in 2017/2018, and LLR has lower discharge delays than the England average. However, we can make further improvements, particularly to reduce delays which are categorised as 'health', and within mental health and community hospitals.

Designing and implementing a consistent approach to 'Discharge to Assess': we have agreed five clear discharge pathways in LLR, and in 2018/2019 we will continue to implement them so that patients are cared for in the most appropriate setting, and that the approach of 'home first' is taken wherever possible, reducing unnecessary stays in hospital. This will have the impact of reducing numbers of assessments done within an acute hospital setting to less than 15% of patients. Concrete actions include procuring the bed based 'Pathway 3' model, including care home beds and therapy to support reablement, and redesigning ICS as part of an integrated home based reablement and rapid response model.

Trusted assessment: developing the trusted assessor role, which currently only covers Pathway 3, so that there are more trusted assessors across the system, and that there are assessors whose work on behalf of care homes. In 2018/2019 we will implement the preferred solution for sharing electronic information to support discharge assessments across health and social care organisations, rolling out a successful model used in Rutland.

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Fully implementing the end to end CHC process within UHL: creating a single team responsible for assessment, case management and brokerage, supporting the discharge to assess approach, and reducing the time taken to complete the CHC process.

Further develop the IDT and the LLR discharge hub: through the Better Care Fund (BCF) LLR health and social care partners have developed plans to improve care and assessment within the community setting that demonstrates how the additional investment in adult social care supports improving discharge processes and community based offers that enable effective discharge. We are mapping our local offer and services against the High Impact Change Model (a way of assessing transfers of care) through which we have identified gaps. Through our Home First work stream we have developed our plan to deliver an integrated approach to allow assessments of future care to be made outside hospital. This has included the development and pilot of reablement within a nursing/care home setting. We are developing a business case for a longer term reablement programme, incorporating learning from the pilot. In addition, as mentioned above, we are in the process of implementing an end to end CHC process. We will also be working with the Care Sector to develop and strengthen the local market to enhance health in care homes using the King's Fund Clinical Network to support this.

We have a number of discharge pathways in place and in 2018/19 we will do work to improve the flow through pathway two and three and to support the quality of care in pathway three we will commission a set of beds in the care home sector supported by therapy and case management.

Baseline Trajectory

A&E 4 Hour Wait – National Standard 90% by September 2018 and 95% by March 2019

Standard	95%	E.B.5	April	May	June	July	August	September	October	November	December	January	February	March
Monthly Diff. Tolerance	25%													
UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST	2015/16	Number Waiting > 4 Hrs	1,391	1,578	1,379	1,433	1,715	1,768	2,131	3,632	2,833	3,694	3,670	4,585
		Total Attendances	18,357	19,135	18,729	18,363	18,216	18,320	19,166	19,895	19,058	19,602	18,540	20,378
		%	**92.4%**	**91.8%**	**92.6%**	**92.2%**	**90.6%**	**90.3%**	**88.9%**	**81.7%**	**85.1%**	**81.2%**	**80.2%**	**77.5%**
	2016/17	Number Waiting > 4 Hrs	3,549	4,227	3,771	4,652	3,859	3,932	4,439	4,591	4,973	4,242	2,853	3,315
		Total Attendances	18,924	20,983	19,462	20,149	19,377	19,553	20,470	20,517	20,328	19,330	17,567	20,620
		%	**81.2%**	**79.9%**	**80.6%**	**76.9%**	**80.1%**	**79.9%**	**78.3%**	**77.6%**	**75.5%**	**78.1%**	**83.8%**	**83.9%**
	2017/18	Number Waiting > 4 Hrs	3,707	4,853	4,325	3,863	3,069	3,108	3,535	4,193	5,715	-	-	-
		Total Attendances	19,539	20,440	19,309	19,090	18,300	19,394	20,411	20,576	20,064	-	-	-
		%	**81.0%**	**76.3%**	**77.6%**	**79.8%**	**83.2%**	**84.0%**	**82.7%**	**79.6%**	**71.5%**			
	2018/19 Plan	Number Waiting > 4 Hrs	5,841	5,388	4,305	3,606	2,994	2,855	3,038	2,714	2,420	2,048	1,668	1,483
		Total Attendances	29,952	30,790	28,700	28,850	27,217	28,550	30,375	30,160	30,245	29,258	27,800	29,667
		%	**80.5%**	**82.5%**	**85.0%**	**87.5%**	**89.0%**	**90.0%**	**90.0%**	**91.0%**	**92.0%**	**93.0%**	**94.0%**	**95.0%**

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High Level Plan

Inflow : Key Actions	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018	Sept 2018	Oct 2018	Nov 2018	Dec 2018	Jan 2019	Feb 2019	Mar 2019
CCB/UHL sign off of Redirection of Adults Protocol at LRI Front Door/implementation												
Mental health triage car service funding solution confirmed/service commences												
Ambulatory pathways developed at LRI and in community												
Implementation of telehealth for care homes												
HCP advice & guidance service available to EMAS												
Direct booking of appointments with MV, Oadby & LUCC from LRI Front Door												
Procurement of clinical navigation hub												
Coverage of enhanced GP access consistent across all localities												
Direct booking of GP practice appointments from CNH in place for all CCGs												

Flow: Key Actions	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018	Sept 2018	Oct 2018	Nov 2018	Dec 2018	Jan 2019	Feb 2019	Mar 2019
Workforce remodelling to resolve the problem of evening & overnight deterioration in ED performance												
Robust winter and bank holiday processes implemented												
Implement hot floor to ensure efficient patient flow												
Develop educational tools and support for Safer Programme with reporting for adherence in place												
Maximise benefit from implementation of medical step down ward once re-sited at LRI												

Discharge: Key Actions	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018	Sept 2018	Oct 2018	Nov 2018	Dec 2018	Jan 2019	Feb 2019	Mar 2019
Procurement of Pathway 3 14 reablement beds, framework and in reach therapy												
DTOC Monitoring and Improvement – review and refresh the monitoring and monitor improvement through the DWG – T&F group set up												
Implementation of electronic Trusted Assessment												
Embedding the Integrated Discharge Team and develop the LLR Discharge Hub												
Redesign of ICS												
Implementation of CHC end to end Process within UHL												
Increase the usage of HART and home-based reablement to support Home First												

Gross Savings

	City	East	West	Total
ED Front Door 1	97,007	24,000	45,570	**166,577**
ED Front Door 2	63,960	2,000	10,140	**76,100**
Ambulatory Pathways 1	113,274	30,000	58,869	**202,143**
Ambulatory Pathways 2	174,082	57,000	140,806	**371,888**
Ambulatory Pathway 3	32,000	13,000	27,200	**72,200**
Clinical Triage	34,000	11,000	10,017	**55,017**
Clinical Navigation Hub	105,000	35,000	74,404	**214,404**
NEPTS Eligibility	136,000	56,000	152,000	**344,000**
Urgent Diagnostics	2,000	4,000	34,404	**40,404**
Reduce Conveyance	184,170	0	13,545	**197,715**
Discharge Pathways	168,000	125,000	166,000	**459,000**
Frailty	78,750	34,000	63,750	**176,500**
Passporting	17,293	11,000	21,134	**49,427**
Total	**1,205,536**	**402,000**	**817,839**	**2,425,375**

Investment

	City	East	West	Total
ED Front Door 1				
ED Front Door 2				
Ambulatory Pathways 1				
Ambulatory Pathways 2				
Ambulatory Pathway 3				
Clinical Triage	18,000	7,000	5,000	**30,000**
Clinical Navigation Hub	20,000	11,000	14,000	**45,000**
NEPTS Eligibility				
Urgent Diagnostics	500	1,500	13,000	**15,000**
Reduce Conveyance				
Discharge Pathways	84,000	83,000	83,000	**250,000**
Frailty				
Passporting				
Total	**122,500**	**102,500**	**115,000**	**340,000**

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Net Savings

	City	East	West	Total
ED Front Door 1	97,007	24,000	45,570	**166,577**
ED Front Door 2	63,960	2,000	10,140	**76,100**
Ambulatory Pathways 1	113,274	30,000	58,869	**202,143**
Ambulatory Pathways 2	174,082	57,000	140,806	**371,888**
Ambulatory Pathway 3	32,000	13,000	27,200	**72,200**
Clinical Triage	16,461	4,000	5,017	**25,478**
Clinical Navigation Hub	85,406	24,000	60,403	**169,809**
NEPTS Eligibility	136,000	56,000	152,000	**344,000**
Urgent Diagnostics	1,000	2,000	21,404	**24,404**
Reduce Conveyance	184,170	0	13,545	**197,715**
Discharge Pathways	84,000	42,000	83,000	**209,000**
Frailty	78,750	34,000	63,750	**176,500**
Passporting	17,293	11,000	21,134	**49,427**
Total	**1,083,403**	**299,000**	**702,838**	**2,085,241**

Activity Changes

	City	East	West	Total
A&E Attendance	-2,969	-3,890	-2,486	**-9,435**
NEL Admissions 0 LOS	-242	0	-264	**-506**
NEL Admissions +1	-41	0	0	**-41**

Scheme: LLR Integrated Teams	**Nine Must Do**		**STP Priority**	**√**	**GIRFT**		**MOO**	**√**	**RightCare**		**Other**		

Scheme Description:

We are in the process of redesigning services to support a model where ill health can be prevented, unnecessary demand on the health and social care system avoided and hospital stays reduced. We are creating teams of health and care workers, who under the direction of local GPs provide comprehensive support to vulnerable patients and those with long term and complex conditions. There will be two types of teams, those based in a geographical area (known as 'integrated locality teams') and others focused on specific conditions or issues (known as 'specialist integrated teams'). The teams will be made up of staff from different organisations and disciplines. They will work with patients to help them look after themselves and therefore, wherever possible, prevent conditions deteriorating or crises occurring, as well as ensuring when they do need care it is provided quickly. Key areas of focus in 2018/19 are:

End of Life Care: following redesign of the End of Life Care pathway into an integrated, patient-centred coordinated offer involving several organisations in 2017/18, we will progress the integration of community teams and reducing organisational boundaries. GP's will be supported to identify patients that are End of Life and ensure a more efficient patient offer is available. We will expand day and night services to meet current demand and support gaps that have been quantified through a Health Needs Assessment. We will develop a co-ordination centre for community services accessible by clinicians, patients and carers offering 24/7 access to specialist support. We will also develop and implement a training and education strategy across LLR for all professionals who will work in some capacity with palliative patients.

We will support the delivering of the integrated service through implementation of a joint communications and co-production plan that will co-produce services with people and their carers who have "lived experiences" of services and also inform a wider audience of new efficient patient offer.

Integrated Cardio Respiratory Service: development of an integrated cardiorespiratory community service following integration of respiratory services and cardiology services to provide timely specialist interventions from acute and community services. A coordinated crisis response pathway will support patients along with appropriate telehealth and assisted technology. We will establish respiratory MDTs to support professionals with case management for different levels of acuity and establish a referral management process to ensure appropriate onward referral, refer back to GP for inappropriate referrals (with specialist support) and refer into specialist community based clinics.

This work will start with the integration of LPT and UHL pulmonary rehabilitation services to provide a consistent and efficient offer across LLR and establish a single referral process into the service and the promotion of self-care. We will offer specialist support and knowledge transfer to primary care. In addition, work will commence to ensure the pneumonia pathway is in line with NICE guidelines incorporating elements which can be managed in the community, diverting patients from acute services. We will upskill primary care clinicians to case identify and mange patients better through knowledge transfer, ensuring referrals to outpatients are appropriate through PRISM referral pathways.

To move to this integration we will use the Experience Led Commissioning research and high impact actions to influence service delivery and move from co-designing to co-producing the service with patients involved in the mobilisation phase.

Falls Service: we will implement a prevention, patient self-care and treatment pathway to ensure improved patient outcomes and quality of life, retaining independence where possible and ensuring parity of access to services across the region. It will include a coordinated crisis response pathway. This will minimise admissions to hospital as a result of falls, ensuring residents have access to strength and balance facilities to reduce the risk of injurious falls, and can manage their own care in order to retain independence. There will be a new Triage and Assessment process. Patients will have easier access to information and advice, including strength and balance training, advice on how to safely get up after a fall, and lifestyle information which will also be supported by Public Health messaging. We will make available Advice and Guidance on self-care aspects of preventing falls across main speciality areas and ensure maximisation of primary care usage to avoid deterioration and allow early interventions.

Multi Morbid Pathways and Integrated Locality Teams: during 2017/18 eleven Integrated Locality Leadership Teams have been established across LLR. To date their work has involved a variety of test beds across the localities. The aim was to test our various locally-grown models of integrated working. The range of models included collaborative working between primary care and care home staff, care coordination for patients with complex health and social care needs, a programme if multi-disciplinary team meetings to address the needs of high risk patients and a structured programme of enhanced primary care for multi-morbid and frail patients. It is recognised that in order to achieve the upscale required for proactively managing high risk patient, there are key building blocks that need to be committed to and consistently developed across LLR; these being MDTs, Care Coordination and Risk Stratification. These will be monitored through GP QIPP and Improvement Scheme Frameworks and through provider contracts.

To support this work and to move towards a model of place-based care and full population health and care management strategy, further organisational development has been planned. A series of workshops will be held focusing on LLR prevention offer at a 'place' and commitment to develop a consistent LLR model of care coordination. In parallel to this work, development of a number of pathways impacting on the multi-morbid and frail population in LLR will be redesigned and or improved. These opportunities are primarily within the CVD and Respiratory areas. This work will be undertaken through a collaborative approach with partners working across the system.

We will expand the current patient and carer engagement activities across all integrated locality teams using different methodologies based on the needs of each team.

High Level Plan

Key Actions – Cardio Respiratory	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018	Sept 2018	Oct 2018	Nov 2018	Dec 2018	Jan 2019	Feb 2019	Mar 2019
Establish steering group to support key decision making and implementation of project												
Develop and agree Terms of Reference for Steering Group												
Sign off Service Specification												
Agree methodology for identifying target practices in LLR upskilling and specialist support												
Governance structure for Rehab Services												
Review scoping work for the integration of community pharmacy												
Agree framework to support target practices and measure impact of work												
KPIs and Evaluation Framework to measure effectiveness of service												
Contractual forms for Rehab services												
Review evaluation of clinics, agree requirements of specialist OP clinics in the community												
Options for Crisis Response pathway in the community												
IT infrastructure to support MDT working												
Joint contract form - Combined reporting between multiple providers												
Discuss and agree Triage criteria for triaging OP referrals												
Proposal and plan for the integration of community pharmacy												
Proposal for OP clinics in community												
Agree contractual arrangements for rehab services												
Comms and Engagement planning and update												
Options for Crisis Response pathway in the community												
Progress on pharmacy work												
Contractual options for crisis response pathway												
Findings from system wide end to end pathway review												
Update on triage progress												
2019/20 planning update												
Agree contractual forms for crisis response pathway												
Update on GP targeted programme												
Develop plans for 19/20 based on key priority areas												
Review progress on rehab contractual forms												
Progress on MDT working												
Review progress on implementation of crisis response pathway												
Agree plans for 19/20												
Comms and engagement												

Review progress on rehab services												
Review progress on Pharmacy programme, agree next steps												
Review progress on Crisis response implementation pathway												

Key Actions – End of Life	**Apr 2018**	**May 2018**	**Jun 2018**	**Jul 2018**	**Aug 2018**	**Sept 2018**	**Oct 2018**	**Nov 2018**	**Dec 2018**	**Jan 2019**	**Feb 2019**	**Mar 2019**
Complete notice period on contracts of existing service providers												
Fully integrate current CNS teams through series of pilots												
Check demand and capacity modelling through rapid cycle testing/series of pilots												
Establish Telephony systems for co-ordination hub to facilitate delivery of ICPCT work												
Roll out of SCR V2.1 across LLR (EPaCCS)												
Establish a functional co-ordination centre for the ICPC Service including a single point of access through series of pilots												
Complete integration of existing service providers and have a fully functional Integrated Community Palliative Care Service												
Complete a new contracting form for this service for 19/20 - Alliance or Lead provider (to be determined)												

Key Actions - Falls	**Apr 2018**	**May 2018**	**Jun 2018**	**Jul 2018**	**Aug 2018**	**Sept 2018**	**Oct 2018**	**Nov 2018**	**Dec 2018**	**Jan 2019**	**Feb 2019**	**Mar 2019**
Implementation												
Implementation- Training of non-falls sector staff in falls prevention and management												
Implementation- Weekly monitoring of activity to identify and resolve issues												
Implementation- Further development of prevention programme - short, medium and longer term strategy												
Prevention Programme- Write specification for BAU delivery												
Prevention Programme- Tender for BAU delivery												
Prevention Programme- Supplier in place for prevention delivery from April 2019												
EMAHSN Falls Project												
EMAHSN- Embed final solution and delivery into overall programme schedule												
EMAHSN- Go live at demonstrator sites												
Assistive Technology (AT) in Care Homes project- Single therapy assessment process, including for AT, in place												
Appoint LLR Falls Service Manager from existing workforce for Business as Usual												
Finalise handover and programme documents/budget for Business as Usual												

Key Actions – Integrated Teams	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018	Sept 2018	Oct 2018	Nov 2018	Dec 2018	Jan 2019	Feb 2019	Mar 2019
Agree process measures for implementing building blocks												
Ensure process measures for building blocks are embedded in GP incentive schemes across the three CCGs												
Proforma/reporting requirements agreed with CCG practices/Federations – includes methodology and frequency												
Baseline to be established in Q1 for process measures and NEL admissions for the three cohorts of patients												
Roll out of risk stratification tool across LLR												
Using 17/18 FOT activity and spend for NEL admissions for the three cohorts of patients, apply 3% growth and using Luton MDT model, establish QIPP target for each CCG												
Ensure measures are incorporated into community contracts under information schedule												
Develop reporting system for monitoring process measures and overlay with NEL KPIs (spend, short stay, activity etc.)												
Organisational Development through in-place leadership funds												
CCGs to develop and have signed off 18/19 plan for moving towards a place-based system.												
Develop and agree model of care coordination												
Agree areas of focus for CVD and Respiratory												
Analysis of multi-morbid population – population profiling and segmenting												
Develop a unified strategy for optimising the health and social wellbeing outcomes												
Identified steps to bridge the gap between current ILT working and integrated team working to the whole population												
Mapping of assets currently available within each locality												
Scope contractual options to support an Integrated care model												
Scope shadow governance options												
Develop a wraparound prevention offer at 'place'												

Gross Savings

	City	East	West	Total
End of Life Care	567,711	662,000	567,945	**1,797,656**
Cardiology and Respiratory	268,052	39,000	177,227	**484,279**
Falls	0	209,246	322,520	**531,766**
Total	**835,763**	**910,246**	**1,067,692**	**2,813,701**

Investment

	City	East	West	Total
End of Life Care	111,910	122,686	107,765	**342,361**
Cardiology and Respiratory	55,287	39,000	48,419	**142,706**
Falls	0	209,246	247,000	**456,246**
Total	**167,197**	**370,932**	**403,184**	**941,313**

Net Savings

	City	East	West	Total
End of Life Care	455,801	539,714	459,946	**1,455,461**
Cardio Respiratory	212,765	0	129,227	**341,992**
Falls	0	0	75,500	**75,500**
Total	**668,566**	**539,714**	**664,673**	**1,872,953**

Activity Changes

	City	East	West	Total
A&E Attendances	0	-72	-76	**-148**
NEL Admissions +1	-192	-32	-223	**-447**
Follow Ups	0	0	-141	**-141**
CHC Fast Tracks	-118	-51	-118	**-287**

Scheme: Medicines Optimisation	**Nine Must Do**		**STP Priority**	**√**	**GIRFT**		**MOO**		**RightCare**		**Other**		

Scheme Description

Over the last three years the NHS organisations in LLR have implemented a range of evidence-based prescribing measures. This has included medicine switches, reducing wastage and implementing guidance. We recognise that more could be done to improve medicine optimisation by working collaboratively across all NHS organisations. For example, nationally 6.5% of emergency admissions and re-admissions are caused by avoidable adverse reactions to medicines; there is over £150m a year of avoidable medicines wastage and only 16% of patients take their medicines as prescribed. Medicines Optimisation is an STP workstream supported by existing Medicines Optimisation activities in each individual organisation The collaborative work will be led by the LLR Medicine's optimisation Programme board which has identified key areas of focus over the next 5 years:

Development of a patient centred care approach for prescribing: this will ensure that:

- the development of new pathways of care ensure that the prescription and supply of medicines for patients is considered at a system level rather than at organisational level improving quality and overall value for money
- there will be improved communication to ensure that information regarding prescriptions is accessible to relevant professionals
- the supply of medicines across the primary and secondary care interface will be reviewed and improved
- a plan for self-care is promoted is developed and facilitated.

Improve medicine's governance and safety. This will focus on:

- sharing and standardising (where possible) standards and policies across LLR
- the development of a system-wide medicine's safety strategy
- the development of a system-wide audit tool
- supporting the work of the LLR Infection Prevention Programme Board to address antimicrobial prescribing.

Implement the Medicine's Value Programme consistently across LLR to:

- improve the supply of medicines where there are issues with supply ensuring value for money across the system
- improve the timely discharge of patients by piloting news ways of working and improve the appropriateness of prescriptions
- streamlining the supply of medicines across the primary and secondary care to reduce wastage and ensuring that patients bring medicines into hospital with them and are transferred with the patient
- reduce waste in primary and secondary care we will review our repeat prescription processes in primary care and from secondary care on treatment courses and duration
- maximise the use of prescribing analysis support tools (e.g. Eclipse) to reduce polypharmacy which leads to a reduction in preventable hospital admissions
- develop effective medication review particularly aimed at decreasing admission, readmission and waste
- improve the management of patients on high cost drugs, review and propose cost-effective supply routes
- develop STP wide formularies, including electronic system of pre-approval of high cost drugs
- review purchasing guidelines and wholesale dealers' authorisations to ensure value for money purchasing across the system.

Develop a joint medicine's optimisation workforce plan to:

- optimise the pharmacy workforce across the STP footprint including community pharmacists
- develop non-medical prescribers
- Undertake a gap analysis of educational needs to enable new ways of working.

LLR High cost drugs (including biologics and biosimilars): in 2018/19 we will:

- continue the biosimilar switch programme enabled in 2017-2018 with a further business case to deliver additional savings using the same model but moving towards a biologics team rather than for specific areas. The use of Homecare to deliver further efficiencies and the implementation of Bluteq to manage expenditure and provide a pre use verification system already used for NHSE funded high cost drugs
- implement the savings realised from the patent expiry (Oct 18) of Humira®
- dispensing of medicines through Trust Med Pharmacy for some high cost drugs such as Tolvaptan
- implement Bluteq for pre use verification and payment monitoring.

LLR 3x CCG Actions: in 2018/19 the three LLR CCGs will work collaboratively to:

- consider where there are opportunities for greater collaboration
- ensure that the medicine impact of both "left shift" and increased prevention are understood and accounted for
- provide real time prescribing data analysis functionality for the CCGs and its member practices as Eclipse Live
- assess position against NHSE Low Priority Prescribing Consultations (Wave 1 and 2) against current formulary and prescribing recommendations already in place instigating reviews where required – see table further down
- deliver Catheter and ONS formulary implementation
- continue to asses rebates in line with the current policy
- evaluate CRP-POCT for respiratory tract infections within GP practice setting from the pilot completed in 2017-2018
- continue with repeat prescribing process reviews and implementation of guidance
- continue to develop the Optimise Prescribing support tool.

Leicester City CCG: specific actions for 2018/19 are:

- continue our pharmacist led work with care homes to optimise patients' medications to reduce medicine related harm and associated unplanned avoidable admission
- continue our Care Homes Dieticians Team to review ONS and embed a food first approach into care
- continue our Practice Medicines Co-ordinator programme and further develop this to include expanding the training of practice prescription and administration staff in relation to reducing avoidable waste from repeat prescriptions so each practice has two or more trained individuals
- following stakeholder engagement which finished in December 2016/17 we will develop and implement revised policies and guidance for the management of repeat prescriptions across all sectors
- continue our programme of prescribing productivity through drug switches, Optimise RX, Rebates, NP8, Unlicensed Specials, Patent Expiries, Top 100 reviews, targeted medication reviews, repeat prescribing reviews, and formulary reviews
- continue our practice level Prescribing Quality Scheme Practice to deliver QIPP productivity from PMC repeat prescription process, productivity and waste reduction

- continue the Medicines Optimisation Team Dietician service that is supporting practices to undertake ONS reviews, discharge letter reviews and promotion of food first this builds on the work of the care home dietician.

East Leicestershire & Rutland CCG: specific actions for 2018/19 are:

- efficient audit and monitoring of progress and delivery of prescribing QIPP areas and patient safety issues using more real-time data, comparing practices within the CCG and CCGs with CCGs also using Eclipse Solutions
- enablement of the CCG to meet its statutory requirements towards long term conditions
- QIPP 1- GPSIP based on Antimicrobials, quality audits, cost effective changes, additional elements will include rebates, Optimise RX, non GP sip elements, practice pharmacist monthly reports
- QIPP 2 – Repeat ordering – based on full year effect of roll out of repeat ordering for MRH locality
- QIPP 3 – Pregabalin - full year effect of pregabalin switch
- QIPP 4 – Technician Care home project aimed at reducing waste through audit and non-clinical individual patient medication reviews.

West Leicestershire CCG: specific actions for 2018/19 are:

- Prescribing productivity, drug switches, Optimise RX, NP8, Unlicensed Specials, Top 100 reviews repeat prescribing review
- Rebates
- Medicines Optimisation Team Dietician, ONS Reviews, discharge letter reviews
- Care Homes Pharmacy Team -Medication Reviews and admission avoidance, quantity rationalisation and waste audits.

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A breakdown of the 18 Ineffective and Low Clinical Value Medicine list for LLR is detailed below. This shows that the majority are already within our LLR policy for low value medicines.

18 Ineffective and Low Clinical Value Medicine	In Local Policy	In Local Policy review 2018/19	Not in Local plan 2018/19
Co-Proxamol	■		
Dosulepin		■	
Glucosamine and Chondroitin	■		
Herbal Medicines	■		
Homeopathy	■		
Immediate Release Fentanyl	■		
Lidocaine Plasters		■	
Liothyronine	■		
Lutein and Antioxidants		■	
Omega-3 Fatty Acid Compounds		■	
Once Daily Tadalafil	■		

18 Ineffective and Low Clinical Value Medicine	In Local Policy	In Local Policy review 2018/19	Not in Local Policy plan 2018/19
Oxycodone and Naloxone combination		■	
Paracetamol and Tramadol combination		■	
Perindopril Arginine	■		
Prolonged-release Doxazosin	■		
Rubefacients (excluding topical NSAIDs)			■
Travel Vaccines		■	
Trimipramine			■

We will review the outcome of the national consultation on the 33 Over the Counter Medications against our Local Policy and update and implement as required.

High Level Plan

Key Actions	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018	Sept 2018	Oct 2018	Nov 2018	Dec 2018	Jan 2019	Feb 2019	Mar 2019
Implement prescribing schemes across CCGs												
Prioritise STP workstreams												
Completed business cases HCD biosimilars switches												
Completed Business case Bluteq												
Complete business case Care Home West												
Eclipse approval following pilot for City and West												
Eclipse pilot progression East CCG												
PMO tool used for reporting												
Confirm LLR formulary position against NHSE Low priority consultation Wave 1 and wave 2												
Implement identified QIPP areas based on approved business cases												

Gross Savings

	City	East	West	Total
CCG QIPP	2,700,000	3,000,000	3,182,000	**8,882,000**
Category M	500,000			**500,000**
NCSO	1,600,000			**1,600,000**
Biosimilar Switches	394,179	424,000	394,179	**1,212,358**
Patent Expiry Humira®	185,384	200,000	185,384	**570,768**
Biologics Support Service	198,000	0	0	**198,000**
VAT Free Tolvaptan	19,874	19,874	19,874	**59,622**
Total	**5,597,437**	**3,643,874**	**3,781,437**	**13,022,748**

Investment

	City	East	West	Total
CCG QIPP			182,000	**182,000**
Total	**0**	**0**	**182,000**	**182,000**

Net Savings

	City	East	West	Total
CCG QIPP	2,700,000	3,000,000	3,000,000	**8,700,000**
Category M	500,000			**500,000**
NCSO	1,600,000			**1,600,000**
Biosimilar Switches	394,179	424,000	394,179	**1,212,358**
Biologics Support Service	198,000	0	0	**198,000**
Patent Expiry Humira®	185,384	200,000	185,384	**570,768**
VAT Free Tolvaptan	19,874	19,874	19,874	**59,622**
Total	**5,597,437**	**3,643,874**	**3,599,437**	**12,840,748**

Activity Changes

Not applicable

Scheme: Continuing Health Care	**Nine Must Do**		**STP Priority**	√	**GIRFT**		**MOO**	√	**RightCare**		**Other**		

Scheme Description

On 1 April 2017, NHS England started a programme to look at how Continuing Healthcare (CHC) services can be improved. The programme is called the NHS Continuing Healthcare Strategic Improvement Programme and it will run for two year (until 31 March 2019). The programme, and therefore the aim of CCGs, is to ensure that there is fair access to CHC funding and thus make sure there are: better outcomes, a better experience for individuals and a better use of resources not only for those individuals going through the eligibility process but in relation to the ongoing CHC funded care. The major change within LLR during 2017/18 has been the introduction of new pathways for determination of eligibility for Continuing Healthcare and the new end to end pathway has been implemented. These pathways have improved the length of time from acceptance of checklist to outcome of eligibility assessment as well as ensured that individuals are having access to other services for example reablement to maximise their potential before being considered for CHC funding. Our progress against the improvement programme is detailed in the table below.

