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Leeds CITY COUNCIL

SCRUTINY BOARD (ADULT SOCIAL SERVICES, PUBLIC HEALTH, NHS)

Meeting to be held in Civic Hall, Leeds, LS1 1UR on Tuesday, 24th November, 2015 at 2.00 pm

(A pre-meeting will take place for ALL Members of the Board at 1.30 p.m.)

MEMBERSHIP

Councillors

C Anderson	Adel and Wharfedale;
B Flynn	Adel and Wharfedale;
P Gruen (Chair)	Cross Gates and Whinmoor;
A Hussain	Gipton and Harehills;
G Hussain	Roundhay;
S Lay	Otley and Yeadon;
C Macniven	Roundhay;
B Selby	Killingbeck and Seacroft;
A Smart	Armley;
E Taylor	Chapel Allerton;
S Varley	Morley South;

Co-opted Member (Non-voting)

Dr J Beal - Healthwatch Leeds

Richard Taylor - Healthwatch Leeds

Please note: Certain or all items on this agenda may be recorded

Agenda compiled by:
Steven Courtney
Scrutiny Support Unit
Tel: 24 74707

Principal Scrutiny Adviser:
Steven Courtney
Tel: 24 74707

A G E N D A

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1			**APPEALS AGAINST REFUSAL OF INSPECTION OF DOCUMENTS** To consider any appeals in accordance with Procedure Rule 25* of the Access to Information Procedure Rules (in the event of an Appeal the press and public will be excluded). (* In accordance with Procedure Rule 25, notice of an appeal must be received in writing by the Head of Governance Services at least 24 hours before the meeting).	
2			**EXEMPT INFORMATION - POSSIBLE EXCLUSION OF THE PRESS AND PUBLIC** 1 To highlight reports or appendices which officers have identified as containing exempt information, and where officers consider that the public interest in maintaining the exemption outweighs the public interest in disclosing the information, for the reasons outlined in the report. 2 To consider whether or not to accept the officers recommendation in respect of the above information. 3 If so, to formally pass the following resolution:- **RESOLVED –** That the press and public be excluded from the meeting during consideration of the following parts of the agenda designated as containing exempt information on the grounds that it is likely, in view of the nature of the business to be transacted or the nature of the proceedings, that if members of the press and public were present there would be disclosure to them of exempt information, as follows: **No exempt items have been identified.**	

Item No	Ward/Equal Opportunities	Item Not Open		Page No
3			**LATE ITEMS** To identify items which have been admitted to the agenda by the Chair for consideration. (The special circumstances shall be specified in the minutes.)	
4			**DECLARATION OF DISCLOSABLE PECUNIARY INTERESTS** To disclose or draw attention to any disclosable pecuniary interests for the purposes of Section 31 of the Localism Act 2011 and paragraphs 13-16 of the Members' Code of Conduct.	
5			**APOLOGIES FOR ABSENCE AND NOTIFICATION OF SUBSTITUTES** To receive any apologies for absence and notification of substitutes.	
6			**MINUTES - 20 OCTOBER 2015** To confirm as a correct record, the minutes of the meeting held on 20 October 2015.	1 - 14
7			**MINUTES OF EXECUTIVE BOARD** To receive for information purposes the minutes of the Executive Board meeting held on 21 October 2015.	15 - 32
8			**CHAIR'S UPDATE** To receive an update from the Chair on scrutiny activity, not specifically included on this agenda, since the previous Board meeting.	33 - 34

Item No	Ward/Equal Opportunities	Item Not Open		Page No
9			**CARE QUALITY COMMISSION INSPECTION OUTCOMES** To consider a report from the Head of Scrutiny and Member Development presenting a summary of Care Quality Commission (CQC) inspection reports relating to Health and Social Care organisations within the Leeds boundary.	35 - 118
10			**CHARGING FOR NON-RESIDENTIAL ADULT SOCIAL CARE SERVICES** To consider a report from the Director of Adult Social Services outlining the main aspects of the consultation currently underway on charging for non-residential Adult Social Care services and inviting members of Scrutiny Board to provide comments as part of the consultation process.	119 - 126
11			**THE ADULT SOCIAL CARE RESIDENTIAL AND NURSING FRAMEWORK CONTRACT** To consider a report from the Director of Adult Social Services setting out details associated with the Adult Social Care Residential and Nursing Framework Contract. **(Report to follow)**	
12			**PUBLIC HEALTH 2015/16 BUDGET - UPDATE** To consider a report from the Head of Scrutiny and Member Development introducing a verbal update from the Director of Public Health on the Council's 2015/16 Public Health budget following publication of the Department of Health response to the consultation carried out earlier in the year.	127 - 154
13			**PRIMARY CARE** To consider a report from the Head of Scrutiny and Member Development that introduces a range of information relating to the development of general practice (GP services) in Leeds.	155 - 252

Item No	Ward/Equal Opportunities	Item Not Open		Page No
14			**CANCER WAITING TIMES** To consider a report from the Head of Scrutiny and Member Development that introduces a joint report from Leeds' Clinical Commissioning Groups and Leeds Teaching Hospitals NHS Trust around Cancer Waiting Times and associated levels of performance against national targets.	253 - 262
15			**WORK SCHEDULE - NOVEMBER 2015** To consider a report from the Head of Scrutiny and Member Development introducing the Scrutiny Board's outline work schedule for the remainder of the current municipal year (2015/16).	263 - 272
16			**DATE AND TIME OF NEXT MEETING** Tuesday, 22 December 2015 at 2:00pm (pre-meeting for all Board members at 1:30pm) **THIRD PARTY RECORDING** Recording of this meeting is allowed to enable those not present to see or hear the proceedings either as they take place (or later) and to enable the reporting of those proceedings. A copy of the recording protocol is available from the contacts on the front of this agenda. Use of Recordings by Third Parties – code of practice a) Any published recording should be accompanied by a statement of when and where the recording was made, the context of the discussion that took place, and a clear identification of the main speakers and their role or title. b) Those making recordings must not edit the recording in a way that could lead to misinterpretation or misrepresentation of the proceedings or comments made by attendees. In particular there should be no internal editing of published extracts; recordings may start at any point and end at any point but the material between those points must be complete.	

Item No	Ward/Equal Opportunities	Item Not Open		Page No

SCRUTINY BOARD (ADULT SOCIAL SERVICES, PUBLIC HEALTH, NHS)

TUESDAY, 20TH OCTOBER, 2015

PRESENT: Councillor P Gruen in the Chair

Councillors B Anderson, C Anderson, P Grahame, A Hussain, G Hussain, S Lay, C Macniven, B Selby, A Smart and S Varley

37 Late Items

There were no additional late items, however the following details were provided as supplementary information:

- Minutes - 8 September 2015 – comments from the Care Quality Commission (minute 40 refers)
- Draft Health and Wellbeing Board minutes (30 September 2015) (minute 42 refers)
- CQC Inspection Outcomes (updated schedule) (minute 45 refers)
- Air Quality Scrutiny Inquiry (minute 46 refers)
- Public Health 2015/16 Budget – Update (minute 47 refers)

The above details were not available at the time of agenda despatch, but were pertinent to the areas under discussion at the meeting and accepted by the Scrutiny Board.

38 Declaration of Disclosable Pecuniary Interests

There were no disclosable pecuniary interests declared at the meeting.

39 Apologies for Absence and Notification of Substitutes

The following apologies and notification of substitutes were provided at the meeting:

- Cllr Billy Flynn – Cllr Barry Anderson attending as a substitute
- Cllr Eileen Taylor – Cllr Pauleen Grahame attending as a substitute
- Mr Richard Taylor – HealthWatch Leeds

40 Minutes - 8 September 2015

The draft minutes from the previous meeting held on 8 September 2015 were presented for consideration.

The Principal Scrutiny Adviser drew the Board's attention to comments submitted by the Care Quality Commission (CQC) in reference to Minute 33 (specifically Waterloo Manor Independent Hospital) and the initial response provided. Following a short discussion, members of the Board agreed the draft minutes accurately reflected the significant issues raised and discussed at the meeting.

RESOLVED –

That the minutes of the Scrutiny Board (Adult Social Services, Public Health, NHS) meeting held on 8 September 2015, be approved as an accurate and correct record.

41 Minutes of Executive Board - 23 September 2015

The draft minutes of the Executive Board meeting held on 23 September 2015 were presented to the Scrutiny Board for consideration.

RESOLVED –

The draft minutes of the Executive Board meeting held on 23 September 2015 were noted.

42 Minutes of Health and Wellbeing Board - 30 September 2015

The draft minutes of the Health and Wellbeing Board meeting held on 30 September 2015 were presented to the Scrutiny Board for consideration.

RESOLVED –

The draft minutes of the Health and Wellbeing Board meeting held on 30 September 2015 were noted.

43 Chair's Update

The Chair provided a verbal update on some of the scrutiny activity since the previous Board meeting and not otherwise included elsewhere on the agenda. The update included:

- Consideration of the impact of further budgetary savings identified by NHS Trust Development Authority / Monitor for NHS provider Trusts.
- Recent Care Quality Commission activity relating to Leeds and York Partnership Foundation Trust and services provided at Bootham Park Hospital in York.
- Matters discussed at the recent Health Service Developments working group.

Members of the Board received the update and highlighted a number of points, including:

- The importance of keeping local ward members informed about proposed service changes and associated engagement and consultation activity.
- The quality and consistency of patient engagement and consultation.
- The extent of proposed changes to and/or mergers of local GP practices
- The need to consider the consultation and health impact assessment outcomes associated with the Children's Epilepsy Surgery Service review (discussed at the recent Health Service Developments working group.

Councillor Pauleen Grahame queried progress in relation to Windmill Health Centre and the Chair agreed to seek a progress update outside of the meeting.

RESOLVED –

To note the update provided by the Chair, along with the proposed actions.

NB Cllr S Lay joined the meeting at 2:30pm during consideration of this item.

44 Request for Scrutiny - Tobacco Investments

The Head of Scrutiny and Member Development submitted a report that introduced a request for scrutiny for the Board's consideration.

The request had been submitted by Councillor Matthew Robinson and related to the City Council's investment, via the West Yorkshire Pension Fund, in tobacco companies and its spending on smoking prevention.

Those present for the discussion were:

- Cllr Matthew Robinson (Ward Member for Harewood)
- Cllr Mulherin (Executive Board Member for Health, Wellbeing and Adults)

Councillor Robinson introduced and summarised the request for scrutiny presented as part of the agenda papers.

Councillor Mulherin commented on the matters previously discussed at the September 2015 full Council meeting and the actions taken as Chair of Leeds' Health and Wellbeing Board.

The Board considered the request for scrutiny and the main points discussed included:

- The investment decision-making processes for the West Yorkshire Pension Authority and the Council's role in such processes.
- The wider issues associated with ethical/ moral investments.
- The potential role of the West Yorkshire Joint Health Overview and Scrutiny Committee currently being established.
- The role/ involvement of other Council Scrutiny Boards, in particular Scrutiny Board (Strategy and Resources) in examining wider issues around pension fund investments.

In summarising the discussion, the Chair outlined that the Scrutiny Board was in favour of taking some action that was likely to involve the West Yorkshire Joint Health Overview and Scrutiny Committee and the Scrutiny Board (Strategy and Resources). This would necessarily include some further discussions and advice on the most appropriate way forward.

The Chair proposed to take the matter forward and provide an update to the Scrutiny Board at a future meeting.

On conclusion of the discussion, the Chair thanked Cllr Robinson for his attendance and contribution to the discussion.

RESOLVED –

To note the request for scrutiny received and agree the actions proposed by the Chair.

45 Care Quality Commission (CQC) Inspection Outcomes

The Head of Scrutiny and Member Development submitted a report that provided details of recently reported Care Quality Commission inspection outcomes for health and social care providers across Leeds.

The Principal Scrutiny Adviser provided an updated schedule of inspection outcomes was presented at the meeting to provide additional inspection outcomes reported since production of the agenda.

The Scrutiny Board considered and discussed the information presented and raised a number of points, including:

- The details presented showed some improvement compared to previous reports, however 50% of the organisations inspected were rated as 'requires improvement': a position which members of the Scrutiny board cannot be satisfied with.
- The information presented showed only the headline judgements, and future reports could usefully provide more detail against the inspection areas.
- The Scrutiny Board could usefully seek assurance from commissioners regarding the actions taken on receipt of inspection outcomes, including the role of any quality surveillance groups within the City.

- The possibility of undertaking some joint work with HealthWatch Leeds around 'enter and view'.
- Local Member involvement in GP Patient Groups.

The Executive Member for Health, Wellbeing and Adults was invited to comment and recognised the concerns raised by the Board. It was suggested that the Care Quality Commission be invited to a future meeting to discuss matters in more detail.

RESOLVED –

(a) To note the report and the outcomes of the inspections presented.
(b) To seek details of the quality assurance processes among service commissioners in Leeds, in particular Adult Social Services.
(c) To invite the Care Quality Commission to the next meeting of the Scrutiny Board to discuss issues around quality of services in Leeds in more detail.
(d) On behalf of the Scrutiny Board, that the Chair of the Scrutiny Board discuss the possibility of undertaking some joint work with HealthWatch Leeds around 'enter and view', and report the outcome to a future meeting.

46 Air Quality - Scrutiny Inquiry

The Head of Scrutiny and Member Development submitted a report confirming that Air Quality had been identified as a specific area for more detailed consideration during 2015/16. The report confirmed that as part of the initial guidance in scoping the Board's inquiry, the following matters were identified as possible considerations (along with supporting data, where appropriate):

- Air quality across the City, including particular hot spots
- How Leeds compares to other areas – West Yorkshire; Core Cities; Other comparator groups
- Impact of poor air quality on the City – health, environmental, financial etc.
- Details of main causes of poor air quality
- How to improve air quality – including a cost / benefit analysis of the improvement actions
- A summary of air quality legislation – what responsibilities the Council has; any enforcement powers available and if/how these are used.
- Details of any guidance/ good practice (e.g. NICE guidance) and how the Council performs against the guidance.

Appended to the report was the Executive Board report due to be considered at the meeting on 21 October 2015.

The following representatives were in attendance for the discussion:

- Polly Cook (Executive Programme Manager) – Projects, Programmes, & Procurement Unit, Leeds City Council
- Andrew Hall (Head of Transportation) – City Development, Leeds City Council
- Cllr Mulherin (Executive Board Member for Health, Wellbeing and Adults)
- Ian Cameron (Director of Public Health) – Public Health, Leeds City Council

The Executive Programme Manager and Head of Transportation addressed the Scrutiny Board and provided the context and background to the Executive Board report due to be considered the following day.

The Director of Public Health confirmed the Executive Board report was a joint report and included details of the associated health impacts of poor air quality. Air quality remained a significant issue for the Council and it represented another health inequality issue across the City.

The Executive Board Member for Health, Wellbeing and Adults outlined some key areas of work across the Council to help address air quality issues, including creating the infrastructure to encourage walking and cycling and ensure health considerations have a better connection to future developments.

The Chair addressed the Board and made the following comments:

- The issue was not purely a city-centre issue and it was important to look across the whole of the City.
- It was important to recognise that air quality in areas of Leeds was not sufficiently good and that was not a satisfactory position.
- To make improvements, action needed to be taken and while some actions may not be easy; some steps would be easier on the way to improvement.
- Referencing the banning of smoking in public places, it should be recognised that the 'impossible' can become 'possible'.

The Chair then opened the matter for broader consideration and questions from members of the Scrutiny Board. A number of comments were made during the discussion with those present at the meeting, including:

- Welcoming the thrust and ambitions of the Council's efforts and joint work with the Combined Authority, but recognising the resources needed to achieve many of the aims and objectives were subject to successful bids to Government.
- Partnership working with some partners appeared better developed then with others.
- The role of trade associations, such as the Road Haulage Association bus companies and Taxi and Hackney Carriage associations.
- The role of school travel plans in helping to address issues of poor air quality.

- The need to improve the rigor by which development proposals are assessed in terms of impacts.
- Improvements needed to air quality monitoring to map impacts across the City.
- DEFRA appeared to be encouraging funding bids from Leeds in order to help address the predicted level of non-compliance with air quality standards.
- The need to balance the impacts between developing brownfield site and greenbelt areas of the City.
- While recognising the need to plan for future improvements, it should be recognised that some improvement is needed immediately and strong leadership was needed.

Following conclusion of the discussion, the Chair invited the Principal Scrutiny Adviser to outline some proposed next steps, which included:

- Reviewing the information presented and identifying any additional or supplementary details that may be required.
- Seeking the input from other witnesses or stakeholder identified at the meeting, such as the Road Haulage Association, the Combined Authority and others.

At the conclusion of the discussion, the Chair thanked those present for their contribution to the meeting.

RESOLVED –

To note the information presented to the meeting and agree the next steps outlined at the meeting.

NB Following conclusion of the discussion on the item, Cllr P Grahame and Cllr A Hussain left the meeting.

The meeting was then adjourned at 3:55pm and recommenced at 4:05pm

47 Public Health 2015/16 Budget - update

The Head of Scrutiny and Member Development submitted a report to introduce a further update from the Director of Public Health regarding the Public Health budget for 2015/16 (i.e. the current year).

Appended was the Financial Health Monitoring report presented to the Executive Board at its meeting on 23 September 2015. This detailed some of the proposed actions to meet the in-year budget reduction, once formally announced.

The following were in attendance for the discussion:

- Cllr Mulherin (Executive Board Member for Health, Wellbeing and Adults)
- Ian Cameron (Director of Public Health) – Public Health, Leeds City Council

The Executive Board Member for Health, Wellbeing and Adults addressed the Scrutiny Board and provided the background and context for the discussion. The Director for Public Health outlined that a formal announcement from the Department of Health had still not been made; therefore the level of the budget reduction remained unconfirmed.

It was suggested that the reason for the delay in the Department of Health's announcement was due to the overall level of responses to the consultation; the possible threat of judicial review; and the different formula for reductions proposed by Manchester.

Members of the Scrutiny Board considered and discussed the information presented and raised a number of matters, including:

- The inadequacy of the Department of Health proposals and its associated consultation process.
- Confirmation that concern had been expressed by Councillor Nash regarding the continuation of the 'Skyline Service' in Leeds that provided support to those suffering from HIV.
- The Council faced some very significant challenges and unpalatable, difficult decisions implementing the proposed budget reductions.
- Addition savings of £600,000 would still need to be made to meet the anticipated level of budget reduction. Members queried how this would be achieved.
- Concern that it had not been confirmed whether or not the reduction would be a 'one-off' or recurrent for future years.

In addressing the Scrutiny Board and responding to the comments and concerns expressed by members, the Executive Board Member for Health, Wellbeing and Adults and Director of Public Health made the following comments:

- Confirmation that this represented a very significant and unexpected in-year challenge, with £600,000 still to be identified.
- The Council was committed to support work around 'Best Start', including the Family Nurse Partnership, Health Visitors and Children's Centres.
- In identifying potential reductions the approach had been to seek to minimise the impact of the people of Leeds and on areas where activity had been planned but not yet implemented.
- A number of contacts, including that held by the Skyline Service, were due to end in March 2016 and it was necessary and standard practice to review contracts and the services they provide.

In summarising the discussion, the Chair expressed a view that the Council as a whole should look to shoulder some of the burden of this unexpected in-year challenge. It was also important for the Council to ensure its message to the public and service providers was that the reductions were necessary to meet the Department of Health in-year demands.

RESOLVED –

a) That the details presented in the report and highlighted at the meeting be noted.
b) That, the Director of Public Health continues to keep the Scrutiny Board updated on developments as work progresses, including how the savings are to be achieved.

48 Director of Public Health Annual Report (2014-15)

The Head of Scrutiny and Member Development submitted a report that introduced the 2014/15 Annual Report from the Director of Public Health presented to the Executive Board at its meeting on 23 September 2015. It also presented the progress against the recommendations from the 2013 Annual Report presented to the Health and Wellbeing Board at its meeting on 30 September.

The following were in attendance for consideration of this item:

- Ian Cameron (Director of Public Health) – Public Health, Leeds City Council
- Cllr Mulherin (Executive Board Member for Health, Wellbeing and Adults)

The Director of Public Health addressed the Scrutiny Board and outlined the main elements of the report and recommendations under the themes of:

- Health planning and urban design
- Engaging local communities

The Scrutiny Board considered and discussed the report presented and raised a number of matters, including:

- Issues of special planning for existing communities and how this could have a positive impact on health inequalities.
- The ongoing work to embed the work of Public Health across the different areas of the Council.
- Questions around how the recommendations would be taken forward by the responsible organisation subsequently monitored and reported.
- Requests for an update / response at an appropriate time from responsible individuals / organisation, including the Clinical Commissioning Groups, the Chief Planning Officer and Leader of Council

RESOLVED –

That the Director of Public Health Annual Report 2014/15, be noted.

49 Annual Report of the Health Protection Board

The Head of Scrutiny and Member Development submitted a report that introduced the first Annual Report of the Health Protection Board. The Annual Report had previously been submitted and presented to the Health and Wellbeing Board at its meeting on 30 September 2015.

RESOLVED –

That the first Annual Report of the Health Protection Board as presented, be noted.

50 Progress on Implementation of the Care Act 2014

The Director of Adult Social Services submitted a report that outlined the Council's progress against the requirements of the Care Act 2014.

Those in attendance for this item were:

- Shona McFarlane (Chief Officer (Access and Care Delivery)) – Adult Social Services, Leeds Council

In introducing the item and outlining the report, the Chief Officer (Access and Care Delivery) confirmed that the Council's focus had been on achieving compliance with the first phase of Care reforms detailed in the Care Act 2014, and in so-doing there had been a strengthening of the Council's partnership arrangements.

It was outlined that Phase 2 of the Act, which provided for the Care Cap and Care Account and was due to be implemented in March 2016, would have resulted in some significant changes, including a cap on care costs of £72,000. However, it was confirmed that earlier in the summer, the Government had announced a delay on implementing the cap on costs until 2020.

Members discussed the details presented and queried the level of Council resources assigned to preparing for Phase 2 implementation ahead of the Government announcement. The Chief Officer (Access and Care Delivery) confirmed there were no details of any specifically identifiable expenditure in this regard.

RESOLVED –

That the progress report as presented and outlined at the meeting, be noted.

51 Future Provision of Homecare - update

The Head of Scrutiny and Member Development submitted a report that detailed the work of the Scrutiny Board in the previous municipal year (2015/16) in relation to the future external provision of home care services.

Appended to the report was the statement of the former Scrutiny Board and an update from the Director of Adult Social Services outlining progress and detailing how the Scrutiny Board comments had been taken into account.

In attendance for the item were:

- Shona McFarlane (Chief Officer (Access and Care Delivery)) – Adult Social Services, Leeds Council
- Michelle Atkinson (Older People Commissioning Manager) – Adult Social Services, Leeds Council
- Mark Phillott (Head of Contracts, Bus Development and Markets Management) – Adult Social Services, Leeds Council

In introducing the item, the Older People Commissioning Manager confirmed that good progress continued to be made, and particularly highlighted the extensive work undertaken with service uses around service quality standards. An update was provided in the following areas:

- Quality Standards and Outcome Based Commissioning
- Flexible and Responsive Services
- Compliance and Monitoring
- Safeguarding
- The Ethical Care Charter
- Locality based Services
- Contract Type and Pricing

The Older People Commissioning Manager also drew the Board's attention to an error in the written update, regarding the number of providers that had expressed an interest in being considered to be part of the future framework arrangements. The actual number was 26 and not 254 as detailed in the briefing note.

Specific assurance of progress against the Scrutiny Board's previous recommendations was also provided.

At the conclusion of the discussion, the Chair thanked those in attendance for their contribution to the discussion.

RESOLVED –

To note the information presented and to record the Scrutiny Board's satisfaction with progress to date.

52 Proposed West Yorkshire Joint Health Overview and Scrutiny Committee - membership nomination

The Head of Scrutiny and Member Development submitted a report seeking membership nominations for the proposed West Yorkshire Joint Health Overview and Scrutiny Committee.

The Principal Scrutiny Adviser introduced the report and confirmed that, at its meeting on 19 October 2015, General Purposes Committee had agreed to make recommendations to full Council regarding the establishment of the West Yorkshire Joint Health Overview and Scrutiny Committee detailed in the report.

The Scrutiny Board was asked to consider nominating two members from within its current membership to serve on the proposed West Yorkshire Joint Health Overview and Scrutiny Committee.

The Scrutiny Board discussed the report and its associated nominations.

RESOLVED –

That the following members be presented to full Council as the Scrutiny Board's nominations for the proposed West Yorkshire Joint Health Overview and Scrutiny Committee:

(a) Councillor Peter Gruen (as Chair of the Scrutiny Board); and,
(b) Councillor Billy Flynn

53 Work Schedule - October 2015

The Principal Scrutiny Adviser provided a report that introduced an updated work schedule for the remainder of the municipal year.

The Chair advised the Board that the updated work schedule reflected the Boards previous discussions while taking account of necessary issues associated with scheduling items for the remainder of the municipal year.

The Board briefly discussed and agreed to consider further aspects of its inquiry into Air Quality through a working group arrangement that would subsequently report to the full Board.

RESOLVED –

(a) That, subject to any on-going scheduling decisions, the Board's work schedule as presented be agreed.

(b) To establish a working group (open to all members of the Board) to take forward and consider further matters associated with the Air Quality inquiry.

