Leicester City Clinical Commissioning Group
West Leicestershire Clinical Commissioning Group
East Leicestershire and Rutland Clinical Commissioning Group

Meeting Title	**Commissioning Collaborative Board (Joint Committee) - Meeting in Public**	**Date**	**Thursday 21 June 2018**
Meeting no.	**6**	**Time**	**1:00pm – 2:35pm**
Chair	**Professor Mayur Lakhani (Chairman) – West Leicestershire CCG**	**Venue / Location**	**Conference Room, 8th Floor, Leicester City Clinical Commissioning Group, St John's House, 30 East Street, Leicester, LE1 6NB**

	AGENDA ITEM	**ACTION**	**PRESENTER**	**PAPER**	**TIMING**
CCBP/18/42	Welcome and Introductions		Professor Lakhani		1:00pm
CCBP/18/43	Apologies for Absence: • Karen English	To receive	Professor Lakhani	**verbal**	1:00pm
CCBP/18/44	Notification of Any Other Business	To receive	Professor Lakhani	**verbal**	1:00pm
CCBP/18/45	Declarations of Interest on Agenda Topics	To receive	Professor Lakhani	**verbal**	1:00pm
CCBP/18/46	To receive questions from the Public in relation to items on the agenda only	To receive	Professor Lakhani	**verbal**	1:05pm
GOVERNANCE ARRANGEMENTS					
CCBP/18/47	Minutes of the meeting held on 17 May 2018	To approve	Professor Lakhani	**A**	1:15pm
CCBP/18/48	Matters Arising: Update on actions from the meeting held on 17 May 2018	To receive	Professor Lakhani	**B**	1:20pm
ITEMS FOR DECISION, ACTION AND ESCALATION					
CCBP/18/49	Second Primary Care Blood Collection	To approve	Simon Pizzey/Tracey Knight	**C**	1:25pm
CCBP/18/50	Transforming Care Plan Sustainability Proposal	To approve	Donna Enoux	**D**	1:35pm
CCBP/18/51	Progress on QIPP Schemes	To receive	Spencer Gay	**E**	1:45pm
CCBP/18/52	Cancer Alliance Funding	To receive	Sue Lock	**F**	1:55pm
CCBP/18/53	Progress update on Community Redesign Programme	To receive	Tamsin Hooton	**G**	2:05pm
CCBP/18/54	Progress update on LLR Frailty work and Terms of Reference	To receive	Sarah Prema and Tamsin Hooton	**H**	2:15pm
CCBP/18/55	Progress on Joint Working Arrangements	To receive	Clinical Chairs	**verbal**	2:25pm
DATE OF NEXT MEETING					

Leicester City Clinical Commissioning Group
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	AGENDA ITEM	ACTION	PRESENTER	PAPER	TIMING
The next meeting of the Commissioning Collaborative Board will take place on **Thursday 19 July 2018, Conference Room, 8th Floor, Leicester City CCG, St John's House, 30 East Street, Leicester, LE1 6NB**					

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LEICESTER, LEICESTERSHIRE AND RUTLAND CCGs COMMISSIONING COLLABORATIVE BOARD

Minutes of the Public Commissioning Collaborative Board held on Thursday 17 May 2018 at 1:00pm in the Conference Room, 8th Floor, St John's House, 30 East Street, Leicester, LE1 6NB

PRESENT:

Dr Chris Trzcinski	Deputy Clinical Chair, West Leicestershire CCG (Chair)
Dr Richard Palin	Clinical Chair, East Leicestershire and Rutland CCG
Dr Andy Ker	Vice Clinical Chair, East Leicestershire and Rutland CCG
Mrs Karen English	Managing Director, East Leicestershire and Rutland CCG
Mr Toby Sanders	Managing Director, West Leicestershire CCG
Ms Sue Lock	Managing Director, Leicester City CCG
Mr Spencer Gay	Chief Finance Officer, WL CCG
Dr Avi Prasad	Co-Chair, Leicester City CCG
Ms Gillian Adams	Independent Lay Member, West Leicestershire CCG
Mr Zuffar Haq	Independent Lay Member, Leicester City CCG
Ms Donna Enoux	Chief Finance Officer, East Leicestershire and Rutland CCG
Mrs Michelle Iliffe	Director of Finance, Leicester City CCG
Ms Tamsin Hooton	Director of Urgent and Emergency Care, West Leicestershire CCG
Mrs Caroline Trevithick	Chief Nurse and Quality Lead West Leicestershire CCG
Ms Sarah Prema	Director of Strategy and Implementation, Leicester City CCG
Mr Clive Wood	Independent Lay Member, East Leicestershire and Rutland CCG
IN ATTENDANCE	
Mr Derek Laird	Chief Executive Officer, Thames Ambulance Service Limited (TASL) **(for item CCBP/18/39)**
Mr Hayden Newton	Director of Quality and Governance **(for item CCBP/18/39)**
Ms Tracy Hodgkiss	Director of Performance **(for item CCBP/18/39)**
Mr Mike Casey	Director of Operations **(for item CCBP/18/39)**
Mr Louise De Groot	Locality Manager for TASL **(for item CCBP/18/39)**
Ms Joan Majo	International Director HTG (**Parent Group of TASL) (for item CCBP/18/39)**
Mr Michael Ryan	Interim Head of Operational Resilience & Emergency, WLCCG **(Observing)**
Mrs Jayshree Raval	Commissioning Collaborative Support Officer, East Leicestershire and Rutland CCG **(minutes)**

ITEM	DISCUSSION	LEAD RESPONSIBLE
CCBP/18/32	**Welcome and Introduction** Dr Chris Trzcinski welcomed members of the Commissioning Collaborative Board (CCB) members to the joint meeting of CCB in public. It was noted that there were no members of the public present at the meeting.	
CCBP/18/33	**Apologies received** The following apologies were noted: - Professor Mayur Lakhani, Clinical Chair, West Leicestershire CCG - Professor Azhar Farooqi, Clinical Chair, Leicester City CCG	

CCBP/18/34	**Notification of Any Other Business** The Chairman had not received notification of any additional items of business.	
CCBP/18/35	**Declarations of Interest on Agenda Items** The Chair reminded members of their obligation to declare any interest they may have on any business arising at committee meeting which might conflict with the business of NHS Leicester City CCG, East Leicestershire and Rutland CCG or West Leicestershire CCG.	
CCBP/18/36	To **RECEIVE** questions from the Public in relation to items on the agenda only. There were no members of public present at the meeting.	
CCBP/18/37	To **APPROVE** the minutes of the Public Commissioning Collaborative Board meeting held on19 April 2018 **(Paper A)** The minutes of the Public Commissioning Collaborative Board meeting held in April 2018 were approved as an accurate record of the meeting subject to the following minor amendments: On page 9, the sentence beginning with Mr Sanders……. Frailty and multi mobility to read as "multi morbidity". On page 10, Meeting included to read as " Meeting concluded" It was **RESOLVED** to: - **APPROVE** the minutes of the last meeting.	
CCBP/18/38	To **RECEIVE** the Matters Arising: actions from Commissioning Collaborative Board held on 22 March 2018 **(Paper B)** There were no matters arising following the meeting held in March 2018. It was **RESOLVED:** - **RECEIVE** the matters arising, and note the progress to date.	
CCBP/18/40	To **RECEIVE** update on Community Services Redesign **(Paper D)** Ms Hooton presented the report that outlined the scope of the Community Services Redesign Project, which has been initiated by the Leicester, Leicestershire and Rutland Clinical Commissioning Groups (LLR CCGs).The report explained that the purpose of the redesign is to re-specify and redesign a range of core community services, aiming to deliver: - Better integrated services that reflect the evidence base for best practice community services - Provide better value for money - Support the wider STP plan for out of hospital care. Ms Hooton went through the objectives of the redesign, highlighting that the Community Services Redesign (CSR) will need to address the developing role of Integrated Locality Teams (ILTs) to reflect in	

	the community services specification. In addition there will need to be clear links between the governance of ILT and the CSR. It was noted that the CSR work is a commissioning redesign project, leading to recommendations on the specification and commissioning of community health services. Ms Hooton stated that the project will be led by the LLR CCG. In addition the project governance, in terms of decision making on service changes and funding, will be overseen by the Collaborative Commissioning Board (CCB). The report also highlighted that there will be a core project team supporting this piece of work. Ms Hooton informed that there are a number of key interdependencies for the CSR, which will need to be managed effectively in order to ensure that the redesign delivers the wider objectives of the Sustainability and Transformation Plan (STP). Ms Hooton added that in order to address the interdependencies between the CSR work, the ILT and Home First work-streams, it is proposed that an oversight group of senior officers is established to bring together and manage the activities currently being led by the Home First and Integrated Teams Programme Boards. This oversight group will lead work across the LLR health and care system to agree and implement a model of community services to deliver a 'Home First' approach and to join up care services around local populations. Ms Prema highlighted that the CSR project needs to be aware of the probability of overlapping work between the work-streams and how this will be taken through. Ms Hooton stated that there will be some overlapping of work and it is under review. In response to Dr Ker's query, Ms Hooton informed that engagement with providers and stakeholders takes place through the Home First Programme Board. It was suggested to explore the knowledge and work that has already been carried out by the ILTs to assist with the review work. Ms Hooton explained that she has explored this area and there is some work that can be taken forward and continue to build on it. Mr Wood stated that the report talks about appointing a patient representative on the core team and asked if this had been completed. Ms Hooton informed that a patient representative has just been appointed. Ms Lock asked if colleagues from University of Hospital (UHL) have been involved in the scoping of the work in order to understand the discharge process. It was suggested to have clinical input from UHL on the clinical reference group. Under Frailty, Ms Hooton explained that although this is not a separate work-stream in the LLR STP structure; a system wide approach is being developed to consider how to effectively organise a collective approach to frailty across the STP and	

<table>
<tr><td></td><td>utilising the governance structure in place.

It was RESOLVED:
- RECEIVE the paper to NOTE the scope of the Community Services Redesign, high level milestones and next steps.</td><td></td></tr>
<tr><td>CCBP/18/39</td><td>To RECEIVE presentation on Thames Ambulance Service Limited (TASL) (Paper C)

The following members from TASL attended CCB to provide update on TASL's performance since the appointment of the Senior Executive Team:

Mr Derek Laird, Chief Executive Officer
Mr Hayden Newton, Director of Quality and Governance
Ms Tracy Hodgkiss, Director of Performance
Mr Mike Casey, Director of Operations
Mr Louise De Groot, Locality Manager for TASL
Ms Joan Majo, International Director HTG.

Mr De Groot and Ms Majo sat in the public gallery observing the discussions.

Dr Trzcinski welcomed the TASL colleagues to the meeting and introduction went around the room.

Mr Laird started the presentation by providing some background on TASL. He stated that:
- TASL has been operating since 1985.
- Headquarters are in Lincoln.
- Has 21 operational bases.
- 700,000 patient journeys are made annually.
- 350 Vehicles.
- 800+ Staff.
- £25m turnover.
- Grown by 500% in 18 months.