Opportunity Area	Scheme in place 17/18	Planned completion 18/19	Scheme(s)
Initial Assessments	Y		End to end process - ***in place***
	Y		Joint funding review - ***in place***
Market Management	Y		DPS for care homes - ***in place* and extended into 2018/19**
	Y		Integrated Dom care City and County - ***in place*** Integrated reablement in the County – ***in place***
		Y	Integrated Dom care Rutland – ***planned for 2018/19***
Care Brokerage	Y		Dynamic Purchasing System for care homes - ***scoping to take place in 2018/19***
	Y		Integrated Dom care City and County - ***in place*** Integrated reablement in the County – ***in place***
		Y	Integrated Dom care Rutland – ***planned for 2018/19***
Quality of Package Reviews		Y	Development joint QM tools with the LAs – ***planned for 2018/19***
CHC Optimisation	Y		Whole review of CHC including extending the PHB offer to Fast Tracks and PHBs as the default offer for - ***in place* and extended into 2018/19**
Care Home review – commissioner	Y		A joint care homes specification on a LLR footprint – ***planned for 2018/19***
		Y	DPS - ***in place* and extended into 2018/19**
High cost placements – review to move away from spot purchase	Y		Part of the legacy reviews - ***in place***
	Y		Review of the functioning of the risk and complex care panel and application of settings of care - ***in place and continuing through 2018/19***
	Y	Y	Review of top 100 high cost placements on a regular basis including those in the LD pool – ***planned for 2018/19***

NHSE Benchmarking data from the Funded Care report

The Funded Care report is a report produced (last updated February 2018) that ranks the CCG's 1- 210 with the upper 25th percentile ranked 1 to 52 and the lowest 25th percentile ranked at 158 – 210. The aim for any CCGs should be, to be outside of the upper and lower percentiles, and be ranking at mid-table ideally within 10% either way of midpoint (74 -105- 126). This is because being in the top 25th percentile suggests that you have too many CHC cases and being in the bottom 25th percentile that you have too few.

The benchmarking data indicates that there have been improvements in the determination of eligibility across the CCGs across both generic CHC and Fast Tracks. The data below gives an indication of the opportunities available:

Generic CHC activity YTD ranking by quarter per 50,000

	Q4 16/17 CHC Gen	Q1 17/18 CHC Gen	Q2 17/18 CHC Gen	Q3 17/18 CHC Gen
LR CCG	13	51	49	49
LC CCG	28	77	88	92
WL CCG	17	41	45	57

Fast track activity YTD ranking by quarter per 50,000

	Q4 16/17 FT	Q1 17/18 FT	Q2 17/18 FT	Q3 17/18 FT
ELR CCG	118	81	93	101
LC CCG	172	163	171	174
WL CCG	147	138	150	159

Those in the upper percentile suggest that there are too many individuals being found eligible for CHC (highlighted in amber), and those in the lower (highlighted in yellow), that the CCG is not doing all it can to identify those that should be CHC funded. For LLR the generic CHC activity indicates an overall improvement but still opportunities for ELR and WL CCGs. For fast tracks the indication is that there are limited opportunities as ELR are within the mid-range and both LC and WL CCGs are in or around the lower 25th percentile which could indicate too few fast track cases. Further analysis needs to be undertaken as to the impact of the implemented plans for End of Life care (reduce fast tracks) and whether this is having a beneficial effect and is responsible for the drop in the numbers of newly eligible.

Deloitte NHS England QIPP Phase 2 CHC at Scale

In February 2018 NHS England released the outcome from an external review of all continued NHS funded care expenditure (based on CCG clusters- built on demographic characteristics). The model uses the forecast from ISFE, applies growth, and calculates the CCG spend by 50,000 head of population. Following this analysis, the review compares each CCG to the mean for that particular cluster and, using various assumptions, calculates the potential opportunities for CCGs to achieve better use of resources whilst improving outcomes and patient experience.

Model Clusters

The model divides all CCGs into 6 clusters based off demographics, similar key profiles and reviews expenditure.

- Cluster 3 - ELR and WL CCGs (37 CCGs in the cluster)
- Cluster 5 - LC CCG (13 CCGs in the cluster)

Model Expenditure 2017/18 per 50,000 populations

	Expenditure 17/18 per 50,000 population	Average spend for the cluster 17/18 per 50 population	Difference
ELR CCG	£4,221,801	£5,355,574	-£-1,333,773
LC CCG	£5,167,348	£4,364,727	£802,621
WL CCG	£4,143,880	£5,355,574	-£1,211,694

The total expenditure for 2017/18 indicates that ELR are -£1,133,773 (-27%) and WL -£1,211,694 (-29%) adrift of the mean. This could indicate that the expenditure on CHC funded placements and packages of care are less than other CCGs per 50,000 of population. Again caution needs to be taken with the data as there is an indication that funds allocated to the LD pooled budget (£12m) in the County may not have been included in the Deloitte submission whilst they are used to fund CHC placements and packages of care. Leicester City CCG is £802,621 (16%) above the mean suggesting there are opportunities for QIPP achievement in 2018/19.

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We know from the work we have been doing as a system over the last two years and the above indicators there is still opportunity within CHC for both quality and cost improvement. The full year effect of the work we have undertaken this year is £2m and new schemes including a focus on funded nursing care and joint funded cases will bring further savings. To support our continued improvement in CHC in 2018/19 we will:

Right Time, Right Location Assessments: ensure that assessments occur at the right time and place, with fewer assessments taking place in hospitals by working closer with clinical teams across LLR to make this happen and by funding alternative pathways, such as Discharge to Assess, and placements prior to a determination of eligibility to facilitate the timely discharge. This will ensure that patients are assessed for ongoing care in the most appropriate setting. The impact of this will be shorter length of stays in discharge to assess placements improving patients' rehabilitation potential and as a result reduce health related funding.

Decision Making: make sure that all decisions and rationales that relate to eligibility are transparent from the outset for individuals, carers, family and staff.

Patient and Carers Experience: reduce the across LLR variation in patient and carer experience of CHC assessments, eligibility and appeals.

Continued expansion of Personal Health Budgets (PHB's): LLR CCGs will continue to incrementally increase the uptake of PHBs.

Learning Disabilities: case note review of placements and developments of PHB's. Promoting PHBs as an enabler for transforming care. The CCGs are now in a position to offer PHBs to service users that are eligible through the transforming care programme.

High Level Plan

Key Actions	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018	Jan 2019	Feb 2019	Mar 2019
End to end process in place for UHL												
Fast Track PHB offer developed												
Care Home specification completed and approved												
Reablement Task and Finish Group workload completed												

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Gross Savings

	City	East	West	Total
CHC Schemes	2,432,054	1,861,000	2,476,000	**6,769,054**
TOTAL	**2,432,054**	**1,861,000**	**2,476,000**	**6,769,054**

Investment

None required.

Net Savings

	City	East	West	Total
CHC Schemes	2,432,054	1,861,000	2,476,000	**6,769,054**
TOTAL	**2,432,054**	**1,861,000**	**2,476,000**	**6,769,054**

Activity Changes

Not applicable

Scheme: Adult Mental Health	**Nine Must Do**	**√**	**STP Priority**	**√**	**GIRFT**		**MOO**		**RightCare**		**Other**		

Scheme Description

Adult Mental Health: we will work to achieve specific national planning guidance to move towards parity of esteem including achieving NICE and national mental health access standards, eliminate out of area placements by 2020 and reduce the incidence of suicide. This is part of a wider 5 year programme to transform mental health services.

Widen choice and effectiveness in crisis and acute response to reduce demand for beds: by 2020/21, the aim is to eliminate all inappropriate out of area acute inpatient placements. This will be achieved by improving local crisis and community service provision and improved case management. Not only will this reduce costs but it will remove the need for patients to be transported outside of their community.

Liaison Psychiatry: the intention is to be Core 24 compliant by 2020. Work is currently taking place with the Clinical Network and provider representatives to ensure the submission of a refreshed and robust transformation funding proposal to support delivery of this standard.

Early Intervention in Psychosis: we will continue to meet the waiting time standard that 50% of people experiencing first episode psychosis will be treated with a NICE-approved care package within two weeks of referral. To date, we have achieved an average of 73%.

Increase timely clinical efficiency and partnership processes: to create alternatives to acute admission e.g. crisis café; enable timely flow through acute hospital beds; effective care management, evidence based care cluster pathways, access and support to mainstream and potentially bespoke accommodation.

Reduce suicide and increase resilience and promote recovery and independence: to enable people to manage their health more effectively we will develop awareness, reduce stigma and support skills in the population, build on the benefits of improved children's Mental Health services and schools. We will develop integrated locality based recovery networks, social prescribing and supporting access to employment, accommodation and workplace health. All of our plans will contribute to reducing suicides in line with the national requirement of 10% by 2020/21.

Meet recovery and rehabilitation needs locally: we will develop a local integrated offer enabling fewer placements out of area; conducting rigorous reviews so that people have appropriate care packages closer to home at reduced cost, using investments to build local infrastructure with social care and housing partners.

IAPT: Within 2017/18 the service experienced a number of staffing issues which prevented the achievement of the nationally mandated targets. CCGs have been working with the provider to develop a robust recovery plan and expand the reach of the IAPT service into Long Term Conditions and physical health, whilst the provider has resolved staffing issues and has implemented initiatives which will increase access to the service (for example a change of model to spoke and hub, increased digital offerings and group work). For West Leicestershire and East Leicestershire and Rutland CCGs the intention is for the service to achieve 15% consistently in 2018/19 prior to discussions with the provider to release more funding to achieve the national target of 19%. Leicester City CCG is planning to deliver the 19% target by Quarter 4 2018/19.

Individual Placement Support: a bid is currently being prepared to NHS England to expand our Individual Placement Support to increase the numbers of people supported from the current baseline of 118 to 212 in 2018/19 and 295 in 2019/20; an increase of over 150%.

Physical health checks and interventions to people with severe mental illness: during 2018/19 we will work to ensure that those with mental health illnesses have access to physical health checks and where appropriate targeted interventions. This will be delivered via the development of a cross-organisation action plan (addressing both community and acute). The level of physical health access for those with severe mental health will also be assessment criteria within the LLR wide 2018/19 community service review.

Liaison and diversion services: The three CCGs within LLR will work (during 2018/19) to comply with NHSE national requirements by ensuring that we identify vulnerable people early on and work to avoid the negative health/social impacts of un-addressed mental illness (including a reduction in interactions with the criminal justice system). This will be delivered via the development of a cross-organisation action plan (addressing both community and acute).

Dementia: In 2018/19 we will:

Diagnosis Rates: work is on-going across LLR to continually improve early diagnosis rates; all 3 CCGs are achieving the prevalence rate national target of 67% or more.

Post Diagnostic Support Programmes: to support people living with dementia and their carers, post diagnostic support services have been commissioned across LLR:

- Leicestershire County Council, Leicester City Council and the 3 CCGs have commissioned a dementia support service for Leicestershire and Leicester City. The service offers a single point of access service in community settings and in University Hospitals Leicester (UHL). The aim of the service is to provide support through different formats, such as one-to-one, group support, and support programmes for carers and professionals.
- For Rutland, Rutland County Council has commissioned a dementia support service for those living with dementia and their carers provided by Age UK. This service also offers single point of contact and different formats of support; including peer group and activity support, memory cafés, intensive support to identify the needs of the service user and agree outcomes. Rutland County Council has also employed an Admiral Nurse (a specialist dementia nurse) that will provide support for the Rutland area.

Dementia Strategy: a new joint LLR Living Well with Dementia Strategy 2019-2022 is currently being developed, to be published over the summer/autumn 2019. The vision, guiding principles and aims of the strategy are linked to NHS England's transformation framework – 'The Well Pathway' – that, in turn, is based on NICE guidelines. In 2018/19 we will undertake engagement and consultation on the draft strategy.

Dementia Friendly GP Practices: As part of the national drive for Dementia Friendly Communities, the 3 CCGs have developed a template to support and champion dementia friendly GP practices. The template has been designed to support practices to support their patients living with dementia and their carers. CCGs will be working closely with our GP practices to become dementia friendly.

Length of Stay – Patients with Severe Dementia within Acute Hospitals: Multiagency work has commenced to consider support networks and packages of care required that will encompass issues, challenges and potential risks to enable people living with severe dementia to be transferred from UHL appropriately and timely. This programme of work will review and consider appropriate and timely packages of care that will include care home provision.

High Level Plan

Key Actions	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018	Sept 2018	Oct 2018	Nov 2018	Dec 2018	Jan 2019	Feb 2019	Mar 2019
Reduce number of bed days in AMH OOC Acute placements to 637												
Reduce number of bed days in AMH OOC Acute placements to 552												
Reduce number of bed days in AMH OOC Acute placements to 736												
Reduce number of bed days in AMH OOC Acute placements to 630												
Reduce local DTOC & LOS rates in line with national average												
Autism Post Diagnostic Review												
Develop employment initiatives												

Gross Savings

	City	East	West	Total
Adult Mental Health	180,000	1,447,000	789,000	**2,416,000**
TOTAL	**180,000**	**1,447,000**	**789,000**	**2,416,000**

Investment

None required

Net Savings

	City	East	West	Total
Adult Mental Health	180,000	1,447,000	789,000	**2,416,000**
TOTAL	**180,000**	**1,447,000**	**789,000**	**2,416,000**

Activity Changes

Not applicable

Baseline Positon and Trajectory

IAPT Roll Out – National Standard 19% for 2018/19

CCG	Quarter 1	Quarter 2	Quarter 3	Quarter 4
LC CCG	**4.3%**	**4.3%**	**4.5%**	**4.8%**
ELR CCG	**3.8%**	**3.9%**	**4.0%**	**4.8%**
WL CCG	**3.8%**	**3.9%**	**4.0%**	**4.8%**

Commissioned activity for IAPT is in the form of a block contract with Nottinghamshire Healthcare Foundation Trust, which will be in its third contractual year in 2018/19. In 2017/18 there have been challenges to achieving the national target, largely due to workforce shortage, which is a national problem. The provider is working with commissioners and NHSE to produce a robust recovery plan which is sustainable. This plan includes workforce retention and demand and capacity, and will be supported by a single management model across all of LLR IAPT. CCGs are also working with the provider to expand the reach of the IAPT service into Long Term Conditions and physical health.

IAPT Recovery – National Standard 50%

CCG	Quarter 1	Quarter 2	Quarter 3	Quarter 4
LC CCG	**50.1%**	**50.1%**	**50.1%**	**50.1%**
ELR CCG	**50.1%**	**50.1%**	**50.1%**	**50.1%**
WL CCG	**50.1%**	**50.1%**	**50.1%**	**50.1%**

Scheme: Community Services Review	**Nine Must Do**		**STP Priority**	√	**GIRFT**		**MOO**		**RightCare**		**Other**		

Scheme Description

Across the three Leicester, Leicestershire and Rutland CCG's approximately £95,000,000 is spent with the local mental health and community provider (Leicestershire Partnership Trust) to meet the LLR population's community health needs. Within the community services pathway (at 2015/16) there are approximately 60-70 sub-services.

The financial year 2018/19, will be the fifth financial year since the community services pathways were last reviewed and it is now appropriate to undertake a full service review (during 2018/19), to ascertain if the structure of our services is still fit for purpose (to deliver for the needs of our population). This service review will also look to identify if there are any potential efficiency opportunities that can be made through either improving the delivery of existing services or transforming and or aligning pathways to best practice identified through NHS Benchmarking, Menu of Opportunities or RightCare data packs.

This service review will be clinically led with a distinct clinical focus. The service review will fundamentally put patients and their needs at the centre of the process and will also follow a number of distinct steps or stages to ensure that the three LLR CCGs can base any decisions on what is best for the patients we serve in terms of health outcomes. The service review will be led by the East Leicestershire and Rutland CCG hosted Mental Health and Community Commissioning team. The key questions within the activity review include:

- Why were the service/sub-service(s) commissioned?
- How are the service/sub-service(s) delivered (location, skill mix etc.)?
- Who are the central users of the service?
- What are the referral pathways?
- What is the capacity and utilisation of the pathways?
- What is the cost per episode/service usage?
- For inpatient and community services how do the pathways benchmark against peers on length of stay/size of caseload?

The key questions within the outcomes review include:

- What are the current levels of patient satisfaction/experience with the community service/sub-service(s)?
- What is the LLR referring GP perception of the community service/sub-service(s)?
- What are the core outcomes utilised to measure the service (including health & wellbeing)?

The service review will be delivered in collaboration with all secondary care, primary care and local authority partners across the system. It is anticipated that the service review will result in a release of 5% of cost (following the delivery of pathway efficiencies and transformation). It is anticipated that 25% of this opportunity will be delivered in Quarter 4 of 2018/19 and the remaining 75% in 2019/20.

A central premise of this service review will be to ensure that the structure of Leicestershire, Leicester & Rutland community services support the innovation and

developments arising from the integrated teams programme.
The scope of this review will also include an assessment of the community hospital facilities across LLR. Across LLR there are nine community hospitals providing a mixture of inpatient beds, therapy services, outpatient appointments, diagnostic investigations and elective care treatments. Some of them also act as the team bases for the local community nursing teams. These facilities are variable in terms of the quality of the estate condition and some are not fit for the provision of 21st century healthcare. Some also have smaller single wards which are isolated and cause sustainability issues, but their proximity to the community makes them a popular choice for patients.

Key objectives of this service review will include:-

- Set out a clear and transparent service specification that describes the model of community services in LLR, which delivers a 'Home First' approach, and supports the integration of services.
- Ensure that community services wrap around primary care and facilitate integrated working at locality level
- Deliver efficiencies and have a positive impact on acute and emergency services
- Enable an effective balance between planned and unplanned care, delivering as much productivity from services as possible
- Deliver improved outcomes in relation to patient care and patient experience, through a strong evidence base for redesigned services
- Deliver cost savings and other efficiencies by reducing duplication, preventing admission, enabling rapid discharge and supporting people to live as independently as possible
- Enable a discharge to assess approach across community services – ensuring that people can leave hospital when they are medically optimised
- Embeds a re-ablement approach throughout community services
- Supports trusted assessment and information sharing between services to deliver seamless patient care
- Supports the identification and management of frailty in the community, in line with a consistent, system wide frailty strategy
- Is sustainable in terms of workforce, supports staff retention and increased satisfaction
- Articulate the bed-based capacity required in LLR now, and in the future, and specify the clinical/care model required in bed based services

High Level Plan

Key Actions	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018	Sept 2018	Oct 2018	Nov 2018	Dec 2018	Jan 2019	Feb 2019	Mar 2019
Following initial sign off of the project, further engagement with stakeholders to develop and refine the project plan.												
Benchmarking of community services capacity and expenditure compared to other peer comparators. Support will be sought from Deloitte to undertake this work as one of the first steps in the project.												
Review of evidence of best practice from integrated community services elsewhere in the UK or abroad.												
Articulation of a high level model for integrated community services, along with engagement across partners on the model to sense check the model												
Modelling of the impact of implementing the redesigned services, including the anticipated cost of provision, and the impact on acute and social care demand and service costs resulting from the changes to community health services.												
A clear specification(s) for the in-scope community services; setting out a detailed model for integrated community health and social care services and non-acute bed based intermediate care, rehabilitation and re-ablement services, which reflects the objectives described in section 2. The draft specification should be completed by the end of September 2018.												
CCGs to agree the commissioning approach to deliver the agreed service model, including any procurement or contracting implications.												
Implementation of service changes												

Gross Savings

	City	East	West	Total
Community Services Review	573,000	1,108,600	944,942	**2,626,542**
TOTAL	**573,000**	**1,108,600**	**944,942**	**2,626,542**

Investment

None identified

Net Savings

	City	East	West	Total
Community Services Review	573,000	1,108,600	944,942	**2,626,542**
TOTAL	**573,000**	**1,108,600**	**944,942**	**2,626,542**

Activity Changes

Not applicable

Scheme: CCG Efficiencies	**Nine Must Do**		**STP Priority**	**√**	**GIRFT**		**MOO**		**RightCare**		**Other**		

Scheme Description

Single Management Team: Leicester City, East Leicestershire and Rutland and West Leicestershire CCGs are discussing a proposal of creating a single management team under a single Accountable Officer. The main drivers to this approach are to ensure that there is sufficient senior executive focus and capacity to deliver both the LLR Sustainability and Transformation Partnership's strategic plan and the yearly Operational Plan. In creating a single management team it is expected that there will be some savings circa £500,000 full year effect.

Running Costs Efficiencies: All three CCGs will continue their programme of reducing running costs particularly in relation to non pay costs.

High Level Plan

Key Actions	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018	Sept 2018	Oct 2018	Nov 2018	Dec 2018	Jan 2019	Feb 2019	Mar 2019
CCG Collaboration												
CCG Efficiencies												

Gross Savings

	City	East	West	Total
CCG Efficiencies	167,000	166,000	507,000	**840,000**
Total	**167,000**	**166,000**	**507,000**	**840,000**

Investment

None required

Net Savings

	City	East	West	Total
CCG Efficiencies	167,000	166,000	507,000	**840,000**
Total	**167,000**	**166,000**	**507,000**	**840,000**

Activity Changes

Not applicable

Scheme: Home First	**Nine Must Do**	**√**	**STP Priority**	**√**	**GIRFT**		**MOO**		**RightCare**		**Other**		

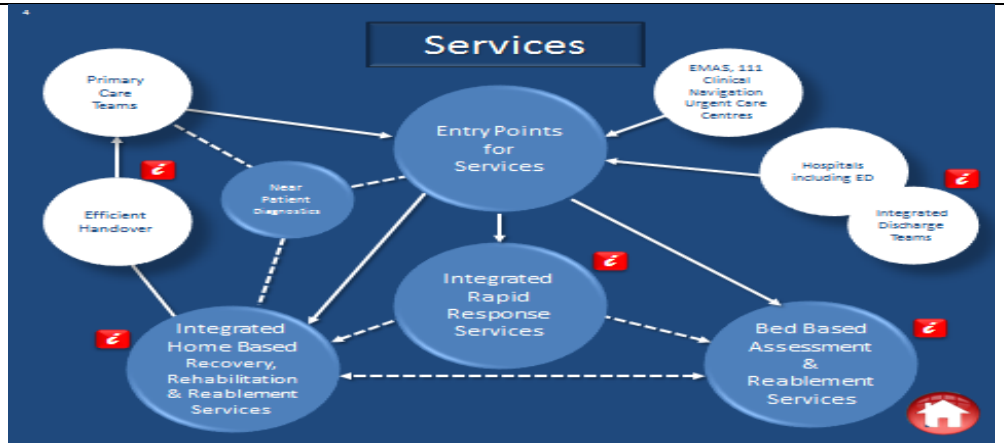
Scheme Description

Background: The LLR vision for integrated Home First services is for people with health and social care needs to have those needs met at home, wherever possible, through the delivery of integrated care pathways by health and social care services working together with partners in housing and the voluntary and community sector.

The key principles for 18/19 are to:

- Provide safe and appropriate care in peoples' own home;
- Reduce dependency on acute hospitals, community hospitals, and care homes;
- Ensure transitional services are available in a timely manner to meet the needs of people whose health and care needs are deteriorating in order to avoid admission to high cost bed based care;
- Ensure services are available in a timely manner to meet the needs of people whose health and care needs are improving in order to return people to their home environments;
- Deliver a standardised and consistent outcome for our citizens through LLR wide service redesign with interventions delivered at a local level, reflective of local circumstances;
- Utilise resources more effectively based on detailed understanding of population need, demand, service journeys and real time data;
- Focus on prevention, the individuals' responsibility for their own health and wellbeing, early diagnosis and management of risk factors;
- Create far more cost efficient and clinically effective person centred models of care through co-design;
- Through the integration of health, social care, housing and community services, care will be delivered in the right place, by the right people at the right time in the right place;
- Joint accountability for care co-ordination and outcomes, across organisational boundaries and teams;
- Ensure future service delivery is financially sustainable in line with the STP requirements.

Key Deliverables: The Home First programme has delivered a Design Blueprint which is currently helping to define the Target Operating Model and Services Roadmap' which has identified the services needed to support a home first approach. This is currently being mapped to existing services to identify any gaps in provision and or capacity. The Home First programme has a number of key inter-dependencies. These relationships will be defined in the Target Operating Model. The Design Blueprint has defined how the individual Home First services should come together to form an integrated model.

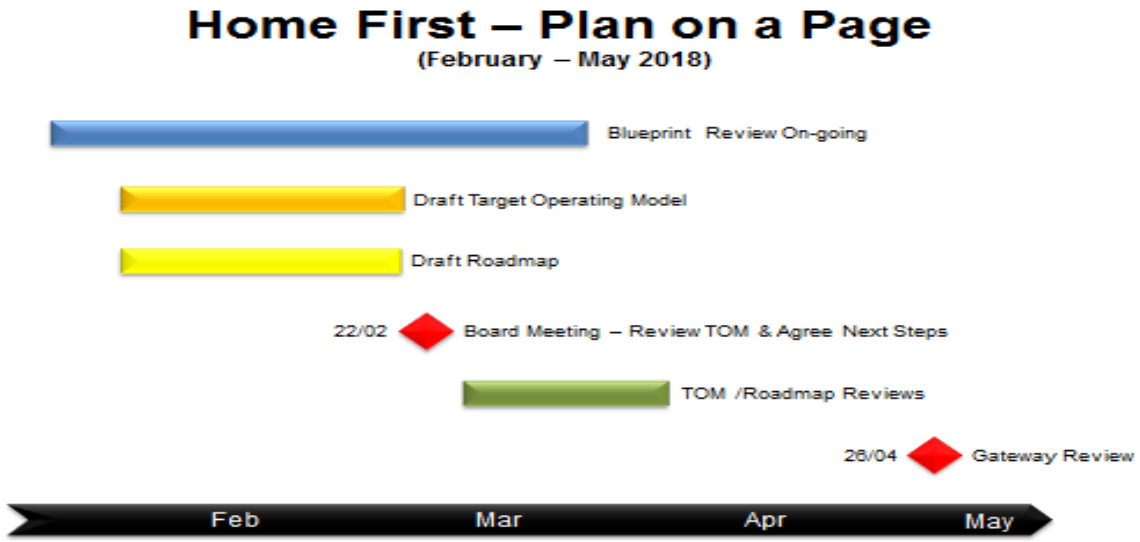


The programme has currently identified the following patient outcomes (for 2018/19);

- I can stay at home when I am ill with the support I need
- I am supported to restore my health, wellbeing and independence after an illness or being in hospital
- Demand is managed so Health and Social Care services are available when I need them
- When I use Home First services they are personalised to me and provided by people working together
- Wherever I live in LLR services are effective and efficient.

High Level Plan

The programme is currently working to the following short-term plan subject to approval of the Target Operating Model and agreement on scope, following which revised plans will be drawn up.