54 Date and Time of Next Meeting

Tuesday, 24 November 2015 at 2:00pm (pre-meeting at 1:30pm)

(The meeting concluded at 5:15pm)

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EXECUTIVE BOARD

WEDNESDAY, 21ST OCTOBER, 2015

PRESENT: Councillor J Blake in the Chair

Councillors D Coupar, M Dobson, S Golton, J Lewis, R Lewis, L Mulherin, M Rafique and L Yeadon

SUBSTITUTE MEMBER: Councillor J Procter

APOLOGIES: Councillor A Carter

56 Substitute Member

Under the terms of Executive and Decision Making Procedure Rule 3.1.6, Councillor J Procter was invited to attend the meeting on behalf of Councillor A Carter, who had submitted his apologies for absence from the meeting.

57 Exempt Information - Possible Exclusion of the Press and Public

RESOLVED – That, in accordance with Regulation 4 of The Local Authorities (Executive Arrangements) (Meetings and Access to Information) (England) Regulations 2012, the public be excluded from the meeting during consideration of the following parts of the agenda designated as exempt on the grounds that it is likely, in view of the nature of the business to be transacted or the nature of the proceedings, that if members of the public were present there would be disclosure to them of exempt information so designated as follows:-

(a) Appendix 3 to the report entitled, 'The Regeneration of the New Briggate Area', referred to in Minute No. 71 is designated as exempt from publication in accordance with paragraph 10.4(3) of Schedule 12A(3) of the Local Government Act 1972 on the grounds that the information contained within the submitted appendix relates to the financial or business affairs of a particular organisation and of the Council. It is considered that the public interest in maintaining the content of the appendix as exempt from publication outweighs the public interest in disclosing the information, due to the impact that disclosing the information would have on the Council and third parties.

(b) Appendix 2 to the report entitled, 'East Leeds Extension Update and Next Steps', referred to in Minute No. 74 is designated as exempt from publication in accordance with paragraph 10.4(3) of Schedule 12A(3) of the Local Government Act 1972 on the grounds that the information contained within the submitted appendix relates to the financial or business affairs of a particular person, and of the Council. This information is not publicly available from the statutory registers of information kept in respect of certain companies and charities. It is

considered that since this information was obtained through initial one to one discussions for the acquisition of the property/land, then it is not in the public interest to disclose this information at this point in time.

Also, it is considered that the release of such information would or would be likely to prejudice the Council's commercial interests in relation to other similar transactions in that prospective purchasers of other similar properties would have access to information about the nature and level of consideration which may prove acceptable to the Council. It is considered that whilst there may be a public interest in disclosure, much of this information will be publicly available from the Land Registry following completion of this transaction and consequently the public interest in maintaining the exemption outweighs the public interest in disclosing this information at this point in time.

58 Late Items

There were no late items as such, however, prior to the meeting Board Members were provided with the following for their consideration:

- Correspondence which clarified that in relation to agenda item 16 (The Regeneration of the New Briggate Area), those references in paragraph 5.1, Recommendation 4(a) and Recommendation 6.1(a) should read *26-32 Merrion Street*, rather than *26-32 Merrion Way* (Minute No. 71 refers);
- An updated version of the covering report and appendix 3 to agenda item 18 (The Community Infrastructure Levy: Spending of the Neighbourhood Fund and Other Spending Matters) (Minute No. 73 refers);
- An updated version of appendix B to agenda item 20 (Learning Places Programme: Capital Programme Update) (Minute No. 75 refers).

59 Declaration of Disclosable Pecuniary Interests

There were no Disclosable Pecuniary Interests declared at the meeting, however in relation to the agenda item entitled, 'The Regeneration of the New Briggate Area', Councillors J Procter and Yeadon drew the Board's attention to their respective positions on the Leeds Grand Theatre and Opera House Board of Management (Minute No. 71 refers).

60 Minutes

RESOLVED – That the minutes of the previous meeting held on 23rd September 2015 be approved as a correct record.

COMMUNITIES

61 Long Term Strategic Partnership with Leeds City Credit Union

The Assistant Chief Executive (Citizens and Communities) submitted a report which provided an update on the Council's continued joint work with Leeds City Credit Union (LCCU) to tackle poverty in Leeds. In addition, the report also presented the long-term strategy for ongoing partnership working and

specifically, set out the options available in respect of the Council's continuing financial support and future investment in such matters.

Members welcomed the contents of the submitted report, placed on record their thanks for the valuable and innovative work being undertaken in this area and highlighted how such work provided a key example of civic enterprise.

RESOLVED -

(a) That the significant progress made and the projects developed through the partnership between the Council and Leeds City Credit Union, which has helped in the delivery of the Council's strategic objectives on financial inclusion and poverty alleviation be noted and welcomed, and that the ongoing strategic approach towards the partnership work also be welcomed;

(b) That authority be given to the Council entering into an agreement with the Credit Union in connection with the continuing support from the Council to the Credit Union, with the approval of the terms of such an agreement being delegated to the Assistant Chief Executive (Citizens and Communities);

(c) That approval be given to the re-scheduling of the loan to the Credit Union, as set out in paragraph 3.38 of the submitted report, with the detailed arrangements being subject to determination by the Assistant Chief Executive (Citizens and Communities).

62 Re-location of Red Hall Horticultural Nursery to Whinmoor Grange

Further to Minute No. 76, 4th September 2013, the Director of Environment and Housing submitted a report regarding the latest designs and costs relating to the relocation of the Parks and Countryside horticultural nursery from Red Hall to Whinmoor Grange along with the relocation of other operational services currently based at Red Hall. In addition, the report sought approval of an injection into the capital scheme and subsequent expenditure of £6.5m for the construction and relocation works from Red Hall to Whinmoor Grange.

The Board paid tribute to the valuable work undertaken by the horticultural nursery service. Furthermore, Members emphasised the ongoing partnership work taking place between the service and community organisations across the city and highlighted the need for such partnership working to continue and develop further with the help of the proposed new facility.

A Member raised the issue of the proposed entry point to the facility and highlighted the need to ensure that it remained in keeping with the wider area.

RESOLVED –

(a) That an injection of £6.5m into Capital Scheme No. 32415/000/000 be approved;

(b) That expenditure of up to £6.5m to design and build a replacement horticultural nursery for Leeds City Council Parks and Countryside at Whinmoor Grange and for the relocation of other services from the existing Red Hall depot, be approved, subject to planning approval and Local Growth Fund loan agreement;

(c) That in accordance with Contracts Procedure Rule 3.1.8, approval be given to the selection of a single stage develop and construct procurement approach via an open non-EU procurement, in order to obtain a specialist contractor to undertake the proposed construction of a horticultural nursery glasshouse at Whinmoor Grange, with the evaluation criteria of 70% of marks for the lowest compliant cost and 30% of marks for quality criteria;

(d) That the current designs, as detailed at appendix 1 to the submitted report, and the costs for Whinmoor Grange nursery, be approved, subject to the necessary planning approval;

(e) That it be noted that the Chief Officer (Parks and Countryside) will be responsible for the implementation of such matters, and to ensure that the Parks and Countryside service vacate the Red Hall site by the end of 2016.

63 Commissioning a new model for the delivery of Supporting People Services

The Director of Environment and Housing submitted a report providing a performance summary of the Housing Related Support commissioned programme during 2014/15 and updating the Board on the review and progress made towards developing a new model for the city which included the intended outcomes and benefits. In addition, the report sought the Board's input and guidance on the model and forward work programme.

Members welcomed the proposed key principles and features of the new model, with reference being made to the person centred approach and the potential establishment of a triage system.

RESOLVED –

(a) That the progress of the review, as detailed within the submitted report, be noted;

(b) That approval be given to proceed with the recommendations within the submitted report for the re-procurement / re-contracting of housing related support services in the context of the proposed key principles and features of a new model to a maximum budget of £10.4 million;

(c) That it be noted that the Director of Environment and Housing will use his delegated authority in order to take commissioning and decommissioning decisions which will be a direct consequence of this key decision. (For example, approval of the detailed specifications for the procurement and subsequent contract awards, which will be at

most significant operational decisions. This is subject to the decisions being in line with the key principles and features as described within the submitted Executive Board report).

ENVIRONMENTAL PROTECTION AND COMMUNITY SAFETY

64 Improving Air Quality within the City

Further to Minute No. 139, 17th December 2014, the Director of Environment and Housing and the Director of Public Health submitted a joint report providing an update on the progress which had been made since the submission of the previous report. In addition, the report also provided details of health implications arising from air quality levels, on the West Yorkshire Low Emission Strategy Paper, Leeds' action plan and also on a number of current and related funding opportunities.

Responding to Members' enquiries, officers provided an update on the range of actions currently being taken to improve air quality in Leeds. In addition, it was highlighted that further monitoring of air quality levels was to be undertaken which would enable more quantifiable actions to be identified, and it was noted that such information would be presented to the Board for consideration.

Furthermore, Members highlighted the pivotal role to be played by the public in improving air quality levels in Leeds, and emphasised the vital importance of raising the public awareness and understanding of such matters.

RESOLVED –

(a) That the raising of the public's awareness and understanding of such matters be identified as a key priority in the approach towards improving air quality levels in Leeds;

(b) That the progress which the Council has made to date and its plan for the expansion of its own alternative fuel vehicles and associated infrastructure, be noted;

(c) That the West Yorkshire Low Emissions Strategy (WYLES) and Leeds' Air Quality Action Plan, be endorsed;

(d) That the PM2.5 targets for 2020 and 2030, as referred to within paragraph 3.6 of the submitted report be adopted;

(e) That the allocation of parking spaces for electric vehicles in Council car parks, to be implemented by the end of the financial year as part of the 'Cutting Carbon and Improving Air Quality' breakthrough project, be supported;

(f) That the enforcement of the planning conditions on new developments to increase charging infrastructure across the city be supported, which is an on-going action that falls under the Chief Planning Officer's responsibility to monitor all new developments;

(g) That the establishment of walking and cycling friendly infrastructure be supported, with the use of appropriate planning conditions to ensure that new developments support alternative modes of transport;

(h) That support be given to further work being undertaken to determine the scope and number of potential Clean Air Zones required within the city in order to ensure that compliance with EU directives is met as a minimum, and which will look to improve public health outcomes for the citizens of Leeds;

(i) That it be noted that the Director of Environment and Housing will oversee the delivery of the study and will submit a progress report to Executive Board as part of the breakthrough project's annual report.

(Under the provisions of Council Procedure Rule 16.5, Councillor S Golton required it to be recorded that he abstained from voting on the matters referred to within this minute)

ECONOMY AND CULTURE

65 Strong Economy, Compassionate City

The Chief Executive submitted a report which presented the Council's vision for a strong economy and compassionate city and highlighted the actions being taken to sustain and accelerate the economic progress that the city has achieved, whilst also ensuring that all people and communities in Leeds contributed towards and benefitted from such economic success.

Responding to Members' enquiries, it was noted that the update report, scheduled to be submitted to the Board in Spring 2016 would provide further information on the actions being taken in the areas of social enterprise and also inward investment.

Members highlighted the linkages between the Council's breakthrough projects and the vision to have a strong economy and be a compassionate city. Also, the Board considered the role played by the Government in the development of the city's economy. Furthermore, emphasis was placed upon the important contribution made by Leeds' cultural offer towards the Council's overarching vision.

RESOLVED –

That the following be approved:-

Tackling Low Pay

i) **Living wage city** – Leeds City Council will work with partners to develop a Living Wage City campaign to encourage employers to pay the Living Wage as accredited by the National Living Wage Foundation. The aim should be to significantly increase the number of Living Wage businesses in Leeds over the next year.

ii) **Supporting people to get better jobs** – Leeds City Council will work with the Leeds City Region Enterprise Partnership, the Chamber of Commerce and education and training providers in order to develop proposals to create a careers advice and in-work progression service, and support for employers, aimed at helping people move out of low paid work into better jobs.

Regenerating places

iii) **A new approach to regeneration –** the Council will identify a rolling programme of prioritised schemes in deprived areas, with an emphasis upon bringing together the approach to supporting people and communities with interventions to deliver positive physical development and change, with a particular focus on early intervention to tackle the causes of poverty. A report recommending the details of the approach be submitted to Executive Board by early 2016.

A life ready for learning – putting children at the heart of the growth strategy

iv) **Strengthening business engagement in schools** – The Council will work with business leaders, head teachers, universities and colleges and leading experts and enterprises in the third sector to look at how to build on existing work to strengthen business engagement in Leeds schools, with the aim of ensuring that all secondary schools, particularly those with a high proportion of pupils from deprived areas, have strong partnerships with business.

v) **Enhancing careers advice and guidance for young people** – The Council will work with business leaders, head teachers, universities and colleges, leading experts in the third sector, and the national Careers and Enterprise Company to look at how to strengthen independent careers advice in schools, with the aim of ensuring that all secondary schools are offering good quality careers advice.

Supporting business to invest in growth and communities

vi) **Key Account Management** – the Key Account Management approach to working with businesses should be extended across the Council and a wider range of businesses in order to strengthen the approach to promoting business growth and community investment, with the aim of ensuring regular contact with 150 businesses that are significant strategically.

vii) **Promoting community investment** – the Council works with other organisations and business leaders in order to develop an initiative to encourage more businesses in Leeds to commit to investing in their workforce and their local communities, with the aim being for 50 businesses to strengthen their community investment work.

Creating quality places and spaces

viii) **Creating quality places and spaces** – we will continue to seek to improve the quality of design of new development, including through refreshing the 'Neighbourhoods for Living' design guidance document.

ix) **Securing good jobs and skills outcomes from major development and infrastructure projects** – we will set out how we will build on the achievements and learning over recent years to set out how we can strengthen our approach to using major developments and infrastructure projects to support training and jobs for local people. A report setting out the details of this approach be submitted to Executive Board by early 2016.

Backing innovators and entrepreneurs

x) **Keeping graduates in Leeds** – we will develop an initiative to improve levels of graduate retention in Leeds, including interventions to help tackle skills shortages and fill vacancies at graduate level in the digital sector, and a Leeds graduate careers fair and clearing system to connect students to future job opportunities in Leeds. A report setting out the details of this approach be submitted to Executive Board by early 2016.

xi) **Backing innovators** – we will develop an initiative to support the future growth of innovative businesses that have been incubated by Universities and other bodies, and are now looking to grow and move on to new business space and employ more people. A paper setting out the details of this approach should be submitted to Executive Board by early 2016.

xii) **Backing entrepreneurs** – we will develop a new enterprise programme using European Funds to provide support for people starting new businesses. We will also provide support for small business accelerators in the city, including the proposed digital business accelerator.

Next Steps

xiii) That it be noted that the Chief Executive, supported by the Chief Officer Economy and Regeneration, is responsible for the implementation of such matters, and will update Executive Board on progress in spring 2016.

66 Medium Term Financial Strategy 2016/17 - 2019/20

The Deputy Chief Executive submitted a report setting out the principles and assumptions underlying the proposed financial strategy for the Council covering the years 2016/17 to 2019/20.

Members were provided with the timescales and framework for the preparation of the 2016/17 Initial Budget Proposals which were scheduled to be presented to the Board in December 2015 and which would inform the Council's future priorities and strategies. It was also noted that announcements regarding the Government's Spending Review and details of

the Local Government Settlement would not be released until November and December 2015 respectively.

Furthermore, the Board was provided with an update on the current position regarding the Public Health grant and the implications arising from the in-year reduction which was announced in June 2015. Also, cross-party support was sought in relation to raising the Council's concerns on the current in-year grant reduction, and also in respect of the Council's future allocation of Public Health grant.

RESOLVED – That the Medium Term Financial Strategy for 2016/17 – 2019/20 be approved, and that agreement be given for the assumptions and principles, as outlined within the submitted report, being used as a basis for the detailed preparation of the Initial Budget Proposals for 2016/17 and which will inform the Council's future priorities and strategies.

RESOURCES AND STRATEGY

67 Financial Health Monitoring 2015/16 - Month 5

The Deputy Chief Executive submitted a report setting out the Council's projected financial position for 2015/16 together with other key financial indicators, after 5 months of the financial year.

Responding to a Member's enquiry, it was undertook that the Member in question would be provided with an update on the financial position regarding the healthy schools initiative and also the Early Years service. Furthermore, officers undertook to provide an update to the same Member on the projected shortfall in advertising income.

RESOLVED - That the projected financial position of the Council for 2015/16, as detailed within the submitted report, be noted.

68 Gambling Act 2005 Statement of Licensing Policy

Further to Minute No. 29, 15th July 2015, the Assistant Chief Executive (Citizens and Communities) submitted a report on the Statement of Licensing Policy in respect of the Gambling Act 2005. The report included the comments of the Scrutiny Board (Citizens and Communities) and recommended that the matter be referred to full Council for formal approval, in accordance with the Council's Budget and Policy Framework Procedure Rules.

In considering the report, emphasis was placed upon the importance of the national lobby regarding the impact of gambling and also on the introduction of Local Area Profiles and the proposed involvement of Community Committees in the development of such profiles.

RESOLVED – That the contents of the submitted report be noted, which includes the comments of the Scrutiny Board (Citizens and Communities), and that the matter be referred to full Council for the purposes of formal approval.

(In accordance with the Council's Executive and Decision Making Procedure Rules, the matters referred to within this minute were not eligible for Call In as the power to Call In decisions does not extend to those decisions made in accordance with the Budget and Policy Framework Procedure Rules, which includes those resolutions above)

EMPLOYMENT, ENTERPRISE AND OPPORTUNITY

69 Equality Update: Improvement Priorities 2016-2010, and the Equality Framework Re-accreditation

The Assistant Chief Executive (Citizens and Communities) submitted a report setting out the approach taken to develop the Equality Improvement Priorities 2016-20 and how these priorities supported the ambitions of the city. In addition, the report also outlined the plans for the Council's reassessment against the Equality Framework for Local Government, in which the local authority currently held an 'excellent' accreditation.

Members welcomed the contents of the submitted report, and it was emphasised that equality improvement was a key priority for the Council. In addition, it was acknowledged that a proactive approach needed to continue in order to ensure that the Council was an attractive employer to all communities.

Responding to a Member's specific enquiry, an update was provided on the actions being taken to promote the Council as an employer at graduate level.

RESOLVED -

(a) That the contents of the submitted report, be noted;

(b) That the contents of the Equality Framework narrative be noted, and that an update on the outcomes and actions arising be provided to Executive Board in Spring 2016;

(c) That the Equality Improvement Priorities 2016-20 be endorsed, and that it be noted that annual reports will be provided on progress against these.

REGENERATION, TRANSPORT AND PLANNING

70 An Approach to Street Design and the Public Realm in Leeds City Centre

The Director of City Development submitted a report outlining an approach towards street design and the public realm. The report identified some key principles to ensure schemes were designed and implemented within agreed corporate parameters and objectives, and included artist impressions of how the city centre may look if such an approach was adopted. Additionally, the submitted report included a prioritised programme for public realm improvements in the city centre.

Members discussed the potential approach towards the promotion of more pedestrian accessible spaces in the city centre and the impact of such an

approach. In addition, the Board considered the benefits of simplistic and consistent designs and also the sources of funding which could be used for such initiatives.

In conclusion, emphasis was placed upon the need for the associated consultation exercise which was proposed to be as comprehensive and inclusive as possible.

RESOLVED –

(a) That the principle of the Council developing a strategic plan for public realm improvements in the City Centre, based upon the principles as outlined in paragraph 3.7 of the submitted report, be endorsed;

(b) That approval be given to the Council consulting and engaging with stakeholders on potential schemes to be brought forward, based upon the design ideas and opportunities document, as detailed at Appendix 1 to the submitted report;

(c) That subject to the outcome of the consultation, officers be requested to submit a report to a future Executive Board outlining a proposal plan of public realm improvements, costings and funding, and that it be noted that the Head of Strategic Projects, City Development, will be responsible for the submission of this report.

71 The Regeneration of the New Briggate Area

The Director of City Development submitted a report regarding the issues and opportunities related to the regeneration of the New Briggate area. The report identified how the area could be re-energised through partnership working between the Council and other stakeholders.

It was noted that prior to the meeting, correspondence had been circulated to Board Members clarifying that those references in paragraph 5.1, Recommendation 4(a) and Recommendation 6.1(a) should read *26-32 Merrion Street*, rather than *26-32 Merrion Way*.

Following consideration of Appendix 3 to the submitted report, designated as exempt from publication under the provisions of Access to Information Procedure Rule 10.4(3), which was considered in private at the conclusion of the meeting, it was

RESOLVED –

(a) That approval be given to 26-32 Merrion Street being declared surplus and marketed, with the property being added to the capital receipt programme. In addition, it also be agreed that the approval for the terms of any such disposal be delegated to the Director of City Development;

(b) That in principle support be given to the invitation of proposals for the potential development of the pay and display car park and the re-ordering of the public open space at Belgrave Gardens, for further

consideration by the Council, in order to provide an additional capital receipt;

(c) That officers be requested to undertake an initial 'expressions of interest' marketing exercise for the lease of 34-40 New Briggate (i.e. the vacant shops under The Grand and Howard Assembly Rooms) with a reverse premium payment available (as detailed within the exempt Appendix 3 to the submitted report);

(d) That officers be requested to develop an initial feasibility scheme for improvements to the public realm of New Briggate and the immediate surrounding area;

(e) That officers be requested to continue partnership working and improvements to the public realm in order to stimulate the regeneration of this area, and to develop options above and beyond the 'match funding' of any contribution by the Council; and

(f) That officers be requested to report back to Executive Board on progress in due course;

(g) That it be noted that the Head of Land and Property will be responsible for the implementation of matters relating to resolutions a), b) and c) above and that the Head of Strategic Projects, City Development, will be responsible for the implementation of matters regarding resolutions d), e) and f) above.

72 Our Transport Vision for a 21st Century Leeds

The Director of City Development submitted a report setting out a transport vision for Leeds as a prosperous, liveable, healthy and sustainable 21st century city. In addition, the report recognised the challenges and complexities of changing the way we travel into and around the city in order to create a more people friendly and productive urban core, identifying the key policy principles that the Council would need to adopt in order to deliver a transport system fit for a Leeds as a 21st century city.

Members discussed the range of initiatives which were currently being used to address the volume of car journeys within the city centre, and also considered the issue of car parking provision and the role which such provision could play in the overall transport vision.

When considering the suite of reports which had been submitted to the Board regarding pedestrian movement, transport and the public realm, it was suggested that when such matters were presented to the Board in the future, consideration be given to them being presented as one package.

RESOLVED –

(a) That the transport vision, as outlined in paragraph 3.11 of the submitted report be approved, and that the key policy principles, as

presented within the paragraphs (a) – (i) of the same report, be adopted;

(b) That officers be requested to use the vision and principles to work with the West Yorkshire Combined Authority in order to help shape the Single Transport Plan, and that as part of this, develop a compelling ambition for investment in an integrated mass transit network with supporting strategic park and ride infrastructure, and HS2 connectivity package;

(c) That officers be requested to submit a report to Executive Board in 2016 which reviews the long term options for the Leeds Inner Ring Road;

(d) That in accordance with the Leeds Core Strategy Local Development Framework, officers be requested to submit a Car Parking Supplementary Planning Document to Executive Board for the purposes of adoption during 2016;

(e) That in partnership with the Communications Team and the West Yorkshire Combined Authority, officers be requested to develop a holistic transport communications strategy, compatible with social media that engages key stakeholders, government, and the general public in a city wide conversation;

(f) That the Director of City Development be instructed to co-ordinate the work, as detailed within the resolutions above, with an update being submitted to Executive Board in 2016.

73 The Leeds Community Infrastructure Levy - Spending of the Neighbourhood Fund and Other Spending Matters

Further to Minute No. 156, 11th February 2015, the Director of City Development and the Assistant Chief Executive (Citizens and Communities) submitted a joint report detailing the process undertaken to generate spending guidance for Community Committees in making decisions on the Community Infrastructure Levy (CIL) Neighbourhood Fund, with a number of potential options being presented for consideration. Additionally, the report also proposed some minor changes to the Regulation 123 List and the withdrawal of the Council's policy allowing discretionary charitable relief for investment activities to address and clarify some implementation issues following 6 months of charging.

Prior to the meeting, Board Members had been provided with an updated version of the covering report and appendix 3, for their consideration, which superseded the versions contained within the original agenda papers.

Responding to an enquiry, the Board was provided with details of how receipts from CIL could potentially be brought forward and incorporated into the Council's budget process.

Having discussed the issue of the CIL neighbourhood fund being allocated to the local Community Committee in those areas where there was no town or parish council, it was highlighted that such matters were already being discussed with Community Committee Chairs, and it was noted that Executive Board would be kept fully informed as discussions in this area continued.

RESOLVED –

(a) That approval be given to the CIL neighbourhood fund spending guidance for use by Community Committees, as set out in Appendix 1 to the submitted report;

(b) That the proposed minor changes to the Regulation 123 List, as set out in Appendix 2 to the submitted report be agreed, that it be noted that such changes will be subject to local consultation and that the Chief Planning Officer be authorised to consider any representations made and to make any further amendments considered necessary as a result of the consultation, prior to the implementation of the revised list;

(c) That approval be given to the removal of the Council's policy allowing discretionary charitable relief for investment activities, to take effect from 1 December 2015;

(d) That the amendment to the Community Committee Executive Delegation Scheme, as set out within Appendix 3 to the submitted report, as revised and circulated to Board Members prior to the meeting, be approved, noting that the delegation is shared with the Assistant Chief Executive (Citizens and Communities);

(e) That it be noted that the Chief Planning Officer will be responsible for the implementation of such matters.

