NHS
East Leicestershire and Rutland
Clinical Commissioning Group

Meeting Title	East Leicestershire and Rutland Clinical Commissioning Group – Governing Body meeting	Date	Tuesday 10 January 2017
Meeting no.	34.	Time	9:30am – 11:00am
Chair	Dr Richard Palin (Chairman)	Venue / Location	Guthlaxton Committee Room, County Hall, Glenfield, Leicester, LE3 8TB.

	AGENDA ITEM	ACTION	PRESENTER	PAPER	TIMING
B/17/1	Welcome and Introductions		Dr Richard Palin		9:30am
B/17/2	To receive questions from the Public in relation to items on the agenda	To receive	Dr Richard Palin	**verbal**	9:30am
B/17/3	Apologies for Absences: • Dr Andy Ker	To receive	Dr Richard Palin	**verbal**	9:40am
B/17/4	Declarations of Interest on Agenda Topics	To receive	All	**verbal**	9:40am
B/17/5	Minutes of the meeting held on 13 December 2016	To approve	Dr Richard Palin	**A**	9:40am
B/17/6	Matters Arising: Update on actions from the meeting held on 13 December 2016	To receive	Dr Richard Palin	**B**	9:45am
B/17/7	Notification of Any Other Business	To receive	Dr Richard Palin	**verbal**	9:50am
B/17/8	Patient Story	To receive	Dr Richard Palin	**DVD**	9:50am
REPORTS					
B/17/9	Chairman's Report	To receive	Dr Richard Palin	**C**	10:05am
B/17/10	Accountable Officer's Corporate Report	To receive	Karen English	**D**	10:10am
FINANCE AND PERFORMANCE					
B/17/11	Finance Report: Month 8 update	To receive	Donna Enoux	**E**	10:15am
B/17/12	Corporate Performance Assurance Report	To receive	Yasmin Sidyot	**F**	10:30am
STRATEGY AND COMMISSIONING					
B/17/13	Locality Chairs' Report: ▪ Oadby and Wigston ▪ Melton, Rutland and Harborough ▪ Blaby and Lutterworth	To receive	Locality Chairs	**G**	10:45am

	AGENDA ITEM	ACTION	PRESENTER	PAPER	TIMING
DATE OF NEXT MEETING					
B/17/14	The next meeting of the East Leicestershire and Rutland CCG Governing Body will take place on **Tuesday 14 February 2017, Guthlaxton Committee Room, County Hall.**				11:00am

A

Blank Page

EAST LEICESTERSHIRE AND RUTLAND CLINICAL COMMISSIONING GROUP

Minutes of the Governing Body Meeting held on Tuesday 13 December 2016 at 9:30am at Guthlaxton Committee Room, County Hall, Leicester, LE3 8TB

Present:

Dr Richard Palin	Chairman
Mrs Karen English	Managing Director
Dr Andy Ker	Clinical Vice Chair
Dr Hilary Fox	GP, Melton, Rutland and Harborough Locality Lead
Dr Graham Johnson	GP, Blaby and Lutterworth Locality Lead
Dr Nick Glover	GP, Blaby and Lutterworth Locality Lead
Dr Girish Purohit	GP, Melton, Rutland and Harborough Locality Lead
Dr Vivek Varakantam	GP, Oadby and Wigston Locality Lead
Dr Tabitha Randell	Secondary Care Clinician
Mr Alan Smith	Independent Lay Member
Mr Warwick Kendrick	Independent Lay Member
Mr Tim Sacks	Chief Operating Officer
Mrs Donna Enoux	Chief Finance Officer
Mrs Carmel O'Brien	Chief Nurse and Quality Officer
Ms Jane Bethea	Public Health Consultant, Public Health
Mrs Yasmin Sidyot	Head of Strategy and Planning

In Attendance:

Mrs Daljit K. Bains	Head of Corporate Governance and Legal Affairs
Mr Jim Bosworth	Associate Director, Contracting
Ms Pragati Baddhan	Senior Communications and Engagement Officer
Ms Sue Staples	Healthwatch Leicestershire
Ms Julie Cockcroft	Commissioning Collaborative Support Officer (minutes)

Members of the Public: there were members of the public present.

ITEM	DISCUSSION	LEAD RESPONSIBLE
B/16/152	**Welcome and Introductions** Dr Richard Palin, Chairman, welcomed all to the December 2016 meeting of the East Leicestershire and Rutland Clinical Commissioning Group (ELR CCG) Governing Body. An introduction of the Board members was made for the benefit of the members of the public present.	
B/16/153	**To Receive Questions from the Public in Relation to Items on the Agenda** There were no questions received from members of the Public.	
B/16/154	**Apologies for Absence:** • Mr Clive Wood, Deputy Chair and Independent Lay Member • Dr Tim Daniel, Public Health Consultant, Public Health	
B/16/155	**Declarations of Interest on Agenda Topics** All GP members declared an interest in any items relating to primary care where a potential conflict may arise and also where there are	

ITEM	DISCUSSION	LEAD RESPONSIBLE
	any items concerning the Leicester, Leicestershire and Rutland Provider Arm where GP members' are minor shareholders. Dr Palin informed that the Register of Interests is available on the CCG's website which details all declarations made by the members of the Governing Body. It was **RESOLVED** to: • **RECEIVE and NOTE** the declarations made.	
B/16/156	**Minutes of the Meeting Held on Tuesday 8 November 2016 (Paper A)** The minutes of the meeting held on Tuesday 8 November 2016 (Paper A) were accepted as an accurate record of the meeting subject to the following amendments: **Page 7,** fourth paragraph, "fomat" to read "format. **Page 8, B/16/143 – Finance Report:** • The first sentence of the second paragraph should read, "Mrs Enoux reported that the *first draft of the* financial plan for 2017/18 was now finalised and highlighted the following key points". • The third bullet point should read, "The contracting envelopes include *approximately* £10m QIPP for LPT and £20m QIPP for UHL". • The figure on the first line of the third paragraph should be *"£2,595k".* • The fourth line of the fourth paragraph should read, "...*in order to achieve the final year end control total".* • The last sentence of the sixth paragraph should read, "*It was noted that next year would be another financially challenging year for ELR CCG".* It was **RESOLVED** to: • **APPROVE** the minutes of the previous meeting with the amendments highlighted.	
B/16/157	**Matters Arising: Update on Actions from the Meeting held on Tuesday 8 November 2016. (Paper B)** The action log (Paper B) was received and updates noted against the following actions: • **B/16/97 – Let's Talk Wellbeing – Presentation by Leicestershire and Rutland IAPT Service** It was noted that information was sent electronically to GP	

ITEM	DISCUSSION	LEAD RESPONSIBLE
	Practices and consisted of a letter detailing the insomnia initiative and self-referral form. Printed versions of the forms were being distributed to GP surgeries. **Action Complete** • **B/16/121 – Finance Report: Month 5 – Update** It was noted that a Finance Report update was included in the agenda for the December 2016 meeting. **Action Complete** • **B/16/122 – Integrated Governance Committee meeting – Summary Report, October 2016** It was noted that the e-referral process was under review as highlighted in the Corporate Performance Report on the agenda and updates against the standard are discussed at the Integrated Governance Committee. **Action Complete** • **B/16/128 – Corporate Performance Assurance Report – EMAS Performance** It was noted that Governing Body members were provided with a summary report in December 2016, ahead of the Governing Body meeting. **Action Complete** • **B/16/128 – Corporate Performance Assurance Report – EMAS Performance** It was noted that a 'deep dive' into Urgent Care was presented to the PPAG meeting held on 24 November 2016, which included EMAS performance. **Action Complete** • **B/16/147 – Locality Chairs' Report** It was noted that the Communications Team compile a high level summary bulletin from the CCG to the PPEG containing key messages and updates. **Action complete** It was **RESOLVED** to: • **RECEIVE** the matters arising.	
B/16/158	**Notification of Any Other Business** The Chairman had not received notification of any additional items of business.	
B/16/159	**Chairman's Report (Paper C)** Dr Richard Palin, Chair of the Governing Body presented this report, which provided an overview and update on some of the key constitutional and strategic areas that affect the Governing Body, including meetings attended in November 2016. Dr Palin drew the Governing Body's attention to the following stakeholder engagement events on the draft Sustainability and Transformation Plan (STP):	

ITEM	DISCUSSION	LEAD RESPONSIBLE
	• Rutland Community Hospital attended by Mr Sacks and Dr Ker. Healthwatch Rutland facilitated the event and all questions raised would be forwarded to the CCG for response. • Lutterworth Community Hospital to be attended by Dr Palin, Mrs O'Brien and Ms Bilsborough. It was **RESOLVED** to**:** • **RECEIVE** the Chairman's report.	
B/16/160	**Accountable Officer's Corporate Report (Paper D)** Mrs Karen English, Managing Director presented this report, which set out some of the key activities the Executive Management Team (EMT) have been involved in since the last meeting of the Governing Body in November 2016. Mrs English drew the Governing Body's attention to the following areas of activity: • The CCG Operational Plan for 2017/18 was submitted to NHS England on Friday 24 November 2016 in line with the national timescales. • Contract negotiations and local mediation for University Hospitals Leicester (UHL) and Leicestershire Partnership Trust (LPT) contracts. It was confirmed that contract negotiations have to be settled by 23 December 2016 The QIPP totals across Leicester, Leicestershire and Rutland were confirmed as: £11m for LPT; and £17.8m for UHL. • The Sustainability and Transformation Plan (STP) has been published and consultation events were being held with key stakeholders. • The CCG's Head of Patient Safety, Ms Tracy Ward won the award for Leading Systems Transformation at the East Midlands Leadership Academy recognition awards The Governing Body recognised Ms Ward's achievement, noting the award was for "somebody who has achieved great systems leadership, encompassing complex relationship building, improving patient care and sharing best practice". It was **RESOLVED** to**:** • **RECEIVE** the report.	
B/16/161	**Summary Report from the Financial Turnaround Committee (November 2016) (Paper E)** Dr Graham Johnson, GP, Blaby and Lutterworth Locality Lead presented this report, which provided a summary of the key areas of discussion and outcomes from the Finance Turnaround Committee in November 2016. The Committee meeting had focused on QIPP delivery and the	

ITEM	DISCUSSION	LEAD RESPONSIBLE
	Finance Report (Month 7). Dr Johnson highlighted that each QIPP scheme had been red, amber and green (RAG) rated noting that the RAG rating was applied to the level of certainty of achieving the forecast outturn and the associated value. The Committee noted that the schemes with a "red" rating were: **Urgent and Emergency Care:** • **Vanguard Strand 1** – whilst the pilot for Vanguard Strand 1 is delivering a positive impact, the delays to this work stream will mean that the savings to be delivered have reduced. The revised forecast is £188,082. • **Vanguard Strand 3** – this scheme is a mitigation against under-performance in relation to Vanguard Strand 1 planned savings. However, this scheme has had problems with recruitment and is underperforming against a previous forecast of £65k. Dr Johnson confirmed that Ambulance Handover fines would therefore need to be paid and that the saving of £151k would need to be found from other QIPP schemes. It was noted that the responsibility for providing RAG rating in relation to delivering the QIPP forecast outturn sits with each Senior Responsible Officers (SRO) and that the QIPP RAG ratings were monitored and scrutinised on a monthly basis. Mrs Enoux confirmed that in addition to the scrutiny undertaken by the Financial Turnaround Committee there was a weekly review and update of QIPP scheme RAG ratings, focusing on variance to forecast outturns. It was noted that each QIPP scheme will be rated in order of financial risk to the CCG in the next QIPP paper to Finance Turnaround Committee. It was noted that the "blue" rated QIPP schemes were schemes which had been closed or identified as discontinued. Mrs Enoux highlighted that is was unlikely all schemes had been identified as there were a number of schemes were back ended with the anticipation that forecast outturns may change. Summary Report from the Financial Turnaround Committee (November 2016) It was **RESOLVED to:** • **RECEIVE** the report.	**Donna Enoux**
B/16/162	**Finance Report: Month 7 update (Paper F)** Mrs Enoux, Chief Finance Officer presented this report which	

ITEM	DISCUSSION	LEAD RESPONSIBLE
	provided details of the financial position of East Leicestershire and Rutland CCG (ELR CCG) at month 7 of 2016/17 noting the forecast achievement of the year end control total surplus and the associated risks and mitigations. Mrs Enoux highlighted the following: • ELR CCG financial position forecast remains on track • There was no significant movement for under or over spend • There was a net overspend within Co-Commissioning which reflects the financial pressure of Long Street Surgery • Running costs remain underspent • Capital spend remains on track with the prediction to be spent by the end of the financial year • Better Payment Practice Code (BPPC) - there was a focus to achieve the year-end target of 95% The main risks that have the potential to adversely affect the CCG's financial position for 2016/17 were highlighted as: • Non achievement of existing and recently identified QIPP schemes • UHL further over performance against various Points of Delivery • In year cost pressures relating to support to GP practices. • Resolution of a number of ongoing contract discussion areas including; o UHL to Alliance "left shift" o ICS beds development is not neutral for CCGs. o Out Of County and Independent Sector provider continued over performance due to capacity constraints at UHL • Adult Mental Health and female PICU out of County placement costs. Appendix G detailed the current identified risks and mitigations. Mr Alan Smith made reference to paragraph 10 on page 2 which stated the Acute Commissioning activity was based on information from April to August. Mrs Enoux confirmed the activity was actually based on information from April to September 2016. In response to a question from Mr Kendrick, Mrs Enoux confirmed that the £1.4m for Coding & Counting was included in the forecast outturn and would need to be delivered. Dr Varakantam asked for clarification on Coding and Counting and SLAM data. Mrs Enoux confirmed that the SLAM data in the month 7 report was based on actuals to date and that further work was being undertaken on Coding and Counting data adjustments for end of year with challenges back to UHL.	

ITEM	DISCUSSION	LEAD RESPONSIBLE
	Dr Johnson made reference to Appendix B Acute Commissioning forecast which at worse was £7,822k and at best £2,244k and asked what levels of confidence there were that the best case would be achieved given that this was a high value contract that posed substantial risk to the CCG. Mrs Enoux responded that UHL were being challenged on their calculations with monthly adjustments made but emphasised that the UHL QIPP was high risk as the majority of savings were back ended. Mrs Enoux stated that the figures for most likely and best case were very similar and acknowledged that the plan had to be delivered as there was no contingency. In response to a query from Dr Johnson, Mrs Enoux stated that Leicester City CCG hosted contract team worked closely across the three CCGs on forecasting and challenging. Mrs English stated that the next three months should deliver a significant impact and that rigorous scrutiny and challenges were paying off. It was **RESOLVED** to: • **RECEIVE** the report.	
B/16/163	**Activity Reporting – Gemima and SLAM comparison (Paper G)** Mrs Enoux, Chief Finance Officer presented this report which provided a summary of the main differences between Gemima (year on year) activity reporting and Service Level Agreement Monitoring (SLAM) data. The report also outlined the actions currently being taken to address some of the differences within the Gemima reporting suite. It was noted that a number of the Gemima reports that were accessed by clinicians were "year on year" comparisons whereas the finance reports would always show a variance against the agreed annual plan for the area in question, so the data could not be compared like for like. It was noted that exclusions and adjustments were detailed in Appendix A. Dr Johnson made reference to the figures contained within Appendix A stating that in general Gemima data were 10 – 11% down but still over plan which raised concern regarding the figures in the original plan. Dr Johnson stated the importance of GP performance reports being able to see what practices were achieving compared to previous years. Mrs Enoux confirmed that Gemima could be used to inform GP performance reports and clarified that this report outlines the differences between Gemima and SLAM data.	