Mr Laird explained the changes that have been made since he came into post. He informed that the following senior executive team have been put in place since his appointment:
- Director of Quality & Clinical Governance
- Director of Operations
- Head of Patient Experience
- Head of Quality & Governance
- Associate Director of Corporate Services
- Associate Director of HR
- HR Business Partner
- Operational restructure

The main focus has been to:
- Improve governance processes.
- Improve patient experience.
- Stakeholder Engagement.
- Care Quality Commission (CQC) findings.</td><td></td></tr>
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	- Improved Key Performance Indicators (KPI's). - Improved complaints handling. - Technology led Improvements. - Reporting to CCGs on a monthly basis on their financial position. - Work towards agreeing the financial recovery plan. Mr Newton talked through a number of priorities under Governance and Quality such as: - Implementing the agreed structure underneath the Clinical Governance Directorate. - Training the Safeguarding leads. - Review of safeguarding pathways for each locality to ensure they are simple and clear. - Process for incident reporting and management of the process. - Base audits reported through quality schedule. - Improvement in the quality of reporting. - Fostering good relationship with the CCGs. - Base station inspections to ensure processes are being followed. - Centralised complaints system in place and improved response times. - Strengthening the shared learning process across organisations. - Building good rapport with staff. Mr Newton elaborated on each of the priorities highlighted above in more detail. Ms Hodgkiss went on to then talk through the areas which have been and are being focused since the mobilisation of the service. She highlighted the main areas of focus: - **Mobilisation**: is under review to ensure appropriate organisational and technical infrastructures and mechanisms for putting resources are in place. - **Renal and discharge:** the focus is on these areas to ensure renal patients are picked up and collected on time. There is some improvement noted however there is still more work to do. - **Outpatients:** Work has commenced on this area as it is acknowledged there are gaps identified in this area. Ms Hodgkiss explained the areas of focus in detail and talked through some of the initiatives that have been introduced to improve performances of the service. Mr Casey explained the work taken forward in regards to the communications and how information is cascaded both at executive level and at operational level. Mr Laird summarised that since his appointment and of his executive team work has been taken forward in focused areas. He informed that progress has been made and some improvement has been noted however acknowledged that further work is required in	

	order for the governance and processes to embed overtime. Mr Haq asked when Mr Laird envisages TASL breaking even going forward. Mr Laird explained that it was difficult to provide a timeline as work is still underway in regards to embedding processes and governance to ensure that core KPIs are being met. Mr Haq asked a further question stating that improvements have been noted in outpatients and renal areas, however what plans are in place to address other areas where performance is seen to be not up to the standard. Mr Laird reiterated that the aim is to focus on area by area in order to introduce and embed process within each of the areas and assured that all areas will be addressed. Lastly Mr Haq queried the retention of staff and how this would be managed. Mr Laird highlighted that retention of staff is difficult however he would like to offer training opportunities in a controlled manner to staff as carer progression which will help staff to progress within the organisation. In addition it was noted that TASL is working with the Grimsby Institution to take on people who have been unemployed for some time and put them through the training programme for which the funding has been provided by the Government. Mr Wood queried the call centre and the discharge % highlighted in the presentation. He asked how these were measured as the information provided did not reflect the improvements stated during the presentation. Mr Laird's response explained how the % had been worked up which indicated the improvements stated earlier. Dr Ker queried what process was in place to receive patient feedback. Mr Casey and Ms Hodgkiss informed that patient feedback is received via: - Friends and Family tests - Renal events - Complaints - Feedback from hospitals - Feedback from the co-ordinators Mr Newton explained that next steps will be to contact patients who have used TASL and get their views and feedback in regards to their experience of the service. This will assist in building a portfolio of comments which will be utilised in improving the service. Mrs Iliffe queried the financial recovery plan which was mentioned during the presentation and also commented on the monthly reporting to the CCGs. She stated that the monthly reports have not been provided to the CCGs regularly and requested that the financial recovery plan is shared with the CCGs. Mr Laird agreed that previously the CCGs did encounter delays in receiving monthly reports and this was due to staffing issue. He explained that a Management Accountant has recently been appointed who will ensure reports are provided to the CCGs in a timely manner going forward. In addition Mr Laird informed that he would be happy to share the financial recovery plan with the Chief Finance Officers should they wish to review it.	

	In response to Ms Lock's query in regards to relationship with the Trusts, Mr Laird informed that TASL has fostered good working relationship with the Acute Trust and with some of the senior managers. Ms Adams asked if Mr Laird could indicate some timeline in regards to when would TASL be able to achieve all the 22 KPIs. Mr Laird informed that it would be difficult to provide a timeline however assured CCB members that they are working towards improving performances and are working closely with the CCG colleagues. He added the main priority is to ensure patients are receiving good service. He noted that improvement will be seen in the next few months. Dr Trzcinski thanked the TASL team for attending the meeting and updating against the areas where measures and processes have been put in place and as a result improvements have been noted. It was **RESOLVED** to: - **RECEIVE** the TASL presentation. All colleagues from TASL left the meeting. Dr Palin and Ms Hooton left the meeting.	
CCBP/18/41	To **RECEIVE** LLR PMO Approach to QIPP Delivery **(Paper E)** Mr Spencer Gay presented this paper which highlighted: - The work to date in forming standardised Programme Management processes across LLR CCGs to support QIPP delivery. - The status on the development of an LLR Programme Management Office with associated governance on QIPP delivery mechanisms, reporting and responsibilities is presented. - The next steps towards maximising deliverability of QIPP through a Programme Management Office approach. Mr Gay informed that there are currently differing method approach to Programme Management and variations in practice and reporting across the three CCGs. He stated that work to date have been carried out to align the processes across the CCGs and in addition a single Senior Responsible Officer (SRO) would develop a strong Programme Management Office (PMO) function that will result in programme leads having a clear understanding of the remit and requirements of the PMO, standardisation of processes and reporting and a clear governance framework. Dr Palin re-joined the meeting. Mr Gay talked through paragraphs 23 and 24 of the report which indicated the function of PMO in terms of what their responsibilities will be or will not be. In addition paragraph 25 highlighted individuals who will be part of the LLR PMO core team, what would be their roles and responsibilities and what governance process will be put in place.	

	Mr Gay stated that the Quality Assurance Group (QAG) meeting will be the key in driving forward the work of the LLR PMO approach and have: - Oversight and assurance of all QIPP schemes through standardised reporting. - Escalation, support and challenge of Senior Responsible Officers (SRO's) responsible for delivery of QIPP project/programmes. He drew CCB's attention to paragraph 31 of the report which demonstrated the standardised governance framework to provide clear assurance and escalation procedures for the QIPP programme. Mr Gay stated that following discussions at the recent Joint Management Teams (JMTs) meeting, the diagram now includes JMTs as the forum to report updates on a regular basis prior to presentation at CCB. In addition it was highlighted that summary reports will be presented at the Governing Bodies to provide high level summary on QIPP at the individual Senior Management Team meetings and at Governing Bodies. Ms Hooton re-joined the meeting Under role of CCB, Mrs Trevithick highlighted that the Chief Nurses and the chairs are working on some of the QIPP schemes and suggested that it would be useful to report into CCB in regards to updates similar to the PMO reports prior to going to the Governing Bodies. It was agreed that it would be useful to present updates at CCB however they would also need to be presented at the QAG. Dr Palin queried the newly formed Joint Management Teams meeting in regards to have the Terms of Reference for the meeting gone to the Governing Bodies or CCB for approval. The Managing Directors explained that it is not a newly formed but replaces the Managing Directors (MDs) meetings. It is a meeting in common to discuss common areas of work and have a more collaborative approach towards these areas. It was highlighted that the CCGs will still continue to meet with their individual Senior Management Teams as planned. Some comments were raised following presentation of the paper as: - It is positive that staff is working together already. - To ensure equal equity of resource is allocated to this piece of work from the three CCGs - To be mindful of the achievements made so far. - CCB support the paper however to ensure that the wider QIPP schemes which are worked on by staff outside the PMO do not lose the momentum. - It was noted that the Terms of Reference (ToRs) for CCB provides an opportunity to work collectively and more collaboratively and therefore CCB should be the forum taking bigger part in driving the work forward. - CCB to note that the consultancy support being offered by Deloitte has been procured by NHS England. They have offered funding to CCG's dependent on CCG's perceived needs.	

	- What mechanisms will be put in place for those schemes which may not achieve or are off track prior to reporting at CCB. - Reports coming to CCB will have updates with mitigating actions for those schemes which are not performing well. - A paper will be presented at the future Joint Management Teams meeting which will highlight the mechanisms. It was **RESOLVED** to: - **SUPPORT** the paper Meeting concluded at 2:51pm	

Date of Next Meeting

Thursday 21 June 2018, Leicester City CCG, Conference Room, 8th Floor, St Johns House, 30 East Street, Leicester, LE1 6NB.

West Leicestershire CCG to Chair the meeting from May – August 2018 Inclusive.

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Commissioning Collaborative Board (CCB)

Public Action Notes

Key

Completed	On-Track	No progress made

Minute No	Meeting Date	Item	Responsible Officer	Action Required	To be completed by	Progress as at 21 June 2018	Status

No actions to record from the May 2018 CCB meeting.

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Leicester City Clinical Commissioning Group
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COMMISSIONING COLLABORATIVE BOARD MEETING

Paper C

Title of the report:	**Second Primary Care Blood Collection**
Report to:	Commissioning Collaborative Board (CCB)
Section:	Public
Date of the meeting:	21st June 2018
Report by:	Jamie Barrett - Head of Primary Care East Leicestershire and Rutland CCG Tracey Knight - Locality Lead East Leicestershire and Rutland CCG Hafiz Arif - Head of Operations – Pathology UHL, Simon Pizzey – Head of Strategy East Leicestershire and Rutland CCG Hema Jesa, Strategy and Implementation Manager, Leicester City CCG Jennie Caukwell, Delivery Manager, West Leicestershire CCG
Sponsoring Director:	Sarah Prema, Director of Strategy and Implementation, LCCCG
Presented by:	Simon Pizzey, Head of Strategy and Planning, East Leicestershire and Rutland CCG Tracey Knight, Locality Lead, East Leicestershire and Rutland CCG

CCG Involvement to date:

	City	**East**	**West**	**Insert name of any other groups ie ECN**
Clinician	Dr T Bentley Dr U Roy	Dr N Glover Dr G Johnson Dr A Ker	Dr N Pulman Dr C Barlow Dr N Sanganee Dr G Hanlon Dr YB Shah	ELR CCG Primary Care Development Group ELR and City CCG GP Locality Forums West CCG equivalent
Manager	Aimee Geary Hema Jesa	Tracey Knight Jamie Barrett Simon Pizzey	Jennie Caukwell	ELR CCG Executive Management Team ELR and City CCG Practice Managers Forum West CCG equivalent

Formally signed off by CCG (sub-group or equivalent) prior to CCB:

City	East	West
GP Reference Group	**EMT May/June 2018 Clinical Leads Meeting June 2018**	**LDM June 2018**

SUMMARY:

1. This paper proposes that there is an increase in the number of Primary Care pathology collections from one to two per day.