74 East Leeds Extension update and next steps

The Director of City Development submitted a report regarding the progress made in planning for the delivery of major housing growth and infrastructure investment in the East Leeds Extension. The report also sought specific approval on a number of matters which would enable the investment to progress.

Members noted how the East Leeds Orbital Road was a key piece of infrastructure which was integral to the East Leeds Extension development, and as such, raised concerns regarding the lead role that the Council was being required to take in order to ensure that the Orbital Road was delivered.

Following consideration of Appendix 2 to the submitted report, designated as exempt from publication under the provisions of Access to Information Procedure Rule 10.4(3), which was considered in private at the conclusion of the meeting, it was

RESOLVED –

(a) That the submitted report, together with the positive progress made by the Council in its enabling activities to bring forward the major strategic growth area of the East Leeds Extension and the major infrastructure project for the East Leeds Orbital Road, be noted;

(b) That in principle approval be given to the Council continuing to develop a funding case for the costs of the East Leeds Orbital Road through the West Yorkshire Plus Transport Fund, prudential borrowing and developer contributions, with the Council also continuing to explore alternative means of financing;

(c) That the commitment to the East Leeds Orbital Road Roof Tax be reaffirmed as the principle mechanism through which developer contributions will be secured from the East Leeds Extension towards the delivery costs of the East Leeds Orbital Road, as set out in paragraphs 3.1.6 – 3.1.8 of the submitted report;

(d) That the programme for the planning, procurement and construction of the East Leeds Orbital Road, as set out in paragraphs 3.1.10 – 3.1.13 of the submitted report be noted, and that approval be given for the Chief Officer (Highways and Transportation) to submit a detailed planning application for the project, in consultation with the Executive Member for Regeneration, Transport and Planning;

(e) That the progress made in assembling land to facilitate the route of the East Leeds Orbital Road at the Northern Quadrant be noted, and that the recommendations, as detailed within the exempt Appendix 2 to the submitted report, be approved;

(f) That it be noted that the Council will make land available on the Red Hall site for the initial A58 junction infrastructure which will enable access to the Northern Quadrant site, as set out in paragraphs 3.3.12 – 3.3.14 of the submitted report, subject to the discharge of relevant statutory processes by the Head of Land and Property and the delegated approval of the Director of City Development;

(g) That approval be given for the Chief Planning Officer to prepare and publish a Draft Planning Brief for Red Hall, with the detailed timetable to be agreed with the Executive Member for Regeneration, Transport and Planning;

(h) That approval be given to the approach towards marketing and disposal of the Red Hall site, as set out in paragraphs 3.4.18 – 3.4.22 of the submitted report, with the details to be confirmed by the Director of City Development in consultation with the Executive Member for Regeneration, Transport and Planning;

(i) That approval be given for the Chief Planning Officer to prepare and publish a Draft Development Framework for the Southern and Middle

Quadrants, with the detailed timetable to be agreed with the Executive Member for Regeneration, Transport and Planning;

(j) That a co-ordinated programme of public and stakeholder engagement for the East Leeds Extension from November 2015 be approved, which will include public consultation on the East Leeds Orbital Road, Red Hall and the Southern & Middle Quadrants, with the details being confirmed by the Head of Regeneration in consultation with the Executive Member for Regeneration, Transport and Planning and also Ward Members.

CHILDREN AND FAMILIES

75 Learning Places Programme - Capital Programme Update

Further to Minute No. 187, 22nd April 2015, the Director of Children's Services, the Deputy Chief Executive and the Director of City Development submitted a joint report presenting an update on the three year strategy for providing sufficient school places in the city, and also on the progress made in respect of the projects currently forming part of the Learning Places Programme. In addition, the report sought the Board's approval for further authority to spend on the programme, and provided an update on the applications submitted and approved for access to the programme risk fund.

Prior to the meeting, Board Members had been provided with an updated version of appendix B to the submitted report, for their consideration, which superseded the version contained within the original agenda papers.

Responding to a Member's enquiry, the Board received an update on the outcomes of the research undertaken by Leeds Beckett University regarding the relationship between the size of a school and the educational outcomes, and it was undertaken that full details would be provided to the Member in question.

The Board also received an update on the continued work of the cross-party steering group, with emphasis being placed upon the Council's commitment to continue such work on a cross-party basis.

In discussing the approach being taken by the Council in respect of the Learning Places Programme, it was highlighted that although all available options would be considered as part of the strategy to ensure there were sufficient good quality learning places in Leeds, the key priority was to ensure that the specific needs of the local community were met.

RESOLVED –

(a) That additional authority to spend on the Learning Places programme for the Roundhay scheme, with a value of £13m, be approved, which resets the overall approval of the schemes currently in the programme to £56.355m;

(b) That approval be given for the balance of the programme risk fund to be reset to £5.635m, in order to facilitate effective risk management at programme level;

(c) That approval be given for any savings made on applications to the programme risk fund being returned to the risk fund in order to support the continued management of programme risks;

(d) That the scale of identified need at primary level, and the indicative financial implications of £146m, be noted;

(e) That the projected funding deficit which currently stands at £69.5m and is based on Education Funding Agency (EFA) rates, be noted, and that it also be noted that this figure is likely to increase due to a number of factors, as set out in paragraph 4.4.5 of the submitted report;

(f) That it be noted that the Head of Learning Systems continues to have client responsibility for the programme, and that the Chief Officer, Projects, Programmes and Procurement Unit continues to be responsible for the delivery of the projects in the Learning Places programme.

DATE OF PUBLICATION: FRIDAY, 23RD OCTOBER 2015

LAST DATE FOR CALL IN OF ELIGIBLE DECISIONS: 5.00 P.M., FRIDAY, 30TH OCTOBER 2015

(Scrutiny Support will notify Directors of any items called in by 12.00noon on Monday, 2nd November 2015)

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Leeds CITY COUNCIL

Report author: Steven Courtney
Tel: 247 4707

Report of Head of Scrutiny and Member Development

Report to Scrutiny Board (Adult Social Services, Public Health, NHS)

Date: 24 November 2015

Subject: Chairs Update Report – November 2015

Are specific electoral Wards affected? If relevant, name(s) of Ward(s):	☐ Yes	☒ No
Are there implications for equality and diversity and cohesion and integration?	☐ Yes	☒ No
Is the decision eligible for Call-In?	☐ Yes	☒ No
Does the report contain confidential or exempt information? If relevant, Access to Information Procedure Rule number: Appendix number:	☐ Yes	☒ No

1 Purpose of this report

1.1 The purpose of this report is to provide an opportunity to formally outline some of the areas of work and activity of the Chair of the Scrutiny Board since the previous Scrutiny Board meeting in October 2015.

2 Main issues

2.1 Invariably, scrutiny activity often takes place outside of the formal monthly Scrutiny Board meetings. Such activity can take the form of working groups, but can also take the form of specific activity and actions of the Chair of the Scrutiny Board.

2.2 The purpose of this report is to provide an opportunity to formally update the Scrutiny Board on activity since the last meeting, including any specific outcomes. It also provides an opportunity for members of the Scrutiny Board to identify and agree any further scrutiny activity that may be necessary.

2.3 The Chair and Principal Scrutiny Adviser will provide a verbal update at the meeting, as required.

3. Recommendations

3.1 Members are asked to:

a) Note the content of this report and the verbal update provided at the meeting.
b) Identify any specific matters that may require further scrutiny input/ activity.

4. Background papers[1]

4.1 None used

[1] The background documents listed in this section are available to download from the Council's website, unless they contain confidential or exempt information. The list of background documents does not include published works.

Leeds CITY COUNCIL

Report author: Steven Courtney
Tel: 247 4707

Report of Head of Scrutiny and Member Development

Report to Scrutiny Board (Adult Social Services, Public Health, NHS)

Date: 24 November 2015

Subject: Care Quality Commission (CQC) – Inspection Outcomes

Are specific electoral Wards affected? If relevant, name(s) of Ward(s):	☐ Yes	☒ No
Are there implications for equality and diversity and cohesion and integration?	☐ Yes	☒ No
Is the decision eligible for Call-In?	☐ Yes	☒ No
Does the report contain confidential or exempt information? If relevant, Access to Information Procedure Rule number: Appendix number:	☐ Yes	☒ No

1 Purpose of this report

1.1 The purpose of this report is provide members of the Scrutiny Board with details of recently reported Care Quality Commission inspection outcomes for health and social care providers across Leeds, alongside additional information regarding the monitoring of quality and regulation of health and social care providers in Leeds.

2 Summary of main issues

2.1 Established in 2009, the Care Quality Commission (CQC) regulates all health and social care services in England and ensures the quality and safety of care in hospitals, dentists, ambulances, and care homes, and the care given in people's own homes. The CQC routinely inspects health and social care service providers, publishing its inspection reports, findings and judgments.

2.2 To help ensure the Scrutiny Board maintains a focus on the quality of health and social care services, the purpose of this report is provide an overview of recently reported CQC inspection outcomes for health and social care providers across Leeds.

2.3 Since the beginning of the current municipal year, processes for routinely presenting and reporting CQC inspection outcomes to the Scrutiny Board on a monthly basis have been established. Such processes continue to be developed and refined in order to help the Scrutiny Board maintain an overview of quality across local health and social care service providers.

CQC Inspection reports

2.4 Appendix 1 provides a summary of the inspection outcomes reported to the Scrutiny Board during the current municipal year. It also specifically highlights reports published since the Board's previous meeting in October 2015 for consideration by the Scrutiny Board. The full inspection reports are available from the CQC website and links to individual inspection reports are included in Appendix 1; however the full inspection reports are not routinely provided as part of this report.

2.5 A further update will be provided at the meeting should the details of any further inspection reports become available.

2.6 A CQC representative was invited to the Scrutiny Board meeting, but is unable to attend. It is hoped a representative will attend the Board's meeting in December 2015.

Scrutiny Board visits

2.7 At the previous Board meeting, there was discussion around the potential of a series of joint HealthWatch and Scrutiny Board visits to some service providers to help inform Members' understanding of service quality. Positive discussions have taken place with Healthwatch Leeds in this regard with a view to establishing a programme of visits in the near future. More details will be provided as and when they become available.

Adult Social Care Monitoring

2.8 To help members' understanding of Adult Social Services' role in maintaining an overview of quality across adult social care providers and its relationship with the CQC, a briefing note is provided at Appendix 2.

2.9 Appropriate representatives from Adult Social Services have been invited to attend the meeting to address any specific queries from members of the Scrutiny Board.

CQC consultation and engagement

2.10 Since the previous meeting in October 2015, it has come to light that the CQC has commenced some engagement and consultation activity around (a) the future of health and care quality regulation – attached at Appendix 2, and (b) regulatory fees (from April 2016) – attached at Appendix 3.

2.11 The closing date for responses to the engagement work around the future of health and care quality regulation is 22 November 2015. The consultation on the proposals for regulatory fees remains open until 15 January 2016.

3. Recommendations

3.1 That the Scrutiny Board considers the details set out in this report and its appendices and determines any further scrutiny activity and/or actions, as appropriate.

4. Background papers[1]

4.1 None used.

[1] The background documents listed in this section are available to download from the Council's website, unless they contain confidential or exempt information. The list of background documents does not include published works.

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APPENDIX 1

SUMMARY OF RECENT CARE QUALITY COMMISSION (CQC) INSPECTION REPORTS

Publication Date	Organisation	Type of provider	Outcome	Web link to the report
29 July 2015	Homecare Support – Leeds (LS7 2AH)	Homecare	Good	http://www.cqc.org.uk/location/1-456708711
31 July 2015	Springfield Care Home (LS25 1EP)	Residential Care	Requires improvement	http://www.cqc.org.uk/location/1-154091843
31 July 2015	Spinney Residential Home (LS12 3QH)	Residential Care	Requires improvement	http://www.cqc.org.uk/location/1-112270555
17 Aug. 2015	Waterloo Manor Independent Hospital (LS25 1NA)	Hospital - mental health	Inadequate	http://www.cqc.org.uk/location/1-156620871
18 Aug. 2015	Ethical Homecare Solutions (LS7 3DX)	Homecare	Requires improvement	http://www.cqc.org.uk/directory/1-321807303
18 Aug. 2015	Hopton Court (LS12 3UA)	Residential Care	Requires improvement	http://www.cqc.org.uk/directory/1-309428606
18 Aug. 2015	Owlett Hall (BD11 1ED)	Nursing Care	Requires improvement	http://www.cqc.org.uk/directory/1-141599363
20 Aug. 2015	Oakwood Hall (LS8 2PF)	Nursing Care	Requires improvement	http://www.cqc.org.uk/directory/1-123576529
21 Aug. 2015	Yorkshire Ambulance Service NHS Trust (WF2 0XQ)	Ambulance Service	Requires improvement	http://www.cqc.org.uk/provider/RX8
25 Aug. 2015	Caremark (Leeds) (LS6 2QH)	Homecare	Requires improvement	http://www.cqc.org.uk/directory/1-232681786
26 Aug. 2015	Adel Grange Residential Home (LS16 8HX)	Residential Care	Requires improvement	http://www.cqc.org.uk/directory/1-110993039

Publication Date	Organisation	Type of provider	Outcome	Web link to the report
26 Aug. 2015	Atkinson Court Care Home (LS9 9EJ)	Nursing Care	Requires improvement	http://www.cqc.org.uk/directory/1-126476576
7 Sept. 2015	Airedale Residential Home (LS28 7RF)	Residential Care	Requires Improvement	http://www.cqc.org.uk/directory/1-128272457
10 Sept. 2015	Brooklands Residential Home (LS19 7RR)	Residential Care	Inadequate	http://www.cqc.org.uk/directory/1-117613913
11 Sept. 2015	Oaklands Residential Home (LS26 9AB)	Residential Care	Good	http://www.cqc.org.uk/directory/1-1963864878
11 Sept. 2015	Sheild Recruitment Limited (LS1 2NL)	Homecare Agency	Good	http://www.cqc.org.uk/directory/1-1289082975
16 Sept. 2015	Kirkstall Court (LS5 3LJ)	Rehabilitation / Residential Care	Good	http://www.cqc.org.uk/directory/1-112566812
17 Sept. 2015	Oakwood Lane Medical Practice (LS8 3BZ)	GP Practice	Good	http://www.cqc.org.uk/location/1-2000523982
17 Sept. 2015	The North Leeds Medical Practice (LS17 6PZ)	GP Practice	Good	http://www.cqc.org.uk/location/1-574141809
17 Sept. 2015	Carlton House (LS26 0SF)	Residential Care	Requires Improvement	http://www.cqc.org.uk/directory/1-130890582
24 Sept. 2015	Collingham Church View Surgery (LS22 5BQ)	GP Practice	Good	http://www.cqc.org.uk/location/1-547723756
24 Sept. 2015	Summerfield Court (LS13 1AJ)	Residential Care	Requires improvement	http://www.cqc.org.uk/directory/1-1441008775
30 Sept. 2015	Suffolk Court (LS19 7JN)	Residential Care	Good	http://www.cqc.org.uk/directory/1-136455689
30 Sept. 2015	Oakhaven Care Home (LS6 4QD)	Residential Care	Requires improvement	http://www.cqc.org.uk/directory/1-116738339

Publication Date	Organisation	Type of provider	Outcome	Web link to the report
1 Oct. 2015	Hilton Road Surgery (LS8 4HA)	GP Practice	Requires Improvement	http://www.cqc.org.uk/location/1-583516067
2 Oct. 2015	Brandon House Nursing Home (LS8 2PE)	Nursing Care	Requires improvement	http://www.cqc.org.uk/directory/1-126778737
9 Oct. 2015	Wharfedale House - Care Home Physical Disabilities (LS22 6PU)	Residential Care	Good	http://www.cqc.org.uk/directory/1-120087427
12 Oct. 2015	Home Lea House (LS26 0PH)	Residential Care	Good	http://www.cqc.org.uk/directory/1-136455527
12 Oct. 2015	Seacroft Grange Care Village (LS14 6JL)	Nursing Care	Requires improvement	http://www.cqc.org.uk/directory/1-990605516
15 Oct. 2015	Aire View (LS5 3ED)	Residential Care	Requires improvement	http://www.cqc.org.uk/directory/1-134645463
15 Oct. 2015	St Lukes Care Home (LS28 5PL)	Nursing Care	Requires improvement	http://www.cqc.org.uk/directory/1-116738422
16 Oct. 2015	Astha Limited - Leeds (LS7 2AH)	Homecare Agency	Requires improvement	http://www.cqc.org.uk/directory/1-1554674153
22 Oct. 2015	Amber Lodge – Leeds (LS12 4LL)	Residential Care	Requires improvement	http://www.cqc.org.uk/directory/1-123208614
28 Oct. 2015	Anchor Trust (The Laureates) (LS20 9BJ)	Homecare Agency	Good	http://www.cqc.org.uk/directory/1-126242468
28 Oct. 2015	Rossefield Manor (LS13 3TG)	Homecare Agency	Good	http://www.cqc.org.uk/directory/1-283353126
28 Oct. 2015	Acre Green Nursing Home (LS10 4HT)	Nursing Care	Requires improvement	http://www.cqc.org.uk/directory/1-309409391

Publication Date	Organisation	Type of provider	Outcome	Web link to the report
28 Oct. 2015	St Anne's Community Services - Leeds DCA 2 (LS11 6JU)	Homecare Agency / Supported living	Requires improvement	http://www.cqc.org.uk/directory/1-121773590
29 Oct. 2015	EcoClean Community Care (LS16 6PD)	Homecare Agency	Good	http://www.cqc.org.uk/directory/1-1177041289
30 Oct. 2015	Grace Homecare (LS11 6XD)	Homecare Agency	Good	http://www.cqc.org.uk/directory/1-1242015563
30 Oct. 2015	Helping Hand Care Services Limited (LS7 4NB)	Homecare Agency	Good	http://www.cqc.org.uk/directory/1-140567061
30 Oct. 2015	St Anne's Community Services – Benedicts (LS22 7TF)	Nursing Care	Good	http://www.cqc.org.uk/directory/1-121773225
30 Oct. 2015	Spring Gardens (LS21 3LJ)	Residential Care	Requires improvement	http://www.cqc.org.uk/directory/1-136455675
30 Oct. 2015	Ashcroft House – Leeds (LS16 9BQ)	Residential Care	Inadequate	http://www.cqc.org.uk/directory/1-109574569
3 Nov. 2015	Berkeley Court (LS8 3QJ)	Residential Care	Requires improvement	http://www.cqc.org.uk/directory/1-145939999
9 Nov. 2015	Grove Court Nursing Home (LS6 3AE)	Nursing Care	Good	http://www.cqc.org.uk/directory/1-160600751
9 Nov. 2015	Charlton Court Nursing Home (LS28 8ED)	Nursing Care	Requires improvement	http://www.cqc.org.uk/directory/1-278008729
10 Nov. 2015	Donisthorpe Hall (LS17 6AW)	Nursing Care	Inadequate	http://www.cqc.org.uk/directory/1-114958058
11 Nov. 2015	Cardinal Court Extra Care Sheltered Housing (LS11 8HP)	Homecare Agency	Good	http://www.cqc.org.uk/directory/1-283353021

Publication Date	Organisation	Type of provider	Outcome	Web link to the report
11 Nov. 2015	Yorkshire Senior Care t/a Home Instead Senior Care (LS22 7FD)	Homecare Agency	Good	http://www.cqc.org.uk/directory/1-334454074

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Adult Social Care Services
BRIEFING PAPER

ADULT COMMISSIONING BRIEFING NOTE	DATE: 11th November 2015
SUBJECT: **Adult Social Care Monitoring**	
PURPOSE: To provide an update to the Scrutiny Board on the Adult Social Care contract monitoring process.	

BACKGROUND INFORMATION:

Over the past few years, Adult Social Care has been developing its contract monitoring processes in various are service areas, to ensure services commissioned by the directorate are delivering quality services in accordance with their contract.

Homecare

This was first quality monitoring system established and was put in place when the contract was commissioned in 2010. The Quality Standard Assessment (QSA) was developed as part of the contract for the current framework and all contracted providers are subject to monitoring process as part of their contract. The QSA consists of a set of quality standards that cover areas such as Needs and Risk Assessment, Care Planning, Security, Health And Safety, Protection from Abuse, Complaints, Diversity And Inclusion. The validation process for the QSA consists of a provider self-assessment against the standards, a desktop evaluation by the contract officer, a visit to the providers office to validate the content of their self-assessment and a service user survey to seek their views on the quality of service being provided.

Older People's Care Homes

The Quality Framework (QF) was developed as part of the care home commissioning process during 2012 and was developed in conjunction with care home providers in the city. The QF is incorporated into the care home framework contract and providers who tendered to be part of the framework are now subject to the validation process as part of the QF. The QF consists of a 3 overall quality sections (Quality of Service, Environment and Resources, Financial Security and Development), with 11 separate standards within these sections which cover areas such as Promoting health, wellbeing and independence; Leadership and management is effective in ensuring a high quality service for residents and Residents, their families; and commissioner/s can be confident that the care home operator is able to meet the financial demands of providing safe and appropriate services. The QF is assessed through a validation process which consists of a provider self-assessment and a validation visit to the home over a number of days which will observe practices in the home, scrutinize relevant documents and engage with staff, service users and their relatives to seek their views on the quality of the service being provided. Since the validation visits commenced early in 2013, all 95 care homes on the framework have received a validation visit and have been awarded a QF rating of either Core with an improvement plan, Core or Enhanced.

Learning Disability, Mental Health, Physical Impairment Care Homes and Supported Living

During 2014, the contracts team have introduced a new framework contract for LD care homes, which incorporates a QSA process to monitor the quality of the service being provided. The QSA process contains 5 standards which are Assessment and Planning; Security, Health and Safety; Safeguarding and Protection from Abuse; Fair Access, Fair Exit, Diversity and Inclusion; and Autonomy, Involvement, Choice, and Empowerment. The process consists of a provider self-assessment against the standards and a validation visit to the care home to scrutinize documents observe practice and engage with residents and staff to seek their views on the quality of service being provided. Validation visits are currently underway at all Leeds based LD care homes. The contracts team are in the process of introducing a new contract and QSA for LD supported living contracts, and the same process and documents will be introduced for Mental Health and Physical Impairment care homes and supported living services.

General contracts

In addition to the registered service contract, other contracts will be monitored proportionately, depending on their value and risk to the authority. These will include contracts such as the Neighborhood Networks and advocacy contracts , which will be monitored though quarterly contract management meetings.

CQC inspection of registered services

CQC have now introduced their new inspection process which will rate providers under 4 categories, Outstanding, Good, Requires Improvement and Inadequate. CQC have now commenced their new inspection process and approximately 50% of registered providers have been inspected under the new process. CQC have indicated that the inspection of all registered providers will be completed by October 2016.

Main issues:

Improving the contract management process

A main risk identified on the directorate's risk register is the failure, in terms of quality, of a CQC registered provider. Whist ASC can only monitor the provider with whom we have a contract, the directorate contracts with the majority of care home providers in the city and a significant number of domiciliary care providers. It is therefore imperative that robust contract monitoring processes are in place for these services.

The homecare QSA process is currently being reviewed as part of the homecare re-commissioning project which has previously been reported to the Scrutiny Board.

As part of the development of the care homes QF, it was agreed with providers that after the first round of validation visits, the QF would be reviewed to assess its effectiveness and to suggest improvements to the standards. This review is currently underway and contract officers are working with the Leeds Care Association Leadership Group to agree and necessary changes to the QF document. As previously mentioned, validation visits have now taken place at all care homes which are part of the framework contract, and for the first time, ASC has a baseline of quality on which to assess the improvements to the homes. All care homes are now going through a second year validation and where improvements have failed to be made, further

action can be considered, such as suspension of new local authority placements, removal from the framework contract or reporting issues to the regulator. The contracts monitoring team are now fully established and each officer has a portfolio of homes which they will monitor. This will allow a closer working relationship with home managers and CQC inspectors and will allow the possibility of being able spot and address quality issues which may arise in a home, much sooner than has previously been possible.

Given the LD contract and QSA process has only recently been introduced, there are no plans to review this until the first round of validation visits have been completed.

A regular information sharing meeting has been established with CQC which includes colleagues from safeguarding and the South and East CCG and is attended by contract team leaders from all the service areas. The group will continue to review the effectiveness of the information obtained to improve services in the city.

Provider forums are now in place for all service areas with a main theme of being able to share best practice throughout the sectors.

CONCLUSIONS & RECOMMENDATIONS:

Scrutiny members are asked to note the content of this briefing.

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Care Quality Commission

Building on strong foundations

Shaping the future of health and care quality regulation

October 2015

The Care Quality Commission (CQC) is the independent regulator of health and adult social care in England

We make sure health and social care services provide people with safe, effective, compassionate, high-quality care and we encourage care services to improve

Our role

- We register care providers.
- We monitor, inspect and rate services.
- We take action to protect people who use services.
- We speak with our independent voice, publishing regional and national views of the major quality issues in health and social care.

Our values

- Excellence – being a high-performing organisation
- Caring – treating everyone with dignity and respect
- Integrity – doing the right thing
- Teamwork – learning from each other to be the best we can.