ITEM	DISCUSSION	LEAD RESPONSIBLE
	Mrs Sidyot joined the meeting Dr Fox asked if milestone data could be used for GP performance reports. Mr Sacks stated that performance reports needed to make direct comparisons year on year and that Gemima would achieve this. **Mr Sacks agreed to meet with Dr Fox outside of the meeting to work through how data was used within localities.** It was **RESOLVED to:** • **RECEIVE** the report.	Tim Sacks / Hilary Fox
B/16/164	**Summary Report from the Provider Performance Assurance Group (PPAG) (November 2016) (Paper H)** Mr Warwick Kendrick presented this report, which provided assurance to the Governing Body from the Provider Performance Assurance Group (PPAG) meeting held in November 2016. Mr Warwick drew the Governing Body's attention to the detailed review undertaken by PPAG in respect of Urgent Care A&E Delivery Board, A&E Performance and East Midlands Ambulance Service (EMAS), in particular noting: • The urgent care recovery action plan (RAP) was scrutinised by the A&E Delivery Board with PPAG members informed that NHS England and the A&E Delivery Board were confident of the progress being made against key interventions within the RAP. • PPAG members raised concerns regarding the ineffectiveness of the streaming service given the continued high number of patients attending ED leading to over performance against contract activity. • Further concerns were raised regarding the lack of access to diagnostics by Lakeside, as this was considered to be part of the original contract intention to reduce attendance at ED. • Failure of EMAS to achieve the Red 2 and A19 trajectory with performance in October 2016 deteriorating since September 2016. • With regards to the joint investigation held by EMAS and Commissioners the contract team have been asked to provide assurance to PPAG members at their meeting in January 2017 in respect of implementation of the actions and recommendations set out in the Care Quality Commission's enforcement notice. Dr Palin asked if the delays were related to sharing imaging or specific to the implementation of EMRAD. Dr Varakantam stated that different priorities had been set within radiology plain film and MRI scans and that there were concerns regarding full assurance on clearing the backlog. It was **RESOLVED to:** • **RECEIVE** the report.	

ITEM	DISCUSSION	LEAD RESPONSIBLE
B/16/165	**Corporate Performance Assurance Report (Paper I)** Mrs Sidyot, Head of Strategy and Planning presented this report that provides an overview of performance for East Leicestershire & Rutland CCG and LLR where data is available for September/October 2016; including the key performance indicators that the CCG are held to account for that are detailed in the CCG Improvement and Assessment Framework for 2016/17. The report outlined that the following indicators were not achieving standards: • Cancer Waits; 62 Day Wait STF trajectory; 2WW Breast Symptoms, 31 Day, 31 Day Surgery and Radiotherapy. This position has altered slightly from last month from 6 indicators not achieving to 5 indicators. Close monitoring is continuing. • Mental Health; Improved Access to Psychological Therapies (IAPT) Roll Out (local data), Recovery and Access to talking therapies < 6 weeks (local data). This has altered from last month, as Recovery is underachieving 50% standard in September 2016. • Learning Disabilities; Q2 Specialist In-patient Care. The position has deteriorated from Q1 for LLR. • Maternity; Neonatal mortality and still births and women's experience of maternity services. • Dementia; Diagnosis. • Urgent Care; Emergency admissions for urgent care sensitive conditions, A&E 4 Hour Wait, Ambulance Handovers, Ambulance Response times, Crew Clear and Delayed Transfers of Care. Ambulance Response Times for Red 1 continues to achieve between August to October against the STF trajectory. • Elective Access – 18 weeks RTT, 52 Week Waits, 6 weeks diagnostics and Cancelled Operations • Additional Indicators: Health Acquired Infection – CDIFF. NHS 111 - calls answered within 60 seconds reported as non-achievement for October 2016. Dr Johnson made reference to item 4.9 on page 8 regarding Cancer 31 day wait which outlined the issues regarding the High Dependency Unit and ITU beds. It was noted that the ITU beds were not yet open due to lack of clinical staff at UHL and the need for more clinicians and ITU nurses. Dr Johnson made reference to item 9.7 on page 16 and asked why the STF trajectory had not been agreed. Mrs Sidyot confirmed that UHL had provided a target which has not been accepted by NHS England.	

ITEM	DISCUSSION	LEAD RESPONSIBLE
	Dr Purohit made reference to item 8 – Dementia and questioned the data that indicated only one patient had been diagnosed with Dementia between September and October 2016. Dr Purohit suggested the data be checked as there was an expectation that more patients would have been diagnosed given the increased activity within the memory clinic during the last few months. Dr Johnson made reference to item 9.9 on page 17 which stated that UHL were expecting to recover the ambulance handover standard by May 2017 and emphasised there was no evidence to support this statement. Dr Johnson raised concerns regarding the financial risk to CCGs and asked if potential additional charges had been factored into financial forecasts. Mrs Enoux confirmed there would be an update presented to Managing Directors on 14 December 2016 and that risks will be reviewed in relation to ELR CCGs financial position. Mr Sacks provided feedback from on-call activities stating that at one point there were 22 ambulances waiting at UHL with a longest wait time of 4 hours leading to an average of a 2 hour wait for Red 2 ambulance calls to be despatched. Ms Staples explained that Health Watch had spent some time in A&E recently and had reported a worrying situation which leaves it hard to believe the standards would improve. *Mr Sacks left the meeting* It was **RESOLVED to:** • **RECEIVE** the report.	
B/16/166	**Locality Chairs' Report (Paper J)** The purpose of this report was to provide an overview of the monthly GP Locality meetings held across Melton, Rutland and Harborough, Blaby and Lutterworth and Oadby and Wigston, which are key to the development of the CCG and allows member practices an opportunity to debate current general practice and highlight themes they wish to inform the Board. The key areas of the report were presented as follows: • **Melton and Harborough – Dr Purohit:** **Finance** - Dr Purohit informed that members had taken the opportunity to continue discussions about what General Practice could do to support managing Primary Care finances. Locality group had a discussion about potential QIPP schemes. **Communications** – a discussion had taken place how the CCG could improve communications with practices noting that the results	

ITEM	DISCUSSION	LEAD RESPONSIBLE
	of the 360 Degree Stakeholder Survey showed that the CCG was not doing as well this year in terms of communicating with practices. • **Rutland - Dr Fox** Dr Fox informed that members had discussed suggestions submitted by Primary Care in October for saving money to meet the budget challenge. Dr Fox made reference to the developments within palliative care services in Rutland and in particular Dove Cottage, which was the new hospice day care service for Rutland patients. • **Oadby - Dr Varakantam** Dr Varakantam informed that members had received feedback on proposed QIPP schemes and noted that the majority of suggestions put forward were already being looked at and were pleased to receive a breakdown of the CCG running costs. Demand management was discussed and GPs were open to auditing data but raised concerns regarding the reliability of data available through Gemima. Frustrations were also raised regarding the PRISM system and members were keen to hear that there would be additional training and support provided by the PRISM team. Feedback was received from the last 360° Stakeholder Survey and members raised concerns regarding the amount of time required to complete various surveys and forms; and asked for the CCG to consider more easy and efficient methods to communicate and receive feedback from member practices. • **Blaby & Lutterworth – Dr Johnson** Dr Johnson informed that members had received an update on Primary Care finances with the importance of continued practice peer reviews for GP referral demand management highlighted. Members welcomed the RCGP approach to dementia diagnosis and were keen to adopt this approach within the locality. Members had discussed the 360° Stakeholder Survey results for 2015/16 noting the importance of practices completing the survey when it comes out in January 2017. Members raised concerns regarding the increasing number of C Diff occurrences. Members noted that Countesthorpe Health Centre had been experiencing a 2 month wait for patients referred for complex wounds provided by LPT and expressed concern that this was unsafe for	

ITEM	DISCUSSION	LEAD RESPONSIBLE
	patients. Mrs English clarified that these concerns would need to be raised through the contract monitoring route rather than the Governing Body unless the same difficulties were being experienced across a number of practices. Dr Purohit stated that some practices in Harborough were experiencing similar delays and were working with LPT to identify and resolve the problems. Dr Purohit agreed to raise concerns through the CHS Sub Group and Mr Bosworth would progress concerns through the contracting route. Dr Palin asked if practices had resolved the use of additional resource for C Diff. Dr Johnson responded that this was being progressed through discussions with practices and pharmacists but stressed the concerns raised by GPs regarding the increasing numbers for C Diff cases. **It was agreed that Mrs O'Brien would provide an update in respect of the C.Diff position at the next meeting of the Governing Body in January 2017.** Dr Ker stated that mixed messages were being received with regards to not prescribing of specific antibiotics and concerns were noted regarding the need for alternative antibiotics to be found. **It was RESOLVED to:** **RECEIVE** the report. *The meeting closed for a ten minute break and resumed at 11 am.*	**Mrs O'Brien**
B/16/167	**Governance structure to support the Sustainability and Transformation Plan (STP) (Paper K)** Mrs English, Managing Director presented this report which outlined the draft terms of reference for the System Leadership Team (SLT) for approval by the Governing Body. Mrs English explained that the SLT was being formed as part of the governance structure to support the STP. The BCT Partnership Board had been disbanded with key people now represented on the System Leadership Team. *Mr Sacks re-joined the meeting* Mrs English stated that STP governance would form part of CCG Governance Structure and changes to CCG Constitution would need to be made. It was noted that the Head of Corporate Governance and Legal Affairs had presented various iterations to the Executive Management Team in order to obtain initial feedback and comments to inform the documents. For instance, comments provided included: capital decisions, membership and quoracy. It was noted that a flow diagram of decision making could be found at Appendix B Mrs Bains added that feedback had been provided on the following concerns:	

ITEM	DISCUSSION	LEAD RESPONSIBLE
	• SLT could not be constituted as a Joint Committee consisting of both commissioners and providers, this was not legally permissible; • A joint committee of the 3 CCGs could be established by the respective CCG Governing Bodies and that the meeting would need to be held in public in line with national guidance; • 1 member forming the quoracy was not considered to be sufficient per CCG and in the initial feedback it was proposed that this be increased to 2 and include a clinician, however it was noted that the document presented remained unchanged and stated the meeting would be quorate with 1 member. • It was noted that earlier iteration proposed authority be delegated in respect of finances, however no detail on the level of financial delegation was provided and therefore it was suggested that financial delegations remain with the CCG Governing Body. Dr Ker expressed concern regarding the lack of clinicians within the membership of SLT given that the original intention was this would be clinically led. Mrs English confirmed these concerns had been raised in feedback to West Leicestershire CCG who was coordinating the work. It was noted within the terms of reference for SLT where members do not feel they are in position to support the consensus position reached by the SLT they reserve the right to refer the issue back to the Governing Body of their organisation for further consideration before the issue comes back to the SLT to take a decision. Mr Kendrick made reference to paragraph 4, page 3 of the Governance for the STP and asked how issues of conflict of interest and procurement could be addressed within the SLT. Mrs English referred to paragraph 26 of the Terms of Reference for SLT which outlined the draft Conflicts of Interest and stated this had been drafted following guidance from NHS England. It was felt that clarification was required on the role of a nominated deputy to step in and vote on an occasion of conflict of interest. Dr Johnson asked if consideration had been given to the practicalities of consulting with CCG Governing Bodies prior to decisions being taken by SLT. It was noted that SLT meetings had been scheduled to take place after Governing Body meetings had been held in order for discussion and decisions to be taken to feed into the SLT process. Dr Palin responded that SLT members would have the right not to agree with decisions taken and bring back to Governing Bodies for further consideration. Dr Palin clarified that as the decision making members for SLT both	

ITEM	DISCUSSION	LEAD RESPONSIBLE
	he and Mrs English would veto any decisions taken if it was felt the issues had not received adequate discussion and agreement at Governing Body. It was noted that the SLT would have financial oversight of system control totals and that individual organisations would retain responsibility for the local application of system plans, individual organisation operational plans, financial planning and reporting and taking decisions on the outcomes of consultations. Mrs English emphasised that there was no appetite from NHS England or across the three CCGs to merge the CCGs into one organisation. Ms Staples acknowledged the value of the role of SLT but raised concerns regarding the lack of patient representatives within the membership. It was noted that the membership list was not included in the report and that this would have been useful as part of the discussion and decisions regarding approval of the SLT Terms of Reference. Dr Johnson made reference to the membership section (39 – 45) on page 8 of the Governance for the STP and raised the question of decision making given that the six decision making members for SLT were from the three CCGs, with the providers being non-decision making members. Dr Palin made reference to section 23 of the SLT Terms of Reference and stated the requirement for membership of the screening panel. Mrs Bains agreed to seek clarification as part of the feedback to Ms Brutnall. Mrs Bains noted and summarised the following areas that the Governing Body requested be reviewed and / or clarification sought in relation to the terms of reference and scheme of delegation: • **Quoracy:** o It was not considered sufficient to have 1 member from the CCG present to form the quoracy; the suggestion was to have at least a minimum of 2; o the quoracy should also include a clinician from each CCG (whether a GP or nurse) so that the focus remains on being a clinically led health system; and o deputies – the Governing Body agreed that where the clinician may be conflicted one of our lay members would deputise. It was agreed that we may not have the same deputy each time, it depends on capacity, availability and whether they are conflicted.	

ITEM	DISCUSSION	LEAD RESPONSIBLE
	• **Decision to revert to Governing Body:** o The Governing Body members referred to paragraph 17 in the terms of reference ("Where members don't feel they are in a position to support the consensus position reached by the SLT they reserve the right to refer the issue back to the governing body of their organisation for further consideration before the issue comes back to the SLT to take a decision"). This was considered not to be correct. The Governing Body emphasised that if the CCG members present do not feel they can make a decision at the SLT then the decision will be reverted to the Governing Body. • **Membership:** o the Governing Body asked that the SLT consider having a representative from Healthwatch and lay members on the meetings to provide the patient voice, scrutiny and challenge. • **Timing of SLT meetings:** o The Governing Body members were concerned about the timing of SLT meetings and the potential impact on decision making for the Governing Body, late reports / decisions etc. • **Screening Panel:** o The Governing Body asked that the Screening Panel membership and remit be reviewed by the Executive Management Team. The Governing Body members agreed that the points summarised captured the issues raised. **Mrs Bains to provide feedback to West Leicestershire CCG.** It was **RESOLVED to:** • **RECEIVE** the report and • **AGREED:** • to the proposal to establish SLT as a formal joint committee of the three CCGs subject to amendments being made as requested and clarification provided where requested as discussed. • the membership of the SLT includes representatives from the NHS Statutory Providers and Local Authorities in LLR, though they will not have decision making authority. • the Terms of Reference of the SLT subject to clarification on the changes and feedback listed above • to amend the CCG constitution and scheme of reservation and delegation accordingly to include provision for the SLT as a joint committee of the three CCGs, with decision making authority for the matters specified within the SLT	**Daljit Bains**

ITEM	DISCUSSION	LEAD RESPONSIBLE
	Terms of Reference.	
B/16/168	**Emergency Preparedness, Resilience and Response (EPRR) Compliance Report (Paper L)** Mr Tim Sacks, Chief Operating Officer presented this report which provided an update in relation to the Emergency Planning Resilience and Planning (EPRR) NHS England Core Standards submission for 1016-17 for the LLR CCGs. Mr Sacks explained that as part of the EPRR process CCGs were asked to ensure all EPRR related documentation was current and updated where necessary. This includes business continuity plans and polices, the LLT Major Incident Plan (Appendix 1) and the LLR Surge & Capacity Plan (contained within Appendix 1). It was noted that CCG corporate teams were currently updating business continuity plans. Mr Sacks stated that the protocols and procedures for escalation were set out in the Major Incident Plan and informed members that escalation level 4 had been reached recently and that escalation level 3 and 4 were regular occurrences. Mrs O'Brien stated that the on-call Director needs to be able to make the connections between what is happening within UHL and EMAS and how this affects service delivery for both organisations. It was noted that NHS England conduct triangulation for major incidents with the on-call Director present at the daily conference call addressing key actions. It was **RESOLVED to:** • **RECEIVE** the report and • **AGREED** to approve the LLR Major Incident Plan	
B/16/169	**Summary Report from the Audit Committee (16 November 2016) (Paper M)** Mr Kendrick, Chair of the Audit Committee presented this report which provided a summary of the key areas of discussion and outcomes from the Audit Committee meetings held in November 2016. The report provided assurance to the Governing Body in respect of the effectiveness of risk management systems and processes across the CCG; and also items for escalation for consideration by the Governing Body ensuring that the Governing Body is alerted to emerging risks or issues. The key areas and issues to note were as follows: • the Board Assurance Framework Survey that Governing Body members participated in – the findings and actions agreed with the	