1.1. The proposal to have two collections shows the following benefits:

- Increases phlebotomy capacity in primary care
- Allows for urgent blood tests to be administered which might reduce need for admission
- Improves the patient experience by giving them better access options for phlebotomy
- Issues between the timing of collections vs ability to receive results are lessened.
- Reduces the risk of patients having to make unnecessary/additional visits to primary or secondary care due to sample degradation or spurious results which can result from sample processing delays.
- Illustrates a cost benefit in terms of potential to avoid ED attendances

1.2. The existing one collection a day increases the risk of sample degradation resulting from delays in transporting the sample from the GP practice to the laboratory (potassium in particular). This delay can lead to spurious potassium results which may lead to unnecessary ED attendances and possible admission.

1.3. UHL is requesting a contribution of £48k between the 3 CCGs which will enable them to deliver the additional collection service to all 181 LLR practices (including branch practices).

2. The paper links to CCG strategic objectives.

Through better commissioning, improve local and national health outcomes, particularly by addressing poor outcomes and inequalities;

☒ Help create the safest, highest quality health and care services;
☒ Balance the NHS budget and improve efficiency and productivity;
☒ Lead a step change in the NHS in preventing ill health and supporting people to live healthier lives;

☒ Maintain and improve performance against core standards;
☒ Improve out-of-hospital care;
☒ Support research, innovation and growth.

RECOMMENDATIONS:

The Commissioning Collaborative Board (Joint Committee) is asked to:

- **RECEIVE** the report
- **APPROVE** the proposal to increase the number of pathology collections from once a day to twice a day and funding to be split on a fair share basis reflecting the number of practices per CCG.

Second Primary Care Blood Collection

INTRODUCTION

Background

1.1. There are currently 181 GP practices across LLR including branch surgeries. Historically, LLR practices have only received one sample collection a day with a significant variation in collection times with the earliest at 9am and the latest at 4pm. It is recognised that not all these practices will use the UHL service but the majority do, so this is the focus.

1.2. The 3 LLR CCGs commission this service, which currently forms part of the Pathology Direct Access element of the CCG UHL contract. This means that UHL are paid per blood test, but the tariff only accounts for the one collection of samples. Therefore there could be an additional cost per test with the introduction of a second collection however the only increase in demand from a second blood collection would be for the occasional urgent patient where doing a blood test might reduce need for admission.

1.3.There is a need for an additional collection of bloods due to the increase in additional phlebotomy activity expected of primary care e.g. NHS Health checks, remote PSA monitoring (including SCAs and near patient testing), PRISM pathways, demand management and left shift to reduce follow-ups, plus the increased number of blood tests being requested from primary care by secondary care – one pathology collection per day is no longer fit for purpose for either primary or secondary care and does not offer quality of care for patients.

1.4. Today's demands on primary care means there is a need for 2 collections per day and in order to achieve this there needs to be a suitable infrastructure in place to enable the collection of samples to meet the GPs increased workload and continued development of community based left shift which is one of the main aims of the LLR STP. From a patient perspective two collections a day will provide greater choice as for the practice will have more capacity and flexibility to put on phlebotomy sessions to suit the patient and facilitating transformation of the structure of on the day access.

1.5. The existing one collection a day increases the risk of sample degradation resulting from delays in transporting the sample from the GP practice to the laboratory. This delay can lead to spurious potassium results which may result in unnecessary ED admissions. This provides a poor patient experience and is also costly to the health economy; both unnecessary and avoidable.

1.6. Historically blood collection routes have evolved in an ad hoc fashion trying to fit in with individual practice clinics. In collaboration with LLR CCG representatives UHL's Pathology service have reviewed their drivers' routes across the whole of LLR in order to accommodate 2 collections per day by improving the efficiency of the

current collection and adding a second collection in the afternoon. This has been produced using logistical software.

Additional investment

2.1. The proposal would involve the move to the new and far more efficient logistically planned model of routing which due to the efficiencies gained only adds a small investment cost to each of the CCG's for doubling much needed service capacity.

2.2. The annual recurrent cost to UHL of providing the additional daily collection is shown in the table below;

Description	Cost £
Staffing costs	49,608
Vehicle leasing cost	5,610
Fuel and consumables	9,200
Total	**64,408**

2.3. UHL is requesting a contribution of £48,608 across the 3 CCG's or 75% of the total cost to commence 01 April 2018. This will need to be reviewed on an annual basis in line with contract negotiations and is anticipated to form part of the UHL baseline in future years.

2.4. There will however be a possible secondary care cost pressure of the additional samples which will be an additional cost per test with the introduction of the second collection. The only increase in demand from a second blood collection should be for the occasional urgent patient where doing a blood test might reduce need for admission. It would be prudent to monitor the outcome of the second collection to ensure that any future contracting and commissioning takes this in

2.5. Primary care could centrifuge and spin the samples themselves to cope with this increased demand. The cost of this hardware are £900 each, one per practice is across LLR is £142k. This would be an initial outlay and then on going revenue costs for calibration maintence and testing. An extra collection would therefore be more cost effective.

Benefits of having a primary care second blood collection

3.1 UHL Pathology has undertaken a high level audit to ascertain whether a second daily collection impacts the number of spurious potassium results which are those tests which would be deemed as 'urgent' and a timely result being processed. The findings are provided below;

3.2 The sample audit of a pilot practice took place with Latham House Medical Practice (this practice has a list size of 35,594). The audit reviewed 6 months of

activity for the period 01 July 2016 to 31 December 2016 [pre pilot] and 01 July 2017 to 31 December 2017 [post pilot].

3.3**.** For the period **pre pilot**, 27 results from a total sample size of 7,886, reported potassium over 6.0mmol. Of these 27, 11 were correct and 16 spurious, 13 of which were as a result of transport delays or adverse temperature changes during transport.

3.4. For the period **post pilot**, 34 results from a total sample size of 8,406, reported potassium over 6.0mmol. Of these 34, 17 were correct and 17 spurious, 12 of which were as a result of transport delays or adverse temperature. A second collection therefore reduced spurious potassium results by 10%. Please see table below.

Pre Pilot Audit (7886)	
27 Abnormal Results	0.34238%
16 spurious	59%
13 Transport Delays	81%
Post Audit Pilot (8406)	
34 Results	0.40%
17 Spurious	50%
12 Transport Delays	71%
Extrapolated Data	
Total Tests Completed – actual data	1,030,947
Abnormal Results - extrapolated	3505
Spurious Abnormal Results - extrapolated	2068
Transport delays	1675
Savings Opportunity	
100% prevention of Transport related ED Attendances	£222,794
10% Prevention of Transport related ED	£22,279
15% prevention of transport related ED due to improved routing and temperature control bags	£33,419
Anticipated saving on transport delayed potassium results	**£55,699**

3.5. It is important to note that the pilot only included the second collection and the journey routes had not been reviewed and completely redesigned at this point.

3.6. With the new routing system in place and 2nd collections it is anticipated that a further 15% of spurious potassium results due to transport delays can be avoided as the new routing ensures that urgent samples are tested within the timeframes

required to avoid spurious results due to transport delays. UHL has also introduced temperature controlled bags to avoid changes in temperature.

3.7. It is anticipated that there is a level of 'invest to save' associated with the second collection. The savings represented in this paper have only looked at one element to justify funding to what is an essential investment in Primary Care infrastructure.

3.8. Another factor is the growth of pathology testing over the past 3 years is the number of pathology tests from Primary Care which has risen by nearly 16% this is due to the left shift work from secondary care as highlighted in the table below. Due to the direction with STP priorities this will continue to increase and the commissioning system needs to be able to flex to accommodate this.

Activity growth of Pathology testing in Primary Care	
Taken from SLAM data source	
2014/15 to 2015/16	6.34%
2015-16 to 2016/17	2.83%
2016/17 to 2017/18 (forecast)	6.59%
Activity Total Growth from 2014/15	**15.76%**

3.9. It has been noted by GPs that the additional blood collection has a significant chance of reducing all manner of acute admissions if used with plans to book patients into extended hours general practice for review and acute on the day access for patients. An example of this is patients presenting at the their practice in an afternoon with abdominal pain where GP concerned about appendicitis or pancreatitis could have amylase, full blood count (FBC), blood culture (BC) and C-Reactive Protein Test (CRP) checked and if normal would significantly reduce chance of admission. Equally any patients presenting after lunch with any possible sepsis where admission was being considered would have much less chance of ending up in ED/CDU if prompt FBC and CRP were tested.

3.10. Practices have to send patients to ED to get urgent bloods taken if they have already had their one blood collection; this is another area where savings and ED capacity can be gained.

3.11. Practices with one blood collection will generally hold their Shared Care and INR monitoring blood clinics in a morning. Patients often find this difficult to attend due to work commitments and often do not attend; this can be seen as inconvenient to patients and also a potential patient safety issue.

3.12. The STP outlines the need to strengthen our GP surgeries to grow and develop so they can manage the increasing demands placed on them. The STP further outlines the need for focusing on building capacity and resilience in practices and the current one collection of bloods entails a large majority of practices only being able to

take bloods in the morning. One of the ways that practices cope with one blood collection is by using practice nurse appointments to take bloods. This is a very inefficient use of their time which could be used for patients with chronic illness; this then leads to freeing up time for GPs for proactive care of complex and frail patients which can also avoid unnecessary admissions into secondary care.

Funding/Contracting

3.14. Funding for the 2018-19 investment would be based on a fair share split reflecting the number of practices in each CCG. The table below shows the contribution from each CCG. Beyond 2018/19 with review of the activity linked to the second collection the aim is this to form part of the main UHL acute contract. For 2018/19 this would appear as a cost pressure on each CCGs acute contract budget line. A reminder that this this is not expected to increase the demand for tests more a that in primary care the demand is planned and profiled better across the working day.

CCG	Total Number of Main and Branch	% of LLR Total Number	Funding Proportion
ELR CCG	*48	27%	£13,394
LC CCG	*71	39%	£19,347
WL CCG	*62	34%	£16,866
Total	*181	100%	£49,608

*NHSE GP List (updated Monthly)

RECOMMENDATIONS

- **RECEIVE** the report
- **APPROVE** the proposal to increase the number of pathology collections from once a day to twice a day and funding to be split on a fair share basis reflecting the number of practices per CCG.

D

NHS

Leicester City Clinical Commissioning Group
West Leicestershire Clinical Commissioning Group
East Leicestershire and Rutland Clinical Commissioning Group

COMMISSIONING COLLABORATIVE BOARD MEETING

Paper D

Title of the report:	Proposed Sustainability of Learning Disability Services beyond Transforming Care Programme
Report to:	Commissioning Collaborative Board (CCB)
Section:	Public
Date of the meeting:	21 June 2018
Report by:	Colin Groom, Deputy Chief Finance Officer, East Leicestershire and Rutland CCG, Clare Nagle, Transforming Care Programme Manager, East Leicestershire and Rutland CCG Cheryl Bosworth, Implementation Manager, Contract, East Leicestershire and Rutland CCG
Sponsoring Director:	Karen English, Managing Director, East Leicestershire and Rutland CCG
Presented by:	Donna Enoux, Chief Finance Officer, East Leicestershire and Rutland

CCG Involvement to date:

	City	**East**	**West**	**Insert name of any other groups ie ECN**
Clinician				
Manager				

Formally signed off by CCG (sub-group or equivalent) prior to CCB:

City	**East**	**West**

SUMMARY:

1. This paper seeks to summarise the potential investments required to ensure that LLR can sustain the service improvements and requirements of the LD TCP once the NHSE supported transformation phase has concluded. It highlights developments to date, the remaining activities and changes required for the final year of the programme and provides recommendations regarding ongoing investments for the partnership to consider.