Contents

Foreword

Our strategy for 2013-16 set out the case for change in quality regulation, leaving behind a model in which people had lost confidence. Over the last three years health and social care quality regulation has been improved, with intelligence-led, expert, rigorous inspections and ratings of services. However there is much further to go. Our strategy for 2016-21 will set out the case for developing our approach – building on the strong foundations we now have in place.

Our purpose remains the same – to make sure services provide safe, high-quality, effective, compassionate care and to encourage services to improve. We will complete comprehensive inspections of all services that we rate by the end of 2016 – this will provide a powerful baseline understanding of the quality of health and adult social care services in England for the first time.

Regulation alone cannot drive the change needed but it has a crucial role to play in encouraging improvement, alongside other influences on quality – such as providers and their staff, people who use services, professionals, and commissioners and funders. It also helps provide transparency so people know how good the services are that they use. But we recognise that it is first and foremost providers themselves who can and must bring about improvements for people who use services. Quality regulation, while a crucial influence on quality, can never be a guarantee.

Quality regulation cannot stand still as the health and social care landscape changes. We must be flexible and responsive – able to register and inspect new models of care, and to comment on quality for specific population groups and across local areas whilst providing information for the public which supports them to choose between individual care services. We must play our part in the productivity challenge across public services by supporting providers to use resources as efficiently as possible to deliver high quality care, and by looking at how we can deliver our own purpose with fewer resources.

This document sets out the challenges as we see them and, because we do not have the resources to do everything we would like to do, some of the choices we face in considering how we carry out our role. We want you to help us decide what our priorities should be. It is part of a conversation we began in March this year with our publication *Shaping the future*.

Many of you have contributed to the thinking set out here. We would like to thank you for your feedback, and for your commitment to helping us continue to improve and make a real difference. We want to keep listening and would like to hear your views on this document. We will then look at this feedback and use it to set out our views for consultation on our strategy in January 2016.

David Behan, Chief Executive
and **Michael Mire, Acting Chair**

1 Introduction

This document is the basis for developing the new Care Quality Commission (CQC) strategy, which will start in April 2016. It sets out our thinking so far on the next phase of our approach to the quality regulation of health and social care services. It does not cover everything we will need to do in the next five years, but asks for your views on the main strategic choices. It is written with the assumption that our statutory role stays unchanged for the period up to 2021.

In January we will publish a strategy document that reflects your reactions to this paper and sets out for further consultation how CQC will operate over the strategic plan period. In April we will publish our final strategy for 2016-21 that will tell you what we have decided to do, with your help. We will set out in our business plan for 2016/17 how we will implement our new strategy in its first year.

People have a right to expect safe, effective, compassionate and high-quality care. As the quality regulator of health and social care in England, we play a vital role in assessing the quality of care so that these expectations are met and in providing information to support people to choose care services.

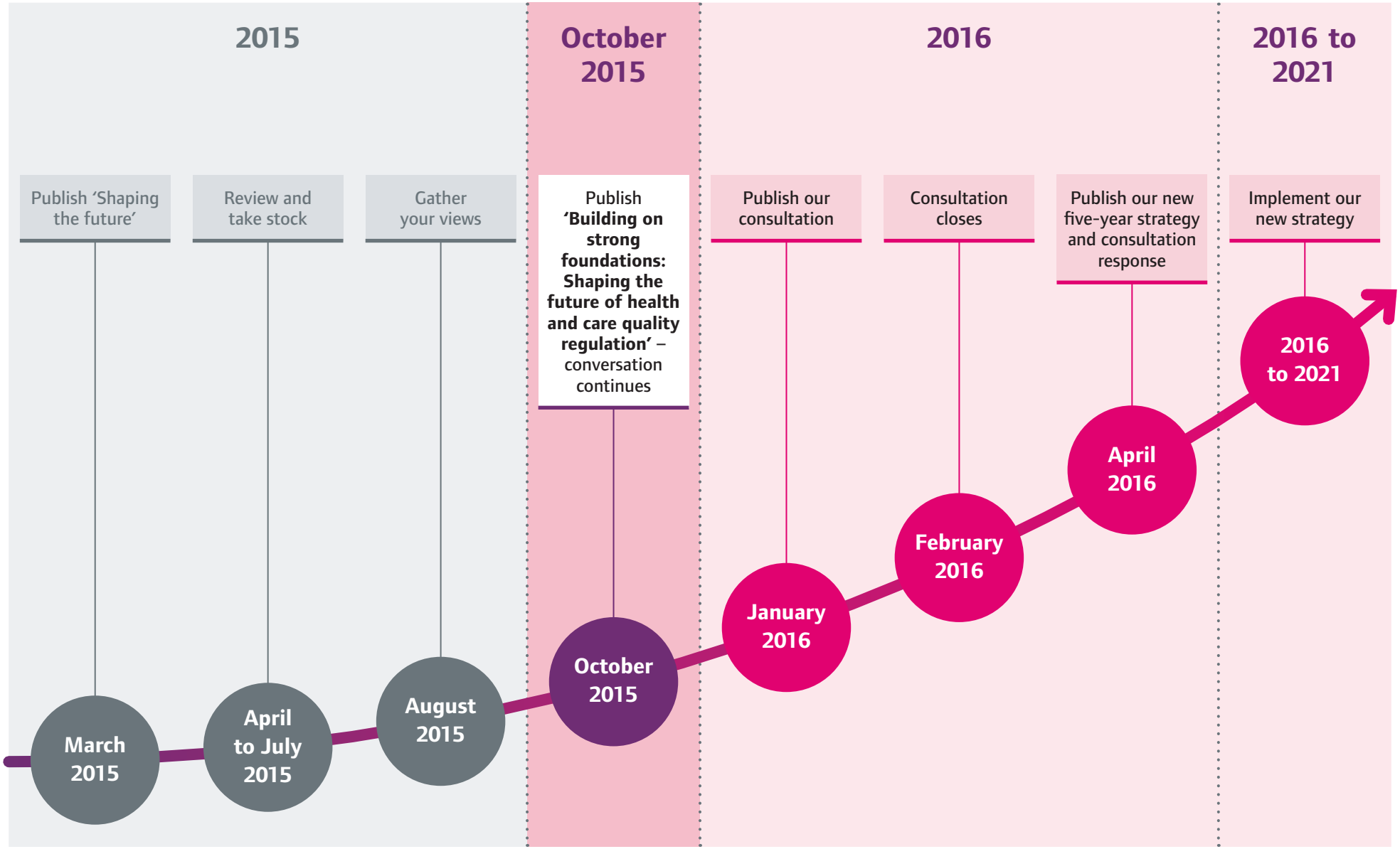
We would like you to tell us what you think about our ideas – what you think will have the most impact on the quality of care and what you think will not work. Your answers will be invaluable in helping us to develop our new strategy.

How you have helped us so far

Over the last few months we have been asking for your views on our current strategy and what we could focus on in our new strategy. We have been talking to providers, the public, professionals, stakeholders, CQC staff and commissioners of care services. We ran an online survey in the summer and received more than 700 responses.

Your feedback has helped us shape the ideas in this document and will continue to help us. The 'You have said so far' boxes throughout the document indicate the key issues you have told us about.

We would like to hear your views at every stage of the process as we keep refining our strategy which we intend to publish in April. The next page shows our consultation and publication timeline.


2015
October 2015
2016
2016 to 2021
Publish 'Shaping the future'
Review and take stock
Gather your views
Publish **'Building on strong foundations: Shaping the future of health and care quality regulation'** – conversation continues
Publish our consultation
Consultation closes
Publish our new five-year strategy and consultation response
Implement our new strategy
March 2015
April to July 2015
August 2015
October 2015
January 2016
February 2016
April 2016
2016 to 2021

2 The changing health and care landscape

Regulation cannot stand still as the health and social care landscape is changing. As demand increases and needs change, care has to respond to this in a context of constrained resources. The NHS has to achieve sustained efficiency savings over the next five years, more than ever before. And adult social care services will have less total funding even though more people will need care. Dealing with these pressures, by saving money and transforming models of care, will be a major focus for all services over the coming years. At the same time, the continued period of low public spending means that CQC needs to find ways to deliver its purpose with fewer resources. The upcoming spending review will set the context for the entire health and care sector, including regulators and other national bodies.

There is a consensus in the NHS on the transformation needed to respond to these pressures, based on the *Five Year Forward View* plan for prevention, joined-up person-centred care, new models of care, and productivity improvements including increasing use of digital technology.

For adult social care, there is less national consensus on how to ensure the sector is able to deliver the care people need. Across sectors, we are likely to see varied responses, as different services and systems adapt to an increasingly challenging environment. Innovation, including technological advances, has the potential to change current models of care in new ways that are hard to predict. This means that we need to develop flexible models and ways of working that help us to make changes quickly and easily as we go.

Although most services continue to deliver good or outstanding care, there is still inadequate care, and there are quality challenges across all sectors as described in our 2014/15 *State of Care* report. As services focus on financial issues as well as the need for innovation and transformation, there is a risk that quality may suffer – even if benefits are delivered in the long term.

There is a debate over the best way to drive change in a time of transformation. We recognise that change should be led from inside organisations, drawing on learning from peers rather than solely through regulation. This raises the question of how CQC as the quality regulator can work with others to get the right balance between encouraging providers to improve and controlling quality by taking enforcement action. We expect, and welcome, challenge from providers and partners as to the value that we bring to the sector.

The changing health and social care context does not change our fundamental purpose. But we need to think how best to deliver this purpose in the future, so that people who use services continue to have a strong, independent regulator on their side – encouraging improvement, providing information about quality, and taking action against poor care.

What we now know about quality

Our new inspection and ratings approach means that we now know more about quality of care than ever before.

- Many of the services we have rated deliver good or outstanding care, although this differs by sector. The quality of care provided in the primary medical services sector was particularly high, with over 85% of GP practices we have rated being good or outstanding.
- A substantial proportion of services received a rating of requires improvement.
- Seven per cent of services were rated inadequate. In 2014/15 we carried out 1,179 enforcement actions.
- More than 70% of providers say that CQC inspections gave them information that helped them to improve their service.
  - Half of re-inspections have resulted in improved ratings.
  - Almost all of the 11 NHS trusts that were put into special measures in 2013 had demonstrated some improvement when we inspected eight to 10 months later. Five had improved sufficiently to exit special measures.

Source: CQC *State of Care* 2014/15

3 Building on strong foundations

The regulation of the quality of care has been improved, but we need to do more.

Three years ago our approach to regulation was not working. There was learning for CQC from failings at Mid Staffordshire NHS Foundation Trust, Winterbourne View and University Hospitals of Morecambe Bay NHS Foundation Trust. At the same time there was heavy criticism from the Health Select Committee and others of our strategy, performance and leadership.

In response to these events, and through wide-ranging and in-depth co-production with our stakeholders, we developed our 2013-16 strategy, *Raising standards, putting people first*, which includes our current purpose and role. We later developed our values.

- **Our purpose** is to make sure health and social care services provide safe, effective, compassionate, high quality care and encourage care services to improve.
- **Our role** is to monitor, inspect and regulate services to make sure they meet fundamental standards of quality and safety. We publish what we find, including performance ratings to help people choose care.
- **Our values** are excellence (being a high-performing organisation), caring, (treating everyone with dignity and respect), integrity (doing the right thing) and teamwork (learning from each other to be the best we can).

We put in place an approach to deliver comprehensive, expert-led inspections in adult social care, hospitals and primary medical services, that are trusted by the public and seen as robust by those we regulate. These inspections are carried out by teams of specialists in their field, like hospital consultants or GPs. We ask the same five questions about every service we inspect:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive?
- Is it well-led?

We listen more to people who use services and their families and carers about their experiences of care. These include concerns about poor care either from people using services or staff who work in services. On our inspections we

use Experts by Experience, people who have had experience of recently using a service. Any changes to our methods are made through a process of co-production that includes taking advice from groups representing people who use services.

We have developed Intelligent Monitoring systems that use national and local data to inform our decision making, and enable quick responses to identified risks. This includes making increasing use of people's experiences of care, as well as statistical information. We use this intelligence to help us decide when, where and what to inspect to make sure we are looking at the right places at the right time.

We have introduced four ratings to make it easier for people to find out about the quality of local services, and to encourage improvement among providers. These are: outstanding, good, requires improvement and inadequate. We are open and transparent about how we work and we publish all of our information, including ratings and reports. We believe that transparency is essential for improving quality as it makes it possible to learn from others.

We take enforcement action when fundamental standards of care are not met. When services are found to be inadequate we normally apply a process of 'special measures', which sets out a clear timeframe within which we expect the service to improve, and we assess whether this has happened by re-inspecting.

We are applying our new approach to regulation to more than 40,000 health and social care services across England. We will complete our programme of comprehensive inspections next year. For the first time we will be able to compare the quality of health and social care services across England, based on an agreed definition of what good quality care looks like.

We know from our inspection findings so far that our approach has been effective in driving improvement in services and protecting people using services from poor quality care, including taking enforcement action when this is necessary. Our approach has also helped us to identify and share examples of good practice so others can benefit, and to find and take action against poor care.

Part of our purpose is to encourage improvement. Although the primary responsibility for delivering good care lies with the organisations providing care, we have a crucial role in assessing the quality of care and intervening when necessary to support improving care. However we cannot do this alone and so we work closely with our partners – providers and their staff, people who use services, professionals and commissioners and funders, as well as other national bodies such as NHS England, NHS Improvement, National Institute for Health and Care Excellence (NICE), professional regulators and professional bodies, to influence quality.

We need to do more

Our shift from being a regulator that focused purely on legal compliance with standards, to one with robust, intelligence-driven, expert-led inspections and ratings has been widely welcomed. In general, the people we work with support our more rigorous inspections and the actions we take if we find poor care. The majority of services say that they identify areas for improvement following a CQC inspection.

You have said so far

Our new inspection and ratings model, and especially its increased focus on people who use services and their carers, is a major achievement. You also said that we have achieved a higher level of transparency and accountability through our new approach. However you said consistency needs to improve in terms of how our model is applied by different sectors and between inspection teams.

We have engaged well with stakeholders across the health and care system to design our new approach. You said that as an organisation we are now more open about our work, but that improvements could be made about how we work with our partners, especially around engaging with the services we inspect.

As a result of our work, providers have seen improvements in quality of care and you or your organisation has changed the way you work as a result of our inspections.

Over the last three years, we have become a source of advice and support rather than just an authority, and we have provided useful guidance that helps providers to understand and drive improvement.

We need to focus on being a more efficient and effective regulator. You suggested focusing more on certain areas during inspection, for example the skills of staff providing specific services, and having a more robust approach to inspection in mental health and domiciliary care (care at home). You also said that we need to make improvements to the way we inspect, for example responding quickly when there are concerns raised.

We have listened closely to our partners and those who use services and we know there are a number of areas where we need to improve and do more. For example:

- We have made some major operational changes, but many of the supporting systems and processes we use are not yet efficient enough. This means we are not consistently delivering the standards of excellence we demand of others, for example publishing reports quickly following inspections.
- Our current inspection model does not yet fully reflect people's experiences as they move between services. The exceptions to this are our thematic reports, for example *Cracks in the pathway* looked at the experiences of people with dementia as they move between hospitals and care homes. Also, where we cannot easily observe care being delivered, for example in services in the community and in people's homes, we need to think of additional ways to gather the views of people receiving those services.
- Our new approach involves more use of data but we need to work on ensuring this is always easy for inspectors to use, and that the data clearly informs inspection planning, decisions and judgements.
- Despite the introduction of Intelligent Monitoring, we need to do more to bring together the full range of information, including what we know from people who use services, those close to them and staff, to identify risks quickly and systematically.
- We need to work more closely with local authorities and NHS commissioners, as well as other partners.

We are also working to understand the impact of our regulatory activities and how the cost of our activities to CQC and others compares with the benefits delivered. We are assessing the impact on all sectors of registration, monitoring, inspection, ratings, reporting, enforcement and

using our independent voice. We are looking at evidence from surveys of providers, the public, and inspection teams as well as performance measures. This is very important as an increasing proportion of our budget comes from the fees we charge services that are regulated by us, and so we must demonstrate evidence of our impact and value for money.

To deliver our purpose we must understand and focus on what matters to people, build trust and confidence in our work, empower people to understand the quality of care they should expect, and help them to choose between services if they want to. We will continue our work to raise awareness and understanding of CQC's role and purpose, including improving our public website so it is easier to find information. We remain committed to listening to and acting on people's views and experiences of care, working with the public to develop and improve our approach, and providing high quality information about care services.

Tell us what you think

1 Are there any other important issues, relating to our approach to regulation and the context in which we are working, that we need to consider?

4 The next phase in CQC's regulatory approach

We believe a well-functioning health and care system needs improvement to be led by providers and encouraged through quality regulation. In our inspections so far we have seen many high-performing, well-led services that are continuously learning and improving.

We have also, however, found significant variation in quality and we know that leadership appears to have a strong influence on all other aspects of quality, particularly safety. This variation shows that there continues to be a need for independent quality regulation, alongside improvement led by providers, professionals, managers and staff. People who use services need CQC to identify what needs improvement and to encourage it.

This leads us to the next phase in CQC's regulatory approach, one in which we maintain our responsibilities towards ensuring high quality care but begin to build a more collaborative approach where responsibility for quality improvement is increasingly shared with providers and our partners. National and local organisations must actively find ways to reduce overlapping regulation by working together more effectively.

We need to make any changes to how we work while maintaining and improving what we do now. In the challenging context that health and care services are facing, it is more important than ever that CQC, as the independent quality regulator, maintains its focus on taking tough action to protect people where we find poor care.

Tell us what you think

2 Given that regulation is just one influence on care quality, how do you think CQC can best work with others to encourage improvement in the quality of care over the next five years?

What this next phase means for you

While writing this document, we reflected on the potential impacts that any changes to our approach could have on you, whether you are a provider, a member of the public or a CQC staff member. This is not a complete list of all the potential impacts and we welcome your feedback.

The public

We want the next phase in the development of our approach to give you increased confidence that we are on your side. We want to make sure we are providing you with the right information to help you choose care. That could be about how individual services are performing or about care across your area, or your care pathway. We also will make more use of feedback on the quality of care from people who use services.

We will continue to develop how we inspect services which we think pose the greatest risk first and we will prioritise our inspections to target where we think there may be problems, while still encouraging and making sure there is good care across all services.

Providers

As a provider you should be confident that we will improve the way we work with you and make sure we continue to find better ways to do our work. If you have improved the way you work and you have successfully maintained a good level of care, we will take this into account in our registration and inspection, while still giving you the right information to keep improving. We want you to be confident that although we know the sector is facing some critical pressures, we are thinking about ways of working which may help alleviate these.

We outline later in this chapter the potential to move towards co-regulation. This means that for providers who have had a comprehensive inspection, we could make greater use of the information about quality that they provide us with, and verify this with other information sources, including people's experiences of care, to help us to target our inspections.

CQC staff

As a CQC staff member, you should feel confident that our future approach will continue to identify poor care and encourage better care. We remain committed to listening to your views, and the views of other stakeholders as we develop as an organisation. We want to be more targeted in our work and to use our resources better, including through improving our processes and systems.

Making our model more efficient and effective

Our findings so far have demonstrated the need for strong, independent quality regulation. In the next phase of our development, we want to focus on making our approach more efficient and effective. This is so that we are better able to deliver our purpose of ensuring services provide people with safe, high-quality, compassionate care and that we encourage services to improve, and also so that we can demonstrate the value for money we deliver.

This section sets out some of the choices that we are facing as we continue to embed and refine our approach. These have been informed by our discussions with you. They are not mutually exclusive and we need to strike the right balance between them. This balance is likely to differ between the sectors we regulate, depending, for example, on the availability of data. Later on we look at potential new areas of activity for CQC that we may be required to respond to in the changing health and care landscape.

We welcome your views on whether the following are the right areas to focus on when improving our current regulatory model:

- Risk-based registration
- Smarter monitoring and insight from data
- A greater focus on co-regulating with providers
- More responsive and tailored inspections

Risk-based registration

We could develop a more proportionate, risk-based approach to each new registration application and to registration changes. This would mean handling lower risk changes to registration, such as a high performing GP practice group opening a new GP practice, in a more streamlined way. We would handle higher risk changes, such as a new provider opening a brand new care home for people with a learning disability, with appropriate expertise in order to keep people safe. We would also encourage innovation and ensure we can register new models of care in a fair way. We would use a range of tools to make expert judgements and appropriately respond to different risks, including using Experts by Experience and sector specialist inspectors. The approach would include:

- Developing a more differentiated approach based on what we know about the relative risks to the public of different services and types of registration change.
- Strengthening and clarifying the links between our approach and expectations at registration and at inspection, including how we use sector specialist inspectors and registration inspectors.
- Improving how we gather the right information from registration to use for our monitoring and inspection.
- Making sure guidance for providers is clear about what our ongoing quality expectations are and what they need to do to register.
- Improving our approach to handling the greater diversity of providers and new models of care including joint enterprises, 'vanguard' projects and national collaborations, particularly the appropriate level to register the organisation.

Tell us what you think

3 We have described what **risk-based registration** could look like.

a What do you like about this?

b What do you not like about this?

4 What impact would risk-based registration have on you?

Smarter monitoring and insight from data

Our 2015-16 business plan sets out our intention to develop and extend our existing Intelligent Monitoring into a comprehensive surveillance model – 'CQC Insight'. This will combine numerical data with feedback from people who use services. The existing data, however, is not yet robust enough across all sectors to be a reliable measure of quality without inspections alongside it. We will therefore work with others to improve our data, and to develop a shared view of the most important quality and risk indicators in health and social care. As a result, CQC will be better able to protect people who use services by triggering action where concerns are raised, and targeting inspection resources where the risks to the public are greatest. Specifically, this would include:

- Increasing analysis of short and long-term trends in the performance of providers.
- Developing data that predicts risks and builds on the evaluation of our existing intelligence.
- Improving use of inspector intelligence and risk assessment.
- Using feedback better from people who use services and improving the use of other qualitative data.
- Improving the interpretation and dissemination of our risk intelligence products.
- Identifying key intelligence triggers for regulatory action.

Tell us what you think

5 We have described what **smarter monitoring and insight from data** could look like.

a What do you like about this?

b What do you not like about this?

6 What impact would smarter monitoring and insight from data have on you?

A greater focus on co-regulating with providers

We could move towards an approach of co-regulation, which would mean CQC supporting providers to assess and share evidence on their own quality of care against each of our key questions. We could explore this further for providers who have already been through a comprehensive inspection under our new approach and who could, using detailed key lines of enquiry, report on any changes to the quality of care provided since their previous inspection.

We could compare this evidence from the provider with the monitoring data we hold about them and other data including the views of people who use services, staff and local partners. We could use all of this information to target our activity so we make sure we prioritise the right things on inspection. We would never rely solely on the information that providers give us without challenge.

Co-regulation could encourage providers to develop their own systems and processes for understanding quality, which we know is an essential step in developing a culture of continuous improvement. While CQC must always act swiftly where risks emerge, it is providers who deliver improvements, and we want to encourage and support them to do so.

Tell us what you think

7 We have described what a **greater focus on co-regulating with providers** could look like.

a What do you like about this?

b What do you not like about this?

8 What impact would a greater focus on co-regulating with providers have on you?

More responsive and tailored inspections

Developing our inspection approach so it is more responsive to risk and tailored to the particular situation of each service would have a number of benefits. It would help us target our resources better towards providers that are higher risk, and strengthen how we identify and share good practice. This would only be possible if the previous three areas – risk-based registration, smarter monitoring and insight from data and a greater focus on co-regulating with providers – are taken forward.

Examples of how we might develop our approach in this way include:

- Reducing the number of large comprehensive inspections we do of all the services offered by a provider at the same time.
- Inspecting services we have already found to be of good or outstanding quality less frequently or less intensively than other services, or relying more on other sources of information and assurance besides inspection.
- Exploring how we can use random sampling in the selection of providers to inspect alongside our assessment of risk.
- Further aligning our inspection activity with other partners in the sector to remove duplication of effort.
- Making sure we look carefully at the way care for specific conditions provided by different services is being delivered.
- Ensuring that we inspect in ways that take account of and support the development of new models of care.

Tell us what you think

9 We have described what **more responsive and tailored inspections** could look like.

a What do you like about this?

b What do you not like about this?

10 What impact would more responsive and tailored inspections have on you?

Tell us what you think

11 In this section we have detailed four areas which will help successfully achieve the next phase of our regulatory approach. In order of importance, which will have the most impact in encouraging improvements in the quality of care?

Looking at the quality of care for populations and places

The previous section focused on making our approach to regulation more efficient and effective. This section on populations and places, and the next section on use of resources consider potential new areas of activity for CQC that may be required as a result of the changing health and care landscape. We do not have the resources to do everything we would like to do, so we are asking for your views to help us focus on the right priorities for the next five years.

People are living longer and with more and multiple long-term conditions. As a result, traditional ways of delivering health and care often no longer meet people's needs. We know that quality issues occur when care is not coordinated or person-centred. Too often people find themselves receiving poor quality care, or no care, as they fall through the gaps in the system. The NHS *Five Year Forward View* sets out a strong vision for the future of health and care, and the sector is already responding by developing new models of integrated care and stronger local partnerships.

In our *Shaping the future* document, which accompanies our 2015/16 business plan, we set out our intention to develop an approach to regulating new models of care and to assessing the quality of care for specific populations and across local areas.