ITEM	DISCUSSION	LEAD RESPONSIBLE
	Audit Committee.. • Internal Audit Process – the Internal Auditors presented their progress report, noting specifically that audit follow-ups are now only outstanding for a couple of audits from 2015/16. It was noted that Audit reviews for 2016/17 were progressing. This included the Governing Body members completing an online survey in relation to their understanding of the purpose of the Board Assurance Framework and risk registers. The findings of the survey were presented to the Audit Committee with some of the key findings outlined in the report, which included: o That nearly half of the survey respondents did not have a good understanding of the Board Assurance Framework and its purpose; and o Two thirds of the respondents felt that key partnership risks were not adequately captured within the Board Assurance Framework. It was therefore agreed that a development session would be held for the Governing Body in early 2017 focusing on the Board Assurance Framework and risk management. A date for the session would be agreed with the Chairman and circulated. It was **RESOLVED to:** • **RECEIVE** the report.	
B/16/170	**Summary Report from the Primary Care Commissioning Committee (6 December 2016) (Paper N)** Dr Randell, Secondary Care Clinician and Vice-Chair of the PCCC presented this report, which provided the Governing Body with an overview of the discussions, actions and decisions made at the Primary Care Commissioning Committee (PCCC) meetings held on 6 December 2016. Dr Randell took the report as read, highlighted that PCCC received reports and updates in relation to the following: • Review of the PCCC terms of reference following the clarification received from NHS England in relation to the Conflicts of Interest (CoI) Guidance and the appointment of a lay vice chair to the Committee; • Care Quality Commission inspection report relating to The Glenfield Surgery; and • Update on the Primary Care Co-Commissioning Finance for 2016-17 (Month 7, October 2016). Dr Glover made reference to the revised Terms of Reference (Appendix 1) and NHS England insistence that a Lay Member be appointed as Vice Chair of PCCC. Dr Glover raised concerns	

ITEM	DISCUSSION	LEAD RESPONSIBLE
	regarding the remit of PCCC and stressed the requirement for clear direction on the purpose of the Committee. Mr Sacks stated that the remit for PCCC had not developed in the way originally intended and felt the Committee could be used more effectively. Mrs Bains informed that the PCCC had been established within NHS England guidelines. Mr Sacks expressed concern that PCCC had become a narrow meeting and required review in terms of its ability to discuss and debate wider areas. Dr Palin stated that a solution was required that addressed the concerns raised. **It was proposed that Mrs Bains would review the remit for PCCC to identify potential changes with proposals for any changes presented to the Chairman two weeks before the next formal meeting of the PCCC.** Members of the Governing Body voted on the approval of the revised terms of reference for PCCC as at Appendix 1. All members agreed with the amendments proposed in the revised version, with the exception of Mrs English and Dr Fox who abstained from voting. As the majority voted in favour the revised terms of reference were approved. It was **RESOLVED to:** • **RECEIVE** the report • **APPROVE** the revised terms of reference as at Appendix 1 • **AGREE** that Mrs Bains would review the remit for PCCC to identify potential changes with proposals for any changes presented to the Chairman two weeks before the next meeting of the PCCC.	**Mrs Daljit Bains**
B/16/171	**Integrated Governance Committee Summary Report (6 December 2016) (Paper O)** Dr Randell, Secondary Care Clinician and Chair of the Integrated Governance Committee (IGC) presented this report, which provided a summary of the key areas of discussion and outcomes from the IGC meeting held on 6 December 2016: • Agreed the revisions to the Committee terms of reference for onward approval by the Governing Body; • Better Care Together – Health Innovation and Improvement - Tier 3 Weight Management Pathway (Medical Input Pilot): approved funding of £1,667 for 2016/17 and 2017/18 for an 8 month pilot project across LLR operated by specialists at UHL in conjunction with the existing tier 3 services; • the draft commissioning plan had been submitted on 24 November 2016; and feedback awaited from NHS England; • an update received on the work in progress to refresh and prepare the Leicestershire Better Care Fund (BCF) plan for 2017/18 was presented for information.	

ITEM	DISCUSSION	LEAD RESPONSIBLE
	• Corporate Performance Report: noting performance has deteriorated in a number of areas; • Cancer Deep Dive presented, noting areas for further development; and • Briefing Regarding Needs Led Resource Allocation System for Personal Health Budgets. Dr Randell made reference to positive performance against the following standards: • Maternal Smoking at Delivery (Improvement and Assessment Framework: Better Health Dashboard) – the Committee noted the achievement of the year to date target at 6.90% against the standard to remain below 8.6%; and • Cancer 2 week wait % of patients seen within two weeks of an urgent referral for breast symptoms. Dr Randell made reference to the Committee terms of reference and the proposed changes to ensure a valid quorum due to current capacity constraints. Dr Purohit emphasised that the change in quoracy was a consequence of having a GP vacancy and that having only 1 GP for quoracy could potentially affect decisions made. It was **RESOLVED to:** • **RECEIVE** the report and • **AGREED** to approve the revised Terms of Reference for the Integrated Governance Committee as set out within Appendix 1	
B/16/172	**Date of next meeting** The next meeting of the East Leicestershire and Rutland CCG Governing Body will be take place on **Tuesday 10 January 2017, Guthlaxton Committee Room, County Hall Leicester, LE3 8TB.**	

B

Blank Page

NHS EAST LEICESTERSHIRE AND RUTLAND CLINICAL COMMISSIONING GROUP

ACTION NOTES

Key

Completed	On-going	Outstanding

Minute No.	Meeting	Item	Responsible Officer	Action Required	To be completed by	Progress as at 10 January 2017	Status
B/16/161	13 December 2016	**Summary Report from the Financial Turnaround Committee (November 2016)**	**Donna Enoux**	Summary Report from the Financial Turnaround Committee (November 2016).	February 2017	Work in progress.	**AMBER**
B/16/163	13 December 2016	**Activity Reporting – Gemima and SLAM comparison**	**Tim Sacks / Dr Hilary Fox**	To meet with Dr Fox outside of the meeting to work through how data was used within localities.	January 2017	**A verbal update to be provided at the meeting.**	**AMBER**
B/16/166	13 December 2016	**Locality Chairs' Report**	**Carmel O'Brien**	To provide an update in respect of the C.Diff position at the next meeting of the Governing Body in January 2017.	January 2017	**A verbal update to be provided at the meeting.**	**AMBER**
B/16/167	13 December 2016	**Governance structure to support the Sustainability and Transformation Plan (STP)**	**Daljit K. Bains**	To provide feedback to West Leicestershire CCG in respect of the amendments and points of clarification on the SLT terms of reference and scheme of delegations.	December 2016	Feedback from the Governing Body emailed to West Leicestershire CCG on 20 December 2016. Update and further iteration of the terms of reference awaited. **ACTION COMPLETE**	**GREEN**

Minute No.	Meeting	Item	Responsible Officer	Action Required	To be completed by	Progress as at 10 January 2017	Status
B/16/170	13 December 2016	**Summary Report from the Primary Care Commissioning Committee (6 December 2016)**	**Daljit Bains**	Review the remit for PCCC to identify potential changes with proposals for any changes presented to the Chairman two weeks before the next formal meeting of the PCCC.	February 2017	A discussion to take place with the Chair of the PCCC by mid-January 2017 with regards to proposed changes before presenting them to the CCG Chairman by end January 2017.	**AMBER**

C

Blank Page

EAST LEICESTERSHIRE AND RUTLAND CLINICAL COMMISSIONING GROUP

GOVERNING BODY MEETING

10 January 2017

Chairman's Report

Introduction

1. The purpose of this report is to provide an overview and update of some of the key constitutional or strategic areas that affect the Governing Body and meetings that I have attended since my last report in December 2016.

Meetings attended

2. Dr Graham Johnson deputised for me and attended the System Leaders' meeting on 15 December 2016, which is at present a collaborative forum set-up to support the development of the Sustainability and Transformation Plan (STP) and local service reconfiguration.

Recommendations

The East Leicestershire and Rutland CCG Governing Body is requested to:

RECEIVE the contents of the report.

Dr Richard Palin
Chairman

D

Blank Page

NHS EAST LEICESTERSHIRE AND RUTLAND CLINICAL COMMISSIONING GROUP
GOVERNING BODY MEETING
10 January 2017

Accountable Officer's Corporate Report

Introduction

1. This report sets out to the Governing Body some of the key activities the Executive Management Team (EMT) and I have been involved in since the last meeting of the Governing Body in December 2016.

CCG Operational Plan and Financial Plan

2. We submitted the draft version of our Operational Plan and Financial Plan by 23 December 2016 in line with the national timescales. The plan is based on the Leicester, Leicestershire and Rutland (LLR) Sustainability and Transformation Plan (STP) footprint; it focusses on the key delivery areas articulating what we are doing in delivering the '9 must dos', delivery of the constitution targets and key actions to take place during 2017/18 -2018/19.

Better Care Funds (BCF) Leicestershire and Rutland

3. The NHS planning guidance confirmed the continuation of the Better Care Fund (BCF), and the ongoing requirements for integration policy implementation by 2020, specific national guidance for the BCF refresh for 2017/18-2018/18 is yet to be published.

4. Ahead of this, work is already well underway to refresh both the Leicestershire and Rutland BCF plans for the period 2017/18 – 2018/19 and progress continues to be reported to the CCG's Integrated Governance Committee. It is anticipated that the plans will need to be approved by the Governing Body in March 2017 ahead of submitting them to NHS England to progress through the national assurance process.

PUBLICATIONS

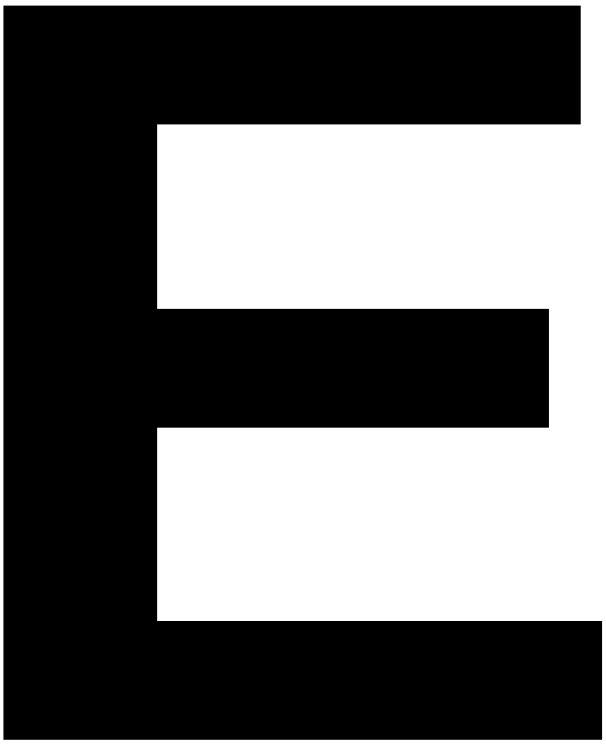
5. Publications and updates published by NHS England via its fortnightly newsletter *Bulletin for CCGs* can be found at the following http://www.england.nhs.uk/publications/bulletins/bulletin-for-ccgs/. The Executive Management Team undertakes a regular review of the content of the Bulletin and ensure actions are taken accordingly. Assurances and updates are reported through to the Governing Body as evident on the agenda and through updates in the Accountable Officer's report.

Recommendation

The East Leicestershire and Rutland CCG Governing Body is requested to:

RECEIVE the contents of the report.

Karen English
Accountable Officer



Blank Page

EAST LEICESTERSHIRE AND RUTLAND CLINICAL COMMISSIONING GROUP GOVERNING BODY MEETING

Front Sheet

REPORT TITLE:	**Finance Report – November 2016 (month 8)**
MEETING DATE:	**10 January 2017**
REPORT BY:	**Colin Groom, Deputy Chief Finance Officer**
SPONSORED BY:	**Donna Enoux, Chief Finance Officer**
PRESENTER:	**Donna Enoux, Chief Finance Officer**

EXECUTIVE SUMMARY:

This report contains the financial position for 2016/17 for East Leicestershire and Rutland Clinical Commissioning Group (ELR CCG) at month 8.

RECOMMENDATIONS:

The ELR CCG Board is requested to:

Receive for information the contents of the report and the appendices attached.

Note the financial position at month 8 and the forecast achievement of the year end control total surplus and the associated risks and mitigations.

REPORT SUPPORTS THE FOLLOWING STRATEGIC AIM(S) 2015 – 2016:			
Transform services and enhance quality of life for people with long-term conditions		Improve integration of local services between health and social care; and between acute and primary/community care.	
Improve the quality of care – clinical effectiveness, safety and patient experience		Listening to our patients and public – acting on what patients and the public tell us.	
Reduce inequalities in access to healthcare		Living within our means using public money effectively	✓
Implementing key enablers to support the strategic aims (e.g. constitutional and governance arrangements, communications and patient engagement).			

EQUALITY ANALYSIS

An Equality Analysis and due regard to the positive general duties of the Equality Act 2010 has not been undertaken in the development of this report as it is judged that it is not proportionate on the basis that the financial reporting underpins the commissioning strategy and priorities of the CCG. The commissioning strategy and priorities have and continue to be equality impact assessed as the strategy is reviewed and refreshed and this includes the financial plans.
This completes the due regard required.

EAST LEICESTERSHIRE AND RUTLAND CLINICAL COMMISSIONING GROUP GOVERNING BODY MEETING
10 January 2017

Finance Report

Introduction

1. This report provides details of the financial position for East Leicestershire and Rutland Clinical Commissioning Group (ELR CCG) at month 8 of 2016/17.

2016/17 Allocations

2. The overall revenue allocation for ELR CCG at month 8 stands at £408,927k, a non-recurrent decrease of £443k for an adjustment relating to the risk pooling of the cost of treatment of overseas visitors

3. The CCG has a confirmed capital allocation of £483k, unchanged from month 7.

4. The allocation is detailed in Appendix A.

Financial Performance

5. The summary budget statement in Appendix B details performance against budget as at 31 October 2016.

6. As reported in previous months, a profiling issue within the CCG's financial plan relating to its QIPP programme continues to generate in year variances from plan.

7. The original planned surplus for month 8 was £6,401k but the actual surplus is £4,141k, a variance of £2,260k due to this phasing issue. The CCG year-end target surplus remains unchanged at £3,681k.

8. Adjusting for the effect of non-recurrent allocations and expenditure, the underlying position for the CCG is forecast to be a surplus of £6,843k for the year, an increase over the figure of £5,623k quoted in the previous report. This reduction is the result of a review of non recurrent items as part of the production of the draft two year financial plan for 2017-18 and 2018-19 and the identification of a number of 2016/17 QIPP schemes that will have a full year effect into 2017-18.

Acute Commissioning

9. Acute budgets for the year total £188,972k and £127,050k for the year to date. These annual budgets include £135,666k in respect of University Hospitals of Leicester, £7,318k in respect of the Alliance, £25,155k in respect of NHS providers outside Leicestershire and Rutland and £7,146k in respect of East Midlands Ambulance Service.

10. Based on activity information for April to September, Acute expenditure is showing a £3,027k year to date overspend largely as a result of significant over performance in emergency activity and an element of elective activity to support the management of waiting lists. The updated forecast outturn, including the impact of QIPP schemes anticipated to deliver in the final months of the year is that this overspend will reduce to £2,593k by year end.

11. Material overspends within acute commissioning include University Hospitals Leicester (£797k year to date, reducing to £391k by year end), Out of County contracts (£1,067k year to date reducing to £968k by year end), Independent sector contracts (£1,159k year to date rising to £1,258k by year end) and East Midlands Ambulance (£284k year to date rising to £469k by year end).