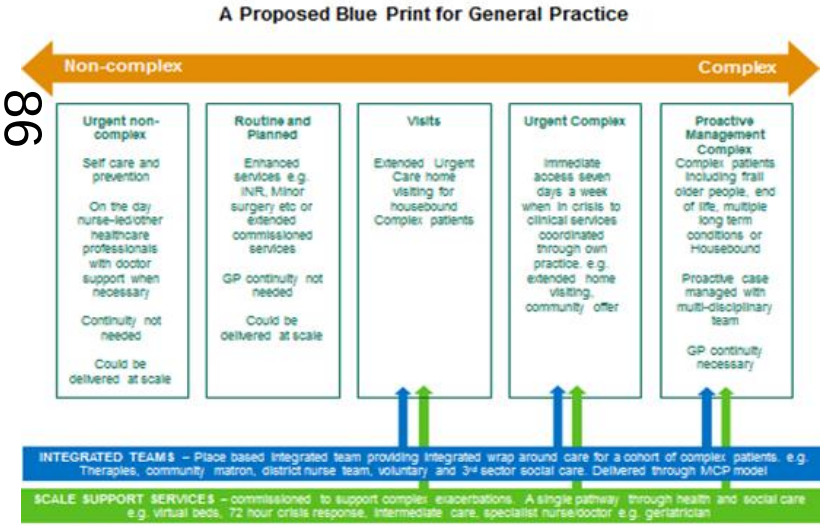
Scheme: LLR Primary Care	**Nine Must Do**	√	**STP Priority**	√	**GIRFT**		**MOO**		**RightCare**		**Other**		

Scheme Description

Key Deliverables: This project summary sets out the LLR vision for primary care as set out in the STP plan. This is much more about how general practice will need to evolve and adapt over the next few years to manage the demand and the changing nature of primary care and an ageing population. This has been detailed in the LLR GP 5 year forward view plan which can be viewed here https://eastleicestershireandrutlandccg.nhs.uk/wp-content/uploads/2018/02/3.-GPFYFVFinal.pdf .

The Model: Our model for primary care is based on the GP as expert clinical generalist working in the community with general practice being at the centre, ensuring the effective co-ordination of care. The GP has a pivotal role in tackling co-morbidity and health inequalities but increasingly they will work with specialist co-located in primary and community settings, supported by community providers and social care to create integrated out of hospital care.

Key to supporting patients is the ability to provide a differential service according to need. Not every patient requires contact with a doctor or an appointment on the same day. A cohort of patients, especially those with multiple co-morbidities who are at risk of admission for their complex condition require a more pro-active offer that could involve a multi-disciplinary team including social care, community nursing and specialist care. Integrated care combines a range of disciplines across health, social services and voluntary organisations to create person-centred care. This new model of general practice is demonstrated in the diagram below.



To meet the needs of patients, now and in the future, the model of delivery will need to adapt. This adaptation is based around patient need and seeing the right health care professional for their condition. The evidence shows that patients with complex needs require a coordinated package of care that will require care planning, regular proactive interventions and support.

This continuous care is best provided by a multi-disciplinary team with the GP at the heart of that care. This level of service utilises a GPs skills to best effect and patients will be streamed accordingly. All other patients will have access with another appropriate health care professional when needed, supported by a GP. This will be achieved by:-

- Developing localities and MCPS.
- Work with Federations to enable more collaboration between practices.
- Ensure access to extended primary care services in the evening and weekend outside of core GP opening hours in multiple sites across the geography.
- Develop integrated place-based teams with the general practice at the heart of care.
- Implement the local Digital Roadmap and the requirements set out in the GP IT Operating Model 2016/18.
- Support practices through the Estate and Technology Transformation Fund process based on the LLR Estate Strategy.
- Support practices to take forward the initiatives within the General Practice Five Year Forward View including the 10 High Impact Changes and the General Practice Development Programme.

What do we are we doing: the following actions are being taken to stabilise general practice and support the transformation of primary care by delivering the *General Practice Forward View and Next Steps on the NHS Five Year Forward View*.

General Practice Forward View Plan: in line with the 2017-19 Planning Guidance each CCG has developed a General Practice Five Year Forward View Operational Plan, which can be found at https://www.westleicestershireccg.nhs.uk/sites/default/files/Paper%20C%20-%20%20GP%205%20Year%20Forward%20%20Plan%20-%20Appendix%201.pdf . The plan has been produced based on the actions that we are taking at an LLR level and builds on the actions set out in this Project Document. In addition it provides an overview of finances for each CCG and how access in each area is being addressed.

Extended Access: through our design of urgent and emergency care we will be delivering extended hours in line with the national requirements. This access will not necessarily be from a GP, but a nurse, pharmacist, Advanced Nurse Practitioner, Extended Care Practitioner or other health professional according to need. This offer is intrinsically linked with the already developed plans, being piloted and evaluated now through the Leicester, Leicestershire and Rutland Emergency and Urgent Care Vanguard. By October 2018 this will have generated a new model of home visiting, Out-of-Hours provision, clinical navigation, Urgent Care and enhanced primary care access, which in combination will provide a twenty-four hour service across LLR and meet the requirement for 100% the population having access to extended GP services.

Workforce: we have been working across the system and together with other partners such as HEE, LMC and LPC over the last two years to develop solutions to the workforce issues we face. Baseline assessments have been completed, three multi-disciplinary training hubs have been established and Education networks are working across the footprint. This has resulted in new delivery models and extended roles including Clinical Pharmacists. This plan is detailed in the 2018 General Practice Workforce Plan which can be found at https://eastleicestershireandrutlandccg.nhs.uk/wp-content/uploads/2018/02/LLR-GP-Workforce-Plan_Jan-18-FINAL.pdf. Our plan covers international recruitment; retention of current GPs; GP recruitment particularly of those on GP trainees who do their VTS in LLR; increasing locum doctors to employed roles; and clinical pharmacists.

Investment in General Practice: all three CCGs are on track to invest the £3 per patient. Leicester City CCG is supporting practices to work at scale either in collaboration across a number of practices or within a Federated model. East Leicestershire and Rutland CCG are supporting the GP Federation to support transformation of General Practice Services and to develop locality plans describing formal joint working arrangements, delivery of clinical and non clinical services and how patient outcomes will be improved. West Leicestershire CCG is support an outcome based federation level QIPP scheme. The initiative represents a fundamental shift from previous practice level schemes and is aligned to our strategic priorities which include; the sustainability of general practice, primary care at scale, addressing unwarranted variation, supporting clinical behavioural change and financial sustainability. The 2017/18 scheme included a focus on efficiency, integrated teams and embedding processes to support delivery of high quality care.

ETTF: a total of 18 practices have been supported to improve their existing premises or build new ones. Electronic record sharing, SCR 2.1 has been rolled out to 138 practices across LLR. Phase 2 secondary care access has been mobilised and phase 3 is currently being developed with social care.

Sustainability and Resilience Funding: work to support practices implement the High Impact Actions has been developed to support practices in 2018/19. It is planned that all practices will be required to have undertaken at least two high impact actions. Online consultation, clinical navigators and records management are being piloted. In 2018/19 all practices will have benefitted from these developments or systems.

Communications and engagement: we will engage with practices across LLR to share our vision for the future of General Practice and share examples of good practice. Regular communications with practices will keep them updated about developments related to the General Practice Forward View. We will publish good news stories about changes that are taking place to enable the public to become accustomed to different relationships they now have with their practice. We will implement demand management campaigns throughout the year on different topics including missed appointments, NHS 111 and self-care using established local patient groups and patient participation groups to support this. We will also keep wider stakeholders fully up to date with progress. We will also share findings of engagement being completed at the end of 2017/18, to understand people's experiences of changes in primary care including extended hours and use it to influence further service development.

High Level Plan

Key Actions	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018	Sept 2018	Oct 2018	Nov 2018	Dec 2018	Jan 2019	Feb 2019	Mar 2019
Evaluation of primary care new models of care.												
Integration of Locality/ Hub based working with Local Authority and Integrated teams												
Develop new ways of joint working / contracting to deliver sustainable models												
Implementation for staffing to deliver pilot phases of new models of care												
Recruitment of practices for future cohorts												
General Practice Improvement Leaders Programme recruitment												
Ten high impact actions launch event and rollout of supported cohorts												
GPRP six month review												
Estates investment in line with national ETTF programme												
A integrated service that provides at least 45 minutes of GP services per 1000 patients in evenings and weekends												
A clinical triage service that enables patients to access the right service first time												
An integrated home visiting service available 24/7 for urgent and Complex patients												

Scheme: Cancer	**Nine Must Do**	√	**STP Priority**	√	**GIRFT**		**MOO**		**RightCare**	√	**Other**		

Scheme Description

Cancer outcomes vary across Leicester, Leicestershire and Rutland. Of the three CCGs Leicester City has the worst outcomes and East Leicestershire and Rutland have the best. All three CCGs have poorer performance in some areas of cancer outcomes compared to the England or Strategic Clinical Network rates. Our one-year survival rates range from 70% in East Leicestershire and Rutland to 66% in Leicester City with a requirement to achieve 75% by 2020. Diagnosing cancer early not only saves lives but limits treatment costs. When ovarian cancer is detected at Stage 1 the five year survival rate is nine in ten with treatment costs of £5,300. However if detected at Stage 4 the five year survival is one in ten with treatment costs of £15,100. By 2030 LLR will have 50,200 people who are survivors of cancer. Screening rates are also differential across Leicester, Leicestershire and Rutland – for example for people aged 60-69 screened for bowel cancer in the last 30 months in 2016/17, latest data, Leicester City's rate was 44.6%; West Leicestershire was 63%; and East Leicestershire and Rutland was 62.7% against a national average of 57.4% and a 2020 target of 75%. We are developing solutions that will not only meet the NHS Constitutional Standards but will also prevent and detect more cancers early and support patients through treatment and into survivorship. We are working towards implementing the Achieving World Class Cancer Outcomes Strategy 2015/20.

What do we plan to do

To deliver NHS standards and world class outcomes for cancer care, we will:

Prevention: develop and continue to run programmes to prevent and detect early cancers and reduce the risk factors such as smoking and obesity. Smoking is the biggest preventable cause of all cancers. In LLR the aim will be to look towards national models of targeted low dose CT screening for lung cancer and respiratory conditions and look towards implementation to support the prevention and early diagnosis agenda. Models from Manchester and Liverpool are being reviewed and the health economic analysis worked through. Work is being done to support the prevention agenda such as the pilot around Teachable Moments with Cancer Research UK to improve awareness around signs and symptoms and screening programmes. In addition there is focused work on bowel and cervical cancer screening programmes specifically where uptake rates are lower than the national average.

Improve the early detection of cancers: to ensure progress towards the 2010/21 ambition for 62% of patients to be diagnosed at stage 1 or 2 we will do this through a programme of prevention and early detection, raising the profile of symptoms, improving pathways and access to diagnostics, for example introduce Cancer Mind Maps into primary care and working towards the national optimal lung cancer pathway. Continue to assess the impact of the Faecal Immunochemical Test (FIT test) - introduced into LLR in February 2018, on early detection of lower GI cancer. The optimal lung cancer pathway recommends a regular pre clinic triage and assessment of CT scans performed on patients referred on the cancer two-week wait pathway via a daily MDT triage clinic. We propose a daily MDT CT Triage clinic of patients referred on the cancer two-week wait and also of all patients admitted on the emergency pathway with a possible diagnosis of lung cancer which replicates the Manchester RAPID pathway aiming to ensure all patients have a clear diagnosis within seven days of referral.

Recovery Packages: commission a Recovery Package to support patients following diagnosis and treatment including the provision of holistic needs assessments, care plans, treatment summaries, health and wellbeing events and cancer care reviews. To do this we will work with Macmillan Cancer Research UK and the East Midlands Cancer Alliance, the acute trust and primary care to develop a local offer for patients accessing a seamless initially in three tumour sites (breast, colorectal and prostate). Implement a

Macmillan Project officer in the CCG working in collaboration with the UHL Macmillan Cancer Pathway Lead with the aim to ensure there is ongoing provision of the community Recovery Package for people affected by cancer across LLR. This role will provide dedicated CCG cancer support to the community hubs and provide a link between both UHLs and the CCGs recovery packages.

Risk Stratified Follow Up Pathways: to introduce new approaches to follow up in Prostate, Breast and Lower GI pathways aligned to the ambition of the Recovery Package. As per NHSE guidance, this will ensure that patients have their needs met in a timely manner, are better informed about their disease, treatment and any longer term effects. With the focus on health and wellbeing, patients can be supported to take back control of their lives as soon as they are able reducing unnecessary outpatient appointments for those who no longer require face to face appointments releases capacity for those with complex needs and helps improve access for new referrals. The CCG are supporting UHL to agree the protocols for stratifying breast cancer patients and review remote monitoring by the end of 2018/19.

Review and redesign pathways: to meet the 2020 requirement that all patients should have access to high quality services we will work with our local Cancer Alliance on improving pathways for patients, for example use the FIT test as part of the bowel cancer pathway to reduce unnecessary two-week waits referrals by 20-40% and invasive diagnostic tests. Monitor the bowel and thyroid straight to test uptake rates and ensure patients are offered the most appropriate test in the most appropriate location e.g. primary care setting in a timely manner.

Ensure sufficient capacity to meet the 2020 standard of 95% of people with a suspected cancer should receive a definitive diagnosis or otherwise within four weeks of referral. As per the RightCare for lung cancer 23 lives could be saved in LCCCG alone from <75 lung cancer if found and treated sooner. Continue to remotely monitor patients who have had prostate and thyroid for whom cancer care has been moved into the community with support from UHL. With further data and patient feedback, discussions will be held around this service provision with the aim over time to move this provision to stable prostate cancer patients being reviewed in primary care. In the same way, commission pathways for MGUS to be delivered in the community in accordance with Care Closer to Home.

Continue to promote and ensure the utilisation of PRISM for all 2 week wait referrals which is now being used by all GP practices. Aim to implement the Vague Symptom Clinic (VSC) pathway which is a new rapid outpatient clinic designed for patients with more complex needs and (non-specific cancer) vague symptoms such as non-specific weight loss / loss of appetite, as well as presenting with abnormal imaging which is suspicious of metastases showing no primary cancer. Primary Care will be able to refer patients directly into VSC for investigating patients as an alternative to referring into ED.

Regional work: ensure that there is a more regional approach to deliver high quality cancer care e.g. the prostate cancer ECAG is developing robotic surgery in urology on a wider East Midlands footprint and also work with other specialities around innovations. The CCG will be working closely with the East Midlands Cancer Alliance to review and implement rapid assessments and diagnostic pathways for lung, prostate and colorectal cancers.

Baseline Positon and Trajectory

Cancer Waiting Times for 2018/19

Month	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
Cancer 2 Week Wait	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%
Cancer 2 Week Wait - Breast	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%
Cancer 31 Day First	94%	95%	96%	96%	96%	96%	96%	96%	96%	96%	96%	96%
Cancer 31 Day Drugs	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%
Cancer 31 Day Subs Surgery	86%	86%	88%	90%	92%	94%	94%	94%	94%	94%	94%	94%
Cancer 31 Day Radiotherapy	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%
Cancer 62 Day	78%	81%	83%	85%	85%	85%	85%	85%	85%	85%	85%	85%
Cancer 62 Day Screening	86%	87%	88%	89%	90%	90%	90%	90%	90%	90%	90%	90%

The plan is to achieve all cancer standards within the first two quarters of 2018/19. The winter pressures on elective care have had an impact on implementing the cancer recovery pan. This has been reviewed and the actions agreed to work to delivering the current trajectory. These standards are high priority for LLR CCGs with a cancer and RTT board that meets monthly to scrutinise progress against delivery of the actions.

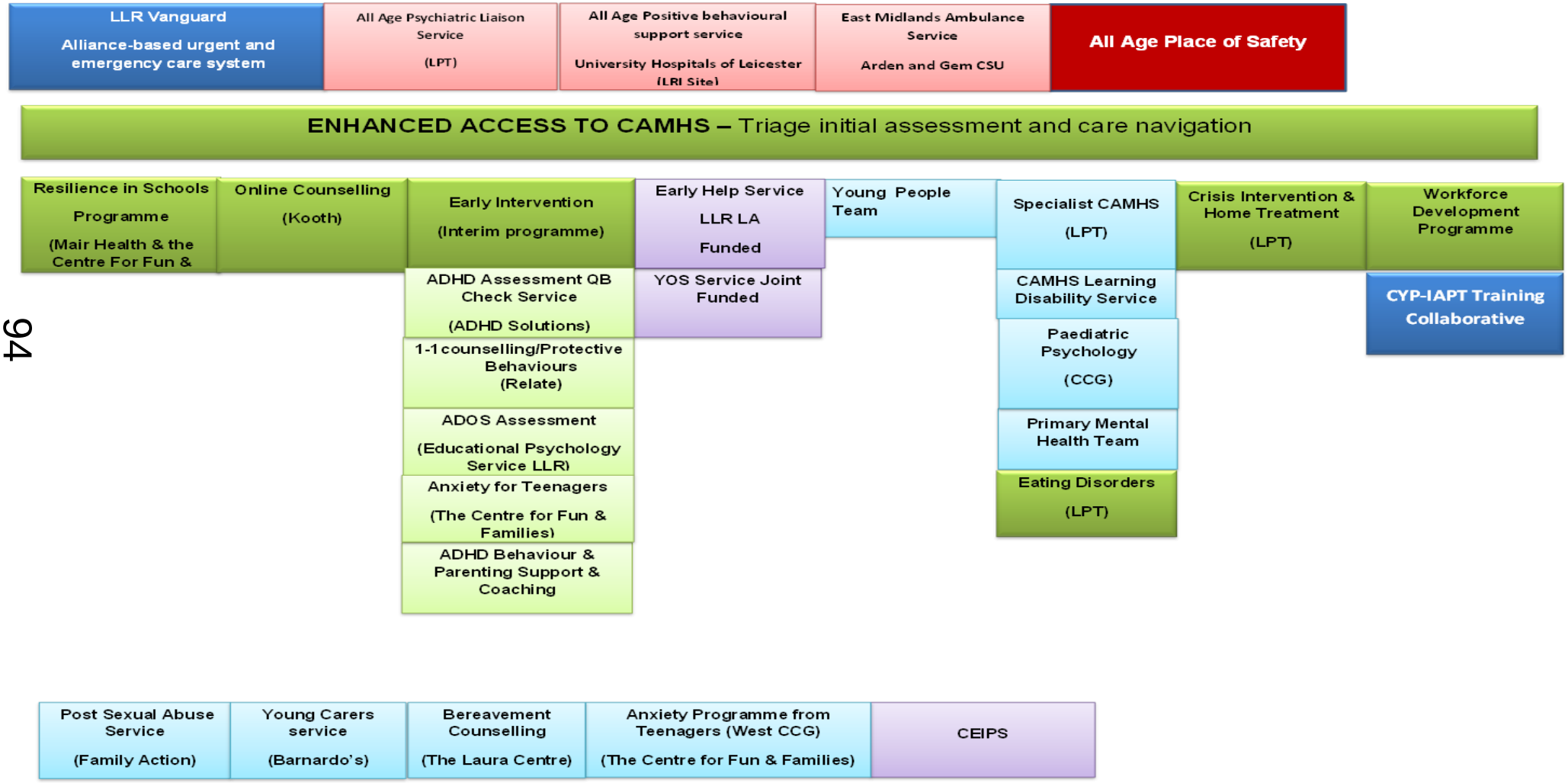
High Level Plan

Key Actions	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018	Sept 2018	Oct 2018	Nov 2018	Dec 2018	Jan 2019	Feb 2019	Mar 2019
Review data around bowel and cervical screening uptake rates												
Assess the impact of the co-produced bowel screening patient letters sent in 17/18 & uptake rates												
Work with PHE, primary care, acute trusts and patients around promoting uptake rates												
Review effectiveness of Teachable Moments												
Review the utilisation of FIT as part of the bowel cancer pathway (6 months after go live)												
Increase FIT offer to a wider cohort of patients prior to 2WW referral												
Develop a business case around implementation of the NOLCP												
Change pathway around abnormal Chest X-Ray for patients at risk of lung cancer												
Introduce pre-clinic triage for patients at risk of lung cancer as per optimal pathway												
Recruit to community Macmillan Project Officer for the Recovery Package												
Undertake patient engagement around the Recovery Package offer in the community												
Undertake large scale scoping of a community recovery centre												
Set up governance arrangements with acute trust around the community recovery centre												
Introduce Risk Stratified Follow Up Pathways for Breast and Lower GI pathways												
Continue to remotely monitor patients who have had prostate and thyroid cancer												
Commission pathways for MGUS to be delivered in the community												
Ensure the utilisation of PRISM for all 2 week wait referrals												
Go live with the Multi-Diagnostic Centre for patients with vague symptoms												
Review the prostate cancer pathway and work with EMCA around best practice												
Deliver the Constitutional Standard Supported by the Recovery Action Plan												
Continue to monitor implementation and roll out of Next Steps and Timed Pathways												

Scheme: Child and Adolescent Mental Health	**Nine Must Do**	√	**STP Priority**	√	**GIRFT**		**MOO**		**RightCare**		**Other**	√	Future in Mind

Scheme Description

The Local LLR Future in Mind transformation plan describes the system-wide pathway delivered by a range of organisations and professionals to promote, protect and improve the mental health and wellbeing of our children and young people as described in the model below.



2018/19 will be the third year of the transformation journey for local CAMH services. In year one we developed the plan and vision with all partners, and in year 2 we began implementing the plan. Over this period we have increased capacity in eating disorders services, from 20 to 100 patients per year, which has contributed to a significant improvement in waiting times and (since summer 2017) provider-level compliance with the 2020/21 national waiting times standards for eating disorders. We have expanded CAMHs capacity to achieve and sustain the 13 week waiting time target; and introduced new services including the Crisis Resolution and Home Treatment Service, the Early Intervention Service, online counselling and resilience programmes in schools.

In the third year, 2018/19, our focus is to embed the new and enhanced services into practice, and to focus on joint working to deliver a system-wide approach to children and young people's mental health and wellbeing services which will enable seamless access to services. We offer these services to a range of Children and Young People including: Looked After Children, unescorted child asylum seekers, youth offenders, with behavioural, emotional and mental health needs. In 2018/19 we will:

- Develop a multi-organisational triage, assessment and navigation service that will be the first point of contact for all referrals. The staff working in this service will triage C&YP into the appropriate service to meet their needs.
- Adopt of a model of care that can be implemented by all providers and establishment of common language. We are currently looking at using the THRIVE model. This is a conceptual framework of person-centred care for child and adolescent mental health. It enables care to be delivered according to the needs and preferences of children and young people and their families, and aligns itself to our system-wide approach as described in the diagram above.
- Improve the experience of young people that transition into adult services by developing multi-agency pathways that can prepare and support young people during this episode in their care. This will be delivered through the triage and navigation service , it will ensure that young people at the age of 17.5 years will have a plan of care that will be discussed with the adult services and the adult team will ensure there is a plan of care in place for when this young person reaches the age of 18. The care will be transferred gradually over a period of time. No young person should find themselves without the ongoing care that they receive, and the young person and their families will transition gradually into adult services.
- Develop the workforce across all services and organisations to increase the overall number of staff, the skill mix and the skills and knowledge of the staff employed within these services, which will increase the range of services available to C&YP and increase access to evidence-based practice.
- Agree appropriate ways to measure and demonstrate an improvement in quality and performance of services and therefore deliver improved outcomes for children and young people, for instance in setting a local ambition that an additional 30% of the referrals into CAMHs will receive evidence-based interventions through the new Early Intervention Service.
- Strengthen our marketing, communication and engagement with stakeholders to ensure full participation in the delivery of the transformation plan and demonstrate outcomes for children and young people.
- Participate in local developments for in-patient CAMHS services, in particular working through our Crisis Intervention and Home Treatment service to provide community services which will contribute to lower demand and shorter lengths of stay for (NHSE-commissioned) in-patient services.

High Level Plan

Key Actions	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018	Sept 2018	Oct 2018	Nov 2018	Dec 2018	Jan 2019	Feb 2019	Mar 2019
Education and training for CYP IAPT												
Out of area placement												
Development of an EMHWB triage and navigation service												
Recruit additional capacity to commence workforce development scheme of work												
Commence marketing, engagement planned events and meetings												

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Scheme: Children's, maternity and neonates	**Nine Must Do**		**STP Priority**	**√**	**GIRFT**		**MOO**		**RightCare**		**Other**	**√**	**SEND, Better Births**

Scheme Description

Our focus is on improving outcomes in maternity, children's emotional health and wellbeing, young people and family services. This involves a range of organisations working together efficiently to improve productivity across universal, targeted and specialist services to improve outcomes for children and young people.

Continue to improve the quality of maternity and neonatal services: we have established the Local Maternity System (LMS); and developed the local maternity plan with actions, named leads and key milestones to oversee delivery of the 2018/19 maternity quality and safety standards. This will lead to improved access and outcomes for women and their babies based on the principles within Better Births. We will work towards delivering the national ambition in "savings Babies Lives" care bundle to reduce stillbirths, neonatal deaths and brain injury by 20% in 2020 and 50% in 2030. The current baseline is 73 neonatal deaths, and we plan to reduce this by 2 in the first year followed by 3 each subsequent year. Work will be undertaken in 2018/19 to further consolidate and develop the neonatal service to meet the responsibilities arising from our role as lead centre for the Central Newborn Network.

We will establish the Maternity Voices Partnership which will plan and organise the engagement activity and any subsequent consultation for Better Births.

Actions to improve continuity of care include the formation of a Maternity Network, and development of integrated pathways between primary and secondary care. There is also a detailed action plan to agree changes to midwife working patterns and workflow to achieve increased continuity during pregnancy. Our LMS considers that reaching continuity for 20% of women booking by March 2019 represents a stretch, however we are setting challenging plans to support achievements of this. To promote choice and personalisation of maternity services, we have developed trajectories to ensure all women have a personalised care plan and named midwife by 2021, as well as a trajectory to increase the number of women receiving midwife-led care by 0.5% year on year, to achieve a minimum level of 30% by 2021.

We currently offer all four birth options across LLR, allowing women to make personalised choices for maternity care. Our plans are to continue to offer all four birth options, including a stand-alone unit, if this is proven to be viable and sustainable. This will form part of the STP public consultation on maternity services in 2018, along with options on providing all obstetric led maternity services from one site. We are developing a bid in conjunction with the East Midlands Perinatal Network to enable increase capacity to meet women's specialist perinatal mental health needs. All women will receive postnatal care in line with NICE guidance and we will endeavour to provide choice in how and where this is delivered. We will develop integrated perinatal pathways which identify women early and provide assessment support and treatment close to home to minimise need for admission to mother and baby units.

Care in the right place at the right time: the population of children and young people with general and complex health needs that require clinical intervention is increasing. Work continues to deliver The New Children Hospital Model; following confirmation that Children's Congenial Cardiac Services will continue to be provided across LLR. The new model will consider choice and appropriate service delivery for children and young people aged 0- to 18 and 365 days. The Children's Single Front Door Model will commence in July 2018, delivering robust streaming, assessment and delivery of clear pathways for Emergency and ambulatory care.

Work will be done in 2018/19 to identify where there are both efficiency and quality opportunities to redesign children's elective care pathway which will be supported by the

Planned Care workstream utilising learning from the review of adult pathways. Services reviews have commenced on the Diana Community Services, Paediatric Phlebotomy and Community Medical Provision. In-depth work will be complete on each area with future delivery options being presented within year.

One Child one Chair: the one chair model was adopted in 2017/18 and demonstrated cost saving and improved quality of care with positive feedback from children, young people and families. The model has been adopted as part of the re-procured wheelchair contract.

LPT and Alliance Service specification reviews: SEND and TCP: work continues on delivery of the requirements of the SEND Code of Practice 2015 to ensure CCG'S are meeting statutory requirements. Work to integrate the e SEND and TCP action plans continues focusing on joint commissioning, transitions, continuing healthcare, DCO role, and a dynamic register identifying the most vulnerable children and young people.