You have said so far

You had mixed views on whether we should assess the quality of care in an area.

You were supportive of an approach which focuses on care pathways and joined-up services, and the possibility that this approach could mean services better meet the needs of the local population. And you also expressed a desire to understand more about what was happening locally as well as the cost of care by local area.

However you were concerned about how useful a geographical view would be to you, and about the resources required to develop new methodologies.

Considering your views, we think there are a few choices about how we respond to this agenda.

Improving our current inspection approach

We could assess how well providers are working in partnership in and across their organisations to deliver person-centred care. This could be backed up by more integrated working across our three inspection directorates, for example, enabling local cross-sector inspection teams to better share intelligence about provider risk. By the end of next year, our baseline of comprehensive inspections will help us bring together our findings across a local area and provide a joined-up view of the overall quality of health and adult social care services in that area.

Going beyond our existing provider-based approach

We could continue the work we have begun this year to focus our thematic reports on the quality of care for specific populations (for example, older people) and in local areas. This would mean we could continue to develop approaches to assess quality beyond specific providers, for example following individuals' experiences of care across different services, and doing assessments of the quality of care that people receive in a particular place. We would develop this work with partner organisations, including to complement existing approaches such as NHS England's process for assuring clinical commissioning groups.

Additionally, there is the potential for a more radical shift in the long term that would involve reducing some aspects of comprehensive provider assessment, once all services have been inspected. If we followed this approach, we would need to consider who would be held to account for the quality of care when our assessment reaches beyond individual providers. This approach could improve information about the quality of care that groups, such as older people, experience as they move between different services, but could also lead to a corresponding reduction in information about individual providers meaning people might have less up-to-date information to help them choose services. The more we shift in this direction the more we will need to redirect resources away from our existing provider-based approach.

Tell us what you think

12 We have described how we could assess how well organisations are working together to provide health and care services for specific populations and in specific local areas.

a What do you like about this?

b What do you not like about this?

13 How useful would this information be for you?

14 Should it be a priority for CQC, given that it would mean allocating resources from other activities?

Assessing how providers use resources

On 15 July 2015, the Secretary of State announced that CQC would start to assess NHS trusts' use of resources. This means we will begin to check that hospitals are using their resources (for example staff, equipment and facilities) in the best way possible. We will begin to pilot our approach in NHS acute trusts from April 2016. We have published the initial proposals for our assessment approach, which can be found at www.cqc.org.uk/useofresources

CQC has an existing objective in the Health and Social Care Act 2008 to encourage "the efficient and effective use of resources in the provision of health and social care services". Assessing how hospitals use resources is consistent with that objective, and an appropriate development in light of the efficiency challenges that NHS trusts face. In an environment of tight resources, providers will need to be more efficient and effective to sustain and improve quality. Poor quality care can introduce additional costs, while inefficient services can affect quality of care.

You have said so far

We should use our position to highlight the challenges that the health and adult social care sector is facing in terms of resources. You also said we were well placed to monitor and encourage efficiency improvements in providers, while making sure there is still a focus on assessing the quality of care.

In line with CQC's purpose, we plan to look at how resources are being used efficiently and effectively to provide good quality care. Our approach will be consistent with, and may happen alongside, our existing inspections and ratings.

- We will develop a clear framework for our use of resources assessments based around key lines of inquiry and data given by providers in advance of inspection.
- We will use high-level monitoring to understand performance across NHS trusts on an ongoing basis. In developing the metrics we use for this monitoring activity, we plan to draw on the work of the Carter review.
- We will conduct some inspection fieldwork to test and validate the information and data we gather prior to an inspection.
- We will use this information to assess and rate providers on their use of resources on a four-point scale. This would be published with our inspection reports, but we do not currently plan to incorporate our use of resources rating into our quality ratings.

There will also be some differences from our approach to assessing quality: our assessments of use of resources will be based more heavily on data and monitoring, with limited fieldwork. We do not initially plan to rate individual services for their use of resources, only the trust as a whole.

CQC's assessment of use of resources will be of real benefit, as it will bring an increased focus on how resources can be used to deliver high quality healthcare as efficiently and economically as possible. We will ensure that a focus on the use of resources does not detract from our assessments of other aspects of quality, and in fact it may help us to highlight inefficiencies or resource shortages that impact on the access, experience and outcomes for particular groups of people. CQC's new role will also help increase transparency by making more information on how trusts use resources publicly available.

Tell us what you think

15 We have described how we could assess the use of resources in NHS trusts.

a What do you like about this?

b What do you not like about this?

In this chapter we have looked at the next phase in CQC's regulatory approach. We have described three ways we could develop our approach.

Tell us what you think

16 In terms of the three ways we could develop our regulatory approach, which one would you most like us to focus on, given that CQC has to prioritise where it allocates its resources?

Rank in order of importance:

- Making our model more efficient and effective
- Looking at the quality of care for populations and places
- Assessing how providers use resources

Equality, diversity and human rights

The approaches in this document would all be likely to impact on the equality and human rights of people using the services that we regulate. We would like to hear your views on this issue.

Tell us what you think

17 As an organisation, we embed equality and human rights in our regulatory approach. What impact do you think the ideas in this document would have in terms of people's equality and human rights?

5 What happens next

We will look at the comments you send us and use them to set out our views for consultation on our strategy in January 2016. After analysing the responses and considering other information such as examples of good regulatory practice in the UK and internationally, we will finalise and publish the strategy in April 2016. This will set out our future direction for the next five years and be developed into costed options to be delivered through our annual business plan.

Thank you for taking the time to contribute to the development of our future work. Your feedback and comments are very valuable to us. **You can respond through our online form or by email: strategyconsultation@cqc.org.uk**

How to contact us

Call us on **03000 616161**

Email us at **enquiries@cqc.org.uk**

Look at our website **www.cqc.org.uk**

Write to us at
Care Quality Commission
Citygate
Gallowgate
Newcastle upon Tyne
NE1 4PA

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CQC-294

Consultation

Regulatory fees – have your say

Proposals for fees from April 2016 for all providers that are registered under the Health and Social Care Act 2008

November 2015

The Care Quality Commission is the independent regulator of health and adult social care in England.

Our purpose

We make sure health and social care services provide people with safe, effective, compassionate, high-quality care and we encourage care services to improve.

Our role

We monitor, inspect and regulate services to make sure they meet fundamental standards of quality and safety and we publish what we find, including performance ratings to help people choose care.

Our values

Excellence – being a high-performing organisation

Caring – treating everyone with dignity and respect

Integrity – doing the right thing

Teamwork – learning from each other to be the best we can

Published November 2015

Contents

Foreword

Our purpose is to make sure health and social care services provide people with safe, effective, compassionate, high-quality care and we encourage care services to improve.

We regulate over 30,000 health and adult social care providers with more than 40,000 locations and set clear expectations of what good care looks like and when improvements need to be made. Under our 2013-2016 strategy, *Raising Standards, Putting People First*, we have introduced tougher registration checks, specialist and expert-led inspections, and ratings based on what matters most to the people using services. We use Intelligent Monitoring – our sources of information about providers – to help us to decide when, where and what to inspect, and report on our judgements in a fair, consistent and robust way. Our strategy for 2016-2021, which we are currently developing, will include refining our model to make it more efficient and effective. To continue to carry out our work effectively we must be a strong, independent and impartial regulator, and have sufficient resources to do the job well. We must use those resources effectively to encourage the highest standards of quality and safety and ensure that we can act quickly when we find inadequate care.

Protecting the public in this way has a financial cost. We are partly funded by grant-in-aid[1] from the government. However, government policy for all fee-setting regulators is that the full costs of their chargeable activities must be recovered through fees from providers. As we do not yet fully recover the costs of our chargeable activities, we need to be increasingly funded by the providers we regulate through the fees we charge them. This means that we have to account to both providers and taxpayers for how we use our budget. This year there is additional detailed scrutiny on the costs of public spending under the government's Spending Review 2015.

We have already put in place significant changes to the way we regulate and inspect services. Our comprehensive, more specialist and expert-led inspections, implemented across all the sectors we regulate, have increased the costs of regulation. Our fee consultation last year set out proposals for how we would start to change the balance in the amount funded by central government and by providers' fees to pay for those costs. This consultation sets out the further changes we propose to make to fees for providers in 2016/17 and beyond, to meet our obligation to achieve full chargeable cost recovery.

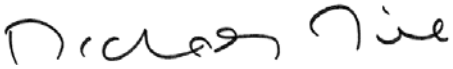
We have always consulted widely on our proposed changes to fees, and will continue to do so, as the effect on costs of our inspection approach becomes clearer in the light of our developing wider strategy. Alongside formal consultation though, we remain committed to involving providers directly in developing our fees strategy and work closely with the members of the Fees Advisory Panel to help us do that. The final decision on fees for 2016/17 rests

[1] Grant-in-aid is funding from the government. See our *Draft regulatory impact assessment* for current levels of fees, total fee income and grant-in-aid contribution, in each sector.

with the Secretary of State, and we expect this decision to be made in March 2016.

We do not underestimate the impact on providers of paying fees, and we will continue to look carefully at our costs relating to regulation. We have a responsibility to cover our costs by charging fees, but we are also accountable for demonstrating that we are fair, efficient, effective and proportionate. In this context, it should be noted that the budget for CQC in relation to the overall spending on health and adult social care in England is 0.16%.

Please send us your comments and suggestions on our proposals. It is important that the fees we set are fair, and that they reinforce the priority that providers should give to delivering high-quality, compassionate and safe care.



Michael Mire
Interim Chair

David Behan
Chief Executive

1. Summary

Background

The Health and Social Care Act 2008 includes powers for the CQC to set regulatory fees, subject to consultation.[2] Following this consultation, we will prepare the fees scheme and our Board will seek the Secretary of State's approval of our recommendations. The fee scheme cannot take effect until he has consented to it.

CQC is funded through both grant-in-aid from the Department of Health and fee income. We are required by government policy to set fees that cover our chargeable costs, and in doing so reduce our reliance on grant-in-aid. We must therefore take account of that obligation when developing our consultation proposals.

Summary of proposals

This paper sets out our proposals in relation to fees for the 2016/17 fee scheme. We know that providers also want clarity about our intention for fee increases over future years. This paper therefore sets out our proposals for the pace at which we achieve full chargeable cost recovery. We also set out our proposals for the dental sector.

Proposal 1

Our first, and main, proposal is to achieve full chargeable cost recovery over a defined timescale. This applies to all registered providers, except for the dental sector. We are seeking views on two options for the timetable to move to a position where CQC recovers full chargeable costs:

- Option 1 – recovery over **two years** between 2016-2018
- Option 2 – recovery over **four years** between 2016-2020

Because we are offering two options for the timescale to achieve full chargeable cost recovery, the annual fees we are proposing for 2016/17 will be different under each option. In tables 1 and 2 below, we have shown examples of the fees we are proposing for 2016/17, and the estimated fee charges for future years for each option. At this stage, we can only estimate fees for the years beyond 2016/17, as they will depend on many variables, including budgetary agreements and potential changes to our methodology. We have, therefore, only shown these as indicative charges in this consultation document.

We welcome respondents to this consultation making any other suggestions about how we may raise sufficient fees so that, combined with grant-in-aid, we are able to perform our statutory functions. Please see page 29.

[2] See annexes E and F in this document for more information about our powers to set fees.

Full details for all fee category bands for both options are shown in Annexes A and B.

Table 1

Proposal 1: Option 1 – Examples of proposed annual fees for 2016/17 and estimated annual fees for 2017/18 under a two-year timescale for each fee category (for full details, please see Annex A)

		Actual fee	Proposed fee	Estimated fee
Fee category	**Example band size**	**2015/16**	**2016/17**	**2017/18**
NHS trusts*	Turnover from £125,000,001 to £225,000,000	£78,208	£136,864	£215,835
Independent hospitals	4 to 6 locations	£37,987	£42,545	£46,800
Single specialty services	4 to 6 locations	£6,704	£6,704	£7,441
Community healthcare services	4 to 6 locations	£6,704	£7,039	£7,391
Independent ambulance services	4 to 10 locations	£4,469	£4,692	£4,927
Single location GPs	5,001 up to 10,000 registered patients	£725	£2,574	£4,839
Multiple location GPs	5 locations	£2,681	£9,518	£17,893
Care home providers	From 26 to 30 service users at a location	£3,761	£4,212	£4,661
Hospice services	4 to 6 locations	£6,638	£7,435	£8,226
Community social care	Single location	£796	£2,229	£3,287

* Please note, where this document refers to NHS trusts, it includes NHS trusts and foundation trusts.

Table 2

Proposal 1: Option 2 – Examples of proposed annual fees for 2016/17 and estimated annual fees from 2017/20 under a four-year timescale for each fee category (for full details, please see Annex B)

		Actual fee	Proposed fee	Estimated fee		
Fee category	**Example band size**	**2015/16**	**2016/17**	**2017/18**	**2018/19**	**2019/20**
NHS trusts	Turnover from £125,000,001 to £225,000,000	£78,208	£109,491	£144,200	£180,250	£215,835
Independent hospitals	4 to 6 locations	£37,987	£40,266	£42,682	£44,603	£46,800
Single specialty services	4 to 6 locations	£6,704	£6,704	£7,441	£7,441	£7,441
Community healthcare services	4 to 6 locations	£6,704	£6,905	£7,112	£7,255	£7,391
Independent ambulance services	4 to 10 locations	£4,469	£4,603	£4,741	£4,836	£4,927
Single location GPs	5,001 up to 10,000 registered patients	£725	£1,341	£2,146	£3,219	£4,839
Multiple location GPs	5 locations	£2,681	£4,960	£7,936	£11,904	£17,893
Care home providers	From 26 to 30 service users at a location	£3,761	£4,062	£4,306	£4,486	£4,661
Hospice services	4 to 6 locations	£6,638	£7,169	£7,599	£7,918	£8,226
Community social care	Single location	£796	£1,369	£2,054	£2,772	£3,287

Proposal 2

Our second proposal relates to fees for dental providers. The chargeable costs for this sector are fully recovered under the current fee levels, and those costs will remain the same during 2016/17. After that time, the costs of regulating this sector are expected to fall. On this basis, we will hold dental fees charges at current levels for 2016/17, and propose to then decrease them in 2017/18, maintaining them at that level until 2019/20 so as to reflect the reduction in costs and maintain full chargeable cost recovery levels, as illustrated in Table 3 below. Whether a two or a four year option is decided for other sectors under Proposal 1 will have no material impact on the dental sector, as the decrease in their fees under this proposal will take effect in the second year, 2017/18, and be maintained until 2019/20.

Table 3
Proposal 2 – Examples of estimated annual fees for 2017/18
(for full details, please see Annex C)

		Actual fee		Estimated fee
Fee category	**Example band size**	**2015/16**	**2016/17**	**2017/18**
Single location dentist	5 dental chairs	£1,100	£1,100	£935
Multiple location dentist	5 locations	£4,000	£4,000	£3,400

Full details of both our proposals are in section 3.

We do not propose to make any other changes to the fees scheme for 2016/17.

Summary of our strategic direction and its relationship to setting fees

We are currently developing a new strategy to be launched in spring 2016. This will be a five-year strategy that will set out our vision for health and adult social care quality regulation in the future.

It will include the measures we will take to refine our established regulatory model to make it more efficient and effective. This will undoubtedly influence the costs of regulation, which we will continue to monitor closely, as the changes we make to our approach become embedded over time.

Our fee consultation is being published in advance of our five-year strategy, so does not yet take full account of the vision we will launch in the Spring. This is unavoidable given that, in order to meet the Department of Health's anticipated reduction in our grant-in-aid, which is designed to move CQC towards compliance with the government's policy of achieving full chargeable cost recovery, we need to consult now on proposed fee increases so that we can publish the fee scheme in time to take effect on 1 April 2016.

As part of our overall strategic direction, we are positioning fees as the charge providers pay to be able to enter and remain in a regulated market. Our income from fees enables us to ensure, through our regulatory work, that health and social care services provide people with safe, effective, compassionate, high-quality care. It also enables us to encourage improvement in care services. This is our fundamental purpose, and will not change, even though our strategic direction will develop.

We have included more information about our strategy in section 4 of this document.

Summary of proposed changes to other regulations and their relationship to fees

The Department of Health will be publishing two consultations which have a bearing on fees; one that will propose making minor changes to the scope of

providers who need to be registered with CQC, and a second which will propose extending CQC's fee-setting powers.

We have included more information about the relationship and potential effect of these two consultations on CQC's fees in section 4 of this document.

Other information

Following on from proposals we first set out in 2013, our latest key document – *A Fresh Start for Registration*[3] – sets out the improvements we are making to further strengthen our approach to registration, which is the first legal step of our regulatory process. We have included more information about our registration strategy and its impact on fees in section 4 of this document.

We have also recently published a number of documents on our website (www.cqc.org.uk) that explain our new approaches in some of the different sectors we regulate, such as independent doctors, substance misuse services and health and care provision in secure settings. You may find it helpful to read those relevant to you alongside this consultation.

Please also read on our website the *Draft regulatory impact assessment* that sets out how we will evaluate the impact of different options for fees. It also provides the analysis behind our proposals.

We carried out an Equality and Human Rights impact assessment (EQIA) of our proposals, also available on our website. Our assessment identified that our fee proposals would have no impact on how the organisations we regulate deliver their functions in terms of equality or human rights. If you wish to comment on our EQIA, please include any feedback in your responses to questions 2 or 3 on page 29.

Responding to the consultation

We will take your responses to this consultation into account to finalise these proposals.

See section 5 for how to send us your comments. Please make sure that your comments reach us by noon on **15 January 2016.**

When we have analysed the feedback from this consultation in January 2016, we will prepare a response and a final fees scheme, which CQC's Board will recommend to the Secretary of State, who is responsible for making the final decision about fees charges, and whose consent is required in order for the scheme to come into effect. We expect to publish our response and our final fees scheme in March 2016, for implementation on 1 April 2016.

This means that we will not be able to confirm exactly what fees providers will be paying in 2016/17 until relatively close to when the scheme takes effect.

[3] www.cqc.org.uk/content/cqc-welcomes-fresh-start-registration

Providers may therefore wish to take the fee levels set out in this document as being indicative of the amounts we propose to ask the Secretary of State to approve from 1 April 2016 and estimates of those that may apply in subsequent years. CQC will not make any decisions about fees for 2016/17 until we have reviewed the responses to this consultation. However, fees for 2016/17 are unlikely to be set at a level that is higher than the amounts we have set out in this document.

2. Our budget

Context

Our budget is made up of a combination of grant-in-aid from central government budgets and income from fees paid by providers. Like all public bodies with fee-setting powers, CQC is expected to follow government policy by setting fees that, over time, cover the costs of the services we provide under statute.

The document *Managing Public Money*[4] sets out that recovery of costs by a public body should be:

> "…designed to recover full costs. If the legislation permits, the charge can cover the costs of the statutory body, e.g. a regulator could recover the cost of registration to provide a licence and of associated supervision. It may be appropriate to charge different levies to different kinds of licensees, depending on the cost of providing different kinds of licences" (para 6.5.2)

and that the body should:

> "…always seek to control their costs so that public money is used efficiently and effectively. The impact of lower costs should normally be passed on to consumers in lower charges." (para 6.2.3)

We believe that these principles should also apply to how we use the fees income from providers.

CQC reached the end of its formal transformation programme in March 2015. This involved the development of a new approach to inspection, and substantial organisational restructuring. The costs of this meant that between 2012 and 2015, CQC received additional grant-in-aid as a proportion of its budget. Some of those costs were specific to the transformation work and so were not expected to be repeated; other costs were to fund the requirement for CQC to be an effective regulator on a continuing basis. So during that time, the rise in costs out-stripped increases in fees, and cost recovery levels fell. With the establishment of a steady-state environment, CQC is expected by the Department of Health to return to compliance with government policy to achieve full recovery of its chargeable costs from fees income.

As set out in *Managing Public Money*, certain elements of our registration functions are exempt from being included as recoverable costs from fee charges, such as the costs of our enforcement activity. This means that we will not be required to recover 100% of our costs through fees. Instead, we have set a fee policy that moves us to a full chargeable cost recovery position, so that providers ultimately bear all the chargeable costs, reducing our reliance on grant-in-aid.

[4] https://www.gov.uk/government/publications/managing-public-money

In 2014/15, our fee income recovered just under 54% of chargeable costs. We increased fee charges in 2015/16 by 9% for all sectors, except for dentists, as the first stage in making incremental fee increases to reduce reliance on grant-in-aid for funding our chargeable activities.

CQC's budget is at its current level as part of a series of negotiations with the Department of Health, which has assessed the resources it considers are required to discharge our statutory functions. We are not currently considering substantial changes to the way we discharge these functions and so have made a starting assumption that our current budget will remain static for 2016/17. We have then calculated the level of fees that CQC will need to charge, taking account of the anticipated reduction to our grant-in-aid.

CQC's budget in future years, and the level of fees we will be required to charge, will be affected by factors such as the current spending review and on our own drive to be more efficient. To meet its targets, the government is demanding significant focus on cost reduction from many government organisations and CQC is not exempt from this. Given these variable factors, we are setting out proposals for the fee levels for 2016/17, within a two or a four year timetable for achieving full chargeable cost recovery, and can only show indicative figures for likely fee levels in subsequent years.

Our budget – 2015/16

Our budget for 2015/16 is £249.3 million, of which £4.9 million is separately allocated to Healthwatch England. This means that we are operating with resources of £244.4 million, from a combination of grant-in-aid and income from fees paid by providers. Of this overall resource, £224.4 million is being used to regulate providers and £20 million for other functions. The £224.4 million is an increase of £20 million from 2014/15 and from £180 million in 2013/14. These increases were necessary to fund the significant changes we made to our regulatory approaches, including the recruitment of additional staff to carry them out.

The £224.4 million allocation of the budget is used to resource our registration functions under the Health and Social Care Act 2008 (the 2008 Act). These functions include registering new providers and managers, making changes to existing registrations, monitoring and inspecting services and taking action to address any shortfalls in meeting regulations. As detailed below in section 4, our legal powers enable us to charge fees to providers to cover the cost of regulating them under our registration functions. At the moment, a higher proportion of these costs is met by grant-in-aid than from fee income. We are proposing that this should change in order to bring us into compliance with government policy.

The £20 million allocation of our budget that relates to our other functions includes visiting people detained under the Mental Health Act, monitoring arrangements for the use of controlled drugs and enforcing regulations on the safe use of x-rays. We cannot recover the costs of these functions by charging fees to providers as our legal powers do not enable us to do so. Therefore these costs are fully covered by grant-in-aid.

In 2015/16, we expect our fee income from registered providers to be £113.5 million (50.6% of £224.4 million). The balance of our budget is funded as grant-in-aid from the Department of Health. If our final fees income is above the estimated figure, then our grant-in-aid is reduced. The changes we applied to fee charges in 2014/15 and 2015/16 did not have the effect of significantly increasing our overall cost recovery levels, as our budget increased to a greater extent than the increases in fee charges were able to keep pace with. This, together with anticipated reductions in our grant-in-aid for 2016/17 means that, unless CQC is to make substantial reductions to its operating budget, we need to recover additional sums in fees from registered providers.

Our budget in relation to fees proposals for 2016/17

At the time of publishing this consultation, CQC's total revenue budget for 2016/17 is still under negotiation with the Department of Health so, for the purposes of this consultation, we are assuming the budget to be around the same as for 2015/16.

In 2016/17, we propose to generate an increased proportion of income from fees in order to bring us in line with wider government policy as follows.

If the two-year recovery proposal is decided on by the Secretary of State after the consultation, our estimated income from fees and grant-in-aid (GIA) would be:

Year	GIA	Fees	Absolute increase on previous year	% of cost recovery
	£'M	£'M	£'M	%
2016/17	83.0	166.3	52.8	74.3
2017/18	24.9	224.4	58.1	100.0

In this scenario we propose that this increase is achieved through a differentiated increase to existing fee charges for all providers except for the dental sector, which is already at full chargeable cost recovery.

If the four-year recovery proposal is decided on by the Secretary of State after the consultation, our estimated income from fees and grant-in-aid would be:

Year	GIA	Fees	Absolute increase on previous year	% of cost recovery
	£'M	£'M	£'M	%
2016/17	111.6	137.7	24.1	61.5
2017/18	85.8	163.5	25.9	73.1
2018/19	56.7	192.6	29.1	86.1
2019/20	24.9	224.4	31.8	100.0

In this scenario, again we propose this increase is achieved through a differentiated increase to existing fee charges for all providers except for the dental sector, which is already at full chargeable cost recovery.

We are seeking your views on these scenarios, and your suggestions if you wish to recommend other options – please refer to page 29.

While we accept that any increase in fees will not be welcomed because it will result in higher charges for the individuals and organisations we regulate, the total CQC budget of £224.4 million makes up only 0.16% of the overall value of the sectors. Further details are available in our *Draft regulatory impact assessment*, published on our website.

3. Fee proposals from April 2016

Our proposed changes below are subject to the outcome of this consultation and the final decision of the Secretary of State. We are not planning to make any other changes to our fees scheme for this year.

Annexes A to C at the end of this document show the detailed fees levels for our proposals (see the table below). Options 1 and 2, which are set out in Proposal 1, are both intended as alternatives to achieve full chargeable cost recovery, over two or four years, by differentially increasing fees for all providers, except the dental sector. Proposal 2 is intended to maintain the dental sector at full chargeable cost recovery by decreasing fees in 2017/18.