Non-Acute Commissioning

12. Non-Acute Commissioning budgets for the year total £106,757k. These include £53,657k in respect of Leicestershire Partnership Trust, £23,940k in respect of Continuing Healthcare and £16,988k in respect of pooled budgets with Leicestershire and Rutland County Councils. The year to date position against non-acute budgets is a surplus of £1,106k. This includes a year to date underspend on continuing healthcare of £291k due to the delivery of QIPP savings ahead of the planned trajectory and £875k on partnership agreements with local councils, including accessing BCF contingency reserves to support overspends in emergency activity. This position will partially unwind in the latter months of the year and alongside a number of identified cost pressures the year end projection for the non-acute budgets is to be underspent by £272k in total.

Primary Care Prescribing

13. Practice prescribing budgets total £47,888k including £2,393k of high cost drugs and the CCG share of nationally held drug costs. As at month 8 these budgets have underspent by £136k, largely due to underspend in high cost drugs and central drugs costs. GP prescribing is £2k underspend allowing for the impact of nationally negotiated Category M drug pricing. The overall projection is that the underspend will have increased to £554k by year end.

GP Commissioning

14. Direct Delegated Primary Care funds totalling £41,105k have been allocated to the CCG for 2016/17. A net budget of £39,498k is modelled in Appendix B. In addition, a budget of £988k for the Oadby Walk In Centre is recorded within Primary Care Services and a further £620k is retained centrally to comply with CCG requirements to create 1% non-recurrent reserves to support transformation and a 0.5% contingency. As a result of a number of in year cost pressures this budget is showing a £40k overspend at month 8 and a forecast overspend of £323k by year end.

Other Primary Care Services

15. Budgets totalling £7,852k have been allocated for Other Primary Care Services including Walk in Centres, GP enhanced services and other local initiatives. These budgets are overspent by £334k at month 8 due to the slippage in a range of primary care planned QIPPs and a number of identified cost pressures. The forecast anticipates this overspend reducing to £37k by year end as a result of the delivery of replacement QIPP savings.

Running Costs

16. Running cost budgets have been set at £6,933k in line with the allocation received. These budgets are £196k underspent at month 8 and forecast to underspend by £131k by year end to support direct patient care budgets.

Miscellaneous Including Reserves

17. The annual budget of £7,3470k shown on Appendix B includes the following budgets:

    - 1% non recurrent transformation reserve of £3,988k that CCGs are required to hold fully uncommitted at this stage.
    - 0.5% Contingency of £2,046k put aside to offset any overspends and in year cost pressures that may arise.
    - Corporate functions to directly support clinical services such as Continuing Healthcare and the support to the Better Care Together (BCT) programme totalling £1,312k
    - The year to date overspend of £296k includes the following ;

        - Year to date impact of targeted QIPP £2,260k
        - Year to date utilisation of the contingency reserve (£2,046k)

Capital

18. Appendix F shows the capital funding the CCG has agreed with NHS England and confirms there has been £15k of the CCG IT envelope spent to date. The majority of purchases relating to the St Lukes Hospital development have now commenced and these sums will be transacted in quarter 4.

19. GPIT capital is transacted on the CCGs behalf by NHS England and does not feature on the CCG asset register but is recorded on Appendix F for information. Again no expenditure has been incurred to date, but the Health Informatics Service (LHIS) have now commenced the relevant equipment procurement to ensure installation by the year end.

Better Payment Practice Code (BPPC)

20. The BPPC performance for the CCG as at month 8 is shown in Appendix C. The CCG had encountered significant problems earlier in the year in paying Continuing Healthcare invoices following Arden Gem CSU migrating their patient information system. In month performance across all categories has exceeded the target of paying 95% of invoices within 30 days but the cumulative performance for non NHS invoices remains below the 95% target at 92.29. A series of additional actions are being put in place with AGEM CSU to restore the cumulative performance against this indicator but this will require the payment of almost 100% of invoices for the remainder of the year within 30 days.

21. Compliance with the BPPC 95% targets is as follows:

- NHS creditors (number) – 99.28%
- NHS creditors (value) – 99.88%
- **Non NHS creditors (number) – 92.29%**
- Non NHS creditors (value) – 96.44%

GEM Performance

22. The 'Month End Summary CFO Report' received from Arden and GEM CSU stated that all KPI's in relation to the finance service specification were achieved during month 8.

23. As identified above the CSU have recognised the impact of the migration of the Continuing Healthcare system as the reason for the CCG dropping below the BPPC target and are working with the CCG to ensure this position is recovered in future months.

24. All control codes were reconciled by the agreed deadlines and the full reconciliation pack has also been distributed. The payroll overpayments code remains flagged as amber due to an aged amount paid which is being recovered through Leicester City CCG payroll. The manual payment code is flagged as red this month with July payments to a non NHS organisation and an August payment to an NHS organisation not yet matched to invoices. The payroll deductions in respect of lease car costs is still flagged as red although the lease car provider have issued relevant credit notes, a balance is still to be collected from the staff member concerned. The unidentified receipt code previously flagged as red is now green as relevant August receipts from an NHS Trust have been appropriately resolved. All other accounts are RAG rated green.

25. All payroll pay overs for month 8 were made by the deadlines.

Statement of Financial Position and Cash Flow Statement

26. Appendix D outlines the Statement of Financial Position for ELR CCG as at the end of the last financial year and the latest 3 months of the current year. Trade Receivables and Trade Payables have been broken down to show age of debtors and creditors. All overdue receipts and payments are regularly reviewed and actions undertaken to ensure resolution.

27. Appendix E outlines the Cash Flow Statement for ELR CCG for Month 8. Recognising the fact that a range of QIPP savings are being delivered later in the year, a range of creditors in respect of 2015-16 have been settled and a series of quarterly payments in respect of primary care have been paid in October, the CCG has drawn down against it's cash limit ahead of what might be expected in a strict 1/12th monthly pattern. This equates to drawings being £1,776k ahead of a straight line assumption as at Month 8. This will unwind over the remainder of the financial year as the QIPP is delivered.

28. As shown in the Statement of Financial Position and Cash Flow Statement, the CCG closing cash book balance was £25k and the closing bank balance was £146k. CCG cash targets state that CCGs are to hold no more than 1.25% of their monthly draw down at month end. For November, the target cash book balance was £383k and the CCG has therefore comfortably met this target.

Risks

29. The main risks that have the potential to adversely affect the CCG's financial position beyond the values included in the current forecast for 2016/17 are highlighted below:
    - Non achievement of existing and recently identified QIPP schemes
    - UHL further over performance against various Points of Delivery
    - In year cost pressures relating to support to GP practices.
    - Resolution of a number of ongoing contract discussion areas including;
        - UHL to Alliance "left shift"
        - ICS beds development is not neutral for CCGs.
        - Out Of County and Independent Sector provider continued over performance due to capacity constraints at UHL
    - Adult Mental Health and female PICU out of County placement costs.

Appendix G details the current identified risks and mitigations.

Summary

30. The financial position of ELR CCG is reporting a control total surplus of £4.141m at month 8 compared to the original plan profiling of £6,401m. The CCG is forecasting a surplus of £3.681m for the year in accordance with the plan submitted to NHSE. It must be noted, however, that there are financial risks attached to the current forecasted position as highlighted in this report.

Recommendations:

The East Leicestershire and Rutland CCG Board is requested to:

Receive for information the contents of the report and the appendices attached

Note the financial position at month 8 and the forecast achievement of the year end control total surplus and the associated risks and mitigations.

ELR CCG Allocation 2016/17

Appendix A

	M1 £'000	M2 £'000	M3 £'000	M4 £'000	M5 £'000	M6 £'000	M7 £'000	M8 £'000	Movement from M1 £'000
Recurrent allocation (programme)									
Recurrent baseline	357,473	357,473	357,473	357,473	357,473	357,473	357,473	357,473	0
Primary Care Co-Commissioning	41,307	41,307	41,307	41,307	41,307	41,307	41,307	41,307	0
NUH Pacemakers agreed post base allocation setting	7	7	7	7	7	7	7	7	0
Co-Commissioning Allocation adjustment			(127)	(127)	(127)	(127)	(127)	(127)	(127)
Renal Repatriation				13	13	13	13	13	13
Bone Morphogenetic Protein				(3)	(3)	(3)	(3)	(3)	(3)
Diabetic Eye Screening Programme					(67)	(67)	(67)	(67)	(67)
Total recurrent allocation (programme)	**398,787**	**398,787**	**398,660**	**398,670**	**398,603**	**398,603**	**398,603**	**398,603**	**(184)**
Non recurrent allocation (programme)									
Return of previous year surplus (month 1 figures was as per plan estimate)	3,577	3,579	3,579	3,579	3,579	3,579	3,579	3,579	2
Eating Disorder Service Funding			154	154	154	154	154	154	154
Co-Commissioning Allocation adjustment			(75)	(75)	(75)	(75)	(75)	(75)	(75)
Learning Disability Transformation funding to TCPs				84	84	84	84	84	84
General practice clerical and receptionist training					28	28	28	28	28
CYP Local Transformation Mental Health						0	64	64	64
CEOV adjustment						0		(443)	(443)
						0			0
Total non recurrent allocation (programme)	**3,577**	**3,579**	**3,658**	**3,742**	**3,770**	**3,770**	**3,834**	**3,391**	**(186)**
Total allocations (programme)	**402,364**	**402,366**	**402,318**	**402,412**	**402,373**	**402,373**	**402,437**	**401,994**	**(370)**
Recurrent allocation (running costs)									
Recurrent baseline	6,933	6,933	6,933	6,933	6,933	6,933	6,933	6,933	0
Non recurrent allocation (running costs)									0
Total allocations (running costs)	**6,933**	**6,933**	**6,933**	**6,933**	**6,933**	**6,933**	**6,933**	**6,933**	**0**
TOTAL ALLOCATIONS	**409,297**	**409,299**	**409,251**	**409,345**	**409,306**	**409,306**	**409,370**	**408,927**	**(370)**
Capital Funding Approved by NHSE	**483**	**483**	**483**	**483**	**483**	**483**	**483**	**483**	**0**
Allocations formally received	**0**	**0**	**0**	**0**	**483**	**483**	**483**	**483**	**483**

East Leicestershire & Rutland CCG Summary - 2016/17 **Month 8** **Appendix B**

	Year to Date				Full Year Forecast			Worst Case Forecast Variance (£000)	Best Case Forecast Variance (£000)
	Budget (£000)	Expenditure (£000)	Variance (£000)		Budget (£000)	Expenditure (£000)	Variance (£000)		
Total allocation	**275,020**	**275,020**	**0**		**408,927**	**408,927**	**0**	**0**	**0**
Acute Commissioning	127,050	130,078	3,027		188,972	191,565	2,593	7,227	2,340
Non-acute Commissioning	71,776	70,670	(1,106)		106,756	106,485	(272)	2,555	-301
Practice Prescribing	32,667	32,531	(136)		47,888	47,334	(554)	1,084	-622
GP Commissioning	26,315	26,354	40		39,498	39,821	323	404	242
Primary Care Services	5,277	5,611	334		7,852	7,889	37	516	-368
Miscellaneous (inc reserves)	913	1,210	296	0	7,347	5,350	(1,997)	-733	-1,997
Total Programme Expenditure	**263,999**	**266,454**	**2,455**		**398,313**	**398,444**	**131**	**11,053**	**-706**
Total Running Costs	4,621	4,425	(196)		6,933	6,802	(131)	-81	-131
Total Expenditure	**268,619**	**270,879**	**2,260**		**405,246**	**405,246**	**0**	**10,972**	**-837**
Surplus									
Programme control total	6,400	3,945	(2,455)		3,681	3,550	(131)	-11,053	706
Running Costs control total	0	196	196		0	131	131	81	131
Total control total	**6,401**	**4,141**	**-2,260**		**3,681**	**3,681**	**0**	**-10,972**	**837**
Impact of QIPP profiling error	**-2,260**	**0**	**2,260**						
Revised Year to date position	**4,141**	**4,141**	**0**						

Appendix C

East Leicestershire & Rutland CCG

Better Payment Practice Code November 2016

	NHS Creditors					
	A	B	C	D	E	F
	No of Bills Paid Within Period	No of Bills Paid Within Target	% of Bills Paid Within Target	Value of Bills Paid Within Period	Value of Bills Paid Within Target	% Value of Bills Paid Within Target
	No.	No.	%	£'000	£'000	%
April	329	329	**100.00**	20,477	20,477	**100.00**
May	209	204	**97.61**	19,549	19,542	**99.96**
June	214	211	**98.60**	21,582	21,554	**99.87**
July	351	351	**100.00**	20,760	20,760	**100.00**
Aug	304	302	**99.34**	21,733	21,729	**99.98**
September	307	307	**100.00**	20,081	20,081	**100.00**
October	291	286	**98.28**	20,500	20,340	**99.22**
November	209	208	**99.52**	20,267	20,266	**100.00**
December						
January						
February						
March						
Totals	**2,214**	**2,198**	**99.28**	**164,949**	**164,750**	**99.88**

	Non NHS Creditors					
	A	B	C	D	E	F
	No of Bills Paid Within Period	No of Bills Paid Within Target	% of Bills Paid Within Target	Value of Bills Paid Within Period	Value of Bills Paid Within Target	% Value of Bills Paid Within Target
	No.	No.	%	£'000	£'000	%
	798	797	**99.87**	3,409	3,408	**99.97**
	453	414	**91.39**	3,080	2,968	**96.36**
	598	581	**97.16**	2,939	2,913	**99.14**
	686	528	**76.97**	3,758	3,388	**90.15**
	576	521	**90.45**	3,877	3,748	**96.67**
	722	589	**81.58**	2,130	1,930	**90.61**
	782	775	**99.10**	3,424	3,338	**97.49**
	832	822	**98.80**	3,462	3,456	**99.83**
	5,447	**5,027**	**92.29**	**26,078**	**25,149**	**96.44**

Statement of Financial Position	Balance as at 31 March 2016 £'000s	Balance as at 30 September 2016 £'000s	Balance as at 31 October 2016 £'000s	Balance as at 30 November 2016 £'000s
Non Current Assets:				
Premises, Plant, Fixtures & Fittings	1,604	1,470	1,448	1,442
IM&T	135	115	111	108
Other	0	0	0	0
Long-term Receivables	0	0	0	0
TOTAL Non Current Assets	**1,739**	**1,585**	**1,560**	**1,550**
Current Assets:				
Inventories	0	0	0	0
Trade Receivables	454	852	567	577
UHL Maternity Prepayment	1,395	1,395	1,395	1,395
Prepayments – In Month	266	1,859	1,554	1,392
Accrued Income	1,296	1,360	785	712
VAT and CHC Risk Pool (Aug onwards)	107	57	75	70
Cash and Cash Equivalents	118	105	170	25
TOTAL Current Assets	**3,636**	**5,628**	**4,546**	**4,171**
TOTAL ASSETS	**5,375**	**7,213**	**6,106**	**5,721**
Non Current Liabilities:				
Trade Payables	(2,994)	(1,760)	(3,857)	(4,517)
Prescribing Accruals	(7,523)	(7,499)	(7,625)	(7,482)
Other Accruals	(8,980)	(12,495)	(9,228)	(7,152)
Payroll Creditors	(178)	(199)	(198)	(193)
Provisions	(199)	(199)	(199)	(199)
Borrowings	0	0	0	
Total Current Liabilities	**(19,874)**	**(22,152)**	**(21,107)**	**(19,543)**
TOTAL LIABILITIES	**(19,874)**	**(22,152)**	**(21,107)**	**(19,543)**
ASSETS LESS LIABILITIES (Total Assets Employed)	**(14,499)**	**(14,939)**	**(15,001)**	**(13,822)**
TAXPAYERS EQUITY				
General Fund (Opening Balance, Fixed)	(10,601)	(14,502)	(14,502)	(14,502)
Income & Expenditure (year to date)	(397,791)	(204,586)	(237,852)	(270,879)
Parliamentary Funding (year to date)	357,876	204,146	237,350	271,556
Co Commissioning (year to date)	36,015	0	0	0
Other Reserves	3	3	3	3
Total	**(14,499)**	**(14,939)**	**(15,001)**	**(13,822)**

Sub Analysis 30 November 2016

Trade Receivables	Volume	Value (£'000)
Not yet due	6	20
1-30 days	12	7
31-60 days	9	42
61-90 days	6	53
91+ days	127	455
	160	**577**

£38k oustanding with UHL and West CCG, to be settled as invoices approved.£47k oustanding with Central Nottingham Clinical Services which is in administration. £182k BCT ICS Bed reconfiguration charges to UHL in query.

