NHS
West Leicestershire
Clinical Commissioning Group

Operational Plan
West Leicestershire CCG

Patients, practices and partners working together to create the best value healthcare for the population of West Leicestershire

Patients, Practices, Partners

Table of Contents

Chair's Foreword

Our NHS has never been more high profile or important. The challenges of urgent care over winter and the focus on the NHS in the run up to the national election in May mean that the work we are engaged with is both critical to our patients and centre stage, publicly and politically.

This Plan sets out the things that we will do in 2015/16. It is a refresh of the two year Plan we set out last year, not a rewrite — because the health needs of our population and service challenges we face remain broadly the same.

It therefore builds on the things we have already achieved:

- The award winning Acute Visiting Service (AVS) which provides a rapid response, supporting Primary Medical Care Providers, to patients with urgent health needs who are vulnerable to admission
- The Older Persons' Unit based at Loughborough Hospital, operating via direct referral from GPs providing rapid access, same-day diagnostics and treatment for patients with complex health needs
- The Overnight Nursing Assessment Service, designed to complement existing unscheduled care and social care crisis response services to provide 24 hour unscheduled care service provision

It also includes the things we have learned during the course of the year that we need to do better — fragmentation of care highlighted by Learning Lessons and improving services for frail older people and with complex LTCs, as highlighted by the Ian Sturgess report.

Importantly, it also directly responds to the new national direction, challenges and opportunities articulated in the Five Year Forward View.

Locally we have already developed our system response to the Five year Forward View. Better Care Together (BCT) is a game changer for Leicester, Leicestershire and Rutland (LLR) on two levels, in terms of what we need to do and in how we need to go about doing it. For the first time in a generation, we have a shared direction across health and care for Leicester, Leicestershire and Rutland. But as important as the 'what' is the process of developing the BCT plans, which has brought partners across the system together to work in a much more joint way on co-designing the improvement that we need to make. We have played a key system leadership role in shaping this new sense of collaboration, and we welcome the opportunities it presents to make the changes we know are

needed, at scale and with pace.

So, when we put all this together, our mission, goals and values that are enshrined in our constitution remain as valid and relevant today as when we developed them three years ago. The same is true of the eight work-streams that have framed our work over the last year remain equally relevant. What is different is the specific areas that we will focus our resources on in 15/16 in terms of:

1 Delivery of improvements in access, quality and safety for our patients particularly against national standards for A&E, RTT, cancer and mental health

2 Reshaping our health and care system at scale through Better Care Together co-delivery to transform out-of-hospital care, particularly for complex LTCs and older people with frailty

3 Developing the foundations for new models of integrated care provision through federated localities, specialist/generalist MCP working and primary care co-commissioning.

We're excited and optimistic about the year ahead. Election years are always interesting and this one for the NHS perhaps more than most, but throughout we will retain our sustained focus on what really matters — improving quality and outcomes for our patients and delivering value for money for taxpayers.

1. Operating Context

This refresh is intended to deliver on a range of priorities both at a health system and individual CCG level. These priorities are a combination of plans we have started but are not fully delivered and priorities that have been developed with our governing body as a response to new guidance we have received.

Documents and drivers that affect operations

The documents and drivers that have contributed to getting to this plan are a mixture of national planning guidance and local delivery programmes as listed below:

- The Better Care Together Programme (including workforce planning with LETB and C)
- Better Care Fund
- Health and Well Being Board
- The Five Year Forward View
- Planning Guidance for 2015/16, (Five year View into Action) including delivering the NHS Constitution Standards
- Urgent Care Improvements- responding to the national review of Urgent and Emergency care (Keogh)
- Planned Care Transformation
- Learning Lessons to improve care
- Specialised commissioning / joint commissioning
- Primary Care Co-Commissioning
- Specific CCG intentions to deliver operational plan and identified health need
- Innovative contracting models

This is a large and complex set of drivers. The themes that occur in these documents need to be addressed by all commissioners and providers across the Leicester, Leicestershire and Rutland (LLR) system, as well as an individual contribution delivered by WLCCG. Below, we provide a short descriptor of the key themes and priorities for WLCCG within the context of the local and national system drivers.

BCT, BCF, 5 year forward view and Keogh

Better Care Programme (BCT)

The Better Care programme is a five year strategy for Leicester, Leicestershire and Rutland (LLR). It represents the outputs of ongoing collaborative working between health and social care partners across LLR. The case for change in health and social care across LLR is strong, based on the following:

- We need integrated quality care — most people already receive good quality care, but we know there are areas where we can improve.
- We need to change the workforce — addressing a future forecast shortfall in the local and national workforce, through different ways of working across settings of care. We need to develop capacity and capabilities, both in our people and in the technology that supports them. We have initial outline plans developed with the LetB, we are also in the process of recruiting a whole-time-equivalent role to look only at this area of local development
- We need to meet the changing needs of the LLR population — there is a rising demand for health and social care, with the LLR population forecast to grow by 3%, 2014-19, with a changing age profile, including a 12% growth in the over-65 population.
- We need to ensure value for money — health and social care organisations need to achieve financial sustainability to support the improvements in outcomes we want to achieve against a background of financial constraint.

The case for change creates a real opportunity for us to redesign the way services are provided and to achieve our vision agreed by all partner organisations for LLR:

"…to maximise value for the citizens of Leicester, Leicestershire and Rutland (LLR) by improving the health and well-being outcomes that matter to them, their families and carers in a way that enhances the quality of care at the same time as reducing cost across the public sector to within allocated resources by restructuring the provision of safe, high quality services into the most efficient and effective settings. "

The Five Year Forward View

In October 2014 NHS England, the Care Quality Commission, Health Education England, Monitor, Public Health England and the Trust Development Authority published the Five Year Forward View. This sets a vision of a better NHS, the steps to be taken to get there and the actions needed from others:

- A radical upgrade in prevention and public health, including national action on obesity, smoking, alcohol and other major health risks and work place incentives. These issues are covered in our People Powered Health section
- Integrated personal budgets: patients to have access to a health and social care personal budget (see People Powered Health section)
- A stronger partnership with the voluntary sector: investing significantly in evidence-based approaches, such as, group based education for people with specific conditions and self-management educational courses, as well as encouraging peer-to-peer communities to emerge. This area is being addressed in our long term conditions programme as well as the mental health section of our plan.
- Alternative models of provision: Multispecialty Community Providers (MSCPs) will permit groups of GPs to combine with nurses, other community health services, hospital specialists and perhaps mental health and social care to create integrated out-of-hospital care. Details of our commitment to work with our federations to develop this offer are discussed in our Excellence in Primary Care section.
- Urgent and emergency care services: there is an emphasis on integration between A&E, GP Out-of Hours, Urgent Care Centres, NHS 111 and the ambulance service. Our local five year plan recognises this, and adds a component of demand management and system capacity management through a SPA. There is also strategic work being supervised through the Urgent Care working group where the Better Care Together five year plan is being tested against the reviews of Urgent and Emergency care, (Keogh) to ensure that our plans for Urgent Care deliver a resilient and robust solution for patients that meets those standards as well as supporting local drivers.

Specialised Services Commissioning

2015/16 will see changes in Specialised Commissioning.

Transfer of commissioning responsibility: NHS England is currently undertaking consultation on the transfer of commissioning responsibility for the following services to CCGs from 1st April 2015:

- Renal dialysis
- Morbid obesity surgery

Other services for which commissioning responsibility is planned to transfer to CCGs in April 2015 are:

- Wheelchair services
- Neurology outpatients

The CCGs will work with NHS England to ensure that these changes are implemented and expect the providers to work with us to ensure both a smooth transition and any future service transformation.

Primary Care co-commissioning

Clinical Commissioning Groups will have the option from 1st April 2015 to take on primary care commissioning in conjunction with the NHS Area Team. There are three levels of co-commissioning and a CCG is able to choose the level at which they want to commission primary care services. The levels are:

Delegated commissioning arrangements

Joint commissioning arrangements

Greater involvement in primary care decision making

WLCCG's board has determined that taking on delegated commissioning arrangements is the preferred option. Co-commissioning will be a key enabler in developing integrated out-of-hospital services based around the needs of the local population. It will also drive the development of the new models of care set out in the Five Year Forward View. We developed a Primary Care Plan that was ratified by our board in January to support this aim (Primary Medical Care Plan West Leicestershire).

Focus on Prevention

To support reduction in use of emergency and acute services we, with our local partners, will increase our focus on prevention. This will include early detection programmes, prevention of mental illness and a focus on well-being. The Better Care Fund (BCF) supports this through Local Area Coordination and other out of hospital services including the Older Persons' Unit, Overnight Nursing Assessment Support Service, the Falls development programme and Seven Day Working. In addition to this BCF is working with Public Health and the Unified Prevention Board to ensure all areas of prevention are covered under the work of this programme. This enables shared priorities to be acted on with shared outcomes and shared measures of success. Voluntary services also play a part in supporting our population.

We know through work with the Health and Well Being Board

that our priorities are long term conditions. The clinical priorities featured in the following work-streams all have a focus on early detection of illness and reducing inequality.

Plans are in place to address variable performance across providers where the levels of focus on prevention are not consistent. We have recognised that a limited resource has been allocated to date to primary and secondary prevention schemes, and we will reconsider financial allocation to this area following assessment of Better Care Fund programmes.

2. Our Mission and Values

Our Mission

Patients, practices & partners working together to create the best value healthcare for the population of West Leicestershire

Our Values

Democratic Collaborative Proactive Adaptable Honest Passionate

Goals

1 Improve Health Outcomes

2 Improve the quality of healthcare services

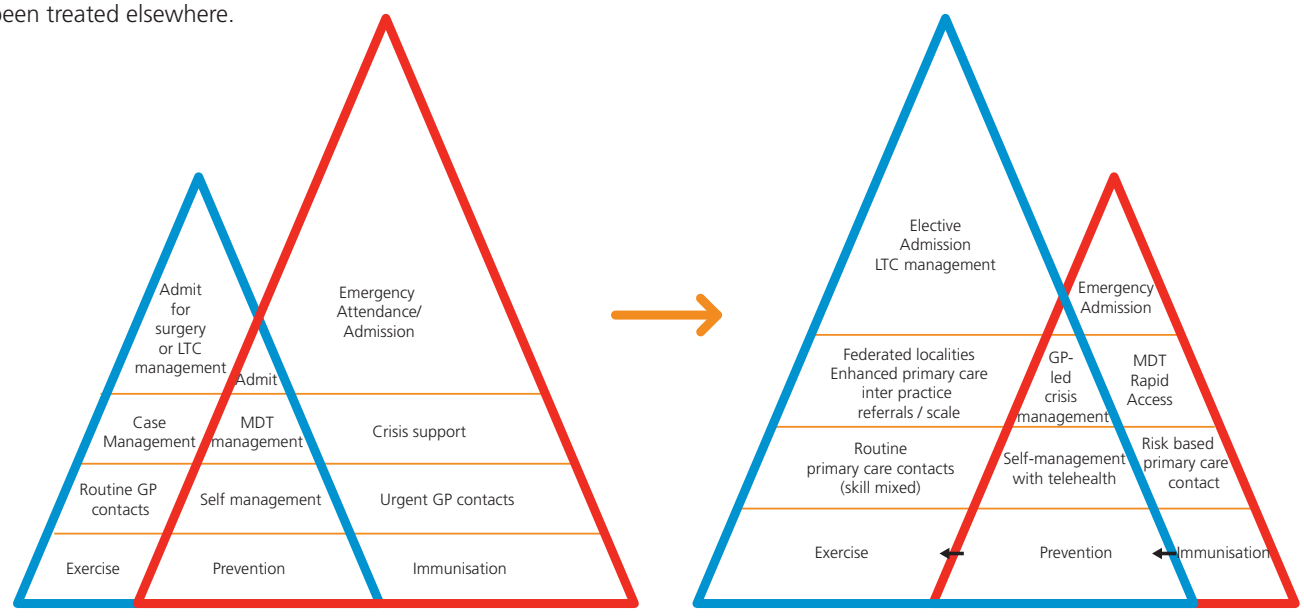
3 Use our resources wisely

Below left: today's situation

The situation in real life is more complicated. Care is provided as planned care and as urgent care, and, in urgent care, there is often a mismatch between need, setting and provision of service. People are admitted inappropriately to A&E, or admitted for a condition which need not have deteriorated to the point of needing emergency care if it had been proactively managed earlier. For this reason, a greater than necessary proportion of activity and cost is in urgent care, with much of the provision at Level 3 being for conditions which might have been treated elsewhere.

Below right: our new model

In our new model, strengthening of the lower tiers and greater attention to proactive care management mean that we can invest to a much greater extent in scheduled care, with a substantial reduction in inappropriate or unnecessary emergency attendance and/or admission. Resources expand for the lower tiers, along with capacity created by our Multi-Speciality Community Providers (Federations), which create a virtuous spiral, since the cost of interventions is lower and so more patients can be supported at the most appropriate level.



Our vision to realise the Five Year Forward View is to work towards Multi-Speciality Community Providers that increase the proportion of care that we offer our population as a scheduled offer. This is based upon our performance challenges and our mandatory requirements for delivery.

System resilience

Urgent Care Working Group (UCWG)

West Leicestershire CCG chairs the LLR UCWG on behalf of the LLR health and social care economy. The UCWG comprises of executive leaders and senior clinicians from every main provider of urgent care services (including primary care, out of hours, ambulance services, community, mental health services, care home providers and the voluntary sector).

Recognising the scale of the challenge we face in LLR, the UCWG has been convening weekly and is supported in day-to-day operational management by a series of operational task focussed sub-groups. These sub-groups are focussed on actions to improve the performance of the urgent care system across LLR.

Building on the recommendations from the LLR Urgent Care Review, the Urgent Care Board agreed to take forward proactive actions in response to the urgent care challenge in order to make a direct impact on activity and flow through Leicester's hospitals to reduce emergency admissions and length of stay. These include an MDT team at the "front door" of primary care co-ordinators/therapists/geriatricians seeing all older people with frailty before they are admitted to improve their care in a more planned way and maximise referrals back out into community based alternatives where appropriate.