Proposals
1. To move to compliance with government policy on setting fee levels, through either: • Option 1 – full chargeable cost recovery over two years, or • Option 2 – full chargeable cost recovery over four years
2. To maintain full chargeable cost recovery levels for the dental sector by decreasing their fees charges in 2017/18

Government policy for fee setting

We explained in the section 'Our budget – 2015/16' above that if our grant-in-aid from the Department of Health is reduced because we are expected to move to compliance with the government policy of setting fees that fully cover our chargeable costs, we will be required to increase our income from provider fees.

In our last fee consultation in October 2014, we said that the proposed 9% across-the-board fee increase represented the first stage of making further incremental increases to achieve full chargeable cost recovery, and that we would consider differentiating those increases by sector to fairly apportion the actual costs of regulation. These proposals for the fee levels for 2016/17 represent the next step in achieving a greater level of cost recovery. In considering the options that we have, we have had to consider government policy in conjunction with the economic state of the health and social care sector. As part of this process we have reviewed the model that we use to understand our costs for each sector.

Methodology we have used for calculating fee levels

Within the proposals for 2016/17 described in this document, we have set out proposals for fee levels for the different sectors that we regulate. Unlike last year, these are not set out as a flat rate. Instead, they are differentiated so

that each sector reaches full chargeable cost recovery at the same time, but with different percentage increases applying to them, depending on how far that sector currently is from reaching full chargeable cost recovery.

Our costs are divided in to direct costs, indirect costs and overheads. Direct costs result from activity directly related to our inspection activity and can be allocated at provider level (though we rarely do that). Indirect costs result from activities that can be apportioned to a particular sector, but cannot be allocated to specific providers. Overheads cannot be allocated to specific sectors and so have to be apportioned using appropriate measures (as an example, human resource costs would be apportioned on headcount as these costs are generally 'driven' by the activities of staff). The costs for all sectors are made up of these three costs. Further detail is provided in the *Draft regulatory impact assessment* in paragraphs 23 to 27.

These costs are then proposed to be distributed among providers in each sector using the structure of the fees scheme to ensure that smaller providers are protected and that providers are charged appropriate to their size.

How we developed our proposals for the period over which we should move to achieve full chargeable cost recovery

We considered a number of options for the period over which we should move to compliance with government policy on full chargeable cost recovery. We sought advice from the Department of Health about what would be considered an acceptable maximum period, and have had discussions about the likely level of grant-in-aid from the Department of Health for 2016/17 and future years.

We were advised that moving to full cost recovery over a four-year period was the longest time we could reasonably expect to be permitted before complying with the policy in full. Two years was the shortest timescale that could reasonably be considered without destabilising individual sectors. Three years did not seem to be sufficiently different from these two periods to be considered as a separate option.

Offering variable timescales to different sectors did not seem fair to a number of sectors so, other than the specific case of dental providers, where full cost recovery has already been achieved, we decided to offer options for two defined timescales for all sectors.

Invitation to comment on our proposals for fee levels for 2016/17

We have explained that we expect our grant-in-aid to reduce in 2016/17, and have set out the context of the government's policy in relation to fee income generally. We have also explained that the final decision on the level of both grant-in-aid and fees rests with the Secretary of State for Health.

We are well aware of the impact of increases on providers and that the increases are significantly higher than anything we have proposed in previous years.

The sectors are currently at different distances from reaching full chargeable cost recovery. For example, the NHS GP sector overall is currently at 15% chargeable cost recovery, compared to 81% for the residential adult social care sector. Therefore fees for NHS GPs in this consultation show relatively larger increases than other sectors over the same timescales. The charts in section 4 illustrate the percentage of full chargeable cost recovery that each sector is currently at in 2015/16. They also show the progression to full chargeable cost recovery in percentage terms for each year under the two-year and four-year trajectories.

We believe we continue to have clear support from providers, the public and our partners for the direction we are taking to change, embed and evaluate our regulatory approach, and for the impact it is making. Our *State of care* report[5] shows how our inspections so far are providing clear evidence to the public that many providers are delivering high quality care, but also demonstrate that care can be inadequate, variable and unsafe. We rate the majority of providers through our judgements, and those ratings enable people, including commissioners of services, to make comparative, informed decisions about care services.

The majority of providers we have inspected confirm that our inspections have helped them to identify where improvements need to be made, and that outcomes for people who use their services had been improved as a result of our inspection activity. We are also seeing evidence that, where we have re-inspected providers to follow up concerns about quality of care, half had improved their original rating, showing the positive impact of inspection on encouraging improvement. We have also increasingly used our enforcement powers to drive out poor quality provision through measures such as cancelling or suspending a provider's registration, ensuring that people using those services are protected from harm.

The CQC Board's policy is that the organisation should continue to be properly resourced for it to be effective. In order to pursue this policy, we are obliged to ensure that funding comes increasingly from fee income from the providers we regulate, while actively seeking ways to improve our efficiency, including making improvements to our operating model.

» Proposal 1: The 2016/17 fee scheme

For 2016/17, we are proposing two alternative fee schemes, designed to move CQC to compliance with government policy over either two or four years, the details of which are set out below.

[5] www.cqc.org.uk/content/state-care-201415

As part of this proposal we also provide indicative figures for the increases in future years to 2019/20. As already described, figures for the years beyond 2016/17 are only estimates, but they provide some idea of the effect of the progression of both trajectories.

Option 1 – Recovery over two years between 2016-2018

Under this option, we propose to achieve full chargeable cost recovery over two years, between 2016-2018.

Rationale

A two-year timetable achieves full chargeable cost recovery across all sectors by the 2017/18 financial year and means larger percentage fee increases would be made relatively quickly. These increases will impact variably on the sectors, depending on their current levels of chargeable cost recovery, and are set against our existing budget figures and the current costs of our regulatory model.

If this option were implemented, we would satisfy HM Treasury policy requirements for achieving full chargeable cost recovery, and would significantly reduce our reliance on grant-in-aid. Providers would also have some information about likely fee charges for the next two financial years, and could plan their financial forecasts using these assumptions.

If this policy is adopted, our estimates for fee charges in the second year may need to be adjusted should our budget or costs significantly change. This might be due to factors such as the outcomes of our budget negotiations and the Spending Review, the future scope of our activity, the developments we plan to make within our new five-year strategy, and the efficiencies we are committed to making.

Advantages and disadvantages of this option are further described in our *Draft regulatory impact assessment*.

The full details of the estimated fee amounts are set out in Annex A. Examples of estimated annual fees and the estimated differential impact by fee category under a two-year timescale, have already been shown in the Summary section on page 7.

Option 2 – Recovery over four years between 2016-2020

Under this option we propose to achieve full chargeable cost recovery over four years, between 2016-2020.

Rationale

A four-year timetable achieves full chargeable cost recovery across all sectors by the 2019/20 financial year. Fee increases would impact variably on the sectors, depending on their current levels of chargeable cost recovery, and are set against our existing budget figures and the current costs of our regulatory model.

If this option were implemented, it would take us longer to satisfy HM Treasury policy requirements for achieving full chargeable cost recovery. It would prolong the period we would have to continue to rely on grant-in-aid to fund a significant amount of our expenditure. However, providers would have lower fee increases than under the two-year model. They will also have some indication of likely fee levels for the next four financial years.

If this policy is adopted, our estimates for fee charges in the second, third and fourth years may need to be adjusted should our budget or costs significantly change in any year during this period. This might be due to factors such as the outcome of our budget negotiations, the future scope of our activity, the developments we plan to make within our new five-year strategy, and the efficiencies we are committed to making.

Advantages and disadvantages of this option are further described in our *Draft regulatory impact assessment*.

The full details of the estimated fee amounts are set out in Annex B. Examples of estimated annual fees and the estimated differential impact by fee category under a four-year timescale, have already been shown in the Summary section on page 8.

We ask respondents to consider both timescale options and indicate their preference for which one should be implemented by responding to the question below (repeated on page 29). In considering their preferred option, we also ask respondents to set out their views about other ways in which fee levels might be set in 2016/17 to those proposed in this consultation document. We will not make any decisions about what we will be recommending to the Secretary of State for his decision until we have reviewed all the responses to this consultation, so your views and comments are welcome.

Readers might also find it helpful to refer to Section 4, 'CQC's strategic direction for fees', before responding to this question.

Consultation questions

1. In setting fees for 2016/17, which of the two options for achieving full chargeable cost recovery would you prefer CQC to adopt (please select one option):

   Option 1 ❑ – recovery of the fees amount over two years between 2016-2018, as set out in Annex A, or

   Option 2 ❑ – recovery of the fees amount over four years between 2016-2020, as set out in Annex B?

2. Would you prefer CQC to adopt another option for setting fees for 2016/17? For example:
   - A different option for how and when CQC should achieve full chargeable cost recovery.
   - A different option on how we divide fees between different types of provider.

   Please explain what option you recommend to CQC and your reasons for proposing this.

Proposal 2: To maintain full chargeable cost recovery levels for the dental sector by decreasing their fees in 2017/18

Proposal

We propose to maintain full chargeable cost recovery levels for the dental sector by decreasing their fees in 2017/18.

Rationale

We have significantly remodelled the regulatory approach we take to inspecting and monitoring dental providers. This means that we plan to physically inspect 10% of dental locations every year, using our comprehensive methodology, with selection based on a balance between risk profiling and random selection. We will also carry out focused follow-up activity and take enforcement action where it is necessary to do so. At the same time, we will continue to monitor every year the remainder of the sector's locations that we have not physically inspected.

Our cost analysis for regulation of the dental sector shows that the sector is already at full chargeable cost recovery. While we have reduced the number of locations we schedule for inspection, we are continuing to develop the information base we expect to use to enable us to effectively monitor those providers who are not inspected. The costs of regulation include a proportion for physical inspection activity, but also include the costs of our ongoing monitoring activities including, in the case of the dental sector, the costs of establishing an effective intelligence base during 2016/17.

The fees for regulating dental providers will be held at their current rate in 2016/17, while we continue to develop the information base to effectively monitor the sector's performance. We expect costs to fall in 2017/18, as the full regulatory model of inspection and monitoring will have embedded by that time. Therefore, our second proposal is to decrease dental fee charges in 2017/18, maintaining that level until 2019/20 to maintain full chargeable cost recovery levels, as illustrated in the examples table below. Whether a two or a four year option is decided on under Proposal 1, this will have no material impact on the dental sector, as the decrease in their fees under Proposal 2 will take effect in the second year, 2017/18, and be maintained until 2019/20.

The full details of the estimated fee amounts are set out in Annex C. The table below illustrates as examples what the increase would mean in actual £ charges to individual providers in various/average fee bands in 2017/18.

Proposal 2 – Examples of estimated annual fees for 2017/18 (for full details, please see Annex C)

Fee category	2017/18		
	Example band size	Effect of proposed decrease (from 2016/17)	Estimated annual fee
Single location dentist	5 dental chairs	-£165	£935
Multiple location dentist	5 locations	-£600	£3,400

Consultation question

3. Do you agree with our proposal to maintain full chargeable cost recovery levels for the dental sector by decreasing their fees in 2017/18?

   Yes ❑

   No ❑

   Not applicable ❑

   If there are aspects of this proposal that you do not agree with, please explain why.

4. CQC's strategic direction for fees

This section covers:

- Our strategic approach to regulation, and fees
- Measuring our costs and resourcing our regulatory approach
- Flexible payments
- Fee charges for making applications to register or to vary conditions, and
- Associated Department of Health consultations

1. Our strategic approach to regulation and fees

In 2013, we launched *Raising Standards, Putting People First* – a three-year strategy introducing our new approach to regulation, which saw unprecedented changes in the way we carry out our role. We are now developing our new five-year strategy, which will set out our vision for health and adult social care quality regulation in the future and which will be published in Spring 2016. Our new strategy will focus on how we can refine our approach to be even more efficient and effective, as well as flexible and responsive to new models of care. We intend that it will be a vision for the future of quality regulation, more than just an organisational strategy.

As the new strategy develops and throughout its implementation, we will consider fully the impact on the costs of regulation of these areas above, and will continue to monitor costs closely as the changes we make to our approach become embedded over time. We will continue to use our costing, performance and evaluation evidence to ensure that we make the best use of the information that is available to us. This will help us to deploy our teams as efficiently as possible, and make sure that we are effective and can demonstrate our value for money.

Our strategic direction for fees will continue in parallel with our five-year strategy. We are positioning fees as a charge to enter and remain in a regulated market. The main rationale for positioning fees in this way is to avoid complexity. While fees charges will remain differentiated between sectors, certain core principles, such as fairness and simplicity, will be consistent in each. Our fees will continue to be linked directly to the total cost of regulation, with the cost primarily at sector, or sub-sector, level rather than at provider level. We will continue to identify the provider characteristics that are the major drivers of cost, such as size, in order to apportion fees fairly among providers.

We are required to change the current balance of our reliance on grant-in-aid to fund a large percentage of our chargeable activities to one where the income for these is recovered from providers, and have set out in this consultation the timescale options to achieve that change. While the balance will change in relation to funding our chargeable costs, our overall income will always be sourced partly from grant-in-aid and partly from provider fees.

Our new strategy will reinforce our role in a changing health and adult social care environment and our fees strategy will play a fundamental part in ensuring our resources are balanced appropriately between income from fees and grant-in-aid.

2. Measuring our costs and resourcing our regulatory approach

We have set out in this document that the current levels of chargeable cost recovery are not sustainable as they are not in line with government policy for regulators to meet the full chargeable costs of their activities through fees.

We described in our last consultation how we were strengthening our methods to collect activity information and measure the costs of the new regulatory approach – these are an important part of our evaluation programme, and how we assess our value for money. We are continuing to embed collection methods for our direct costs, review our indirect costs and overheads, and develop better procedures for managing our costs.

This programme is helping us to improve our understanding of the costs of our approach, and to forecast our resource requirements more accurately. It is also helping us underpin the shift we are required to make from our current reliance on grant-in-aid funding to our chargeable income being funded by fees from providers.

We also continue to actively engage with the members of our Fees Advisory Panel, who represent all the sectors we regulate, in discussions about how we measure and evaluate our costs and translate those into proposals for fee charges.

3. Presenting the increases – absolute values or percentages

This consultation document presents information about the proposed and estimated increases in fees in absolute values rather than in percentage terms. We have only used percentages when we are comparing changes year on year at the fee category level. Responses to previous consultations suggest that providers will judge increases on what they mean to them in percentage terms. Given this, it is important to address why we have predominantly used absolute values in this consultation.

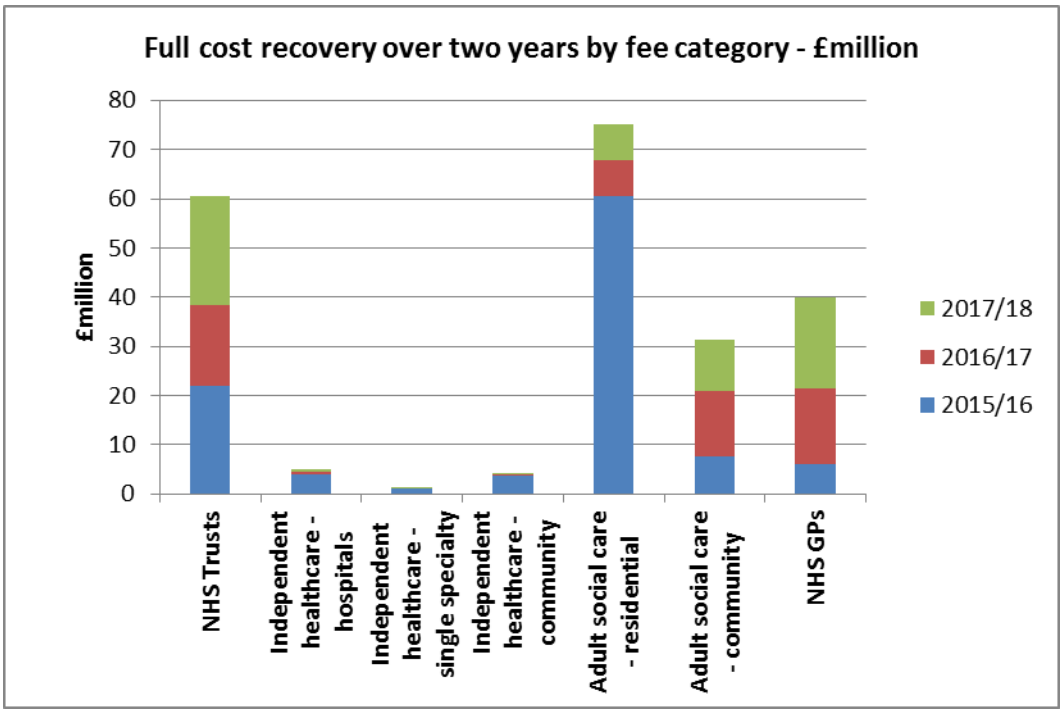
We consider that absolute values more clearly show the actual £ impact of increases, whereas percentages are relative and can give a misleading perspective. This is particularly important in the current situation of the individual sectors being at very different distances from reaching full chargeable cost recovery. We give an example to illustrate this below.

The NHS GP sector overall is currently at 15% cost recovery, compared to 81% for the adult social care residential (ASCR) sector. NHS GPs are the most recent provider group to come in to regulation (in April 2013). The fee charges for the sector that year were set at an estimated 50% of what we expected the cost of regulating the sector to be. As costs have risen, the sector has fallen further back in cost recovery terms. ASCR providers, in contrast, have been

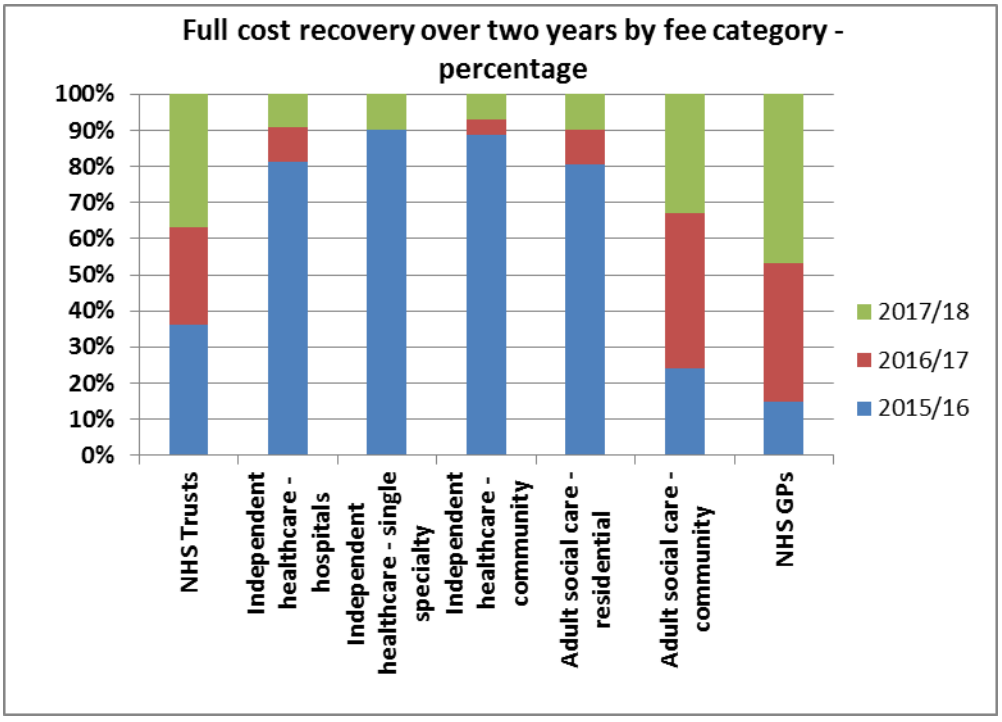
regulated and paying fee charges for over a decade and, having been subject to fee increases over time, are much closer to cost recovery than other sectors. So, moving NHS GPs to full recovery over a two or four year period requires relatively larger percentage increases than in ASCR over the same timescales. Using percentages as a value can make this look unfair for NHS GPs, as their percentage increases over two years (2016/17 and 2017/18) are 255% and 85% compared to 12% and 11% respectively for ASCR providers. We can only make sense of this when looking at the starting point for both sectors, so percentages do not help here.

We have decided not to present both percentages and absolute values in all the illustrative tables as this would swamp the consultation document with too much detail. However, we have set out below what the increases look like in both absolute and percentage terms for each category, for both options.

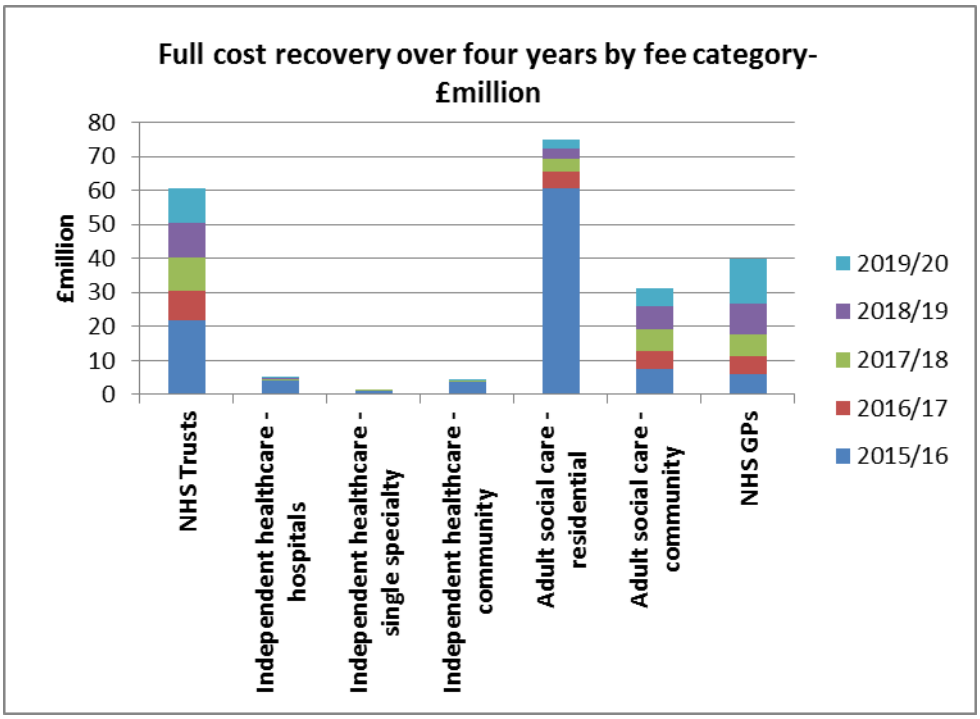
The chart below shows the current levels of fees income in £ from each of the fees categories, and the estimated amount of income that would be required to meet full chargeable cost recovery under a two year timescale:



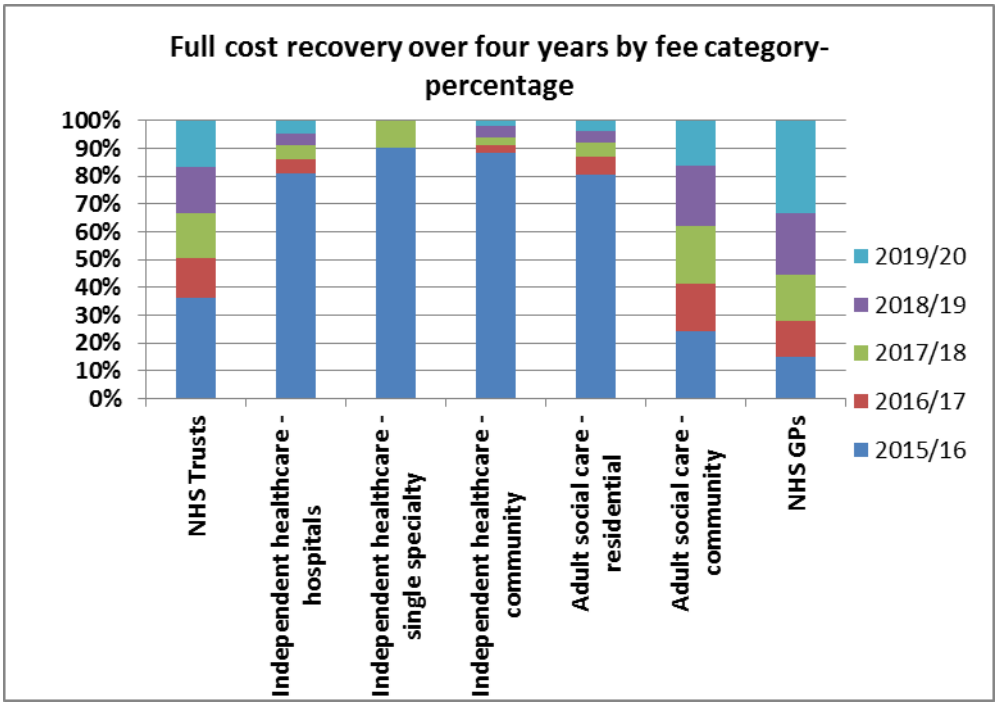
The chart below shows the current level of cost recovery in per cent from each of the fees categories, and the estimated percentage increases that would be required to meet full chargeable cost recovery under a two year timescale:



The chart below shows the current levels of fees income in £ from each of the fees categories, and the estimated amount of income that would be required to meet full chargeable cost recovery under a four year timescale:



The chart below shows the current level of cost recovery in per cent from each of the fees categories, and the estimated percentage increases that would be required to meet full chargeable cost recovery under a four year timescale:



The charts illustrate that it is difficult to make both absolute increases and percentage increases uniform year on year. We have modelled our fee proposals for 2016/17 and the estimated charges for subsequent years to ensure that neither absolute nor percentage increases are extreme, resulting in small variations in the size of increases year on year.