Trade Payables	Volume	Value (£'000)
Not yet due	273	3,347
1-30 days	51	1,596
31-60 days	21	-275
61-90 days	15	96
91+ days	28	-247
	388	**4,517**

Aged creditor report Includes payables that are not due by 31st October, these all been adjusted out of the payables values.e.g UHL invoice for Nov 16 for £11.4m.

31-60 Days net credit includes £327k credit note for agreed adjustments to 15/16 overperformance following the agreement of related challenges.

91+ days net credit includes £230k in respect of in year underperformance on the alliance contract.

These items have been cleared in December

East Leics and Rutland 03W	Cashflow reporting Month 8 2016/17

	Year to date							
	April	**May**	**June**	**July**	**August**	**September**	**October**	**November**
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Receipts								
Balance b/fwd	118	161	205	206	261	305	102	248
NCB-Drawdown	30,787	27,980	32,700	32,200	29,200	28,950	29,600	30,600
Other (including VAT)	434	93	497	607	2,535	283	349	97
Total Receipts	31,339	28,234	33,402	33,013	31,996	29,538	30,051	30,945
Payments								
Creditors NHS	20,690	19,602	21,647	20,902	22,582	20,161	20,644	20,212
Creditors BACS/CHAPS	6,408	4,015	5,462	6,377	4,800	5,255	5,425	5,460
Salary BACS/CHAPS	255	258	264	257	257	259	255	251
Pensions (Including GP pensions)	69	372	463	463	475	453	454	459
Tax & NI	109	122	121	123	124	126	124	123
Standing Orders /Direct Debits	0	0	1	0	0	0	0	0
PCS Payments	3,647	3,660	5,238	4,630	3,453	3,182	2,901	4,294
Total - Expenditure	31,178	28,029	33,196	32,752	31,691	29,436	29,803	30,799
Balance c/fwd	161	205	206	261	305	102	248	146

	April	**May**	**June**	**July**	**August**	**September**	**October**	**November**
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Cumulative Cash Drawn	30,787	58,767	91,467	123,667	152,867	181,817	211,417	242,017
Assumed Drawdown in equal 1/12ths	30,474	60,948	91,423	121,897	152,371	182,845	213,319	243,793
Cumulative Variance to equal 1/12ths profile	313	(2,181)	45	1,770	496	(1,028)	(1,902)	(1,776)

ELR CCG Capital Additions Plan 2016/17 **Appendix F**

Month 8

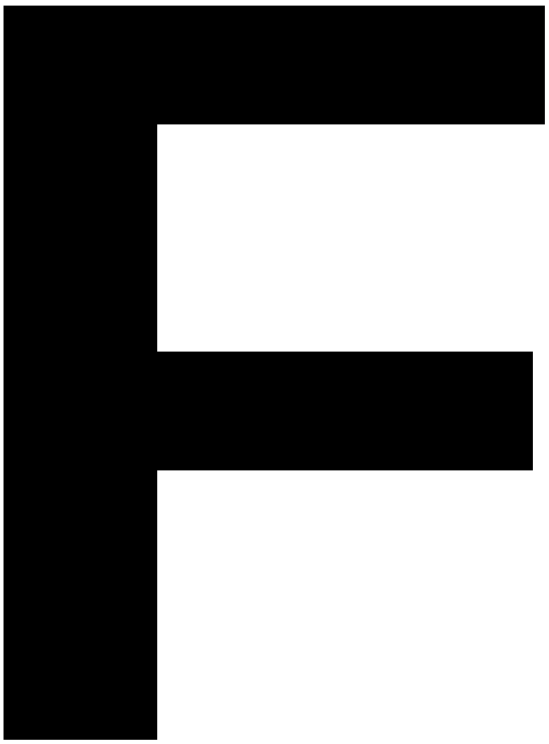
Capital Scheme	Asset Type	Scheme Description	Financial Plan	Year to date Expenditure	Forecast Expenditure	Forecast Variance from Plan	Comments
			£	£	£	£	
CCG IT	IT	IT replacement (RRP) and new server	50,000	15,807	50,000	0	
CCG Capital Subtotal			**50,000**	**15,807**	**50,000**	**0**	
St Lukes Development	P&M	Group 4 (ultrasound, dental and diagnostic)	195,000	0	195,000	0	
St Lukes Development	F&F	Group 3 (FF&E)	164,414	0	164,414	0	
St Lukes Development	F&F	Group 2 (artwork)	29,167	0	29,167	0	
St Lukes Development	IT	IM&T Equipment	43,919	0	43,919	0	
St Lukes Subtotal			**432,500**	**0**	**432,500**	**0**	
CCG Assets - TOTAL			**482,500**	**15,807**	**482,500**	**0**	Allocation Confirmed Month 5
GP IT - NHSE assets	IT	Practice Data Migration	50,000		50,000		*Not applicable to CCG Plan as these are NHSE assets*
GP IT - NHSE assets	IT	Technology Refresh	462,000		462,000		
GP IT Total			**512,000**		**512,000**		

Risks & Mitigations **Appendix G**

Month **8**

RISKS & MITIGATIONS

Provider	WORST £'000	BEST £'000	LIKELY £'000	Description
Contingency	(2,046)	(2,046)	(2,046)	Contingency will be used
Quality Premium	(222)	(222)	(222)	Based on latest workings
Rutland BCF	(158)	(158)	(158)	Access to u/s - agreed with RCC
LCC BCF - HTLAH	(500)	(500)	(500)	BCF contingency for HTLAH QIPP savings for 17/18
LCC BCF	(30)	(30)	(30)	Pay for Performance Pot - residual balance
CAMHS Liaison Psychiatry funding allocation	0	(100)	(100)	
Asylum dispersal (O&W)	0	(15)	(15)	Claw back of upfront payment to Assist Practice site as paid for 100 patients but only 54 being seen (£33k for 100 patients)
Recoup overclaims by practices for AUA DES	(15)	(20)	(20)	15/16 claims
Syrian refugee income		tbc		tbc
ETTF funding already used in position		tbc		tbc
Safeguarding funding		tbc		Simon Mendy to keep CCG informed of potential
Review of FNC price increase		tbc		Potential reduction from Jan 17?
Review of CAT M drugs prices		tbc		
Potential provider overperformance:				
UHL	3,328	391	391	Worst case assumes level of QIPP non delivery
Alliance	(230)	(374)	(374)	Worst case assumes a level of planned care shift
OOC	1,836	806	968	Best case assumes delivery of QIPP & reduced referrals after qtr 1 spike. Worst case assumes shortfalls in QIPP and no referral decrease
IS	1,942	1,166	1,258	Best case assumes full QIPP delivery & further activity reduction in some providers after qtr 1 spike. Worst case assumes inability to reclaim VAT of £500k on the Blatchfords contract & activity increase re UHL capacity constraints
EMAS	469	469	469	All scenarios now include non delivery of QIPP (block contract) and continued payment in respect of handover delays
CNCS	500	0	200	Cost pressure re caretaking still tbc
LPT	2,101	986	986	AMHIP OOC placements, Female PICU, ICS beds, Cytogenetics, MH Rehab beds, Huntingdons
Arriva	181	(113)	(113)	Worst case assumes QIPP re reduced ECR journies cannot be achieved
Community Equipment	(47)	(240)	(240)	Maximum recycling of community equipment per latest QIPP scheme
CHC	1,109	(117)	(117)	Forecasting includes stretch target on CHC QIPP. Worst case scenario assumes a level of risk on fast track and other QIPP elements
ECRs	(195)	(195)	(195)	Acute and MH NCAs/ECRs
LD Pooled Budget	(281)	(281)	(281)	Forecast underspend based on activity to date
Total prescribing	1,084	(622)	(554)	Worst case assumes 50% of prescribing QIPP and reduction in CAT M drugs will not be achieved
LES	147	52	52	Worst case assumes a level of QIPP will not be achieved
Prescribing incentive	(176)	(481)	(176)	Forecast assumes not all practices will achieve against QIPP 1 targets. Best case corresponds with worst case on prescribing, ie QIPP does not deliver and only half of Incentive linked to QIPP 1 is payable
GP IT	50	0	0	Potential shortfall on targetted reductions
Primary Care Co-Commissioning	404	242	323	Forecasts based on latest information reviewed with NHSE. Best & worst adjust for potential volatility (only Q2 results available)
Urgent care centres	385	51	51	Worst case includes risk of non collection of recharges from other CCGs.
Other Primary Care	111	10	111	Worst case relates to non delivery of additional primary care QIPP
Running costs	(81)	(131)	(131)	
Acute, Non Acute & Primary Care - other	211	184	212	
Net 15/16 accrual impact in 16/17	1,200	(64)	(64)	CHC 15/16 accruals may have large positive impact (c.£1m for county)
UHL WIP	976	558	558	
Total	**12,053**	**(794)**	**243**	



Blank Page

EAST LEICESTERSHIRE AND RUTLAND CLINICAL COMMISSIONING GROUP GOVERNING BODY MEETING

Front Sheet

REPORT TITLE:	**Performance Report 2016/17**
MEETING DATE:	**10 January 2017**
REPORT BY:	**Sarah Cooke, Head of Performance, AGCSU**
SPONSORED BY:	**Karen English, Managing Director**
PRESENTER:	**Yasmin Sidyot, Head of Strategy and Planning**

EXECUTIVE SUMMARY:

This report provides an overview of performance for East Leicestershire & Rutland CCG and LLR where data is available for October/November 2016. It sets out the key performance indicators that the CCG are held to account for. These are detailed in the CCG Improvement & Assessment Framework for 2016/17.

Part of the Framework includes a Better Care section which links with six national clinical priorities; mental health; dementia; learning disabilities; cancer; diabetes and maternity, the NHS Constitution. This is set out as a Dashboard in the report.

In summary, the following indicators are not achieving standards. These high risk exceptions are detailed in the report with the associated mitigation in place. In addition, an overview of the CCG's Quality Premium is also stated.

- Cancer Waits; 62 Day Wait STF trajectory; 2WW Breast Symptoms, 31 Day, 31 Day Surgery and Radiotherapy. This position has remained static from last month. However the monthly position for November 2016 has improved. Close monitoring is continuing.
- Mental Health; Improved Access to Psychological Therapies (IAPT) Roll Out, and Access to talking therapies < 6 weeks (local data). This position remains static from last month.
- Learning Disabilities; Q2 Specialist In-patient Care. The position has deteriorated from Q1 for LLR.
- Maternity; Neonatal mortality and still births and women's experience of maternity services.
- Dementia; Diagnosis.
- Urgent Care; Emergency admissions for urgent care sensitive conditions, A&E 4 Hour Wait, Ambulance Handovers, Ambulance Response times, Crew Clear and Delayed Transfers of Care. Ambulance Response Times for Red 1 continues to achieve between August – November 2016 against the STF trajectory.
- Elective Access – 18 weeks RTT, 52 Week Waits, 6 weeks diagnostics and Cancelled Operations
- Additional Indicators: Health Acquired Infection – MRSA – there has been an incidence reported for ELR CCG in November 2016. However, assessment of the Root Cause Analysis resulted in a request for assignment to a third party provider. CDIFF. NHS 111 - calls answered within 60 seconds reported as non-achievement for November 2016.

The Integrated Governance Committee did not sit in January 2017, and as a result an internal quality assurance process has undertaken by the CCG.

RECOMMENDATIONS:
The East Leicestershire and Rutland CCG Governing Body is requested to: **APPROVE the contents of the report**

REPORT SUPPORTS THE FOLLOWING STRATEGIC AIM(S) 2016 – 2017:			
Transform services and enhance quality of life for people with long-term conditions	✓	Improve integration of local services between health and social care; and between acute and primary/community care.	✓
Improve the quality of care – clinical effectiveness, safety and patient experience	✓	Listening to our patients and public – acting on what patients and the public tell us.	✓
Reduce inequalities in access to healthcare	✓	Living within our means using public money effectively	✓
Implementing key enablers to support the strategic aims (e.g. constitutional and governance arrangements, communications and patient engagement).			✓

EQUALITY ANALYSIS
An Equality Analysis and due regard to the positive general duties of the Equality Act 2010 has not been undertaken in the development of this report as it is judged that it is not proportionate on the basis that the Performance Assurance reporting underpins the commissioning strategy and priorities of the CCG. This completes the due regard required.

RISK ANALYSIS AND LINK TO BOARD ASSURANCE FRAMEWORK:	
The content of the report identifies action(s) to be taken / are being taken to mitigate the following corporate risk(s) as identified in the Board Assurance Framework:	**BAF 1: ACUTE** – The quality of care provided by <u>acute</u> providers does not match commissioner's expectation with respect to quality and safety.
	BAF 2: QUALITY – The quality of care provided by <u>non-acute</u> providers does not match commissioner's expectation with respect to quality and safety.
	BAF 8: URGENT CARE – Increased pressure on the Emergency Department which could results in sub-optimal care due to ability to access urgent care services.

EAST LEICESTERSHIRE AND RUTLAND CLINICAL COMMISSIONING GROUP GOVERNING BODY MEETING

Performance Report 2016/17
10 January 2017

1. INTRODUCTION

1.1. This performance report provides an overview of the key performance indicators (KPIs) that the CCG is held accountable for with NHS England during 2016/17. They are part of the CCG's Improvement and Assessment Framework for 2016/17 detailed under the Better Care section (including NHS Constitution indicators) and linking in with the six national clinical priorities. These are mental health; dementia, learning disabilities, cancer, diabetes and maternity.

1.2. The data reported is for October and November 2016 where data is available. Further indicators relating to the six clinical priorities will be populated as data is published in Quarter 3.

1.3. The overview provides assurance on performance achievement against targets/standards at CCG and provider level as appropriate, and the delivery and contractual actions in place to mitigate. It sits alongside the LLR Contracting reports and focusing on areas of concern.

2. DASHBOARD

2.1. The dashboards below provide details of indicators and their RAG rating against national and local standards within service areas. Where key standards were not achieved in 2015/16, trajectories have been set as part of the Sustainability & Transformational Fund (STF), in the 2016/17 planning round. For East Leicestershire & Rutland CCG and the provider UHL, these include;

- Cancer 62 Day Wait
- A&E 4 Hour Wait
- EMAS ambulance response calls

3. RANKING AND PEER GROUPS

3.1 For each of the high risk indicators, where data is available, UHL has been ranked against other acute trusts in the country, and also as part of its peer group. The peer group has been sourced from the public health observatory, and are as follows:

- University Hospital of North Staffordshire NHS Trust
- Heart of England NHS FT
- Mid Yorkshire Hospital NHS Trust
- Leeds Teaching Hospital NHS Trust
- Nottingham University Hospital NHS trust

EAST LEICESTERSHIRE & RUTLAND CCG – KEY PERFORMANCE INDICATORS & MITIGATION

The following indicators are reporting non-achievement of the standards/trajectories.

