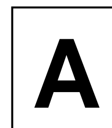
WEST LEICESTERSHIRE CLINICAL COMMISSIONING GROUP



West Leicestershire Clinical Commissioning Group
Minutes of the Board Meeting
Tuesday 11 August 2015 at 13.30 pm
WLCCG Headquarters, Woodgate, Loughborough, Leicestershire LE11 2TZ

Present:

Prof Mayur Lakhani	Chairman (Chair)
Mr Steve Churton	Lay Member and Vice Chairman
Dr Chris Trzcinski	Deputy Chair
Mr Evan Rees	Lay Member
Mr Ray Harding	Lay Member
Dr Mike McHugh	Consultant in Public Health
Dr Darren Jackson	Locality Lead, Hinckley and Bosworth
Dr Nick Pulman	Locality Lead, North West Leicestershire
Dr Chris Barlow	Locality Lead, South Charnwood
Dr Peter Cannon	Locality Lead, North Charnwood
Dr Liz Hepplewhite	Locality Lead, North West Leicestershire
Dr Y B Shah	Locality Lead, South Charnwood
Mr Spencer Gay	Chief Finance Officer
Mrs Angela Bright	Chief Operating Officer
Mr Ket Chudasama	Assistant Director Corporate Affairs
Mrs Caroline Trevithick	Chief Nurse and Quality Lead
Mrs Caron Williams	Assistant Director Strategy and Planning

In Attendance:

Mrs Cheryl Davenport	Director of Health and Care Integration (for item WL/15/197)
Mrs Michele Morton	Senior Committee Clerk (minutes)

Action

WL/15/182 Welcome and Apologies for Absence

Professor Lakhani welcomed all to the meeting. Apologies for absence were received from Mr Toby Sanders, Dr Kathy Teahon, Dr G Hanlon, Dr Nick Willmott and Mrs Fiona Barber.

Professor Lakhani confirmed the Board meeting was quorate with thirteen voting members present.

WL/15/183 Declarations of Interest on Agenda Topics

On behalf of all clinical leads Professor Lakhani declared an interest in **WL/15/188 – MD's Communication** and **WL/15/190 – Urgent Care Board Work Stream Update.**

Drs Pulman and Hepplewhite declared an interest in **WL/15/191 – Ashby and District Hospital**

WL/15/184 To receive questions from the public in relation to items on the agenda

The following questions were received from Mrs Christine Baker on behalf of the Ashby Civic Society. Mrs Trevithick responded to each question individually as follows:

1. Question

Whether all members have seen a copy of the document drawn up by Ashby Civic Society and now widely circulated in the public domain, entitled "The imminent closure of Ashby Hospital: is it flawed?"

Answer

Yes and this was circulated to Board members on 5th August 2015.

2. Question

Whether members are aware of the Society's request to the Health Overview and Scrutiny Committee of the LCC to review the case for closure of the Hospital with a view to referring it to the Secretary of State for Health requesting him to re-consider the closure and disposal?

Answer

Yes, and this was circulated to Board members on 5th August 2015.

3. Question

As your officers have introduced an option for a new location for some outpatient services into the Hood Park Leisure Centre, and as we advised you on 24th May this year that, having taken legal advice, we believe that the proposal to extend the Leisure Centre for Out Patients is contrary to the covenant on Hood Park and thus cannot be given planning permission. Despite four requests to the Council, including an FOI submission, NWLDC has been unable to refute this advice. I therefore now ask you to explain what the plan is for the affected services if you cannot have access to a new build for the services at the Leisure Centre?

Answer

LPT continue to progress this with North West Leicestershire District Council. The CCG believes that this approach supports innovation and focuses on ill health prevention. Should they be unsuccessful in obtaining planning permission, an alternative option would have to be developed by LPT.

4. Question

How effective and financially viable will another option be as set against the rest of the options in the original business case?

Answer

This would have to be considered should an alternative option be put forward.

5. Question

I also ask whether you are aware of the new financial profile of the option of using Hood Park, including a capital build of between £500,000 and £750,000? Please remember that the cost of fixing Ashby hospital was quoted at around £900,000. Does this new option make the closure effective and financially viable?