2. The Transforming Care Partnership invests in community services to enable people with a Learning Disability to have the best possible quality of life, feeling safe and supported and able to participate in their local community. The TCP has looked to make a difference in the way the system works, through use of the Transformation Funding we are able to test and evidence the services work. It is recognised this is a small programme locally, supporting a small population with some specialist and high cost needs. The paper highlights use of the Transformation Funds (Table 1) and below the potential future investments totalling £504k likely to be required once this funding has been exhausted:

- Autism Hub £75k
- Crisis Provision £75k
- Forensic Support £100k
- Advance Practitioner £50k
- Enhanced Support C&YP £104k
- Positive behaviour Support £60k
- Corporate Costs £30k

RECOMMENDATIONS:

The Commissioning Collaborative Board is asked to:

- **RECOGNISE** the interventions and wider system changes the TCP is looking to achieve for people with Learning Disabilities and/or Autism.
- **APPROVE** the proposed non recurrent expenditure from NHSE transformation funds totalling £714k (Recognising Forensic support £200k and Advanced Crisis Practitioner £50k bids awaiting confirmation of funding from NHSE.)
- **CONSIDER,** the outline proposals contained within this paper and opportunities for recurrently contributing to these services from 1 April 2019 onwards to ensure ongoing investment in services for people with Learning Disabilities and/or Autism.
- **CONFIRM** the process by which these development proposals will be further considered and progressed assuming high level support is given.

LEICESTER, LEICESTERSHIRE AND RUTLAND TRANSFORMING CARE PARTNERSHIP. PROPOSED SUSTAINABILITY OF LEARNING DISABILITIY SERVICES BEYOND TRANSFORMING CARE PROGRAMME

INTRODUCTION

1.0 After the publication of 'Building the Right Support' NHS England, the Local Government Association (LGA) and the Association of Directors of Adult Social Services (ADASS) supported the creation of 48 Transforming Care Partnerships (TCPs). The TCPs comprise of representatives from CCG's, local authorities, local health providers (inpatient and acute) and patient and carer reference groups.

1.1 Each of those 48 TCPs developed plans to change services in a way that will make a real difference to the lives of children, young people and adults with a learning disability and/or autism who display behaviour that challenges, including those with a mental health condition. The focus of these plans are reflected in the key principles involving, patient choice in their care, more personalised care in the community, innovative services, more support closer to home, and only remain an in-patient for as necessary.

1.2 Through the LLR multi agency TCP Executive Board and Steering group we have supported and are supporting a number of transformation initiatives but recurrent solutions are required to ensure continued progress in achieving best possible quality of life for people with Learning Disabilities enabling them to feel safe and supported and able to participate in their local community.

CURRENT STATUS

2.0 Locally a 3 year TCP Programme Plan was developed to focus on priorities, including:

- Reduce amount of time(s) in hospital, in number through reduction of in-patients.
- Reduction in number of patients in long stay hospital beds.
- Reduce number of Delayed Transfer of Care patients (DTOC).
- Prevent avoidable admissions, through improved community services.
- Improve the transitions process between children and adult services.
- Increased availability of suitable accommodation.

2.1 The programme has a dedicated Programme Manager, Discharge Co-ordinator, a Support Officer and Learning Disability Implementation Manager who work with colleagues from across the partnership, forming a multi-agency approach. The

programme is governed via an Executive Board and support by a Steering Group with work streams reporting in to this structure.

ACHIEVEMENTS TO DATE

3.0 To date the programme has achieved:

- Closure of 4 beds within the Agnes Unit, from 16 down to 12.
- Extension to the LD Outreach Team (7 days a week, fully multi-disciplinary team).
- Development of online AAR.
- Improved partnership and collaborative working across 7 key organisations.
- Identified community services needed within the Community.
- Secured funding to transform the services identified as needed within the community.

3.1 In completing this work, we are improving the quality of life for people with Learning Disabilities and/or Autism and we are potentially avoiding future costs within the LLR system.

OUTSTANDING WORK

4.0 There remains some work to complete in the final year of the programme this includes:

- Commissioning of community services including, Crisis Care, Autism support for people who do not have LD, Enhanced C&YP support
- Development of a forensic support model for people stepping down from low secure settings
- Developing suitable accommodation and ensure there are appropriate providers in the market to meet the needs of people
- Addressing the number of admissions into hospital, whilst focussing on discharges approx. 25 patients down to 12, as per trajectory
- Consider whether the planned trajectory of 12 inpatients will solely be accommodated in the remaining 12 beds at the Agnes unit, eliminating any future need for out of area placements, or whether some further reduction in Agnes unit beds is possible/ required.

4.1 Ensuring all that is developed remains sustainable and continues to meet the needs of the local LLR population, and the aspirations of *Building the Right Support*.

TRANSITION TO BUSINESS AS USUAL

5.0 The programme formally ends on 31 March 2019, which potentially also ends the level of assurance. Existing structures, services and processes that have been developed will need to continue beyond March 2019 and need to be confirmed and in place i.e. AAR register (through LPT), LAEP CCTR and CTR processes (through CCGs) for people both in and out of hospital, and the multi-agency working

TRANSFORMATIONAL FUNDS

6.0 Transformation money is available and it is proposed to pump prime some of these things for the next 2 years but ultimately they will need to be continued long term i.e.

Service	Outcome/ Planned achievement	Budget (Transformation Funding)	Cost per year (on an recurring basis divided by the 6 statutory partners)			Transformation
			Total	Health	Social Care	
***Autism HUB (or similar)**	Non-clinical autism support and advice to TC population	£125k (19 months assumed)	£75k	£25k	£50k	Community resilience
***Crisis provision (preventing admission)**	Prevention for 25% of potential admissions to in-patient settings	£120k (22 months assumed)	£75k	£50k	£25k	Admission prevention
Forensic support for people with LD	Enhanced community forensic service to manage with complex TC cohort	£200k (18 months assumed, funding bid being reviewed by NHSE)	£100k	£100k	£0	Community resilience
***Advanced practitioner (crisis and admission avoidance)**	Prevention of 25% of admission	£50k (10 months assumed, funding bid being reviewed by NHSE)	£60k	£40k	£20k	Admission Prevention
***Enhanced support for Children and Young People**	Prevention of 50% of potential admissions for C&YP in-patient settings	£104k (12 months assumed)	£104k)	£70k	£34k	Admission Prevention
***Positive Behavioural Support**	Increased knowledge across Providers to manage TC cohort behaviours	£33k (7 months assumed)	£60k	£30k	£30k	Admission Prevention/ Discharge programme
Ongoing discharge co-ordination and corporate costs	Effective discharge management	£82k (12 months assumed)	£30k	£15k	£15k	
Total		**£714k (including assumed forensic bid)**	**£504k**	**£330k**	**£174k**	

Table 1 TCP Services Transformation Funding and Anticipated Costs

6.1 The existing financial model for the programme predicts overall cost reductions for specialised commissioners with a corresponding cost increase for local agencies. There are, therefore, no immediately identifiable funding sources for the above proposals. By contrast, it can be shown that not investing in these services beyond the natural timeline of the existing NHSE supported programme is likely to result in an inability to achieve the discharge trajectories, increased out of area placements and pressure on existing services and budgets.

6.2 The future cost per year funding ensures BAU doesn't revert back to reliance on in-patient care, spot purchasing of care and services, and delivers BRS principles by providing choice and services locally for people with Learning Disabilities and/or Autism.

6.3 It was requested to prioritise the schemes that directly support the discharge programme; however the proposed schemes focus on admission prevention and community resilience, as a result of the transformation programme, therefore should be deemed of equal priority due to the various components interdependencies.

6.4 Note all services to commence form September 2018 through to the assumed period, with the exception of Positive Behaviour Support which has been funded from June 2018 – March 2019, and Discharge Co-ordination/Corporate costs which end in March 2019.

*See separate Business Cases/ Job Descriptions for these services.

RECOMMENDATIONS

The Commissioning Collaborative Board is asked to:

- **RECOGNISE** the interventions and wider system changes the TCP is looking to achieve for people with Learning Disabilities and/or Autism.
- **APPROVE** the proposed non recurrent expenditure from NHSE transformation funds totalling £714k (Recognising Forensic support £200k and Advanced Crisis Practitioner £50k bids awaiting confirmation of funding from NHSE.)
- **CONSIDER,** the outline proposals contained within this paper and opportunities for recurrently contributing to these services from 1 April 2019 onwards to ensure ongoing investment in services for people with Learning Disabilities and/or Autism.
- **CONFIRM** the process by which these development proposals will be further considered and progressed assuming high level support is given.

E

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Leicester City Clinical Commissioning Group
West Leicestershire Clinical Commissioning Group
East Leicestershire and Rutland Clinical Commissioning Group

COMMISSIONING COLLABORATIVE BOARD MEETING

Paper E

Title of the report:	2018/19 QIPP Update
Report to:	Commissioning Collaborative Board (CCB)
Section:	Public
Date of the meeting:	21 June 2018
Report by:	Helen Stubbs, Head of Performance and QIPP, East Leicestershire and Rutland CCG Spencer Gay, CFO, West Leicestershire CCG
Sponsoring Director:	Spencer Gay, Chief Finance Officer, West Leicestershire CCG
Presented by:	Spencer Gay, Chief Finance Officer, West Leicestershire CCG

CCG Involvement to date:

	City	**East**	**West**	**Insert name of any other groups ie ECN**
Clinician				
Manager				

Formally signed off by CCG (sub-group or equivalent) prior to CCB:

City	**East**	**West**

SUMMARY:

The report provides a brief on the Leicester Leicestershire and Rutland (LLR) 2018/19 QIPP Programme

RECOMMENDATIONS:

The Commissioning Collaborative Board is requested to:

- **RECEIVE** the report **FOR INFORMATION,**
- **CONSIDER** how new ideas will be identified, scoped and worked into the CCG plans and
- **ADVISE** any further actions in support of the development of the 2018/19 QIPP Programme.

2018/19 QIPP Update

Executive Summary

Leicester Leicestershire and Rutland (LLR) 2018/19 QIPP Plan Update

1. The 3 LLR CCG QIPP PMO's are working collaboratively on the agreed 2018/19 QIPP plan following approval of the joint working arrangements by the CCG's Joint Management Teams and the Collaborative Commissioning Board in May 2018.

2. The Programme Management Office (PMO) teams have worked together as one team to produce a standard set of operating procedures and reports that support the collection and review of QIPP schemes in line with the timetable to support the monthly reporting of scheme delivery and the completion of the Non-ISFE return.

3. The Dashboard tool that has been developed will ensure all elements of scheme delivery are being reviewed and RAG rated in line with agreed tolerances and where schemes are not progressing that slippage is highlighted at the earliest opportunity.

4. In line with the timetable for submissions the workbooks have been reviewed for the financial reporting period month 2.

5. As agreed by the 3 CCG Chief Finance Officer's the Non-ISFE return to NHS England for month 2 will show a breakeven position due to the lack of actual data for the majority of schemes at this early stage in the year – this is in line with other financial returns for month 2 from LLR CCG's. For month 3 it is expected that this will change and we will start to report actual values and forecasts.