High Level Plan

Key Actions	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018	Sept 2018	Oct 2018	Nov 2018	Dec 2018	Jan 2019	Feb 2019	Mar 2019
Submit refreshed Local Maternity System plan												
Agree implementation process including KPIs, dashboard and highlight report.												
Establish Maternity Voices Partnership.												
Agree models of maternity care.												
Complete consultation on single site as part of STP including options for a stand-alone midwifery unit.												
Workforce modelling.												
Changes to midwife working patterns and work flow to achieve increased continuity during pregnancy.												
Implement and continuously improve our robust approach to reviewing clinical outcomes through LMS via the local Maternity dashboards and implementation of the new national and local maternity datasets												
Implement the local joint strategy to reduce infant mortality, still births and Hypoxic Ischemic Encephalopathy (HIE) babies, addressing environmental, maternal, foetal and clinical factors.												
Continue actions and monitoring to ensure all women have personalised care plans and named midwife by 2021.												
Increase the number of women receiving midwife-led care by 0.5% year on year, to achieve a minimum target of 30% by 2021.												
Submit a bid, in conjunction with the East Midland Perinatal Network, to increase capacity to meet more women's needs in line with national ambition for perinatal health.												
Develop integrated perinatal pathways consistent with NICE guidance.												
Care in the right place at the right time Develop models of secondary care to meet national requirements and improve patient experience (including extending age range to 18 where appropriate).												
Implement children's cardiac review recommendations and move services onto one site.												
Review paediatric ambulatory specification and contracting methods to support Implement children's single front door due to open July 2018.												
Develop streamlined referral pathways into appropriate children's services via PRISM.												
Service review of paediatric phlebotomy provision – options appraisal.												
Service review of paediatric phlebotomy provision – implementation of service.												
Service review of Diana Community Services and Community Medical Provision.												
Further develop DCO role												
Develop Children and Young People's Transforming Care dynamic register												
Ensure clear process in place for dealing with requests and challenges relating to Education, Health and Care Plans, especially Single Route of Redress Trail												

Scheme: Learning Disabilities	**Nine Must Do**	√	**STP Priority**	√	**GIRFT**		**MOO**		**RightCare**		**Other**	√	Transforming Care Partnership

Scheme Description

By 2018/19, our aim is to produce and deliver responsible, high quality, appropriate learning disability services and support in the community that maximises independence, offer choice, are person-centred, good value, and meet the needs and aspirations of individuals and their family carers. In line with national guidance on Transforming Care, we have a comprehensive plan that adopts an all age approach and focus on transition pathways, to transform care for people with learning disabilities, including implementing enhanced community provision, with a corresponding reduction in inpatient capacity, and undertaking our care and treatment reviews. Our plans will:-

Provide proactive, preventive care: in 2018/19 We will empower people by expanding personal health budgets (242 across LLR) and through independent advocacy as well as a greater choice in housing. In order to develop further robustness in our community services, there will be a review of local short break (respite) provision and we will look to commission a crisis service as preventative care.

Provide specialist multi-disciplinary support: in 2018/19 We will provide multi-disciplinary support in the community, including intensive support when necessary to avoid admission to mental health inpatient settings through the provision of a refocused and enhanced Learning Disability Outreach Team, which will reduce the need for inpatient beds. This will be delivered through a system wide plan with targeted actions for all providers.

Improve health and wellbeing: in 2018/19 for people with learning disability and their family carer(s) we will ensure engagement with preventative health initiatives, including Physical Healthcare (Annual Health Checks), Primary care, and Acute Services. This will be delivered through the development of a series of local plans across LLR which draw upon the expertise of local authorities (including public health) and NHS services.

Support for Children and Young People: throughout 2018/19 we will work with partners to provide appropriate support with early intervention to prevent crisis, and admissions. We will look to develop clear pathways for young people transitioning into Adult Services (particularly those in out of county residential schools).

Development of a Step Down Facility/ Service: during 2018/19, the service will facilitate discharge from hospital to a step down service that can be tailored to meet the temporary needs of the patient while awaiting appropriate community provision. This service will be of particular benefit to those people requiring repatriation from out of county inpatient settings.

Improve access to health care: we will continue to work with our primary care providers to deliver the target of 75% of people on a GP register are receiving an annual health check by 2020. During 2018/19 we will ensure that we are at a minimum 64% compliant with this target.

Reduce inappropriate hospitalisation: the above actions will support a reduction in the number of people with a learning disability, autism or both inappropriately in hospital, details of our trajectory to achieve this is detailed in the baseline trajectory section.

Care, Education and Treatment Review (CETR): on the 1st of April 2018/19 a new policy and associated standard operating procedure will be released to ensure that children with learning disabilities receive a care, education and treatment review assessment prior to hospital admission. This policy will also ensure that 75% of those who have been admitted for inpatient care will receive the same assessment immediately post discharge. This will ensure that 70% of admissions have had a pre-admission CTR; 30% of admissions to have had a pre-admission LAEP; and 0% of admissions to have had no intervention prior to admission.

High Level Plan

Key Actions	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018	Sept 2018	Oct 2018	Nov 2018	Dec 2018	Jan 2019	Feb 2019	Mar 2019
Review CTR processes and Discharge pathway												
Consult on respite and short breaks												
Increase Personal Health Budgets												
Implement agreed changes to short breaks												
Review Crisis Response												
Continued delivery against Inpatient trajectory												

Baseline Positon and Trajectory

In 2018/19 the trajectory for reducing the number of individuals (adults and children) with learning disabilities and or autism that are currently receiving inpatient hospital care is set out below:

	Apr 18	May 18	June 18	Jul 18	Aug 18	Sept 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19
LLR	20	19	18	18	17	16	15	14	14	14	13	**12**

Annual Health Checks delivered by GPs for patients on the Learning Disability Register for 2018/19

CCG	Quarter 1	Quarter 2	Quarter 3	Quarter 4
LC CCG	9.9%	19.9%	16.6%	19.9%
ELR CCG	10.6%	10.6%	21.3%	23.8%
WL CCG	9.2%	9.2%	9.2%	29%

Note: WL CCG are planning to deliver 66.3% of their verified LD register which shows 1300 patients compared to the national figure of 1523.

Scheme: Self Care and Prevention	**Nine Must Do**		**STP Priority**	√	**GIRFT**		**MOO**		**RightCare**		**Other**		

Scheme Description

The public sector has a crucial leadership role around prevention: through its role as a major local employer and the priority it gives to prevention as part of core business. We want to accelerate this work locally by making sure that all staff are equipped to provide basic advice about healthy lifestyles and that patients who need extra support to make changes to improve their health and well-being can be referred onto lifestyle services that may help to reduce or slow down deterioration of existing conditions, or prevent other problems from developing.

Making sure that we have a workforce that sees prevention as part of our core business and is equipped to give patients, carers and the public brief advice and information to manage their own health and well-being is therefore an important part of local plans. We also know that more can be done to promote self-care locally and giving people more advice and information about what to do to manage their own health better. Our community pharmacies are a local and accessible port of call and we want to develop this as a key part of our approach to prevention.

Our plans to strengthen primary care and create a more effective and skilled workforce in the community are crucial to the prevention agenda. By wrapping integrated health care around vulnerable patients and those with long term or complex conditions we will be better able to prevent deterioration in those with established disease or those who show significant risk factors. This will involve early identification of those with disease or at risk and good long-term condition management. It is worth noting that while many public health measures take a long time to show any statistical benefit, interventions targeted at patients who are living with a condition can show positive results within three to five years.

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Local authorities deliver many of the interventions with longer term impact (10-15 years), including those tackling the wider determinants of health (including economy, housing, educational attainment, transport, recreation, air quality, regulations regarding food, alcohol and tobacco, and working to create an environment that supports community wellbeing). Other local authority services – such as smoking cessation, drug and alcohol treatment and interventions to reduce obesity, improve diet and increase levels of physical activity will show quicker returns and are therefore an important part of a local approach to prevention.

Local authorities also have a role in promoting mental wellbeing, reducing social isolation, supporting carers and promoting healthy ageing including support for vulnerable groups such as the frail elderly and those with dementia, which will include commissioning for other council departments and partners.

What we plan to do

The main preventable diseases and conditions in LLR and their underlying, modifiable causes of ill health and hospital admission include CVD, Type 2 Diabetes, respiratory conditions, Cancer, Frailty and Dementia. The same preventable lifestyle risk factors, including smoking, alcohol use, being overweight and physical inactivity, contribute to a number of major conditions. Social isolation and loneliness are significant risk factors for frailty and dementia. The detection and management of atrial fibrillation and type 2 diabetes have a positive impact on frailty, dementia and falls.

We know that locally we have some gaps in what we do to prevent avoidable illness. We have looked at national evidence about what is effective in preventing illness (Public Health England's 'Menu of Interventions') to establish what more needs to be done locally and this has been used to inform our local priorities. This evidence base shows us

what approaches are most likely to demonstrate the quickest returns on investment (within three to five years), based on national and international evidence.

Primary Care: in addition to the strengthening of primary care and comprehensive management of patients with long term and complex conditions which will help maintain better health in the local population, additional specific actions to prevent ill-health and disease will include: Develop an inpatient smoking cessation provision so that patients in hospital can get on-the-spot support to quit smoking during their stay in hospital.

Cardiovascular Disease: develop a cardiovascular disease (CVD) programme across LLR to improve the overall integration of primary and secondary CVD prevention work and develop a more coordinated approach to the treatment and management of CVD and its risk factors. This will include maximising the reach and impact of the NHS Healthcheck programme.

Alcohol treatment services: strengthen existing referral pathways to alcohol treatment services so that people in hospital as a result of alcohol or substance misuse can be quickly referred by front-line hospital staff. This is incentivised through national quality payments to University Hospitals Leicester

Make Every Contact Count: ensure the NHS and social care workforce are trained and supported to provide brief advice to patients about healthy lifestyles and that patients admitted to hospital are screened for smoking status, body mass index and alcohol consumption.

Lifestyle services: ensure patients who need extra support are referred to local lifestyle services to make lifestyle changes such as stopping smoking, getting active or managing weight.

Self-care: develop new approaches to supporting self-care, including implementing a Healthy Living Pharmacy scheme across LLR.

Workplace health: prioritise workplace health across public sector providers: Significant improvements could be made by improving the health and well-being of staff within the large public sector workforce. This includes priorities such as implementing the national workplace wellbeing charter, smoke free policies, active travel, food plans and healthy hospital food.

Diabetes: in Leicester city, we will focus specifically on taking steps to combat diabetes, working with Leicester Diabetes Centre and the global Cities Combatting Diabetes programme.

Our local prevention plans also include key proposals to improve antibiotic prescribing – an important public health priority. We know that patients are sometimes prescribed antibiotics inappropriately and that globally and nationally this is contributing to the development of antibiotic resistance.

Communications: self-care campaigns to educate the public will be implemented throughout the year on various themes, developed by partners including public health and supported by all organisations in the health economy.

Scheme: Acute Reconfiguration	**Nine Must Do**		**STP Priority**	√	**GIRFT**		**MOO**		**RightCare**		**Other**		

Scheme Description

For nearly two decades the need to consolidate acute services in Leicester has been widely recognised. The current, three acute sites configuration is an accident of history, not design, and as the pressure on local health and social care services has increased it has become more and more of a barrier to improving patient care in LLR. We are proposing to reduce the number of three acute hospitals to two, focusing on Leicester Royal Infirmary and Glenfield Hospital, because:

(i). We believe patients will be better served by shifting the balance of care from acute hospitals to community facilities and people's own homes, where it is safe and appropriate to do so.

Currently, our health and social care system is heavily dependent upon hospital treatment. However, evidence shows that patients, particularly elderly patients, spend too long recovering in large acute hospitals and potentially deteriorating as a result. Our plans for the development of health and social care in LLR are based on a "Home First" principle. This assumes that people are better served by a system that seeks to support them to maintain their own health and avoid crises that result in the need for medical or social intervention. When there is a need for intervention, we believe it is better for that to occur either in their own home or in a community hospital. However, when a patient must be treated in hospital, the Home First principle should be applied, whereby a patient's discharge is planned to enable them to get back into their home or community environment as soon as possible and appropriate, with minimal risk of readmission.

(ii). The current three-site configuration does not give us the best patient outcomes because staff are spread to thinly.

The current three-site hospital configuration is suboptimal in clinical performance terms, which has a direct impact on patient outcomes and experience. This results in duplication and sometimes triplication of services, which is inefficient. Clinical resources are therefore spread too thinly making services operationally unstable. Many elective (planned) and outpatient services currently run alongside emergency services and as a result when emergency pressures increase, it is elective patients who suffer delays and last minute cancellations. Over the last two decades there has been sustained under-investment in UHL's acute estate relative to other acute hospitals across the UK. There is a significant backlog maintenance requirement which will be reduced substantially through the consolidation of services onto two sites and a change of use for the LGH.
By focusing resources on two acute sites, outcomes for patients can be improved through increased consultant presence and earlier regular senior clinical decision-making.

(iii). Operating two acute hospitals will be financially sustainable.

The Trust's financial recovery is directly linked to site consolidation. The "reconfiguration dividend" has been calculated at £24.5 million per annum recurrent savings from the year the changes are complete. This would eliminate the "structural" element of UHL's current deficit.

Our plans will therefore:

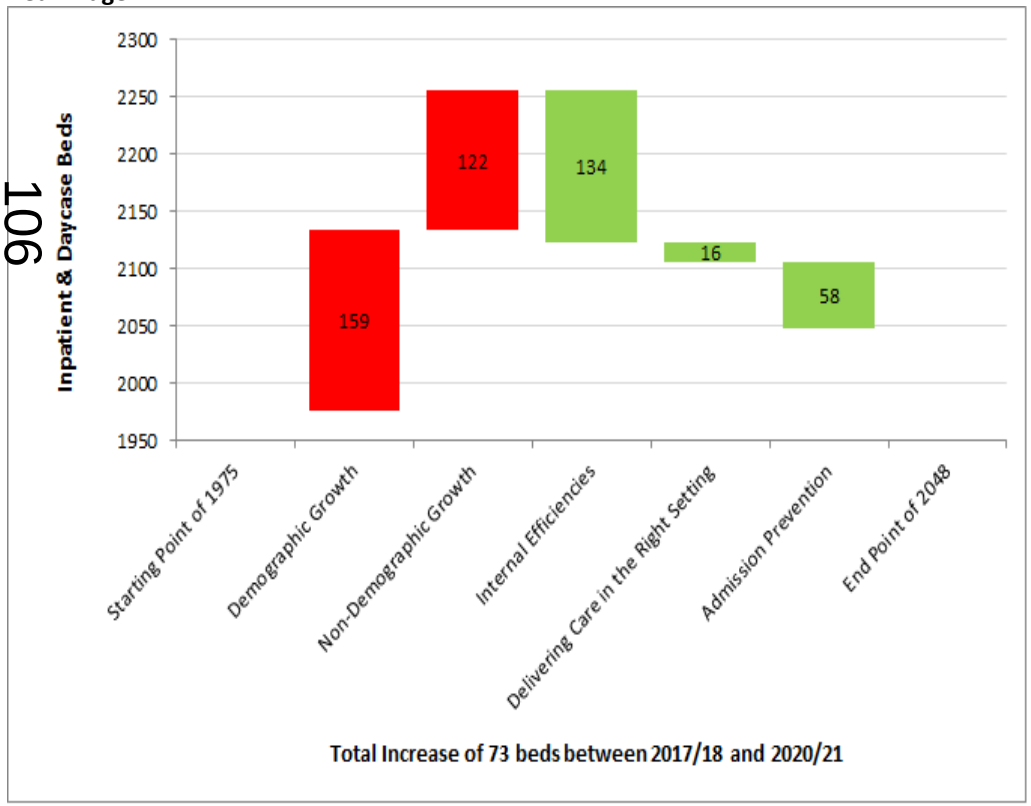
- **Consolidate services onto two acute sites:** subject to consultation and availability of capital we will reconfigure our hospitals to move all acute clinical services onto two sites, the Leicester Royal Infirmary and Glenfield Hospital and retain some non-acute health services on the site of Leicester General Hospital**.** Phase One of the

changes is nearing completion with a new Emergency Floor which opened in April 2017; Phase Two of the Emergency Floor which is due to open in June 2018; capital has been allocated for the improvements in ICU services and Business Cases are currently being developed for approval. A capital bid has been made for the remaining capital schemes and the outcome of this is expected in 2018.

- **Maternity Services:** subject to consultation and the availability of capital funding we will remodel maternity services to consolidate onto one site at the Royal Infirmary, and subject to the outcome of consultation a midwife lead unit at the General Hospital will be considered. The capital requirement is part of the bid on which approval is awaited.

For both of the above a Pre-Consultation Business Case is currently under development and will be considered by the CCG Governing Bodies in April 2018 and NHS England in May 2017. The impact of these changes on acute bed numbers is demonstrated in the bed bridge below – this shows that the overall bed base will grow by 73 beds between 2017/18 and 2020/21.

Bed Bridge



Implementation Plan

Gross Savings

The reconfiguration of the acute hospitals will enable the structural deficit of £24.5m held by UHL to be cleared. The STP financial model expects this to take place in 2023/24 once the reconfiguration work is complete.

Investment

The level of capital funding required for these changes is detailed below.

	17/18 £000s	18/19 £000s	19/20 £000s	20/21 £000s	21+ £000s	Total £000s
UHL Reconfiguration Programme	**1,438**	**58,383**	**97,916**	**110,246**	**101,191**	**369,174**
External Funding Requirement						
Funding Approved (subject to Approval of Business Case)	(1,438)	(27,392)	(1,970)	-	-	**(30,800)**
Other STP Bids (PDC or IBD - funding to be determined)	-	(30,991)	(95,946)	(110,246)	(101,191)	**(338,374)**
	(1,438)	**(58,383)**	**(97,916)**	**(110,246)**	**(101,191)**	**(369,174)**

Net Savings

Not applicable

Activity

Not applicable

Scheme: IM&T	**Nine Must Do**		**STP Priority**	**√**	**GIRFT**		**MOU**		**RightCare**		**Other**		

Scheme Description

Our ambition is to use an integrated patient record to improve patient care and safety and deliver significant savings to the LLR health and care system in terms of money and time. However, there are a number of challenges to overcome in order to achieve this aim. Within the local health care system organisations have their own IT systems, which in many cases are unable to share and make use of each other's information. This is a significant barrier to creating a transferable care record. It would be far safer and more efficient if clinical systems in use by different health and social care organisations were integrated or just the same. There is currently no national solution to achieve this. Locally we recognise that using existing systems and national initiatives that become available is better than ad hoc or separate systems.

In addition, there is a challenge in supporting staff to take up new IT solutions. Previous technological improvements have not been adopted by all of the workforce and full benefit has not been realised. Similarly, communication and engagement is needed with patients to make them aware of the health and social care benefits that are becoming available with better use of technology. Furthermore, under existing arrangements information sharing agreements between organisations can take months to update, slowing the progress towards shared records.

Vision - Our vision is to provide secure, shared access to electronic patient records across all clinical systems within LLR to improve patient outcomes and support integrated care by 2021.

This will enable clinicians to have access to a patient's care record at any point in the care pathway, from GP appointment, to urgent or emergency situations, within hospital and back at their local surgery after discharge.

We want to remove the use of paper, move a majority onto secure electronic communications and deliver paper free at point of care, with a key focus to make the use of fax obsolete as a method of communication. In doing this we can improve communication within Health and Care, e.g. communication between hospitals and GP practices can be refined to highlight actions points to improve the quality of care.

Not only will this integration and improvement be safer and more efficient in terms of time and money spent by the NHS, it will also make a huge difference to the patient experience, since people will not have to constantly repeat the same information whenever they are transferred from one part of the system to the other.

In addition, the LLR vision includes empowering patients to use technology, like apps, to support self-care but with the promise of direct access to services should the patient require it, as opposed to booked follow up appointments and clinics.

Use of real-time and historic data will help predictive modelling and improvements in clinical service delivery at the point of care. While population health analysis will support the planning and purchase of health services for local people.

To deliver this digital transformation, changes in technology alone will not be enough. Digital inclusion and digital literacy of the workforce, patients and carers are important

factors in delivering the change.

Our Local Digital Road Map (LDR) sets out our vision for the future both for IM&T that supports the delivery of care and using technology to support patients; this can be found at http://www.bettercareleicester.nhs.uk/EasysiteWeb/getresource.axd?AssetID=48200 .

What we plan to do

In 2018/19, the focus will be on supporting the delivery of e-consultation, using electronic systems to discharge patients to social care, sharing patient information between different clinical systems and supporting the use of a more detailed electronic Summary Care Record within NHS providers, e.g. hospitals. There will also be improved communication regarding existing technology to maximise its use.

However, the focus of the IM&T community will be to deliver enabling technologies critical to the successful delivery of the clinical and non-clinical STP transformation programmes. These activities will be blended with national mandated IM&T deliverables and Health and Social Care priorities outside of the STP work. The revised Local Digital Road Map (LDR) in 2018 will set out our vision for the future both for IM&T that supports the delivery of care and using technology to support patients.

Eight Key STP IM&T Objectives have been identified, these are in order of priority and we aim to provide:-

- The ability to have shared electronic patient record along a patient pathway, where all parties can contribute to the care planning and care delivery and move the patient along the pathway, between organisations seamlessly and without having to ask the patient for information again nor re-key data.
- To improve data capture from clinicians so that standard templates are used with conditional pathways, and that this data capture is shared with staff subsequently who are involved in the care of that patient.
- To develop a portfolio of domestic assistive technology appropriate for LLR, that not only remotely capture data, but also are subject to a process where that information is assessed based on rules and also passed for action to a live service to consider intervention.
- To develop an ecosystem of apps that are considered suitable for physical health, mental health and care that can be supplied or even prescribed to patients, giving more immediate access to their health status, potential direct access to service instead of follow ups and creating efficiency for busy clinicians who collect this information manually.
- Where IT systems are best of breed and have niche functionality to ensure that there is a high level of interoperability that does not act as a barrier to objective 1.
- To ensure that referrals into services follow strict pathway guidance ensuring that referral contain all information required to assess a patient and that pathway map to the correct service and do not require re-referring.
- Use real-time and historic data to support predictive modelling and improvements in clinical service delivery at the point off care and to support population health analysis and management for effective commissioning.
- To ensure that IM&T projects are seen as service transformation programmes where IM&T is the enabler of change, so that the benefits are realised and the transformation is delivered.

To support this programme in 2018/19:

- The LLR IM&T community has agreed to work towards extending TPP SystmOne as the main system supporting pathways in LLR and other systems must interoperate and share with it. As opportunities arise where it contractually makes sense to do so, we want to test the feasibility of a swap to SystmOne and follow this up with a migration project. Areas of particular interest to review are Adult Social Care, UHL, PAS functionality, UHL Maternity, UHL Therapy and the Alliance. GP Practice Systems that are on EMIS would also be considered for encouragement to migrate to SystmOne.
- Continue to support PRISM as a pathway navigation tool, ensure there is robust governance of SystmOne and EMIS templates, and that there is electronic transmission of that information along the pathway. The biggest challenge for 2018 will be establishing trusted assessment templates on SystmOne that Health and Care can collect data upon once, and share as a core common dataset of a patient's Health and Care record. Early pilot work in Rutland is currently being reviewed which if agreed has the potential to form a new model of information sharing out of providers into adult care.
- Develop through a partnership approach a resource of shared expertise within LLR to blend a mixture of procurement, integration, business change and product development to deliver a set of Digital Self Care products, initial target areas being scope are Falls, Prevention and Out-Patient Follow Up reduction.
- Support the development of an LLR business intelligence strategy with a clear implementation plan, including data sources, storage and analytic tools and develop a collaborative approach to the utilisation of this shared resource.
- Ensure that IM&T projects where IT has acted as the catalyst enabler are challenged by STP workstreams to be end-to-end projects delivering all the business change within the business case for the project. These changes could encompass pathway change projects involving multiple organisations and as such could be complex.

Appendix 1

Mapping of our key actions the Nine Must Dos

	Nine 'Must Dos'	Integrated Teams	Urgent Care	Medicinces	BCF	Cancer	CHC	Childrens and Maternity	Community Health Services	Dementia	IM&T	Learning Disabilities	Mental Health	Planned Care	Primary Care
1	Develop a high quality and agreed STP, and subsequently achieve what you determine are your most locally critical milestones for accelerating progress in 2016/17 towards achieving the triple aim as set out in the Forward View.	■	■	■	■	■	■	■	■	■	■	■	■	■	■
2	Return the system to aggregate financial balance. This includes secondary care providers delivering efficiency savings through actively engaging with the Lord Carter provider productivity work programme and complying with the maximum total agency spend and hourly rates set out by NHS Improvement. CCGs will additionally be expected to deliver savings by tackling unwarranted variation in demand through implementing the RightCare programme in every locality.	■	■	■	■	■	■	■	■	■	■	■	■	■	■
3	Develop and implement a local plan to address the sustainability and quality of general practice, including workforce and workload issues.										■				■
4	Get back on track with access standards for A&E and ambulance waits, ensuring more than 95 percent of patients wait no more than four hours in A&E, and that all ambulance trusts respond to 75 percent of Category A calls within eight minutes; including through making progress in implementing the urgent and emergency care review and associated ambulance standard pilots.		■						■						
5	Improvement against and maintenance of the NHS Constitution standards that more than 92 percent of patients on non-emergency pathways wait no more than 18 weeks from referral to treatment, including offering patient choice.													■	
6	Deliver the NHS Constitution 62 day cancer waiting standard, including by securing adequate diagnostic capacity; continue to deliver the constitutional two week and 31 day cancer standards and make progress in improving one-year survival rates by delivering a year-on-year improvement in the proportion of cancers diagnosed at stage one and stage two; and reducing the proportion of cancers diagnosed following an emergency admission.					■									
7	Achieve and maintain the two new mental health access standards: more than 50 percent of people experiencing a first episode of psychosis will commence treatment with a NICE approved care package within two weeks of referral; 75 percent of people with common mental health conditions referred to the Improved Access to Psychological Therapies (IAPT) programme will be treated within six weeks of referral, with 95 percent treated within 18 weeks. Continue to meet a dementia diagnosis rate of at least two-thirds of the estimated number of people with dementia									■			■		
8	Deliver actions set out in local plans to transform care for people with learning disabilities, including implementing enhanced community provision, reducing inpatient capacity, and rolling out care and treatment reviews in line with published policy.											■			
9	Develop and implement an affordable plan to make improvements in quality particularly for organisations in special measures. In addition, providers are required to participate in the annual publication of avoidable mortality rates by individual trusts.	■	■	■	■	■	■	■	■	■	■	■	■	■	■

Planning for 2018/2019 – Key Performance Indicators (KPIs) **Appendix 2**

As part of the 2018/2019 planning round, NHS England has asked that the CCGs provide targets and trajectories for a number of KPIs. These include the following:

Constitution KPIs:

- Incomplete 18 Weeks Referral to Treatment (RTT)
- RTT 52 Week Waits
- Diagnostic Waiting Times
- Cancer 2 Week Wait & 2 Week Wait Breast Symptoms
- Cancer 31 Days First Definitive Treatment, Surgery, Anti-Cancer Drug Regimens & Radiotherapy
- Cancer 62 Day - Urgent Referral to First Treatment, cancer screening service & referral from a consultant's decision to upgrade
- A&E 4 Hour Wait trajectories (Monthly). Leicester City CCG to report only on UHL

Mental Health

- Dementia estimated Diagnosis Rate
- IAPT; Access, Recovery & Waiting Times 6 Weeks & 18 Weeks
- Early Intervention for Psychosis 2 Weeks waits
- C&YP receiving treatment from NHS funded community services
- C&YP Eating Disorder Services –1 Week & 4 Weeks waits
- Out of Area Placements – NEW (to be reported in April 18 submission only)

Primary Care

- Extended access (evening and weekends) at GP services

Other Commitments

- E-Referrals Coverage
- Personal Health Budgets
- Children Waiting <18 weeks for Wheelchairs
- Annual Health Checks delivered by GPs for patients on the Learning Disability Register – NEW

LD Patient Projections

- LD/Autism – Reliance on Inpatient Care (CCGs & NHS England) – this will be completed by ELR CCG only as Lead

RTT 18 Weeks – National Standard - Waiting List should be sustained at or below March 2018 levels in March 2019