Answer

Hood Park provides a sustainable option for the future. It promotes innovation and is in line with the CCG strategic objectives. The figures quoted for ADH address backlog maintenance issues and even if the current building was repaired to a satisfactory standard, it would still remain unsuitable for providing modern healthcare.

6. Question

You will be aware of the Care Quality Commission's assessment (July 2015) of community hospital services provided by LPT. It is a poor rating. You will also be aware from Item "WL/15/170. CQC Review "from your own Board papers, of Mr.

Sanders reported observation that "A number of Better Care Together initiatives were dependent on LPT being able to increase capacity in community settings, to be able to transfer and take out services from UHL. LPT were already facing internal workforce constraints so the CCG would need to consider whether it was **safe** to proceed at the current pace". Indeed the CQC rated the safety of LPT's community services, and its ability to lead them, as "requiring Improvement". We would like to know how you can now be confident, with these new doubts, of the ability of LPT to deliver all the changes you have planned for Ashby and District?

Answer
It is important to note that LPT's Community Health Services Adults received a 'good' rating from the CQC. The concerns in community hospitals resulting in a 'requires improvement' rating related primarily to staff and the Trust has a plan in place to address these issues.

7. *Question*
Are you aware that there is a new focus for population planning in Ashby-de-la-Zouch? The Local Plan sees the population of Ashby growing by 61% over the next 15 years. There will be an additional 8,000 people in Ashby alone if this comes to fruition. Ashby is to be the centre for population growth in the area of North West Leicestershire. Are you being given the opportunity to factor this into the plan to close and dispose of Ashby Hospital and do you think it is a sound plan?

Answer
The CCG's plans took into consideration the growing population in Ashby. The changes in the model of care allowed the CCG to provide care to a larger number of people in their own homes.

8. *Question*
It is more than a year (May 2014) since you decided to close Ashby Hospital and yet so much has changed in the plans set out for consultation and approved by yourselves. Will you be asking for a final, fully costed, proposal for the closure of the hospital to be brought back to the Board for reconsideration?

Answer
The CCG Board has regularly confirmed that WLCCG stands by the decisions made last year. These are in line with the Better Care Together plans for WLCCG and LLR.

Professor Lakhani thanked members of the Ashby Civic Society for submitting the public questions and he invited them to submit any further queries in writing, through the usual channels.

WL/15/185 Minutes of the meeting held on 14 July 2015

The minutes of the meeting held on 14 July 2015 were approved and accepted as an accurate record, with the exception of:

WL/15/163 – Vanguard Application for Urgent and Emergency Care – penultimate paragraph should read … Mrs Bright said the SRG was keen to share any lessons learned at an urgent and emergency **care** level, and also to learn lessons from **within** the networking area.
WL/15/164 – Urgent Care Improvement Plan – second paragraph third sentence should read … **atrial** (instead of arterial) … - 5th paragraph, last word should read …PRISM.
WL/15/165 – Improving Access to Psychological Therapies – Notts Healthcare NHS Trust – second paragraph, first line should have the work **patient** removed.

WL/15/186 Actions Arising from the meeting held on 14 July 2015

Members noted that all actions were either completed, or ongoing, and an updated action sheet would be appended to the minutes.

WL/15/187 Chairman's Announcements and Report

Professor Lakhani made the following announcements:

- The CCG had been successful in a bid for work to improve the urgent care system and this would be discussed later in the meeting.
- The Better Care Together consultation was progressing well. Opinions were being sought from a variety of stakeholders and as part of the process a presentation was given at the clinical Senate (for external clinical scrutiny), to look at the case for change for each of the 9 BCT work streams. This had been positively received. Some areas required further work but the strong plan continued to move forward.
- UHL had shared the latest SHMI indicators on mortality which were published nationally. For the first time since its inception results were at their lowest level. This was a significant positive development which UHL should be commended for. Improvements had occurred due to changes made in the pathways, which demonstrated that a clinically led change process had made a significant difference.

