WEST LEICESTERSHIRE CLINICAL COMMISSIONING GROUP

A

West Leicestershire Clinical Commissioning Group
Minutes of the Board Meeting
Tuesday 11 April 2017, 14.30 – 16.30
WLCCG Headquarters, Woodgate, Loughborough, Leicestershire LE11 2TZ

Present:

Professor Mayur Lakhani	Chair (Chair)
Mr Toby Sanders	Managing Director
Dr Chris Trzcinski	Deputy Chair
Mr Steve Churton	Lay Member
Ms Gillian Adams	Lay Member
Mr Ray Harding	Lay Member
Mrs Angela Bright	Chief Operating Officer
Dr Chris Barlow	Locality Lead, South Charnwood
Dr Nick Pulman	Locality Lead, North West Leicestershire
Dr Nick Willmott	Locality Lead, Hinckley and Bosworth
Dr Geoff Hanlon	Locality Lead, North Charnwood
Mr Spencer Gay	Chief Finance Officer
Mr Ket Chudasama	Assistant Director Corporate Affairs
Mrs Fiona Barber	Healthwatch Representative
Dr Mike McHugh	Public Health Consultant
Dr Peter Cannon	Locality Lead, North Charnwood
Mrs Caroline Trevithick	Chief Nurse and Quality Lead

In Attendance:

Mr Derek Kitchen	Managing Director, MLCSU
Mr Martin Pope	Mobilisation Director, MLCSU
Mrs Cheryl Davenport	Director of Health and Care Integration, Leics County Council
Mr Jon Wilson	Director of Adults and Communities, Leics County Council
Mrs Ruth Brutnall	Head of Corporate Governance
Ms Alison Moss	Committee Clerk (minutes)

Action

WL/17/063 Welcome and Apologies for Absence

Professor Lakhani welcomed all to the public Board meeting including one member of the public. Apologies for absence were received from Mr Paul Hanlon and Dr Y B Shah.

Professor Lakhani confirmed the Board meeting was quorate with 12 voting members present.

WL/17/064 Declarations of Interest on Agenda Topics

The following declarations of interest were recorded:

WL/17/075 – Update from Remuneration Committee held on 27 March – Toby Sanders to be absent and all CMT members, declaration only
WL/17/080 – Better Care Fund Plan 2017/18 - 2018/19 – All GPs and Dr Mike McHugh, declaration only.

WL/17/065 To receive questions from the public

Professor Lakhani reported that a number of questions had been received from Mr McKay covering several issues. A written response to his questions would be appended to the April Board minutes. Answers to some of his questions relating to papers on the agenda would be answered during the meeting. **KC**

WL/17/066 Minutes of the meeting held on 14 March 2017

The minutes of the meeting held on 14 March 2017 were approved and accepted as an accurate record with the exception of:

WL/17/052 – Report from the Quality and Performance Sub-group, Page 5, 5th paragraph, last line the word perianal should read perennial. 11th paragraph, first line should ready …Mr Harding said that PPAG was sceptical that patients waiting beyond…..
WL/17/054 – Performance Report, Page 9, 3rd paragraph, 1st line should read Mrs Bright said that the A&E Delivery Board was leading on the issue. 9th paragraph, second line ULH should read UHL.
WL/17/054 Performance Report – page 9, 8th paragraph should be replaced with: Dr McHugh said that it was symptomatic of the culture which he considered to be risk adverse but noted that there were resources to do things differently albeit scarce. There was a need to weigh the risks of crews waiting with patients who might need care to the risk of not sending an ambulance to an emergency. He said that there was a need to also consider how much risk individual patients themselves should carry and the importance of advocating self-care.

WL/17/067 Actions Arising from the meeting held on 14 March 2017

Members noted that all actions were either completed, or ongoing, and an updated action sheet would be appended to the minutes. Also appended were answers to Mr McKay's public questions from March and April 2017.

WL/17/068 Chairman's Announcements

Professor Lakhani welcomed Dr Nil Sanganee to his first meeting of the Board. Dr Sanganee was the newly elected GP representative from the North West Leicestershire locality. No appointment was made in the last election for a Hinckley and Bosworth GP representative and a further election would be held at the end of March 2017.

It was RESOLVED to:

- **RECEIVE** the above update.

WL/17/069 Managing Director's Communication

Paper D, presented by Mr Sanders summarised the latest CCG news, developments, upcoming events, national guidance and policy updates. He highlighted the following points:

- Mrs Bright would be retiring at the end of September and the CMT had been considering future arrangements in relation to her role, notably in the context of resilience within WLCCG as an organisation. As a result, two rather than one director roles would be created, both non-voting, to support:

1. GPFV, contracting, primary care, federation support, co-commissioning, member practice engagement – to be created with minor restructuring within the team
2. A post with a focus on service improvement, system redesign, community teams, out of hospital agenda, integration with the local authority.

A process would also be established to appoint a deputy role from within the existing CMT members and the plan was for the new arrangements to be in place by the end of September 2017. The financial implications were moderate and sustainable within current running costs.

Mr Churton thanked Mr Sanders for attending the remuneration committee meeting to discuss the above changes. The group had recognised the above proposals were an executive decision and within the remit of the managing director.

Mrs Bright announced one of her senior managers, Cathrina Tierney-Reed was intending to retire at the end of August and that post should be considered in terms of the overall recruitment.

In respect of feedback received on the GPFV WLCCG was in a strong position in comparison with other CCGs within the Midlands and East and the wider region.

It was RESOLVED to:

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

WL/17/070 Managing Director, Midlands and Lancs CSU - Introduction

Dr Pulman declared an interest in respect of his role in IM&T with Argen/GEM.

Professor Lakhani welcomed Mr Derek Kitchen, Managing Director, and Mr Martin Pope, Mobilisation Director, Midlands and Lancs CSU who introduced themselves and gave a presentation that included the following points.

- MLCSU had:
  - 1450 experienced professionals
  - Serving 46 CCGs
  - Covering a total population of 11.2 million
  - With a total commissioning budget of £13 billion and an annual turnover of £85 million
- Working together with 9 other North and West counties, providing a wealth of experience.
- Alignment of capability and capacity with:
  - A Board of Directors
  - Service Directors and Clinical Leads
  - Local Team Leaders/experts/specialists and centres of excellence

Mr Harding pointed out the new contract had coincided with the year end and he sought reassurance that the situation was adequately covered. Mr Kitchen acknowledged the importance of the year end and he added that MLCSU had worked in the past with the previous supplier and would continue to do so on handover arrangements and so far mobilisation had gone well.