Leicester City

		E.B.3	April	May	June	July	August	September	October	November	December	January	February	March
RTT Incomplete Pathway	2015/16	Pathways < 18 Weeks	18,115	18,723	18,839	17,763	18,488	18,582	18,076	17,755	19,382	18,596	18,380	19,001
		Total Pathways	18,832	19,487	19,731	18,764	19,796	19,636	19,450	19,000	20,901	20,012	19,722	20,565
		%	**96.2%**	**96.1%**	**95.5%**	**94.7%**	**93.4%**	**94.6%**	**92.9%**	**93.4%**	**92.7%**	**92.9%**	**93.2%**	**92.4%**
	2016/17	Pathways < 18 Weeks	19,773	20,283	20,228	19,748	19,854	19,772	19,211	19,715	19,823	19,237	21,503	20,370
		Total Pathways	21,385	21,942	21,928	21,363	21,581	21,543	20,983	21,364	21,684	21,145	23,364	22,124
		%	**92.5%**	**92.4%**	**92.2%**	**92.4%**	**92.0%**	**91.8%**	**91.6%**	**92.3%**	**91.4%**	**91.0%**	**92.0%**	**92.1%**
	2017/18	Pathways < 18 Weeks	20,516	21,115	21,335	21,337	21,902	21,782	21,695	-	-	-	-	-
		Total Pathways	22,395	22,758	23,062	23,106	23,822	23,773	23,580	-	-	-	-	-
		%	**91.6%**	**92.8%**	**92.5%**	**92.3%**	**91.9%**	**91.6%**	**92.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**
	2018/19 Plan	Pathways < 18 Weeks	20,297	20,532	20,696	20,870	21,103	21,090	21,022	20,968	20,505	19,966	20,929	21,823
		Total Pathways	23,739	23,709	23,625	23,555	23,579	23,381	23,127	22,916	22,860	22,612	23,126	23,720
		%	**85.5%**	**86.6%**	**87.6%**	**88.6%**	**89.5%**	**90.2%**	**90.9%**	**91.5%**	**89.7%**	**88.3%**	**90.5%**	**92.0%**

East Leicestershire & Rutland

		E.B.3	April	May	June	July	August	September	October	November	December	January	February	March
RTT Incomplete Pathway	2015/16	Pathways < 18 Weeks	14,576	15,285	15,704	15,740	15,950	15,901	15,691	15,581	15,025	15,509	15,826	16,050
		Total Pathways	15,092	15,878	16,328	16,491	16,906	16,761	16,657	16,539	16,001	16,499	16,831	17,145
		%	**96.6%**	**96.3%**	**96.2%**	**95.4%**	**94.3%**	**94.9%**	**94.2%**	**94.2%**	**93.9%**	**94.0%**	**94.0%**	**93.6%**
	2016/17	Pathways < 18 Weeks	16,556	16,531	16,772	16,566	16,382	16,794	16,457	16,789	16,857	16,195	15,770	17,710
		Total Pathways	17,696	17,759	18,055	17,842	17,745	18,301	17,893	18,110	18,325	17,680	17,418	19,336
		%	**93.6%**	**93.1%**	**92.9%**	**92.8%**	**92.3%**	**91.8%**	**92.0%**	**92.7%**	**92.0%**	**91.6%**	**90.5%**	**91.6%**
	2017/18	Pathways < 18 Weeks	17,981	18,175	18,505	18,830	19,005	18,609	18,610	-	-	-	-	-
		Total Pathways	19,747	19,766	20,105	20,577	20,800	20,513	20,349	-	-	-	-	-
		%	**91.1%**	**92.0%**	**92.0%**	**91.5%**	**91.4%**	**90.7%**	**91.5%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**
	2018/19 Plan	Pathways < 18 Weeks	17,897	18,105	18,249	18,401	18,608	18,597	18,537	18,488	18,081	17,605	18,330	18,925
		Total Pathways	20,932	20,906	20,832	20,769	20,791	20,617	20,393	20,206	20,157	19,938	20,254	20,570
		%	**85.5%**	**86.6%**	**87.6%**	**88.6%**	**89.5%**	**90.2%**	**90.9%**	**91.5%**	**89.7%**	**88.3%**	**90.5%**	**92.0%**

West Leicestershire

		E.B.3	April	May	June	July	August	September	October	November	December	January	February	March
RTT Incomplete Pathway	2015/16	Pathways < 18 Weeks	16,953	17,579	17,782	17,600	17,847	17,744	17,625	17,356	17,029	17,379	17,668	18,237
		Total Pathways	17,613	18,277	18,629	18,499	18,806	18,569	18,615	18,234	18,102	18,552	18,817	19,564
		%	**96.3%**	**96.2%**	**95.5%**	**95.1%**	**94.9%**	**95.6%**	**94.7%**	**95.2%**	**94.1%**	**93.7%**	**93.9%**	**93.2%**
	2016/17	Pathways < 18 Weeks	17,873	18,033	17,837	17,987	17,826	18,230	18,074	19,461	19,250	18,846	17,716	20,368
		Total Pathways	19,107	19,227	19,193	19,366	19,276	19,805	19,657	20,992	20,991	20,582	19,471	22,124
		%	**93.5%**	**93.8%**	**92.9%**	**92.9%**	**92.5%**	**92.0%**	**91.9%**	**92.7%**	**91.7%**	**91.6%**	**91.0%**	**92.1%**
	2017/18	Pathways < 18 Weeks	20,230	20,327	20,139	20,442	20,952	20,838	21,003	-	-	-	-	-
		Total Pathways	22,214	22,102	21,859	22,354	22,982	22,916	22,877	-	-	-	-	-
		%	**91.1%**	**92.0%**	**92.1%**	**91.4%**	**91.2%**	**90.9%**	**91.8%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**
	2018/19 Plan	Pathways < 18 Weeks	20,133	20,366	20,528	20,701	20,933	20,919	20,852	20,799	20,339	19,805	20,647	21,342
		Total Pathways	23,547	23,517	23,434	23,364	23,389	23,192	22,940	22,731	22,675	22,429	22,814	23,197
		%	**85.5%**	**86.6%**	**87.6%**	**88.6%**	**89.5%**	**90.2%**	**90.9%**	**91.5%**	**89.7%**	**88.3%**	**90.5%**	**92.0%**

RTT 52 Week Waits – National Standard - Zero

Leicester City

		E.B.18	April	May	June	July	August	September	October	November	December	January	February	March
RTT 52 Week Waits	2015/16	Pathways >52 Weeks	-	20	86	97	93	-	-	-	-	1	-	5
	2016/17	Pathways >52 Weeks	1	2	2	1	1	2	1	3	8	10	14	10
	2017/18	Pathways >52 Weeks	8	5	10	10	10	2	1	1	2	-	-	-
	2018/19	Pathways >52 Weeks	-	-	-	-	-	-	-	-	-	-	-	-

East Leicestershire & Rutland

		E.B.18	April	May	June	July	August	September	October	November	December	January	February	March
RTT 52 Week Waits	2015/16	Pathways >52 Weeks	-	18	64	66	66	1	1	1	-	-	-	-
	2016/17	Pathways >52 Weeks	-	-	1	1	-	1	2	5	5	8	26	22
	2017/18	Pathways >52 Weeks	18	15	6	5	6	1	-	-	1	-	-	-
	2018/19	Pathways >52 Weeks	-	-	-	-	-	-	-	-	-	-	-	-

West Leicestershire

		E.B.18	April	May	June	July	August	September	October	November	December	January	February	March
RTT 52 Week Waits	2015/16	Pathways >52 Weeks	-	26	86	85	86	-	-	-	-	1	1	-
	2016/17	Pathways >52 Weeks	1	1	2	3	3	3	3	5	6	3	7	7
	2017/18	Pathways >52 Weeks	7	4	4	7	7	4	2	2	2	-	-	-
	2018/19	Pathways >52 Weeks	-	-	-	-	-	-	-	-	-	-	-	-

Diagnostics Waiting Times < 6 Weeks – National Standard 1%

Leicester City

Standard	1%	E.B.4	April	May	June	July	August	September	October	November	December	January	February	March
Monthly Diff. Tolerance	25%													
Diagnostics Test Waiting Times	2015/16	Number Waiting > 6 Wks	117	58	368	669	851	595	542	469	405	241	121	84
		Total Number Waiting	5,525	5,702	6,040	5,848	5,951	6,048	6,129	6,311	6,091	6,204	6,696	6,830
		%	**2.1%**	**1.0%**	**6.1%**	**11.4%**	**14.3%**	**9.8%**	**8.8%**	**7.4%**	**6.6%**	**3.9%**	**1.8%**	**1.2%**
	2016/17	Number Waiting > 6 Wks	28	37	35	40	82	89	37	36	46	34	39	46
		Total Number Waiting	5,594	6,741	6,626	6,392	6,480	6,632	6,879	6,312	6,022	5,448	5,613	6,218
		%	**0.5%**	**0.5%**	**0.5%**	**0.6%**	**1.3%**	**1.3%**	**0.5%**	**0.6%**	**0.8%**	**0.6%**	**0.7%**	**0.7%**
	2017/18	Number Waiting > 6 Wks	43	56	43	31	48	22	39	-	-	-	-	-
		Total Number Waiting	6,112	6,660	6,944	6,091	6,546	6,841	6,809	-	-	-	-	-
		%	**0.7%**	**0.8%**	**0.6%**	**0.5%**	**0.7%**	**0.3%**	**0.6%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**
	2018/19 Plan	Number Waiting > 6 Wks	64	70	73	64	69	72	71	71	68	69	69	69
		Total Number Waiting	6,479	7,060	7,361	6,456	6,939	7,251	7,218	7,220	6,832	6,979	6,979	6,979
		%	**1.0%**	**1.0%**	**1.0%**	**1.0%**	**1.0%**	**1.0%**	**1.0%**	**1.0%**	**1.0%**	**1.0%**	**1.0%**	**1.0%**

East Leicestershire & Rutland

Standard	1%	E.B.4	April	May	June	July	August	September	October	November	December	January	February	March
Monthly Diff. Tolerance	25%													
Diagnostics Test Waiting Times	2015/16	Number Waiting > 6 Wks	107	42	276	487	578	452	412	349	339	179	71	67
		Total Number Waiting	4,706	4,799	5,173	4,920	4,962	5,073	5,136	5,481	5,153	5,210	5,422	5,594
		%	**2.3%**	**0.9%**	**5.3%**	**9.9%**	**11.6%**	**8.9%**	**8.0%**	**6.4%**	**6.6%**	**3.4%**	**1.3%**	**1.2%**
	2016/17	Number Waiting > 6 Wks	28	26	31	20	66	84	26	28	51	47	33	50
		Total Number Waiting	4,626	5,458	5,463	5,173	5,168	5,239	5,260	5,175	4,876	4,832	4,969	5,329
		%	**0.6%**	**0.5%**	**0.6%**	**0.4%**	**1.3%**	**1.6%**	**0.5%**	**0.5%**	**1.0%**	**1.0%**	**0.7%**	**0.9%**
	2017/18	Number Waiting > 6 Wks	47	40	45	45	30	24	22	-	-	-	-	-
		Total Number Waiting	5,242	5,752	5,771	5,257	5,580	5,709	5,724	-	-	-	-	-
		%	**0.9%**	**0.7%**	**0.8%**	**0.9%**	**0.5%**	**0.4%**	**0.4%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**
	2018/19 Plan	Number Waiting > 6 Wks	55	60	61	55	59	60	60	62	59	59	59	59
		Total Number Waiting	5,557	6,097	6,117	5,572	5,915	6,052	6,067	6,285	6,000	5,962	5,962	5,962
		%	**1.0%**	**1.0%**	**1.0%**	**1.0%**	**1.0%**	**1.0%**	**1.0%**	**1.0%**	**1.0%**	**1.0%**	**1.0%**	**1.0%**

West Leicestershire

Standard	1%	E.B.4	April	May	June	July	August	September	October	November	December	January	February	March
Monthly Diff. Tolerance	25%													
Diagnostics Test Waiting Times	2015/16	Number Waiting > 6 Wks	171	96	287	406	511	391	356	318	289	197	102	63
		Total Number Waiting	5,597	5,779	5,835	5,709	5,464	5,650	5,761	6,047	5,767	5,857	6,063	6,162
		%	**3.1%**	**1.7%**	**4.9%**	**7.1%**	**9.4%**	**6.9%**	**6.2%**	**5.3%**	**5.0%**	**3.4%**	**1.7%**	**1.0%**
	2016/17	Number Waiting > 6 Wks	34	24	45	20	64	67	29	28	45	43	41	42
		Total Number Waiting	5,143	6,010	6,188	6,358	5,793	5,807	5,795	6,008	5,616	5,510	5,690	5,953
		%	**0.7%**	**0.4%**	**0.7%**	**0.3%**	**1.1%**	**1.2%**	**0.5%**	**0.5%**	**0.8%**	**0.8%**	**0.7%**	**0.7%**
	2017/18	Number Waiting > 6 Wks	53	47	36	50	38	33	17	-	-	-	-	-
		Total Number Waiting	6,144	6,735	6,535	6,179	6,564	6,845	6,761	-	-	-	-	-
		%	**0.9%**	**0.7%**	**0.6%**	**0.8%**	**0.6%**	**0.5%**	**0.3%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**
	2018/19 Plan	Number Waiting > 6 Wks	64	71	69	65	69	72	71	74	71	69	69	69
		Total Number Waiting	6,513	7,139	6,927	6,550	6,958	7,256	7,167	7,495	7,172	7,020	7,020	7,020
		%	**1.0%**	**1.0%**	**1.0%**	**1.0%**	**1.0%**	**1.0%**	**1.0%**	**1.0%**	**1.0%**	**1.0%**	**1.0%**	**1.0%**

Cancer 62 Day Waits – National Standard 85%

Leicester City

Standard	85%	E.B.12	April	May	June	July	August	September	October	November	December	January	February	March
Monthly Diff. Tolerance	25%													
Cancer Waiting Times - 62 Day GP Referral	2015/16	Number Treated < 62 Days	34	27	45	29	40	43	37	36	30	32	31	34
		Total Number Seen	47	39	55	41	48	52	48	45	40	42	43	45
		%	**72.3%**	**69.2%**	**81.8%**	**70.7%**	**83.3%**	**82.7%**	**77.1%**	**80.0%**	**75.0%**	**76.2%**	**72.1%**	**75.6%**
	2016/17	Number Treated < 62 Days	34	36	32	46	47	28	33	46	39	38	31	42
		Total Number Seen	43	59	42	53	61	38	46	55	47	47	39	52
		%	**79.1%**	**61.0%**	**76.2%**	**86.8%**	**77.0%**	**73.7%**	**71.7%**	**83.6%**	**83.0%**	**80.9%**	**79.5%**	**80.8%**
	2017/18	Number Treated < 62 Days	37	38	41	41	42	55	46	-	-	-	-	-
		Total Number Seen	47	57	52	54	56	68	57	-	-	-	-	-
		%	**78.7%**	**66.7%**	**78.8%**	**75.9%**	**75.0%**	**80.9%**	**80.7%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**
	2018/19 Plan	Number Treated < 62 Days	39	49	46	49	51	62	51	34	42	48	48	48
		Total Number Seen	50	60	55	57	59	72	60	40	49	56	56	56
		%	**78.0%**	**81.7%**	**83.6%**	**86.0%**	**86.4%**	**86.1%**	**85.0%**	**85.0%**	**85.7%**	**85.7%**	**85.7%**	**85.7%**

East Leicestershire & Rutland

Standard	85%	E.B.12	April	May	June	July	August	September	October	November	December	January	February	March
Monthly Diff. Tolerance	25%													
Cancer Waiting Times - 62 Day GP Referral	2015/16	Number Treated < 62 Days	62	60	58	64	62	60	68	63	70	59	60	67
		Total Number Seen	76	82	74	84	82	76	88	75	80	80	80	81
		%	**81.6%**	**73.2%**	**78.4%**	**76.2%**	**75.6%**	**78.9%**	**77.3%**	**84.0%**	**87.5%**	**73.8%**	**75.0%**	**82.7%**
	2016/17	Number Treated < 62 Days	66	79	68	77	87	68	57	51	66	68	61	81
		Total Number Seen	82	99	83	89	104	89	71	64	76	89	75	89
		%	**80.5%**	**79.8%**	**81.9%**	**86.5%**	**83.7%**	**76.4%**	**80.3%**	**79.7%**	**86.8%**	**76.4%**	**81.3%**	**91.0%**
	2017/18	Number Treated < 62 Days	77	74	75	77	80	70	57	-	-	-	-	-
		Total Number Seen	87	87	96	90	100	86	67	-	-	-	-	-
		%	**88.5%**	**85.1%**	**78.1%**	**85.6%**	**80.0%**	**81.4%**	**85.1%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**
	2018/19 Plan	Number Treated < 62 Days	72	75	85	81	91	78	61	76	67	78	78	78
		Total Number Seen	92	92	102	95	106	91	71	89	78	91	91	91
		%	**78.3%**	**81.5%**	**83.3%**	**85.3%**	**85.8%**	**85.7%**	**85.9%**	**85.4%**	**85.9%**	**85.7%**	**85.7%**	**85.7%**

West Leicestershire

Standard	85%	E.B.12	April	May	June	July	August	September	October	November	December	January	February	March
Monthly Diff. Tolerance	25%													
Cancer Waiting Times - 62 Day GP Referral	2015/16	Number Treated < 62 Days	44	57	81	50	70	65	60	51	56	56	57	51
		Total Number Seen	61	76	92	66	81	89	78	59	73	70	73	67
		%	**72.1%**	**75.0%**	**88.0%**	**75.8%**	**86.4%**	**73.0%**	**76.9%**	**86.4%**	**76.7%**	**80.0%**	**78.1%**	**76.1%**
	2016/17	Number Treated < 62 Days	64	60	62	56	84	62	55	62	65	61	62	65
		Total Number Seen	89	74	86	73	108	75	78	85	85	85	80	75
		%	**71.9%**	**81.1%**	**72.1%**	**76.7%**	**77.8%**	**82.7%**	**70.5%**	**72.9%**	**76.5%**	**71.8%**	**77.5%**	**86.7%**
	2017/18	Number Treated < 62 Days	76	86	78	67	79	64	79	-	-	-	-	-
		Total Number Seen	94	112	101	84	100	79	101	-	-	-	-	-
		%	**80.9%**	**76.8%**	**77.2%**	**79.8%**	**79.0%**	**81.0%**	**78.2%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**
	2018/19 Plan	Number Treated < 62 Days	78	96	88	74	90	71	91	75	71	83	83	83
		Total Number Seen	100	119	106	87	105	84	106	88	83	97	97	97
		%	**78.0%**	**80.7%**	**83.0%**	**85.1%**	**85.7%**	**84.5%**	**85.8%**	**85.2%**	**85.5%**	**85.6%**	**85.6%**	**85.6%**

Cancer 62 Day Cancer Screening Service – National Standard 90% (small numbers impact on percentages)

Leicester City

Standard	90%	E.B.13	April	May	June	July	August	September	October	November	December	January	February	March
Monthly Diff. Tolerance	25%													
Cancer Waiting Times - 62 Day Screening	2015/16	Number Treated < 62 Days	14	11	7	13	6	4	2	8	23	5	11	6
		Total Number Seen	16	14	8	14	6	6	3	9	23	5	11	8
		%	**87.5%**	**78.6%**	**87.5%**	**92.9%**	**100.0%**	**66.7%**	**66.7%**	**88.9%**	**100.0%**	**100.0%**	**100.0%**	**75.0%**
	2016/17	Number Treated < 62 Days	6	3	3	2	1	2	2	2	1	1	-	2
		Total Number Seen	7	3	4	2	1	3	5	4	1	1	1	3
		%	**85.7%**	**100.0%**	**75.0%**	**100.0%**	**100.0%**	**66.7%**	**40.0%**	**50.0%**	**100.0%**	**100.0%**	**0.0%**	**66.7%**
	2017/18	Number Treated < 62 Days	2	3	2	6	9	3	6	-	-	-	-	-
		Total Number Seen	2	3	3	6	11	4	5	-	-	-	-	-
		%	**100.0%**	**100.0%**	**66.7%**	**100.0%**	**81.8%**	**75.0%**	**120.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**
	2018/19 Plan	Number Treated < 62 Days	2	3	3	5	11	4	6	9	7	6	6	6
		Total Number Seen	2	3	3	6	12	4	6	10	7	6	6	6
		%	**100.0%**	**100.0%**	**100.0%**	**83.3%**	**91.7%**	**100.0%**	**100.0%**	**90.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**

East Leicestershire & Rutland

Standard	90%	E.B.13	April	May	June	July	August	September	October	November	December	January	February	March
Monthly Diff. Tolerance	25%													
Cancer Waiting Times - 62 Day Screening	2015/16	Number Treated < 62 Days	7	10	6	8	7	3	3	3	1	1	3	10
		Total Number Seen	8	10	6	9	7	3	4	3	2	3	6	11
		%	**87.5%**	**100.0%**	**100.0%**	**88.9%**	**100.0%**	**100.0%**	**75.0%**	**100.0%**	**50.0%**	**33.3%**	**50.0%**	**90.9%**
	2016/17	Number Treated < 62 Days	7	4	5	6	6	11	6	8	16	15	9	21
		Total Number Seen	7	4	6	8	7	14	6	9	17	16	14	21
		%	**100.0%**	**100.0%**	**83.3%**	**75.0%**	**85.7%**	**78.6%**	**100.0%**	**88.9%**	**94.1%**	**93.8%**	**64.3%**	**100.0%**
	2017/18	Number Treated < 62 Days	30	29	22	17	22	7	14	-	-	-	-	-
		Total Number Seen	30	32	23	20	22	9	6	-	-	-	-	-
		%	**100.0%**	**90.6%**	**95.7%**	**85.0%**	**100.0%**	**77.8%**	**233.3%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**
	2018/19 Plan	Number Treated < 62 Days	27	30	21	18	21	9	14	16	8	18	18	18
		Total Number Seen	32	34	24	21	23	10	15	17	8	20	20	20
		%	**84.4%**	**88.2%**	**87.5%**	**85.7%**	**91.3%**	**90.0%**	**93.3%**	**94.1%**	**100.0%**	**90.0%**	**90.0%**	**90.0%**

West Leicestershire

Standard	90%	E.B.13	April	May	June	July	August	September	October	November	December	January	February	March
Monthly Diff. Tolerance	25%													
Cancer Waiting Times - 62 Day Screening	2015/16	Number Treated < 62 Days	13	9	15	20	21	17	21	14	17	12	6	11
		Total Number Seen	13	12	16	20	22	20	22	15	18	15	10	14
		%	**100.0%**	**75.0%**	**93.8%**	**100.0%**	**95.5%**	**85.0%**	**95.5%**	**93.3%**	**94.4%**	**80.0%**	**60.0%**	**78.6%**
	2016/17	Number Treated < 62 Days	15	5	8	10	7	9	8	13	14	12	16	17
		Total Number Seen	16	5	10	10	10	11	8	13	16	13	17	18
		%	**93.8%**	**100.0%**	**80.0%**	**100.0%**	**70.0%**	**81.8%**	**100.0%**	**100.0%**	**87.5%**	**92.3%**	**94.1%**	**94.4%**
	2017/18	Number Treated < 62 Days	6	4	4	6	7	6	6	-	-	-	-	-
		Total Number Seen	8	5	4	8	9	7	8	-	-	-	-	-
		%	**75.0%**	**80.0%**	**100.0%**	**75.0%**	**77.8%**	**85.7%**	**75.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**
	2018/19 Plan	Number Treated < 62 Days	7	4	3	7	9	7	9	13	12	9	9	9
		Total Number Seen	8	5	4	8	10	7	10	14	13	9	9	9
		%	**87.5%**	**80.0%**	**75.0%**	**87.5%**	**90.0%**	**100.0%**	**90.0%**	**92.9%**	**92.3%**	**100.0%**	**100.0%**	**100.0%**

Cancer 31 Day Wait – National Standard 96%

Leicester City

Standard	96%	E.B.8	April	May	June	July	August	September	October	November	December	January	February	March
Monthly Diff. Tolerance	25%													
Cancer Waiting Times - 31 Day First Treatment	2015/16	Number Treated < 31 Days	86	81	95	95	87	85	81	74	84	75	65	83
		Total Number Seen	89	83	96	98	90	91	85	78	91	83	70	89
		%	**96.6%**	**97.6%**	**99.0%**	**96.9%**	**96.7%**	**93.4%**	**95.3%**	**94.9%**	**92.3%**	**90.4%**	**92.9%**	**93.3%**
	2016/17	Number Treated < 31 Days	78	92	78	83	95	72	81	86	66	71	58	88
		Total Number Seen	79	98	82	89	105	77	85	90	75	75	62	94
		%	**98.7%**	**93.9%**	**95.1%**	**93.3%**	**90.5%**	**93.5%**	**95.3%**	**95.6%**	**88.0%**	**94.7%**	**93.5%**	**93.6%**
	2017/18	Number Treated < 31 Days	76	101	92	91	89	99	107	-	-	-	-	-
		Total Number Seen	79	108	98	96	98	105	110	-	-	-	-	-
		%	**96.2%**	**93.5%**	**93.9%**	**94.8%**	**90.8%**	**94.3%**	**97.3%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**
	2018/19 Plan	Number Seen < 2 Wks	79	108	100	98	100	107	113	103	85	99	99	99
		Total Number Seen	84	114	104	102	104	111	117	107	88	103	103	103
		%	**94.0%**	**94.7%**	**96.2%**	**96.1%**	**96.2%**	**96.4%**	**96.6%**	**96.3%**	**96.6%**	**96.1%**	**96.1%**	**96.1%**

East Leicestershire & Rutland

Standard	96%	E.B.8	April	May	June	July	August	September	October	November	December	January	February	March
Monthly Diff. Tolerance	25%													
Cancer Waiting Times - 31 Day First Treatment	2015/16	Number Treated < 31 Days	130	135	116	132	133	121	130	102	129	110	126	132
		Total Number Seen	138	137	123	137	134	128	136	107	132	120	129	138
		%	**94.2%**	**98.5%**	**94.3%**	**96.4%**	**99.3%**	**94.5%**	**95.6%**	**95.3%**	**97.7%**	**91.7%**	**97.7%**	**95.7%**
	2016/17	Number Treated < 31 Days	129	150	133	126	143	144	105	105	143	146	134	156
		Total Number Seen	134	151	136	137	152	154	109	109	146	156	140	158
		%	**96.3%**	**99.3%**	**97.8%**	**92.0%**	**94.1%**	**93.5%**	**96.3%**	**96.3%**	**97.9%**	**93.6%**	**95.7%**	**98.7%**
	2017/18	Number Treated < 31 Days	156	153	169	160	178	147	136	-	-	-	-	-
		Total Number Seen	161	158	170	164	180	152	149	-	-	-	-	-
		%	**96.9%**	**96.8%**	**99.4%**	**97.6%**	**98.9%**	**96.7%**	**91.3%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**
	2018/19 Plan	Number Seen < 2 Wks	161	159	174	168	184	155	152	158	142	162	162	162
		Total Number Seen	171	167	180	174	191	161	158	164	147	168	168	168
		%	**94.2%**	**95.2%**	**96.7%**	**96.6%**	**96.3%**	**96.3%**	**96.2%**	**96.3%**	**96.6%**	**96.4%**	**96.4%**	**96.4%**

West Leicestershire

Standard	96%	E.B.8	April	May	June	July	August	September	October	November	December	January	February	March
Monthly Diff. Tolerance	25%													
Cancer Waiting Times - 31 Day First Treatment	2015/16	Number Treated < 31 Days	116	129	144	138	152	148	133	115	136	118	108	123
		Total Number Seen	125	133	157	140	158	152	139	121	141	120	118	127
		%	**92.8%**	**97.0%**	**91.7%**	**98.6%**	**96.2%**	**97.4%**	**95.7%**	**95.0%**	**96.5%**	**98.3%**	**91.5%**	**96.9%**
	2016/17	Number Treated < 31 Days	150	138	146	124	166	144	118	149	143	144	140	151
		Total Number Seen	156	148	150	135	178	148	124	158	155	157	145	156
		%	**96.2%**	**93.2%**	**97.3%**	**91.9%**	**93.3%**	**97.3%**	**95.2%**	**94.3%**	**92.3%**	**91.7%**	**96.6%**	**96.8%**
	2017/18	Number Treated < 31 Days	155	163	165	137	162	142	158	-	-	-	-	-
		Total Number Seen	158	168	170	141	166	146	167	-	-	-	-	-
		%	**98.1%**	**97.0%**	**97.1%**	**97.2%**	**97.6%**	**97.3%**	**94.6%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**
	2018/19 Plan	Number Seen < 2 Wks	157	169	174	144	170	150	171	164	148	161	161	161
		Total Number Seen	167	178	180	149	176	155	177	170	153	167	167	167
		%	**94.0%**	**94.9%**	**96.7%**	**96.6%**	**96.6%**	**96.8%**	**96.6%**	**96.5%**	**96.7%**	**96.4%**	**96.4%**	**96.4%**

Cancer 31 Day Wait Surgery – National Standard 94% (small numbers impact on percentages)