It was RESOLVED:

- To **RECEIVE** the above updates.

WL/15/188 Managing Director's Communication

Paper B, presented by Mrs Bright on behalf of Mr Sanders, summarised the latest CCG news, developments, upcoming events, national guidance and policy updates:

- Attention was drawn to the plan on a page appended to the report and produced by Mrs Williams and her team. The annual plan was shared with staff, GP practices and other stakeholders and defined the CCGs priorities for the year. This would be a useful document to share with localities. Mrs Williams agreed to make two minor adjustments; a repeat sentence under the work areas and deletion of a bullet point under the financial plan. **CW**
- Two workshops were planned, one for Hinckley and services within Hinckley which was open for clinical staff, patients and the public. People would be invited to contribute towards the next stage of reshaping healthcare services.
- An event was planned around child and adolescent mental health services where views would be sought from children and their relatives on the services they currently received.
- Work was ongoing with residential and nursing homes on using other services as an alternative to admission to acute hospitals. This linked to the out of hospital work currently being developed in urgent care.

It was RESOLVED:

- To **RECEIVE** the update from the Managing Director.

WL/15/189 Urgent and Emergency Care Vanguard Programme

Board members watched a brief TV episode of ITV news which aired the Vanguard Programme and included an interview with Mr Sanders.

Mrs Bright presented paper C which provided details of the successful WLCCG Vanguard application. Eight new vanguards were announced nationally on 31st July 2015, that would launch the transformation of urgent and emergency care for more than nine million people. This included the LLR System Resilience Group that would take the lead in improving urgent care for 1.1 million people in the area. The urgent and emergency care vanguards were tasked with changing the way in which all organisations worked together to provide care in a more joined up way for patients.

Urgent care would be delivered, not just in hospitals but also by GPs, pharmacists, community teams, ambulance services, NHS 111, social care and others, and through patients being given support and education to manage their own conditions. Another aim was to break down boundaries between physical and mental health and to improve the quality of care and experience for all. The eight new vanguards would spearhead the work and, like other vanguards, would benefit from a programme of support and investment from the £200 million transformation fund.

A national launch would take place on 27th August when more information would be forthcoming on the possibility of any further resources. Eight colleagues from LLR would be attending the launch, together with a Healthwatch representative, local authority colleagues and EMAS. Following the launch internal capacity across LLR to deliver the programme would become clearer, particularly around project management resource and an update would be given on this at the September Board meeting.

TS

Alongside the Vanguard programme a regional urgent and emergency care network was being established, bringing together SRGs working at county level. This would provide a regional perspective and Mr Sanders had been nominated and had agreed to Chair the network on behalf of the East Midlands region. Some administrative resource would be available for the network and workshops were planned where members of the Urgent Care Board would be able to better understand how things would work and how the network would have a local impact.

Mrs Williams drew the Board's attention to question 4 of the Vanguard application, 'system-wide targeting for transformation', and she added this articulated exactly what would be done differently in future. This was a key example that the whole would be greater than the sum of its parts and investments would be maximised. The CCG had also made some local provision in terms of investment.

Dr Cannon commended the Vanguard application and said it had added confidence to the BCT programme, particularly with the evolving Local Area Co-ordinator roles. As plans developed it would be important to keep in mind the local perspective. He was also very pleased to note the section on mental health services and the high relevance this was given.

Professor Lakhani concluded by saying this was an excellent development of the LLR bid which WLCCG had been actively involved in shaping.

It was RESOLVED:

- To **RECEIVE** the Urgent and Emergency Care Vanguard Application.

WL/15/190 In-Flow/Demand – Urgent Care Board Work Stream Update

Mrs Bright presented paper D which followed on from the July WLCCG Board meeting when a request was made to discuss in more detail the work programme of the LLR Inflow/Demand Work Stream, particularly with regard to the range of

actions and their impact on emergency admissions and Emergency Department attendance. She gave some background information on the development of the group which included:

- The production of an improvement plan, divided into key work streams looking at areas such as out of hours and enhancing alternatives to admissions for patients.
- Each work stream produced five areas of focus, with key actions to be undertaken each quarter and these were tested and challenged to confirm their appropriateness.