In addition WLCCG have convened an Out of Hospital Implementation Board to oversee the impact of all WLCCG services in place as alternatives to hospital admission. This group meets on a monthly basis during which the effectiveness of individual schemes are reviewed and their activity monitored. In between meetings a sub group meets on a weekly basis to review real time hospital admission data in order to provide clinical challenge if an alternative option could have been chosen as opposed to an emergency admission.

The UCWG also recommends priority areas of investment for urgent care to CCG Boards. This includes application of both winter funding, and any re-investment of the Marginal Rate of Emergency Threshold (MRET).

Planning for seasonal variation

The UCWG leads the planning for seasonal peaks / winter demand - including the formation, co-ordination and oversight of the LLR Surge and Resilience Plan. A formal sub-group of the UCWG meets monthly through the year to continuously develop this. The plans are tested annually, in conjunction with national and local planning leads.

Planned Care Transformation and Referral to Treatment

The LLR Planned Care transformation programme has a focus on innovation and continually improving whole care pathways and quality outcomes. The programme aims to ensure patients receive a quality service, with positive outcomes, when they need planned care with consistency and equity of access and service across both primary and secondary care.

As a Better Care Together work-stream, the Planned Care transformation programme thinks differently about the way in which services are delivered. Pathway transformation will ensure that patients will be treated as close to home as possible when it is appropriate and clinically safe to do so.

The three local CCG boards endorse the BCT direction of travel fully and have worked further to refine the focus on next steps with their boards. The top priority programmes that were identified through this process for 2015/16 are:

- Ophthalmology
- Musculoskeletal

Improvements in these areas will deliver a scale of change that adds to system resilience and develops stronger strategic links to support the local Referral to Treatment (RTT) Board.

The local RTT Board has worked systematically with our providers to develop plans that have given us confidence to set recovery trajectories to the nationally mandated access targets that succeed from Q1 next year.

The RTT board has also agreed to support a programme of work around the delivery of cancer targets. There is a recognition that the programme structure is supportive and constructive, offering rapid system wide resolution to threats to access targets that our patients have a mandated right to expect. The first area that the board is required to look at is 62 day cancer waits, to ensure this critical access standard is recovered in line with our forecast trajectory.

Improving the urgent care system in Leicester, Leicestershire and Rutland

The Leicester, Leicestershire and Rutland health system commissioned a report to identify the key actions that health and social care plus individual organisations need to take to improve our local urgent care system. The report was undertaken by Dr Ian Sturgess, over a 6 month period and indicates that LLR has the potential to be a high performing system but that it is currently fragmented. If the report is studied in more detail it indicates that whilst wholesale actions have been undertaken, these actions have not been linked together in a way that allows them to deliver cohesive benefits

for patients. In summary we need to do more to understand the journey through the eyes of our patients. Through this planning round we are working with our providers through the UCWG with short, medium, and long term actions which ensure we apply our skills, resources, and daily actions to improve this journey effectively. A short term action plan is currently being monitored weekly and this has seen an improvement in performance that has allowed us to set a recovery trajectory against the NHS A & E mandated standard of 4 hours that delivers from Q1 of 2015.

A longer term strategic plan that links to BCT and the Keogh findings from the national review of urgent and emergency care is under development, and will report back by the end of March. Key emerging themes are:

- Developing communication and navigation aides
- Supporting workforce in changing their roles to meet the need
- Reducing inflow, both attendances and admissions
- Improving internal processes to support flow
- Improving outflow, for example discharge processes
- Using our resources through contracting and procurement effectively to support sustainable delivery going forward.

Learning lessons to improve care

In the summer of 2014, the Leicester, Leicestershire and Rutland provider organisations (University Hospital of Leicester and Leicestershire Partnership Trust) and three Clinical Commissioning Groups published the Learning Lessons to Improve Care report. The report detailed the findings of a clinical audit commissioned by health organisations in Leicester, Leicestershire and Rutland to examine the quality of care of patients, and the action plan to address the areas of improvement identified.

The Joint Action Plan outlines five themes:

1 System wide clinical leadership to ensure that patient care issues are addressed across the health community

2 Patient and staff engagement, listening and action

3 Effective care across interfaces between providers of health services

4 Transforming Emergency Care in our wards, hospitals and communities

5 Transforming End Of Life Care

The Learning Lessons to Improve Care Clinical Taskforce developed the plan and continues to meet monthly, chaired by Professor Lakhani and Dr Kevin Harris. This group is developing a phased time-fame for delivery of the plan over the year ahead. The group will also be responsible for ongoing oversight and monitoring of impact.

- Review conducted
- Results analysed & short term Action Planning undertaken
- Outcome of review & Joint Action Plan published
- Communication with families commenced
- Implementation and monitoring delivery of short term actions
- Public and Clinical Engagement
- Planning medium and longer term actions
- Develop Outcomes Framework for next review
- Implement and monitor delivery of medium and longer term actions
- Test Outcomes Framework
- Interim review via 1st Pulse Check
- Finalise Outcomes Framework
- Interim review via 2nd Pulse Check
- Next Review – March 2016

3. The 8 work-streams and how they will deliver QIPP

Our priority programmes have been produced after consideration of the strategic direction that we intend and need to take, and our local operational challenges.

The diagram below shows an overview of our eight priority Programmes and how they all fit together, and they are for all patients, all conditions and all providers. Interrelated to our eight Programmes at the operational level is the work in our 5-Year Strategic Plan which is closely linked to our LLR Unit of Planning and the Leicestershire and Rutland Better Care Fund Plan.

1 Empowering patients to shape services and their care

Introduction

In 2014 we developed and implemented more patient-centred engagement and involvement to better empower patients to shape services and the care that they receive. Using Experience Led Commissioning (ELC) methodology we are ensuring that insights from patients, carers, staff and stakeholders are at the heart of CCG clinical commissioning and their experiences are acted upon at all stages of the commissioning cycle, tackling poor quality care.

Achievements

- We implemented the New Start, New You campaign, with a range of partners providing 250 people with health checks and signposting and providing information, advice and guidance on keeping well to many others.
- We commenced engagement on Hinckley and Bosworth community services, using ELC methodology. We have to date, had conversation with 945 patients, carers, staff, health care professionals and stakeholders people to assess what matters most to them to inform future commissioning.
- We are piloting a social prescribing project with a GP practice, their PPG and VAL to appropriately refer patients , who may have one of a range of common mental health problems to community activities
- We have involved our 48 Patient Participation Groups in the development of the Primary Care Medical Plan using the insights and experiences to shape the actions to be implemented.
- In October 2014, we have implemented the national requirement of a 'right to have' a personal health budget for people who are eligible for NHS Continuing Healthcare.

Situation

Whilst still in its infancy, this work stream made positive strides in 2014 and laid solid foundations on which to build on and enhance the CCG work to engage communities, continuing to implement our statutory duty to ensure that patient involvement impacts our commissioning decisions.

We will now continue to implement existing projects and develop new initiatives in line with planning guidance including joint plans with our local authority partners to extend our

current work with carers in line with the new duties on local authorities from April 2015 under the Care Act 2014. It will also include joint work with the Leicester, Leicestershire and Rutland health economy on Better Care Together.

Plan intentions

Driven by the People Powered Health Delivery Group we will implement new initiatives in line with planning guidance:

Support choice, control and prevention

Over the plan period, we will:

- Empower patients by extending choice and control including informing them that from April 2015 they have online access to their GP records
- Working with Healthwatch, expand the offer of Personal Health Budgets (PHB) to ensure that by April 2016 PHB and integrated person budgets are available to people with learning disabilities including children with special educational needs – in line with key findings from Francis, Berwick and Winterbourne View Reports reduce the number of inpatients for this cohort of patients by increasing availability of community services.
- Support through communications and engagement the better prevention of cancer, swift access to diagnosis and better treatment and after care
- Work with the local authority to identify and support carers in line with the new statutory duties and integrate family carer support project working with both the local authority and other community partners and GPs
- Work with GPs and providers to ensure that patients are aware of their rights and are offered choice in mental health services and are able to make well-informed, meaningful choices at appropriate points along the pathway
- Support the review of choices available for women accessing maternity services by working with service users and public to consider what more can be done to offer meaningful choice,
- Work further with Voluntary Action Leicester to energise community volunteering and encourage new roles for volunteers, working with NHS.
- Further roll-out of the social prescribing across West Leicestershire.

Communications, patient engagement and involvement

Patient experience

- Consolidate into one database all patient experiences and customer insights received via a range of mechanisms
- Ensure that ELC methodology is used to engage and capture cross-community experiences to influence our commissioning decisions including the development of locality federations, maternity services, care homes and frail older people services.

Communications, patient engagement and involvement

- Re-launch and grow our patient membership from May 2015 by 500.
- Improve and expand the use of our IT platforms to assist communications, engagement and involvement with patients and create digital participation spaces with Loughborough University by autumn 2015.
- Deliver a programme of marketing campaigns to help to encourage a cultural change around the choice, use and access to local health services
- Evaluate and analyse feedback from Hinckley Review and ensure that insights and experiences influence the options for community services by September 2015.
- Ensure joint communications and engagement work on each of the Better Care Together work streams and lead on engagement of the Frail Older Person work stream.
- Maximise and review the effectiveness of our relationship with local authorities, Voluntary Action Leicestershire and Healthwatch
- Develop our Equality Delivery System (EDS) plan ensuring we listen to our citizens who are vulnerable and who have protected characteristics

Delivering this work programme will empower patients to take a leading role in shaping the services, monitoring performance, identifying areas where we have gaps or performance issues and ensuring there is high quality care for patients.

Three Bullets:

- Ensure high quality of patient care by listening and learning from patient experiences and acting on feedback
- Empower patients to take a leading role in shaping the

services we commission

- Work closely on joint plans with our health and social care partners on new initiatives that support patient choice and control

Impact on national priorities

NHS Constitution

18 Week RTT Admitted Pathways < 18 weeks
18 Week RTT Non-Admitted Pathways < 18 weeks
Patients should be admitted, transferred or discharged within 4 hours of their arrival at an A&E Department
Category A (Red 1) within 8 minutes
(Conditions that may be immediately life threatening and most time critical)

NHS Outcomes Framework Indicators

4b	Patient experience of hospital care
4c	Friends and Family test
4.2	Responsiveness to in-patients' personal needs
4.3	Patient experience of A&E services
4.4	Access to (i) GP services and (ii) NHS dental services
4.7	Patient experience of community mental health services
4.9	People's experience of integrated care

2 Excellent Primary Medical Care

Introduction

West Leicestershire CCG has developed a Primary Medical Care Plan, a system change plan which responds to the challenge, set out by Better Care Together, of a 'left-shift' from acute care to out-of-hospital care. It responds to key principles established by extensive engagement with clinicians, stakeholders and patient representatives.

It is widely acknowledged that strong and effective primary medical care is a critical aspect of an effective and highly performing health care system. Over the last three years, the CCG has worked with our member practices to get the basics right in primary and community care to create a platform for more significant transformational change.

More recently we worked with our practices and stakeholders to develop a Primary Medical Care Plan (PMCP) that clearly sets out the CCG's ambition for the development of general practice over the next 5 years. In our model, the practice and primary healthcare team remains the basic unit of care, with the individual patients list retained as its foundation. However, an increasingly significant proportion of care will be provided by practices coming together to collaborate in federations leading to the integration of multispecialty teams at a local level.

Achievements

We have:

- Worked with our member practices and stakeholders to develop a Primary Medical Care Plan (PMCP) with a clear vision for General Practice
- Facilitated the development of four legally established federations
- Completed 50 practice appraisals thereby helping to drive up quality in Primary Medical Care
- Established a concordat with NHS England to develop a consistent approach to managing risk and sharing information
- Improved access to primary and community services over the seven day period through the development of 4 pilots covering WLCCG in line with the clinical standards for seven day working.
- Invested £1.7m in our practice level Quality QIPP scheme which has contributed to increasing levels of prevalence in key disease areas
- Coordinated a programme of Protected Learning Time Events for our practice teams linked to CCG priorities.

Situation

Primary Medical Care in West Leicestershire is performing

strongly, both by comparison with the national average and within its own comparator group. However, with an ageing workforce, underinvestment in premises, and very significant challenges ahead resulting from demographic change, rising costs of healthcare and increasing demand, it is clear that the situation is not sustainable over the next five years.

The challenges are too great for individual practices to meet, and there is general acceptance that primary medical care needs to grow and change.

The PMCP we have developed is a system-change plan that sits between the LLR Better Care Together 5 Year Strategic Plan and the CCG's own Operational Plan. In doing so it responds not only to the challenges faced by general practice, but also the wider issues faced by the whole health economy.

From April 2015, the CCG will have delegated responsibility for the commissioning of General Practice. This significant change in responsibility is seen as a key enabler which will further support the transformation of primary medical care, allowing the exploration of new contractual forms that align values and behaviours of providers, to improve the out of hospital offer to our patients .

Plan Intentions

We will focus on continuing to support the capacity and capability of general practice responding to both the challenges laid out by Better Care Together and the implementation of the Primary Medical Care Plan:

Federated localities - making General Practice thrive

- By April 2015 we will have an agreed plan in place to support development of federations in the short, medium and long-term
- By September 2015 federations will develop and agree a business plan and business case setting out their objectives.

Better collaboration and reducing bureaucracy

- By March 2016 a reduction in time spent on unwarranted bureaucratic processes freeing up clinical and managerial time to focus on patient care
- By April 2015 CCG to agree QIPP programme on a federated locality level
- By April 16 federations to develop a business case to share skills/ expertise and back office functions to improve efficiency and effectiveness.

Co-commissioning of Primary Medical Care

- By March 2016 successful implementation of delegated co-commissioning with tangible benefits for practices and patients
- By September 2015 review our approach to practice appraisals in light of co commissioning responsibilities.

Helping practices to be attractive places to work

- Workforce audit completed with gaps identified to inform local workforce plans which will target existing general practice workforce; identify new roles and capabilities in new staff groups; support undergraduate training and GP training at a federated level.

Invest in practice premises

- By August 2015 commission and complete a primary medical care premises audit to inform the development of CCG and federated locality based premises strategy
- Premises investment secured through local and national funding streams including £1bn NHS Primary Care Infrastructure Fund launched in January 2015.