Dr Pulman said IT systems often worked in silos and he sought reassurance that genuine information sharing would be developed. Mr Kitchen replied CSUs usually operated in a competitive environment that did not encourage the sharing of

information. However collaboration had grown in the last five years and he referred to the Aristotle model that was currently being developed. He acknowledged that some local data issues existed and these would be handled as a next stage of improvement and dealt with in the CSU monthly development days. An example of that were invoices and payments for CHC.

In respect of the development of clinical networks Mr Kitchen reported that an initial clinical conference had been held in 2017, bringing together all the CHC nurses.

Mr Sanders thanked Mr Kitchen for introducing himself at such an early stage and he welcomed Mr Pope as the CCG link. He felt Mr Pope's role would be key in developing a robust interface between the organisation and team working.

Mr Sanders stressed the importance of maintaining the basic services at a high level whilst in mobilisation mode and beyond. He also said he would be keen to explore possible options for MLCSU to become involved in STP to help integrate and support the sustainability of services moving forward.

Mr Chudasama said mobilisation had gone smoothly and a key objective would be to ensure that the workforce and OD perspective remained motivated and committed to working in a different way. Positive feedback had been received from staff so far and this was encouraging.

Mrs Trevithick said she was pleased Mr Pope would be spending time at the CCG and developing relationships across the three CCGs. She asked how MLCSU saw their relationship developing with NHS England in the future, notably with an aim of developing a single operating model. Mr Kitchen replied regular meetings with relevant offers took place where knowledge of what might be happening in the future was explored, and some ideas for taking for taking forward had been generated. Services directors also met on a monthly basis to share what went through the single operating model.

Ms Hooton asked what MLSCU saw as the key risks in relation to CHC workforce. Mr Pope replied they had been fortunate with the workforce and many of the gaps had been filled. He acknowledged CHC was a difficult area to recruit into, however adverts had been placed. Confirmation of the structure was being finalised and potential staff had been identified from other areas, interested in joining the team.

Dr McHugh referred to the public health function that had moved into the domain of the local authority but retained the role of supporting CCGs. To be successful they required business intelligence support but currently had no access to NHS data. He asked how MLCSU saw their role in improving that. Mr Kitchen replied that MLCSU did work with public health departments in other parts of the patch and controversy existed around what could be shared from an information governance point of view. The organisation however worked with vast amounts of data and was working with local authorities in terms of matching health service data, for example in adult social care, and would be happy to hold further discussions to see what could be achieved.

Professor Lakhani concluded by saying he would be keen to see what a primary care offer might look like and he would welcome some support on some research projects currently stuck in transition due to information governance issues. Mr Pope replied this was already being looked into.

Mr Kitchen and Mr Pope were thanked for their presentation and left the meeting.

It was RESOLVED to:

- **RECEIVE** an introduction from MLCSU

WL/17/071 Finance Report – Month 11

Public question: Could the CCG outline particularly in relation to non-elective activity and GP referrals what work was being done to address the overspend and challenge spend. Was the CCG confident that the surplus of £4 million would be achieved and given the poor performance in a number of indicators in the performance report was the surplus at the expense of quality? What assumptions were being made about CHC and how confident was the CCG about this?

Mr Gay presented paper D that summarised the financial position and associated risks of WLCCG as at 28th February 2017. In addition, the report highlighted the key in-year financial risks for the CCG and actions which were in place to mitigate those risks. Board members noted the following:

- The year to date position showed a £3.9m surplus delivered in the 11 months to 28th February 2017. When the 1% fund (which the CCG's had been instructed not to spend) was taken into account the variance to plan was an adverse £4m. There was significant over-performance against planned expenditure with acute hospitals, particularly in relation to non-elective activity and GP referrals. Work continued to address the overspend and challenge spend.
- Despite increasing financial pressure the CCG was predicting achievement of its required outturn for 2016/17. This equated to an overall surplus of £4.257 million and the retention of the non-recurrent reserve.
- The financial forecast for the year included significant assumptions regarding contractual challenges, prescribing outturn and CHC. The financial forecast was heavily dependent on a number of non-recurrent initiatives that would not be available in future years.
- Many of the CCG's QIPP plans for 16/17 and 17/18 financial years were focused on aiming to reduce acute demand where appropriate. In 2017/18 in particular a new targeted scheme was being implemented called the Federation QIPP scheme, which aimed to support GP Federations/Localities to take control of demand in their area and take steps to reduce expenditure for the CCG where possible, whilst ensuring patient care was an absolute priority. In terms of challenging spend processes had been established which automatically challenged the CCG providers on a monthly basis should it be felt that the level of expenditure was not accurate.
- Assumptions had been made in forecasting the level of spend in CHC, as the finance report stated that "continued to be a risk to the financial position" – CHC was a high risk area given the scale of fluctuation as a result of natural factors, for example, the number of people receiving CHC went up and down, and also the high, and variable cost of CHC packages of care. This meant the CCG could not be highly confident about the final level of spend for the year. The draft accounts that had been produced subsequent to the board meeting suggested that CHC spend estimates were still broadly in line with the expected forecast spend.

Mr Gay confirmed the CCG was confident the £4 million surplus had not been achieved at the expense of quality and every effort continued to achieve a high level of performance.

Dr Pulman referred to the challenge and spend aspect of UHL's activity and reported that work was being carried out by locality groups to develop good practice procedures and this was not always related to financial cuts.

It was RESOLVED to:

- **RECEIVE** the Finance Report – Month 11.

WL/17/072 Board Assurance Framework (BAF)

Public question: The report outlined a high number of risks and actions but did not provide a revised risk score after the mitigation and actions – could this be included in future?

Mr Chudasama presented paper E that had been reviewed and updated to show the latest position as at 31st March 2017. 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. Three risks had been removed from the BAF, all of which related to risks to the outcome of the Urgent Procurement, which had been completed, and two added that both related to the CCG's in-year financial position.

Mr Chudasama asked Board members if they still found that the BAF adequately captured the risks to the CCG objectives. Mr Gay said that he felt an additional risk should possibly included on the BAF in relation to the transfer of the Non Emergency Patient Transport Service from Arriva to Thames Ambulance Service later this year. He also felt the two significant risks on the matrix in relation to Ambulance Handover delays could be combined into one. Mr Sanders responded by saying these were actually two separate risks. He added it would be useful to relook at the ambulance risk as handover arrangements had improved significantly in the last few weeks and within that context it would be useful to compare it with ambulance performance. Dr Willmott said it would be useful to monitor the ambulance handover with the opening of the new ED facility and Ms Hooton added that UHL were conscious of the risk and were aware there might not be any immediate improvement.