It would be important for Board members to be aware that ED attendances and emergency admissions continue to increase and services need to be developed that enable patients to use alternatives to attending ED or being admitted.

As part of his work in improving urgent care, Dr Ian Sturgess had urged local communities to look at initiatives that dealt with demand, and this was reflected in the inflow action plan.

Mrs Bright explained a number of appendices had been included with the report which gave a sense of the enormous amount of work occurring at the present time and this included detailed action plans for each quarter's work which was then considered by the UCB.

A key objective for the in-flow group was to start to look at the consistency of patient flows in pre hospital settings across LLR, so that patients would have equity of access. Excellent collaboration exists between organisations and trajectories had been established, though as yet no evidence had been produced on the impact these were having on acute demand. For West Leicestershire specifically alternatives to acute hospital admissions were:

- Utilisation of the Acute Visiting Service (AVS)
- Establishment of the Older Persons Unit
- Work linked to care and residential homes
- Concerted efforts with EMAS, where patients were being taken directly to the Loughborough UCC instead of the ED at LRI
- Sharing of care plans
- Better use of ambulatory pathways

In respect of the established trajectories some of the baseline information had been found to be inaccurate. This had since been rectified but validation was awaited on new data received before it was shared.

As part of next steps it would be essential to ensure developing community services were targeting and meeting the needs of patients. Further detailed analysis was required and this included working with colleagues in UHL to look at changes to the front door function to manage alternatives to admissions.

Dr Cannon acknowledged the amount of work happening in urgent care which he felt was valid, but expressed concerns about re-structuring arrangements and that BCT had the potential for fragmentation. Notably he felt there was a danger of some public health services such as drugs, alcohol and the preventative agenda being isolated from mainstream services.

Dr Pulman said this was a tremendous piece of work and he was very pleased to see significant changes that had taken place. In particular he said the AVS had been a positive development which had freed up time in GP surgeries. The

capacity within the AVS however had already been exceeded and he asked if there were any plans to review and revise future capacity. He also asked if the AVS was being thoroughly evaluated to ensure referrals were valid and whether information would be fed back through localities.

Dr McHugh referred to point 11 of the report and the recommendation on the strengthening of relationships between primary care and acute care clinicians. He said he had not seen a great deal of progress with this and referred to a BMJ article where one CCG had appointed a GP to work at the interface of CCG and hospital clinicians. Mrs Bright replied the aspect of strengthening work between GPs and hospital consultants was very important. This had been raised at the UCB recently with an acknowledgement that significantly more could be achieved at the interface to enable all clinicians to consider alternatives to admission. At present a high number of patients were still admitted by GPs via the ED, and further work was required to tackle this.

Mrs Williams reported the discharge options in place were working more efficiently than previously and significant improvements had been shown in the reduction for people stranded in hospital which led to an opportunity of being able to develop further options in the front end of the system in addition to the system back end.

Dr Hepplewhite referred to an excellent care homes event recently which had been well attended by care home providers, where presentations had been given from the OPU and the AVS. Care homes were now able to contact the AVS directly without involving GPs in the first instance.

Mr Gay said the work was very positive, yet the fact remained that there was a rising demand in admissions to hospital which would create financial and operational problems for urgent care. The Vanguard programme would assist with some of the pressure but it was unlikely to be sufficient. From this perspective he said it was necessary to start to work up new ideas, for example the expansion to the AVS. Dr Hepplewhite added an advantage of the AVS was that it did not just deal with problems, but added value from an educative point of view, especially for nursing and residential homes.

Dr Barlow said the AVS was excellent but problems were being experienced regarding equality of access. Mrs Bright replied similar services existed in the City and these were becoming more and more aligned with West, which was a positive development. There was an essential link with the AVS and the commissioning of new out of hours services as CCGs were keen to commission an integrated service which responded to urgent care both in an out of hours. When the specification for out of hours was being developed there would be a need to consider not just GPs but the AVS, OPU, nursing and social care. She acknowledged capacity would need to increase, but this would be for a whole range of services.

