HEALTH AND WELLBEING BOARD: 19 NOVEMBER 2015

REPORT OF THE CHIEF EXECUTIVE AND COMMISSIONING SUPPORT PERFORMANCE SERVICE

PERFORMANCE UPDATE AT END OF QUARTER 2 2015/16

Purpose of Report

1. The purpose of the report is to provide the Board with an update on health performance issues at the end of quarter 2 of 2015/16.

Background

2. The Board currently receives a joint report on performance from the County Council's Chief Executive's Department and the Arden/GEM Commissioning Support Performance Service. This particular report encompasses:

   a. Performance against key metrics and priorities set out in the Better Care Fund plan and with progressing health and social care integration; and
   b. An update on key provider performance issues and performance priorities

Better Care Fund and Integration Projects

3. The following section of the report and Appendix A summarises current performance against the schemes within the Better Care Fund (BCF) plan. There is also a summary of the BCF Plan key indicators and progress against delivering on the BCF targets. Where data is not yet available for the metrics and proposed targets the published baselines are shown.

Metric	Commentary
Metric 1: Admissions to Care aged 65+	The current data shows an estimate of the full year figure for 2015/16. The forecast for permanent admissions to either residential or nursing care of people aged 65 and over per 100,000 population based on data at the end of September has increased slightly. However at 630.8 admissions per 100,000, this is still forecast to meet the BCF target.
Metric 2; Older People At Home 91 Days After Discharge	A key measure in the Better Care Fund (BCF) is the metric that measures the proportion of people discharged from hospital via reablement services that are still living at home 91 days later. For those people discharged between April 15 and June 15 with accommodation location between July and September the figure was 82.3% against the BCF target of 82% and

	is currently rated 'green'.
Metric 3: Delayed transfer of care from hospital per 100,000	The BCF target is a measure of delayed days *per 100,000 population*. The target for Q2 is 256.0 and performance at Q2 remains slightly higher at 264.6 delayed days per 1,000 population. Based on the adult social care data snapshot on the last Thursday of August, the position is similar to the previous month (8 ASC delays compared to 9 in July; 38 NHS delays compared to 40 in July). As such the average month since the start of the year remains lower than the average month last year (ASC is 8.0 compared to 11.5 in 2014/15; For NHS delays the difference is 37.6 this year compared to 63.8 last year). For ASC delays, the number of days delayed in August was 129, significantly lower than 208 in July and the lowest monthly total in the past eighteen months (they peaked at 351 in November 2014).
Metric 4: Total non-elective admissions into hospital (general and acute), per 100,000 population, per month	Data for the period January to August 2015 shows a drop from a rate of 742 non-elective admissions per 100,000 population in July to 730 in August. Against a target to reduce non-elective admissions to 56,273 by December 2015, the health and social care economy in Leicestershire is forecast to run over by 2,605 (or 4.6%) and that 58,878 admissions will be made by patients registered with GPs in Leicestershire. Though see BCF avoided admissions para 4 below.
Metric 5: Patient/service user experience. Patients satisfied with support to manage long term health conditions	Based on the aggregated data for July to September 2014 and January to March 2015 61.6% of the people that answered this question in the survey, reported that they have received enough support from local services/ organisations to help manage their long-term condition(s). This is a small drop in performance from 64.2% from 2013/14.
Metric 6: Emergency admissions for injuries due to falls in people aged 65 and over per 100,000 population, per month.	The definition of the data reporting for these indicators is that it is required at resident County HWBB level. GEM currently receives provider information at this level into their database from providers but queries will have to be written to extract it. This is currently being discussed with Public Health and GEM CSU. Further testing on data from the provider will also be needed to ensure data quality and robustness. Getting an accurate process at this stage is imperative for payment by results reasons. The RAG status has not been updated as the current data is not a true reflection of the actual position.

Performance Against Total Non-Elective Admissions

4. The tables below show the total number of avoided admissions that the four emergency admission avoidance schemes achieved against the pay for performance target.