4. CANCER

	Indicator Description	Latest Baseline Position	Outturn/ Standard	Standard/ Target	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	YTD
Cancer	Cancers diagnosed at early stage - % of cancers diagnosed at stage 1 & 2	2013	CCG 48.9%	Above 2013 Position	2014 - CCG 52.2% (England 50.7%) 2015 data due June 2017												
	Cancer 62 Day Waits - % of patients receiving first definitive treatment for cancer within 62 days of an urgent GP referral for suspected cancer	2015/16	78.3%	Trajectory	70.5%	73.8%	85.5%	86%	85.7%	85.9%	85.6%	85.4%	85.4%	85.4%	85.4%	85.4%	
				2016/17 85%	80.2%	79.8%	81.7%	86.5%	83.5%	76.1%	80.3%						
	Cancer 62 Day Waits - % of patients receiving first definitive treatment for cancer within 62 days of referral from an NHS Cancer Screening Service	2015/16	86.1%	90%	100%	100%	83.3%	75%	85.7%	78.6%	100%						86.5%
	Cancer 62 Day Waits - % of patients receiving first definitive treatment for cancer within 62 days of a consultant decision to upgrade their priority status	2015/16	100.0%	No national standard	100%	100%	100%	100%	100%	80%	100%						95.5%
	Cancer 2 Week Wait - % of patients seen within two weeks of an urgent GP referral for suspected cancer	2015/16	91.4%	93%	91.1%	91.1%	90.9%	95.9%	95.1%	95.8%	92.9%						93.2%
	Cancer 2 Week Wait - % of patients seen within two weeks of an urgent referral for breast symptoms	2015/16	95%	93%	97.7%	82.4%	88.9%	95.2%	92.9%	100%	96.2%						92.8%
	Cancer 31 Day Wait - % of patients receiving first definitive treatment within 31 days of a cancer diagnosis	2015/16	96%	96%	96.3%	99.3%	97.8%	92%	94.1%	93.5%	96.3%						95.6%
	Cancer 31 Day Wait - % of patients receiving subsequent treatment for cancer within 31 days where that treatment is surgery	2015/16	86.1%	94%	88.9%	96.7%	88.9%	84%	72.7%	92.6%	96.2%						89.2%
	Cancer 31 Day Wait - % of patients receiving subsequent treatment for cancer within 31 days where that treatment is an anti cancer drug regimen	2015/16	100%	98%	100%	100%	97.4%	100%	100%	100%	100%						99.6%
	Cancer 31 Day Wait - % of patients receiving subsequent treatment for cancer within 31 days where that treatment is radiotherapy treatment course	2015/16	96.1%	94%	100%	92.7%	95.2%	95%	85.5%	86.4%	100%						92.8%
	One-year survival for all cancer	2012	69.3%	Above 2012 Position	2013 - 70% 2014 data due Mar 2017												
	Cancer patient experience	2014	88% - UHL 88.4% - CCG	8.7 Above National position.	2015 8.6 (CCG) Patient`s average rating of care scored from very poor to very good.												

4.1 As October 2016, there continue to be five cancer waiting times that did not achieve the standards at CCG level for year to date, this remains static from last month (see below). However, in October 2016, there were two indicators that did not achieve the standard; 62 day wait and 2 week wait

- Cancer 62 day has to be monitored on a monthly STF basis rather than as a year-end position, and has improved from last month, and is failing the trajectory; 80.3% against trajectory of 85.6%.
- Cancer 2 week wait breast symptoms, 96.8% against 93% standard. YTD 92.8%. This YTD position has improved since last month, however 1 breach was reported.
- Cancer 31 day wait, 96.3% against 96% standard. YTD 95.6%. There YTD remains static from last month.
- Cancer 31 day wait surgery, 96.2% against 94% standard. YTD 89.2%. The YTD position has improved significantly.
- Cancer 31 day wait radiotherapy, 100% against 94% standard. YTD 92.8%. This has improved In September & October.

4.2 Benchmarking at Q2, 2016/17 is as follows:

- Cancer 62 Day Wait - UHL was ranked 114 out of 153 Trusts and was ranked 2 out of 6 of its peer group, an improvement from Q1, of 6 out of 6. UHL is still not achieving the standard. Peterborough was ranked 58 out of 153 Trusts, and achieved 85% standard.

- Cancer 2 Week Wait – UHL was ranked 102 out of 155 Trusts, and it was ranked 3 out of 6 of its peer groups. UHL is achieving the standard and is showing an improved position from Q1. Peterborough achieved 2 week wait at Q2, and was ranked 26 out of 155 Trusts.

- Cancer 31 Day – UHL was ranked 152 out of 154 Trusts, and it was ranked 6 out of 6 of its peer groups. Peterborough was ranked 1 out of 155 Trusts.

Data for Q3 will be published in February 2017

4.3 For the Cancer 62 day wait in October 2016 at CCG level, there were 14 breaches at a variety of tumour sites. These continue to be mainly due to complex pathways and suitability of patients for treatment.

4.4 Actions remain the same as reported last month and continue to focus on Lower GI, Head and Neck and Lung tumour sites pressures, with recruitment underway in various tumour areas although there are skills shortages. Five additional Oncologists are also being sourced. A fortnightly cancer RAP meeting is undertaken to ensure problems are dealt with in a timely manner. Focusing on breaches and eliminating the pathway issues.

4.6 The Cancer/RTT Board has realigned itself to focus on the performance of both with an alternating meeting. A detailed fortnightly meeting with UHL is in place to ensure the actions are smart and are having the desired effect. They will ensure any exceptions are reported at Board level to ensure new actions are created to remedy the issue/blockages.

4.7 Next Steps is one of the key tools that should support recovery of the 62 day cancer standard. The programme has a dedicated Project Manager and is being rolled out gradually across the Trust. The next steps programme has had some impact and on the backlog of 62 day, however the target has not been met. The Next step programme has not been implemented in as many cancer pathways, the cancer centre has advised that this is due to the unexpected increasingly complexity of the programme. The cancer /RTT board is reviewing the performance through the RAP.

4.8 For Cancer 2 week wait in October 2016 at CCG level, the standard was not achieved, however the year to date position is still achieving 93% standard. There were 63 breaches at a variety of tumour sites, which has deteriorated from the 36 reported last month (36). Additional capacity continues to support the patient pathway. For Cancer 2 week wait breast symptoms, there was 1 breach reported due to patient choice.

4.9 For Cancer 31 day wait and subsequent surgery and radiotherapy in October 2016 at CCG level, there were 4, 1 and zero breaches respectively. The breaches were due to complex pathway and patient choice. Actions in place remain the same as reported last month with additional sessions and weekend work in place. The High Dependency Unit and ITU beds remain an issue with the expected ITU beds not yet open and the pilot having closed at the Leicester General Hospital.

4.10 For surgery, the main issues are with Urology and surgical capacity despite having three theatre sessions, weekend working and alternative providers in place. The 31 day target will further deteriorate due to lack of surgical beds as a result of winter pressures. It is not expected to recover soon.

4.11 There has also been an impact due to tertiary referrals for robotic surgery; support from a third party is now in place. Radiotherapy still under performs due to LINAC machines (Radiotherapy treatment machines) not being operational. It is reported that it should recover in November as LINAC machine comes back online. The Cancer/RTT Board had suggested using extra capacity at Peterborough; however UHL is in partnership with another provider.

4.12 The cancer dashboard also details 3 further indicators; diagnosis at early stage 1&2, one year survival and cancer patient experience. Baselines and the latest position are shown, with early diagnosis and survival rag rated as “green”.

4.13 The patient experience indicator RAG rating is based on a survey where patients are rating their care. The National Cancer Patient Experience Survey 2015 data is now available at CCG level and is showing a reduction when compared to the national position. There are several areas where Leicestershire are <u>below</u> nationally expected scores; including information required for care at home; attendance at clinics; impact of cancer on day to day routine; support groups and discussions about worries or fears. Contracts are currently investigating the issues with UHL, and improvements are being discussed.

5. MENTAL HEALTH – IMPROVED ACCESS TO PSYCHOLOGICAL THERAPIES (IAPT)

	Indicator Description	Latest Baseline Position	Outturn / Standard	Standard / Target	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	YTD
Mental Health	IAPT Roll Out - Proportion of people that enter treatment against the level of need in the general population (CCG) National Data	2015/16	14%	15.8%	13.1%	13.7%	10.2%	12.39%	13.48%								
	IAPT Roll Out - Proportion of people that enter treatment against the level of need in the general population (CCG) Local Data	2015/16	14%	15%	13.30%	13.46%	10.22%	11.61%	13.10%	13.53%	12.70%	11.90%					
	IAPT Recovery Rate (CCG) National Data	2015/16	55%	50%	57%	54%	61%	54%	59%								
	IAPT Recovery Rate (CCG) Local Data	2015/16	55%	50%	57%	54%	49%	56%	61%	48%	52%	58%					
	75% of people with relevant conditions to access talking therapies in 6 weeks National Data	2015/16	52%	75%	74%	75%	67%	68.9%	69%								
	75% of people with relevant conditions to access talking therapies in 6 weeks Local Data	2015/16	52%	75%	73%	76%	68%	68%	67%	65%	67%	64%					
	95% of people with relevant conditions to access talking therapies in 18 weeks National Data	2015/16	97%	95%	99%	99%	98%	100%	100%								
	95% of people with relevant conditions to access talking therapies in 18 weeks Local Data	2015/16	97%	95%	99%	99%	98.6%	100%	100%	99%	100%						
	50% of people experiencing first episode of psychosis to access treatment within two weeks - CCG Started Treatment	2015/16	100% (2/2) March-16	50%	100% (1 /1)	100% (4/4)	0% (1 >2-6)	100% (2/2)	100% (2/2)	100% (2/2)	75% (6/8)						
	Children & young people's mental health services transformation	5 Questions: 2 Fully Compliant 3 Partially Compliant		5 Questions Fully Compliant	Requires Improvement (OCT-16) 35% Percentage compliance with a self-assessed list of minimum service expectations for Children and Young People's Mental Health, weighted to reflect preparedness for transformation.												
	Crisis care & liaison mental health services transformation	15 Questions: (1) Liaison MH Services (2) Crisis Resolution Home Treatment Teams (3) Places of Safety		15 Questions Fully Compliant	Requires Improvement (OCT-16) 48% Percentage compliance with a self-assessed list of minimum service expectations for Crisis Care, weighted to reflect preparedness for transformation.												
	Out of area placements for acute mental health inpatient care - transformation	3 Questions: 1 Fully Compliant 1 Partially Compliant 1 Not Compliant		3 Questions Fully Compliant	Mostly meeting expectations (OCT-16) 75% Percentage compliance with a self-assessed list of minimum service expectations for Out of Area Placements, weighted to reflect preparedness for transformation.												
	Mental Health - Care Programme Approach (CPA) - % of patients under adult mental illness on CPA who were followed up within 7 days of discharge from psychiatric in-patient care	2015/16	96.1%	95%	100%	100%	100%	100%	95.2%	100%	94.9%						99.1%

5.1 Performance data for IAPT for November 2016 is only available locally, and should be viewed with caution. National data is available from April to August 2016.

- Roll Out standard 15%. National data is available to August at 13.48%. Local data is fluctuating, and has now deteriorated from September 2016 of 13.53% to 11.90% in November 2016, reporting below the national standard of 15%.
- Recovery 50%. National data reports as achieving in August at 59%. November 2016 local position is reported at 58%.
- < 6 weeks waiting time standard 75%. National data is available to August 2016, reported as 69%. Local data continues to report a deteriorating position, with November at 64% since the previous month at 67%.

5.2 The following actions are in place;

- The electro cranial brain stimulation clinical trial commenced in September targeting complex people who require high intensity work, alternative criteria have been sent to the ethic committee to increase uptake
- Additional plans received by Commissioners are being refreshed to address waiting times and access
- Department of Works & Pensions has been contacted for additional centrally funded Employment Advisors to be progressed in December
- LPT Community Therapy Leads are working to increase referrals, with an extension to Community Nursing Services
- Detailed analysis of performance waiting times has been undertaken and a number of process issues have been resolved to improve performance.
- Ongoing recruitment of Mental Health Facilitators, and PWP workers.
- Insomnia leaflets have been sent to all pharmacies & GPs, to develop group sessions and reduce patient dependency on hypnotics
- Work to strengthen referral routes is underway, including GPs, community hospitals, courts, probation and Job Centres.
- Promotion of IAPT to service users, with a meeting arranged in December, including development of pathways for LTC including Diabetes, COPD and early onset Dementia.
  (Source: PPAG/Area Team Update)

5.3 Data has been published nationally for the three transformational areas;

Children & Young People's mental health services – Requires Improvement with 35% compliance with a self-assessed list of minimum service weighted to reflect preparedness for transformation. Delivery plans are being sourced, and will be available for the next report.

Crisis Care & Liaison Mental Health Services – Requires Improvement with 48% compliance with a self-assessed list of minimum service expectations for weighted to reflect preparedness for transformation.

- Crisis Care – 24/7 crisis response and home treatment services have been commissioned, and are of the appropriate size and skill mix, however there are issues with social care and other elements of the pathway which are putting pressure on the Crisis Team. This is being assessed in more detail. Place of safety refurbishment is underway with monies secured from NHSE, a detailed project plans are being developed.
- Liaison - By 2020/21, all acute hospitals will have all-age mental health liaison teams in place with at least 50% meeting the "Core 24" service standard. Original plans were to have the service in place by January 2018. Limited funding has been made available to implement the ED element of the liaison service, however while the staffing model is deemed to be adequate for 24/7 ED service, it will not cover the in-patient service. A further bid for transforming care money being developed.

Out of Area Placements for Acute Mental Health In-Patient Care – Mostly Meeting Expectations with 75% compliance with a self-assessed list of minimum service expectations for Out of Area Placements, weighted to reflect preparedness for transformation.

6. LEARNING DISABILITIES (LD)

	Indicator Description	Latest Baseline Position	Outturn / Standard	Standard / Target	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	YTD
Learning Disability	Reliance on specialist inpatient care for people with a learning disability and/or autism (per 1m pop)			Trajectory	45.68 (39 patients)			43.34 (37 patients)			39.82 (34 patients)			38.65 (33 patients)			
				LLR 2016/17	52.71 (45 patients)			57.39 (49 patients)			Data due March 2016			Data due June 2017			
				ELR 2016/17	LD inpatients (4 Patients)			LD inpatients (5 Patients)									
					LD Specialised Commissioning inpatients (2 patients)			LD Specialised Commissioning inpatients (3 patients)									
	Proportion of people with a learning disability on the GP register receiving an annual health check	2014/15	54% (CCG) 47% (National position)	Above 2014/15 baseline	Awaiting data publication for 2015/16												

6.1 There are two indicators relating to LD, which are reported as last month:

- At Q2, 2016/17, the LLR rate for reliance on specialist inpatient care for people with a learning disability and/or autism per 1m population was reported as 57.39 (49 patients) against a target of 43.34 (37 patients). This position has deteriorated from Q1. This is an LLR position, with 5 ELR CCG patients in specialist in-patient care, and 3 ELR patients under Specialised Commissioning in specialist in-patient care.
- For LLR, of the 49 patients in Q2 currently reported as in-patients, 30 against a trajectory of 25 were for CCG Commissioned Beds (trajectory 25), and 19 against a trajectory of 12 for Specialised Commissioning.
- For CCG Commissioned beds, there have been a number of discharges but the number of inpatients still remains higher than predicted. There are currently a number of delayed transfers of care due to problems identifying bespoke/appropriate community accommodation and/or awaiting the outcome of Court of Protection applications.
- For Specialised Commissioning the number of inpatients is higher than the predicted trajectory due to a number of people in rehab settings requiring a step-up into a more secure setting. There has also been a readmission of a patient who's community placement broke-down. In addition further work is being undertaken to identify escalating risks and provide earlier support for young people to try and prevent admissions in to secure CAMHS beds.
- The annual health check data at CCG level has not been published due to data quality issues.

7. MATERNITY

	Indicator Description	Latest Baseline Position	Outturn/ Standard	Standard/ Target	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	YTD
Maternity	Neonatal mortality and still births per 1,000 population	2013	4.4	Lower than 2013	2014 6.7												
	Women's experience of maternity services (England)	2015	79.7 (England) No previous CCG data available	Higher Than Baseline	2015 79.2 (CCG)												
	Choices in maternity services	Monitoring commenced in 2016/17			2015 67.3 (CCG) 2nd quartile nationally and rated 2nd out of 10 peers (RAG Rated green as no previous data available and no England position published)												

There has been no change to the information reported last month:

7.1 There are three indicators in the dashboard; infant mortality data for 2014/15 has been populated against 2013 baseline, showing deterioration. In 2013, ELR CCG was ranked 9th out of 209 CCGs and 2nd out of 11 peers.