Mr Gay felt many of the risks appeared to be static and perhaps a rigorous sub group review might move the position. There was a further potential risk on the PTS programme and mobilisation of the PTS target in terms of reputation and impact. Ms Hooton confirmed she had amended the Arriva and that would show on future BAFs. Mr Chudasama said risk registers were reviewed on a quarterly basis at sub groups and any that did not fit into obvious groups were added to the corporate risk register. Mr Harding explained risks were subject to challenge in the sub groups and sub group chairs were then invited to the audit committee and challenged again which made the control process work well. The risks that emerged on the BAF were the more serious ones.

Mrs Bright referred to risk 027 (threat to sustainability of GP workforce in terms of existing capacity and morale, retention and succession planning), and confirmed this would be updated to reflect the work of the GPFV and then be taken through PCCC for a more detailed review.

In respect of corporate risks Mr Chudasama reported that the corporate and contracting leads took those through contracting meetings across CCGs and PPAG and work continued to ensure these were actioned. Dr Cannon added that other groups existed that might be more appropriate to deal with some risks. He emphasised the importance of understanding risks and how they were transmitted through the operational groups and Board members should perhaps be more engaged on an operational basis.

Professor Lakhani queried whether a risk should be added around business

continuity as the CCG would be undergoing considerable change in the future. Mr Chudasama reassured Professor Lakhani this would be covered in the corporate risk register.

In respect of the public question Mr Chudasama said the Board had agreed on the current BAF format as the one that assisted most with understanding of risk, and the impact and what was being done. A decision had been made not to use multiple risk scores as it would make the process unwieldly and Board members were comfortable with that approach which they felt reduced complexity. **ALL**

Board members were invited to submit any comments or ideas following sub group meetings on how the BAF could be enhanced and these could be included in the next BAF iteration.

Following full discussion on any further actions required to address the risks, it was resolved to:

- **APPROVE** the latest iteration of the Board Assurance Framework
- **CONSIDERED** whether there are any areas of risk which are not currently captured or represented adequately on the BAF.

WL/17/073 360 Stakeholder Survey

Mr Chudasama presented paper F and explained that each year the CCG participated in the national 360 degree stakeholder survey, which allowed stakeholders to provide feedback on their working relationship with the CCG. Key points of note:

.

- In 2017 the survey was conducted by Ipsos Mori who contacted core CCG stakeholders from a database provided by the CCG. Fieldwork was conducted between 16 January 2017 and 28 February 2017, which was three months earlier than previous surveys.
- Appendix 1 was the main survey report received by the CCG which had not yet been comprehensively reviewed.
- 65 of the CCG's stakeholders completed the survey. The overall response rate was 77%.
- Slides 3, 4 and 5 gave a summary of the report. There was also a section outlining the overall views of relationships with stakeholders and a section for each of the main stakeholder groups who were invited to complete the survey. For some questions, data had been compared with the results from previous surveys, and averages from a cluster of CCGs, the region and nationally.
- The report would now be reviewed and used as a starting point to inform wider discussions internally and externally with regard to the CCG relationships with other stakeholders.
- The knowledge and learning from the survey would be used to develop an action plan to be discussed and approved by the Board, ensuring areas of good practice were capitalised on and improvements were made in areas of underperformance.

Mr Chudasama said a future TFS session would be used to look at the results in more detail and to develop the key issues into a focused action plan for implementation.

Mrs Barber said that overall the report showed a healthy approach to the way the CCG worked and it was interesting to see the split in answers from GP member practices on some of the questions, particularly around commissioning. She would also be interested to see a comparison with responses from the previous year.

Ms Adams commended the report and supported the suggestion of a TFS discussion. She would also be interested in taking forward some of the quality issues with Mrs Trevithick. She shared Mrs Barber's concerns around the responses from member practices and felt it would be worth an investigation around the risks associated with some of the responses. Mr Sanders made the following points:

1. In respect of a split in responses from member practices, 30 out of 48 responses had been received which meant a significant gap. The responses that indicated the CCG did not have the right priorities were worrying and it would be useful to understand this further. He highlighted the areas around leadership, appropriate skills, confidence and improved outcomes for patients.
2. Monitoring and acting on service quality issues were the areas he would be keen to pursue in a TFS session. Dr Trzcinski added that it would be important to get more member practice views but pointed out they might be influenced by the lack of investment in primary care and possibly a negative view of the NHS. Dr Cannon agreed with Dr Trzcinski's comments and the dissatisfaction portrayed would possibly be towards the CCG as part of the overall NHS. Practices did not always gain a sense that the CCG was appropriately representing them and did not know how successful the CCG was in the management of the large providers. Practices often found it difficult to differentiate between the various health service bodies.

With only one respondent from each practice Dr Barlow pointed out this was not covering the views from all the leaders which perhaps did not provide a true view.

Dr McHugh felt that any qualitative information should be used to demonstrate that leadership was clearly appreciated and that some of the implied criticisms derived from the CCG's efforts to work in difficult circumstances.

Dr Hanlon said the clinical locality leads had a job of developing a number of services such as integrated teams, urgent care and 7 day access and it would be important to consider how to approach some member practices from the perspective of the pressure they felt and how they might be supported.

Mrs Bright referred to last years survey and a discussion held on how the CCG could engage more with member practices rather than at locality meetings and she said this would be worthy of reflection. Dr Pulman agreed and added that the relationship between member practices and the Board was important and it would be worth considering more resources for locality meetings.

Mr Chudasama confirmed to Mr Churton that further detailed information was available from the survey results and it would be useful to identify some areas to major on for the TFS session. MLCSU might be in a position to contribute towards ideas around engagement, with an aim of re-energising local areas of work. For GPs who did not attend locality meetings PLT sessions were a good method of communication specifically around service redesign. **KC**

Mrs Barber said that in her view it was quite clear communication with practices was an issue. Professor Lakhani said one of the main ways practices interfaced with different bodies was through federations whereas prior to that the relationship was directly with the CCG.

Following a full discussion it was RESOLVED to

- **RECEIVE** the report
- **AGREE** the next steps and action to take the learning from the survey and develop an action plan.

WL/17/074 Audit Committee Terms of Reference

Public question – could the public attend and could this be included in the terms of reference?

Mr Chudasama presented paper G and reported that in accordance with the CCG Constitution, the audit committee terms of reference had been reviewed as part of the annual review process. These were last reviewed by the committee in January 2016, and changes reflected the need to include the Auditor Panel arrangements for the appointment of the CCG's external auditor from 2017.

The Audit Committee subsequently reviewed its Terms of Reference in November 2016 and agreed some minor changes to section 7 (external audit) that reflected the fact that the Audit Commission no longer had responsibility for the appointment of the CCG's auditor, and that from 2017/18 financial year, the appointment of the external auditor would be made by the CCG's governing body. Subsequent to that decision a minor amendment had also been proposed to section 8.4 which clarified the name of the 'New Committee' referred to as being the Procurement and Investment Committee. This followed feedback from the internal auditor who suggested this clarification would be helpful.