Dr Cannon highlighted that the AVS was borne out of the enormous pressure on ED and felt it should not be used as a substitute for holistic general practice. The distinction must be very clear over the appropriateness of using the AVS as opposed to a GP home visit.

It was RESOLVED:

- To **DISCUSS** the work programme of the Inflow/Demand Work Stream and considered any further actions that should be considered by the group and/or the Urgent Care Board.

WL/15/191 Ashby and District Hospital Implementation Group – Progress Update

Mrs Trevithick presented paper E, which provided a quarterly update on progress towards relocating remaining services to the alternative accommodation identified and approved in the business case.

Members noted a minor amendment under team bases where it stated the lease on Legion House had been assigned. The lease was in fact in the process of being assigned.

Mrs Trevithick reported she had held a conversation with the Alliance on their proposals and what services might be provided from the new Ashby Health Centre which was expected to open in approximately November 2015.

It was RESOLVED by consensus:

- To **RECEIVE** the quarterly update.

WL/15/192 Board Assurance Framework

Mr Chudasama presented paper F that had been reviewed and updated to show the latest position as at 31 July 2015. The BAF contained risks to the achievement of strategic objectives for the year, plus other risks 'escalated' from the constituent risk registers where there was an inherent risk rating of 12 or more.

Mr Chudasama drew the Board's attention to appendix 2, the BAF concentric diagram which had emerged following the last Board meeting and helped to focus on the risks in greater depth. Comments were invited on the 4 quadrants.

Mr Harding said this was a very powerful diagram which showed the CCG was not responsible for some controls around managing money, but were working with partners for resolution. It also helped to focus on what the CCG was able to have an influence over. Dr Cannon agreed with Mr Harding's comments.

Mr Gay felt the diagram was helpful, but in some ways unhelpful. There was the possibility of believing that no action could be taken for those risks under 'partnership issues that affect us', when in fact it was important to take responsibility and work on those issues which was the nature of being a commissioning organisation. Risks within the CCG's control were very limited however the planning of the financial position was within the control of the CCG which included taking some financial decisions.

Mrs Williams said she was disappointed that 'partner issues that affect us' was something to be considered out of the control of the CCG, when this was the fundamental job of the organisation. These risks therefore might need to be written in a different way. Mr Chudasama replied it was certainly not the intention to give this impression. The aim was to have a set of variables the Board were comfortable with. This was an initial set of mapping exercises to move towards what the organisation needed to do.

Dr Pulman said he found the diagram useful but would prefer to see greater detail, to demonstrate where the CCG was cited on everything and how actions were being prioritised and given direction.

Professor Lakhani pointed out the Out of Hospital Care system was a top priority and it would be interesting to see how this might be reflected on the diagram.

Mrs Trevithick felt this presented a challenge to the way risks were described. Using ED as an example she explained this could be divided into parts the CCG had direct influence over and other parts presented using a different method of influence via contractual arrangements. She preferred the term sphere of influence rather than sphere of concern.

Mr Rees commended the diagram and said it could help with some of the difficult decisions the CCG was required to make, though he also felt some gaps existed.

Dr Shah asked why LPT did not appear on the diagram and Mr Chudasama replied only the risks that reached a certain score were depicted.

Dr Barlow was in favour of the diagram and felt it helped to present day to day issues. He said more time should be spent on ensuring risks did not become too urgent.

Dr Trzcinski said there were issues the CCG needed to work on with partners for resolution and the diagram illustrated this.

Mrs Bright referred to the recent Board Development Session with internal audit where a discussion was held on risk appetite. She said there was a link between the diagram and how acceptable the level of risk was that the CCG was exposed to. If the risk was unacceptable the Board needed to work to reduce the level of risk.

Mr Churton said he found the quadrants useful but that they should be relabelled more appropriately, as some meaning may have been lost in the translation of the heat map into the circle. Dr Jackson agreed with Mr Churton's comments and said the quadrant titles required changing in order to capture the risk appetite.