6. The QIPP PMO review, which shows a considered and risk adjusted position based on the information available through workbooks for milestones, deliverables, risks, issues and Key Performance Indicators (KPI's), and the lack of actual data shows that the current level of confidence in delivery of the forecast outturn to be in the region of one third that of plans and detailed below (further detail is shown in appendix 1 and 2 attached):

	ELR				LC				WL				Total 2018/2019 Annual Plan	Total FOT (Based on workbook submissions)	Total Variance
Program Area	2018/2019 Annual Plan	FOT (Based on workbook submissions)	Variance	1	2018/2019 Annual Plan	FOT (Based on workbook submissions)	Variance	1	2018/2019 Annual Plan	FOT (Based on workbook submissions)	Variance	1			
Acute	(3,329)	(1,253)	2,076		(6,252)	(1,003)	5,249		(3,707)	(1,343)	2,364		(13,288)	(3,599)	9,689
BCF	(1,100)	0	1,100						(1,000)	0	1,000		(2,100)	0	2,100
CHC	(2,440)	(2,323)	117		(2,888)	(2,175)	713		(2,995)	(3,157)	(162)		(8,323)	(7,654)	669
Community Services	(1,520)	0	1,520		(1,151)	0	1,151		(1,501)	0	1,501		(4,172)	0	4,172
Corporate	(768)	0	768		(388)	0	388		(1,390)	0	1,390		(2,546)	0	2,546
LD	(690)	0	690		(81)	0	81		(805)	0	805		(1,576)	0	1,576
Mental Health	(1,447)	(325)	1,122		(180)	(265)	(85)		(789)	(200)	589		(2,416)	(789)	1,627
Non-Acute	(2,191)	(65)	2,126		(419)	(75)	344		(1,597)	(75)	1,522		(4,207)	(215)	3,992
Prescribing	(3,944)	(973)	2,971		(5,797)	(2,806)	2,991		(3,899)	(68)	3,831		(13,640)	(3,848)	9,792
Primary Care	(2,061)	(3,854)	(1,793)		(617)	(300)	317		(2,560)	(70)	2,490		(5,238)	(4,224)	1,014
Urgent Care	(157)	0	157		(282)	0	282		(254)	0	254		(693)	0	693
Grand Total	**(19,647)**	**(8,793)**	**10,854**		**(18,055)**	**(6,624)**	**11,431**		**(20,497)**	**(4,913)**	**15,584**		**(58,199)**	**(20,329)**	**37,870**

7. This position is in line with that being reported by scheme leads – it is worth noting that the position may well improve considerably (as some of the reported under-delivery may be as a result of lack of financial information upon which to report robust forecasts this early in the financial year). Therefore it can be expected that under delivery will decrease in future months, however the current expectation is that there will still be a significant shortfall at that point.

8. The PMO teams have highlighted the gaps with SRO’s and scheme leads and will be agreeing actions that need to be undertaken to move the schemes back on track against plans. Where scheme gaps cannot be addressed, the PMO teams have requested mitigations be considered and have where possible provided a list of additional areas that SRO’s and scheme leads could review to support them to achieve their targets and plans.

9. Where scheme risks are significant the PMO will be escalating to the LLR QAG and the SRO’s will be invited to attend to discuss further and to agree a range of actions and mitigations. A report highlighting escalations will also be provided to CCB each month in future as well as being available for reporting into individual CCG committees and governing bodies as required.

10. Where a scheme is confirmed by the SRO as not viable and will not deliver the financial benefits in the plan for 2018/19 the PMO will work with the scheme lead to close the scheme down with agreement and sign off at LLR QAG. It is important to note that any scheme with the potential to deliver in 2019/20 or beyond will not be closed down it will remain on the list for continued review until a revised delivery plan is agreed.

11. The agreed LLR PMO approach is being applied to existing schemes in order to facilitate maximising their delivery of savings – this is currently the key focus of the PMO. Further ideas are being generated and will be pursued by the PMO teams alongside existing QIPP schemes once they are approved to be implemented. It is recommended that clear leadership is identified in order to

drive the work forward (across LLR) to develop these schemes working in conjunction with planning leads and project SRO's and implementation leads.

12. A detailed line by line review of the plan will be undertaken at the LLR QAG on Friday the 15th June. This will result in clear actions and formal feedback being given to Project/programme SRO's.

Recommendation:

The Commissioning Collaborative Board is requested to:

- **RECEIVE** the report **FOR INFORMATION,**
- **CONSIDER** how new ideas will be identified, scoped and worked into the CCG plans and
- **ADVISE** any further actions in support of the development of the 2018/19 QIPP Programme.

Scheme no. on ELR dashboard (All)

Grouping / Function	Exec Leads	CCG Schemes ELR 2018/2019 Annual Plan
CHC	Paul Gibara	(1,861)
City Only	Julia Corey	
	Michelle Illiffe	
	Tim Sacks/Sarah Prema/Caroline Trevithick	
Community Care	Nicki Harkness	-
	Tamsin Hooton	(1,023)
Contracting	Donna Enoux	(359)
	Sarah Shuttlewood	(955)
	Spencer Gay	
	Tamsin Hooton	(220)
Corporate	CFO's	(723)
	Richard Morris	(45)
	S Prema	-
EAST only	Tim Sacks	(340)
Finance	CFO's	(336)
	Donna Enoux	(1,400)
	S Gay	(17)
ILT	Nicki Harkness	(579)
LD Pool	MH Lead	(603)
Mental Health	MH Lead	(1,116)
	MH Lead	(500)
Multi Morbid/Frailty	Nicki Harkness	-
Planned Care	Ket Chudasama	(637)
	Sarah Shuttlewood	(891)
	Tim Sacks	-
Planned Care Extra	Ket Chudasama	(1,305)
Prescribing	Tim Sacks	(1,644)
	Tim Sacks/Sarah Prema	-
	Tim Sacks/Sarah Prema/Caroline Trevithick	(2,000)
Primary Care	Ian Potter	-
	Ian Potter/Tim Sacks/Richard Morris	-
	Julia Corey	-
	Julia Corey/Tim Sacks/Ian Potter	(2,000)
	Tim Sacks	(61)
Procurement	Michelle Illiffe	(65)
Urgent Care	Urgent Care Lead	(749)
Vol Sector	Donna Enoux	(218)
West and East separately	Julia Corey/Tim Sacks/Ian Potter	-
West only	CFO's	-
	Ian Potter	

West only	Ket Chudasama	
Grand Total		**(19,647)**

Values				
ELR			LC	
FOT (Based on workbook submissions)	Variance	1	2018/2019 Annual Plan	FOT (Based on workbook submissions)
(2,323)	(462)		(2,432)	(2,175)
			(351)	-
			(1,900)	-
			-	-
-	-		(75)	-
-	1,023		(449)	-
-	359		(491)	-
-	955		(1,342)	-
-	220		(312)	-
-	723		(167)	-
-	45		-	-
-	-		(90)	-
-	340			
-	336		-	-
-	1,400		(200)	-
-	17		(17)	-
(469)	110		(669)	(94)
-	603			
(325)	791		(261)	(265)
-	500		-	-
-	-		-	-
(784)	(147)		(1,521)	(908)
-	891			
-	-		-	-
-	1,305		(70)	-
(973)	671		(797)	(68)
-	-		(2,100)	-
-	2,000		(2,700)	(2,738)
-	-		(24)	-
-	-		-	-
-	-		-	-
-	2,000		(300)	(300)
-	61		(73)	-
(65)	-		(75)	(75)
-	749		(1,465)	-
-	218		(174)	-
(3,854)	(3,854)		-	-
-	-		-	-

(8,793)	10,854		(18,055)	(6,624)

LC		WL				Total 2018/2019 Annual Plan
Variance	1	2018/2019 Annual Plan	FOT (Based on workbook submissions)	Variance	1	
257		(2,476)	(3,157)	(681)		(6,769)
351						(351)
1,900						(1,900)
-						-
75		(75)	-	75		(150)
449		(837)	-	837		(2,309)
491		(437)	-	437		(1,287)
1,342		(981)	-	981		(3,278)
		(156)	-	156		(156)
312		(269)	-	269		(801)
167		(984)	-	984		(1,874)
-		(60)	-	60		(105)
90		(146)	-	146		(236)
						(340)
-		-	-	-		(336)
200		(1,300)	-	1,300		(2,900)
17		(17)	-	17		(51)
575		(724)	(300)	424		(1,972)
		(718)	-	718		(1,321)
(4)		(876)	(200)	676		(2,253)
-		-	-	-		(500)
-		-	-	-		-
613		(1,655)	(1,042)	613		(3,813)
						(891)
-		-	-	-		-
70		(686)	-	686		(2,061)
729		(1,599)	(68)	1,531		(4,040)
2,100		-	-	-		(2,100)
(38)		(2,000)	-	2,000		(6,700)
24		(24)	-	24		(48)
-		-	-	-		-
-		-	-	-		-
-		(500)	-	500		(2,800)
73		(136)	(70)	66		(270)
-		(75)	(75)	-		(215)
1,465		(1,086)	-	1,086		(3,300)
174		(580)	-	580		(972)
-		(1,300)	-	1,300		(1,300)
-		-	-	-		-
		(600)	-	600		(600)

		(200)	-	200		(200)
11,431		**(20,497)**	**(4,913)**	**15,584**		**(58,199)**

Total FOT (Based on workbook submissions)	Total Variance	To
(7,654)	(885)	
-	351	
-	1,900	
-	-	
-	150	
-	2,309	
-	1,287	
-	3,278	
-	156	
-	801	
-	1,874	
-	105	
-	236	
-	340	
-	336	
-	2,900	
-	51	
(863)	1,109	
-	1,321	
(789)	1,464	
-	500	
-	-	
(2,735)	1,078	
-	891	
-	-	
-	2,061	
(1,110)	2,930	
-	2,100	
(2,738)	3,962	
-	48	
-	-	
-	-	
(300)	2,500	
(70)	200	
(215)	-	
-	3,300	
-	972	
(3,854)	(2,554)	
-	-	
-	600	

-	200	
(20,329)	**37,870**	

Month 2
QIPP Summary Dashboard - LLR

CCG Schemes (All)