Monthly Performance

	Jan 15	Feb 15	Mar 15	Apr 15	May 15	Jun 15	Jul 15	Aug 15	Sep 15	Oct 15	Nov 15	Dec 15
Monthly Target	166	166	166	168	168	168	172	172	172	174	174	175
Actual avoided admissions	149	139	136	156	157	157	153	150	158			
Monthly variance against target	-17	-27	-30	-12	-11	-11	-19	-22	-14			

Total Performance

	Jan 15	Feb 15	Mar 15	Apr 15	May 15	Jun 15	Jul 15	Aug 15	Sep 15	Oct 15	Nov 15	Dec 15
Cumulative Target	166	332	498	666	834	1,002	1,174	1,346	1,518	1,692	1,866	2,041
Cumulative actual avoided admissions	149	288	424	580	737	894	1,047	1,197	1,355			
Cumulative variance against target	-17	-44	-74	-86	-97	-108	-127	-149	-163			

5. The action plan to improve performance against the four emergency admissions schemes has been comprehensively reviewed and revised and is currently being implemented. In addition, a review of the planned trajectories is currently underway and proposed revised trajectories will be reported to the November Integration Operational Group for agreement. A stock take and position statement including revised risks and issues and actions to address gaps will also be presented to the November meeting.

Integration Project Delivery

6. Within the current Better Care Fund scheme delivery progress updates, a number of issues have been noted and these are set out below.

Scheme	Commentary
Seven day services in primary care	WLCCG - pilot update The draft service specification is due to be updated following discussion at the CCG wide federation leads meeting in August, where queries were raised pertaining to the suggested patient pathway in terms of accessing a local GP over the specified weekend period. Work is now underway to review the pathway and to ensure that there is robust engagement with NHS111 and OOH and that any opportunities to link with existing pathways are maximised. It is envisaged that the pilot will commence in October 2015. ELR CCG - pilot update A proposal to extend the original pilot was considered by the CCG Primary Care Co-Commissioning Committee week beginning 19th October. The enhanced scheme will extend to over 70k patients, targeting 2% of the most vulnerable patients. Expressions of interest from GP practices will be returned by the first week in November, with a planned go-live at the end of November. Practices will be asked to identify estimates of potential avoidable admissions with a likely estimate to be 50 avoided admissions per month. The target/trajectory will therefore remain zero until December.
Glenfield Hospital Admission Avoidance	UHL Programme Lead Helen Crossley and lead respiratory consultant Dr Catherine Free attended the October Integration Operational Group to propose a model of ambulatory care for short stay patients. The Clinical Decisions Unit (CDU) at Glenfield Hospital sees two cohorts of patients – those that come in and will go home on the same day, and those that will be admitted. This proposal aims to create streaming of patients into the two groups from the outset, so that those going home same day can benefit from rapid clinical decision making and effective care planning back into the community, and admission can be avoided. The preferred option discussed was to fund a dedicated clinical assessment and triage function for this stream of patients and to implement this scheme as quickly as possible so that impact could be seen during winter 2015/16. A number of actions were agreed in order to implement the Glenfield scheme successfully, including recognition that a coding change is needed to reflect that same day patients will be coded as attenders not admissions, also that impact will be measured on aspects of flow and admissions, as well as the quality of the interface between Glenfield attendance

	and care planning/navigation in community settings, also the scheme will be subject to the same evaluation methodology and clinical audit as the other emergency admissions avoidance schemes.
Safe Minimum Transfer Data Set	The minimum data set system has experienced some delays as a result of IT resource constraints. The system is to be hosted by UHL however their resources required to support the implementation are all currently assigned to other projects of higher priority. Further to an IT stakeholder meeting held in June, UHL IM&T staff and their managed IT Business partner IBM GBS (Global Business Services) have been revisiting the schedule and resource availability. This process has taken a number of weeks to go through and a revised timeline proposed with a new provisional go live date in November put forward. November is still subject to confirmation and UHL IM&T/IBM GBS will confirm this shortly as part of their internal PID approval process. Once confirmation has been received, project plans will be updated and revised schedules shared.

Provider and CCG Dashboard - Appendix B

7. Attached as Appendix B is a dashboard that summarises information on provider and CCG performance. The Everyone Counts Dashboard sets out the rights and pledges that patients are entitled to through the NHS. The indicators within the dashboard are reported at CCG level. Data reported at provider level does differ, and delivery actions indicate where this is a risk.

University Hospitals of Leicester (UHL) Emergency Department (ED). Waiting Time < 4 Hours

8. The nationally set target is that 95% of patients that attend A&E should be admitted, transferred or discharged within 4 hours of their arrival. This currently stands at 92% at UHL.