7.2 This is being closely monitored through commissioning maternity services; women's experience of maternity services has been populated in CCG level, and is rated "red" against the England average. Joint working on patient experience is being undertaken by Healthwatch, the CCGs and UHL. The Choices in Maternity indicator is rated "green" as ELR CCG is rated 2 out of 10 peers. This is a new indicator and there is no baseline available.

7.3 An LLR Maternity Strategy and action plan has been developed by a range of partner organisations, and the Mortality Strategy Group has been formed as a result. The action plan aims to deliver a multi-focus approach looking at maternal factors and the wider detriments of health which are recognised to be significant issues for Leicester. These plans include: the development of new GROW protocol to identify small babies by personalised growth charts; tailored scanning to identify at risk mothers & babies; new awareness training on reduce foetal movements, promotion of for early booking and safer sleep, with additional training for midwives and targeted work and parenting support for vulnerable & at risk mothers.

8. DEMENTIA

	Indicator Description	Latest Baseline Position	Outturn / Standard	Standard / Target	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	YTD	Monthly Trend
Dementia	Estimated diagnosis rates for people with dementia	2015/16	61.9%	66.7%	60.5%	60.3%	61.6%	61.9%	62.6%	62.7%	62.8%	63.3%						⇧
	People Diagnosed with Dementia (Age 65+) Numerator (Local data)				2782	2773	2835	2849	2879	2886	2887	2912						
	Estimated Prevalence (Age 65+) Denominator (Local data)				4599	4599	4599	4599	4599	4599	4599	4599						
	Dementia care planning and post-diagnostic support. The percentage of patients diagnosed with dementia whose care plan has been reviewed in a face-to-face review in the preceding 12 months	2014/15	73.7% (CCG)	Above 14/15 baseline	74.04% 15/16 QOF Patients receiving Intervention (per cent)													

8.1 There are two dementia indicators, performance is as follows:

- The estimated diagnosis rate for people with dementia for November 2016 is 63.3% against 66.7% standard, and against Quality Premium stretch target of 68%. This has increased since last month by 25 patients on the register, from 2782 in April to 2912 in November 2016.

- Care plan reviewed in 12 months – data for 2015/16 is not yet available.

8.2 Actions in place include; named clinical leads identified in practices through 2016/17 GP Service Improvement Plan, with the CCG's clinical dementia lead ensuring diagnosis rates and service/schemes supporting practice diagnosis are sent to practices on a monthly basis; Protected Learning Time has focused on dementia and care planning, with nurse awareness training; and practice CQUINs are in place providing incentives for completed dementia assessments. The Dementia Friendly framework will be piloted in February 2017 with GP practices.

9. URGENT & EMERGENCY CARE – A&E 4 HOUR WAIT & AMBULANCE HANDOVERS

	Indicator Description	Latest Baseline Position	Outturn/ Standard	Standard/ Target	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	YTD	Monthly Trend
Urgent and Emergency Care	Achievement of milestones in the delivery of an integrated urgent care service				2016 Assessment of progress in implementation of delivering functionally integrated, 24/7, Urgent Care Service accessed via NHS 111. This will be determined by whether CCGs answer "Yes" to eight questions. 4 of the 8 key elements of Integrated Urgent Care were being delivered (ELR) Quartley AUG													
	Emergency admissions for urgent care sensitive conditions (per 100,000 population) (CCG)	2015/16	2067 (ave 516.75 per Quarter)	Below 15/16 baseline	518 (Q1 16/17)			520 (Q2 16/17)									2079 (Rolling 12 months Q2 15/16-Q1 16/17)	⇩
	A&E Waiting Time - % of people who spend 4 hours or less in A&E (UHL)	2015/16	86.89%	2016/17 Trajectory	78%	78%	79%	79%	80%	85%	85%	85%	85%	89%	89%	91.2%		
				95%			80.83%	76.95%	80.12%	79.85%	78.30%	77.63%	As at 18/12 74.37%					⇩
	Trolley Waits in A&E - Number of patients who have waited over 12 hours in A&E from decision to admit to admission (UHL)	2015/16	0	Zero Tolerance	0	0	0	0	0	0	0	0					0	⇔
	Ambulance Handover time - Number of handover delays of > 30 minutes (UHL)	2015/16	20.6%	Zero Tolerance	11.5%	12.3%	11.4%	16.2%	14.9%	15.4%	19.3%	21%					15.3%	⇩
	Ambulance Handover time - Number of handover delays of > 1 hour (UHL)		12.6%	Zero Tolerance	5.7%	5.2%	5.5%	8.5%	6.4%	8.6%	8.8%	11%					7.5%	⇩

9.1 The high risk indicator performance for Urgent & Emergency Care is:

- A&E 4 Hour Wait. In November 2016 the STF trajectory of 85% failed, with 77.63% of patients being seen within 4 hours. The mid-month position for December (18/12/2016) is 74.37% against a trajectory of 85%.

- Ambulance Handovers for November 2016 is 21% for > 30 minutes and 11% > 1 hour against a zero tolerance. Performance has deteriorated from April (11.5%) to November (21%) for delays > 30 minutes, and from April (5.7%) to October (11%) for delays > 1 hour.

9.2 A&E 4 hour wait trajectories as part of STF (UHL) for 2016/17 were set from April 2016 at 78% to achievement of 91% by March 2017.

9.3 Benchmarking for UHL at October 2016 – UHL was ranked 134 out of 145 Trusts (reported nationally) for A&E 4 Hour Wait, and it was ranked 5 out of 6 of its peer groups. Peterborough is ranked 117 and Coventry & Warwickshire ranked 98. The Trusts are not achieving A&E 4 Hour Wait, and their ranking positions have deteriorated since last month.

9.4 UHL has committed to assurance statements to maintain & improve performance as part of the STF for 2016/17, and standard contractual sanctions have been suspended. As the STF trajectory has not been achieved, further improvement trajectories have been incorporated into the 2017 – 2019 contracts, and have been agreed with NHS England.

9.5 Actions continue as reported last month. UHL has been on Business Continuity Level 4 for the majority of 2016 due to occupancy and acuity within A&E, the volume of acute admissions and the flow within the department and across the Trust. The LLR system wide action plan is being monitored on a fortnightly basis through the A&E Delivery Board to recover performance aligning with the contractual process. A workshop will deliver a consensus on expected activity levels for 2016/17 and plans for 2017/18 and 2018/19 contracts. CCGs are working to minimise ED levels, leading on; improved clinical navigation; increased routine and emergency capacity in primary care; increase availability and utilisation of ICS step up facilities and increased flow with EMAS for urgent GP referrals via the Bed Bureau. In addition, the new ED floor will be open in spring 2017, and the CCG and UHL are working jointly to develop operational and clinical models. The ED Streaming Service (EDSS) provided by Lakeside+ sub-contracted has been extended from November –March 2017, with an increase to 3 GPs (Source: PPAG).

9.8 Peterborough did not achieve 4 hour wait 95% standard or STF trajectory in October 2016. The trust is reporting a 13.9% growth in ED attendances this year which is making them a regional outlier as the rate is 4.2% growth. This growth continues to present a major challenge for the trust and underlines the importance of demand management. They have set their own internal short-term recovery plan for this standard, progress is being checked in weekly meetings with NHSE.

9.9 Ambulance Handovers - UHL are expecting to recover the standard by May 2017. This is being picked up as part of the system wide remedial action plan for A&E. There are also actions in place to reduce conveyancing to LRI by increasing “see

and treat" and "hear and treat". In addition the CCG/EMAS contract agrees to pay financial penalties to EMAS for LRI handover delays. The CCG is currently reviewing this agreement, and the risk sharing arrangement, and will only support this where there is evidence of liability on behalf of an ELR patient. ELR specific patients with A&E handover delays of 60 minutes are small in number and as such residual risk would be minimal, however contract agreement needs to be clarified before risk can be quantified.

10. URGENT & EMERGENCY CARE – AMBULANCE RESPONSE TIMES & CREW CLEAR

	Indicator Description	Latest Baseline Position	Outturn / Standard	Standard / Target	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	YTD
Urgent and Emergency Care	Ambulance Clinical Quality - Category A (Red 1) 8 minute response time (EMAS)	2015/16 EMAS	69.1%	EMAS Trajectory	65%	66.9%	67.1%	69.6%	68.9%	67.1%	66.8%	67.5%	67.8%	70.7%	69.9%	71%	68.2%
				75%	66.3%	67.3%	68%	69.1%	73.3%	70.3%	67.8%	70%					69%
		2015/16 LLR	66.9%	LLR/CCG Trajectory	63.3%	61.9%	60.9%	63.4%	63.6%	61.1%	63.6%	64%	61.4%	64%	64%	63%	
				75%	65.5%	65.2%	61.5%	67.9%	70.7%	71.2%	67.3%	68.6%					
		CCG	56.10%	75%	51.2%	50.8%	44.1%	57.7%	59.1%	58.6%	53.8%	55.6%					
	Ambulance Clinical Quality - Category A (Red 2) 8 minute response time (EMAS)	2015/16 EMAS	60.8%	EMAS Trajectory	51.8%	54.5%	61%	62.6%	61.5%	61.1%	62.4%	61.6%	60.4%	61.1%	60.7%	62.5%	60.1%
				75%	57.3%	59.8%	55.5%	53.8%	61.3%	57.3%	58.7%	56.9%					67%
		2015/16 LLR	66.9%	LLR/CCG Trajectory	45.9%	46.3%	52.3%	56.1%	54.8%	52.7%	54.8%	54.3%	53.2%	54.3%	54.3%	54.8%	
				75%	53.3%	54.5%	51.8%	48.3%	58.5%	57.2%	56%	50.5%					
		CCG	56.10%	75%	40.8%	39.1%	36.7%	37.4%	42.7%	42.8%	42%	42.1%					
	Ambulance Clinical Quality - Category A 19 minute response time (EMAS)	2015/16 EMAS	87.4%	EMAS Trajectory	86%	84.8%	86.2%	87.2%	86.5%	86.3%	87.9%	86.6%	87.2%	86.6%	86.2%	87.9%	86.6%
				95%	86.7%	87.2%	83.9%	82.1%	87.2%	84.9%	84.5%	85.3%					90.3%
		2015/16 LLR	66.9%	LLR/CCG Trajectory	77.2%	77.5%	81.4%	84%	83.3%	81.8%	83.3%	82.2%	81.1%	82.2%	82.2%	83.3%	
				95%	84.7%	82.3%	80%	77.7%	85.1%	85.4%	82.7%	79%					
		CCG	84.60%	95%	77.5%	74.7%	70.9%	70%	76.9%	77.4%	75.5%	71.4%					
	Crew Clear delays of > 30 minutes (UHL)	2015/16	4.0%	Zero Tolerance	3.4%	4.6%	5.1%	4.2%	4.7%	4.2%	4.7%	4.3%					4.4%
	Crew Clear delays of > 1 hour (UHL)		0.9%	Zero Tolerance	0.4%	0.5%	0.4%	0.5%	0.5%	0.9%	0.6%	0.7%					0.6%
	Delayed Transfers of care attributable to the NHS per 100,000 population	2015/16	7.6	<7.6	9.5	8.8	8.9	11.4	11.4	11.1	12.2%	11%					10.6
	Population use of hospital beds following emergency admission- days per 1,000 population - National Data	2015/16	0.92 (CCG)	Reduction on baseline	The indicator is indirectly standardised to the national population rates at 2015/16 Q1, by age, sex and need. Quarterly.												
	Population use of hospital beds following emergency admission - days per 1,000 population Local Data	2015/16	404.8 (monthly position 33.7)	Reduction on baseline	39.1	38.4	32.7	34.8									417.2 (Rolling 12 months)

10.1 As at November 2016, data is as follows at EMAS Level:

- Cat A (Red 1) – 70% against 67.5% (EMAS trajectory) and 68.6% against 64% (LLR trajectory). ELR CCG is 20 out of 22 CCGs based on EMAS trajectory. This ranking has remained static since October position.
- Cat A (Red 2) – 56.9% against 61.6% (EMAS trajectory) and 50.5% against 54.3% (LLR trajectory). ELR CCG is 22 out of 22 CCGs based EMAS trajectory. This ranking has remained static since July position.
- Cat A 19 Mins – 85.3% against 86.6% (EMAS trajectory) and 79% against 82.2% (LLR trajectory). ELR CCG is 19 out of 22 CCGs based EMAS trajectory. This has remained static since the July position.

10.2 EMAS ambulance response performance was achieved in November 2016 for Red 1 as a whole and at LLR level against the STF trajectory as predicted. However both Red 2 and 19 minutes failed for EMAS as a whole and achieved at LLR level against the STF.

10.3 Following the last performance report, Commissioners raised concerns regarding the decline in hear and treat. EMAS have advised that this was due to a dip in workforce capacity in the CAT team with the change from agency worker to permanent posts. This performance is expected to increase in the next couple of months, as a result on reducing scene attendance and releasing resource.

10.4 The Contract Performance Notice (CPN) remains in place, with discussion ongoing between CCGs and EMAS on whether to withdraw the CPN as a result of the Joint Investigation recommendations. LLR has requested it remains in place, with EMAS providing an internal remedial action plan to address issues that they can lead on in addition to action by local A&E Delivery Boards (AEDBs) including joint actions with NHS111 which do not require mediation through CCGs and AEDBs.

10.5 A Joint investigation relating to performance has been undertaken, and a number of recommendations are in place, these relate to; handover delays; information supporting Red Acuity; work to reduce the level of calls to EMAS with other providers such as NHS111; sharing of information such as gaps in pathways, service provision and complaints from nursing and care homes to improve the service.

10.6 The Strategic Review has been delayed due to 2017/18 contract negotiations. Deloittes have been commissioned to deliver an element of the strategic contract price review; recommendations were presented to Commissioners on 7 December 2016. An extra-ordinary partnership board is being arranged to allow formal consideration of the results.

10.7 EMAS and CCGs are to procure external support to deliver the Demand and Capacity Review, to be undertaken prior to the CQC visit in February 2017.

10.8 Further actions remain in place as follows: increased capacity in the CAT desk; maintenance of voluntary and private ambulance providers until substantive staff are in place; overseas recruitment in October, with new staff in post early in 2017/18; police and fire services providing Community First responders for defibrillators; turnaround work to be shared with commissioners and Dispatch on Disposition Pilot extension to all Ambulance Trusts in October to increase triage (Source: PPAG)

11. URGENT & EMERGENCY CARE – DELAYED TRANSFERS OF CARE (DTOC)

11.1 DTOC performance is continuing to deteriorate from April (9.5) to November (11) per 100,000 population against the outturn position for 2015/16 of 7.6. This is being closely monitored.

11.2 Population use of hospital beds following emergency admissions. Local data has been published and is showing an increase on 2015/16 baseline from 404.8 days per 1,000 population to 417.2. Data is only available to July 2016 currently.

11.3 A&E actions are in place, which cover both DTOC and use of emergency beds.

12. ELECTIVE ACCESS – 18 WEEKS RTT, 52 WEEK WAITERS, < 6 WEEKS DIAGNOSTICS AND CANCELLED OPERATIONS

	Indicator Description	Latest Baseline Position	Outturn/ Standard	Standard/ Target	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	YTD	Monthly Trend
Elective Access	Patients waiting 18 weeks or less from referral to hospital treatment - RTT - Incompletes (CCG)	2015/16	94.9%	92%	93.6%	93.1%	92.72%	92.85%	92.32%	91.7%	91.95%						92.60%	⇧
	No. of 52 Week Waiters	2015/16	261 (incl Orthodontics at LRI	Zero Tolerance	ALL CCG's 169 (incl Orthodontics LRI)	ALL CCG's 134 (incl Orthodontics LRI)	ALL CCG's 130 (incl Orthodontics LRI)	ALL CCG's 77 (incl Orthodontics LRI)	ALL CCG's 57 (incl Orthodontics LRI)	ALL CCG's 53 (incl Orthodontics LRI)	ALL CCG's 38 (incl Orthodontics LRI)							⇧
	No. of 52 Week Waiters (ELR CCG)		218		0	0	1 (ENT)	1 (Other)	0	1 (ENT)	2 (ENT)						5	⇩
	Diagnostic Test Waiting Time < 6 weeks (CCG)	2015/16	5.9%	Below 1%	0.6%	0.5%	0.6%	0.4%	1.3%	1.6%	0.5%						0.8%	⇧
	Cancelled Operations - % of patients re-admitted within 28 days (UHL)	2015/16	3.8%	Zero Tolerance	18.6% 29 patients	13% 16 patients	11.7% 18 patients	17.5% 20 patients	22.7% 25 patients	9.2% 10 patients	6.7% 9 patients						14.1% 127 patients	⇧

Reporting remains the same as last month as data is not yet available for November 2016. This will be available in January 2017.