Exploiting technology

- By April 2015 explore the feasibility of all practices moving to one GP System of Choice to improve integrated and collaborative working at a federated locality level
- Support the further development and implementation of PRISM across all member practices to achieve improved adherence to planned care pathways
- By September 2015 an action plan developed to explore and agree opportunities for increasing use of technology to support care closer to home.

Listening to and increasing participation of patients

- By March 2016, federated localities to develop a locality based communication strategy including identification and training of community champions
- By September 2015 a comprehensive prevention plan will be adopted by partners covering the major areas of health and social inequalities.

Improving quality and Patients Outcomes by Integrated Working

- By September 2015 utilising Community Hospital Site Groups, Better Care Together and the Alliance identify

opportunities at a locality level to develop out-of-hospital services to provide care closer to home

- By March 2016 through collaborative working with community, social care and voluntary sector colleagues develop an integrated team approach to patient care at a locality/virtual ward level.

Prescribing and Medicines Optimisation

As a CCG, we will build on our LLR 2014/15 Medicines Optimisation and Prescribing Strategy to support the continuous quality improvement of prescribing and medicines management to secure better patient outcomes for our patients. We will:

- By March 2016 deliver QIPP efficiency savings as stated in the Prescribing Growth and QIPP assumptions document
- By the end of September 2016, implement a PLT event for healthcare professionals promoting best practice relating to quality and safety in prescribing
- By March 2016 undertake a maximum of 50 proactive care medication reviews
- By September 2015 Improve antibiotic prescribing in primary and secondary care by appointment of a Primary care Antimicrobial pharmacist

Delivering these initiatives will support the delivery of a strong and effective primary medical care and builds upon the progress made since the CCG was created three years ago. We have ensured that Primary Care remains at the heart of meeting patient's needs and is at the heart of wider primary care in the community meeting these needs. It is exciting times with the development of Federations and the opportunity this gives to further develop and grow multi-disciplinary teams at a local level.

Three Bullets:

- Support the delivery of a strong and effective primary medical care and builds upon the progress made since the CCG was created three years ago
- Primary Care remains at the heart of meeting patient's needs and is at the heart of wider primary care in the community meeting these needs
- Develop Federations to fully utilise the opportunity this brings to develop and grow multi-disciplinary teams at a local level

Impact on national priorities

NHS Constitution

18 Week RTT Admitted Pathways < 18 weeks
18 Week RTT Non-Admitted Pathways < 18 weeks
Patients should be admitted, transferred or discharged within 4 hours of their arrival at an A&E Department (AD)
Improved Access to Psychological Therapies (IAPT) - Proportion of people who enter treatment against the level of need within the population

NHS Outcomes Framework Indicators

2.6.i	Estimated diagnosis rate for people with dementia
3a	Emergency admissions for acute conditions that should not usually require hospital admission
4a	Patient experience of primary care (i) GP Services
4.4	Access to (i) GP services
4.6	Bereaved carers' views on the quality of care in the last 3 months of life

3 Reducing Pressure on Emergency Services

Introduction

There continues to be significant pressures on Emergency Departments across the country, including Leicester, Leicestershire & Rutland (LLR). Although we have seen recent improvements in performance, some people still have to wait longer than the 4-hour wait standard in Leicester Royal Infirmary's Emergency Department. We also have issues where people stay in local acute and community hospitals longer than needed

West Leicestershire CCG along with its partner CCGs and University Hospitals of Leicester NHS Trust commissioned Dr Ian Sturgess to look at the whole healthcare system and following his recommendations, an LLR-wide action plan has been drawn up which will ensure a targeted and collaborative urgent care approach across the local health economy.

Achievements

A range of new services and enhancements to current services were launched during autumn 2014 with the aim of providing care close to home and enabling people to avoid being admitted to hospital wherever possible. These services were as follows:

- From 1 September - 31 December 2014, the Overnight Nursing Assessment Service has supported 112 individuals in their own homes who had overnight needs that otherwise would have been admitted to hospital
- From April 2014 a Specialist Nursing Support Team provided dedicated training and supported implementation of the "Falls Decision Tree" in Care Homes to specifically target admission avoidance
- The Rapid Access Heart Failure clinic saw 150 patients from April to the end of November 2015
- By the end of March 2015, East Midlands Ambulance Service will have trained 120 Paramedics in "Falls Management" to support individuals who have had a fall to recover and remain out-of-hospital.
- Building on the October 2013 model, a new specification was issued for the Acute Visiting Service (AVS) in August 2014 to support General Practice in carrying out home visits for patients presenting with acute conditions, falls and

breathlessness who the GP considers are at risk of admission. Since the service started 1,023 patients have been referred with less than 10% having to be admitted

- We have enabled the local provision of safe and effective treatment for patients with urgent care presentations at Loughborough Urgent Care Centre whereby 32,809 patients have been seen and treated since April to December 2014
- The Older Persons Unit (OPU) opened at Loughborough Community Hospital on 1 October 2014, by Friday 13th February 2015, 141 frail older people were supported and managed in the community
- LLR development of a 2014/15 winter plan that supported delivery improvements over such a critical period that helped manage the winter challenge in the LRI.

Situation

To properly address the local challenges, we have developed an internal implementation board called 'out-of-hospital care', where all urgent care pathways are reviewed against performance metrics to determine effectiveness of commissioned services, gaps in provision that effect patient experience and using a rapid improvement cycle, bring about change that can be implemented at scale and pace.

The CCG works with partner agencies and organisations to co-produce shared plans through the Leicestershire County Better Care Fund work. Work will continue over 2015 and into 2016 to ensure engagement at a local community level, at the system level across the wider CCG and where applicable the whole Leicestershire County, Rutland and Leicester City area.

Prevention of inappropriate secondary care service use remains a crucial element of the planned approach to reducing pressure on emergency services working with Public Health and other partners in taking forward the Leicestershire Unified Prevention offer (Better Care Fund). The CCG already adopts a risk stratification secondary prevention approach that is fully embedded into our proactive care approach, working with patients in primary care to enable early interventions that reduce the risk of crisis and promote self-management.

Our Better Care Fund has a prevention programme that supports joint health and social care metrics. Through Local Area Co-ordination (LAC) we will make local communities resilient, reducing the inequalities that come from not linking health and housing issues. Eight local workers will work in

communities linking and navigating people between health, social, housing, voluntary and community offers to ensure that local inequalities do not translate into poor outcomes for people. This programme is targeted at the most disadvantaged people in the West Leicestershire

Plan Intentions

Building upon services already developed the approach for 2015/16 seeks to:

- Upon programme completion at the end of March 2015 evaluate our individual winter schemes and those across the LLR Unit of Planning in Q1 to ensure system resilience for Q3. We have committed £2.022m based on what we already understand worked well last year.
- As an ongoing commitment throughout the year continue to evaluate the effectiveness of community based services in providing care closer to home
- Developed in early 2015 a new multi-disciplinary team based at Leicester Royal Infirmary to review patients at the point of admission, diverting to community services those suitable, and ensuring those that do require admission get specific support necessary to smooth their hospital journey
- Follow a phased implementation plan over 2015 to increase utilisation and coverage to the Older Persons Unit and the Overnight Nursing Assessment Service reporting quarterly to BCF with formal stock takes against set benchmarks for delivery
- Evaluate the effectiveness of new pathways at

  Loughborough Urgent Care Centre (LUCC) for

  Hyperkalaemia, self-presenting chest pain and infections so that by April 2015 more patients with more complex health needs can be seen and treated safely out of hospital
- Encourage patients who experience appendicular skeletal fractures or injuries to make use of the diagnostics and treatment at LUCC and extended x-ray provision within the hospital thereby reducing unnecessary ED attendance
- By the end of March 2015 reach agreement on the CQUIN to progressing the collaborative approach with EMAS and community based providers to divert activity out-of-hospital so that by the end of March 2016 patients will be seen and treated locally
- To enable a new service in place by March 2016 work is now being undertaken with the East Midlands CCG congress to

ensure that the most resilient 111 option is secured on a regional that reduces diverts to A + E departments and increases non-conveyance options by our 999 providers

- The development of 7 day services since September 2014 has provided additional information on what an OOH's home visiting service and UCC's need to deliver to maximise primary care ownership of their registered population. By March 2016 a more local ownership of OOH's services will be developed as a result through federated primary care

  service models and stronger links to our local urgent care

  centres will be developed through this piece of work.

Delivering these initiatives will make a significant contribution to improved patient flow and minimising inappropriate use of acute services. The delivery ensures improved patient access, equity of access and quality of patient care. Much of this work benefits vulnerable groups particularly such as Frail Older People and helps these individuals stay healthy for longer, recover quicker and when requiring treatment and support ensuring this is provided in their own home or as close to home as possible avoiding, wherever possible, admission to hospital.

Three Bullets:

- Ensure a joined up approach with health and social care partners to address the urgent care challenge
- Reduce inappropriate use of secondary care by commissioning effective admission avoidance services
- Forge stronger links with our communities to address local inequalities through our Better Care Fund programmes

Impact on national priorities

NHS Constitution

Patients should be admitted, transferred or discharged within 4 hours of their arrival at an A&E Department

NHS Outcomes Framework Indicators

2.3.i	Unplanned hospitalisation for chronic ambulatory care sensitive conditions (adults)
2.3.ii	Unplanned hospitalisation for asthma, diabetes and epilepsy in under 19s
3a	Emergency admissions for acute conditions that should not usually require hospital admission
3b	Emergency re-admissions within 30 days of discharge from hospital
	Preventing lower respiratory tract infections (LRTI) in children from becoming serious
3.2	Emergency admissions for children with lower respiratory tract infections (LRTI)

Integrating discharge and reablement support

Introduction

Waiting to leave hospital can be very frustrating for those recovering from an illness. Delays stem from a variety of causes including poor co-ordination of services, delays in identifying appropriate support, process delays, a shortage of on-going therapeutic support, and issues with accommodation. During 2014 the percentage of people who experience a length of stay of at least 11 days has increased by 19%, at an additional cost of £2.4m.

In the planning of our Better Care Fund we have paid particular attention to developing integrated options that aim to improve this poor patient experience. During 14/15 we have significantly increased our resources into this specific area of care adding over £800K to our resources shared between health and social care. Added to this we have taken patient feedback on board. People waiting for discharge do not understand the differences between health and social care, so through our plans we have become more organisationally agnostic. This has led us to developing shared operational procedures for these shared resources. We have also added investments to this area from historic underspends in our Health transfer Funds to develop review teams to reduce the numbers of days that people will be delayed in their onward care journey.

Achievements

During 2014/15 the following developments took place:

Help to Live At Home Project - element 1

- A comprehensive action plan has been drawn up to improve discharge and home care services including adopting recommendations from recent reviews by Dr Ian Sturgess and John Bolton. This comprises:
- Recruiting more staff to concentrate on discharge from hospital (in reach)
- Investing in staff to review care plans 2 weeks after hospital discharge
- Process improvements in adult social care, cultural change to promote more self-care/use of community based assets ahead of statutory support.

Help to Live at Home Project - element 2

- Develop the joint commissioning capability across health

and social care re-modelling domiciliary care services in the medium term

- Decisions about progress were approved by the Integration Executive Board
- Design, Specification and Procurement taken forward from January 2015.

Integrating Single Points of Access (SPA)

During 2014 a benchmark baseline overview of existing SPA/call centres across LLR was collated and is now used to measure progress

- By the end of December 2014 a dedicated SPA GP Line saw drop calls minimised and response times fall below 30 seconds
- Led by BCF, with input from the City and support from BCT, there is now an agreed approach and direction of travel to sustain the developments that delivered this improvement and maintain this level of service during 2015/16
- A full business case is being drafted to be considered at the March Integration Executive in January with a view to a business case by end of March 2015.

Situation

As outlined in the previous section, "Reducing Pressure on Emergency Services", it is a top priority for the CCG to ensure we continue to do all that we can to relieve this pressure by reducing delays in transfers of care and offering consistent discharge/transfer pathways with a "home first" focus.

The CCG works with partner agencies and organisations co-producing shared plans. Much of the work forms part of the Leicestershire County Better Care Fund work which is co-delivered by West Leicestershire and East Leicestershire and Rutland CCGs with Leicestershire County Council. Where the work can be taken forward on a county basis, or on a LLR basis, it is, but the local focus of WLCCG remains working with its local population to meet their needs in an out of hospital setting. All of the work shares planning and delivery resources, co-producing and delivering services, maximising the efficient use of resources.

The work is supported by an empowered patients approach, outlined in detail in work-stream 1 "Empowering Patients to Shape Services and their Care". The benefits from engaging patients to help understand needs, to inform the development of service models and to calibrate services changes we have made, are beginning to accrue. Work continues with this

approach that ensures that the whole community will benefit from equality of access to our discharge and transfer services. We have particularly focused on ensuring the fitness of all services to meet the needs of our vulnerable people who find it difficult to access services traditionally. We have seen this approach deliver real benefits in the development of our local 5 year plan (Better Care Together), allowing us to gain traction and new consensus in areas where we previously struggled to make headway and we are working with the momentum gained through this programme to make progress in this area.

To reduce delays and improve patient experience, we propose that when the patient is medically fit to leave hospital they should not have to remain in hospital whilst longer term reablement is arranged. Instead, we look at the risk of moving patients into another setting for their on-going care needs. This results in patients being transferred through one of three pathways:

Pathway 1: those who are safe to go straight home with support

Pathway 2: those who require some night support to be safe at home

Pathway 3: those at high risk of entering CHC services. These three pathways form what we have called “Discharge to Assess”

Plan intentions

Developments for 2015-16 include:

Building upon the changed culture to promote "Home First" principles and employing safe transfer options, using the "Safe Minimum Data Set" to refer patients to intermediate care or reablement packages implementation March 2016 (care act compliant)

Ensure a new procurement process for the community equipment service is taken forward to ensure a new contract is in place by March 2016.