Scheme Number	Scheme Name	Lead /PMO CCG	Grouping / Function	Exec Leads	2018/2019 Annual Plan	FOT (Based on workbooks submissions)	Variances	Sum of Plan YTD	Sum of Actuals YTD	Sum of YTD Variance	Financial (LLR)	Deliverables	Milestones	Total Risks	Issues	KPIs
1	Ambulatory Care/Frailty/Multi Morbidity	WL	Multi Morbid/Frailty	Nicki Harkness	0	0	0	0	0	0	Red	Red	Red	Red	Red	Red
2	Demand Management HUB: MSK, Dermatology	LC	Planned Care Extra	Ket Chudasama	0	0	0	0	0	0	Red	Green	Amber	Red	Red	Green
4	Orthotics Procurement(Blatchfords)	LC	Procurement	Michelle Illiffe	(215)	(215)	0	0	0	0	Green	Green	Green	Red	Green	Green
5	Pathway 3 Control/Risk Share	WL	Urgent Care	Urgent Care Lead	(800)	0	800	(100)	0	100	Red	Amber	Amber	Amber	Amber	Amber
6	Coding and Counting	LC	Contracting	Sarah Shuttlewood	0	0	0	0	0	0	Red	Red	Red	Red	Red	Green
7	Primary Care - Federation QIPP, Quality SIP etc.	Individual CCG's	West and East separately	Julia Corey/Tim Sacks/Ian Potter	0	(3,854)	(3,854)	0	0	0	Red	Green	Green	Amber	Amber	Amber
8	Plan assumptions/Budget Reviews	Individual CCG's	West only	CFO's	0	0	0	0	0	0	Red	Red	Red	Red	Red	Red
9	Public Health Funding Flu Vaccines	ELR	Finance	Donna Enoux	(800)	0	800	(133)	0	133	Red	Amber	Amber	Amber	Amber	Amber
11	Review/Reduce expenditure on agency staff	Individual CCG's	Corporate	CFO's	(1,034)	0	1,034	(80)	0	80	Red	Amber	Amber	Amber	Amber	Amber
12	Removal of double payment to LPT for UHL discharge co-ordinators (Primary Care Co-ordinators)	ELR	Contracting	Donna Enoux	(393)	0	393	0	0	0	Red	Amber	Amber	Amber	Amber	Amber
13	Block Contracts at UHL	LC	Contracting	Sarah Shuttlewood	(348)	0	348	(58)	0	58	Red	Green	Green	Green	Green	Green
14	UHL Contract Price negotiation - Follow Up Ratios	LC	Planned Care	Sarah Shuttlewood	(891)	0	891	0	0	0	Red	Amber	Amber	Amber	Red	Amber
15	UHL Contract Price negotiation - CAU	LC	Contracting	Sarah Shuttlewood	(300)	0	300	(50)	0	50	Red	Green	Green	Green	Green	Green
16	UHL Contract Price Negotiation - CDU	LC	Contracting	Sarah Shuttlewood	(1,000)	0	1,000	(167)	0	167	Red	Red	Red	Red	Amber	Amber
17	UHL Contract Price Negotiation - RDA's	LC	Contracting	Sarah Shuttlewood	(500)	0	500	(83)	0	83	Red	Amber	Amber	Red	Red	Amber
18	PRIMARY CARE - Federation QIPP scheme impact on acute demand	Individual CCG's	West and East separately	Julia Corey/Tim Sacks/Ian Potter	(1,300)	0	1,300	(217)	0	217	Red	Green	Green	Amber	Amber	Amber
20	All historic AQP contracts to be reviewed	LC	Planned Care Extra	Ket Chudasama	(2,061)	0	2,061	(126)	0	126	Red	Red	Red	Red	Red	Red
21	PRIMARY CARE - CBS investments reviewed	Individual CCG's	Primary Care	Julia Corey/Tim Sacks/Ian Potter	(2,800)	(300)	2,500	(417)	0	417	Red	Green	Green	Amber	Amber	Amber
22	Independent Sector Contract Control	LC	Contracting	Sarah Shuttlewood	0	0	0	0	0	0	Red	Red	Red	Red	Red	Red
23	Independent Sector - manage IPT transfers from UHL	LC	Contracting	Sarah Shuttlewood	0	0	0	0	0	0	Red	Red	Red	Red	Red	Red
24	NCA's tighter controls	LC	Contracting	Sarah Shuttlewood	0	0	0	0	0	0	Red	Red	Red	Red	Red	Red
25	Review all LA Charges that come to the CCG outside of BCF	Individual CCG's	Finance	CFO's	(336)	0	336	0	0	0	Red	Amber	Amber	Amber	Amber	Amber
26	MPC controls	WL	Finance	S Gay	(51)	0	51	(9)	0	9	Red	Red	Red	Red	Red	Red
27	Night Nursing contract negotiation - DHU	WL	Urgent Care	Urgent Care Lead	(416)	0	416	0	0	0	Red	Red	Red	Red	Red	Red
29	DHU - all services/contracting redesign	WL	Urgent Care	Urgent Care Lead	0	0	0	0	0	0	Red	Red	Red	Red	Red	Red
31	LD Pool -improved case management	ELR	LD Pool	MH Lead	(1,321)	0	1,321	0	0	0	Red	Amber	Amber	Amber	Amber	Amber
32	Reduce corporate clinical input	WL	West only	Ket Chudasama	(200)	0	200	(33)	0	33	Red	Red	Red	Red	Red	Red
34	Review and redesign in ICS/IP Beds/District Nursing	ELR	Community Care	Tamsin Hooton	(1,000)	0	1,000	0	0	0	Red	Amber	Amber	Amber	Amber	Amber
35	EMAS - Negotiation of 18/19 contract	WL	Contracting	Tamsin Hooton	(801)	0	801	(97)	0	97	Red	Red	Red	Red	Red	Red
36	LD Short breaks consolidation	ELR	Mental Health	MH Lead	(255)	0	255	0	0	0	Red	Red	Red	Red	Red	Red
37	LPT CQUIN expectation	ELR	Contracting	Donna Enoux	(576)	0	576	(109)	0	109	Red	Amber	Amber	Amber	Amber	Amber
38	Stroke Rehab Bed Numbers Reduction Following redesign and investment	ELR	Contracting	Donna Enoux	(318)	0	318	0	0	0	Red	Amber	Amber	Amber	Amber	Amber

Scheme Number	Scheme Name	Lead /PMO CCG	Grouping / Function	Exec Leads	2018/2019 Annual Plan	FOT (Based on workbooks submissions)	Variances	Sum of Plan YTD	Sum of Actuals YTD	Sum of YTD Variance	Financial (LLR)	Deliverables	Milestones	Total Risks	Issues	KPIs
39	Agnes unit - options for use	ELR	Mental Health	MH Lead	0	0	0	0	0	0	Red	Green	Green	Green	Green	Green
40	Potential realignment of Community Hospital Beds across sites	ELR	Community Care	Tamsin Hooton	(209)	0	209	0	0	0	Red	Amber	Amber	Amber	Amber	Amber
41	AHP/117 repatriation	ELR	Mental Health	MH Lead	0	0	0	0	0	0	Red	Green	Green	Green	Green	Green
43	Vol Sector - Review VFM and service need	ELR	Vol Sector	Donna Enoux	(972)	0	972	0	0	0	Red	Red	Red	Red	Red	Red
44	Derbyshire Healthcare non acute SLA negotiation	WL	Contracting	Spencer Gay	(156)	0	156	(26)	0	26	Red	Red	Red	Red	Red	Red
47	Joint Funding University of Leicester	WL	Primary Care	Ian Potter	(48)	0	48	(8)	0	8	Red	Red	Red	Red	Red	Red
49	Office Accommodation savings	LC	Corporate	Richard Morris	0	0	0	0	0	0	Red	Red	Red	Red	Red	Red
50	In House Legal expertise	LC	Corporate	Richard Morris	(105)	0	105	(10)	0	10	Red	Red	Red	Red	Red	Red
51	Primary Care Global Sum	Individual CCG's	Primary Care	Julia Corey	0	0	0	0	0	0	Red	Green	Green	Amber	Amber	Amber
52	Primary Care Dispensing	Individual CCG's	Primary Care	Julia Corey/Tim Sacks/Ian Potter	0	0	0	0	0	0	Red	Green	Green	Amber	Amber	Amber
54	Estate Consolidation in Primary Care	Individual CCG's	Primary Care	Ian Potter/Tim Sacks/Richard Morris	0	0	0	0	0	0	Red	Green	Green	Amber	Amber	Amber
55	GPIT	Individual CCG's	Primary Care	Tim Sacks	(200)	0	200	(33)	0	33	Red	Green	Green	Amber	Amber	Amber
56	GP Staff Training cessation (East hosted)	Individual CCG's	Primary Care	Tim Sacks	(70)	(70)	0	(12)	0	12	Green	Green	Green	Amber	Amber	Amber
57	Readmissions reduction	WL	Multi Morbid/Frailty	Nicki Harkness	0	0	0	0	0	0	Red	Amber	Amber	Amber	Amber	Amber
58	BCT Partnership office maintain spend in line with 17/18 outturn	LC	Corporate	S Prema	(236)	0	236	(39)	0	39	Red	Green	Green	Green	Green	Green
59	Anticoag at UHL - moved into community	LC	Contracting	Sarah Shuttlewood	(630)	0	630	(105)	0	105	Red	Green	Green	Green	Green	Green
61	Consider Staff Car Parking Charges	LC	Corporate	Richard Morris	0	0	0	0	0	0	Red	Red	Red	Red	Red	Red
62	Prescribing Stretch to £1m	ELR	Prescribing	Tim Sacks	(2,000)	(900)	1,100	(167)	(300)	(133)	Red	Green	Green	Green	Red	Red
63	Prior approvals (IFR's) tighter controls	LC	Contracting	Sarah Shuttlewood	(500)	0	500	(59)	0	59	Red	Red	Red	Red	Red	Red
64	Primary care transformation fund	Individual CCG's	City Only	Julia Corey	0	0	0	0	0	0	Red	Red	Red	Red	Red	Red
65	PLT to be funded from FDR/ PMS	Individual CCG's	City Only	Julia Corey	(70)	0	70	(12)	0	12	Red	Green	Green	Green	Green	Green
66	HNN practice engagement/training funding review	Individual CCG's	City Only	Julia Corey	(150)	0	150	(25)	0	25	Red	Green	Green	Red	Green	Green
67	Prescribing Incentive Scheme	ELR	City Only	Tim Sacks/Sarah Prema/Caroline Trevithick	0	0	0	0	0	0	Red	Green	Green	Green	Red	Red
68	Nursing Homes	ELR	Prescribing	Tim Sacks	0	0	0	0	0	0	Red	Green	Green	Green	Red	Red
69	Practice backfill	Individual CCG's	City Only	Julia Corey	(131)	0	131	(22)	0	22	Red	Red	Red	Red	Red	Red
70	Acute activity funded within BCF	LC	City Only	Michelle Illiffe	(1,900)	0	1,900	(316)	0	316	Red	Green	Green	Green	Green	Green
71	GPAU, Urgent Care flow and pathways - admissions impact	WL	Urgent Care	Urgent Care Lead	0	0	0	0	0	0	Red	Amber	Amber	Amber	Amber	Amber
72	MHSOP Review	ELR	Mental Health	MH Lead	0	0	0	0	0	0	Red	Red	Red	Red	Red	Red
73	Independent Sector Contract - Circle, Loughborough	LC	Contracting	Sarah Shuttlewood	0	0	0	0	0	0	Red	Red	Red	Red	Red	Red
74	Biologics Support Service (UHL)	ELR	Prescribing	Tim Sacks	(198)	0	198	0	0	0	Red	Green	Green	Green	Red	Red
81	Review of IAPT	ELR	Mental Health	MH Lead	(500)	0	500	(83)	0	83	Red	Red	Red	Red	Red	Red
82	Stop Risk Stratification related investments	Individual CCG's	Primary Care	Tim Sacks	0	0	0	0	0	0	Red	Green	Green	Amber	Amber	Amber
A1	Cardiology	WL	ILT	Nicki Harkness	(231)	(246)	(15)	(38)	42	80	Red	Red	Red	Red	Red	Amber
A10	Audiology	LC	Planned Care	Ket Chudasama	(96)	0	96	0	0	0	Red	Amber	Amber	Red	Amber	Green
A11	MSK Physiotherapy	LC	Planned Care	Ket Chudasama	(690)	1	691	(66)	0	66	Red	Amber	Amber	Red	Amber	Green
A12	Physio	LC	Planned Care	Ket Chudasama	(64)	0	64	(8)	0	8	Red	Amber	Amber	Red	Amber	Green