9. Daily performance continues to vary, however the year to date position has improved compared to the same time last year. Actions include: redesign of Leicester Royal Infirmary front door assessment and integrated Urgent Care Centre (handover to go live 3 Nov 2015). Primary Care Co-ordinators supporting the Clinical Decision Unit at Glenfield (3 days per week in October increasing to 7 days by Christmas). Pathway co-ordinators in the Bed Bureau to divert GP admissions and proactive arrangements to manage anticipated demand surge on Fridays and Mondays. A targeted communication campaign for flu vaccine take-up and how to access appropriate services.

Ambulance Response Times, Handovers between UHL ED and Ambulance and Ambulance Crew Clear

10. The Care Quality Commission is due to revisit during the week commencing 16th November. Commissioners have had discussions with the Director of Nursing from EMAS regarding the available localised quality information for the area. It was agreed that the Commissioning Quality Team will produce a draft quality schedule that will enable Commissioners to gain assurance regarding the quality of care.

11. Commissioners met on Monday 12th October with the Trust Development Agency, EMAS and UHL to discuss the opportunities to improve the process and reduce delays in the handover of patients between EMAS and the Emergency Department at Leicester Royal Infirmary. An action plan was agreed to deliver improvement within the next 8 weeks to include a 30% reduction in lost hours and elimination of the 2 hour breaches.

Cancelled Operations - non re-admitted in 28 days

12. This target relates to the percentage of patients that are offered a binding date within 28 days or funded at patients choice, if their operation is cancelled for non-clinical reasons. This was achieved in May, but not consistently performing, with August having 4 breaches. These were Urology and General Surgery patients who breached the 28 day rebooking target. This was due to an increase in the number of cancer cases that created capacity problems in the Intensive Therapy Unit.

13. The key risk remains failure to follow the UHL cancellation escalation policy for patients at risk of cancellation on the day. Escalation is to the Head of Operations for resolution, prior to agreeing to any cancellations.

Pressure Ulcers (Grade 2)

14. UHL reported 10 Grade 2 avoidable pressure ulcers in August 2015. This is above the current threshold of 8 per month. UHL are focusing on the prevention of tissue damage to heels and are reviewing equipment and support surfaces to support pressure ulcer prevention interventions and anti-embolic stockings. UHL are also implementing changes to the Tissue Viability Team to strengthen Pressure Ulcer Prevention.

Never Events

15. No new ‘Never events’ were reported June - August.

52 Week waiters (incomplete at UHL)

16. This relates to Orthodontic patients, this service is commissioned by NHS England. The service is now closed to new referrals with some clinical exceptions. Funding has been secured from NHS England for 2 FTE locums to clear the backlog. NHS England is contacting other providers to see if they

are able to treat any of these patients in the community. A Serious Untoward Incident (SUI) investigation has taken place.

Diagnostic Waiting Times < 6 weeks

17. In order to address long patient waits, UHL are working with Medinet to put on weekend lists, providing 60-90 additional scopes per weekend. The department is also in the process of transferring 300 patients to Circle, as well as approximately 100 patients to Nuffield. Additional lists have also been put on by UHL's own consultants. The extra capacity is complemented by a robust action plan aimed at addressing general performance issues in Gastroenterology, with particular focus on ensuring that all lists are fully booked and efforts to improve Cancer performance via access to Endoscopy tests. There has also been a management review in the department and an Endoscopy Manager has been appointed to focus solely on the service.

18. The Intensive Support Team and NHS Improving Quality team will begin work in Endoscopy on 22/10/15 to further assist resolving and sustaining performance. This is however a stretching plan, but should allow UHL to regain compliance of the diagnostic standard in December2015.

Cancer

19. Cancer performance remains a concern for 62 days. Performance continues to be monitored via the joint Cancer and Referral to Treatment Board. The report from the Intensive Support Team (IST) visit to UHL was received mid-October which contained 37 recommendations. UHL have now shared an action plan based on these recommendations. Progress of the combined plan will be monitored through the Cancer/RTT Board. Elements of cancer performance continue to be reported on a weekly basis. Following the success of the first root cause analysis of the June 62 day breaches a further 3 reviews have taken place. This will become a rolling process with findings and themes being fed into the action plan to ensure it remains 'live'. Areas of good practice identified continue to be implemented with executive oversight to ensure compliance. 2 week wait referrals in August were lower than July at 2,453; however this is 12.5% up on the same time last year. The focus is still on endoscopy due to the impact on cancer performance with a number of key actions in progress to mitigate the current performance position. A 2 year cancer pathway project focussing on UHL cancer pathways from point of referral, referral to treatment, discharge and follow up is underway.