The changes were highlighted in tracked changes in the version of the Terms of Reference attached to the report as Appendix 1. No changes had been made to any other sections.

It was RESOLVED to

- **APPROVE** the Audit Committee Terms of Reference.

WL/17/075 Update from Remuneration Committee held on 27 March 2017

Public question – in light of the financial position of the CCG would the CCG be recommending a 1% pay increase for the MD?

All CMT members declared an interest and Mr Sanders left the room.

Mr Churton presented paper H that provided an overview of the discussions of the Committee and considered the following items:

- The Terms of Dr Jackson's Sabbatical
- Succession Planning for Senior Roles
- Remuneration of MD – the Remuneration Committee considered previous reviews, the revised contract in 2015/16 and the wider remuneration landscape for public sector workers, the nature of the role, his specific STP responsibilities and wider LLR health economy responsibilities and the remuneration of other CCG staff and potential uplifts.

Mr Chudasama confirmed to Dr Pulman that it was not known what decision the other two CCGs had made with respect to their MD's remuneration. Mr Gay added the increase would be in line with other senior NHS managers and should be awarded despite his additional responsibilities.

It was RESOLVED to

- **NOTE** the report of the Remuneration Committee and the decisions

reached regarding Dr Jackson's sabbatical.

- **APPROVE** the recommendation of the Committee regarding a 1% increase in the remuneration of the Managing Director from 1st April 2017.

WL/17/076 Report from Quality and Performance Sub Group

Ms Adams presented paper I that identified the key quality and patient safety concerns from the WLCCG Quality and Performance Sub-Group meeting held in March 2017 and also informed the Board of quality developments that included the following key points:

Enter and View Healthwatch Visit to 4 UCC's - Healthwatch conducted Enter and View visits to 4 of the LLR UCC's in Leicestershire (Loughborough, Oadby, Market Harborough and Melton Mowbray). The findings had been discussed with the providers who were able to provide clarity on some of the observations to Healthwatch, and individual recommendations were made to each UCC. The findings would be picked up by the Quality Contracting Teams.

Self-Care - In the absence of a national framework on self-care and purchasing over the counter (OTC) medicines, difficulties arose with boundary mapping and the inclusivity of WLCCG patients. A self-care agenda for OTC medicines was promoted on the basis of short term self-limiting illnesses aligned with the advice on NHS choices on line. Having a "common theme" would help with implementation; and sign post patients in the first instance to community pharmacists. It would also minimise the potential for OTC drugs to be used inappropriately on a long term basis potentially causing patient harm; ensured that chronic therapy was recorded in the patient notes, and minimised the risk of serious underlying medical problems going undetected. The recommended approach to self-care and purchasing of OTC medicines was approved by the Quality and Performance Sub-Committee.

Dr Hanlon said he would welcome any support for GPs in the implementation of the prescribing changes. Board members noted the Department of Health was introducing their own plans for OTC products and this would hopefully align with WLCCG via the NHS Choices website. Ms Adams suggested a communication to GPs might be helpful as the scheme was less about costs and more about the reduction in consultations and the promotion of self-care. **CTrev**

Mrs Barber asked if there was any intention of linking into the Vanguards for self-care that linked to the GPFV and it was agreed to ask Mrs Stead, Head of Prescribing, for a response. **CTrev**

Infection Prevention and Control – Colleagues within LLR planned to work as a whole health and social care economy on reducing the risk of multi-resistant organisms entering and spreading within LLR by agreeing and implementing the mechanisms identified within the LLR Infection Prevention Strategy 2016-18. The Quality and Performance Sub-Committee approved the LLR Infection Prevention Strategy 2016 – 2018.

It was RESOLVED to

- **RECEIVE** the report from the Quality and Performance Sub Group.

WL/17/077 Summary of CQC report following inspection of Leicestershire Partnership Trust

Mrs Trevithick presented paper J that was published on 26 February 2017, with the trust rated as Requiring Improvement. Requirement notices were issued against 7

regulations:

- Person Centred Care
- Dignity & Respect
- Need for Consent
- Safe Care and Treatment
- Premises and Equipment
- Good Governance
- Staffing

Board members noted that CAMHS inpatients and community learning disabilities services were rated as 'good' overall. However the CQC had rated the Community Child and Adolescent Mental Health Services as 'inadequate' as a result of two areas of focus – safety and responsiveness, with significant areas for improvement in the community teams. Key themes were:

- Risk assessments and care plans were not always in place or updated whilst young people were waiting for treatment.
- Medical devices were out of date for calibration, so accuracy of health checks was not assured.
- Large number of young people awaiting treatment and lengths were up to 108 weeks for certain treatments.
- Hazardous cleaning materials not kept safely.

In terms of next steps Mrs Trevithick informed the Board that the LPT Quality Summit took place on 16th February 2017 with attendance from commissioners and stakeholders. As a result LPT would develop an Action Plan in response to the findings which would be shared with commissioners. The CQC Action plan was a standing agenda item at CQRG, and LPT would submit a self-regulation report as part of the quality improvement process.

Board members noted a key focus of the summit was to progress improvements within the Community CAMHs services and commissioners would be working with LPT to support the improvement. The Trust held a CAMHS Recovery and Improvement Summit on 17th March with attendance from commissioners in order to outline improvement plans and discuss and challenge remedial actions. LPT had established a recovery and improvement team to oversee the improvement and transformation plan. LPT had entered partnership working with a NHS Trust rated 'outstanding' by CQC in order to actively engage and learn in order to improve.

In respect of community health services and bed occupancy which was running at 95%, above the national recommendation of 85%, Mrs Trevithick said it would be important to consider occupancy of community health service beds in relation to the bed bridge situation and Ms Hooton added that occupancy rates should be consistent between the acute and community to ensure a better opportunity for planned discharge arrangements.

It was RESOLVED to

- **RECEIVE** the report.

WL/17/078 Assurance report from the Provider Performance Assurance Group (PPAG) meeting on 16 March 2017

Mr Harding presented paper K, a report PPAG, a meeting held in common of the 3 Leicester, Leicestershire and Rutland CCGs, providing Board members with

assurance about the arrangements in place to collaboratively monitor the contracts and performance of the CCG key providers.

PPAG received a presentation on UHL performance in the form of an in depth review. Some optimism was expressed by the Contract Square regarding UHL's plans and projections, however this was not shared by PPAG members. The overall approach by the Contract Square was recognised as candid and thorough. PPAG had agreed to re-review three particular areas of concern in 3-4 months:

- Non elective activity, currently below target.
- 31 day cancer backlog.
- RTT standards backlog.