Mr Chudasama agreed to revise appendix 2 and present a refresh to the September Board. **KC**

It was RESOLVED by consensus to:

- **APPROVE** the latest iteration of the 2015/16 Board Assurance Framework
- **DISCUSS** the presentation of the risks on the concentric diagram
- **DISCUSS** if any further actions are required to address the risks

WL/15/193 Conflicts of Interest Arrangements

Mr Chudasama presented paper G which sought the Board's approval of a final version of the proposed process for the management of conflicts of interest (CoI). The arrangements proposed within the process had been discussed at previous Board meetings, Board Development Sessions, locality meetings in July, and had also been checked with the CCG's legal advisors.

The establishment of the CoI Screening Panel and "New Committee" were subject to NHS England approval as both of these groups would need to be formally constituted. The CCG's application to NHS England for the approval of constitutional changes would be submitted following Board approval.

Dr Pulman asked if any further work had been carried out to identify out of area GPs for the new committee. Mr Chudasama replied work on this would commence over the next two weeks.

Dr Cannon sought reassurance the new process still allowed full discussion at Board level, on all the commissioning decisions, which would include specification and service requirements. Mr Chudasama replied this depended on the timelines of issues. There would be initial input and the screening panel would intervene at testing points of any journey to identify issues. Dr Cannon said he hoped the screening panel would take into account a prevailing view. As an example Mr Chudasama explained at the start of a procurement the screening panel might make an observation that materiality was gradually increasing. Board GPs would be making commissioning decisions, however as arrangements moved towards procurement and contract lets they would not be involved if conflicted. Mr Churton added there would be a point on the continuum where the conflicted clinicians might be excluded from the process.

Mr Churton pointed out that clinicians should be allowed to nominate deputies for the screening panel.

A brief discussion took place on quoracy of the screening panel when it was noted technically the panel could be convened without a clinician. Mrs Bright informed the Board the point of the screening panel was purely process and advisory in order to determine if any conflicts of interest existed, prior to recommending a course of action to the Board. Localities had particularly liked the idea of an out of area arrangements, with a similar CCG. They also explored the idea of using retired GPs, though it was noted after two years of being retired GPs would no longer appear on the performers list. **KC**

In respect of out of area GPs Dr McHugh felt these GPs would not have an understanding of a whole host of information required for making decisions and if clinicians were not local, this would be less than ideal. Mr Chudasama added as part of the formal procurement process it would be important to ensure local voices were fed in to ensure local knowledge was used in decision making.

Mrs Williams reported any future bidding would be more like an Alliance style and consideration would be given to partnership arrangements, to enable services to be integrated. Everyone therefore would be included in the specification process, and would consolidate NHS provision rather than fragment it. Dr McHugh highlighted the importance of maintaining clinically led commissioning and Mr Harding added existing legislation would ensure appropriate procurement and involvement of clinicians.

It was RESOLVED, by consensus to:

APPROVE the proposed process for the management of CoI (Appendix 1) and the CoI Screening Panel Procedure (Appendix 2)

APPROVE the CoI Screening Panel Terms of Reference (Appendix 3) (subject to NHSE approval of our Constitution amendment)

WL/15/194 CCG Assurance/Development Quarter 4 2014/15

Mr Chudasama presented paper H which was a high level summary of the areas of discussion at the annual CCG Assurance meeting. These included:

- A&E 4 hour standard
- Cancer
- IAPT – continued discussion was taking place with the Area Team on a possible revised trajectory.
- Dementia – this was discussed on a monthly basis with the Area Team. Data was expected at any time and once received it would be possible to see the position at practice level. Dr Jackson commented that a diagnosis could take

between 6-9 months and Dr Trzcinski said attempts were being made to speed up the pathway.

- Length of Stay in mental health

This was a process whereby NHSE were able to assure themselves the CCG was working towards, and meeting the required standards. A formal assurance letter would be sent to the CCG, received by the Board and published on the WLCCG public website.