12.1 RTT - The standard of 92% has been breached at UHL in September and October 2016. There is a risk to the standard in November due to winter pressures. The largest backlogs are in Urology, Orthopaedic Surgery, Ophthalmology and General Surgery. Actions plans are in place for these specialties alongside ENT, Allergy and Spines.

12.2 The use of Medinet to support both RTT and Cancer capacity is continuing, with alternatives to referral to UHL being developed and expanded, including pathways to Alliance. An LLR wide demand management meeting took place in October, with a further meeting with UHL, looking specifically at the increase in ENT and Cardiology GP referrals. An audit of patients were undertaken to assess appropriateness. The CCGs have developed their own demand management plans, and met with NHS England in November 2016.

12.3 The planned care structure is being reviewed to give referral/demand management a higher profile. This includes RTT, demand management and transformation programme together, to create a high level management board and operational group. The contracts team with UHL RTT leads are jointly reviewing the progress against recovery plans and identifying

areas with further action required. Detailed datasets in respect of outpatient activity has been shared with relevant members for discussion at the Planning Care Delivery Group in December 2016. (Source: PPAG & Area Team Response).

12.4 52 Week Waiters - The zero tolerance standard was breached in October 2016. There was two ENT 52 week waiters reported for ELR CCG, The YTD position shows five in total. These occur in a variety of specialities. UHL had 33 patients breaching 52 weeks for Orthodontics and five in ENT. There were five 52 week breaches in ENT with more predicted as backlog is cleared. These five patients were waiting due to capacity issues and with four being seen in October and with the fifth not attending, who has now been discharged. Weekly access meetings are in place to discuss any potential waiters (Source: PPAG).

12.5 6 Week Diagnostic – The waiting time has improved significantly in October to 0.5%; therefore the standard of 1% position has been achieved. Year to date remains below target.

12.6 Cancelled Operations - The position for October 2016 at 6.7% (9 patients) has improved since September, although it is still not achieving the target there has been a reduction of 1patient in October from the previous month, where 10 patients were reported. Cancellations are mainly due to capacity. Performance is being closely monitored to determine the extent of the expected improvement due to ring-fencing the day ward and ward 7. Weekend lists and outsourcing of ENT surgical capacity should reduce cancellations over the coming months. There are 4 HDU beds currently open at the LRI, whilst the 6 predicted ITU beds to be confirmed. Theatre management processes are being overseen (Source: PPAG).

13. HEALTH ACQUIRED INFECTION MRSA AND CDIFF

Additional Indicators Requiring Focus	Indicator Description	Latest Baseline Position	Outturn/ Standard	Standard/ Target	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	YTD/FOT	Monthly Trend
	Healthcare acquired infection (HCAI) measure (MRSA)	2015/16	0	0	0	0	0	0	0	0	0	1					1	⇩
	Healthcare acquired infection (HCAI) measure (Clostridium difficult infection)	2015/16	79	Trajectory	6	6	6	6	6	6	6	6	6	8	8	8	78	
				2016/17 (78)	4	9	9	6	14	12	2	9					65 YTD 98 FOT	⇩
	NHS111 - Abandoned Calls after 30 seconds	2015/16	1.4%	<2.9%	2.3%	2.6%	2.8%	1.9%	0.9%	0.6%	2.2%	1.3%					1.9%	⇧
	NHS111 -Calls answered within 60 seconds	2015/16	90.5%	>95%	85.9%	84.3%	83.2%	92.3%	96.8%	97.6%	89.2%	95.5%					90%	⇧

13.1 MRSA – there has been one incidence reported for an ELR patient in November 2016. The Root Cause Analysis has been signed off, and ELR CCG have requested that it be assigned to a third party.

13.2 13.2 CDIFF – For April to November 2016, 65 incidences have been reported against a trajectory of 48, with 98 predicted against 78 objective to-date. UHL have not yet reported November 2016 position, this will be available for next month. However they are predicting achievement of their objective for 2016/17. Locally the Infection Control Team is closely monitoring the situation, with the three CCGs working together focusing on high risk areas and urgent patient safety issues.

14. NHS 111

14.1 The provider has achieved calls within 60 seconds in November 2016. Validation of data continues to give Commissioners assurance.

15 QUALITY PREMIUM

15.1 The Quality Premium for 2015/16 reported is based on a local view, and may differ from national publication of data. The local current position shows achievement of £222,075.

15.2 The Quality Premium (QP) for 2016/17 is being monitored monthly, and the following indicators are not achieving the target, the delivery actions are included above, with the exception of service areas detailed below:

- Anti-biotic resistance (broad spectrum) prescribing in primary care. The Medicines Management Team monitors GP prescribing of anti-biotics with a number of actions being undertaken locally by GP practices, including; self-assessment checklists; review of "Treating your Infection" leaflets and actions as a result; anti-biotic champions; awareness and revision of prescribing guidelines.

- Improvement in cancers diagnosed at early stage. Although this is increasing from 2013 baseline, it is achieving 3.3% increase against a 4% improvement required, showing a positive position currently. 2015 baseline will be used in the 2016/17 QP when published.

- Increasing the proportion of GP referrals made by e-referral. A joint improvement approach was agreed between UHL and the Leicestershire CCGs with various actions in place including; all practices are compatible with ERS system, with referral advice and guidance, and a list of specialties provided by UHL; review of all specialties to increase slot available to 100% and CCGs are working to reduce Appointment Slot issues, with capacity alerts for specific services.

- Increase in IAPT Access. Local data and national data is now being reported.

- Increase in the reported number of dementia patients on GP registers

16 NHS Constitution Indicators

16.1 Adjustments have been made to standards as a result of the Sustainability & Transformation Fund (STF), and trajectories have been set for three of the Constitution indicators; A&E 4 hour wait; 62 day cancer and EMAS ambulance response calls.

16.2 The current RAG rating is based on the monthly position against trajectory, and there two indicators failing; A&E 4 Hour Wait and Cancer 62 day. This has remained static since last month. Ambulance Response Times Red 1 continues to achieve for August – November 2016.

Blank Page

EAST LEICESTERSHIRE AND RUTLAND CLINICAL COMMISSIONING GROUP GOVERNING BODY MEETING

Front Sheet

REPORT TITLE:	**ELR CCG GP Locality Meeting Themes – December 2016**
MEETING DATE:	**Tuesday 10th January 2016**
REPORT BY:	**Jamie Barrett, Head of Primary Care**
SPONSORED BY:	**Tim Sacks, Chief Operating Officer**
PRESENTER:	**Dr H Fox, Locality Lead, Melton, Rutland and Harborough, Dr G Purohit, Melton, Rutland and Harborough Dr Nick Glover, GP Locality Lead, Blaby & Lutterworth Dr Vivek Varakantam, GP Locality Lead, Oadby & Wigston**

EXECUTIVE SUMMARY:
The purpose of this report is to provide an overview of the monthly GP Locality meetings held across Blaby and Lutterworth, Oadby and Wigston and Melton, Rutland and Harborough. These meetings are key to the CCG development and allow member practices an opportunity to debate current general practice and highlight themes they wish to inform the Board.

RECOMMENDATIONS:
The East Leicestershire and Rutland CCG Governing Body is requested to: **RECEIVE** the report.

REPORT SUPPORTS THE FOLLOWING STRATEGIC AIM(S) 2016 – 2017:			
Transform services and enhance quality of life for people with long-term conditions	Y	Improve integration of local services between health and social care; and between acute and primary/community care.	Y
Improve the quality of care – clinical effectiveness, safety and patient experience	Y	Listening to our patients and public – acting on what patients and the public tell us.	Y
Reduce inequalities in access to healthcare	Y	Living within our means using public money effectively	Y
Implementing key enablers to support the strategic aims (e.g. constitutional and governance arrangements, communications and patient engagement).			Y

EQUALITY ANALYSIS
An Equality Analysis and due regard to the positive general duties of the Equality Act 2010 has not been undertaken in the development of this report as it is judged that it is not proportionate on the basis that on the basis that this purely an information summary of discussions which has occurred.

This completes the due regard required.

RISK ANALYSIS AND LINK TO BOARD ASSURANCE FRAMEWORK:	
The content of the report identifies action(s) to be taken / are being taken to mitigate the following corporate risk(s) as identified in the Board Assurance Framework:	BAF 6
	BAF 6

EAST LEICESTERSHIRE AND RUTLAND CLINICAL COMMISSIONING GROUP GOVERNING BODY MEETING

GP locality Meetings – December 2016

10th January 2016

INTRODUCTION

1. The 32 GP practices across the CCG are split into 3 geographical localities, Blaby and Lutterworth, Oadby and Wigston and Melton, Rutland and Harborough. The purpose of the locality structure is to provide a forum for member practices to feed into the CCG, feedback to their practices and discuss key issues and concerns. In addition the locality structure provides:

- Meetings held monthly, 12 times a year
- A promotion of two-way discussion on all business and a mechanism for GPs to be updated on CCG matters to inform commissioning and planning processes.
- Share learning from adverse events e.g. safeguarding issues etc.
- Opportunities for clinical discussion and education
- Monitoring of performance and quality through the sharing of benchmarked data and information.

LOCALITY MEETING CONTENT

2. These meetings are represented by each practice across the CCG. The theme for the December 2016 meetings can be split up as the following:

Clinical Topics

- First Contact and Social Prescribing (BL only)
- Integrated Locality Teams (MRH and OW only)

Other Agenda Items

- Shaping 2017/18 plans- Engagement and Development Session (All localities)

Standing Agenda Items

- Monitoring of performance and quality through the sharing of benchmarked data and information (sent out with meeting papers but only discussed at OW this month)
- Safeguarding and GP Concerns – an opportunity to share any learning or raise concerns with peers

- Governing Body Update- prepared by the communications team

LOCALITY THEMES

- The sections below represent the key themes from the Localities for the month of December 2016
- Post Board note - practice activity performance will be discussed formally and raised by the relevant locality chair GP.

3. MELTON RUTLAND AND HARBOROUGH LOCALITY Clinical Chairs: Dr Hilary Fox/ Dr Girish Purohit

December 2016

3.1 Members received an introduction to the LLR integrated teams work stream and early work which had been initiated in Rutland and Melton (with Latham House) working alongside the local district councils and LPT teams. The momentum is building to develop the teams and practices were made aware that they would be invited to become more involved over the coming months. The GPs were asked about their experiences with the current integrated care coordinators and a range of views were collated with some practices feeling the experience was positive and productive whilst others felt that the coordinators were not integrated enough and there was more they could be involved in. There were concerns raised that in developing integrated teams, infrastructure would be an issue both in terms of IM&T and co-location in premises.

3.2 Presentations were received on proposed developments for urgent care, GP SIP 2017/18 and the prescribing scheme for next year. For Urgent care , members' comments included the suggestions that urgent centres should be GP led and services should be identical in terms of opening times, staffing and services to avoid confusion for patients. Views were varied around the night service and home visiting. Access issues were raised including whether a walk-in system should be pre-bookable only. The variation in availability of diagnostics across urgent care sites was also highlighted as an issue. For prescribing, members received an outline of the main areas of the prescribing scheme for 2017/18. Concerns were raised about secondary care prescribing which doesn't always adhere to pathway changes which leaves practices to manage the change with the patient. Members were also of the view that Stoma nurses should be employed by secondary care and not via the product suppliers. It was highlighted that the Federation will support smaller practices with a pharmacy provider.

3.3 An outline of the GP SIP 2017/18 was received and practices were pleased to see early information and noted the £6 per patient funding. The issue of the QOF was discussed in detail and members wanted to highlight if there were options to

cease with QOF as it overlaps with other areas of work. It was noted that this could not be instigated for 2017/18 and if QOF ceased, there would need to be alternative measures in place to deliver national and local priorities which would have significant IT implications. It was acknowledged that the CCG recognised the overlaps.

4. BLABY AND LUTTERWORTH – Chair Dr Nick Glover/ Dr Graham Johnson

December 2016

4.1 Senior member support – Disappointment was expressed with continued senior member support being pulled out of the locality meetings at the last minute. The senior management team of the CCG made a commitment to attend monthly locality meetings, and whilst a deputy has always attended, the local GPs expect to see the CCG SMT at the meetings.

4.2 First Contact Plus – Debbie Preston updated the group on the First Contact new web based referral application that was now available to GPs. The item was positively received and the introduction of patient self-referral accessibility which was to commence in January was especially welcomed by the members.

4.3 Urgent Care – Jamie Barratt asked members on their thoughts and ideas for developing the urgent care model for ELR CCG. It was noted that Blaby and Lutterworth locality have no other options for urgent care currently except UHL which can be clearly seen by much higher activity for LRI Urgent Care Centre and A&E compared with other localities. It was requested that conversation rates for LRI UCC to A&E were explored through the contractual route.

4.4 GPSiP – Jamie Barratt highlighted the proposed scheme for 2017/18. Many areas are a continuation of the work in previous schemes with the additional areas this year of renal, cancer and paediatrics. The proposed scheme was well received by the group although it was noted that it was a ‘take it or leave it’ scheme.

4.5 Prescribing – Shazia Patel talked through the proposed GP prescribing scheme for 2017/18. It was noted that the paper had not been received prior to the meeting which was a disappointment and the members felt that the MQT need to be very conscientious in their engagement for this years scheme as lack of engagement on last year’s scheme had greatly affected practice participation.

5. OADBY AND WIGSTON – Chair Dr Vivek Varakantam

December 2016

5.1 Governing Body update – The locality welcomed the update and were pleased with the financial progression to date against the current cost saving measures. The GPs were keen to know more about the STP plan and sought clarity that this links with the GP five year forward view. GPs were advised that a link to the plan will be shared with the group.

5.2 Shaping Primary Care, Urgent Care and Prescribing– Paula Vaughan introduced the main section of the meeting which was to focus on Primary Care, Urgent Care and Prescribing planning for 2017/18.

5.3 Primary Care – GP SiP – Jamie Barret led discussion around the GP Support and Investment Programme plans for 2017/18. Initial plans were shared and discussion was had around changes to investment areas. GPs raised concern on how paediatric urgent referrals in would affect current planning but were receptive to proposals around usage of advice and guidance, e referrals and PRISM. All practices confirmed that they were using PRISM.

5.4 Prescribing – Potential QIPP areas for 2017/18 were shared with the locality. GPs raised concern around budget setting and targets and questioned if these would be looked at as increases in prescribing are reflective of good patient management.

5.5 Urgent Care – Paula Vaughan updated the locality on the LLR Vanguard and the wider plans around urgent care. Home visiting service was a key area of discussion and practices asked for clarity over when this service would change. Base Visits were also of interest to the locality and discussion took place around location of services, times of services and the offer from these services. GPs felt that if the service could offer blood tests or other point of care tests/ diagnostics this would be of value. There was a majority consensus around the ability for these centres to operate on a booked appointment system but some felt that there is no issue with a walk in service. Overall the locality was receptive to proposals and highlighted that they would be keen for these centres to operate outside of GP hours to reduce duplication of services.

Recommendation:

The East Leicestershire and Rutland CCG Governing Body is requested to:

RECEIVE the report