Improved Access to Psychological Therapies

20. Both CCGs performance improved in August and early indications show further improvement in September. Staffing is at full establishment. All GP practices have been contacted regarding current waits and the CCGs are encouraging self-referrals. Self-referral leaflets are now in all Community Hospitals, Libraries, Urgent Care Centres and other community venues. LCR Alliance is looking at the possibility of rolling presentations/adverts in Urgent Care Centres, Universities etc. Arriva (Patient Transport Service) has agreed to put self-referral forms within all vehicles. Voluntary Action Leicester has

been contacted and an IAPT article, with contact details and self-referral information, has been sent to all voluntary organisations and community group members.

Clostridium Difficile (C Diff) Cases – Leicestershire Partnership Trust

21. The trajectory for 2015-16 for Clostridium difficile has been set at 7 by the CCGs. There have been 5 cases in 6 months. All cases undergo a full root cause analysis and lessons learnt are identified and actioned for the staff to take forward.

Potential years of life lost (PYLL) from causes considered amenable to healthcare

22. 2014 data for potential years of life lost (PYLL) for causes amenable to healthcare was published in September. This is an estimate of the average years a person would have lived if he or she had not died prematurely, and it is therefore a measure of premature mortality. To achieve this indicator, a reduction of 3.2% was required. This indicator saw a 16% increase in ELR and a 1.7% reduction in WL.

Unplanned Hospitalisation and Emergency admissions

23. With regard to the readmissions audit a report has been received and further meeting arranged in October 2015 with UHL and commissioners to review further actions required.

24. High levels of activity continue for pneumonia diagnoses and heart failure or shock with complications and comorbidities. On the former, a joint review with commissioners and UHL clinicians confirmed that increased activity has been observed at a national level. On the latter, ongoing monitoring arrangements are in place to track activity levels on a monthly basis and a downward trend is evident in the latest monitoring information.

Health-related quality of life for people with Long Term Conditions

25. This is annual data and the next expected publication is November 2015.

Estimated diagnosis rate of people with dementia

26. Dementia figures have now been added onto the practice profile dashboards and regular dementia communications are sent to GP practice dementia leads and are included in the GP bulletin. Practices within the lowest quartile are being supported via phone calls. Care planning workshops are being held and include multi agency stakeholders. Localised dementia services (health, social and voluntary sectors) are being scoped to pull together service packs for practices.

Proportion of people feeling supported to manage their own condition

27. This indicator measures the degree to which people with health conditions that are expected to last for a significant period of time feel they have had sufficient support from relevant services and organisations to manage their condition and is from the GP Patient Survey. This has been RAG rated red as 2014/15 data is below the 2013/14 baseline across both CCG areas.

Health-related quality of life for carers – ELR only

28. This indicator measures health-related quality of life for people who identify themselves as helping or supporting family members, friends, neighbours or others with their long-term physical or mental illness/disability or because of problems related to old age. There has been no significant change in the health-related quality of life for carers across ELR CCG. This is based on responses to the GP Patient Survey.

Employment of people with mental illness (difference between England population and people with Mental Illness)

29. This is available quarterly and fluctuates considerably given the time of year that employment data is made available. Data for Jan – Mar 15 is currently reported, and this has considerably improved from Jan – Mar 14, but there has been no improvement from the baseline position of July 14 - Sept 14. This will continue to be monitored. This indicator is at Leicestershire County level only, not at CCG level.

Patient experience indicators

30. No new data from that reported in September, and next data expected in January 2016.

Incidence of health associated infection CDIFF – West Leicestershire only

31. There has been an increase in the number of CDiff cases attributed to WL patients in June and July. A deep dive was undertaken and presented to September's Quality and Performance Group to understand any trends or further information on this. The target of 77 cases or less during 2015/16 was based on historic data. During 14/15 there were 80 cases across the CCG.

Recommendations

32. The Board is asked to:

a) note the performance summary, issues identified this quarter and actions planned in response to improve performance; and

b) comment on any recommendations or other issues with regard to the report.

List of Appendices

Appendix A – Better Care Fund Summary Dashboard

Appendix B – Provider and CCG Performance Summary Dashboard

Background papers

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

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