Mrs Trevithick raised the issue of cancer and a request to track patients at 40 days. This was discussed at PPAG in an attempt to clarify any required involvement of GPs and Mrs Lock, MD at LCCCG would be seeking clarification on this. Dr Hepplewhite added it was often difficult to become involved with cancer patients and sometimes the only course of action was for the GP to contact the patient directly.

It was RESOLVED:

- To **RECEIVE** the quarterly update.

WL/15/195 Report from Quality and Performance Sub Group, 16 June 2015

Mr Rees presented paper I which identified the key quality and patient safety concerns from the WLCCG Quality and Performance Sub-Group meeting held in July 2015 that related to contract performance. The following three main areas were highlighted:

- **Ophthalmology –** a mini review was carried out into Ophthalmology services/performance for West Leicestershire. The key issues highlighted were; waiting times, communication and the environment.
- **Clinical Commissioning Group Safeguarding Report and Performance -** Initial Health Assessments for Looked After Children, where a backlog situation had occurred in February/March 2015 when local authorities and social care departments were working together and referring outstanding cases.
- **GP/OOH CQC Themes**
  In March 2015, the CQC conducted reviews at four of the six sites run by CNCS; the provider for the Out of Hours Service for Leicester City, Leicestershire and Rutland. The four sites visited were: Clinic 4 LRI, Hinckley and Bosworth Community Hospital, Loughborough Urgent Care Centre and Fosse House. The CQC identified a number of risk areas during these visits which required immediate remedial action

It was RESOLVED by consensus:

- To **RECEIVE** the contents of the report.

WL/15/196 Assurance report from PPAG – 23 July 2015

Mr Harding presented paper J which provided the Board with a summary of the assurance received from the Contract Squares in relation to performance across the collaborative contracts, and the respective providers' performance. Areas to note:

LPT – following on from the CQC visit, the final report had been presented to the provider and partners at a quality summit held on 7 July 2015. Major concern was expressed at the lack of an appropriate oversight group to oversee the issues. Mrs Trevithick explained that the view of the TDA was because LPT did not have an overall rating of inadequacy it would be difficult to establish an oversight

group. The PPAG felt strongly that an oversight group should be established, at least for those areas rated as inadequate; this view was supported by the board.

In respect of LPT data quality issues an action plan had indicated accurate data was due to be delivered by September, yet data remained inaccurate. The recommended approach was to request a Board to Board in an attempt to resolve the situation.

EMAS – a remedial action plan was in the process of being produced. EMAS contracts continued to be affected by 3rd party interventions. Mrs Bright sought further clarification on this and Mr Harding replied this was mainly inter-provider issues and delays, and PPAG had now become directly involved in the process.

CHC – an agreement had been reached with GEM with regard to a level of additional resource required to fill capacity gaps. Improvement in performance was expected by September 2015.

Cancer – targets for 31 and 62 day remained areas of concern and performance continued to be monitored by the Cancer and RTT Board.

It was RESOLVED by consensus:

- To **RECEIVE** the Assurance Report from PPAG, 23 July 2015.

WL/15/197 Help to Live at Home

Mrs Davenport gave a presentation on Help to Live at Home, Integrated Commissioning for LLR discharge pathway 2, home with support, which included the following information:

- A Leicestershire County Overview – population and home care expenditure.
- The current offer – over 100 agencies involved; increase/competing demands, gaps in provision.
- The skills market – recruitment/retention issues; sustainability.
- The current service model did not maximise reablement and independence at home.
- Joint working arrangements for an extension to the existing framework, and procurement of a new service, with clear objectives, design principles and clear pathways.
- Extension of contract payment mechanisms, a provider delivery model and geographical market divisions.
- The new commissioning approach.

The Help to Live at Home scheme would be moving from an Outline Business Case to Full Business Case which would be submitted to the Board in October 2015.

Mrs Davenport explained considerable challenge existed in the skills market and one of the main aims was for commissioners to gain greater assurance on the terms and conditions of care workers within provider organisations, and to maximise reablement in home care. The commissioning plan includes an important transition period for existing clients during 2016.