Develop Community Equipment Service Specification by end of June 2015

By end of September 2015 start using the “Patient Transfer Minimum Data Set” tool to deliver a 3 day reduction in process time for older adults, amounting to a 15% reduction in length of stay for patients who remain in UHL for more than 15 days

By end of September 2015 ensure that 50% of older adults who need support to leave UHL after a spell of care are transferred under pathway 1 and 2

By the end of March 2016 to increase efficiency of intermediate care services by 5% through the combination of multiple specifications into a single service specification. (2014/15 efficiency out-turn)

Work with our local authority partners through our BCF plans to ensure that there is a safe and enabling resilient home care market available in sufficient quantity to reduce the 'wait care list' held by the LA. This will ensure safe and timely discharge home for people.

Ensuring referrals into continuing healthcare are appropriate, which is expected to lead to a reduction in referrals of 10% by end of March 2016

By 1st April ensure both short-term and long-term plans are in place so that children and adults who are admitted to hospital are discharged efficiently and effectively as soon as it is safe to do so

Better Care Fund Outcome Metrics

All of the above is aligned to the BCF plan and will help to deliver the plan metrics. The specific BCF Plan metrics are:

- Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population
- Proportion of older people (aged 65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services
- Delayed transfers of care from hospital per 100,000 population (average per month)
- Avoidable emergency admissions (composite measure)
- Patient/service user experience
- Injuries due to falls in people aged 65 and over.

People with learning disabilities and mental health needs

Our pathways will work for all disadvantaged groups and will be designed to meet all health inequalities. E.g. people with learning disabilities who are on the Care Programme Approach would be a readily identifiable group who will access services equitably.

Children and young people with learning disabilities

Children and young people who have significant health needs will be offered personal budgets (or personal health budgets) to enable them to remain living in the community and avoid out of area placements.

Delivering these initiatives will make a significant contribution to integrated discharge and reablement leading to improved patient flow and minimising inappropriate excessive use of acute services. The delivery ensures improved patient access, equity of access and quality of patient care. Much of this work benefits vulnerable groups particularly such as Frail Older People and helps these individuals exit hospital quicker, to more appropriate support programmes and wherever possible their own home.

Three Bullets:

- Improve patient flow through the healthcare system and best use of our resources
- Ensure equity of access for all patients to high quality services
- Promote a "Home First" ethos and care closer to home

Impact on national priorities

NHS Constitution

Patients should be admitted, transferred or discharged within 4 hours of their arrival at an A&E Department
Delayed Transfers of Care (DTOC)
Number of patients discharged as a % of occupied bed days (Better Care Fund)
NHS Outcomes Framework Indicators
3a Emergency admissions for acute conditions that should not usually require hospital admission
3b Emergency re-admissions within 30 days of discharge from hospital
3.4 Proportion of stroke patients reporting an improvement in activity/lifestyle on the Modified Rankin Scale at 6 months
Helping older people to recover their independence after illness or injury
3.6.i Proportion of stroke patients reporting an improvement in activity/lifestyle on the Modified Rankin Scale at 6 months
3.6.ii Proportion offered rehabilitation following discharge from acute or community hospital

5 Managing complex and multiple long term conditions

Introduction

A proactive approach is followed whereby individuals most at risk of being admitted to hospital or those who are likely to experience a health crisis are identified through a risk stratification tool. This cohort of patients will benefit from high impact cost effective interventions. Working together with the individual, the GP practice and wider care team agree on the support they need to manage their condition, improve the quality of their care and identify the help they need to maintain independence and control of their lives. The engagement with the individual is ongoing and ensures the health risk is kept at bay and supports self-management of their condition.

Our ageing population and associated growing demands upon healthcare present a major challenge. Effective management of Long Term Conditions (LTCs) is a "must do" to ensure good health care provision and wise use of our resources. Our model of care for managing complex and multiple long term conditions is based upon national and international evidence of best practice, and is called Proactive Care. It supports the CCG's overall drive to move unscheduled clinical presentations towards scheduled/planned interventions within the patient's own home, general practice and local community.

Achievements

Through the practice appraisal process we can demonstrate a year on year improvement in QoF prevalence as shown in the table below:

	2010/11	2011/12	2012/13	2013/14
COPD Prevalence	**1.51 (5520)**	**1.56 (5756)**	**1.64 (6087)**	**1.69 (6230)**
Diabetes Prevalence	**4.46 (-16329)**	**4.63 (17091)**	**5.1 (18912)**	**5.3 (19626)**
End of Life Prevalence	**0.11 (323)**	**0.22 (822)**	**0.33 (1214)**	**0.49 (1828)**

- We supported the identification and out-of-hospital management of patients with complex long term conditions (LTCs) by offering primary healthcare professionals training programmes for Heart failure, Atrial Fibrillation, Respiratory disease and Cancer Survivorship by March 2015.
  1. 125 GPs completed the Heart Failure and Atrial Fibrillation training programme
  2. 60 GPs have completed the Respiratory Disease training programme
  3. 117 GPs have completed Cancer survivorship by March 2015

Through the development and expansion of specialist nursing and rehabilitation teams we have achieved a reduction in the number of patients being admitted as an emergency admission due to:

1 Stroke, by an average of three a month when compared to 2013/14

2 Heart Failure by an average of 16 a month

3 Diabetes by an average of nine a month

- We delivered a bespoke end of life on-call service so that patients in their last days of life are offered the support of their usual GP practice at any time as a pilot which we will expand in 2015.
- 5,800 care plans have been developed and agreed between the accountable GP and vulnerable patients to promote wellbeing and management of their conditions and reduce the risk of an avoidable emergency admission by understanding what to do in a crisis
- We rolled out Sound Doctor to all 50 practices which offer on line advice and education for patients with COPD, Diabetes and back pain. 706 patients have used this service up to December 2014
- We have developed Pre diabetes register in primary care to identify patients at risk of diabetes and proactively manage their health

Dementia

- The introduction of Shared Care arrangements as of 1 April 2015 that enables individuals with dementia who have been supported by specialist services to exit this service and be supported by primary care with input from the community based services
- Also from 1 April 2015, a dedicated hospital-based Dementia Support service to support affected individuals who are admitted, resulting in improved quality of care, and reduced length of stay which, currently, can be twice as long for those with dementia compared to those without

Situation

The CCG believes that the formation of federations of practices provides the opportunity to maximise the proactive care approach already in place, to align the work of health and social care teams moving towards a Multi Speciality Community Provider model (MSCP). General practice is well positioned to take a population health approach because the registered list provides GPs with a stable cohort of patients who live in a defined geographical area, both at individual practice and locality level. Equally important, GPs and their teams are an integral part of their local communities and can work in partnership with patients, voluntary and charitable

organisations to co-produce services that deliver equity and reflect the diverse needs of local populations.

Alcohol and Drug Misuse

Services for alcohol and drug misuse are directly commissioned by Public Health. However, the serious health and social impact of alcohol and drug misuse means that we are committed to joint working in order to:

- Support health promotion initiatives around sensible drinking and the dangers of drug misuse, including addiction to medicines and new addictive drugs
- Promote screening in primary care for alcohol misuse and delivery of brief interventions
- Support shared care in General Practice for drug misusers
- Improve clinical pathways for alcohol and drug problems including so-called "dual diagnosis" where there are co-existent mental health problems. We have taken a leading role in the collaboration of stakeholders for the Crisis Care Concordat which cites pathways for dual diagnosis as a priority
- Secured clinical interfaces between community and criminal justice systems of care for these patients

Autism Spectrum Disorder [ASD]

A long standing gap in the provision of suitable services to meet the needs of adults with ASD has been recognised nationally (Autism act 2009, Adult Autism strategy 2012). We are responding to this through joint working between Primary care, Adult Mental health and Learning Disabilities services and the three Local Authorities to develop ASD-specific care pathways based on NICE guidance. Key deliverables include:

- Completion of Autism Self-assessment Framework
- Continued development and delivery of the Winterbourne View response
- Improved access to diagnosis and post-diagnostic support for ASD including Asperger's syndrome
- Improved training of front-line professionals in ASD
- Improved carer support.

Plan intentions

We will further develop effective pathways for people with LTCs and end-of-life needs, building personalised care and

support into these pathways so that more people experience control of their condition and care. This will be achieved through:

- Learning from the quality audit of Directed Enhanced Service care plans commissioned during 2014, in order for us to have processes in place to enable fully interoperable digital care plans for 2% of patients at risk of avoidable emergency admissions by April 2016.
- By July 2016 ensure care and support planning and person-centred outcomes are built into service specifications and existing LPT CHS contracts
- Ongoing commissioning of "Sound Doctor" to offer online access for patients with dementia and their carers by April 2015; cardiovascular disease by September 2015; and continue the offer of existing LTC information so that by April 2016 1,400 people will have accessed this online resource
- Commissioning a community-based service by June 2015 we will increase the number of housebound patients on general practice register (estimated 0.5% of the practice list size) who have care plans and tailored supported interventions to enable them to live safely and independently
- By July 2015 commission an out-of-hours service that supports patients in their last days of life enabling them to die in their preferred place of death and avoid unnecessary hospital admissions

Dementia

- A year-long planned rolling programme of support for GPs, Care Homes and other health and social care professionals to develop their understanding, knowledge and confidence in caring for individuals with dementia
- Ongoing programme of support for GPs to identify and diagnose dementia as early as possible raising the CCG rate of diagnosis to the national standard of 67%
- Continued development of the Local Authority co-commissioned community based dementia support service, provided by Alzheimer's Society, supporting Primary Care, other health and social care professionals, patients and their families so that all primary care practices are making full use of this service

Joint working between commissioners and providers

- Enabling early identification of crisis for patients residing in care homes through planned weekly GP visits, ongoing

reviews of care plans and up-skilling care home staff with tools to check for change in the patient's conditions so that by March 2016 there will be a 10% reduction in avoidable emergency admissions from care homes

- The emerging federations, review the usage of the risk stratification tool alongside the effectiveness and alignment of the Virtual Ward approach, to further develop integrated community health and social care teams to maximise the out-of-hospital offer to our patients
- Developing a Respiratory Virtual Review service by September 2015
- Developing a Complex COPD MDT Service between secondary care specialists, community respiratory nurses and GPs to manage patients proactively at home by September 2015
- Developing a Stroke and Neurology Community based Rehabilitation Team from Autumn 2015, ensuring all cases are reviewed in line with National Institute for Health and Care Excellence (NICE) guidance

Maximise use of technology and innovation

- Following the evaluation of the care home virtual consultation offer a range of tele-consultations to all practices so that by March 2016 on line consultations will be available to patients and healthcare professionals across the CCG
- Supporting clinical discussions and decision-making by working through a model of teleconferencing with geriatricians and other specialists so that by March 2016 teleconferencing capability will be available to multi-disciplinary teams across primary, community and secondary care

Delivering these initiatives continues to build upon the successful adoption of a proactive approach towards managing the challenges of complex and multiple long term conditions. Utilisation of the risk stratification tool and ensuring the most in need people are prioritised in the system to be seen, treated and supported. The work enables individuals to maintain independence, exert control over their own health and well-being and develop an ongoing engagement with health care provision that supports them at the appropriate level of need.

Three Bullets:

- Build upon the successful adoption of a proactive approach towards managing the challenges of complex and multiple long term conditions
- Utilise the risk stratification tool to ensure the most in need

people are prioritised in the system to be seen, treated and supported.

- Enable individuals to maintain independence, exert control over their own health and well-being and develop an ongoing engagement with health care provision that supports them at the appropriate level of need.

Impact on national priorities

NHS Constitution

18 Week RTT Admitted Pathways < 18 weeks
18 Week RTT Non-Admitted Pathways < 18 weeks
Patients should be admitted, transferred or discharged within 4 hours of their arrival at an A&E Department
Improved Access to Psychological Therapies (IAPT) - Proportion of people who enter treatment against the level of need within the population

NHS Outcomes Framework Indicators

1.1 Under 75 mortality rate from cardiovascular disease
1.2 Under 75 mortality rate from respiratory disease
1.3 Under 75 mortality rate from liver disease
1.4 Under 75 mortality rate from cancer
2 Health-related quality of life for people with long-term conditions
2.1 Proportion of people feeling supported to manage their condition
2.3.i Unplanned hospitalisation for chronic ambulatory care sensitive conditions (adults)
2.3.ii Unplanned hospitalisation for asthma, diabetes and epilepsy in under
2.6.ii A measure of the effectiveness of post-diagnosis care in sustaining independence and improving quality of life (dementia)
3a Emergency admissions for acute conditions that should not usually require hospital admission

6 Improving Mental Health Services – delivering parity of esteem

Introduction

The mental health pathway continues to be under significant pressure, particularly in acute and crisis services. There is a major system challenge with ready access to crisis services for people of all ages. This can sometimes lead to some people seeking help at accident and emergency and adding to demand on this service. Demand upon service, extended lengths of stay in hospital for some and delays in transfers of care, has sometimes resulted in out of county services being required to meet need. Service pressures also have contributed to CQC reports identifying significant system challenges for the CCG to meet in ensuring we provide quality services.

Work has already begun to meet these challenges and to make the service and system improvements necessary to meet need and deliver quality services. The Leicestershire CCGs have worked together in commissioning an independent external service review of adult mental health to inform strategic planning which has shaped the approach now being followed and outlined in this plan. Work has begun and progress is being made with 2015/16 being a year for further development and improvement. Key challenges for the year ahead are identified as:

- Timely access
- Demand management and maximising efficiency of current provision
- Reduction in out of area placements
- Reduction in the stigma of Mental Health
- And equity of service with physical health provision

Changes are being supported by a new approach to contracting that adopts a shared risk approach between Service Providers and Commissioners. This change and the system improvements were agreed following a process of co-production between service users, service providers and Commissioners and are universally supported.

In addition over the last year we have seen an increase in the number of referrals to CAMHS with higher level of need resulting in a greater demand on CAMHS services. We will co-produce with our users, providers and local authority colleagues to develop new pathways to ensure improved access and quality services for children and their families.

All this work forms a crucial part of our local plans but also of our 5 year plan Better Care Together. In developing the 5 year BCT workbook, additional investments were identified for mental health which come on stream this year. The focus of these investments is to reduce the inequalities of opportunity that mental health patients face and to address the inequality of life expectancy this leads to.