Mr Harding reported that:

- PPAG members were informed that the Arriva contract had been extended for 3 months to allow for safe mobilisation to the new provider. It was noted that there were less contractual levers during the extension and that management of the remaining contract would be maximised with a robust process of challenges in respect of performance, activity and cost.
- In respect of Continuing Healthcare – the Contracts Team highlighted a number of risks that continued to be managed with the current provider, Arden and GEM CSU, while the transition took place to the new provider Midlands and Lancashire CSU. These included Arden and GEM CSU's inability to process all CHC applications in line with the National Framework.

It was RESOLVED to

- **RECEIVE** the Assurance report from PPAG.

WL/17/079 Next Steps on the National 5 Year Forward View

Mr Sanders presented paper L that outlined the key points in the NHS England Publication Next Steps on the NHS Five Year Forward View. The document reviewed the progress made since the launch of the NHS Five Year Forward View in October 2014 and set out a series of practical and realistic steps for the NHS to deliver a better, more joined-up and more responsive NHS in England.

Mr Sanders made two points:

- A significant reinforcement around the expectations for collaborative system working and a huge focus around the need for close working between commissioners and providers.
- A pragmatic recognition of the need to make appropriate choices and trade-offs within a constrained environment; the details of which had still to be clarified.

Hard copies of the document were available on request.

It was RESOLVED to

- **RECEIVE** the Next Steps on the National 5 Year Forward View.

WL/17/080 Better Care Fund Plan 2017-18 – 2018-19

All GPs and Dr McHugh declared an interest.

Mrs Davenport presented paper M that outlined the work to prepare the Better Care Fund (BCF) Plan for 2017/18 – 2018/19 which was nearing its conclusion in

Leicestershire. The report provided an update on the following:

- The additional social care allocation announced by the government in the March Budget.
- The grant conditions issued to local authorities in respect of the allocation.
- The publication of the integration and BCF policy framework for 2017/18 – 2018/19. Technical guidance remained outstanding at present.
- How the Leicestershire BCF spending plan and Leicestershire BCF submission were being updated to take account of the BCF policy framework and the additional social care allocation.
- The process and timetable for submitting BCF plans to NHS England, for regional and national assurance.

A meeting was planned with partners for 21st April to go through the proposed areas of investment for the additional social care allocation in more depth, and there had also been engagement with the A&E Delivery Board on April 5th. Mrs Davenport would be attending the WLCGG Finance and Planning meeting in April for a final update. Three categories of spend were under consideration:

1. Existing priorities for adult social care, per the LCC adult social care strategy
2. Improvement to hospital discharge and DTOC
3. Programme management and other support for specific LLR STP workstreams, primarily Home First

At present there was no submission date to NHS England for the full BCF plan as technical guidance is still pending.

Mr Sanders commented that some Board members had been already been directly involved in the BCF planning, and he asked if there was anything the CCG could do internally to ensure that F&P discussions were as valuable and meaningful as possible. Mrs Bright added that a meeting had been held with Mr Wilson where the initial details of the ASC allocation had been scrutinised line by line, that should help with F&P discussions and give people sufficient opportunity to consider the different areas being put forward. She said the CCG had already provided significant feedback and the local authority should be commended for their work on the better care fund as they had provided a clear breakdown of how the money was being spent.

Ms Hooton said she had commented on the BCF through the item at the A&E Delivery Board. She asked how the local authority was planning to set targets and monitor arrangements for BCF metrics. Mrs Davenport replied that analytical work had been undertaken as part of the BCF refresh process and a number of meetings had been held to go through the assumptions around the targets for 2017/18.

In respect of anticipated improvements in DTOC Mrs Davenport said account was being taken of where performance had been previously good and needed to be made sustainable and options had been discussed at the integration executive around percentage level improvements for the target for 2017/18. There would need to be a further sense check of the DTOC target once the additional investments being outlined had been agreed, and the technical guidance was published.

Mr Wilson informed the Board the important thing was to identify sustainable improvement rather than the establishment of unachievable targets or placing undue pressure on services, and a number of processes were already coming on

stream in the current year to support that. Ms Hooton felt it would be helpful to recognise some of the factors that affected DTOC on an LLR basis.

Mrs Barber said she would be interested in more detail behind the 4 key areas and what the differential was between them in terms of proportionate spend and where the greatest impact was demonstrated around the production of outcomes. Mrs Davenport replied the Integration Executive had scrutinised a more detailed spreadsheet against a number of outcomes. The impact on DTOC had been identified by the mapping against the 8 national high impact changes for example.

Mrs Barber asked how the forthcoming local elections would impact on the results and Mr Wilson confirmed final approval of the BCF plan would not be until after the local elections.

Mrs Davenport confirmed that no public engagement would be take place around the new adult social care allocation due to the short timescales involved in responding to this additional national requirement, but the BCF plan/submission will be considered by the Health and Wellbeing Board, a meeting held in public, at their next meeting in June, which will include assurance on the adult social care allocation components.

It was RESOLVED to

- **RECEIVE** the Better Care Fund Plan 2017/18 – 2018/19.

WL/17/081 Areas of Focus for Future Board Meetings

Professor Lakhani advised that any suggested areas of focus for future Board meetings should be directed to Mr Chudasama, with a draft iteration of the agenda for the next circulated to members to review.

WL/17/082 Performance Report

Members received for information, paper N, the Performance Report.

WL/17/083 Minutes of the Primary Care Commissioning Committee held on 16 February 2017

Members received for information, Paper O, the minutes of the Primary Care Commissioning Committee held on 16 February 2017.

WL/17/084 Minutes of the Quality and Performance Sub-group held on 21 February 2017

Members received for information, Paper P, the minutes of the Quality and Performance Sub-group held on 21 February 2017.

WL/17/085 Minutes of the Audit Committee held on 17 January 2017

Members received for information, paper Q, the minutes of the Audit Committee held on 17 January 2017.

WL/17/086 Any Other Business

No other business.

WL/17/087 Date and Time of Next Meeting

The next meeting of the West Leicestershire Clinical Commissioning Group will be

Held on Tuesday 9 May 2017, 13.30 at WLCCG Headquarters, Woodgate, Loughborough, Leicestershire LE11 2TZ.

NHS
West Leicestershire
Clinical Commissioning Group

CCG Headquarters
55 Woodgate
Loughborough
Leicestershire
LE11 2TZ

Tel: 01509 567 700
Fax: 01509 567 792

RE: Questions for the Board from Mr Paul McKay – March 2017

Question 1: *Paper C. The government recently announced additional funding in the Budget. Why is this not included in the National update and what plans does the CCG have to improve performance and spend the monies?*

Response to Q1: This question was put to the Board on 14th March and the response is reflected in the minutes. For your reference, the Government announcement was made on the same day as the papers were despatched which is why it was not included.