Leicester City

Standard	94%	E.B.9	April	May	June	July	August	September	October	November	December	January	February	March
Monthly Diff. Tolerance	25%													
Cancer Waiting Times - 31 Day Surgery	2015/16	Number Treated < 31 Days	15	11	24	15	11	21	14	16	16	24	18	8
		Total Number Seen	16	12	24	15	13	22	16	21	17	27	20	10
		%	**93.8%**	**91.7%**	**100.0%**	**100.0%**	**84.6%**	**95.5%**	**87.5%**	**76.2%**	**94.1%**	**88.9%**	**90.0%**	**80.0%**
	2016/17	Number Treated < 31 Days	11	20	15	15	18	11	15	10	16	20	13	22
		Total Number Seen	11	21	18	17	23	14	16	14	18	23	16	22
		%	**100.0%**	**95.2%**	**83.3%**	**88.2%**	**78.3%**	**78.6%**	**93.8%**	**71.4%**	**88.9%**	**87.0%**	**81.3%**	**100.0%**
	2017/18	Number Treated < 31 Days	12	20	21	20	18	15	27	-	-	-	-	-
		Total Number Seen	12	23	22	20	20	20	28	-	-	-	-	-
		%	**100.0%**	**87.0%**	**95.5%**	**100.0%**	**90.0%**	**75.0%**	**96.4%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**
	2018/19 Plan	Number Treated < 31 Days	11	21	20	19	19	20	29	27	16	21	21	21
		Total Number Seen	13	24	23	21	21	21	30	28	17	22	22	22
		%	**84.6%**	**87.5%**	**87.0%**	**90.5%**	**90.5%**	**95.2%**	**96.7%**	**96.4%**	**94.1%**	**95.5%**	**95.5%**	**95.5%**

East Leicestershire & Rutland

Standard	94%	E.B.9	April	May	June	July	August	September	October	November	December	January	February	March
Monthly Diff. Tolerance	25%													
Cancer Waiting Times - 31 Day Surgery	2015/16	Number Treated < 31 Days	23	15	24	28	23	26	23	25	18	16	18	21
		Total Number Seen	25	17	27	31	30	30	24	33	19	20	22	24
		%	**92.0%**	**88.2%**	**88.9%**	**90.3%**	**76.7%**	**86.7%**	**95.8%**	**75.8%**	**94.7%**	**80.0%**	**81.8%**	**87.5%**
	2016/17	Number Treated < 31 Days	16	29	16	21	16	25	25	28	29	33	26	36
		Total Number Seen	18	30	18	25	22	27	26	30	30	35	29	40
		%	**88.9%**	**96.7%**	**88.9%**	**84.0%**	**72.7%**	**92.6%**	**96.2%**	**93.3%**	**96.7%**	**94.3%**	**89.7%**	**90.0%**
	2017/18	Number Treated < 31 Days	29	34	44	31	27	37	32	-	-	-	-	-
		Total Number Seen	32	36	46	31	31	41	35	-	-	-	-	-
		%	**90.6%**	**94.4%**	**95.7%**	**100.0%**	**87.1%**	**90.2%**	**91.4%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**
	2018/19 Plan	Number Treated < 31 Days	29	33	43	30	30	41	35	43	27	36	36	36
		Total Number Seen	34	38	49	33	33	43	37	45	28	38	38	38
		%	**85.3%**	**86.8%**	**87.8%**	**90.9%**	**90.9%**	**95.3%**	**94.6%**	**95.6%**	**96.4%**	**94.7%**	**94.7%**	**94.7%**

West Leicestershire

Standard	94%	E.B.9	April	May	June	July	August	September	October	November	December	January	February	March
Monthly Diff. Tolerance	25%													
Cancer Waiting Times - 31 Day Surgery	2015/16	Number Treated < 31 Days	36	25	20	27	24	26	35	26	28	23	20	23
		Total Number Seen	39	27	22	27	28	29	39	29	31	27	26	31
		%	**92.3%**	**92.6%**	**90.9%**	**100.0%**	**85.7%**	**89.7%**	**89.7%**	**89.7%**	**90.3%**	**85.2%**	**76.9%**	**74.2%**
	2016/17	Number Treated < 31 Days	28	23	21	21	23	33	26	34	25	30	25	33
		Total Number Seen	29	27	25	29	27	37	28	40	27	31	27	34
		%	**96.6%**	**85.2%**	**84.0%**	**72.4%**	**85.2%**	**89.2%**	**92.9%**	**85.0%**	**92.6%**	**96.8%**	**92.6%**	**97.1%**
	2017/18	Number Treated < 31 Days	30	35	26	23	19	27	23	-	-	-	-	-
		Total Number Seen	34	39	27	24	22	31	30	-	-	-	-	-
		%	**88.2%**	**89.7%**	**96.3%**	**95.8%**	**86.4%**	**87.1%**	**76.7%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**
	2018/19 Plan	Number Treated < 31 Days	31	35	26	23	21	32	31	45	32	32	32	32
		Total Number Seen	36	41	29	25	23	33	32	47	34	33	33	33
		%	**86.1%**	**85.4%**	**89.7%**	**92.0%**	**91.3%**	**97.0%**	**96.9%**	**95.7%**	**94.1%**	**97.0%**	**97.0%**	**97.0%**

Cancer Waits - All other Indicators have been set at the National Standard as follows:

- Cancer 2 Week Wait – National Standard 93%
- Cancer 2 Week Wait Breast Symptoms – National Standard 93%
- Cancer 31 Day Wait Drug Regimen – National Standard 98%
- Cancer 31 Day Radiotherapy – National Standard 94%

A&E 4 Hour Wait – National Standard 90% in Sept 18 and 95% in March 19 This is submitted by the LC as Lead Commissioner for UHL, on behalf of LLR

Leicester City

Standard	95%	E.B.5	April	May	June	July	August	September	October	November	December	January	February	March
Monthly Diff. Tolerance	25%													
UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST	2015/16	Number Waiting > 4 Hrs	1,391	1,578	1,379	1,433	1,715	1,768	2,131	3,632	2,833	3,694	3,670	4,585
		Total Attendances	18,357	19,135	18,729	18,363	18,216	18,320	19,166	19,895	19,058	19,602	18,540	20,378
		%	**92.4%**	**91.8%**	**92.6%**	**92.2%**	**90.6%**	**90.3%**	**88.9%**	**81.7%**	**85.1%**	**81.2%**	**80.2%**	**77.5%**
	2016/17	Number Waiting > 4 Hrs	3,549	4,227	3,771	4,652	3,859	3,932	4,439	4,591	4,973	4,242	2,853	3,315
		Total Attendances	18,924	20,983	19,462	20,149	19,377	19,553	20,470	20,517	20,328	19,330	17,567	20,620
		%	**81.2%**	**79.9%**	**80.6%**	**76.9%**	**80.1%**	**79.9%**	**78.3%**	**77.6%**	**75.5%**	**78.1%**	**83.8%**	**83.9%**
	2017/18	Number Waiting > 4 Hrs	3,707	4,853	4,325	3,863	3,069	3,108	3,535	4,193	5,715	-	-	-
		Total Attendances	19,539	20,440	19,309	19,090	18,300	19,394	20,411	20,576	20,064	-	-	-
		%	**81.0%**	**76.3%**	**77.6%**	**79.8%**	**83.2%**	**84.0%**	**82.7%**	**79.6%**	**71.5%**			
	2018/19 Plan	Number Waiting > 4 Hrs	5,841	5,388	4,305	3,606	2,994	2,855	3,038	2,714	2,420	2,048	1,668	1,483
		Total Attendances	29,952	30,790	28,700	28,850	27,217	28,550	30,375	30,160	30,245	29,258	27,800	29,667
		%	**80.5%**	**82.5%**	**85.0%**	**87.5%**	**89.0%**	**90.0%**	**90.0%**	**91.0%**	**92.0%**	**93.0%**	**94.0%**	**95.0%**

Dementia Diagnosis – National Standard 66.7%

Leicester City

Standard	66.7%	E.A.S.1	April	May	June	July	August	September	October	November	December	January	February	March
Monthly Diff. Tolerance	25%													
Dementia - Estimated Diagnosis Rate for people aged 65+	2016/17	Number of people aged 65 or over diagnosed with dementia	2,238	2,242	2,358	2,376	2,410	2,437	2,459	2,482	2,487	2,472	2,467	2,457
		Estimated prevalence of dementia based on GP registered population	2,694	2,694	2,694	2,694	2,694	2,694	2,694	2,694	2,694	2,694	2,694	2,694
		%	**83.1%**	**83.2%**	**87.5%**	**88.2%**	**89.5%**	**90.5%**	**91.3%**	**92.1%**	**92.3%**	**91.8%**	**91.6%**	**91.2%**
	2017/18	Number of people aged 65 or over diagnosed with dementia	2,461	2,466	2,488	2,474	2,467	2,474	2,481	2,495	-	-	-	-
		Estimated prevalence of dementia based on GP registered population	2,861	2,861	2,861	2,861	2,861	2,861	2,861	2,861	2,861	2,861	2,861	2,861
		%	**86.0%**	**86.2%**	**87.0%**	**86.5%**	**86.2%**	**86.5%**	**86.7%**	**87.2%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**
	2018/19 Plan	Number of people aged 65 or over diagnosed with dementia	1,943	1,943	1,943	1,943	1,943	1,943	1,943	1,943	1,943	1,943	1,943	1,943
		Estimated prevalence of dementia based on GP registered population	2,913	2,913	2,913	2,913	2,913	2,913	2,913	2,913	2,913	2,913	2,913	2,913
		%	**66.7%**	**66.7%**	**66.7%**	**66.7%**	**66.7%**	**66.7%**	**66.7%**	**66.7%**	**66.7%**	**66.7%**	**66.7%**	**66.7%**

East Leicestershire & Rutland

Standard	66.7%	E.A.S.1	April	May	June	July	August	September	October	November	December	January	February	March
Monthly Diff. Tolerance	25%													
Dementia - Estimated Diagnosis Rate for people aged 65+	2016/17	Number of people aged 65 or over diagnosed with dementia	2,782	2,773	2,835	2,849	2,879	2,886	2,887	2,912	2,897	2,851	2,853	2,949
		Estimated prevalence of dementia based on GP registered population	4,599	4,599	4,599	4,599	4,599	4,599	4,599	4,599	4,599	4,599	4,599	4,599
		%	**60.5%**	**60.3%**	**61.6%**	**61.9%**	**62.6%**	**62.7%**	**62.8%**	**63.3%**	**63.0%**	**62.0%**	**62.0%**	**64.1%**
	2017/18	Number of people aged 65 or over diagnosed with dementia	2,934	2,964	3,003	2,996	3,020	2,999	3,024	3,049	-	-	-	-
		Estimated prevalence of dementia based on GP registered population	4,494	4,494	4,494	4,494	4,494	4,494	4,494	4,494	4,494	4,494	4,494	4,494
		%	**65.3%**	**66.0%**	**66.8%**	**66.7%**	**67.2%**	**66.7%**	**67.3%**	**67.8%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**
	2018/19 Plan	Number of people aged 65 or over diagnosed with dementia	3,094	3,094	3,094	3,094	3,094	3,094	3,094	3,094	3,094	3,094	3,094	3,094
		Estimated prevalence of dementia based on GP registered population	4,638	4,638	4,638	4,638	4,638	4,638	4,638	4,638	4,638	4,638	4,638	4,638
		%	**66.7%**	**66.7%**	**66.7%**	**66.7%**	**66.7%**	**66.7%**	**66.7%**	**66.7%**	**66.7%**	**66.7%**	**66.7%**	**66.7%**

West Leicestershire

Standard	66.7%	E.A.S.1	April	May	June	July	August	September	October	November	December	January	February	March
Monthly Diff. Tolerance	25%													
Dementia - Estimated Diagnosis Rate for people aged 65+	2016/17	Number of people aged 65 or over diagnosed with dementia	3,008	2,900	2,977	2,981	3,000	3,036	3,084	3,105	3,125	3,081	3,101	3,169
		Estimated prevalence of dementia based on GP registered population	4,684	4,684	4,684	4,684	4,684	4,684	4,684	4,684	4,684	4,684	4,684	4,684
		%	**64.2%**	**61.9%**	**63.6%**	**63.6%**	**64.0%**	**64.8%**	**65.8%**	**66.3%**	**66.7%**	**65.8%**	**66.2%**	**67.7%**
	2017/18	Number of people aged 65 or over diagnosed with dementia	3,171	3,153	3,181	3,170	3,222	3,236	3,269	3,281	-	-	-	-
		Estimated prevalence of dementia based on GP registered population	4,403	4,403	4,403	4,403	4,403	4,403	4,403	4,403	4,403	4,403	4,403	4,403
		%	**72.0%**	**71.6%**	**72.2%**	**72.0%**	**73.2%**	**73.5%**	**74.2%**	**74.5%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**
	2018/19 Plan	Number of people aged 65 or over diagnosed with dementia	3,025	3,025	3,025	3,025	3,025	3,025	3,025	3,025	3,025	3,025	3,025	3,025
		Estimated prevalence of dementia based on GP registered population	4,534	4,534	4,534	4,534	4,534	4,534	4,534	4,534	4,534	4,534	4,534	4,534
		%	**66.7%**	**66.7%**	**66.7%**	**66.7%**	**66.7%**	**66.7%**	**66.7%**	**66.7%**	**66.7%**	**66.7%**	**66.7%**	**66.7%**

IAPT Roll Out – National Standard 19% for 2018/19

Leicester City

17/18 Standard	4.20%	E.A.3	Q1	Q2	Q3	Q4
18/19 Standard	4.75%					
IAPT roll-out	2015/16	Number of people who receive psychological therapies	1,445	1,395	1,140	880
		Number of people who have depression and/or anxiety disorders	36,009	36,009	36,009	36,009
		%	**4.0%**	**3.9%**	**3.2%**	**2.4%**
	2016/17	Number of people who receive psychological therapies	1,740	1,145	1,025	1,035
		Number of people who have depression and/or anxiety disorders	36,009	36,009	36,009	36,009
		%	**4.8%**	**3.2%**	**2.8%**	**2.9%**
	2017/18	Number of people who receive psychological therapies	850	-	-	-
		Number of people who have depression and/or anxiety disorders	36,010	-	-	-
		%	**2.4%**	**0.0%**	**0.0%**	**0.0%**
	2018/19 Plan	Number of people who receive psychological therapies	1,539	1,539	1,620	1,711
		Number of people who have depression and/or anxiety disorders	36,011	36,011	36,011	36,011
		%	**4.3%**	**4.3%**	**4.5%**	**4.8%**

East Leicestershire & Rutland

17/18 Standard	4.20%	E.A.3	Q1	Q2	Q3	Q4
18/19 Standard	4.75%					
IAPT roll-out	2015/16	Number of people who receive psychological therapies	920	1,030	1,025	1,025
		Number of people who have depression and/or anxiety disorders	27,593	27,593	27,593	27,593
		%	**3.3%**	**3.7%**	**3.7%**	**3.7%**
	2016/17	Number of people who receive psychological therapies	865	900	805	780
		Number of people who have depression and/or anxiety disorders	27,593	27,593	27,593	27,593
		%	**3.1%**	**3.3%**	**2.9%**	**2.8%**
	2017/18	Number of people who receive psychological therapies	755	-	-	-
		Number of people who have depression and/or anxiety disorders	27,594	-	-	-
		%	**2.7%**	**0.0%**	**0.0%**	**0.0%**
	2018/19 Plan	Number of people who receive psychological therapies	1,035	1,069	1,104	1,311
		Number of people who have depression and/or anxiety disorders	27,594	27,594	27,594	27,594
		%	**3.8%**	**3.9%**	**4.0%**	**4.8%**

West Leicestershire

17/18 Standard	4.20%	E.A.3	Q1	Q2	Q3	Q4
18/19 Standard	4.75%					
IAPT roll-out	2015/16	Number of people who receive psychological therapies	1,060	1,400	1,080	1,295
		Number of people who have depression and/or anxiety disorders	33,319	33,319	33,319	33,319
		%	**3.2%**	**4.2%**	**3.2%**	**3.9%**
	2016/17	Number of people who receive psychological therapies	1,110	1,135	1,075	910
		Number of people who have depression and/or anxiety disorders	33,319	33,319	33,319	33,319
		%	**3.3%**	**3.4%**	**3.2%**	**2.7%**
	2017/18	Number of people who receive psychological therapies	795	-	-	-
		Number of people who have depression and/or anxiety disorders	33,320	-	-	-
		%	**2.4%**	**0.0%**	**0.0%**	**0.0%**
	2018/19 Plan	Number of people who receive psychological therapies	1,250	1,291	1,333	1,583
		Number of people who have depression and/or anxiety disorders	33,320	33,320	33,320	33,320
		%	**3.8%**	**3.9%**	**4.0%**	**4.8%**

IAPT Recovery – National Standard 50%

Leicester City

Standard	50.00%	E.A.S 2	Q1	Q2	Q3	Q4
Diff. Tolerance	25%					
IAPT Recovery Rate	2015/16	The number of people who have finished treatment having attended at least two treatment contacts and are moving to recovery (those who at initial assessment achieved "caseness" and at final session did not).	150	155	165	290
		The number of people who have finished treatment within the reporting quarter (having attended at least two treatment contacts and coded as discharged) minus the number of people who have finished treatment not at clinical caseness at initial assessment.	505	570	615	1,840
		%	**29.7%**	**27.2%**	**26.8%**	**15.8%**
	2016/17	The number of people who have finished treatment having attended at least two treatment contacts and are moving to recovery (those who at initial assessment achieved "caseness" and at final session did not).	65	115	125	150
		The number of people who have finished treatment within the reporting quarter (having attended at least two treatment contacts and coded as discharged) minus the number of people who have finished treatment not at clinical caseness at initial assessment.	240	370	370	440
		% *	**27.0%**	**31.1%**	**33.8%**	**34.1%**
	2017/18	The number of people who have finished treatment having attended at least two treatment contacts and are moving to recovery (those who at initial assessment achieved "caseness" and at final session did not).	155	-	-	-
		The number of people who have finished treatment within the reporting quarter (having attended at least two treatment contacts and coded as discharged) minus the number of people who have finished treatment not at clinical caseness at initial assessment.	480	-	-	-
		%	**32.3%**	**0.0%**	**0.0%**	**0.0%**
	2018/19 Plan	The number of people who have finished treatment having attended at least two treatment contacts and are moving to recovery (those who at initial assessment achieved "caseness" and at final session did not).	253	290	272	272
		The number of people who have finished treatment within the reporting quarter (having attended at least two treatment contacts and coded as discharged) minus the number of people who have finished treatment not at clinical caseness at initial assessment.	505	580	543	543
		%	**50.1%**	**50.0%**	**50.1%**	**50.1%**

East Leicestershire & Rutland

Standard	50.00%	E.A.S 2	Q1	Q2	Q3	Q4
Diff. Tolerance	25%					
IAPT Recovery Rate	2015/16	The number of people who have finished treatment having attended at least two treatment contacts and are moving to recovery (those who at initial assessment achieved "caseness" and at final session did not).	305	320	320	325
		The number of people who have finished treatment within the reporting quarter (having attended at least two treatment contacts and coded as discharged) minus the number of people who have finished treatment not at clinical caseness at initial assessment.	545	650	600	615
		%	**56.0%**	**49.2%**	**53.3%**	**52.8%**
	2016/17	The number of people who have finished treatment having attended at least two treatment contacts and are moving to recovery (those who at initial assessment achieved "caseness" and at final session did not).	390	360	280	280
		The number of people who have finished treatment within the reporting quarter (having attended at least two treatment contacts and coded as discharged) minus the number of people who have finished treatment not at clinical caseness at initial assessment.	695	670	545	515
		% *	**56.2%**	**53.7%**	**51.4%**	**54.4%**
	2017/18	The number of people who have finished treatment having attended at least two treatment contacts and are moving to recovery (those who at initial assessment achieved "caseness" and at final session did not).	300	-	-	-
		The number of people who have finished treatment within the reporting quarter (having attended at least two treatment contacts and coded as discharged) minus the number of people who have finished treatment not at clinical caseness at initial assessment.	515	-	-	-
		%	**58.3%**	**0.0%**	**0.0%**	**0.0%**
	2018/19 Plan	The number of people who have finished treatment having attended at least two treatment contacts and are moving to recovery (those who at initial assessment achieved "caseness" and at final session did not).	311	311	311	311
		The number of people who have finished treatment within the reporting quarter (having attended at least two treatment contacts and coded as discharged) minus the number of people who have finished treatment not at clinical caseness at initial assessment.	621	621	621	621
		%	**50.1%**	**50.1%**	**50.1%**	**50.1%**

West Leicestershire

Standard	50.00%	E.A.S 2	Q1	Q2	Q3	Q4
Diff. Tolerance	25%					
IAPT Recovery Rate	2015/16	The number of people who have finished treatment having attended at least two treatment contacts and are moving to recovery (those who at initial assessment achieved "caseness" and at final session did not).	280	340	300	385
		The number of people who have finished treatment within the reporting quarter (having attended at least two treatment contacts and coded as discharged) minus the number of people who have finished treatment not at clinical caseness at initial assessment.	590	765	655	810
		%	**47.5%**	**44.4%**	**45.8%**	**47.5%**
	2016/17	The number of people who have finished treatment having attended at least two treatment contacts and are moving to recovery (those who at initial assessment achieved "caseness" and at final session did not).	395	385	370	375
		The number of people who have finished treatment within the reporting quarter (having attended at least two treatment contacts and coded as discharged) minus the number of people who have finished treatment not at clinical caseness at initial assessment.	825	830	805	790
		% *	**48.1%**	**46.4%**	**46.0%**	**47.5%**
	2017/18	The number of people who have finished treatment having attended at least two treatment contacts and are moving to recovery (those who at initial assessment achieved "caseness" and at final session did not).	340	-	-	-
		The number of people who have finished treatment within the reporting quarter (having attended at least two treatment contacts and coded as discharged) minus the number of people who have finished treatment not at clinical caseness at initial assessment.	655	-	-	-
		%	**51.9%**	**0.0%**	**0.0%**	**0.0%**
	2018/19 Plan	The number of people who have finished treatment having attended at least two treatment contacts and are moving to recovery (those who at initial assessment achieved "caseness" and at final session did not).	365	365	365	365
		The number of people who have finished treatment within the reporting quarter (having attended at least two treatment contacts and coded as discharged) minus the number of people who have finished treatment not at clinical caseness at initial assessment.	729	729	729	729
		%	**50.1%**	**50.1%**	**50.1%**	**50.1%**

IAPT Waiting Times 6 Weeks – National Standard 75%

Leicester City

Standard	75%	E.H.1 _A1	Q1	Q2	Q3	Q4
Diff. Tolerance	25%					
IAPT Waiting Times - 6 Weeks	2016/17	Number of ended referrals that finish a course of treatment in period who received their first appointment within 6 weeks of referral	35	100	135	245
		Number of ended referrals that finish a course of treatment in period	285	415	395	475
		% *	**12.2%**	**24.1%**	**34.2%**	**51.6%**
	2017/18	Number of ended referrals that finish a course of treatment in period who received their first appointment within 6 weeks of referral	325	-	-	-
		Number of ended referrals that finish a course of treatment in period	510	-	-	-
		%	**63.7%**	**0.0%**	**0.0%**	**0.0%**
	2018/19 Plan	Number of ended referrals that finish a course of treatment in period who received their first appointment within 6 weeks of referral	417	452	493	454
		Number of ended referrals that finish a course of treatment in period	555	602	657	605
		%	**75.1%**	**75.1%**	**75.0%**	**75.0%**

East Leicestershire & Rutland

Standard	75%	E.H.1 _A1	Q1	Q2	Q3	Q4
Diff. Tolerance	25%					
IAPT Waiting Times - 6 Weeks	2016/17	Number of ended referrals that finish a course of treatment in period who received their first appointment within 6 weeks of referral	550	490	380	415
		Number of ended referrals that finish a course of treatment in period	760	725	585	560
		% *	**72.2%**	**67.6%**	**65.0%**	**74.1%**
	2017/18	Number of ended referrals that finish a course of treatment in period who received their first appointment within 6 weeks of referral	375	-	-	-
		Number of ended referrals that finish a course of treatment in period	545	-	-	-
		%	**68.8%**	**0.0%**	**0.0%**	**0.0%**
	2018/19 Plan	Number of ended referrals that finish a course of treatment in period who received their first appointment within 6 weeks of referral	570	533	510	497
		Number of ended referrals that finish a course of treatment in period	760	710	680	662
		%	**75.0%**	**75.1%**	**75.0%**	**75.1%**

West Leicestershire

Standard	75%	E.H.1 _A1	Q1	Q2	Q3	Q4
Diff. Tolerance	25%					
IAPT Waiting Times - 6 Weeks	2016/17	Number of ended referrals that finish a course of treatment in period who received their first appointment within 6 weeks of referral	570	585	635	665
		Number of ended referrals that finish a course of treatment in period	895	880	875	855
		% *	**63.8%**	**66.5%**	**72.6%**	**77.8%**
	2017/18	Number of ended referrals that finish a course of treatment in period who received their first appointment within 6 weeks of referral	515	-	-	-
		Number of ended referrals that finish a course of treatment in period	710	-	-	-
		%	**72.5%**	**0.0%**	**0.0%**	**0.0%**
	2018/19 Plan	Number of ended referrals that finish a course of treatment in period who received their first appointment within 6 weeks of referral	672	640	588	580
		Number of ended referrals that finish a course of treatment in period	895	853	783	773
		%	**75.1%**	**75.0%**	**75.1%**	**75.0%**

IAPT Waiting Times 18 Weeks – National Standard 95%

Leicester City

Standard	95%	E.H.2_A2	Q1	Q2	Q3	Q4
Diff. Tolerance	25%					
IAPT Waiting Times - 18 Weeks	2016/17	Number of ended referrals that finish a course of treatment in period who received their first appointment within 18 weeks of referral	125	225	245	335
		Number of ended referrals that finish a course of treatment in period	285	415	395	475
		% *	**44.3%**	**54.2%**	**62.0%**	**70.5%**
	2017/18	Number of ended referrals that finish a course of treatment in period who received their first appointment within 18 weeks of referral	415	-	-	-
		Number of ended referrals that finish a course of treatment in period	510	-	-	-
		%	**81.4%**	**0.0%**	**0.0%**	**0.0%**
	2018/19 Plan	Number of ended referrals that finish a course of treatment in period who received their first appointment within 18 weeks of referral	528	573	625	576
		Number of ended referrals that finish a course of treatment in period	555	602	657	605
		%	**95.1%**	**95.2%**	**95.1%**	**95.2%**

East Leicestershire & Rutland

Standard	95%	E.H.2_A2	Q1	Q2	Q3	Q4
Diff. Tolerance	25%					
IAPT Waiting Times - 18 Weeks	2016/17	Number of ended referrals that finish a course of treatment in period who received their first appointment within 18 weeks of referral	750	720	580	560
		Number of ended referrals that finish a course of treatment in period	760	725	585	560
		% *	**98.6%**	**99.3%**	**99.1%**	**100.0%**
	2017/18	Number of ended referrals that finish a course of treatment in period who received their first appointment within 18 weeks of referral	540	-	-	-
		Number of ended referrals that finish a course of treatment in period	545	-	-	-
		%	**99.1%**	**0.0%**	**0.0%**	**0.0%**
	2018/19 Plan	Number of ended referrals that finish a course of treatment in period who received their first appointment within 18 weeks of referral	722	675	646	629
		Number of ended referrals that finish a course of treatment in period	760	710	680	662
		%	**95.0%**	**95.1%**	**95.0%**	**95.0%**

West Leicestershire

Standard	95%	E.H.2_A2	Q1	Q2	Q3	Q4
Diff. Tolerance	25%					
IAPT Waiting Times - 18 Weeks	2016/17	Number of ended referrals that finish a course of treatment in period who received their first appointment within 18 weeks of referral	885	880	865	845
		Number of ended referrals that finish a course of treatment in period	895	880	875	855
		% *	**98.6%**	**100.0%**	**98.9%**	**98.8%**
	2017/18	Number of ended referrals that finish a course of treatment in period who received their first appointment within 18 weeks of referral	690	-	-	-
		Number of ended referrals that finish a course of treatment in period	710	-	-	-
		%	**97.2%**	**0.0%**	**0.0%**	**0.0%**
	2018/19 Plan	Number of ended referrals that finish a course of treatment in period who received their first appointment within 18 weeks of referral	851	811	744	735
		Number of ended referrals that finish a course of treatment in period	895	853	783	773
		%	**95.1%**	**95.1%**	**95.0%**	**95.1%**

EIP – Psychosis – National Standard 53% for 2018/19 (small numbers impact on percentages)