Achievements

- Over the last year 17 people who were in rehabilitation settings not best suited to meet their needs were found more appropriate alternative care that helped them to get on with their lives in their new homes, with the support they needed
- We opened a new service on 3 November 2014 that provides step-down beds to help people re-integrate into society who cannot go straight home after their episode of mental ill health
- As of 1st April we made substantive the previously funded as a pilot police triage car. By placing mental health professional support alongside police officers, this helps people with mental health conditions that come into contact with the police and ensures their problems are resolved in a simple direct way
- Also as of the 1st April we started working with a new provider for Improving Access to Psychological Therapy services (IAPT). The new service makes it easier for people to access help by enabling them to self-refer directly to the service
- During 2014 additional investment was made to increase the number of nurses in the acute mental health wards so that when people are most ill they have dedicated one-to-one time with a named nurse. This investment reduces the amount of time they need to spend in hospital by providing good quality care.

Children's

- We have increased funds to Child and Adolescent Mental Health Services (CAMHS) to enhance access to a telephone service providing professional advice
- We provided specialist training for front line staff on child mental health
- An agreement was made to move children's inpatient mental health care from Oakham House to Coalville Hospital from April 2015 on a temporary basis while a new

long term base is found

- An independent review of CAMHS Community Service was commissioned and completed. This resulted in a plan to improve process and access for young people
- Funding was given to educational psychology and social care to improve access to family therapy.

Plan intentions

Prevention

As part of our LLR Better Care Together work which is also part of our Leicestershire County work with the Public Health led Unified Prevention Board, we have a planned approach towards mental health prevention and good health and well-being maintenance. This work also seeks to identify and make better use of resources to support development with recent successes in supporting a roll out programme of Mental Health First Aid training to non-mental health professionals.

Acute and Crisis Care for Adults

- Launched in early 2015 a new mental health crisis service for adults, run by Leicestershire Partnership Trust, based at the Bradgate Mental Health Unit has made access simpler, clearer and more streamlined resulting in increased GP utilisation. This will meet the national 4 hour standard as outlined in the Mental Health Crisis Care Concordat.
- This new crisis service directly links with new "Crisis House" due to open in March 2015 to offer an alternative to emergency secondary care admission. The Richmond Fellowship, a registered charity, will deliver the crisis house service which is based in Ratby.
- A recent new mental health provision in our accident and emergency department has been developed which over the next six months will be further developed to offer a more integrated physical and mental health service including strong liaison psychiatry services in the acute sector
- Over 2015-16, we will remodel our LPT provided community mental health teams to improve the range of care available locally within the community and also to allow an urgent response to be provided within 5 days. Again this work is part of the CCG focus but also ties into the LLR BCT work and will ensure consistent growth and development across the area to deliver parity of esteem.
- Finally the work delivered through the Better Care Together programme we will act to reduce the gap in life expectancy for people with severe mental illness and this will be a key

metric used to measure progress in our health care system.

Dementia

Plans to improve the dementia pathway are covered in the Long Term Conditions section of this plan and forms part of the BCT Frail Older People work. Mental Health provision supports this approach and where the condition is mental health related, picks up the lead responsibility and manages the transition.

Information Technology

The new service for IAPT will continue to increase the use of technology to make the service more efficient to meet the national access and recovery targets. This will use text messaging and social media apps to connect with patients to help them through their treatment. A user friendly website means patients can access the service whenever they need to.

Children's Mental Wellbeing

Families and children have told us that they struggle to receive the service they need. To address the issues raised we plan to do the following:

- Commission a counselling service for children and young people
- Establish a specialist community eating disorders service for children and young people
- Implement improvements to the CAMHS community service to address waiting times, access and discharge processes
- Ensure that specifications are in place for all Tier 2 and Tier 3 CAMHS. Specifications to include referral time targets, key performance indicators and outcome.

Early Intervention in Psychosis

NHS England has set a national target that for 2015/16, 50% of people experiencing a first episode of psychosis will have access to specialist treatment within two weeks of referral and receive treatment in line with NICE guidelines. To achieve this we will give additional funding to Leicestershire Partnership Trust to meet these outcomes.

The plan is designed to deliver progress against the five key areas of focus identified in the introduction;

- Timely access
- Demand management and maximising efficiency of current provision

- Reduction in out of area placements
- Reduction in the stigma of Mental Health
- And equity of service with physical health provision

Each of the programmes and initiatives contribute to specific areas of delivery the cumulative impact upon the key areas and contribute to the overall improvement of quality and performance in mental health.

Three Bullets:

- Increased efficiency within mental health services that manages demand appropriately, includes timely access and therefore provides services that are equitable to physical health provision
- Reduction in placements made out of area
- A reduction in the stigma associated with mental health problems

Impact on national priorities

NHS Constitution

Care Programme Approach (CPA): The proportion of people under adult mental illness specialties on CPA who were followed up within 7 days of discharge from psychiatric inpatient care during the period
The proportion of the people that enter treatment against the level of need in the general population - i.e. the proportion of people who have depression and/or anxiety disorders who receive psychological therapies
Improved Access to Psychological Therapies (IAPT) - Proportion of people who enter treatment against the level of need within the population

NHS Outcomes Framework Indicators

1.5 Excess under 75 mortality rate in adults with serious mental illness
1.7 Excess under 60 mortality in adults with learning disabilities
2.5 Employment of people with mental illness
2.6.i Estimated diagnosis rate for people with dementia
• Dementia CQUIN Find
• Dementia CQUIN Assess and Investigate
• Dementia CQUIN Refer
2.6.ii A measure of the effectiveness of post-diagnosis care in sustaining independence and improving quality of life (dementia)
4.7 Patient experience of community mental health services

7 Planned Care

Introduction

We generally have good quality planned care in West Leicestershire. Our patients benefit from choice of planned care provision available in local community hospitals in addition to that available in several acute trusts. However, we still have a challenge to reduce waiting times, both for being seen and for being treated.

Achievements

- 2014/15 we commissioned an Alliance contract which incorporates partnership working between ourselves and several local providers. This allows us to co-produce and co-commission effective care pathways for local people.
- The local population worked with us to choose the alliance providers and design the pathways for change. This co-production removed waste from the system and has saved £1.6 million.
- We have communicated with our GPs to make them fully aware of what is available locally to meet their population's needs. This has helped us resolve on a micro-scale some of our local issues around waiting for care which has enable UHL to reduce waiting times and numbers waiting.
- We have worked with UHL to offer choice to patients on their follow-up appointments, with self-determined treatment pathways
- We have worked with 945 patients and stakeholders in Hinckley and Bosworth through Experience-Based Learning events to determine how best to configure local services
- There are site patient and stakeholders groups for all hospital sites across the CCG which have are configured to review how best to maximise utilisation of each site. The work is co-ordinated to overall development of planned care and is tuned to deliver as and when system change requires.

Situation

The level of capacity in the LLR system is under pressure to meet the needs of the population. As elsewhere in the country, the growth in Urgent Care demand has affected our ability to offer consistent support to people within the 18 weeks that is their right to expect.

We have worked collaboratively across the system with our providers, fellow CCGs and patients to co-produce the best plan to improve this situation. This co-production piece is overseen by an RTT board which reports its outcomes to the system so improvements can be measured. This has given us sufficient confidence to be able to plan recovery trajectories that see us achieving RTT standards for our population from April 1.

Plan intentions

- By August 2015 we will have developed a referral hub. This will use information technology, i.e. PRISM (Pathway and Referral Implementation System) to offer consistent pathway and standards information to ensure patient referrals go to the right clinician first time. By the end of March 2016 we will evaluate the impact on patient satisfaction, reductions in RTT wait times and efficiencies in UHL's resource deployment.
- By end of June we will have joined up to the regional response of effectively managing our resources through service entry thresholds as we work through the opportunities PRISM presents. Ensuring patients utilise all appropriate community services before entering the acute system will increase efficiencies, improve patient outcomes and help maintain RTT waiting times.
- Over the year we are following a phased reduction in the level of dependencies of the settings of care that people receive support in. Our patients have said they want their surgical interventions to be closer to home and to minimise the disruption to them. So we, with their support, are moving inpatients spells to day case, day case to outpatient procedures or clean rooms and also reducing the need to acute follow up appointments where appropriate.
- Over the year we are following a phased programme of work to move activity closer to patient homes where appropriate utilising capacity and skills within primary care and local community hospitals.
- The CCG will work with the Alliance Partnership to move more Ophthalmology, ENT, pain management and hernias into community and Primary Health care services and will explore further potential options to move more care into local community hospitals and Primary Care across 6 prioritised specialties.
- As part of the West Leicestershire CCG Primary Medical Care Plan we are following a phased approach for increased primary care and community provision of MSK services, which will include a system of primary care triage to reduce

referrals for Trauma and Orthopaedics

- As part of the West Leicestershire CCG Primary Medical Care we are pursuing a planned approach to estate management investing in our capacity to enhance delivery
- The RTT board are moving to fortnightly meetings where we fully engage partners to maintain the mandated standards we have worked so hard to recover. Eventually it is expected that reductions in waiting times and consistent quality of care will deliver natural repatriation of activity into the county from surrounding hospitals.
- As of the first quarterly report we will incorporate Cancer performance management within the remit of the RTT Board to ensure senior level oversight of issues and that appropriate action is taken by both providers and commissioners to ensure delivery of cancer waiting time standards.
- To support the Hinckley and Bosworth future configuration development programme data gathering is due to complete by the end of March 2015. This will then enable a future timeline for programme development to be agreed and followed that enables the programme to be completed by the end of the year.

This will support delivery of RTT to national standards from quarter 1.

In addition this will deliver significant activity moves for three specialities into community / primary care settings.

Three Bullets:

- Referral To Treatment is to be maintained within national targets from quarter 1
- Hinckley and Bosworth options appraisal to be completed and consulted upon if required
- Significant activity from three specialities to be shifted into community / primary care settings

Impact on national priorities

NHS Constitution

18 Week RTT Admitted Pathways < 18 weeks
18 Week RTT Non-Admitted Pathways < 18 weeks
Diagnostic Waits < 6 weeks

NHS Outcomes Framework Indicators

3.1	Total health gain as assessed by patients for elective procedures
4.1	Patient experience of outpatient services
4.8	Children and young people's experience of outpatient services

8 High Quality Care

Introduction

Our ambition in WLCCG is to offer patients the very best care we can within the resources we have. Our focus is always that people are the centre of our care. In order to understand the quality of care from the providers of services we use a range of activities to improve the quality of care. To do that we use robust methods including: contracting, monitoring and reporting, and where we use the learning from complaints and adverse incidents to improve health outcomes for people.

Achievements

Our achievements in 14/15 include the following:

Patient Experience:

- Led on the outcomes from the Learning Lessons to Improve Care review to ensure that patient experience, safety and outcomes inform our commission activities
- Recruited an additional Patient Leader to work in equal partnership and collaboration with our clinical and managerial leaders in the CCG and strategically respond to 'Creating a Revolution in Patient and Customer Services Experience'
- Monitored patient experience of our providers through national and local surveys and patient feedback, including the national Friends and Family Test (FFT), introducing the Loughborough Urgent Care facility to the FTT, reporting via the NHS Contract to understand the patient experience of urgent care and identify areas for improvement for timely access to urgent treatment

Patient Safety:

- Through contractual mechanisms for our provider services ensured compliance with the 'Duty of Candour', the robust monitoring of the NHS Safety Thermometer and other quality metrics, safeguarding adult and children arrangements, including MCA and DoLS are in place and monitored the safety of patient eligible for continuing health care funding in nursing homes and other residential settings
- Joined the 'Sign Up to Safety' national campaign to reduce avoidable harm by 50% over the next 3 years to demonstrate our commitment and high priority of patient safety in the CCG

- Delivered identified CCG priorities for Safeguarding that include prevention of female genital mutilation, sexual violence, domestic abuse, and the PREVENT agenda through multi-agency working and the LLR Safeguarding Boards for Children and Adults
- Led on Care and Treatment Reviews for people with Learning Disabilities from West Leicestershire as per the requirements for the 'Transforming Care Concordat,' and as a result of the Winterbourne View failings to identify people for more appropriate local community based services and ensured they are discharged to these community services

Improving Health Outcomes

- Led and driven the Chief Nursing Officer of England's six values of nursing (the 6Cs: compassion, courage, competency, commitment, care [quality/safety], communication) to improve health outcomes for people through developing capability and competence. This has resulted in the development of Practice Nurse mentors and NMC Sign-Off Mentors, an innovative pilot of Pre-Registration Nurse Placement in General Practice and the development of health care assistants in General Practice to support clinical staff in secondary health prevention and primary health promotion work. In addition, through the Better Care Together programme we will ensure the 6cs feature in all provider plans.

Situation

We have had a strong year of delivery focusing on the essentials of the Francis, Berwick and Winterbourne View reviews to ensure high quality and patient safety. Learning Lessons to Improve Care has been a strong challenge where we reviewed the quality of care for people at the end of their lives. We found it could be improved and have steadily addressed the specific issues of our system. We are taking forward clinical leadership challenges and service developments that were identified through this process. Patient safety and a positive experience of care forms the basis for all of our commissioning activities. We aim to reduce avoidable harm and learn lessons when care fails to deliver to the highest standard.

Plan intentions

Patient Safety

- As part of our ongoing commitment to reducing avoidable harm and safety prevention we will focus our work on 'Sign Up to Safety'. This aims to reduce harm and embed a culture

within the CCG that places patient safety at the heart of everything it does, The three priority areas within our action plan for year one of the three year campaign includes developing and implementing Primary Medical Services Incident Reporting, where we will create a patient safety culture through sharing of learning and Learning Lessons to Improve Care, through system-wide clinical leadership, patient engagement, effective care across provider interfaces

- The CCG will have clinical membership at the local Patient Safety Collaborative led by the Academic Health Science Network that will focus on empowering staff, patients and carers to co-produce, co design and co deliver local improvements in patient care
- We will reduce the incidence of Clostridium difficile to a maximum of 77 cases.