Draft lotting arrangements were presented and it was noted some of the proposed boundaries for home care activity passed through individual practice areas. It was confirmed there would be more than one provider within each locality (for both patient choice and market resilience purposes).

Dr Jackson queried whether it would be more appropriate to have the geographical areas co-terminus with the virtual wards and Mrs Davenport replied it had not been

possible to configure the areas to fit exactly in this way as the determinant in this case was to achieve lots of home care activity that were broadly of similar sizes. Dr Pulman suggested a revision of some of the West Leicestershire groupings so that they were co-terminus with practice areas and localities. Mr Rees said the geographical areas did not recognise natural transport routes which would increase transport costs for providers.

Dr Hepplewhite felt this was an ideal opportunity to become involved in the specification for the induction and training of new staff, which could include ongoing training. She added the workforce in care homes often had a rapid turnover. Mrs Trevithick said it would also be helpful to factor in a health and social care protocol for staff, and in relation to the transition of patients she asked how patient choice would be managed, especially if patients did not wish to change their current carers. Mrs Davenport replied an existing provider might remain in situ, however patients who wished to make alternative choices would be provided with a personal budget for that purpose, and this was being factored in the financial modelling. Board members noted that patients were often attached to their carers and not to a specific organisation.

Board members noted the advantages of people being transferred out of hospital through a supportive service, which would also significantly reduce CHC spend.

Dr Pulman asked if the changes would be used as an opportunity to move away from paper care records and to develop electronic systems. Mrs Davenport replied there was no national mandate for this, however the patient NHS number would be attached to the adult care records and work continued with a number of providers on a variety of IT solutions.

Mrs Davenport was thanked for her presentation.

It was RESOLVED by consensus:

- To **RECEIVE** the presentation on Help to Live at Home.

WL/15/198 Areas of Focus for Future Board Meetings

Professor Lakhani invited a reflective view of the new style of Board meeting which had focused on more essential items. Comments included:

- The re-engineering of the BAF provided a positive aspect.
- BCT presentations demonstrated a lack of co-ordination between the work streams. Mr Chudasama added Board Development Sessions would also include BCT presentations.

Potential future Board topics:

- Presentation on cancer but acknowledgement that a deep dive had taken place at a recent Q&P meeting.
- Developing patient engagement (ELC, People Powered Health Group, patient stories).
- IM&T (important decisions that had an impact on what people were leading on) – could be more appropriate for a Board Development Session).
- Long term conditions trajectories.
- Prevention agenda and self-care (Dr McHugh to present on what was happening in Public Health and working collaboratively with the local authority). **MMc**
- Performance and performance improvement issues – due to the way risk was being articulated the Board should look at what could be influenced.
- Progress with the new framework and new models of primary care (could include issues such as the dental strategy).

It was RESOLVED by consensus:

- To **DISCUSS** the above.

WL/15/199 PMO Operational Plan Delivery Update

Members receive the PMO Operational Plan Delivery Update for information.

WL/15/200 Minutes of the Planning and Delivery Sub Group held on 23 June 2015

Members received for information the minutes of the Planning Delivery Sub Group held on 23 June 2015.

WL/15/201 Minutes of the Quality and Performance Sub Group held on 16 June 2015

Members received for information the minutes of the Quality and Performance Sub Group held on 16 June 2015.

WL/15/201 Minutes of the Finance sub group held on 7 July 2015

Members received for information the minutes of the Finance sub group held on 7 July 2015.

WL/15/202 Minutes of the Commissioning Collaborative Board held on 25 June 2015

Members received for information the minutes of the Commissioning Collaborative Board held on 25 June 2015.

WL/15/203 Minutes of the Primary Care Commissioning Committee held on 16 June 2015

Members received for information the minutes of the Primary Care Commissioning Committee held on 16 June 2015

WL/15/204 Date and Time of Next Meeting

The next meeting of the West Leicestershire Clinical Commissioning Group will be held on Tuesday 08 September 2015 at WLCCG Headquarters, Woodgate, Loughborough, Leicestershire LE11 2TZ.