Leicester City

17/18 Standard	50%	E.H.4	Q1	Q2	Q3	Q4
18/19 Standard	53%					
Diff. Tolerance	25%					
EIP - Psychosis treated with a NICE approved care package within two weeks of referral	2016/17	Number of referrals to and within the Trust with suspected first episode psychosis or at 'risk mental state' that start a NICE-recommended package care package in the reporting period within 2 weeks of referral.	12	12	23	24
		Number of referrals to and within the Trust with suspected first episode psychosis or at 'risk mental state' that start a NICE-recommended care package	15	15	32	31
		%	**80.0%**	**80.0%**	**71.9%**	**77.4%**
	2017/18	Number of referrals to and within the Trust with suspected first episode psychosis or at 'risk mental state' that start a NICE-recommended package care package in the reporting period within 2 weeks of referral.	12	22	-	-
		Number of referrals to and within the Trust with suspected first episode psychosis or at 'risk mental state' that start a NICE-recommended care package	24	23	-	-
		%	**50.0%**	**95.7%**	**0.0%**	**0.0%**
	2018/19 Plan	Number of referrals to and within the Trust with suspected first episode psychosis or at 'risk mental state' that start a NICE-recommended package care package in the reporting period within 2 weeks of referral.	14	13	14	13
		Number of referrals to and within the Trust with suspected first episode psychosis or at 'risk mental state' that start a NICE-recommended care package	25	23	25	24
		%	**56.0%**	**56.5%**	**56.0%**	**54.2%**

East Leicestershire & Rutland

17/18 Standard	50%	E.H.4	Q1	Q2	Q3	Q4
18/19 Standard	53%					
Diff. Tolerance	25%					
EIP - Psychosis treated with a NICE approved care package within two weeks of referral	2016/17	Number of referrals to and within the Trust with suspected first episode psychosis or at 'risk mental state' that start a NICE-recommended package care package in the reporting period within 2 weeks of referral.	5	6	12	7
		Number of referrals to and within the Trust with suspected first episode psychosis or at 'risk mental state' that start a NICE-recommended care package	6	6	16	9
		%	**83.3%**	**100.0%**	**75.0%**	**77.8%**
	2017/18	Number of referrals to and within the Trust with suspected first episode psychosis or at 'risk mental state' that start a NICE-recommended package care package in the reporting period within 2 weeks of referral.	11	10	-	-
		Number of referrals to and within the Trust with suspected first episode psychosis or at 'risk mental state' that start a NICE-recommended care package	14	14	-	-
		%	**78.6%**	**71.4%**	**0.0%**	**0.0%**
	2018/19 Plan	Number of referrals to and within the Trust with suspected first episode psychosis or at 'risk mental state' that start a NICE-recommended package care package in the reporting period within 2 weeks of referral.	8	8	8	8
		Number of referrals to and within the Trust with suspected first episode psychosis or at 'risk mental state' that start a NICE-recommended care package	15	14	14	14
		%	**53.3%**	**57.1%**	**57.1%**	**57.1%**

West Leicestershire

17/18 Standard	50%	E.H.4	Q1	Q2	Q3	Q4
18/19 Standard	53%					
Diff. Tolerance	25%					
EIP - Psychosis treated with a NICE approved care package within two weeks of referral	2016/17	Number of referrals to and within the Trust with suspected first episode psychosis or at 'risk mental state' that start a NICE-recommended package care package in the reporting period within 2 weeks of referral.	5	7	17	10
		Number of referrals to and within the Trust with suspected first episode psychosis or at 'risk mental state' that start a NICE-recommended care package	7	7	21	13
		%	**71.4%**	**100.0%**	**81.0%**	**76.9%**
	2017/18	Number of referrals to and within the Trust with suspected first episode psychosis or at 'risk mental state' that start a NICE-recommended package care package in the reporting period within 2 weeks of referral.	6	11	-	-
		Number of referrals to and within the Trust with suspected first episode psychosis or at 'risk mental state' that start a NICE-recommended care package	11	16	-	-
		%	**54.5%**	**68.8%**	**0.0%**	**0.0%**
	2018/19 Plan	Number of referrals to and within the Trust with suspected first episode psychosis or at 'risk mental state' that start a NICE-recommended package care package in the reporting period within 2 weeks of referral.	6	9	5	7
		Number of referrals to and within the Trust with suspected first episode psychosis or at 'risk mental state' that start a NICE-recommended care package	11	16	9	12
		%	**54.5%**	**56.3%**	**55.6%**	**58.3%**

Improve Access Rate to Children & Young People Mental Health – National Standard 32% for 2018/19

Leicester City

2017/18 Standard	30%
2018/19 Standard	32%

Improve Access Rate to CYPMH

E.H.9	17/18 CCG Revised Estimate*	Q1 18/19	Q2 18/19	Q3 18/19	Q4 18/19
1a - The number of new children and young people aged 0-18 receiving treatment from NHS funded community services in the reporting period.	1,412	376	376	376	376

	17/18 Estimate	18/19 Plan		17/18 to 18/19 change
Annual change for 1a - The number of new young people receiving treatment from NHS funded community services	1,412	1,504		6.5%

	17/18 CCG Revised Estimate**	Q1 18/19	Q2 18/19	Q3 18/19	Q4 18/19	18/19 estimate
2a - Total number of individual children and young people aged 0-18 receiving treatment by NHS funded community services in the reporting period.	2,648	709	709	709	709	2,836
2b - Total number of individual children and young people aged 0-18 with a diagnosable mental health condition.	8,820					8,820
Percentage of children and young people aged 0-18 with a diagnosable mental health condition who are receiving treatment from NHS funded community services.	30.0%					32.2%

East Leicestershire & Rutland

2017/18 Standard	30%
2018/19 Standard	32%

Improve Access Rate to CYPMH

E.H.9	17/18 CCG Revised Estimate*	Q1 18/19	Q2 18/19	Q3 18/19	Q4 18/19
1a - The number of new children and young people aged 0-18 receiving treatment from NHS funded community services in the reporting period.	932	249	249	249	249

	17/18 Estimate	18/19 Plan		17/18 to 18/19 change
Annual change for 1a - The number of new young people receiving treatment from NHS funded community services	932	996		6.9%

	17/18 CCG Revised Estimate**	Q1 18/19	Q2 18/19	Q3 18/19	Q4 18/19	18/19 estimate
2a - Total number of individual children and young people aged 0-18 receiving treatment by NHS funded community services in the reporting period.	1,692	453	453	453	453	1,812
2b - Total number of individual children and young people aged 0-18 with a diagnosable mental health condition.	5,639					5,639
Percentage of children and young people aged 0-18 with a diagnosable mental health condition who are receiving treatment from NHS funded community services.	30.0%					32.1%

West Leicestershire

2017/18 Standard	30%
2018/19 Standard	32%

Improve Access Rate to CYPMH

E.H.9	17/18 CCG Revised Estimate*	Q1 18/19	Q2 18/19	Q3 18/19	Q4 18/19
1a - The number of new children and young people aged 0-18 receiving treatment from NHS funded community services in the reporting period.	1,068	285	285	285	285

	17/18 Estimate	18/19 Plan		17/18 to 18/19 change
Annual change for 1a - The number of new young people receiving treatment from NHS funded community services	1,068	1,140		6.7%

	17/18 CCG Revised Estimate**	Q1 18/19	Q2 18/19	Q3 18/19	Q4 18/19	18/19 estimate
2a - Total number of individual children and young people aged 0-18 receiving treatment by NHS funded community services in the reporting period.	2,140	573	573	573	573	2,292
2b - Total number of individual children and young people aged 0-18 with a diagnosable mental health condition.	6,827					6,827
Percentage of children and young people aged 0-18 with a diagnosable mental health condition who are receiving treatment from NHS funded community services.	31.3%					33.6%

Mental Health Children & Young People Eating Disorders (ED) Waiting Times 4 Weeks – National Standard 95% (small numbers impact on percentages)

Leicester City

Standard (to be achieved by 2020)	95%	E.H.10	Q1	Q2	Q3	Q4
Diff. Tolerance	25%					
Waiting Times for Routine Referrals to CYP Eating Disorder Services - Within 4 Weeks	2017/18 Plan	Number of CYP with ED (routine cases) referred with a suspected ED that start treatment within 4 weeks of referral	5	2	4	4
		Number of CYP with a suspected ED (routine cases) that start treatment	5	2	4	4
		%	100.0%	100.0%	100.0%	100.0%
	2018/19 Plan	Number of CYP with ED (routine cases) referred with a suspected ED that start treatment within 4 weeks of referral	-	8	8	6
		Number of CYP with a suspected ED (routine cases) that start treatment	-	8	8	6
		%	0.0%	100.0%	100.0%	100.0%

East Leicestershire & Rutland

Standard (to be achieved by 2020)	95%	E.H.10	Q1	Q2	Q3	Q4
Diff. Tolerance	25%					
Waiting Times for Routine Referrals to CYP Eating Disorder Services - Within 4 Weeks	2017/18 Plan	Number of CYP with ED (routine cases) referred with a suspected ED that start treatment within 4 weeks of referral	10	1	6	6
		Number of CYP with a suspected ED (routine cases) that start treatment	10	1	6	6
		%	100.0%	100.0%	100.0%	100.0%
	2018/19 Plan	Number of CYP with ED (routine cases) referred with a suspected ED that start treatment within 4 weeks of referral	11	7	14	11
		Number of CYP with a suspected ED (routine cases) that start treatment	11	7	14	11
		%	100.0%	100.0%	100.0%	100.0%

West Leicestershire

Standard (to be achieved by 2020)	95%	E.H.10	Q1	Q2	Q3	Q4
Diff. Tolerance	25%					
Waiting Times for Routine Referrals to CYP Eating Disorder Services - Within 4 Weeks	2017/18 Plan	Number of CYP with ED (routine cases) referred with a suspected ED that start treatment within 4 weeks of referral	6	13	10	10
		Number of CYP with a suspected ED (routine cases) that start treatment	6	13	10	10
		%	**100.0%**	**100.0%**	**100.0%**	**100.0%**
	2018/19 Plan	Number of CYP with ED (routine cases) referred with a suspected ED that start treatment within 4 weeks of referral	13	13	6	11
		Number of CYP with a suspected ED (routine cases) that start treatment	13	13	6	11
		%	**100.0%**	**100.0%**	**100.0%**	**100.0%**

Mental Health Children & Young People Eating Disorders (ED) Waiting Times 1 Week – National Standard 95% (small numbers impact on percentages)

Leicester City

Standard (to be achieved by 2020)	95%	E.H.11	Q1	Q2	Q3	Q4
Diff. Tolerance	25%					
Waiting Times for Urgent Referrals to CYP Eating Disorder Services - Within 1 Week	2017/18 Plan	Number of CYP with ED (urgent cases) referred with a suspected ED that start treatment within 1 week of referral	3	-	2	2
		Number of CYP with a suspected ED (urgent cases) that start treatment	3	-	2	2
		%	**100.0%**	**0.0%**	**100.0%**	**100.0%**
	2018/19 Plan	Number of CYP with ED (urgent cases) referred with a suspected ED that start treatment within 1 week of referral	-	1	-	-
		Number of CYP with a suspected ED (urgent cases) that start treatment	-	1	-	-
		%	**0.0%**	**100.0%**	**0.0%**	**0.0%**

East Leicestershire & Rutland

Standard (to be achieved by 2020)	95%	E.H.11	Q1	Q2	Q3	Q4
Diff. Tolerance	25%					
Waiting Times for Urgent Referrals to CYP Eating Disorder Services - Within 1 Week	2017/18 Plan	Number of CYP with ED (urgent cases) referred with a suspected ED that start treatment within 1 week of referral	2	3	3	3
		Number of CYP with a suspected ED (urgent cases) that start treatment	2	3	3	3
		%	100.0%	100.0%	100.0%	100.0%
	2018/19 Plan	Number of CYP with ED (urgent cases) referred with a suspected ED that start treatment within 1 week of referral	1	1	-	1
		Number of CYP with a suspected ED (urgent cases) that start treatment	1	1	-	1
		%	100.0%	100.0%	0.0%	100.0%

West Leicestershire

Standard (to be achieved by 2020)	95%	E.H.11	Q1	Q2	Q3	Q4
Diff. Tolerance	25%					
Waiting Times for Urgent Referrals to CYP Eating Disorder Services - Within 1 Week	2017/18 Plan	Number of CYP with ED (urgent cases) referred with a suspected ED that start treatment within 1 week of referral	3	3	3	3
		Number of CYP with a suspected ED (urgent cases) that start treatment	3	3	3	3
		%	100.0%	100.0%	100.0%	100.0%
	2018/19 Plan	Number of CYP with ED (urgent cases) referred with a suspected ED that start treatment within 1 week of referral	-	-	1	-
		Number of CYP with a suspected ED (urgent cases) that start treatment	-	-	1	-
		%	0.0%	0.0%	100.0%	0.0%

Out of Area Placements (ELR return only)

East Leicestershire & Rutland only

Out of Area Placements STP: Leicester, Leicestershire and Rutland STP

		E.H.12	Q1	Q2	Q3	Q4
Out of Area Placements	2017/18	Inappropriate Out of Area Placement Bed Days	1,404	2,163	2,025	
	2018/19 Plan	Inappropriate Out of Area Placement Bed Days	1,092	910	910	728

Extended Access (evening & weekends) at GP Services

Leicester City

		E.D.14	April	May	June	July	August	September	October	November	December	January	February	March
Extended access (evening and weekends) at GP services	2017/18	Proportion of CCG weighted population benefitting from extended access services commissioned 365 days a year for each day of the week by the CCG (including bank holiday). For Monday to Friday each day of the week should include any extended access after 6.30pm, before 8.00am (this would be in addition to evening provision not a replacement or substitute for evening appointments) and any extended access provided in-hours as long as it is distinguishable from core services. For Saturday and Sunday this should include any extended access provided. All currently provided services including extended hours Direct Enhanced Services (DES) should not be included.						100%		100%	100%			
	2018/19 Plan	CCG weighted population benefitting from extended access services commissioned 365 days a year for each day of the week by the CCG (including bank holiday). For Monday to Friday each day of the week should include any extended access after 6.30pm, before 8.00am (this would be in addition to evening provision not a replacement or substitute for evening appointments) and any extended access provided in-hours as long as it is distinguishable from core services. For Saturday and Sunday this should include any extended access provided. All currently provided services including extended hours Direct Enhanced Services (DES) should not be included.	358,786	358,786	358,786	358,786	358,786	358,786	358,786	358,786	358,786	358,786	358,786	358,786
		CCG Weighted Population	358,786	358,786	358,786	358,786	358,786	358,786	358,786	358,786	358,786	358,786	358,786	358,786
		%	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**

East Leicestershire & Rutland

		E.D.14	April	May	June	July	August	September	October	November	December	January	February	March
Extended access (evening and weekends) at GP services	2017/18	Proportion of CCG weighted population benefitting from extended access services commissioned 365 days a year for each day of the week by the CCG (including bank holiday). For Monday to Friday each day of the week should include any extended access after 6.30pm, before 8.00am (this would be in addition to evening provision not a replacement or substitute for evening appointments) and any extended access provided in-hours as long as it is distinguishable from core services. For Saturday and Sunday this should include any extended access provided. All currently provided services including extended hours Direct Enhanced Services (DES) should not be included.						100%		100%	100%			
	2018/19 Plan	CCG weighted population benefitting from extended access services commissioned 365 days a year for each day of the week by the CCG (including bank holiday). For Monday to Friday each day of the week should include any extended access after 6.30pm, before 8.00am (this would be in addition to evening provision not a replacement or substitute for evening appointments) and any extended access provided in-hours as long as it is distinguishable from core services. For Saturday and Sunday this should include any extended access provided. All currently provided services including extended hours Direct Enhanced Services (DES) should not be included.	301,905	301,905	301,905	301,905	301,905	301,905	301,905	301,905	301,905	301,905	301,905	301,905
		CCG Weighted Population	301,905	301,905	301,905	301,905	301,905	301,905	301,905	301,905	301,905	301,905	301,905	301,905
		%	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**

West Leicestershire

		E.D.14	April	May	June	July	August	September	October	November	December	January	February	March
Extended access (evening and weekends) at GP services	2017/18	Proportion of CCG weighted population benefitting from extended access services commissioned 365 days a year for each day of the week by the CCG (including bank holiday). For Monday to Friday each day of the week should include any extended access after 6.30pm, before 8.00am (this would be in addition to evening provision not a replacement or substitute for evening appointments) and any extended access provided in-hours as long as it is distinguishable from core services. For Saturday and Sunday this should include any extended access provided. All currently provided services including extended hours Direct Enhanced Services (DES) should not be included.						0%		0%	0%			
	2018/19 Plan	CCG weighted population benefitting from extended access services commissioned 365 days a year for each day of the week by the CCG (including bank holiday). For Monday to Friday each day of the week should include any extended access after 6.30pm, before 8.00am (this would be in addition to evening provision not a replacement or substitute for evening appointments) and any extended access provided in-hours as long as it is distinguishable from core services. For Saturday and Sunday this should include any extended access provided. All currently provided services including extended hours Direct Enhanced Services (DES) should not be included.	0	0	0	187,384	187,384	347,007	347,007	347,007	347,007	347,007	347,007	347,007
		CCG Weighted Population	347,007	347,007	347,007	347,007	347,007	347,007	347,007	347,007	347,007	347,007	347,007	347,007
		%	**0.0%**	**0.0%**	**0.0%**	**54.0%**	**54.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**

E-Referral Coverage – National Standard 80% by Sept 17 and 100% by Sept 18

Leicester City

2017/18 Standard	80%	E.P.1	April	May	June	July	August	September	October	November	December	January	February	March
2018/19 Standard	100%													
Monthly Diff. Tolerance	25%													
E-Referral Coverage	2017/18	Total number of patients referred to 1st Outpatient Services (including two-week-waits), via e-RS	3485	4257	4478	4179	4205	3996	0	0	0	0	0	0
		Overall number of patients referred to 1st Outpatient Services (including two-week-waits)	5024	6231	6333	5950	5990	1679	0	0	0	0	0	0
		%	**69.4%**	**68.3%**	**70.7%**	**70.2%**	**70.2%**	**238.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**
	2018/19 Plan	Total number of patients referred to 1st Outpatient Services (including two-week-waits), via e-RS	4,261	5,549	5,907	5,802	6,096	6,166	6,437	6,258	6,270	6,270	6,270	6,270
		Overall number of patients referred to 1st Outpatient Services (including two-week-waits)	5,326	6,605	6,713	6,307	6,349	6,166	6,437	6,258	6,270	6,270	6,270	6,270
		%	**80.0%**	**84.0%**	**88.0%**	**92.0%**	**96.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**

East Leicestershire & Rutland

2017/18 Standard	80%	E.P.1	April	May	June	July	August	September	October	November	December	January	February	March
2018/19 Standard	100%													
Monthly Diff. Tolerance	25%													
E-Referral Coverage	2017/18	Total number of patients referred to 1st Outpatient Services (including two-week-waits), via e-RS	3600	4297	4379	4102	4245	3860	0	0	0	0	0	0
		Overall number of patients referred to 1st Outpatient Services (including two-week-waits)	5002	6050	5976	5620	5788	997	0	0	0	0	0	0
		%	**72.0%**	**71.0%**	**73.3%**	**73.0%**	**73.3%**	**387.1%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**
	2018/19 Plan	Total number of patients referred to 1st Outpatient Services (including two-week-waits), via e-RS	4,242	5,387	5,574	5,481	5,890	5,689	6,255	6,200	6,036	6,036	6,036	6,036
		Overall number of patients referred to 1st Outpatient Services (including two-week-waits)	5,302	6,413	6,334	5,958	6,135	5,689	6,255	6,200	6,036	6,036	6,036	6,036
		%	**80.0%**	**84.0%**	**88.0%**	**92.0%**	**96.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**

West Leicestershire

2017/18 Standard	80%	E.P.1	April	May	June	July	August	September	October	November	December	January	February	March
2018/19 Standard	100%													
Monthly Diff. Tolerance	25%													
E-Referral Coverage	2017/18	Total number of patients referred to 1st Outpatient Services (including two-week-waits), via e-RS	3562	4251	4409	3997	4262	4075	0	0	0	0	0	0
		Overall number of patients referred to 1st Outpatient Services (including two-week-waits)	5678	6921	6685	6375	6522	8187	0	0	0	0	0	0
		%	**62.7%**	**61.4%**	**66.0%**	**62.7%**	**65.3%**	**49.8%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**
	2018/19 Plan	Total number of patients referred to 1st Outpatient Services (including two-week-waits), via e-RS	4,815	6,163	6,236	6,217	6,637	6,712	7,234	7,366	6,928	6,928	6,928	6,928
		Overall number of patients referred to 1st Outpatient Services (including two-week-waits)	6,018	7,336	7,086	6,758	6,913	6,712	7,234	7,366	6,928	6,928	6,928	6,928
		%	**80.0%**	**84.0%**	**88.0%**	**92.0%**	**96.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**

Personal Health Budgets

Leicester City

		E.N.1	Q1	Q2	Q3	Q4
Personal Health Budgets	2017/18 Plan	1) Personal health budgets in place at the beginning of quarter (total number per CCG)	75	106	137	168
		2) New personal health budgets that began during the quarter (total number per CCG)	31	31	31	31
		3) Total number of PHB in the quarter = sum of 1) and 2) (total number per CCG)	**106**	**137**	**168**	**199**
		4) GP registered population (total number per CCG)	390,673	390,673	390,673	390,673
		Rate of PHBs per 100,000 GP registered population	**27.13**	**35.07**	**43.00**	**50.94**
	2018/19 Plan	1) Personal health budgets in place at the beginning of quarter (total number per CCG)	75	115	155	195
		2) New personal health budgets that began during the quarter (total number per CCG)	40	40	40	40
		3) Total number of PHB in the quarter = sum of 1) and 2) (total number per CCG)	**115**	**155**	**195**	**235**
		4) GP registered population (total number per CCG)	392,906	392,906	392,906	392,906
		Rate of PHBs per 100,000 GP registered population	**29.27**	**39.45**	**49.63**	**59.81**

East Leicestershire & Rutland

		E.N.1	Q1	Q2	Q3	Q4
Personal Health Budgets	2017/18 Plan	1) Personal health budgets in place at the beginning of quarter (total number per CCG)	66	93	120	147
		2) New personal health budgets that began during the quarter (total number per CCG)	27	27	27	27
		3) Total number of PHB in the quarter = sum of 1) and 2) (total number per CCG)	**93**	**120**	**147**	**174**
		4) GP registered population (total number per CCG)	327,598	327,598	327,598	327,598
		Rate of PHBs per 100,000 GP registered population	**28.39**	**36.63**	**44.87**	**53.11**
	2018/19 Plan	1) Personal health budgets in place at the beginning of quarter (total number per CCG)	90	120	150	180
		2) New personal health budgets that began during the quarter (total number per CCG)	30	30	30	30
		3) Total number of PHB in the quarter = sum of 1) and 2) (total number per CCG)	**120**	**150**	**180**	**210**
		4) GP registered population (total number per CCG)	329,395	329,395	329,395	329,395
		Rate of PHBs per 100,000 GP registered population	**36.43**	**45.54**	**54.65**	**63.75**

West Leicestershire

		E.N.1	Q1	Q2	Q3	Q4
Personal Health Budgets	2017/18 Plan	1) Personal health budgets in place at the beginning of quarter (total number per CCG)	73	103	133	163
		2) New personal health budgets that began during the quarter (total number per CCG)	30	30	30	30
		3) Total number of PHB in the quarter = sum of 1) and 2) (total number per CCG)	**103**	**133**	**163**	**193**
		4) GP registered population (total number per CCG)	383,781	383,781	383,781	383,781
		Rate of PHBs per 100,000 GP registered population	**26.84**	**34.66**	**42.47**	**50.29**
	2018/19 Plan	1) Personal health budgets in place at the beginning of quarter (total number per CCG)	102	132	162	192
		2) New personal health budgets that began during the quarter (total number per CCG)	30	30	30	30
		3) Total number of PHB in the quarter = sum of 1) and 2) (total number per CCG)	**132**	**162**	**192**	**222**
		4) GP registered population (total number per CCG)	386,378	386,378	386,378	386,378
		Rate of PHBs per 100,000 GP registered population	**34.16**	**41.93**	**49.69**	**57.46**

Children Waiting Times 18 Weeks for a Wheelchair – National Standard 100% by Q4 18/19

Leicester City

2017/18 Standard	92%	E.O.1	Q1	Q2	Q3	Q4
2018/19 Standard	100%					
Diff. Tolerance	25%					
Children Waiting more than 18 Weeks for a Wheelchair	2016/17	Number of children whose episode of care was closed within the reporting period where equipment was delivered in 18 weeks or less of being referred to the service	50	73	63	62
		Total number of children whose episode of care was closed within the quarter where equipment was delivered or a modification was made.	57	79	76	78
		%	**87.7%**	**92.4%**	**82.9%**	**79.5%**
	2017/18	Number of children whose episode of care was closed within the reporting period where equipment was delivered in 18 weeks or less of being referred to the service	64	57	-	-
		Total number of children whose episode of care was closed within the quarter where equipment was delivered or a modification was made.	73	60	-	-
		%	**87.7%**	**95.0%**	**0.0%**	**0.0%**
	2018/19 Plan	Number of children whose episode of care was closed within the reporting period where equipment was delivered in 18 weeks or less of being referred to the service	71	60	66	70
		Total number of children whose episode of care was closed within the quarter where equipment was delivered or a modification was made.	77	64	70	70
		%	**92.2%**	**93.8%**	**94.3%**	**100.0%**

East Leicestershire & Rutland

2017/18 Standard	92%	E.O.1	Q1	Q2	Q3	Q4
2018/19 Standard	100%					
Diff. Tolerance	25%					
Children Waiting more than 18 Weeks for a Wheelchair	2016/17	Number of children whose episode of care was closed within the reporting period where equipment was delivered in 18 weeks or less of being referred to the service	26	54	46	44
		Total number of children whose episode of care was closed within the quarter where equipment was delivered or a modification was made.	31	58	55	56
		%	**83.9%**	**93.1%**	**83.6%**	**78.6%**
	2017/18	Number of children whose episode of care was closed within the reporting period where equipment was delivered in 18 weeks or less of being referred to the service	45	40	-	-
		Total number of children whose episode of care was closed within the quarter where equipment was delivered or a modification was made.	51	42	-	-
		%	**88.2%**	**95.2%**	**0.0%**	**0.0%**
	2018/19 Plan	Number of children whose episode of care was closed within the reporting period where equipment was delivered in 18 weeks or less of being referred to the service	50	42	46	49
		Total number of children whose episode of care was closed within the quarter where equipment was delivered or a modification was made.	54	45	49	49
		%	**92.6%**	**93.3%**	**93.9%**	**100.0%**

West Leicestershire

2017/18 Standard	92%	E.O.1	Q1	Q2	Q3	Q4
2018/19 Standard	100%					
Diff. Tolerance	25%					
Children Waiting more than 18 Weeks for a Wheelchair	2016/17	Number of children whose episode of care was closed within the reporting period where equipment was delivered in 18 weeks or less of being referred to the service	38	64	55	53
		Total number of children whose episode of care was closed within the quarter where equipment was delivered or a modification was made.	39	69	66	67
		%	**97.4%**	**92.8%**	**83.3%**	**79.1%**
	2017/18	Number of children whose episode of care was closed within the reporting period where equipment was delivered in 18 weeks or less of being referred to the service	55	49	-	-
		Total number of children whose episode of care was closed within the quarter where equipment was delivered or a modification was made.	62	51	-	-
		%	**88.7%**	**96.1%**	**0.0%**	**0.0%**
	2018/19 Plan	Number of children whose episode of care was closed within the reporting period where equipment was delivered in 18 weeks or less of being referred to the service	61	50	56	60
		Total number of children whose episode of care was closed within the quarter where equipment was delivered or a modification was made.	66	54	60	60
		%	**92.4%**	**92.6%**	**93.3%**	**100.0%**

Annual Health Checks delivered by GPs for patients on the Learning Disability Register – NEW

Leicester City

2018/19 Target for CCG	1929	E.K.3	Q1	Q2	Q3	Q4
Diff. Tolerance	25%					
AHCs delivered by GPs for patients on the Learning Disability Register	2017/18	Patients aged 14 or over on the GPs Learning Disability Register receiving a health check within the quarter	235	378		
		Population on the GPs Learning Disability Register	2267	2267	2267	2267
		%	**10.4%**	**16.7%**	**0.0%**	**0.0%**
	2018/19 Plan	Patients aged 14 or over on the GPs Learning Disability Register receiving a health check within the quarter	225	451	376	451
		Population on the GPs Learning Disability Register	2267	2267	2267	2267
		%	**9.9%**	**19.9%**	**16.6%**	**19.9%**