Safeguarding

- Following on from the Care and Treatment Reviews for people with Learning Disabilities and the Winterbourne Concordat for people in inpatient services, we will use the recommendations and actions from these reviews to ensure we can commission and provide patient centred alternatives to hospital, and where this work will be undertaken with local health and social care agencies to develop and provide to enable people to be closer to their families. Monthly reporting on the Care and Treatment Review outcomes will be provided to NHS England and updates will be provided to the Health and Wellbeing Board
- In line with our responsibility for safeguarding in light of the Supreme Court Judgment (Cheshire West) and the much wider definition of deprivation of liberty (DoL) for people in supported living / domiciliary care we will continue the work with the other LLR CCGs, the LLR Safeguarding Team, Leicester County Council and GEM CSU Continuing Health Care, and following the scoping exercise to identify those people who may meet the 'acid test', and for the Court of Approval, and to ensure the care we commission is DoL compliant.
- We will work with our partner agencies through the Local Safeguarding Children's Board to reduce the risk of child sexual exploitation
- We will continue to work with the LLR Safeguarding Children and Adult Boards to understand the quality of care experienced by vulnerable groups and where this work will include patient experience feedback data from the multi-agency Board membership to inform commissioning and

service delivery.

Quality Improvement and Monitoring for all CCG commissioned services

Through the NHS Standard Contract we ensure:

- The five safety pledges are embedded into existing quality and contractual processes for NHS Providers via the Clinical Quality Review Groups, Senior Leadership and Contracts Management and the WLCCG Quality Assurance Framework
- Clinical quality indicators within Providers Quality Schedules provide commissioner with evidence that they have a food and drink strategy in accordance with the Hospital Food Standards Report
- Sepsis and acute kidney injury, as two specific clinical priorities for improving patient outcomes for 2015/16
- Clear clinical accountability for patient safety is embedded within these organisations, and where this will be monitored to ensure learning into action via regular quality visits by commissioners
- Primary and secondary care providers validate their antibiotic prescribing data following the Public Health England (PHE) validation protocol
- Service delivery improvement plans (SDIPs) to implement at least five of the ten clinical standards for seven day services
- We will work with providers to embed the practice of clear accountability with a doctor responsible for a patients care within and across different care settings that fits with the Academy of Medical Royal Colleges guidance.

Improving quality and outcomes

- The CCG will ensure there are clear links and processes for identifying and implementing the revitalised National Quality Board priorities and work programmes, and the system wide quality improvements to measure quality across providers, and commissioning
- To strengthen our quality assurance mechanisms we will use the CQC inspection reports and ratings as they roll these out during 2015 and 2016, to seek assure of quality of care-learning from where care is good or outstanding. Where care requires improvement or is inadequate we will ensure local organisations co-produce agreed improvement plans that drive quality standards and outcomes-with stakeholders from social care, where appropriate to improve care
- For improvement in quality and outcomes for maternity

services further work will be completed in 15/16 as part of Better Care Together to include:

- Sustainable Long Term Models for Maternity
- Improved Access to Maternity and perinatal outcomes
- Neonates in the right cot at the right time

Patient Experience

- For the 'seldom heard groups' we will work closely with Healthwatch to focus on these groups of people and improve engagement to ensure better access to services for people with protected characteristics
- As part of our methods of engagement, we will review the NHS Citizen approach to engage local patients, the public and community who are interested in becoming more involved with their local NHS services and participate more fully in the decision making processes
- The CCG Chief Nurse and Caldicott Guardian will ensure that the CCG meets the Caldicott Review recommendations for information sharing through local sharing agreements and the Caldicott Log that is monitored via the CCG Quality and Performance Sub-Group.

Research and Innovation

- We will champion innovation, evidenced based practice and the adoption of research and innovation approaches to improve the quality of health services. This will be through: promotion of innovation to support delivery in QIPP, development of communities of learning and Community Education Provider Networks that are supported by Health Education England, managing the knowledge base, fostering a learning culture, and promoting research and use of research

REFER TO SPECIFIC EXAMPLES WE ARE DOING FROM INNOVATION HEALTH AND WEALTH??

Refer to how we will use Academic Health Science Networks to promote research??

The plan aims to deliver high quality care that embeds the learning of the national reviews for quality and safety including Francis, Berwick and Winterbourne and the LLR Learning Lessons work, in order to ensure:

- Patient centred care through co-production and co-design of health care services and that meets the needs of people in West Leicestershire

- Patient safety through challenging providers to develop organisation wide cultures of open and honest care
- Safeguarding vulnerable people and groups that include those with learning disabilities and frail older people
- Compassionate care through embedding the nursing strategy of the 6C's and actions that aim to help people stay independent, maximise wellbeing and improve health outcomes, build effective clinical leadership, ensuring the right staff, with the right skills, in the right place.

Three Bullets

- Patient centred care through co-production and co-design of health care services that meets the needs of people in West Leicestershire
- Patient safety through challenging providers to develop organisation wide cultures of open and honest care, and that safeguards vulnerable people and groups, which include learning disabilities and frail older people
- Compassionate care through embedding the nursing strategy of the 6C's and actions, which aim to help people stay: independent, maximise wellbeing and improve health outcomes, build effective clinical leadership, and thereby ensuring the right staff, with the right skills, in the right place."

Impact on national priorities

NHS Constitution

18 Week RTT Admitted Pathways < 18 weeks
18 Week RTT Non-Admitted Pathways < 18 weeks
Diagnostic Waits < 6 weeks
Patients should be admitted, transferred or discharged within 4 hours of their arrival at an A&E Department
No patient should wait over 12 hours in A&E
Mixed Sex Accommodation (MSA) Breaches
Mental Health - Proportion of people on Care Programme Approach (CPA) who were followed up within 7 days of discharge
Category A (Red 1) within 8 minutes
(Conditions that may be immediately life threatening and most time critical
Category A (Red 2) within 8 minutes
(Conditions that may be immediately life threatening but less time critical than Red 1)
Category A within 19 minutes

NHS Outcomes Framework Indicators

5a	Patient safety incident reporting
5b	Safety incidents resulting in severe harm or death
5.2	Incidence of healthcare associated infection (HCAI), (ii) incidence of C.Difficile
5.3	Proportion of patients with category 2, 3 and 4 pressure ulcers

4. Financial Plan

Introduction

This section outlines the financial plan for West Leicestershire CCG for the 2015/16 financial year. It outlines the context within which the plan has been produced and also provides specific details on plans for investments and savings. It provides confirmation that the CCG intends to deliver financially against key NHS England requirements.

Overall, since WLCCG operates within a limited financial budget, it has 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

WLCCG commences 2015/16 on the back of strong organisational financial performance in the previous two years — delivering an increasing surplus in each of the two years beyond the required level of 1% of turnover. (Surplus of £4.9m delivered in 2013/14 against a target of £3.5m, and set to deliver a £5.8m surplus in 2014/15 against an initial target of £4.9m). This level of historic surplus in addition to funding growth of circa 5% to be received in 2015/16 provides a strong starting point for planning financial delivery during 2015/16 and also gives the CCG the ability to prioritise investments for the maximum benefit of patients within West Leicestershire.

Conversely the CCG operates within the Leicestershire health and social care economy within which significant financial pressures are present within partner organisations. As a result of the level of financial deficit at University Hospitals Leicester NHS Trust, Leicestershire has been identified nationally as a "financially challenged health economy" and as such is subject to external scrutiny regarding plans in place to deliver financial balance across all organisations over the coming years. The local response to this has been to draft an agreed Health and Social Care plan (Better Care Together — BCT) to transform the way that care is delivered to ensure improved financial and non-financial performance. The scale of changes anticipated within this plan will require significant investment to enable the required changes to take place.

The Financial Plan

In line with requirements from NHS England for 2015/16, the CCG plans to deliver:

- A 1% surplus
- A minimum of a 2% underlying surplus
- Investment into mental health services in line with our allocation growth
- Holding a contingency of at least 0.5%
- A minimum 1% non-recurrent transformation fund
- At least 2% of QIPP savings planned
- Risk adjusted surplus of 1%
- Required Investment into the Better Care Fund

The table below summarises, at a high level, the increased funding which the CCG will receive in 2015/16 and how it is utilised in the current expenditure plans:

Financial Plan Summary 2015/16	**£'000**
Recurrent Baseline Growth	19,575
Reduction in running costs allocation	-899
Better Care Funding from NHS England	6,343
Non recurrent allocations	-2,255
Overseas Visitors Allocation reduction	63
Winter Resillience Funding	2,022
NET CHANGE IN FUNDING	**24,849**
Full Year effects	1,564
Demographic Growth	5,051
General growth	1,883
inflation	7,351
Efficiency	-10,401
QIPP	-9,201
Cost Pressures	10,251
Non recurrent reserve reduction	-4,953
Reduction in Surplus	-798
additional Investment in BCF	14,175
Investment	
Winter Resillience Funding	2,022
Mental Health Growth	1,657
Transitional Funding - BCT	2,940
primary Care transition funding	724
Replacement of Contingency reserve	2,891
NET CHANGE IN EXPENDITURE	**25,156**

Quality, Innovation, Productivity and Prevention (QIPP)

Last year WLCCG 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.

As a result of our prioritised investments and delivery of QIPP savings, the CCG enters 2015/16 in a strong financial position upon which to plan for further success in 2015/16. However a significant level of QIPP savings is still planned to be delivered in order to maximise the amount of funding available for investments, particularly to enable the scale of system transformation outlined in the Better Care Together plan referred to above.

QIPP projects have been developed for 2015/16 in conjunction with the local authority, local providers and neighbouring CCGs. A significant focus of these plans is on reducing urgent care attendances and admissions by enhancing community and primary care services at specific points to improve patient pathways.

All projects put forward have undergone a rigorous challenge process to ensure they are clinically safe, move the CCG towards its goals and have been developed in conjunction with the local clinicians.

QIPP schemes currently devised will release approximately £9m to help meet the health challenges of our growing population. This represents approximately 2% of our allocated funding. The following table summarises the QIPP schemes in place for 2015/16:

Source	Scheme	Description	Gross QIPP £
Funded form BCF	7 Day working	Providing targeted Primary Medical cover over weekends	501,800
	Integrated Crisis Response Service	Providing clinical support over night	195,000
	Older Persons Unit	Providing enhanced clinical services from community hospital	936,000
	Falls Service	Falls targeted work	58,500
	Single Point Access	Expansion and development of SPA service	169,000
	BCF Funded Total		1,860,300
	Out of Hospital Care Programme	AVS - Monday - Friday UCC Diverts - via EMAS UCC pathway changes - X-Ray, sepsis etc Nursing homes - education, pathways, care homes End of life - GP services, night services	735,207
	Respiratory	Education and service expansion focused on respiratory disease	400,000
	CVD / HF - urgent care - Elective admission savings	Consolidation of 14/15 activities and expansion of work around HF in community and primary care settings	594,779
	CVD / HF - urgent care - CHC savings	Consolidation of 14/15 activities and expansion of work around HF in community and primary care settings	133,735
	CCG Funded Total		1,863,721

Source	Scheme	Description	Gross QIPP £
Better Care Together	Planned care	10% reduction in planned care activity - ENT/Ophthalmology/ T&O - FV	482,204
	Planned care	40% left shift of care over 4 years - FV (yellow forms state 25% decrease in year)	454,400
	Long Term Conditions	Workbook savings not accounted for elsewhere	234,151
	LD savings Via CHC		114,000
	MH Workplan		228,000
	Better Care Together led schemes		1,512,755
Pathway Change Out of Area	urgent care reductions OOA	Effect of pathway changes above on out of area contracts	250,000
Continuing Health Care		Improvements to Fast-Trac and Authorising Funding	1,205,000
Prescribing	To be confirmed	Estimate	1,500,000
Community Properties	Reduction in estate	Ashby Facilities costs released from contract	450,000
Alliance	Contractual agreements	Capital Charges recharge to Alliance	200,000
LPT	Contractual agreement	Reuse of Mothballed wards	259,000
Community Equipment	Contractual agreement	Updated allocation of costs across CCG's	100,000
Identified QIPP			**9,200,776**

Investments

WLCCG has received a positive uplift to our funding for 15/16 to help us to plan effective investments. This 5% increase in funding will be used to fund inflation, population and other demographic growth, and unavoidable cost pressures as required. In addition the CCG will invest significantly into the following four areas:

- A "better care" fund is being created in conjunction with the Local Authority and ELCCG. This fund is the major source to cover investments planned to provide services within the community and primary care that will reduce urgent care admissions at acute hospitals by 3.5% and bring together health and social care services to improve patient experience and deliver efficiencies in both areas
- Significant Mental Health investments are being made to develop services to deliver fast and effective support to the population. These investments are in line with the overall uplift in funding to ensure "parity of esteem" for Mental Health in line with Physical Health
- Transformation/Transition funds have been set aside to ensure the system changes envisioned within the BCT plan can be actioned appropriately. These funds are expected to be utilised non-recurrently for double running costs and preparatory work on projects in primary care and community setting. This encompasses both the nationally required 1% non-recurrent funds and approximately a further 1% to be made available from allocation growth and the draw-down of last years surplus (plans are in place to spend the level of surplus beyond the minimum requirement of 1%subject to NHS England approval — this equates to an additional spend of approximately £1.7m and would result in the CCG achieving the minimum of 1% surplus in 2015/16)
- CCG plans will be required to cover "winter resilience" — plans to increase system capacity appropriately during the busiest months of the year. We have set aside £2m of our funding allocation for this purpose (this is different from previous years since historically additional funding has been received separately for this purpose).

Summary

WLCCG is planning to deliver on all key financial requirements of planning guidance. Specific points to note are as follows:

- Delivery of an ambitious but deliverable level of QIPP savings (2%) in order to make significant investments both within and outside of the Better Care Fund.

- Reducing the level of surplus planned from £5.8m in 2014/15 to £4.1m in 15/16 in order to maximise the level of non-recurrent funding available to enable the level of system transformation required in the Better Care Together plan. This will be subject to NHS England approval.

5. Measures of Success — Performance

All of the WLCCG priority work-streams and transformational investments are designed to deliver improvements to performance within our system and to improve experience for our patients as a result.

Performance improvements were identified by our Board as one of the top three priority areas of focus: "The delivery of improvements in access, quality, choice, and safety for our patients, particularly against national standards for A&E, RTT, Cancer and Mental Health".