Question 2: *Paper D. The paper recommends the decommissioning of three services; Carers Health and Wellbeing Service, Local Area Coordination, Supporting Leicestershire. Why is there no accompanying EIA? Can the CCG make this decision without an EIA? What will be the impact on the public if these services are decommissioned? What other options were considered? How is the decision to cease the carers support in line with the Care Act?*

Response to Q2: This question was briefly put to the Board on 14th March and the response is reflected in the minutes. Further comments have been added by our Head of Governance.

Paper D presented the planned allocation of resources for the Better Care Fund for 2017/18, which brings together health and social care services. The fund is a pooled budget put in place to support improvements in the integration of health and care services. Leicestershire County Council will be undertaking an Equalities Impact Assessment on the Full Better Care Fund, to ensure the schemes and fund are considered as a whole.

As part of the planning for 2017-18, the funding of all the schemes funded by the Better Care Fund was reviewed. The Local Area Coordination Scheme and the Supporting Leicestershire Families scheme have not been decommissioned, but the funding for the schemes has changed, with these services being funded by Leicestershire County Council for 2017/18.

The funding for the Carers Health and Wellbeing Service was removed. This service was additional to the support funded by the local authority through the Support for Carers service which offers care and support as well as urging carers to have an assessment to see if they are eligible to claim allowances or other support. Staff working in general practice will still be able to refer carers to the service

through the county council's First Contact Plus, which offers access to a wide range of community-based support.

Local authorities have an ongoing duty to support carers under the Care Act and this duty would be maintained. The Carers Health and Wellbeing was additional to that provided by the local authorities and was commissioned by the CCGs. Existing local authority advice and assessment support to carers will continue and there will be some redesign in the next year within the Home First work stream of the STP where the new national carers strategy would be taken into consideration.

Question 3: *Paper E. What is the CCG doing to improve the monitoring the 104 day waiters and how does this compare to other CCGs in Leicestershire? What is the CCG doing to follow up the requirements to involve GPs with patients who had waited over 62 days and how many patients are waiting? What is the target the CCG is aiming for? Can the CCG confirm its commitment that there shouldn't be anyone waiting this long?*

Response to Q3: UHL (University Hospitals of Leicester NHS Trust) provide the CCG with an anonymised list of all patients waiting over 104 days on a weekly basis; this includes length of wait and reason for the delay. There are currently 7 patients across the whole of Leicester, Leicestershire and Rutland (LLR) who have been waiting over 104 days for treatment. Each of these patients has complex health problems which require a co-ordinated plan of care to prioritise treatment enabling the most effective outcome. As the report presented to the Board detailed, UHL performance is on par with other comparable sized organisations with the Public Health demographics evidencing that the City is an outlier for contributory factors such as BMI, smoking and ethnicity.

Across LLR there are 49 patients who have been waiting over 62 days for treatment. As for all patients attending UHL for an outpatient's appointment, the hospital sends update letters to GP's when treatment or medication has been changed or delayed. Recently, following concerns from GP's, the CCG have tasked the cancer centre team within UHL to review their processes ensuring that this is being adhered to and that the letter provides sufficient details for the GP to support the patient.

It is very difficult to put a target on something like this. The ideal would be to have no patient waits for treatment, however this is not realistic as we need to provide patients with choice; for example, some patients who are symptom free may choose to delay chemotherapy until after a holiday or when their condition changes. As mentioned previously, some patients have very complex health issues which require treatment before their body is fit enough to cope with the chemotherapy or radiology. For this reason, the CCG does not monitor an absolute target but reviews causes of delays for all patients waiting over 62 days and will challenge the Trust if these delays are due to process or system issues.

We would like to assure you that the CCG takes waiting times for all treatment very seriously and we meet with the Trust on a monthly basis to review all performance data. For cancer services we have additional meetings and reporting structures in place in order to allow a more intensive monitoring of performance and timely challenge should there be any concerns.

Question 4: *Paper F. When will patients be able to access urgent and on the day services seven days per week? What is the CCG doing to improve access to GPs which is considerably lower as the report highlights to the England average? Can the CCG clarify what is meant by "Practices will work collaboratively, and there will be full integration with community and social care services". The national evidence is that integration does not improve outcomes or deliver efficiencies. Why does the CCG support this? What mitigation is in place to deal with the hugest risk that demand for primary care will increase due to an ageing population, demographic change, and use of services?*

Response to Q4: The CCG works with member practices to support them to review access to their services, and more specifically to review their demand and capacity levels on a regular basis. Where practices identify gaps in capacity, they are encouraged to consider and implement actions that could realise an increase in access to a health care professional, and to communicate any resultant changes to their patients in a timely manner.

An important element of our future model is the provision of integrated services between health and social care. This is particularly important when commissioning care and services for patients in areas such as residential care, learning disabilities, mental health, and prevention services and in the development of community teams supporting people at home with long-term illnesses. This will not see the formal merger of teams, but will bring existing services together to work closely at a local level, and across Leicester, Leicestershire and Rutland, with local authority partners.

Another strand of the STP is the future sustainability of primary care and GP services. This is being addressed through our General Practice Five Year Forward View. The Board considered the latest version of this plan at its meeting in March, please see http://www.westleicestershireccg.nhs.uk/sites/default/files/Paper%20F%20-%20General%20Practice%205%20Year%20Forward%20View.combined_0.pdf.

Question 5: *Paper G. What is the CCG doing to improve Dementia Diagnosis? Does the CCG agree that the performance for cancer waiting times needs urgently addressing and when will the national target be met? When will the CCG move to an extended hours and 7 day service to improve primary access, reduce demand on A&E and the 4 hour wait? When will performance improve?*

Response to Q5: This question was put to the Board on 14th March and the response is reflected in the minutes. For your reference, WLCCG is only just falling short of the target for dementia diagnosis and further discussion will be held at the locality meetings. In regards to cancer, there needs to be stability in the overall performance before the CCG can commit to hitting a target on a sustainable basis.

Please see the Five Year Plan at http://www.westleicestershireccg.nhs.uk/sites/default/files/Paper%20E%20-%20Draft%20STP.combined.pdf which answers the remainder of your queries on this issue.

Question 6: *Paper H Can the CCG confirm its performance against the key targets as outlined in the paper? Why isn't this covered in the performance report and what is the CCG doing to improve access (section 7)?*

Response to Q6: Performance against key targets is available in Paper G at http://www.westleicestershireccg.nhs.uk/sites/default/files/Paper%20G%20%20-%20WL%20Performance%20Report%20March%2017%20KC%20comments_0.pdf which also includes action points.