Scheme Number	Scheme Name	Lead /PMO CCG	Grouping / Function	Exec Leads	2018/2019 Annual Plan	FOT (Based on workbooks submissions)	Variances	Sum of Plan YTD	Sum of Actuals YTD	Sum of YTD Variance	Financial (LLR)	Deliverables	Milestones	Total Risks	Issues	KPIs
A13	Diagnostics - Imaging	LC	Planned Care	Ket Chudasama	(472)	1	473	(79)	0	79	Red	Amber	Amber	Red	Amber	Green
A14	Diagnostics - Non Imaging	LC	Planned Care	Ket Chudasama	(8)	0	8	(1)	0	1	Red	Amber	Amber	Red	Amber	Green
A15	ED Front Door Model 1	WL	Urgent Care	Urgent Care Lead	(167)	0	167	(28)	0	28	Red	Amber	Amber	Amber	Amber	Amber
A16	ED Front Door Model 2	WL	Urgent Care	Urgent Care Lead	(76)	0	76	(13)	0	13	Red	Amber	Amber	Amber	Amber	Amber
A17	Increase & Improve Ambulatory Pathways 1	WL	Urgent Care	Urgent Care Lead	(202)	0	202	(34)	0	34	Red	Amber	Amber	Amber	Amber	Amber
A18	Increase & Improve Ambulatory Pathways 2	WL	Urgent Care	Urgent Care Lead	(372)	0	372	(62)	0	62	Red	Amber	Amber	Amber	Amber	Amber
A19	Increase & Improve Ambulatory Pathways 3	WL	Urgent Care	Urgent Care Lead	(72)	0	72	(12)	0	12	Red	Amber	Amber	Amber	Amber	Amber
A2	Respiratory	WL	ILT	Nicki Harkness	(111)	0	111	(18)	0	18	Red	Red	Red	Red	Red	Amber
A20	Improved Clinical Triage	WL	Urgent Care	Urgent Care Lead	(25)	0	25	(4)	0	4	Red	Amber	Amber	Amber	Amber	Amber
A21	Expansion of Clinical Navigation Hub	WL	Urgent Care	Urgent Care Lead	(169)	0	169	(28)	0	28	Red	Amber	Amber	Amber	Amber	Amber
A22	Tighten Eligibility for NEPTS	WL	Urgent Care	Urgent Care Lead	(344)	0	344	(57)	0	57	Red	Amber	Amber	Amber	Amber	Amber
A23	Urgent Diagnostic Pathways	WL	Urgent Care	Urgent Care Lead	(24)	0	24	(4)	0	4	Red	Amber	Amber	Amber	Amber	Amber
A24	Increase Support for EMAS to reduce conveyances	WL	Urgent Care	Urgent Care Lead	(198)	0	198	(33)	0	33	Red	Amber	Amber	Amber	Amber	Amber
A25	Discharge Pathways	WL	Urgent Care	Urgent Care Lead	(209)	0	209	(36)	0	36	Red	Amber	Amber	Amber	Amber	Amber
A26	Frailty	WL	Urgent Care	Urgent Care Lead	(177)	0	177	(31)	0	31	Red	Amber	Amber	Amber	Amber	Amber
A27	Passporting	WL	Urgent Care	Urgent Care Lead	(49)	0	49	(8)	0	8	Red	Amber	Amber	Amber	Amber	Amber
A28	Medicines Optimisation (CCG)	ELR	Prescribing	Tim Sacks/Sarah Prema/Caroline Trevithick	(6,700)	(2,738)	3,962	(1,114)	(418)	696	Red	Green	Green	Green	Red	Red
A29	Cat M	ELR	Prescribing	Tim Sacks/Sarah Prema	(500)	0	500	(84)	0	84	Red	Green	Green	Green	Red	Red
A3	Falls	WL	ILT	Nicki Harkness	(76)	(618)	(542)	(13)	0	13	Green	Amber	Red	Red	Red	Amber
A30	NSCO	LC	Prescribing	Tim Sacks/Sarah Prema	(1,600)	0	1,600	(266)	0	266	Red	Green	Green	Green	Green	Green
A31	Biosimilar Switches	ELR	Prescribing	Tim Sacks	(1,212)	(210)	1,002	(202)	(210)	(8)	Red	Green	Green	Green	Red	Red
A32	Patent Expiry Humira®	ELR	Prescribing	Tim Sacks	(570)	0	570	(94)	0	94	Red	Green	Green	Green	Red	Red
A33	Move to VAT Free Route (TMP)- Tolvaptan	ELR	Prescribing	Tim Sacks	(60)	0	60	(12)	(1)	11	Red	Green	Green	Green	Red	Red
A34	Adult Mental Health	ELR	Mental Health	MH Lead	(1,139)	0	1,139	(92)	0	92	Red	Red	Red	Red	Red	Red
A35	Section 117 and AHP	ELR	Mental Health	MH Lead	(540)	(789)	(249)	(90)	(789)	(699)	Green	Green	Green	Green	Green	Green
A36	MH OOA Placements - additional provision in LPT	ELR	Mental Health	MH Lead	(237)	0	237	(21)	0	21	Red	Red	Red	Red	Red	Red
A37	Learning Disabilities Short Breaks	ELR	Mental Health	MH Lead	(82)	0	82	0	0	0	Red	Red	Red	Red	Red	Red
A38	Community Health Services Various schemes	ELR	Community Care	Tamsin Hooton	(975)	0	975	(64)	0	64	Red	Amber	Amber	Amber	Amber	Amber
A39	Community Equipment Scheme (returned equipment)	ELR	Community Care	Nicki Harkness	(150)	0	150	(24)	0	24	Red	Amber	Amber	Amber	Amber	Amber
A4	EoL - CHC Deflected Patients	WL	ILT	Nicki Harkness	(1,455)	0	1,455	(243)	0	243	Red	Amber	Red	Red	Red	Red
A41	CHC	ELR	CHC	Paul Gibara	(4,819)	(6,005)	(1,186)	(803)	(2,848)	(2,046)	Green	Green	Green	Amber	Green	Green
A42	CHC Stretch	ELR	CHC	Paul Gibara	(1,950)	(1,650)	300	(325)	0	325	Amber	Red	Red	Red	Red	Red
A43	BCF Slippage/contingency/savings plan	ELR	Finance	Donna Enoux	(2,100)	0	2,100	(350)	0	350	Red	Amber	Amber	Amber	Amber	Amber
A44	Integrated urgent care - Primary care	Individual CCG's	West only	Ian Potter	(600)	0	600	0	0	0	Red	Amber	Red	Green	Red	Red
A46	2. Repeat Ordering - FYE 3. Pregabalin - FYE 4. Technician Care Home Project - Reducing Waste	ELR	Prescribing	Tim Sacks	0	0	0	0	0	0	Red	Green	Green	Green	Red	Red
A47	Ambulatory Care -look at closer to home services	Individual CCG's	EAST only	Tim Sacks	(300)	0	300	0	0	0	Red	Green	Green	Amber	Amber	Amber

Scheme Number	Scheme Name	Lead /PMO CCG	Grouping / Function	Exec Leads	2018/2019 Annual Plan	FOT (Based on workbooks submissions)	Variances	Sum of Plan YTD	Sum of Actuals YTD	Sum of YTD Variance	Financial (LLR)	Deliverables	Milestones	Total Risks	Issues	KPIs
A48	Recharge for UCC outside LLR	Individual CCG's	EAST only	Tim Sacks	(40)	0	40	(7)	0	7	Red	Amber	Amber	Amber	Amber	Amber
A49	Primary Care Stretch Target - as part of contractual review	Individual CCG's	EAST only	Tim Sacks	0	0	0	0	0	0	Red	Green	Green	Amber	Amber	Amber
A5	E0L Reduction in Emergency Admissions	WL	ILT	Nicki Harkness	(99)	0	99	(17)	0	17	Red	Amber	Red	Red	Red	Red
A51	ICS notice (ELR - Consider alongside 34, A51, 40.)	ELR	Community Care	Tamsin Hooton	(125)	0	125	0	0	0	Red	Amber	Amber	Amber	Amber	Amber
A6	Demand Savings: New Appointments	LC	Planned Care	Ket Chudasama	(672)	(660)	12	(112)	(110)	2	Green	Green	Green	Red	Green	Green
A7	Demand Savings: Follow Up Appointments	LC	Planned Care	Ket Chudasama	(369)	(328)	41	(37)	0	37	Amber	Red	Red	Red	Red	Green
A8	Demand Savings: Low Value Treatments	LC	Planned Care	Ket Chudasama	(137)	(170)	(33)	(5)	0	5	Green	Amber	Amber	Red	Amber	Green
A9	Pathway Redesign	LC	Planned Care	Ket Chudasama	(1,305)	(1,579)	(274)	32	124	92	Green	Green	Green	Red	Green	Green
A40	CCG Efficiencies (incl Execs)	Individual CCG's	Corporate	CFO's	(840)	0	840	(112)	0	112	Red	Amber	Amber	Amber	Amber	Amber
A50	Paediatric Pathways	Individual CCG's	Planned Care	Tim Sacks	0	0	0	0	0	0	Red	Green	Green	Amber	Amber	Amber
Grand Total					(58,199)	(20,329)	37,870	(7,208)	(4,509)	2,699						

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COMMISSIONING COLLABORATIVE BOARD MEETING

Paper G

Title of the report:	Community Services Redesign
Report to:	Commissioning Collaborative Board (CCB)
Section:	Public
Date of the meeting:	21 June 2018
Report by:	Vicky Wright, Senior Programme Manager (NMC)/ Programme Manager for the Community Services Redesign, West Leicestershire CCG
Sponsoring Director:	Karen English, Managing Director, East Leicestershire and Rutland CCG
Presented by:	Tamsin Hooton, Director Lead for Community Services Redesign

CCG Involvement to date:

	City	East	West	Insert name of any other groups i.e. ECN
Clinician	Avi Prasad, Sulaxmi Nainini	Andy Ker	Chris Trzcinski	
Manager		Karen English	Toby Sanders	

Formally signed off by CCG (sub-group or equivalent) prior to CCB:

City	East	West

<u>SUMMARY:</u>

1. The attached paper sets out the early progress of the Community Services Redesign Project, which is has been initiated by the CCGs in order to re-specify and redesign a range of core community services, aiming to deliver better integrated services that reflect the evidence base for best practice community services, provide better value for money and support the wider STP plan for out of hospital care.

2. Early progress includes:

- A detailed project plan that brings together key interdependent work across the system.
- Initial communication and engagement activities and an evolving plan to gather the views of patients, public and stakeholders.
- Commencement of an evidence based review and capacity and demand analysis by Deloitte.
- A series of workshops planned to bring together evolving Home First and ILT models and test and refine the future model with clinicians across the system.