4. Flexible payments

We introduced a facility for paying fees by instalments starting with providers who were invoiced in June 2015. This had been a longstanding request from providers to help them balance their cash-flow. This is being rolled out to providers as their invoices are raised and all providers will have been offered this option by May 2016. At the time of preparing this consultation, 30% of providers, where the offer of this facility has been made, have signed up to take advantage of it. Further information about how to register for flexible payments is available on our website at:
www.cqc.org.uk/content/payment-instalment

5. Fee charges for making applications to register or to vary conditions

Our strategic approach to regulation over the last three years included the development of our model for controlling entry to the health and adult social care market. This included having tougher, more rigorous checks on new providers who want to register for the first time, as well as for existing providers who want to vary their conditions of registration.

Following on from proposals we first set out in 2013, our latest key document – *A Fresh Start for Registration* – sets out the improvements we are making to further strengthen our approach to registration, which is the first legal step of our regulatory process. Our document sets out how we determine who is able to enter the regulated health and adult social care market, and the steps we will take when cancelling or placing conditions on a provider's registration when required. Our vision for the future of registration as part of our approach to regulation will be embedded within our new five-year strategy from 2016.

In our last fee consultation we said that we intended in future to re-introduce separate charges for applications to register and vary conditions of registration. This was partly to provide an incentive for applicants to provide high quality applications that demonstrate that they will be able to meet fundamental standards of care.

However, given that we are embarking on an improvement programme for our registration model, and this is at early stages of development, we are not yet in a position to develop firm proposals for consultation, but will do so in due course.

6. Associated Department of Health consultations

The Department of Health will be publishing two consultations during the autumn which have a bearing on fees, one which will propose making minor changes to the scope of providers who need to be registered with CQC, and a second, which will propose extending CQC's fee-setting powers.

Review of Regulations
The Department's Review of Regulations consultation, to be published in autumn 2015, will propose a number of amendments to existing regulations so that certain providers would be exempted from the need to register with CQC, while others would come into the scope of regulation. Several new exemptions will be proposed, some will be removed and some regulations will be amended to provide a clearer definition about which providers must register. Subject to regulations coming into effect, there may be an impact on fee charges for affected providers which we will review at the appropriate time.

Regulations to clarify the scope of CQC's fee setting powers
Our current powers to set fees extend only to our registration functions under Chapter 2 of the 2008 Act, where our activities fall into the scope of cost recovery through fees. Our registration functions include our comprehensive inspections which are used for a number of purposes, including assessing whether providers are breaching their registration requirements, rating the quality of providers' performance and gathering evidence for potential enforcement activity. However, there are parts of our regulatory work that are not recoverable through fees, such as charging for ratings, as these fall into Chapter 3 of the 2008 Act.

In order to provide clarity about the scope of our fee-setting powers, the Department of Health will be consulting on making changes to regulations. We advise providers to look out for both of these consultations on the Department of Health's website:
www.gov.uk/government/organisations/department-of-health

5. How to give us your views

The questions we have asked about fees from April 2016 for providers that are registered under the Health and Social Care Act 2008 are:

1. In setting fees for 2016/17, which of the two options for achieving full chargeable cost recovery would you prefer CQC to adopt (please select one option):

   Option 1 ❑ – recovery of the fees amount over two years between 2016-2018, as set out in Annex A, or

   Option 2 ❑ – recovery of the fees amount over four years between 2016-2020, as set out in Annex B?

2. Would you prefer CQC to adopt another option for setting fees for 2016/17? For example:

   - A different option for how and when CQC should achieve full chargeable cost recovery.
   - A different option on how we divide fees between different types of provider.

   Please explain what option you recommend to CQC and your reasons for proposing this.

3. Do you agree with our proposal to maintain full chargeable cost recovery levels for the dental sector by decreasing their fees in 2017/18?
   - Yes ☐
   - No ☐
   - Not applicable ☐

   If there are aspects of this proposal that you do not agree with, please explain why.

Please send us your response by noon on 15 January 2016

You can respond to our consultation in three ways:

Online
Use our online form at **www.cqc.org.uk/FeesConsultation2015**

By email
Email your response to **feesconsultation2015@cqc.org.uk**

By post – write to us at:
Freepost RLYL-HLLY-ZTJS
Fees Consultation 2015
Care Quality Commission
Finsbury Tower
103/105 Bunhill Row
London
EC1B 1QW

Annex A – Table of estimated fee charges by fee category over two years

NHS trusts (Part 1 of Schedule of existing fee scheme)

	Actual fee	Proposed fee	Estimated fee
Amount of turnover	2015/16	2016/17	2017/18
Up to £75,000,000	£44,690	£78,208	£123,333
From £75,000,001 to £125,000,000	£61,449	£107,536	£169,584
From £125,000,001 to £225,000,000	£78,208	£136,864	£215,835
From £225,000,001 to £325,000,000	£94,996	£166,243	£262,165
From £325,000,001 to £500,000,000	£111,725	£195,519	£308,333
More than £500,000,000	£128,484	£224,847	£354,584

Healthcare hospital services (Part 2, column 2 of Schedule of existing fee scheme)

	Actual fee	Proposed fee	Estimated fee
Number of locations	2015/16	2016/17	2017/18
1	£9,505	£10,646	£11,710
2 to 3	£18,993	£21,272	£23,399
4 to 6	£37,987	£42,545	£46,800
7 to 10	£75,973	£85,090	£93,599
11 to 15	£122,898	£137,646	£151,410
More than 15	£167,588	£187,699	£206,468

Healthcare – Single specialty services (Part 2, column 3 of Schedule of existing fee scheme)

	Actual fee	Proposed fee	Estimated fee
Number of locations	2015/16	2016/17	2017/18
1	£1,679	£1,679	£1,864
2 to 3	£3,352	£3,352	£3,721
4 to 6	£6,704	£6,704	£7,441
7 to 10	£13,407	£13,407	£14,882
11 to 15	£26,814	£26,814	£29,764
More than 15	£53,628	£53,628	£59,527

Community healthcare services (Part 2, column 3 of Schedule of existing fee scheme) – includes health service bodies (NHS Blood and Transplant) under paragraph 2(c)(i) of existing fee scheme

	Actual fee	Proposed fee	Estimated fee
Number of locations	2015/16	2016/17	2017/18
1	£1,679	£1,763	£1,851
2 to 3	£3,352	£3,520	£3,696
4 to 6	£6,704	£7,039	£7,391
7 to 10	£13,407	£14,077	£14,781
11 to 15	£26,814	£28,155	£29,562
More than 15	£53,628	£56,309	£59,125

Community healthcare services (independent ambulance services) (Part 3 of Schedule of existing fee scheme)

	Actual fee	Proposed fee	Estimated fee
Number of locations	2015/16	2016/17	2017/18
1	£894	£939	£986
2 to 3	£1,788	£1,877	£1,971
4 to 10	£4,469	£4,692	£4,927
11 to 50	£11,173	£11,732	£12,318
51 to 100	£26,814	£28,155	£29,562
More than 100	£53,628	£56,309	£59,125

Community healthcare services – Individual registered at one location providing only diagnostic and screening services (Paragraph 2(c)(ii) of existing fee scheme)

	Actual fee	Proposed fee	Estimated fee
Number of locations	2015/16	2016/17	2017/18
1	£278	£292	£306

Primary care services (Medical) – One location (Part 4 of Schedule of existing fee scheme)

	Actual fee	Proposed fee	Estimated fee
Number of registered patients	2015/16	2016/17	2017/18
Up to 5,000	£616	£2,187	£4,111
5,001 to 10,000	£725	£2,574	£4,839
10,001 to 15,000	£839	£2,978	£5,599
More than 15,000	£948	£3,365	£6,327

Primary care services (Medical) – One location where walk-in-centre forms part or all of location (Paragraph 2(d)(i) of existing fee scheme)
and
Primary care services (Medical) – One location providing out-of-hours services (Paragraph 2(d)(iii) of existing fee scheme)

	Actual fee	Proposed fee	Estimated fee
Location	2015/16	2016/17	2017/18
1	£948	£3,365	£6,327

Primary care services (Medical) – More than one location (Part 5 of Schedule of existing fee scheme)

	Actual fee	Proposed fee	Estimated fee
Number of locations	2015/16	2016/17	2017/18
2	£1,341	£4,761	£8,950
3	£1,788	£6,347	£11,933
4	£2,235	£7,934	£14,916
5	£2,681	£9,518	£17,893
6 to 10	£3,352	£11,900	£22,371
11 to 40	£6,704	£23,799	£44,742
More than 40	£16,759	£59,494	£111,850

Care services – Providers of care services who also provide accommodation (Part 8 of Schedule of existing fee scheme)

	Actual fee	Proposed fee	Estimated fee
Maximum number of service users	2015/16	2016/17	2017/18
Less than 4	£276	£309	£342
From 4 to 10	£719	£805	£891
From 11 to 15	£1,439	£1,612	£1,783
From 16 to 20	£2,104	£2,356	£2,607
From 21 to 25	£2,878	£3,223	£3,567
From 26 to 30	£3,761	£4,212	£4,661
From 31 to 35	£4,425	£4,956	£5,484
From 36 to 40	£5,090	£5,701	£6,308
From 41 to 45	£5,755	£6,446	£7,132
From 46 to 50	£6,420	£7,190	£7,956
From 51 to 55	£7,080	£7,930	£8,774
From 56 to 60	£7,744	£8,673	£9,597
From 61 to 65	£8,851	£9,913	£10,969
From 66 to 70	£9,734	£10,902	£12,063
From 70 to 75	£10,622	£11,897	£13,164
From 76 to 80	£11,505	£12,886	£14,258
From 81 to 90	£12,393	£13,880	£15,358
More than 90	£13,838	£15,499	£17,149

Care services – Hospices (Part 9 of Schedule of existing fee scheme)

	Actual fee	Proposed fee	Estimated fee
Number of locations	2015/16	2016/17	2017/18
1	£1,662	£1,861	£2,060
2 to 3	£3,319	£3,717	£4,113
4 to 6	£6,638	£7,435	£8,226
7 to 10	£13,963	£15,639	£17,304
11 to 15	£26,552	£29,738	£32,905
More than 15	£53,105	£59,478	£65,812

Community social care services (Part 10 of Schedule of existing fee scheme)

	Actual fee	Proposed fee	Estimated fee
Number of locations	2015/16	2016/17	2017/18
1	£796	£2,229	£3,287
2 to 3	£2,213	£6,196	£9,140
4 to 6	£4,425	£12,390	£18,275
7 to 12	£8,851	£24,783	£36,555
13 to 25	£17,702	£49,566	£73,109
More than 25	£35,403	£99,128	£146,214

Note: Should regulations be made requiring independent midwives to register from April 2016, their fee for 2016/17 will be £872 for each location under paragraph 2 (c)(iii)of the existing fee scheme. We intend to review that fee charge once those providers have registered and a costed methodology is in place, so that we can move to a position of full chargeable cost recovery at an appropriate time.

Annex B – Table of estimated fee charges by fee category over four years

NHS trusts (Part 1 of Schedule of existing fee scheme)

	Actual fee	Proposed fee	Estimated fee		
Amount of turnover	**2015/16**	**2016/17**	**2017/18**	**2018/19**	**2019/20**
Up to £75,000,000	£44,690	£62,566	£82,399	£102,999	£123,333
From £75,000,001 to £125,000,000	£61,449	£86,029	£113,300	£141,625	£169,584
From £125,000,001 to £225,000,000	£78,208	£109,491	£144,200	£180,250	£215,835
From £225,000,001 to £325,000,000	£94,996	£132,994	£175,154	£218,942	£262,165
From £325,000,001 to £500,000,000	£111,725	£156,415	£205,999	£257,498	£308,333
More than £500,000,000	£128,484	£179,878	£236,899	£296,123	£354,584

Healthcare hospital services (Part 2, column 2 of Schedule of existing fee scheme)

	Actual fee	Proposed fee	Estimated fee		
Number of locations	**2015/16**	**2016/17**	**2017/18**	**2018/19**	**2019/20**
1	£9,505	£10,075	£10,680	£11,160	£11,710
2 to 3	£18,993	£20,133	£21,341	£22,301	£23,399
4 to 6	£37,987	£40,266	£42,682	£44,603	£46,800
7 to 10	£75,973	£80,531	£85,363	£89,205	£93,599
11 to 15	£122,898	£130,272	£138,088	£144,302	£151,410
More than 15	£167,588	£177,643	£188,302	£196,775	£206,468

Healthcare – Single specialty services
(Part 2, column 3 of Schedule of existing fee scheme)

	Actual fee	Proposed fee	Estimated fee		
Number of locations	2015/16	2016/17	2017/18	2018/19	2019/20
1	£1,679	£1,679	£1,864	£1,864	£1,864
2 to 3	£3,352	£3,352	£3,721	£3,721	£3,721
4 to 6	£6,704	£6,704	£7,441	£7,441	£7,441
7 to 10	£13,407	£13,407	£14,882	£14,882	£14,882
11 to 15	£26,814	£26,814	£29,764	£29,764	£29,764
More than 15	£53,628	£53,628	£59,527	£59,527	£59,527

Community healthcare services (Part 2, column 3 of Schedule of existing fee scheme) – includes health service bodies (NHS Blood and Transplant) under paragraph 2(c)(i) of existing fee scheme

	Actual fee	Proposed fee	Estimated fee		
Number of locations	2015/16	2016/17	2017/18	2018/19	2019/20
1	£1,679	£1,729	£1,781	£1,817	£1,851
2 to 3	£3,352	£3,453	£3,556	£3,627	£3,696
4 to 6	£6,704	£6,905	£7,112	£7,255	£7,391
7 to 10	£13,407	£13,809	£14,223	£14,508	£14,781
11 to 15	£26,814	£27,618	£28,447	£29,016	£29,562
More than 15	£53,628	£55,237	£56,894	£58,032	£59,125

Community healthcare services (independent ambulance services)
(Part 3 of Schedule of existing fee scheme)

	Actual fee	Proposed fee	Estimated fee		
Number of locations	2015/16	2016/17	2017/18	2018/19	2019/20
1	£894	£921	£948	£967	£986
2 to 3	£1,788	£1,842	£1,897	£1,935	£1,971
4 to 10	£4,469	£4,603	£4,741	£4,836	£4,927
11 to 50	£11,173	£11,508	£11,853	£12,091	£12,318
51 to 100	£26,814	£27,618	£28,447	£29,016	£29,562
More than 100	£53,628	£55,237	£56,894	£58,032	£59,125

Community healthcare services – Individual registered at one location providing only diagnostic and screening services (Paragraph 2(c)(ii) of existing fee scheme)

	Actual fee	Proposed fee	Estimated fee		
Number of locations	2015/16	2016/17	2017/18	2018/19	2019/20
1	£278	£286	£295	£301	£306

Primary care services (Medical) – One location (Part 4 of Schedule of existing fee scheme)

	Actual fee	Proposed fee	Estimated fee		
Number of registered patients	2015/16	2016/17	2017/18	2018/19	2019/20
Up to 5,000	£616	£1,140	£1,823	£2,735	£4,111
5,001 to 10,000	£725	£1,341	£2,146	£3,219	£4,839
10,001 to 15,000	£839	£1,552	£2,483	£3,725	£5,599
More than 15,000	£948	£1,754	£2,806	£4,209	£6,327

Primary care services (Medical) – One location where walk-in-centre forms part or all of location (Paragraph 2(d)(i) of existing fee scheme)

and

Primary care services (Medical) – One location providing out-of-hours services (Paragraph 2(d)(iii) of existing fee scheme)

	Actual fee	Proposed fee	Estimated fee		
Location	2015/16	2016/17	2017/18	2018/19	2019/20
1	£948	£1,754	£2,806	£4,209	£6,327

Primary care services (Medical) – More than one location (Part 5 of Schedule of existing fee scheme)

	Actual fee	Proposed fee	Estimated fee		
Number of locations	2015/16	2016/17	2017/18	2018/19	2019/20
2	£1,341	£2,481	£3,969	£5,954	£8,950
3	£1,788	£3,308	£5,292	£7,939	£11,933
4	£2,235	£4,135	£6,616	£9,923	£14,916
5	£2,681	£4,960	£7,936	£11,904	£17,893
6 to 10	£3,352	£6,201	£9,922	£14,883	£22,371
11 to 40	£6,704	£12,402	£19,844	£29,766	£44,742
More than 40	£16,759	£31,004	£49,607	£74,410	£111,850

Care services – Providers of care services who also provide accommodation (Part 8 of Schedule of existing fee scheme)

	Actual fee	Proposed fee	Estimated fee		
Maximum number of service users	2015/16	2016/17	2017/18	2018/19	2019/20
Less than 4	£276	£298	£316	£329	£342
From 4 to 10	£719	£777	£823	£858	£891
From 11 to 15	£1,439	£1,554	£1,647	£1,717	£1,783
From 16 to 20	£2,104	£2,272	£2,409	£2,510	£2,607
From 21 to 25	£2,878	£3,108	£3,295	£3,433	£3,567
From 26 to 30	£3,761	£4,062	£4,306	£4,486	£4,661
From 31 to 35	£4,425	£4,779	£5,066	£5,279	£5,484
From 36 to 40	£5,090	£5,497	£5,827	£6,072	£6,308
From 41 to 45	£5,755	£6,215	£6,588	£6,865	£7,132
From 46 to 50	£6,420	£6,934	£7,350	£7,658	£7,956
From 51 to 55	£7,080	£7,646	£8,105	£8,446	£8,774
From 56 to 60	£7,744	£8,364	£8,865	£9,238	£9,597
From 61 to 65	£8,851	£9,559	£10,133	£10,558	£10,969
From 66 to 70	£9,734	£10,513	£11,143	£11,612	£12,063
From 70 to 75	£10,622	£11,472	£12,160	£12,671	£13,164
From 76 to 80	£11,505	£12,425	£13,171	£13,724	£14,258
From 81 to 90	£12,393	£13,384	£14,188	£14,783	£15,358
More than 90	£13,838	£14,945	£15,842	£16,507	£17,149

Care services – Hospices (Part 9 of Schedule of existing fee scheme)

	Actual fee	Proposed fee	Estimated fee		
Number of locations	2015/16	2016/17	2017/18	2018/19	2019/20
1	£1,662	£1,795	£1,903	£1,983	£2,060
2 to 3	£3,319	£3,585	£3,800	£3,959	£4,113
4 to 6	£6,638	£7,169	£7,599	£7,918	£8,226
7 to 10	£13,963	£15,080	£15,985	£16,656	£17,304
11 to 15	£26,552	£28,676	£30,397	£31,673	£32,905
More than 15	£53,105	£57,353	£60,795	£63,348	£65,812

Community social care services (Part 10 of Schedule of existing fee scheme)

	Actual fee	Proposed fee	Estimated fee		
Number of locations	2015/16	2016/17	2017/18	2018/19	2019/20
1	£796	£1,369	£2,054	£2,772	£3,287
2 to 3	£2,213	£3,806	£5,710	£7,708	£9,140
4 to 6	£4,425	£7,611	£11,417	£15,412	£18,275
7 to 12	£8,851	£15,224	£22,836	£30,828	£36,555
13 to 25	£17,702	£30,447	£45,671	£61,656	£73,109
More than 25	£35,403	£60,893	£91,340	£123,309	£146,214

Note: Should regulations be made requiring independent midwives to register from April 2016, their fee for 2016/17 will be £872 for each location under paragraph 2 (c)(iii) of the existing fee scheme. We intend to review that fee charge once those providers have registered and a costed methodology is in place, so that we can move to a position of full chargeable cost recovery at an appropriate time.

Annex C – Table of estimated fee charges for dental providers

Fees trajectory over two financial years

Primary care services (Dental) – One location (Part 6 of existing fee scheme) – includes domiciliary dental services under paragraph 2(d)(iv) of existing fee scheme where the fee charge is the same as for one dental chair

	Actual fee		Estimated fee
Number of dental chairs	2015/16	2016/17	2017/18
1	£600	£600	£510
2	£750	£750	£638
3	£850	£850	£723
4	£950	£950	£808
5	£1,100	£1,100	£935
6	£1,100	£1,100	£935
More than 6	£1,300	£1,300	£1,105

Primary care services (Dentists) – More than one location (Part 7 of existing fee scheme)

	Actual fee		Estimated fee
Number of locations	2015/16	2016/17	2017/18
2	£1,600	£1,600	£1,360
3	£2,400	£2,400	£2,040
4	£3,200	£3,200	£2,720
5	£4,000	£4,000	£3,400
6 to 10	£4,800	£4,800	£4,080
11 to 40	£10,000	£10,000	£8,500
41 to 99	£30,000	£30,000	£25,500
More than 99	£60,000	£60,000	£51,000

Fees trajectory over four financial years

Primary care services (Dental) – One location (Part 6 of existing fee scheme) – includes domiciliary dental services under paragraph 2(d)(iv) of existing fee scheme where the fee charge is the same as for one dental chair

	Actual fee		Estimated fee		
Number of dental chairs	2015/16	2016/17	2017/18	2018/19	2019/20
1	£600	£600	£510	£510	£510
2	£750	£750	£638	£638	£638
3	£850	£850	£723	£723	£723
4	£950	£950	£808	£808	£808
5	£1,100	£1,100	£935	£935	£935
6	£1,100	£1,100	£935	£935	£935
More than 6	£1,300	£1,300	£1,105	£1,105	£1,105

Primary care services (Dentists) – More than one location (Part 7 of existing fee scheme)

	Actual fee		Estimated fee		
Number of locations	2015/16	2016/17	2017/18	2018/19	2019/20
2	£1,600	£1,600	£1,360	£1,360	£1,360
3	£2,400	£2,400	£2,040	£2,040	£2,040
4	£3,200	£3,200	£2,720	£2,720	£2,720
5	£4,000	£4,000	£3,400	£3,400	£3,400
6 to 10	£4,800	£4,800	£4,080	£4,080	£4,080
11 to 40	£10,000	£10,000	£8,500	£8,500	£8,500
41 to 99	£30,000	£30,000	£25,500	£25,500	£25,500
More than 99	£60,000	£60,000	£51,000	£51,000	£51,000

Annex D – Key principles for setting fees

We work to key principles to guide how we set fees. These reflect the principles for managing public resources and the standards expected of public service bodies, set out in HM Treasury's guide to Managing Public Money.

	Guiding principles	Key actions
1	**Demonstrate fairness and proportionality**	• Involve stakeholders in advising on how to distribute charges and grant-in-aid, and on reasonableness of charges. • Balance providers' different situations, including their size, complexity and inherent risk, with our income requirements and the government requirement for full recovery of chargeable costs.
2	**Reflect costs**	• Ensure we use an evidence-based approach that is derived from a better monitoring of costs, so that our charges increasingly reflect in more detail the costs of our activity.
3	**Make fees simple**	• Make the structure of fees as intuitive as possible, so they are seen to relate to costs.
4	**Be transparent**	• Build the approach from an open discussion about CQC's actual costs. • Involve stakeholders openly and on an ongoing basis.

Annex E – Our fee-setting powers

Our powers for setting fees[6] are flexible, to enable a proportionate approach. For example, they allow us discretion to set:

- Different fees for different types of services.
- Different fees for different types of providers.
- Different fees, based on other criteria that we may specify.
- Flexibility for us to determine when payments fall due.

Our powers for setting fees extend only to our registration functions under part 2, section 85 of the 2008 Act. These functions cover all our activities associated with registering providers, making changes to their registration and carrying out inspections. Other existing responsibilities, such as our work under the Mental Health Act, are not included within our registration functions, and their costs are covered instead by grant-in-aid from the Department of Health.

We do not currently have powers to set fees for any of our activity associated with our functions other than registration, as these fall under different parts of the 2008 Act. We could not include charges for these functions within our annual fee unless the Secretary of State agrees to make regulations to extend our fee-setting powers. The Department of Health is consulting on proposals which will clarify our legal powers to include a fee for other charges within our fees scheme, should we choose to exercise that power. See also section 4 (6) – Associated Department of Health consultations.

[6] See Annex F.

Annex F – Section 85 of the Health and Social Care Act 2008

85 Fees

(1) The Commission may with the consent of the Secretary of State from time to time make and publish provision—

(a) requiring a fee to be paid in respect of—
i. an application for registration as a service provider or manager under Chapter 2,
ii. the grant or subsistence of any such registration, or
iii. an application under section 19(1);
(b) requiring English NHS bodies, English local authorities, persons registered under Chapter 2 and such other persons as may be prescribed to pay a fee in respect of the exercise by the Commission of such of its other functions under this Part as may be prescribed.

(2) The amount of a fee payable under provision under subsection (1) is to be such as may be specified in, or calculated or determined under, the provision.

(3) Provision under subsection (1) may include provision—

(a) for different fees to be paid in different cases,
(b) for different fees to be paid by persons of different descriptions,
(c) for the amount of a fee to be determined by the Commission in accordance with specified factors, and
(d) for determining the time by which a fee is to be payable.