Question 7: *Paper I. Will the CCG meet the QUIPP target in 2016/17?*
How confident is the CCG in meeting the target for 2017/18 of c£18.1m? What are the key plans in place and what are the impacts on the public? Why is there a change of £500k on the December submission? Is the QUIPP target £15.5m for 2018/19 realistic?

Response to Q7: This question was put to the Board on 14th March and the response is reflected in the minutes. For your reference, we have also included the response below.

WLCCG will fall short by £3.5m against the target of c£15m for QIPP in 2016/17. There had been non-recurrent schemes included which meant that the target for the forthcoming financial year was even

more challenging. There is some degree of confidence that the CCG will meet the target for 17/18 and there has been discussions regarding the significant risks that will be faced.

The major financial risk within the plan was the delivery of the unprecedented levels of QIPP across the two financial years. The forecasted level of delivery for 2016/17 was c£11m; the target for 2017/18 was c£18.1M (a change of £500k on the December submission) and £15.5m for 2018/19.

The QIPP target for 2018/19 is dependent on the delivery in 2017/18.

Question 8: *Paper J. Regarding the prescribing target can the CCG clarify if the further £1.6m that is anticipated is by the end of this month?*

Response to Q8: Please see the finance report for month 9 which is available on our website. We will have a full picture of our financial position in the weeks following year end.

Question 9: *Paper K. Can the CGG give an update on the care taking issues and give reassurance to the public that he risk is being managed? Re on the day access? Can the CCG confirm that extended hours are now in place in the GP practices and what improvements has there been in waiting times? The last meeting was 16/2. Why are the notes of the meeting not included in the Boards?*

Response to Q9: In relation to your query regarding provision of caretaking arrangements, the CCG has successfully commissioned a new provider to delivery primary medical services at Centre Surgery. The mobilisation phase ran smoothly and staff are transitioning well in to the new service.

Regarding on the day access, the CCG commissioned an On the Day Access service from all member practices in 2016/17, which they delivered between December 2016 and February 2017. This realised an additional appointment capacity over the winter period of 1589 appointments each week with a GP or nurse.

Through its delegated commissioning arrangements, the CCG commissions extended hours provision from a number of practices, who are at liberty to determine the days and times at which they offer extended hours appointments. There is no requirement for practices to submit audits in relation to the impact upon waiting times, although the CCG encourages practices to undertake local surveys independently of the national PES (patient experience survey), with the support of their PPG, to understand local impact.

The minutes of the Primary Care CoCommissioning Committee (PCCC) are provided to the board once they have been approved by the committee. As the March meeting of the PCCC did not take place until 16 March, the approved minutes for the February meeting will be provided to the April meeting of the Board.

NHS
West Leicestershire
Clinical Commissioning Group

CCG Headquarters
55 Woodgate
Loughborough
Leicestershire
LE11 2TZ

Tel: 01509 567 700
Fax: 01509 567 792

RE: Questions for the Board (April) from Mr Paul McKay

Thank you for your emails, received by West Leicestershire CCG on Tuesday 11th April regarding your questions to the Board.

We are sorry to hear of your concerns regarding the previous questions that you have raised. We would like to assure you that all questions received on Tuesday 11th April, and all questions received prior to this date, were shared with the Board in full, with each member being provided with a hard copy of the full list of questions that were raised by members of the public in relation to the papers being considered at the public Board meeting. However, to ensure that the Board is able to address the matters for consideration at each meeting, not all of your questions can be addressed during the meeting.

When we respond to certain queries in writing, these questions are responded to by officers rather than Board members as they understand the background and detail to the areas where you have raised questions. These responses are then reviewed and signed off by a member of the Board – Ket Chudasama.

Furthermore, we are sorry that you feel that not all of your questions were responded to, in particular your query of why an EIA was not provided (Paper D). However, we note from our previous response to the questions you raised in relation to the papers for consideration at our March Board meeting, that we explained that Leicestershire County Council would be '*undertaking an Equalities Impact Assessment on the Full Better Care Fund, to ensure the schemes and fund are considered as a whole'*. This EIA will cover the service being decommissioned which you have previously highlighted as well as the continuing services. Please refer to our previous response for further information.

We will ensure that the written responses to your previous queries are published with the Board papers in May.

I trust that I have addressed all of your concerns above. Please find below the responses to your recent queries addressed to the April Board.

Question 1: *Paper C. In the same way as the Centre Practice can the Managing Director provide assurance regarding the availability of GPs in Broughton Astley particularly given the high number of new houses? Will the CCG be writing to residents in Broughton Astley?*

Response to Q1: The reference to Centre Surgery reflects the outcome of recent work required to

procure and mobilise a new provider, after the previous contract holders for services at this surgery indicated that they no longer wished to continue to provide these services. This has resulted in a new provider taking on this service, and we wrote to all patients to inform them of this, and to assure them of the continuity of services at the Centre Surgery. Further, we will undertake a local consultation process regarding future provision to inform our future commissioning of local primary care services for patients currently using services at Centre Surgery. There are no current plans to write to residents in Broughton Astley as there are no changes in provision anticipated at your local GP Practice.

Question 2: *Paper D. Can the CCG outline particularly in relation to non-elective activity and GP referrals what work is being done to address this overspend and challenge spend? Is the CCG confident that the surplus of £4m will be achieved and given the poor performance in a number of indicators in the performance report is the surplus at the expense of quality? What assumptions are being made about CHC and how confident is the CCG about this?*

Response to Q2: Many of the CCG's QIPP plans for 16/17 and 17/18 financial years are focussed on aiming to reduce acute demand where appropriate. In 2017/18 in particular we are implementing a new targeted scheme called the Federation QIPP scheme, which aims to support GP Federations/Localities to take control of demand in their area and take steps to reduce expenditure for the CCG where possible, whilst ensuring patient care is an absolute priority. In terms of challenging spend we have processes in place which automatically challenge our providers on a monthly basis should we feel that the level of expenditure is not accurate.

The surplus of £4m has not arisen from reduced or removed funding for services or in a way which would have been to the detriment of quality. The CCG remains committed to meeting it constitutional performance standards .

Many assumptions have been made in forecasting the level of spend in CHC, as the finance report states this "continues to be a risk to the financial position" – CHC is a high risk area given the scale of fluctuation as a result of natural factors, i.e. the number of people receiving CHC goes up and down, and also the high (and variable) cost of CHC packages of care. As you can imagine, this means the CCG cannot be highly confident about the final level of spend for the year. Our draft accounts which have been produced subsequent to the board meeting suggest that CHC spend estimates are still broadly in line with the expected forecast spend.