RECOMMENDATIONS:

NOTE: The early progress of the Community Services Redesign

COMMUNITY SERVICES REDESIGN

1. INTRODUCTION

1.1. CCB received a paper in May that gave an overview of the scope and terms of reference to take forward redesign of a range of adult community services provided by Leicestershire Partnerships. The LLR CCGs confirmed their intention for this work and notice of the review and redesign has been given as part of the 2018/2019 contract. The scope and objectives of the Community Services Redesign project have been developed, with engagement with LPT and other system partners, and agreed by CCB in May 2018.

1.2. Early work has commenced on the community services redesign (CSR) and this paper gives an overview of the planned approach, initial activity and expected outputs.

2. APPROACH

2.1. This project sets out to produce a high level model for integrated community services by the end of September 2018. This will be underpinned by a robust evidence base, capacity and demand assumptions and clinical and managerial engagement of the full range of relevant stakeholders across LLR.

2.2. A commissioner led project team has been brought together including Director, SRO, programme management resource, Integrated Locality Teams (ILT) representation, Home First representation, clinical quality lead, communications, finance and patient representation. This project team will lead and drive pace in the delivery of the work, also reporting into the Home First work streams.

2.3. Whilst this project remains a commissioner led piece of work, close working with LPT as the current provider is essential to ensure our ability to mobilise the new service model once agreed. LPT are closely engaged in the project through a named lead Director (Rachel Bilsborough, Divisional Director for Community Health Service), frequent operational level links, and formal updates via monthly contract meetings.

2.4. A detailed project plan has been developed working towards a high level model by the end of September, and beyond into implementation. This project plan brings together all the key interdependent pieces of work that are already in place across the system that will both inform the CSR and need to consider the work of the CSR in their own ongoing development. The project plan will be shared with the Home First group.

3. COMMUNICATION AND ENGAGEMENT

3.1. A Communications and Engagement plan is being developed. This will bring together the activities of the Community Services Redesign with ILTs and Home First, ensuring consistent messages and alignment of approach. This will also acknowledge the findings of engagement to date across the STP and in the related work streams.

3.2. In collaboration with LPT the communication plan will address commissioner led and provider lead communication activities to ensure patients, staff and system wide stakeholders are able to inform, influence and be kept up to date with the redesign.

3.3. An intensive period of engagement will ensure genuine engagement activities that still meet the timeline of the project. Plans include interviews to collect people's qualitative experiences of services, as well as testing the proposed models; and a series of stakeholder workshops.

3.4. In addition to CSR being a standing agenda item at CCB and Home First, engagement will include presentations being delivered across LLR to LPT Executive, GP Federation and GP locality events, PPG events, UHL and local authorities, to provide an awareness of the outcomes of the work and opportunities to shape and change the future community services model. The CSR is also delivering key Frailty actions and will link into this work via the Frailty Task Force and Frailty Working Group.

4. EVIDENCE REVIEW AND CAPACITY MODELLING

4.1. Deloitte have now commenced work to undertake an evidence based review identifying best practice in community services that can be considered in our local system.

4.2. Deloitte have been commissioned to undertake further work to understand activity and flow across the LLR system; benchmark this against models and spending elsewhere and identify opportunities to move activity in line with a home first approach. The project team are currently working through data provision requests and information governance requirements to enable this work to commence. This work will be used to inform and provide rationale for the redesign.

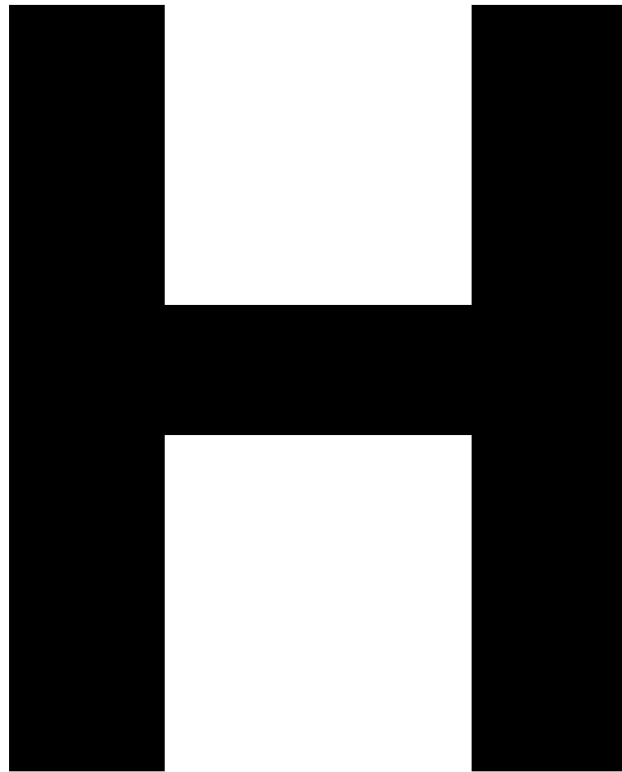
5. MODEL DEVELOPMENT

5.1. The CSR is not starting from a zero position, but will need to reflect the emerging models of Home First services and Integrated Locality Teams. A workshop on 26th June will begin co-production of the Community Services

model, drawing on the outputs from Home First groups and ILTs as well as interpreting the learning from the evidence based review.

5.2. This evolving model will be tested, refined and developed at a further workshop on 3rd July, bringing together clinical representation from across the system. This session will focus on key design features for community services, and the clinical model for both home based and bed based services.

5.3. Following this, further clinical understanding will be sought from a workshop with a wider range of LPT staff in mid-July, as well as visits to community hospitals and other relevant services.



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Leicester City Clinical Commissioning Group
West Leicestershire Clinical Commissioning Group
East Leicestershire and Rutland Clinical Commissioning Group

COMMISSIONING COLLABORATIVE BOARD MEETING

Paper H

Title of the report:	Progress update on Leicester Leicestershire and Rutland (LLR) Frailty work in Primary Care and Terms of Reference
Report to:	Commissioning Collaborative Board (CCB)
Section:	Public
Date of the meeting:	21 June 2018
Report by:	Sarah Prema, Director of Strategy and Implementation, Leicester City CCG Tamsin Hooton, Director of Emergency and Urgent Care, West Leicestershire CCG
Sponsoring Director:	
Presented by:	Sarah Prema, Director of Strategy and Implementation, Leicester City CCG Tamsin Hooton, Director of Emergency and Urgent Care, West Leicestershire CCG

RECOMMENDATIONS:

The Commissioning Collaborative Board is requested to:

- **RECEIVE** the Terms of Reference (ToRs) for the LLR frailty work
- **NOTE** the arrangements put in place to progress LLR Frailty work via the ToRs.

Frailty governance structure
Terms of Reference

Purpose

The governance of the Frailty programme will be split into 2 groups with specific purposes:

The Frailty working group will define and plan to deliver a longer term LLR frailty pathway across the health and care system.

The Frailty working group has the responsibility to drive delivery of the 16 interventions agreed by the LLR Senior Leadership Team as a priority for 18/19.

Process objectives – Task force

1. Identify the 'ask' of the various BCT workstreams so that there is clear direction on the tasks that they need to deliver (and by when). This will involve a more explicit and directive approach with relevant workstreams, particularly the locality teams, home first, AEDB, primary care and the community services redesign work
2. Define and agree a delivery plan covering the more medium to long term service improvements that will not be deliverable/impacting in time for this coming 18/19 Winter but which are necessary to support more sustainable quality improvement
3. Impact assess any related service changes being proposed to ensure any change does not impact negatively on the system wide work programme

Process objectives – Working Group

4. Agree and deliver the support offer/interventions that need to be rapidly in place across the frailty pathway and various settings of care in order to support independence, continuity of care, minimise the need for acute hospital admission and minimise inpatient length of stay (acute and community).
5. Evaluate impact of changes made (qualitative and quantitative) for our patients and wider system partners

Membership of the task force

Designation	Name & title	Organisation	Cross mapped responsibility
Chair	John Adler	UHL	---
Programme Lead	Rachna Vyas	UHL	Programme Plan
Admin support	Liz McCann	BCT PMO	---
Member	Tamsin Hooton	WLCCG	CSR
Member	Mike Ryan	WLCCG	AEDB
Member	Tim Sacks	ELR CCG	Primary Care
Member	Cheryl Davenport	Leics County Council	ILT
Member	Jon Wilson	Leics County Council	Home First
Member	Ruth Lake	Leics City Council	ILT, Home First
Member	Mark Andrews	Rutland County Council	ILT, Home First
Member	Fay Bayliss	LC CCG	QI approach

Member	**Caroline Trevithick**	**WLCCG**	**Clinical Leadership Group, CSR**
Member	**Ursula Montgomery**	**UHL**	**ILT, UHL clinical lead, GP**

Membership of the working group

Designation	Name & title	Organisation	Cross mapped responsibility
Chair	John Adler	UHL	---
Programme Lead	Rachna Vyas	UHL	Programme Plan
Admin support	Liz McCann	BCT PMO	---
Member	Andy Caruthers	UHL	IMT
Member	Yasmin Sidyot	WLCCG	AEDB Flow/outflow lead
Member	Julie Dixon	UHL	AEDB Flow/outflow lead
Member	Sarah Smith	LC CCG	AEDB inflow lead
Member	Ursula Montgomery	UHL/GP	ILT, Home First, AEDB, CSR
Member	Emily Laithwaite	UHL	Frailty clinical lead, UHL
Member	Victoria Wright	WL CCG	CSR delivery lead
Member	Mark Pierce	LCCCG	ILT, OOH delivery - LC
Member	Paula Vaughn	ELR CCG	ILT, OOH delivery - ELR
Member	Steve McCue	WL CCG	ILT, OOH delivery - WL

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Members of the frailty Task force are welcome to attend the working group where relevant items are on the agenda.

Expectations of task force & working group members

1. The Chair will be required to escalate issues and risks to SLT and Chief Officers within 2 working days of being raised
2. The Programme lead will be expected to report progress on the programme every 2 weeks and highlight unmitigated risks to the Chair and the wider task force
3. Members will be required to provide resource and specific commitment to support the programme lead to deliver the objectives as set out below
4. Members will be required to report back to their host organisations on programme progress and report any issues to the task force
5. Members will be required to support the programme lead to work in partnership with local Quality Improvement experts to ensure a rigorous and comprehensive approach to measurement

Frequency & format of meetings

The task force will meet on the 2nd Tues of the month for 90 mins at the LRI.

The working group will meet on the 4th Tues of the month for 90 mins at the LRI.

Admin support will be supplied by the BCT PMO, with papers circulated a minimum of 2 working days before the meeting.

The format will be that of an action focussed ‘scrum’ meeting where participants are expected to report the latest position of their project/intervention and highlight any issues for immediate escalation.

Reporting arrangements

Progress will be reported on a routine monthly basis to SLT, escalating areas that are not progressing as required in order to enable issues/blocks or trade-offs to be worked through by Chief Officers.

Attendance

If attendance is not possible in person there is the option for conference call and in the event of sickness, annual leave etc. it is expected that a briefed deputy will attend.

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