During 2015/16 WLCCG will deliver on performance indicators relating to the NHS Constitution and the NHS Outcomes Framework, ensuring quality of care for our local population and that patient's rights and pledges are maintained through our contracts with local service providers. We acknowledge that local performance has not met required standards and have set local recovery trajectories that represent our commitment to overcoming this.

We have submitted figures stated to 'unify' which demonstrate that we plan to succeed in improving local performance. However, in the absence of guidance we are working up some options they are related to our previous local measures and until that is complete we will offer last year's local measures in this section of the plan.

Indicators	National / Local	Proposed
RTT - The percentage of admitted pathways within 18 weeks for admitted patients whose clocks stopped during the period, on an adjusted basis	National CCGs must show that they are planning to meet each of the NHS Constitution indicators each month in 2015/16	YTD Dec 14: 85.6% Target 15/16: 90%
RTT - The percentage of non-admitted pathways within 18 weeks for non-admitted patients whose clocks stopped during the period.		YTD Dec 14: 96% Target 15/16: 95%
RTT - The percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the pe-		YTD Dec 14: 94.6% Target 15/16: 92%
The percentage of patients waiting 6 weeks or more for a diagnostic test.		YTD Dec 14: 1% Target 15/16: 1%

Indicators	National / Local	Proposed
Cancer- All Cancer two week wait	National CCGs must show that they are planning to meet each of the NHS Constitution indicators each quarter in 2015/16	YTD Dec 14: 92.3% Target 15/16: 93%
Cancer - Two week wait for breast symptoms (where cancer not initially suspected)		YTD Dec 14: 94.3% Target 15/16: 93%
Cancer - All cancer 62 day urgent referral to first treatment wait		YTD Dec 14: 81.7% Target 15/16: 85%
Cancer - 62 day wait for first treatment following referral from an NHS cancer screening service		YTD Dec 14: 85.7% Target 15/16: 90%
Cancer - 62 day wait for first treatment for cancer following a consultant's decision to upgrade the patients priority		YTD Dec 14: 81.8% Target 15/16: 100%
Cancer - Percentage of patients receiving first definitive treatment within 31 days of a cancer diagnosis.		YTD Dec 14: 95.3% Target 15/16: 96%
Cancer - 31 Day standard for subsequent cancer treatments - surgery		YTD Dec 14: 86.4% Target 15/16: 94%
Cancer - 31 Day standard for subsequent cancer treatments -anti cancer drug regimens		YTD Dec 14: 98.9% Target 15/16: 98%
Cancer - 31 Day standard for subsequent cancer treatments - radiotherapy		YTD Dec 14: 95.3% Target 15/16: 94%
HCAI measure (C.Difficile infections)	National CCG level objective set by NHS England based on 12 month cases of Cdiff	2014/15 Forecast Outturn: 83 2015/16 Objective: 77
Dementia - Estimated diagnosis rate	National CCGs should achieve the nationally derived dementia diagnosis rate by March 2015, and sustained monthly through 2015/16.	Jan 15: 57.5% Target 15/16: 66.7% each month
IAPT Access - Roll Out	National CCGs to achieve nationally set IAPT Access by the end of 2014/15 and maintain this throughout 2015/16, with a quarterly run-rate of 3.75%	YTD Nov 15: 13.6% Target 15/16: 3.75% each quarter (15% full-year)
IAPT Recovery Rate	National CCGs must show maintenance of at least the recovery rates achieved at the end of 2014/15. Ongoing improvement is anticipated where a rate of less than 50% was achieved.	YTD Nov 15: 49.7% Target 15/16: 50% each quarter

New Indicators	National / Local	Proposed
IAPT Waiting Times The proportion of people that wait 6 weeks or less from referral to entering a course of IAPT treatment against the number of people who finish a course of treatment in the reporting period.	<u>National</u> CCG must show that by 2016 75% of people referred to the IAPT programme will be treated within 6 weeks of referral and 95% will be treated within 18 weeks of referral	YTD Oct 14: 42% Target Q1 15/16: 50% Target Q2 15/16: 55% Target Q3 15/16: 63% Target Q4 15/16: 75%
The proportion of people that wait 18 weeks or less from referral to entering a course of IAPT treatment against the number of people who finish a course of treatment in the reporting period.		YTD Oct 14: 73% Target Q1 15/16: 75% Target Q2 15/16: 80% Target Q3 15/16: 85% Target Q4 15/16: 95%
Primary Care Satisfaction with the quality of consultation at the GP practice	<u>Local</u> CCGs are asked to make an annual improvement in these areas. The CCG has agreed that given the overall decline in these indicators over the past 18 months, the annual improvement can be evidenced by stopping further deterioration	Jan 15 survey results: Score of 432 / 500 Target 15/16: Score of 432 / 500
Satisfaction with the overall care received at the surgery		Jan 15 survey results: 84.7% Target 15/16: 84.7%
Satisfaction with accessing primary care		Jan 15 survey results: 74.6% Target 15/16: 74.6%

Recovery trajectories have been developed and listed below:

- A&E: Current performance is 88.65%. Plans will deliver recurrent performance of 95% by Q1
- Winter Resilience: We have committed £2.022m based on what we know worked well last year
- RTT: Completed pathways (Admitted) <18wks currently 85.6%. Plans will achieve 90%. Completed pathways (Non admitted) <18wks currently 96%. Plans will deliver 95%. Incomplete pathways <18wks currently 94.6%. Plans will deliver a minimum of 92%
- Cancer: Currently, achieving the 62 day wait for first treatment is at risk. Plans will deliver 85.1% in Q1
- Diagnostics: Currently, the number waiting >6wks is 1%. Plans will deliver within the 1% target
- IAPT: Currently Access is 13.6% of the population. Plans will take this to 15% by Q1
- Dementia: We continue to support GPs identify and diagnose dementia early taking the CCG rate of diagnosis

from 57.5% to the national standard of 67.7%

- Early Intervention: We will use our risk stratification tool for timely intervention by health and social care teams
- Primary Care: We will halt the three year decline in patient satisfaction with access to Primary Care, securing 74.6% satisfaction rate.

Performance trajectories are included in other sections of the plan, as are delivery metrics. The focus of this section is on answering the questions of how we will improve mandated and statutory delivery.

National Measures

A&E waits

ED performance against the four hour wait target (currently 88.65%) is monitored through the LLR Urgent Care Working Group. To meet the standard of 95%, the CCG is actively engaged in the workings of the LLR-wide group and has supported actions which have impacted on admissions, flow and discharge resulting in improvements in performance. Plans will deliver recurrent performance of 95% by Q1. One key success has been on-site support from external agencies across a 7 day period. This multi-agency approach has been successful in improving system wide flow and has been achieved largely with core staffing, making it a sustainable solution. The successes have influenced long term commissioning decisions and improvements in operational grip within the provider organisations. Additional support is provided through £2.022m we have committed for winter resilience based on what we know worked well last year.

Risk areas and mitigations:

Risk — Recovery also depends on other agencies, such as EMAS, delivering the changes to their services in line with the UCB action plan and the wider BCT plan.

Mitigation will include regular monitoring of these plans with direct escalation to the UCB for non-delivery

Risk — Sustainability of such changes throughout the year, including surge periods. This should be noted due to a lack of previous sustainable delivery patterns. Mitigation is sustained winter scheme commissioning and effective surge management through the Urgent Care Board.

Risk — transformative change to processes such as delivery of changes to wider pathways, such as CHC, are required to enable performance to improve.

Mitigation. This risk should be mitigated by the discharge work streams of the UCB. This includes CHC specific actions. Non-delivery will be escalated to UCB for resolution.

Cat "A" Ambulance calls

Plans include changes to contractual reporting with EMAS. The CCG currently monitors Ambulance performance in response times at local CCG level to understand the impact on our local population.

Current performance is as follows:

- Cat "A" Red 1 — 62.9% against a standard of 75%,
- Cat "A" Red 2 — 64% against a standard of 75%
- Cat "A" 19 minute response — 91.2% against a standard of 95%.

Risks and mitigation

Risk — there is always a risk in demand led service of demand outstripping supply and delivery being adversely affected. EMAS continues to deliver under challenging circumstances and across the system efforts are made to mitigate the impact.

Mitigation will include regular monitoring of these plans with direct escalation to the UCB for non-delivery, EMAS is a full and active member of this group and report directly upon delivery in the plan.

Referral To Treatment waiting times

Current performance to ensure that admitted patients starting treatment within a maximum of 18 weeks from referral requires further improvement as current performance is 85.6% against a standard of 90%.

Completed pathways (Admitted) <18wks currently 85.6%. Plans will achieve 90%. Completed pathways (Non admitted) <18wks currently 96%. Plans will deliver 95%. Incomplete pathways <18wks currently 94.6%. Plans will deliver a minimum of 92%

We will develop a referral hub to offer consistent pathway and standards information by using PRISM (Pathway and Referral Implementation System). The consistency this provides will allow our providers to screen and manage patient referrals to the right surgeon first time. The information contained within PRISM's templates allows specifics of a patient's needs to be offered in a concise and structured way, answering all questions on who is the right person to meet the need at the other end as a result.

Cancer Pathways

The CCG has identified cancer as one of the top priorities, but it is not represented in full in our clinical priorities section. Therefore we have included more detail in this section than for other disease areas as we recognise that there are a number of improvements that can be made across elements of pathways for differing types of cancer. The LLR Better Care Together Five-Year Strategic Plan bringing together clinical leads across primary, community and secondary care to identify further improvements at scale for our population over the next five years.

In 2015/16 we will implement improvements in our cancer pathways to meet the required performance standards. Plans will:

- Support target of Diagnostics: Currently, the number waiting >6wks is 1%. Plans will deliver within the 1% target
    - Currently, achieving the 62 day wait for first treatment is at risk. Plans will deliver 85.1% in Q1.
- Develop pathways that ensure that our GPs have direct access to the following diagnostics for suspected cancer to support early diagnosis:
    - chest x ray to support the diagnosis of lung cancer
    - non-obstetric ultrasound to support the diagnosis of ovarian and other abdomino-pelvic cancers
    - flexible-sigmoidoscopy/colonoscopy to support the diagnosis of bowel cancer; MRI to support the diagnosis of brain cancer.
- Raise awareness of cancer symptoms
- Raise awareness and pilot new methods of cancer screening programmes
- Encourage our population to use the health services that address risk factors for cancer through our Lifestyle Hub (e.g. obesity, smoking and alcohol misuse)
- Extend GP access to diagnostics for suspected cancer diagnosis
- Review and implement cancer risk management tools to extend 2 week wait referral
- Work with our partners at the East Midlands Strategic Clinical Network (EMSCN) for Cancer, participating in the High Value Healthcare pathway for Upper GI

Cancer amongst others. The pathway will improve access to the best treatments and outcomes for Upper GI Cancer patients and improve the patient experience.

There are risks to delivery in 15/16. The area of greatest performance challenge we face is delivering great performance against cancer waits on the 62 day Cancer targets. Recovery trajectories have been set and tumour site specific issues alongside pathway issues that impact significantly on delivery of the standard are recognised:

- Head and neck — pathways are complicated and are undertaken at network level / supra network level; pathways often cross providers and the resource is specialist
- Urology — high number of long waiters. Detailed work has been undertaken to implement a sustainable solution which is now in place and will be monitored closely to track progress
- Upper and Lower gastrointestinal cancers — Overall high volume for gastrointestinal cancers; service pressures due to increase in demand from screening programmes impacts on both standards
- Breast — referral from an NHS Cancer Screening Service standard. Recent service pressures due to changes in referral patterns external to LLR impacting on overall capacity
- 2WW standard for urgent GP referral — non achievement of standard undermines achievement of 62 day standard
- PET scans — LLR commissions all indicators for PET scans. Specialised service with limited access (1 day per week) — up to 2 week cycle for access and reporting

To mitigate risks, the following actions have been taken to date to improve performance:

- Clinical problem solving groups established to take look at specific areas; this includes a broad work-stream looking at the possible reasons behind the rise of referrals from primary care:
- Access to PET scans has been addressed and is improving – weekly reviews are in place which have been supporting this. Effective MDT processes critical to this part of the pathway.
- Direct booking to ghost clinics with a weekly update
- Weekly reviews of 62 day+ waiters at patient level
- Additional consultant resource has been recruited

- Extra theatre capacity at Glenfield has been sourced
- Early warning indicator for cancer performance developed
- Crisis meetings with specific tumour site consultants and managers
- Internal review (Diamond Review) of processes around screening programmes.

WLCCG has a level of assurance of delivery, given that LLR has a past history of delivery in these areas. Inclusion of these targets within the remit of the RTT board, effective MDT working and a robust LLR wide plan within the context of wider system change will underpin future delivery.

Dementia diagnosis

Through the work of the Long Term conditions work-streams, the CCG will build on the work already implemented in primary medical care to continue to support GPs identify and diagnose dementia early taking the CCG rate of diagnosis from 57.5% to the national standard of 67.7%.

Ambulance handover

A working group involving UHL, EMAS, and CCGs has been developed to take stock of data quality issues and opportunities to improve performance. Actions have been developed but not yet implemented. We will explore the proposal to move to a new data capture system from April 2015 developed by EMAS and supported by CCGs.

IAPT

IAPT: Currently access is 13.6% of the population. Plans will take this to 15% by Q1. The CCG will work to recover performance against the current standard working to achieve the required access rate of 15% (currently at 13.6%) and the recovery rate of 50% (currently at 49.7%). Developments include:

- Self-referrals implemented
- GP aided self-referrals implemented
- Referrals through IAPT web portals
- Continued roll out of Silver Cloud, a social media based IAPT tool
- Final recruitment to vacancies has taken place after the phasing out agency staff
- Building works are nearing completion which will offer a greater level of telephone triage.

NEW IAPT Mental Health access waits

The proportion of people that wait 6 weeks or less from referral to entering a course of IAPT treatment against the number of people who finish a course of treatment in the reporting period: 683/1865 = 36.7%

The proportion of people that wait 18 weeks or less from referral to entering a course of IAPT treatment against the number of people who finish a course of treatment in the reporting period: 1409/1865 = 75.5%

Coverage: Apr 14–Nov 14 (Total YTD) NB. There are no nationally published data yet, these are calculations based on available technical guidance and are unvalidated.