Question 3: *Paper E. The report outlines a high number of risks and actions but doesn't provide a revised risk score after the mitigation and actions can this be included in future? Why has the risk of ambulances being unable to attend in a timely manner increased? What is being done to urgently address this? What assurance can the CCG provide patients?*

Response to Q3: The Board Assurance Framework shows the risk scores post mitigation – it has been a decision of the CCG Board to not show inherent and residual risk scores, and we are comfortable with this approach, which is also reviewed by our internal auditors. A decision has been made not to use multiple risk scores as they would make the process unwieldy and add an unnecessary complexity. Therefore, we do not anticipate amending the format as you suggest.

In relation to the specific query you raise regarding ambulance handovers, in April UHL opened a new Emergency Department floor which is expected to improve capacity and handover. This will be captured as an action and mitigation in the risk register.

Question 4: *Paper F. What is the CCG doing to work with local groups which has seen a significant drop to 69% from 86% previously Quality is 58% and communication is 60% what is the CCG doing to address this and is the CCG disappointed that over a third of respondents feel that the CCG does not act upon what it is told by patients and the public. Nearly a half of respondents thought that the CCG didn't have the right priorities. Would the CCG comment?*

Response to Q4: The survey was sent to stakeholders of the CCG such as GP member practices, Health & Wellbeing Boards, local Healthwatch, other CCGs, NHS providers, local authorities and other patient groups. As a CCG, we are above average in 26 out of 27 questions, the largest recent increase of which is in respect of system leadership. We will be doing further work in a future Board development session on how we can use these results and what action we should be taking and the focus of this discussion will be centred on the feedback from our member practices. The issues raised in the survey regarding quality will be looked at by the Quality & Performance Committee in a future meeting.

Question 5: *Paper G. Can the public attend? Can this be included in the ToR?*

Response to Q5: No – the audit committee is not a public meeting. This is to ensure that it is able to function effectively and scrutinise issues in confidence where required. Therefore, we will not be amending the Terms of Reference to allow members of the public to attend meetings of the CCG's Audit Committee.

Question 6: *Paper H. In light of the financial position of the CCG will the CCG be recommending a 1% pay increase for the MD?*

Response to Q6: Yes, the Board approved an increase of 1% to the salary paid to the Managing Director at its meeting in April. In reaching this decision the Board considered a number of factors, including those set out in the paper, the national decision to award a 1% uplift to NHS staff on Agenda for Change terms and the additional responsibilities he was exercising on behalf of the system as lead for the LLR STP (Leicester, Leicestershire & Rutland Sustainability & Transformation Plan).

Question 7: *Paper I. In light of comments what is the CCG doing to increase awareness of the NHS app and 111?*

Response to Q7: WLCCG is working with other CCGs and all providers of services working in Leicester, Leicestershire and Lancashire. WLCCG undertakes a range of marketing activities to ensure that people are aware of NHS 111. We ensure that this work is evidenced based and that it is targeting those patients who could be more appropriately referred and cared for through the NHS 111 service rather than using emergency departments. The channels of communications include, but are not limited to, social media, press and print media, public relations and direct mail. We also work extensively with health and care staff and the voluntary and community sector who support the delivery of key messages around the urgent care system.

Question 8: *Paper L. What is the CCG doing to implement 7 days a week GP access? What are the 3 key actions the CCG is doing in helping frail and older people stay healthy and independent. Given the 360 feedback will the CCG listen and ask patients.*

Response to Q8: The GPFV (General Practice Forward View) requires WLCCG, from April 2018, to provide access to pre-bookable and same day appointments to general practice services in evenings, (after 6.30pm), and weekend access to pre-bookable and same day appointments on both Saturday and Sundays to meet local population needs.

NHSE (NHS England) require robust evidence base on utilisation rates, for the proposed distribution of services throughout the week. They indicate that services can be provided on a hub basis with practices working at scale. This year, 2017/18, WLCCG will be developing, implementing and

evaluating a test bed for extended primary care access to develop a model for implementation in 2018/19 (when NHSE funding becomes available). This test bed will reflect and build on the numerous initiatives that WLCCG already has in place to improve access to primary care services.

In order to support frail and older people to stay healthy and independent, we are introducing a range of initiatives. These include the introduction of Integrated Locality Teams which will extend the care and support a patient receives from their GP in a community setting delivered through a multi-disciplinary team consisting of both health and social care. A key focus of this service with be to support all adults with a frailty, regardless of age, but related to impaired function. We are also working with the health economy to introduce a 'Home First' model. The model works on the basis that all teams and individuals, whether in secondary, community or primary care will ask "Why is this patient not at home?" or "How best can we keep them at home". Whilst not exclusively focused on frail and older people, this group of patients will be a key focus. During 2017/18 and 2018/19 we will also be undertaking work to provide integrated community based specialist rehabilitation service for stroke survivors and those with long term neurological conditions linking health, social care and the voluntary sector in addressing patient's needs.

We have a wide range of methods to reach out to people to ensure that we can access as wide a range of communities as possible, including those people with protected characteristic, listening to their experience. These methods include research using the Experience Led Commissioning methodology, a Listening Booth which we set up at a variety of community events, Mystery Shopping, Patient Participation Groups at practice and organisation level, outreach work in the community particularly with voluntary and community organisations, events, online surveys and social media. The experiences and insights that we receive from all these activities influences the design of services and ensures that more person-centred services are delivered.

Question 9: *Paper M. Point 24. Will the public have an opportunity to comment on the CCGs position in relation to the social care spend? Will a paper be tabled at the governance meeting and will this be available?*

Response to Q9: The additional funding is a grant to the Local Authority, and Leicestershire County Council therefore will be responsible for the final approval of the use of these funds. Following joint working between Health and Social Care, a number of priority areas have been identified – set out at paragraph 23 of the paper. A further workshop will be held with partners in Health and Social Care to consider these during April. The proposals will be considered at the next meeting of our Finance & Planning Committee – this meeting is not open to the public and as such the paper will not be made publically available. However, the final Better Care Fund plan will be presented to the Health & Wellbeing Board meeting in June, which will be a public meeting.

Question 10: *Paper N. Cancer performance is still not hitting the targets. Can an independent audit be undertaken to consider what actions are needed! IPAT performance is poor. Has national data been received for Feb and March? Has the social media app for MH been "opened up" and why has this taken so long and why has it not been done before?*

Response to Q10: Paper N was provided to the Board for information only and therefore your queries were not raised at the Board meeting.

The Quality Surveillance Team (previously known as the National Peer Review Programme) have visited UHL and the CCGs and their recommendations have informed the overall Cancer Action Plan.

No national data has been received for February or March. The social media app for mental health has always been open for individuals who are suitable and referred in. The app is also used as an intervention whilst waiting for other treatment.