East Leicestershire & Rutland

2018/19 Target for CCG	1153	E.K.3	Q1	Q2	Q3	Q4
Diff. Tolerance	25%					
AHCs delivered by GPs for patients on the Learning Disability Register	2017/18	Patients aged 14 or over on the GPs Learning Disability Register receiving a health check within the quarter	55	54		
		Population on the GPs Learning Disability Register	1187	1187	1187	1187
		%	**4.6%**	**4.5%**	**0.0%**	**0.0%**
	2018/19 Plan	Patients aged 14 or over on the GPs Learning Disability Register receiving a health check within the quarter	126	126	253	282
		Population on the GPs Learning Disability Register	1187	1187	1187	1187
		%	**10.6%**	**10.6%**	**21.3%**	**23.8%**

West Leicestershire

2018/19 Target for CCG	1408	E.K.3	Q1	Q2	Q3	Q4
Diff. Tolerance	25%					
AHCs delivered by GPs for patients on the Learning Disability Register	2017/18	Patients aged 14 or over on the GPs Learning Disability Register receiving a health check within the quarter	142	127		
		Population on the GPs Learning Disability Register	1523	1523	1523	1523
		%	**9.3%**	**8.3%**	**0.0%**	**0.0%**
	2018/19 Plan	Patients aged 14 or over on the GPs Learning Disability Register receiving a health check within the quarter	140	140	140	442
		Population on the GPs Learning Disability Register	1523	1523	1523	1523
		%	**9.2%**	**9.2%**	**9.2%**	**29.0%**

Learning Disabilities – Reliance on In-Patient Care for People with LD/Autism and those with a Length of Stay over 5years (ELR return only)

E.K.1a			Q1	Q2	Q3	Q4
Reliance on Inpatient Care for People with LD or Autism - Care commissioned by CCGs	2017/18	The number of people from the TCP who have a learning disability and/or autistic spectrum disorder that are in inpatient care for mental and/or behavioural healthcare needs, and whose bed is commissioned by a CCG. This will include all adults in inpatient wards that are not classified as low-, medium- or high-secure.	30	30	35	
		GP Registered Population of Transforming Care Partnership (18+ only)	867498	867498	867498	867498
		Learning Disability Inpatient Rate per Million GP Registered Population	**34.58**	**34.58**	**40.35**	**0.00**
	2018/19 Plan	The number of people from the TCP who have a learning disability and/or autistic spectrum disorder that are in inpatient care for mental and/or behavioural healthcare needs, and whose bed is commissioned by a CCG. This will include all adults in inpatient wards that are not classified as low-, medium- or high-secure.	18	16	14	12
		GP Registered Population of Transforming Care Partnership (18+ only)	867498	867498	867498	867498
		Learning Disability Inpatient Rate per Million GP Registered Population	**20.75**	**18.44**	**16.14**	**13.83**

Please note - 17/18 data is only available in a suppressed form and so figures displayed are rounded to the nearest 5

E.K.1b			Q1	Q2	Q3	Q4
Reliance on Inpatient Care for People with LD or Autism - Care commissioned by NHS England	2017/18	The number of people from the TCP who have a learning disability and/or autistic spectrum disorder that are in inpatient care for mental and/or behavioural healthcare needs, and whose bed is commissioned by NHS England. This will include all adults in inpatient wards that are classified as low-medium- or high-secure, and all children and young people in Tier 4 CAMHS services.	20	20	20	
		GP Registered Population of Transforming Care Partnership (18+ only)	867498	867498	867498	867498
		Learning Disability Inpatient Rate per Million GP Registered Population	**23.05**	**23.05**	**23.05**	**0.00**
	2018/19 Plan	The number of people from the TCP who have a learning disability and/or autistic spectrum disorder that are in inpatient care for mental and/or behavioural healthcare needs, and whose bed is commissioned by NHS England. This will include all adults in inpatient wards that are classified as low-medium- or high-secure, and all children and young people in Tier 4 CAMHS services.	22	22	22	21
		GP Registered Population of Transforming Care Partnership (18+ only)	867498	867498	867498	867498
		Learning Disability Inpatient Rate per Million GP Registered Population	**25.36**	**25.36**	**25.36**	**24.21**

Calculated Summary of E.K.1a + E.K.1b			Q1	Q2	Q3	Q4
Reliance on Inpatient Care for People with LD or Autism	2017/18	The number of people from the TCP who have a learning disability and/or autistic spectrum disorder that are in inpatient care for mental and/or behavioural healthcare needs.	50	50	55	0
		GP Registered Population of Transforming Care Partnership (18+ only)	867498	867498	867498	867498
		Learning Disability Inpatient Rate per Million GP Registered Population	**57.64**	**57.64**	**63.40**	**0.00**
	2018/19 Plan	The number of people from the TCP who have a learning disability and/or autistic spectrum disorder that are in inpatient care for mental and/or behavioural healthcare needs.	**40**	**38**	**36**	**33**
		GP Registered Population of Transforming Care Partnership (18+ only)	867498	867498	867498	867498
		Learning Disability Inpatient Rate per Million GP Registered Population	**46.11**	**43.80**	**41.50**	**38.04**

Please note - 17/18 data is only available in a suppressed form and so figures displayed are rounded to the nearest 5

E.K.2a			Q1	Q2	Q3	Q4
Reliance on Inpatient Care for People with LD or Autism with a length of stay of 5 years and over- Care commissioned by CCGs	2017/18	The number of people from the TCP who have a learning disability and/or autistic spectrum disorder that are in inpatient care for mental and/or behavioural healthcare needs, and whose bed is commissioned by a CCG ahave a length of stay of 5 years and over. This will include all adults in inpatient wards that are not classified as low-, medium- or high-secure.	5	5	5	
		GP Registered Population of Transforming Care Partnership (18+ only)	867498	867498	867498	867498
		Learning Disability Inpatient Rate per Million GP Registered Population	**5.76**	**5.76**	**5.76**	**0.00**
	2018/19 Plan	The number of people from the TCP who have a learning disability and/or autistic spectrum disorder that are in inpatient care for mental and/or behavioural healthcare needs, and whose bed is commissioned by a CCG ahave a length of stay of 5 years and over. This will include all adults in inpatient wards that are not classified as low-, medium- or high-secure.	8	7	7	7
		GP Registered Population of Transforming Care Partnership (18+ only)	867498	867498	867498	867498
		Learning Disability Inpatient Rate per Million GP Registered Population	**9.22**	**8.07**	**8.07**	**8.07**

E.K.2b			Q1	Q2	Q3	Q4
Reliance on Inpatient Care for People with LD or Autism with a Length of Stay of 5 years and over - Care commissioned by NHS England	2017/18	The number of people from the TCP who have a learning disability and/or autistic spectrum disorder that are in inpatient care for mental and/or behavioural healthcare needs, and whose bed is commissioned by NHS England and have a length of stay of 5 years and over. This will include all adults in inpatient wards that are classified as low- medium- or high-secure, and all children and young people in Tier 4 CAMHS services.	10	10	5	
		GP Registered Population of Transforming Care Partnership (18+ only)	867498	867498	867498	867498
		Learning Disability Inpatient Rate per Million GP Registered Population	**11.53**	**11.53**	**5.76**	**0.00**
	2018/19 Plan	The number of people from the TCP who have a learning disability and/or autistic spectrum disorder that are in inpatient care for mental and/or behavioural healthcare needs, and whose bed is commissioned by NHS England and have a length of stay of 5 years and over. This will include all adults in inpatient wards that are classified as low- medium- or high-secure, and all children and young people in Tier 4 CAMHS services.	9	8	7	7
		GP Registered Population of Transforming Care Partnership (18+ only)	867498	867498	867498	867498
		Learning Disability Inpatient Rate per Million GP Registered Population	**10.37**	**9.22**	**8.07**	**8.07**

Please note - 17/18 data is only available in a suppressed form and so figures displayed are rounded to the nearest 5

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Calculated Summary of E.K.2a + E.K.2b			Q1	Q2	Q3	Q4
Reliance on Inpatient Care for People with LD or Autism with a Length of Stay of 5 years and over	2017/18	The number of people from the TCP who have a learning disability and/or autistic spectrum disorder that are in inpatient care for mental and/or behavioural healthcare needs, and have a length of stay of 5 years and over.	15	15	10	0
		GP Registered Population of Transforming Care Partnership (18+ only)	867498	867498	867498	867498
		Learning Disability Inpatient Rate per Million GP Registered Population	**17.29**	**17.29**	**11.53**	**0.00**
	2018/19 Plan	The number of people from the TCP who have a learning disability and/or autistic spectrum disorder that are in inpatient care for mental and/or behavioural healthcare needs, and have a length of stay of 5 years and over.	**17**	**15**	**14**	**14**
		GP Registered Population of Transforming Care Partnership (18+ only)	867498	867498	867498	867498
		Learning Disability Inpatient Rate per Million GP Registered Population	**19.60**	**17.29**	**16.14**	**16.14**

Appendix 3

LLR CCGs' 2018/19 Summary (Net) QIPP Plans

Scheme Name	*Organisation Lead*	*WL (Net) Total Value £000*	*LC (Net) Total Value £000*	*ELR (Net) Total Value £000*	*TOTAL LLR VALUE NET*
Orthotics Procurement	LC	75.00	75.00	65.00	215.00
Pathway 3 Control/Risk Share	WL	300.00	300.00	200.00	800.00
Public Health Funding Flu Vaccines	ELR	300.00	200.00	300.00	800.00
Review/Reduce expenditure on agency staff	Individual CCG's	477.00	-	557.00	1,034.00
Removal of double payment to LPT for UHL discharge co-ordinators (Primary Care Co-ordinators)	ELR	139.50	134.00	119.00	392.50
Block Contracts at UHL	LC	98.05	146.00	104.03	348.07
UHL Contract Price negotiation - Follow Up Ratios	LC			891.00	891.00
UHL Contract Price negotiation - CAU	LC	88.35	123.00	89.13	300.48
UHL Contract Price Negotiation - CDU	LC	294.50	408.00	297.10	999.60
UHL Contract Price Negotiation - RDA's	LC	147.25	204.00	148.55	499.80
PRIMARY CARE - Federation QIPP scheme impact on acute demand	Individual CCG's	1,300.00	-	-	1,300.00
All historic AQP contracts to be reviewed	LC	686.00	70.00	1,305.00	2,061.00
PRIMARY CARE - CBS investments reviewed	Individual CCG's	500.00	300.00	2,000.00	2,800.00
LA Charges Review	Individual CCG's	-	-	336.00	336.00
MPC controls	WL	16.67	17.00	16.67	50.33
Night Nursing contract negotiation - DHU	WL	83.33	83.00	250.00	416.33
LD Pool -improved case management	ELR	718.00	-	603.00	1,321.00
Reduce corporate clinical input	WL	200.00	-	-	200.00
Review and redesign in ICS/IP Beds/District Nursing	ELR	349.00	345.00	305.60	999.60
EMAS - Negotiation of 18/19 contract	WL	268.56	312.00	219.75	800.32
LD Short breaks consolidation	ELR	86.50	81.00	87.00	254.50
LPT CQUIN expectation	ELR	189.00	233.00	154.00	576.00

Scheme Name	Organisation Lead	WL (Net) Total Value £000	LC (Net) Total Value £000	ELR (Net) Total Value £000	TOTAL LLR VALUE NET
Stroke Rehab Bed Numbers Reduction Following redesign and investment	ELR	108.00	124.00	86.00	318.00
Potential realignment of Community Hospital Beds across sites	ELR	104.70	104.00		208.70
Vol Sector - Review VFM and service need	ELR	580.00	174.00	218.00	972.00
Derbyshire Healthcare non acute SLA negotiation	WL	156.00	-	-	156.00
Joint Funding University of Leicester	WL	24.00	24.00	-	48.00
In House Legal expertise	LC	60.00	-	45.00	105.00
GPIT	Individual CCG's	66.00	73.00	61.00	200.00
GP Staff Training cessation (East hosted)	Individual CCG's	70.00	-	-	70.00
BCT Partnership office maintain spend in line with 17/18 outturn	LC	146.00	90.00	-	236.00
Anticoag at UHL - moved into community	LC	206.01	257.00	166.95	629.96
Prescribing	ELR	3,000	2,700	3,000	8,700
Prior approvals (IFR's) tighter controls	LC	147.25	204.00	148.55	499.80
PLT to be funded from FDR/ PMS	Individual CCG's	-	70.00	-	70.00
HNN practice engagement/training funding review	Individual CCG's	-	150.00	-	150.00
Practice backfill	Individual CCG's	-	131.00	-	131.00
Acute activity funded within BCF	LC	-	1,900.00	-	1,900.00
Biologics Support Service (UHL)	ELR	-	198.00	-	198.00
Review Of IAPT	ELR	-	-	500.00	500.00
Cardiology	WL	76.78	154.00	-	230.78
Audiology	LC	47.91	48.00	-	95.91
MSK Physiotherapy	LC	292.06	292.00	106.00	690.06
Physio	LC	32.30	32.00	-	64.30
Diagnostics - Imaging	LC	235.56	236.00	-	471.56
Diagnostics - Non Imaging	LC	3.88	4.00	-	7.88

Scheme Name	*Organisation Lead*	*WL (Net) Total Value £000*	*LC (Net) Total Value £000*	*ELR (Net) Total Value £000*	*TOTAL LLR VALUE NET*
ED Front Door Model 1	WL	45.57	97.00	24.00	166.57
ED Front Door Model 2	WL	10.14	64.00	2.00	76.14
Increase & Improve Ambulatory Pathways 1	WL	58.87	113.00	30.00	201.87
Increase & Improve Ambulatory Pathways 2	WL	140.81	174.00	57.00	371.81
Increase & Improve Ambulatory Pathways 3	WL	27.20	32.00	13.00	72.20
Respiratory	WL	52.45	59.00	-	111.45
Improved Clinical Triage	WL	5.02	16.00	4.00	25.02
Expansion of Clinical Navigation Hub	WL	60.40	85.00	24.00	169.40
Tighten Eligibility for NEPTS	WL	152.00	136.00	56.00	344.00
Urgent Diagnostic Pathways	WL	21.40	1.00	2.00	24.40
Increase Support for EMAS to reduce conveyances	WL	13.54	184.00	-	197.54
Discharge Pathways	WL	83.00	84.00	42.00	209.00
Frailty	WL	63.75	79.00	34.00	176.75
Passporting	WL	21.13	17.00	11.00	49.13
Cat M	ELR	-	500.00	-	500.00
Falls	WL	75.52	-	-	75.52
NSCO	LC	-	1,600.00	-	1,600.00
Biosimilar Switches	ELR	394.18	394.00	424.50	1,212.68
Patent Expiry Humira®	ELR	185.38	185.00	199.64	570.03
Move to VAT Free Route (TMP)- Tolvaptan	ELR	19.87	20.00	19.87	59.75
Adult Mental Health	ELR	547.00	-	592.00	1,139.00
Section 117 and AHP	ELR	111.20	180.00	248.80	540.00
MH OOA Placements - additional provision in LPT	ELR	130.80	-	106.00	236.80

Scheme Name	*Organisation Lead*	*WL (Net) Total Value £000*	*LC (Net) Total Value £000*	*ELR (Net) Total Value £000*	*TOTAL LLR VALUE NET*
Learning Disabilities Short Breaks	ELR	-	-	82.00	82.00
Community Health Services Various schemes	ELR	383.24	-	592.00	975.24
Community Equipment Scheme (returned equipment)	ELR	75.00	75.00	-	150.00
EoL - CHC Deflected Patients	WL	459.95	456.00	539.40	1,455.35
CCG Efficiencies	Individual CCG's	506.50	167.00	166.00	839.50
CHC	ELR	1,826.00	1,782.00	1,211.00	4,819.00
CHC Stretch	ELR	650.00	650.00	650.00	1,950.00
BCF Slippage/contingency/savings plan	ELR	1,000.00	-	1,100.00	2,100.00
Integrated urgent care - Primary care	Individual CCG's	600.00	-	-	600.00
Ambulatory Care -look at closer to home services	Individual CCG's	-	-	300.00	300.00
Recharge for UCC outside LLR	Individual CCG's	-	-	40.00	40.00
EoL Reduction in Emergency Admissions	WL	59.40	-	39.60	99.00
ICS notice (ELR)	ELR	-	-	125.00	125.00
Demand Savings: New Appointments	LC	292.94	144.00	235.00	671.94
Demand Savings: Follow Up Appointments	LC	149.87	87.00	132.00	368.87
Demand Savings: Low Value Treatments	LC	64.79	40.00	32.00	136.79
Pathway Redesign	LC	535.38	638.00	132.00	1,305.38
TOTAL		***20,495.46***	***18,055.00***	***19,645.14***	***58,195.60***

Risk and Mitigations to the Delivery of the Operational Plan

No.	Risks	Mitigations
1.	Unable to identify sufficient savings to ensure delivery of control totals	Systems solutions are being developed by all NHS organisations across LLR – commissioners and providers. Additional external interim management support. The aim of this work is to ensure that savings take costs out of the system rather than moving the impact around the system thus providing a more sustainable solution. Efficiency tools such as RightCare and Getting it Right First Time have been used to identify solutions.
2.	Non delivery of NHS Constitutional Targets	Structure in place to manage performance through contracting teams; key groups such as the A&E Delivery Group and the RTT/Cancer Board who have active plans in place to pursue the achievement of the constitutional targets. Individual CCGs monitor progress through Finance and Performance meetings and escalate to Boards as necessary. At a system level the Provider Performance and Assurance Group (an LLR group made up of Executives; clinical leads and lay member) oversees provider performance including relevant NHS Constitutional Targets. Our plans take account of the 2018/19 Planning Guidance requirements and the key action templates detail specific actions being taken.
3.	Relationships challenges – providers and commissioners	Our local system has good working relationships and is supported by the System Leadership Team who oversee our local Sustainability and Transformation Partnership. 2018/19 solutions have been co-developed by providers and commissioners with an open book approach being applied to understanding the financial position across LLR. We are currently reviewing our delivery arrangements to ensure system wide delivery of the solutions identified.
4.	Cultural change required and change to working behaviours and skills not adequately addressed	Organisational Development Plan for LLR agreed by the System Leadership Team in 2017. Clinical Leadership Group in place which is taking forward the Organisational Development Plan for LLR. The CLG is currently considering ways it can further strengthen its role in supporting change across the system. A number of clinicians have attended NHS Leadership Academy programmes on change.

No.	Risks	Mitigations
5.	Pressures on the acute sector are not reduced and demand continues to grow	Our transformation plans have a strong emphasis on the development of out of hospital services to avoid admission and to enable patients to return home quickly. The redesign of Urgent and Emergency care across LLR came into force from 1st April 2017 and this is having an impact on our A&E and Admissions activity. Our plans around planned care are designed to manage demand and reduce unnecessary activity. Work will happen in year to consider services to support Home First and patients with co-morbidities. In addition our activity plans have been to the national growth rates detailed in the 2018/19 Planning Guidance. They take account of the Planning Guidance around incomplete pathways and 52 week waiters.
6.	There is a disconnect between provider and commissioner plans	Understanding our finances across commissioners and providers has been undertaken jointly following an open book approach – therefore we now have a much more in-depth understanding of the financial position across the NHS in LLR. Our activity plans have been triangulated and the same growth rates have been applied to both provider and commissioner plans. This has included considering the national growth figures provided in the 2018/19 Planning Guidance.
7.	Can the plans be contracted	This is the second year of a two year contract round and therefore contracts are in place. Activity levels are being discussed with providers. There is ongoing dialogue between commissioners and providers with a view to agreeing contracts in line with the national timelines.
8.	Delivery arrangements are insufficient to ensure	Governance and programme management arrangements are in place and being reviewed – see Governance Section. Work is ongoing to ensure resources are aligned to those schemes that are key to the deliverability of the Operational Plan.
9.	Lack of public support through consultation of STP transformational proposals	Continued engagement prior to consultation of the patients, carers, stakeholders and the public including those groups likely to oppose changes to ensure they are engaged with proposed plans prior to consultation.

Activity Plans

Leicester City CCG

POD	2017/18 FOT	Trend and Growth	QIPP	Plan	% Growth
GP Referrals	72,927	583	0	73,510	0.8%
Other Referrals	38,919	1,790	0	40,709	4.6%
1st New Outpatients	92,325	7,107	-1,198	98,234	6.4%
Follow Ups	167,488	9,712	-1,187	176,013	5.1%
Day Cases	31,682	1,839	0	33,521	5.8%
Elective Admissions	4,930	63	-15	4,978	1.0%
Non Elective Admission 0 LOS	14,472	1,052	-242	15,282	5.6%
Non Elective Admissions +1 LOS	27,085	477	-233	27,329	0.9%
A&E Attendances	141,803	4,529	-2,969	143,363	1.1%

East Leicestershire and Rutland CCG

POD	2017/18 FOT	Trend and Growth	QIPP	Plan	% Growth
GP Referrals	70,839	567	0	71,406	0.8%
Other Referrals	35,517	1,634	0	37,151	4.6%
1st New Outpatients	92,544	8,688	-1,011	98,467	6.4%
Follow Ups	169,341	10,497	-1,282	176,284	4.1%
Day Cases	38,934	1,652	0	40,569	4.2%
Elective Admissions	6,454	267	0	6,473	0.3%
Non Elective Admission 0 LOS	9,105	664	-155	9,614	5.6%
Non Elective Admissions +1 LOS	23,400	211	0	23,611	0.9%
A&E Attendances	120,106	5,211	-3,890	121,427	1.1%

West Leicestershire CCG

POD	2017/18 FOT	Trend and Growth	QIPP	Plan	% Growth
GP Referrals	79,932	633	0	79,782	0.8%
Other Referrals	44,022	2,008	0	45,658	4.6%
1st New Outpatients	97,493	8,058	-1758	104,733	6.4%
Follow Ups	192,980	10,146	-2,115	195,875	4.1%
Day Cases	4,353	3,027	0	46,336	7.0%
Elective Admissions	7,218	39	-20	6,509	0.3%
Non Elective Admission 0 LOS	12,536	863	-264	11,311	5.6%
Non Elective Admissions +1 LOS	24,322	1,073	-223	27,273	3.2%
A&E Attendances	128,220	3,911	-2,562	124,017	1.1%

Health and Wellbeing Scrutiny Commission

Work Programme 2018 – 2019

Meeting Date	Topic	Actions arising	Progress
5th Jul 18	1. Lifestyle Services Review – Consultation Findings and Proposals 2. Leicester Royal Infirmary ED – Phase 2 3. NHS Operational Planning and Contracting Guidance 2017 – 2019 4. Integrated Sexual Health Services Update		
23rd Aug 18	1. UHL Cancer Treatment Performance 2. Winter Care Plan – Update on Lessons Learnt 3. CCG's Workforce Strategy and International Recruitment. 4. Joint Health and Wellbeing Strategy 5. Oral Health Update		
11th Oct 18	1. GP Practices in the City 2. Multi-morbidity Update 3. Public Health Performance Report 4. Turning Point – Performance Report		
29th Nov 18	1. Primary Care Update 2. Community Services Review 3. Continuing Healthcare		
15th Jan 19	1. LPT Update on Bank Staff and Infrastructure improvements		
12th Mar 19	1. Update on LPT Transformation Programme		

Appendix E

Items from 2017/18

Meeting Date	Topic	Actions arising	Progress
11 Jan 18	1. CQC Inspections on GP practices 2. Drugs & Alcohol Services (Turning Point) – CQC Inspection 3. Anchor recovery hub – Update on how it is progressing following a move to the new site 4. Public Health Performance Report 5. Draft Revenue Budget 2018/19 Report	1. An update the CCG's workforce strategy and international recruitment to come to a future meeting. 2. It was recommended that signposting be improved at the centre on Granby Street to ensure service users are directed to the correct centre if Granby Street was not appropriate; and a further report with performance data be brought to a future meeting of the Commission.	1. Added to 23/8 2. Info has been circulated to Members.
7 Mar 18	1. CQC Inspection of LPT 2. Winter Care Update 3. STP – Verbal Update 4. Lifestyle Services Review – Update	1. The updated action plan to come back to a future meeting of HWB SC or taken to LLR SC. Infrastructure Plans for the Bradgate Unit and issues around LPT bank staff is added to the Work Programme. An update of the LPT's transformation plan, including the progress made is brought back to a future meeting. The CCG to inform the commission of their thoughts as to the LPT's CQC ratings and what their expectations are. 2. Chair to raise concerns about the term 'stranded patients' for patients in hospital for 7 days with Jon Ashworth as Shadow Health Secretary. A further update on lessons learnt from this winter period to be brought back to a future meeting. A report on performance for Cancer Patients at UHL to be brought back to a future meeting. The minutes of this meeting to be shared with the Health and Wellbeing Board.	

Leicestershire, Leicester and Rutland Joint Health Scrutiny Committee

Meeting Date	Topic	Actions arising
14 Dec 16	1) Sustainability and Transformation Plan	All three council scrutiny committees agreed to consider elements of the STP separately based on local concerns. Another joint meeting will convene when each council has had separate consideration.
14 Mar 17	1) NHS England's Proposals for Congenital Heart Disease Services at UHL NHS Trust	It was agreed to have a further meeting of the committee before the consultation ends to hear views from Members of the public and other stakeholders.
27 Jun 17	1) NHS England's Proposals for Congenital Heart Disease Services at UHL NHS Trust	It was agreed for the committee response to be collated following information heard at the meeting and submitted to NHS England. It was also agreed to write to the Secretary of State to request he looks at the process and reconsiders the review and drop proposals to close the CHD centre at Glenfield Hospital.
27 Apr 18	1) Update on LPT NHS Trust Improvement Plan following their CQC Inspection 2) Update on CHD Services in East Midlands and the NHS England review into PICU and ECMO services nationally 3) Update from UHL NHS Trust following their CQC Inspection 4) Update on EMAS Quality Improvement Plan	1) A further update from the LPT is brought back to the committee in a years' time. 2) It was agreed to continue to monitor performance against the targets set by NHS England and an update be brought to the committee in one year's time, particularly to include targets, issues around winter pressures and the numbers of referrals. It was also agreed that a letter be sent to Nottingham City Council to request that they encourage the University Hospitals of Nottingham to refer their congenital heart patients to UHL and to share with them the minutes of the meeting. 3) Further CQC inspection reports of UHL, along with the resulting action plans, are brought to future meetings of the committee. 4) A further update from EMAS is brought back to the committee in a years' time.
TBC	1) Sustainability and Transformation Plan 2) EMAS Update	

Joint Health and Wellbeing Meetings with other LCC Scrutiny Commissions

Meeting Date	Topic	Actions arising
7 Nov 17	**Joint meeting with Children, Young People and Schools Scrutiny Commissions:** 1) Children's Mental Health - Future in Mind - CAMHS 2) CQC Review of Health Services for LAC and Safeguarding	1) The following is requested at a future joint meeting: • Further meeting to look at the specific services available and at what stage these interventions/services are provided; effectively mapping all services for children's mental health and what is offered and by whom. • What governance structures in place, who is accountable to whom for different elements, including LA, LPT, schools etc, as well as what services are available. • Examples of anonymised case studies which help understand a child's journey through services as part of this report. • Clarity about the role of schools and how they fit into the process and their role in identifying young people and how they are supported to help young people into the right pathway. • Commission Members to have sight of the Local Transformation Plan • Invite headteachers to the next meeting to get their viewpoint. • Further information on the CAMHS 'improvement journey' with particular information on how the improvements have impacted on outcomes. • More detail about what happens to those who are not 'accepted' by CAMHS

Forward Plan Items

Topic	Detail	Proposed Date
Dementia, Dental Care, Diabetes, GPs, Obesity, Smoking, COPD and Substance Misuse	Progress to individual strategies/services	
Patient experience of the system	Work with Healthwatch to gain an understanding of how patients feel about health services	
GP Workforce Plan	To be shared with the Commission.	
Impacts of Brexit on staffing in NHS	What has the immediate impact been? What will continue to happen when we exit the EU? What contingencies are being put in place? Where will the biggest impacts be?	
0-19 Healthy Child Programme	Including Health Visitors and School Nurses	
Healthwatch	Update on the contract	