Cancelled operations

There are two national metrics that relate to Cancelled operations:

All patients who have operations cancelled, for non-clinical reasons to be offered another binding date within 28 days (or the patient's treatment to be funded at the time and hospital of the patient's choice) and there will be no urgent operations cancelled for a second time. Our main provider, UHL, have achieved the zero tolerance target of the first metric and achieved 96% against the 100% target for the second metric.

Mental Health

The CCG aims to deliver against the performance standards for Mental Health through a programme of activity focussed on prevention, early intervention in psychosis and crisis care. This will ensure improved quality of care for patients from childhood to adulthood.

Transforming care

Following on from the Care and Treatment Reviews for people with Learning Disabilities and the Winterbourne Concordat for people in inpatient services, the Chief Nurse will use the recommendations and actions from these reviews to ensure we can commission and provide patient centred alternatives to hospital, and where this work will be undertaken with local health and social care agencies to develop and provide to enable people to be closer to their families. Regular monthly reporting on the Care and Treatment Reviews will be provided to NHS England and updates will be provided to the Health and Wellbeing Board

CQUINs

The CCG will work with the local service providers to implement

quality improvement schemes through CQUINs. Guidance is still awaited in this area but we have ensured that the national CQUIN indicators, including sepsis and the prevention and management of acute kidney injury will be included in the NHS contracts with the relevant service providers. Local schemes are being developed to support the urgent care pathway and, in particular the discharge of patients requiring continuing health care. Further local schemes are bring developed with UHL, LPT and nursing homes to ensure further quality improvements of care. These indicators are currently being negotiated with these providers.

We recognise that improving performance will only be achieved by focussing on all clinical priority work-streams. Consequently, a drive to improve performance is embedded across all plans and not solely those areas that have previously struggled.

Local Measures

In primary care, we will halt the three year decline in patient satisfaction with access to primary care, securing a 74.6% satisfaction rate. We will also increase the number of deaths that occur in the usual place of residence.

Potentially, more specific local measures will be developed when guidance is received.

6. Delivery Model

Over the last four years we have built up a strong track record of delivery and doing the things we say we will do for our population in West Leicestershire. We have also consistently demonstrated strong system leadership in seeking to influence a more collaborative approach across LLR commissioners and providers, and health and care partners.

The last year saw a step change in relationships across the system — driven largely on the back of work around Better Care Together, challenged health economy status, Learning Lessons and urgent care. Coupled with changes in a number of key leadership roles among commissioners and providers, the dynamic of the conversation across LLR has improved considerably. We have been instrumental in shaping this and welcome the new direction and sense of shared purpose it has brought.

The challenge for us all in 2015/16 is how we build on this momentum and work jointly with partners across our area of planning footprint to move from planning to implementation in order to increase the scale and pace of our delivery.

For us in WLCCG, we have identified that our specific contribution will require us to take a differentiated approach to strengthening our delivery arrangements in the following areas.

Continuing to refine the things that are already working

We are strong believers in not fixing things that aren't broken or getting distracted by organisational change processes that do not add enough value to our core purpose. Much of what we have created over the last 4 years is starting to reach a level of organisational maturity. So, while we're always seeking out scope for continuous improvement, in many aspects of our delivery arrangements this is going to be about tweaking what already works rather than more fundamental change:

- Board — our Board membership (clinical, lay and managerial) remained very stable throughout 14/15. 15/16 will see us continue to focus on supporting the personal development of our current Board members (e.g. Top Leaders) whilst also preparing for the re-election/ appointment processes that will run in Q4
- CCG management support — our team based at Woodgate has also remained remarkably stable. This has been a real strength in terms of building relationships, continuity and allowing the organisations systems and processes to mature. However, the anticipated delegation of primary medical

care commissioning expected from 1 April 2015 and the development of federated localities presents the need to adjust our structures to fully support this. We will also take the opportunity to review our project delivery and organisational planning functions. Team and personal development support will continue to be secured from organisational development specialists Healthskills.

- LLR CCG Collaborative — much of our commissioning responsibilities continue to be discharged through our collaborative commissioning arrangements with our two neighbouring LLR CCGs, EL&R and Leicester City. The Collaborative Commissioning Board, PPAG, matrix contracting teams and hosted support continue to be at the heart of these arrangements. 2014/15 saw change in the MD positions at both East and City which necessitated a number of temporary changes to local contract lead arrangements. These will need to be reviewed following the substantive appointment to the EL&R MD post to ensure best mix of skills, experience and organisational balance.
- LA/HWB — continuation of Joint Director of Health and Care Integration with EL&R and LCC and our current Chair will continue to Chair the Integration Executive with a particular focus on delivery of the BCF programme. 2015/16 will also present opportunities to explore new relationships and delivery models with the County Council's appointment of a new Director of Adults & Communities.
- Quality Surveillance Group— this has become and will remain a valuable forum for triangulating intelligence on provider quality related issues with other regulator and commissioner agencies.

Significantly stepping up those areas with potential for greater impact

There are a number of areas that are either emerging where we see major scope for adding significantly more value as well as one particular CSU outsourced function where we continue to have particular cause for concern:

- Better Care Together — this programme has made major progress during 2014/15 and is now at a critical and exciting point of moving from planning into delivery phase. Our successful appointment of a substantive Programme Director and team means we are well placed. However, the arrangements that enabled us to contribute to the plan development phase are not going to be sufficient to drive delivery and we are going to need to work hard in Q1 with the PMO and partners to clarify lead roles, responsibilities and deliverables.

- Alliance — 2014/15 saw the successful transition of elective community hospital services from Derbyshire to an innovative new alliance partnership between UHL, LPT, primary care Provider Company and CCGs. This first year was very much about consolidation and putting in place basis systems, processes and governance (managerial and clinical). 2015/16 needs to see a major step up in terms of delivery and the focus on service and pathway transformation to support delivery of the BCT Planned Care work-stream. This vehicle has huge potential to realise the shift of activity from acute to community settings as well as potential to grow into a genuinely Multispecialty Community Provider model.
- GEM Continuing Health Care — last year's Operational Plan identified this as one of our main areas of CSU related concern and despite some progress in year we remain in a position where we have a stretching Improvement Plan in place but still have insufficient assurance about GEM's capacity and capability to adequately respond to this. If this does not deliver we will need to explore alternative arrangements for the safe and efficient delivery of this critical function for our patients during 15/16.

Establishing new delivery mechanisms to respond to opportunities and challenges ahead

In addition to the above, 15/16 will see us engaging in new areas of activity where we will need to establish a delivery capability that has previously not been required in two areas:

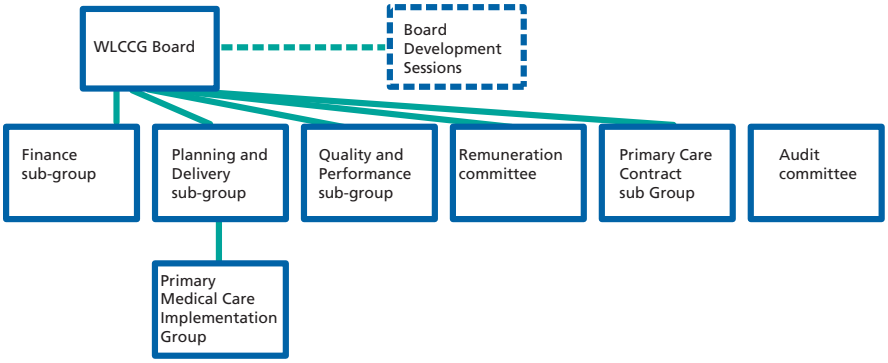
- Primary Care Commissioning Committee — we anticipate being granted delegated authority from NHS England to take on the commissioning of primary medical care from April 2015. In addition to the management support arrangements outlined above, this will require us to establish an additional formal sub-committee of the Board in order to oversee the governance of this new function. This is going to be really important to enabling the 'left shift' to be framed contractually in a way that places resources where clinical services are provided. The development of our Primary Medical Care Plan has indicated a real appetite among our member practices and Board to explore alternative contractual models that have the potential to enable sustainable primary care 'plus' services to be provided
- East Midlands specialised commissioning — arrangements for the transfer of responsibility for some aspects of specialised services commissioning from NHS England to CCGs are still emerging nationally. However, it is clear that we will be taking on a greater role and have therefore

initiated 'in principle' discussions with other East Midlands CCGs about the potential of forming joint arrangements to discharge these responsibilities. This will build on the existing East Mids Congress network but move it onto a more formal 'committee in common' footing and widen the membership to include clinical and potentially lay input. We will also wish to explore the potential for such a joint arrangement to co-ordinate joint policy across other non-specialised services (e.g., IVF and cosmetic procedures) where there would be obvious benefit for patients in consistency.

7. Risks and Mitigation

Board and Sub-Committee Governance Structure

We have developed a comprehensive governance framework which will ensure the assurance, monitoring and delivery of our plan. The diagram shows the Governing Body and Sub-Committee structure, which has recently been updated to reflect monitoring the implementation of the primary medical care plan and the delegated functions for primary care co-commissioning (subject to approval).



Where common areas of commissioning exist between the three LLR CCGs, collaborative governance arrangements have been put in place and are refreshed annually to reflect any changes required. The Commissioning Collaborative Board oversees a number of shared areas including the development and implementation of commissioning plans, delivery of QIPP and transformational programmes and acting upon high risk performance issues. The Provider Performance Assurance Group (PPAG) holds the contract teams to account for management of all major healthcare contracts and receives assurance on all aspects of provider performance. Reports from this group are received by CCG Sub-Committees and the Governing Body.

NHS England Area Team Assurance Role

The CCG Assurance Framework will enable NHS England, through its Area Team for the Central Midlands Area, to meet the statutory responsibility to make an assurance assessment. This process will ensure there is a joint understanding of the development needs of the CCG against six assurance domains and how these can be supported. This assurance process has been designed to provide confidence to internal and external stakeholders and the wider public that CCGs are operating effectively to commission safe, high quality and sustainable services within their resources.

This annual assessment will be made available to the public via our website.

Strategic Risk Management

We have developed an integrated approach to risk management that is used to identify, manage and reduce the risks that threaten the delivery of our strategic objectives. This is delivered through the management of CCG Sub-Committee risk registers and to the Board through the Board Assurance Framework (BAF). Full consideration is given to the risk priorities of partner organisations as well as the CCG in order to ensure the overall risk management system is effective and consistent with the challenges across the local health economy.

Top Risks

We have identified the key strategic risks to the delivery of this Operational Plan. These risks are shown below and will form the basis of our Board Assurance Framework (BAF). The WLCCG Board will consider the mitigating actions for these risks as part of the development of the BAF.

Risks

Failure to achieve our national A&E standard: this target is dependent on other external agencies for delivery
Delivery of changes to wider pathways such as CHC to enable performance to improve.
62-day Cancer wait where there are tumour site specific issues as well as pathway issues that impact significantly on delivery of the standards
Provision of initial support of West Leicestershire federations to ensure there is a common approach and best practice processes are embedded
Alignment of WLCCG programmes with Better Care Together as we reshape our health and social care system at scale particularly for complex long term conditions and older people with frailty
Ensuring that we maintain our level of delivery after the developing of the foundations for new models and contracts for integrated care provision
Achieving full alignment through provider contracts to deliver QIPP, better care funds and better care together plans
Ability to free up sufficient transformational resource to implement Better Care Together

Programme Management Office (PMO) – Assuring Programme Delivery

WLCCG is committed to managing the 8 workstreams which make up our change programmes. We use a standardised project approach, in order to ensure equity and compare the benefits of programmes / investments that deliver services for our patients. To achieve this, we have a Programme Management Office. The PMO supports programme leads and assures the WLCCG Board, that delivery of the Programmes in the CCG's Operational Plan is going to plan.

On a monthly basis, and for each of WLCCG's Programmes, the PMO will:

- review the Programme's projects' action plans, risk logs, highlight reports which detail the progress they are making, and any exception reports where there are concerns on progress

- review our progress against the key performance indicators (KPIs) which are set in the NHS Constitution and the NHS Outcomes Framework
- hold in-depth meetings with the 3 people jointly accountable for the delivery of each Programme (a Senior Responsible Clinician (SRC) who is a GP, a Senior Responsible Officer (SRO) who is an Assistant Director or above from the CCG, and a Programme Lead who is usually a Head of Service in the CCG) to agree the delivery status
- review the QIPP financial investment (spend) and savings status, working closely with Finance

Based on these activities, the PMO produces updates and risk assessments which are reviewed monthly by our Planning and Delivery Board Sub-Committee for review. The PMO then prepares a paper to the Board, so board can remain sighted on the delivery status of our operational plan.

Equality and Diversity

Based on the foundations laid in 2013/14 when we developed mechanisms to collate evidence across all areas of our activities to inform the Equality Delivery System (EDS2) grading process, we have continued to monitor our performance for people with the nine protected characteristics to help us discharge our duties under the Public Sector Equality Duty.

In 2015/16, we will continue to expand our wider community and stakeholder engagement activities as part of our People Powered Health programme and review more detailed equality monitoring information from our main providers through existing contracting arrangements.

We have ensured that all our programmes and projects complete an Equality Impact Assessment, and we are working together with our colleagues across the Leicester Leicestershire and Rutland health and social economy to ensure a consistent and joined up approach to EDS2 as part of the BCT programme.

From April 2015, we will be required to demonstrate progress against a number of indicators of workforce equality and will be required to implement the Workforce Race Equality Standard (WRES), including how we ensure that our Board is broadly representative of the communities we service. We already have a system in place to monitor workforce metrics and Staff Survey findings in partnership with our commissioning support service and the Picker Institute which can be directly used against the 9 metrics in the WRES.

A Delivery Plan for 2015/16 is also in place, with a strong emphasis on clinical and managerial leadership. Progress against the plan and our 4 equality objectives will be monitored

and reported to the Quality and Clinical Governance Sub-Committee, and through our complaints, comments and compliments process. We will also produce and publish our Equality and Diversity Annual Report in April 2015.

Index

D

E

F

R

S

T

U

V

W

Workforce 5, 6, 13, 22, 23, 84

Workforce race equality standard 84