(4) Before making provision under subsection (1) the Commission must consult such persons as it thinks appropriate.

(5) If the Secretary of State considers it necessary or desirable to do so, the Secretary of State may by regulations make provision determining the amount of a fee payable to the Commission by virtue of this section, and the time at which it is payable, instead of those matters being determined in accordance with provision made under subsection (1).

(6) Before making any regulations under this section, the Secretary of State must consult the Commission and such other persons as the Secretary of State thinks appropriate.

(7) For the purpose of determining the fee payable by a person by virtue of this section, the person must provide the Commission with such information, in such form, as the Commission may require.

(8) A fee payable by virtue of this section may, without prejudice to any other method of recovery, be recovered summarily as a civil debt.

Annex G – Protecting your rights

Following the Code of Practice
This consultation follows the Cabinet Office Consultation Principles. In particular we aim to:

- Consult widely throughout the process, allowing sufficient time for written consultation at least once during the development of the policy.
- Be clear about what our proposals are, who may be affected, what questions we want to ask and the timescale for responses.
- Ensure that our consultation is clear, concise and widely accessible.
- Ensure that we provide feedback regarding the responses received and how the consultation process influenced the development of the policy.
- Monitor our effectiveness at consultation, including through the use of a designated consultation coordinator.
- Ensure our consultation follows better regulation best practice, including carrying out a regulatory impact assessment if appropriate.

Confidentiality of information
Information provided in response to this consultation, including personal information, may be published or disclosed in accordance with the access to information regimes (these are primarily the Freedom of Information Act 2000 (FOIA), the Data Protection Act 1998 (DPA) and the Environmental Information Regulations 2004).

If you want the information that you provide to be treated as confidential, please be aware that, under the FOIA, there is a statutory Code of Practice with which public authorities must comply and which deals, among other things, with obligations of confidence. In view of this, it would be helpful if you could explain to us why you regard the information you have provided as confidential. If we receive a request for disclosure of the information, we will take full account of your explanation, but we cannot give an assurance that confidentiality can be maintained in all circumstances. An automatic confidentiality disclaimer generated by your IT system will not, of itself, be regarded as binding.

We will process your personal data in accordance with the DPA and in most circumstances this will mean that your personal data will not be disclosed to third parties.

Further information
If you have any comments or concerns relating to the consultation process that you would like to put to us, please write to:

Care Quality Commission
151 Buckingham Palace Road
London
SW1W 9SZ

How to respond to this consultation

Online

Use our online form at:
www.cqc.org.uk/FeesConsultation2015

By email

Email your response to:
feesconsultation2015@cqc.org.uk

By post

Write to us at:
Freepost RLYL-HLLY-ZTJS
Fees Consultation 2015
Care Quality Commission
Finsbury Tower
103/105 Bunhill Row
London
EC1B 1QW

Please contact us if you would like a summary of this document in another language or format.

If you have general queries about CQC, you can:

Phone us on: 03000 616161

Email us at: enquiries@cqc.org.uk

Write to us at:
Care Quality Commission
Citygate
Gallowgate
Newcastle upon Tyne
NE1 4PA

www.cqc.org.uk

Report author: Ann Hill
Tel: 0113 24 78555

Report of the Director of Adult Social Services

Report to Scrutiny Board (Adult Social Services, Public Health, NHS)

Date: 24th November 2015

Subject: Charging for Non-Residential Adult Social Care Services

Are specific electoral Wards affected? If relevant, name(s) of Ward(s):	☐ Yes	☒ No
Are there implications for equality and diversity and cohesion and integration?	☒ Yes	☐ No
Is the decision eligible for Call-In?	☐ Yes	☒ No
Does the report contain confidential or exempt information? If relevant, Access to Information Procedure Rule number: Appendix number:	☐ Yes	☒ No

Summary of main issues

1. This review of the charging arrangements for non-residential services is taking place in the context of the financial challenges facing the Council, the growing demand for Adult Social Care services and the lower income from Adult Social Care charges in Leeds compared with other authorities.

2. The proposals currently being consulted on are:
    - Changing the way that we work out how much people are asked to pay towards the services they receive
    - Removing the maximum weekly contribution which currently caps the amount anyone pays for their services at £215 per week
    - Phasing-in the increases for those people who would face the largest increases in their charge

3. The likely impact of the proposals on customers is as follows:
    - 5,200 people (66%) would see no change in their payments
    - 600 people (8%) would pay up to £5 per week extra for their services
    - 400 people (5%) would pay between £5 and £10 per week extra
    - 1200 people (16%) would pay between £10 and £50 per week extra
    - 400 (5%) will pay an extra £50 or more per week for their services.

Recommendations

4. Members are asked to consider the main aspects of the Adult Social Care charging consultation currently underway and to provide their comments as part of the consultation process.

1 Purpose of this report

1.1 This report outlines the main aspects of the consultation currently underway on charging for non-residential Adult Social Care services and invites members of Scrutiny Board to provide their comments as part of the consultation process.

2 Background information

2.1 Reviewing customer fees and charges is an important aspect of the Council's medium term financial planning to help to address the continued reductions in government funding. Although several changes have been made to the Adult Social Care charging policy, the most recent taking effect in January 2014, customers in Leeds continue to pay less than in many authorities.

2.2 The demands on social care services continue to increase. This reflects an ageing population with more complex needs, particularly for people with learning disabilities, together with the impact of inflation and the National Living Wage. Within this challenging financial context the Council needs to consider changes to charging to help fund the adult social care services that some of the most vulnerable people in the city rely on.

2.3 The Care Act which took effect in April 2015 brought charging for residential and non-residential adult social care services together into one set of charging regulations and guidance. Previously they operated under separate and different government guidance. The Care Act guidance outlines areas of discretion that councils may consider and these are included within this charging review.

2.4 The main non-residential adult social care services are home care and supported living, day care and associated transport, telecare services and direct payments. The current charges for services are shown at Appendix 1. There are no plans to increase these charges as part of this charging review. All customers have a financial assessment and the Government's charging regulations ensure that their charges are affordable. People pay whichever is the lower of the charge for their services and the amount the financial assessment shows they can afford. Appendix 2 outlines the financial assessment methodology.

3 Main issues

3.1 The proposals for consultation are:

- Changing the way that we work out how much people are asked to pay towards the services they receive
- Removing the maximum weekly contribution which currently caps the amount anyone pays for their services at £215 per week
- Phasing-in the increases for those people who would face the largest increases in their charge

3.2 The Care Act charging regulations prescribe the treatment of income and allowances within the financial assessment, but give councils discretion to be more generous if they wish. Some of the figures currently used in the financial assessment in Leeds are more generous than those set out in the Care Act regulations so some people are paying less for their services than they could. We

are consulting on adopting the figures set out in the Care Act Regulations. The table in Appendix 3 sets out the five aspects of these proposals.

3.3 The current £215 maximum weekly contribution applies to all customers, however high their level of service, income or savings. It is based on 50% of the cost of a typical residential care package for older people. Councils can choose to set a maximum if they wish, but many do not. In recent years the trend has been for councils to raise or remove their maximum weekly charge.

3.4 The phasing-in proposals are for a cap of £35 per week on any increase in a person's charge for the first six months, with a further £35 on top of this for a further six months. The full charge would therefore apply a year after implementation for those people whose payment increased by more than £70 per week. This approach is consistent with previous charging reviews.

3.5 The likely impact on customers of the proposals being consulted on is as follows:

- 5,200 people (66%) would see no change in their payments
- 600 people (8%) would pay up to £5 per week extra for their services
- 400 people (5%) would pay between £5 and £10 per week extra
- 1200 people (16%) would pay between £10 and £50 per week extra
- 400 (5%) will pay an extra £50 or more per week for their services.

3.6 Following the consultation a report with final recommendations will be submitted to Executive Board. This report is scheduled for early 2016 and any changes will not take effect until April 2016 at the earliest.

4 Corporate Considerations

4.1 Consultation and Engagement

4.1.1 A comprehensive consultation process is taking place from 21st September to 11th December 2015. All customers in receipt of Adult Social Care services have been sent copies of the consultation documents and contact details for any assistance they require. The consultation documents have also been sent to voluntary organisations, health partners, staff and members and consultation events are being held covering these groups. The consultation is available on the Council's Talking Point consultation portal. A service user focus group is engaged in the consultation process, including reviewing the consultation feedback.

4.2 Equality and Diversity / Cohesion and Integration

4.2.1 An equality, diversity, cohesion and integration impact assessment will be undertaken involving the service user focus group before Executive Board is asked to decide on any changes to charging.

4.3 Council policies and Best Council Plan

4.3.1 This charging review supports the Council values of spending money wisely. Through supporting the financial sustainability of Adult Social Care services it supports making Leeds the best place to grow old.

4.4 Resources and value for money

4.4.1 These proposals would generate estimated net additional income to the Council of £3.8m in a full year. As with previous charging reviews, the additional income arising from the proposals within this review will be reinvested to help protect adult social care services and mitigate future financial pressures within Adult Social Care services.

4.5 Legal Implications, Access to Information and Call In

4.5.1 None.

4.6 Risk Management

4.6.1 None

5 Conclusions

5.1 This review of the current charging arrangements is taking place in the context of the financial challenges facing the Council, the growing demand for Adult Social Care services and the lower income from Adult Social Care charges in Leeds compared with other authorities.

6 Recommendations

6.1 Members of Scrutiny Board are asked to consider the main aspects of the Adult Social Care charging consultation currently underway and to provide their comments as part of the consultation process.

7 Background documents[1]

7.1 None.

[1] The background documents listed in this section are available to download from the Council's website, unless they contain confidential or exempt information. The list of background documents does not include published works.

Appendix 1

Standard Rates for Adult Social Care Services

These are the amounts that people pay if their financial assessment calculates that they can pay for their service in full.

Type of Service	**Charge**
Home Care and Supported Living	£13.80 per hour
Housing Support Services	£18.50 per hour
Day Centres	
Older People	£25.40 per day
Physical Disabilities	£44.50 per day
Learning Disabilities	£44.50 per day
Transport	
Transport to services	£5.40 per day
Shared Lives Sitting Services	
Outreach - daytime support	£8.00 per hour
Outreach - waking night-time support	£9.60 per hour
Day Support Service	£8.00 per hour
Mental Health Services	
Day Services - group session	£9.30 a session
Day Services - one-to-one support	£18.50 per hour
Telecare Services	
Telephone monitoring of Telecare pendant alarm	£2.60 per week
Mobile response service for Telecare pendant alarm	£0.50 per week
Telephone monitoring of Telecare pendant alarm with additional Telecare sensors	£3.10 per week
Telephone monitoring of Telecare pendant alarm with additional Telecare sensors and ‘GPS’ systems	£9.30 per week
Mobile response service for Telecare	£3.10 per week

Appendix 2

Financial Assessment Methodology

The financial assessment calculates how much someone can afford to pay towards their services. The way this is done is shown below:

Income:	Earnings ignored Mobility allowances ignored Benefits and pension income included Notional income based on capital included
Less:	Personal allowances (for daily living costs) Housing costs Disability related costs
Equals:	Assessed weekly contribution (the amount the financial assessment shows that they can afford)

If the financial assessment shows that a person can afford to make a contribution they will actually pay the lower of two amounts, either:

- The amount the financial assessment shows that they can afford, or;
- The charge for their services at the standard rates (for people receiving direct payments this would be the amount of the direct payment).

Appendix 3

Consultation Proposals – Changes to the Financial Assessment Methodology

What do we do now?	What are we thinking of doing?
Disability Benefits • For people who only have day time care needs who receive the high rate of Disability Living Allowance (care component), Attendance Allowance or Personal Independence Payment (daily living component) of £82.30 per week, only £55.10 of this income is included to work out what someone could afford to pay for their services.	Disability Benefits • For people who only have day time care needs the full amount of Disability Living Allowance, Attendance Allowance or Personal Independence Payment (£82.30 per week) that a customer receives would be included as income in the financial assessment. This means that the assessed weekly contribution would increase by £27.20.
Living Costs • Allowances to cover daily living costs vary depending on the benefits a person gets. For working age customers the allowances in Leeds are higher than those in the Care Act regulations. For most people they are £24.62 higher.	Living Costs • All customers of working age will be given the same allowance for daily living costs using the figures in the Care Act regulations. This means that the assessed weekly contribution would increase by £24.62 for most people.
Children • For those responsible for children no extra allowance for daily living costs is made in working out what someone could afford to pay for their services financial assessment for daily living costs.	Children • An extra allowance for daily living costs of £83.65 per child per week will be given to those responsible for children. This means that the assessed weekly contribution would reduce by £83.65 so most people would no longer have to pay for their services.
Water Costs • An allowance is given for water charges to work out what someone could afford to pay for their services.	Water Costs • No allowance for water charges will be given unless they are especially high because of a person's disability. This means that the assessed weekly contribution would increase by the amount of the water charges.
Housing Costs • An allowance is given for housing costs to work out what someone could afford to pay for their services. These costs are divided between the numbers of adults living in the property.	Housing Costs • An allowance for housing costs is only given for the person legally liable to pay the housing costs. This means for some people the assessed weekly contribution would not change, for some it would go up and for others it would go down.

Report author: Steven Courtney
Tel: 247 4707

Report of Head of Scrutiny and Member Development

Report to Scrutiny Board (Adult Social Services, Public Health, NHS)

Date: 24 November 2015

Subject: Public Health 2015/16 Budget – Update

Are specific electoral Wards affected? If relevant, name(s) of Ward(s):	☐ Yes	☒ No
Are there implications for equality and diversity and cohesion and integration?	☐ Yes	☒ No
Is the decision eligible for Call-In?	☐ Yes	☒ No
Does the report contain confidential or exempt information? If relevant, Access to Information Procedure Rule number: Appendix number:	☐ Yes	☒ No

1 Purpose of this report

1.1 The purpose of this report is to introduce a further update from the Director of Public Health regarding the Public Health budget for 2015/16 (i.e. the current year).

2 Summary of main issues

2.1 At the Board's previous meetings the Director of Public Health and Executive Member for Health, Wellbeing and Adults have advised the Scrutiny Board of the Treasury announcement that would see Public Health funding reduced by approximately £200M across England for 2015/16 (the current year): Equating to around £3M for Leeds. It has previously been outlined to the Board that this is likely to have a significant impact on the Council's 'prevention agenda'.

2.2 The Scrutiny Board was also advised of the Council's response to the Department of Health consultation '*Local authority public health allocations 2015/16: in-year savings – A consultation*', which ran until 28 August 2015.

2.3 The Government response to the public consultation has now been published and is appended to this report. In addition to analysing the consultation responses, this also confirms Leeds' overall contribution to the in-year reduction as £2.818M.

2.4 The Director of Public Health has been invited to provide a further verbal update to the Scrutiny Board including progress against achieving the confirmed level of savings required.

3. Recommendations

3.1 That the Scrutiny Board considers the report and details presented at the meeting, and determines any future scrutiny actions or activity.

4. Background papers[1]

4.1 None used.

[1] The background documents listed in this section are available to download from the Council's website, unless they contain confidential or exempt information. The list of background documents does not include published works.

Department of Health

Local authority public health grant allocations 2015/16

Government response to public consultation on in-year savings

and

Equality and health inequalities analysis

November 2015

Title: Local authority public health grant allocations 2015/16 Government response to public consultation on in-year savings and equality and health inequality analysis
Author: Public Health Policy and Strategy Unit, Department of Health
Document Purpose: Engagement and transparency
Publication date: 4th November 2015
Target audience: Local authorities in England
Contact details: Public Health Policy and Strategy Unit Room 165 Department of Health Richmond House 79 Whitehall London SW1A 2NS consultation.laphallocations@dh.gsi.gov.uk

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www.gov.uk/dh

Local authority public health grant allocations 2015/16

Government response to public consultation on in-year savings

and

Equality and health inequalities analysis

Prepared by:

Public Health Policy and Strategy Unit, Department of Health

Contents

Background and context

Since 2013 local authorities (LAs) in England have had a duty to take the steps that they believe are appropriate to improve the health of their populations. The Department of Health (DH) funds LAs for this with a grant. Other than requirements to discharge a limited number of public health functions prescribed in regulations and to comply with certain conditions that DH attaches to the grant, it is for LAs to determine how best to invest these resources.

In 2015/16 the total grant amounted originally to £2.8 billion, supplemented by a further £430 million when responsibility for services for children aged 0 – 5 transferred to LAs from NHS England on 1 October.

On 4 June 2015 the Chancellor of the Exchequer announced a package of savings to be made across government in 2015/16, the current financial year, to reduce public debt. These savings amount to £3 billion across government and include £200 million to be saved from the public health grant.

The distribution of the grant between LAs is informed by a 'fair shares' formula developed by the Advisory Committee on Resource Allocation (ACRA) and intended to reflect relative need for public health services across England. ACRA is an independent committee and its members include public health experts, GPs, NHS managers and academics.

The ACRA formula produces a 'target' share for each LA of the overall national allocation, intended to reflect local needs for public health interventions. In most cases this is higher or lower than the grant that LAs have actually received. This is because LAs' grants were originally based on the previous level of local NHS spending on a given set of public health activities (in order to provide a stable background for the transfer of responsibilities to LAs). All LAs benefitted from growth in their public health grants in 2013/14 and 2014/15, with those below their target allocations gaining the most.

DH is currently consulting separately on proposed adjustments to the ACRA formula designed to reflect variations in need more closely.

Between 31 July and 28 August DH invited views on three questions:

- how best to distribute the £200 million saving between the LAs affected;
- what DH, the NHS and Public Health England (PHE) can do to support LAs through the challenge of implementing the saving; and
- how DH can best assess the impact of the saving.

This document describes the responses to those questions that DH received and sets out how it will take matters forward in the light of those responses. It also analyses the impact of the Department's plans on inequalities in health and on people with characteristics protected by equalities legislation.

Summary of responses

The consultation exercise closed on the 28th August. DH received 219 responses from LAs, stakeholders, third sector organisations and individual members of the health and care workforce. Out of the total of 152 LAs in England with public health duties, 123 (81 per cent) responded.

Question 1

How should DH spread the £200 million saving across the LAs involved?

The consultation document suggested that DH could, for example:

A. Devise a formula that claims a larger share of the saving from LAs that are significantly above their target allocation.

B. Identify LAs that carried forward unspent reserves into 2015/16 and claim a correspondingly larger share of the savings from them.

C. Reduce every LA's allocation by a standard, flat rate percentage. Nationally the £200 million saving amounts to about 6.2 per cent of the total grant for 2015/16, so that would also be the figure DH applies to individual LAs.

D. Reduce every LA's allocation by a standard percentage unless any can show that this would result in particular hardship, taking account of the following criteria:

- inability to deliver savings legally due to binding financial commitments;
- substantial, disproportionate and unavoidable adverse impact on people who share a protected characteristic within the meaning of section 149 of the Equality Act 2010;
- high risk that, because of its impact, the decision would be incompatible with the Secretary of State's duties under the NHS Act 2006 (in particular the duty to have regard to the need to reduce inequalities between people with regard to the benefits they can receive from public health services);
- the availability of funding from public health or general reserves; or
- any other exceptional factors.

The consultation document made clear that, subject to the outcome of the consultation, DH's preferred option was C.

Out of the 123 LA responses, two did not respond to this question and one preferred a combination of options A and C. Thirteen LAs and two other respondents

suggested a new option - to use a weighted need based per head of population figure to calculate each LA's saving – and 107 LAs selected one of the options A to D. The table below sets out the response to the different options.

Table 1

Question 1 – Preferred option	Number of LAs and if above or below target allocation	Other respondents	All respondents
A – Take larger sum from LAs above target	54 (52 below target) (2 above target)	14	68
B – Take proportionate to reserves	10 (2 below target) (8 above target)	4	14
C – Take flat rate 6.2%	31 (15 below target) (16 above target)	11	42
D – Flat rate unless hardship	12 (9 below target) (3 above target)	11	23
New option - take per head of population based on weighted need	13 (8 below target) (5 above target)	2	15
Nil or no response	32 (18 below target) (14 above target)	54	86
Total	152	97	249
Notes: Two LAs submitted responses but did not select any of the options and stated that they would prefer no cuts. 30 LAs did not respond to the consultation.			
One other respondent would prefer a combination of option A and C. Not shown in table but included in total number of responses.			

Question 2

How can DH, Public Health England and NHS England help LAs to implement the saving and minimise any possible disruption to services?

Some LAs were keen to look at what can be achieved with the remaining budget and asked for support in identifying innovative interventions that offer value for money. Others felt that there was little that DH, PHE or NHS England can do to ease this process. They expressed concerns on the timing of the budget reduction and the

challenges this poses in planning public health services. Some LAs felt legal support would be helpful in looking at how services could be decommissioned.

LAs felt that the decision to make the saving was inconsistent with the emphasis of the NHS Five Year Forward View on prevention. Some highlighted the fact that between 40 per cent and 80 per cent of their public health budgets go to NHS providers.

This table lists suggestions from all respondents and the numbers making them.

Table 2

Early funding announcement for better planning.	25
Tools to help commissioners identify interventions that offer greatest VFM.	24
Appropriate time and legal support required to renegotiate contracts and give notice.	15
Be more aware of the impact of the saving on NHS services.	14
Saving should not be recurrent.	13
Savings should be shared with PHE.	10
Act a focal point or broker for discussions about economies of scale and other efficiencies. To help address fall out from staffing, contractual issues, etc.	9
Keep ring-fence around the grant for clarity.	9
Work with CCGs to minimise impact.	6
NHS commissioners/trusts to supplement health programmes to ease the challenges.	6
Clarity on health visitor target numbers.	5
Permit a targeted approach to NHS Health Checks and support with more national marketing campaigns.	5

Remove prescription in regulations of steps that all LAs must take.	5
Redirect Health Premium Incentive Scheme budget to reduce the saving.	4
PHE, DH, LGA and NHS England could model the saving's impact.	3
Carry out equality analysis to review the impact.	3
Implement payment by results, using data which are currently available, in order to drive change.	1
NHS could be asked to reduce waste.	1
Clarify performance assessment.	1

Question 3

How best can DH assess and understand the impact of the saving?

The three options that DH suggested were:

- to undertake a national survey of directors of public health and other key stakeholders;
- commission PHE centre directors to review the local impact and contribute to a national report for DH; and
- work through representative bodies to gather feedback on local impact.

All were favoured by some LAs and other respondents, and the table below lists further suggestions from respondents and the numbers making them.

Table 3

A national survey of directors of public health and other key stakeholders and PHE centre directors to review Local impact.	60
Conduct a health impact assessment on the social and economic impact of the budget reductions for each local authority.	35
Link the assessment or survey to the Public Health Outcomes Framework to evaluate the potential impact.	31

Ask how each LA made up its share of savings in the planning phase.	21
Discuss this with CCGs and NHS service providers to identify the impact on all services and third sector providers.	19
Request evidence from LGA, DCLG, ADPH and Faculty of Public Health regarding the impact as well as undertake benchmark studies to understand impact on savings (including on the NHS).	12 12
Speak to service user groups who have direct experience.	2
Ensure the assessment is not burdensome for LAs.	2
Improve data sharing between the various agencies involved in the commissioning and delivery of public health services.	1
Seek specific information through the annual Public Health Grant Statement of Assurance.	1

Government position

DH is grateful for the helpful and constructive responses to its questions. It has made its decisions after considering them carefully in the light of the three underpinning principles that it set out in the consultation document:

- the need to save £200 million from this year's grant as an important contribution to reducing the national deficit;
- the need to do so in a way that is consistent with the Department's public sector equality duty and the Secretary of State's health inequalities duty; and
- the need to do so in a way that minimises any disruption to public health services.

Equality and health inequality analysis

Section 149 of the Equalities Act 2010 sets out the public sector equality duty (PSED) which requires public authorities, including the Secretary of State for Health and LAs, to (among other things):

"… have due regard to the need to -

(a) eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under this Act;

(b) advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it;

(c) foster good relations between persons who share a relevant protected characteristic and persons who do not share it."

Section 1C of the NHS Act 2006 requires the Secretary of State to:

"… have regard to the need to reduce inequalities between the people of England with respect to the benefits that they can obtain from the health service."

A condition that DH attaches to the public health grant confers the same requirement on LAs in the way that they use the money.

From the outset of this exercise the Department's priority has been to make the saving in a way that:

minimises disruption by preserving as far as possible the important public health services used by vulnerable people, including those with characteristics protected by equalities legislation or who experience inequalities in their health; and
complies with all its policies and statutory duties on equality.

To support this objective, its consultation document stated specifically that:

“Views on the questions from all will be carefully considered and are equally welcome, particularly in relation to any people sharing a protected characteristic as defined in the Equality Act 2010. Please include in responses any views about ways to minimise possible disruption to services and adverse impacts on public health.”

As well as the responses to the consultation, and to set the issue in the appropriate context, DH has considered other existing evidence on the effect on inequalities in health and between people with protected characteristics of the distribution of available resources between LAs.

Distribution

DH undertook an equality analysis when allocating the grant between LAs for 2013/4 and 2014/15 (a two-year settlement). The settlement for 2015/16 was the same in cash terms as in 2014/15 and was distributed on the same basis (with minor adjustments to correct some local anomalies).

The table below summarises the factors related to health inequalities and protected characteristics that ACRA took into account when it considered the impact of the allocation formula. ACRA uses standardised mortality ratio for people aged under 75 years of age (SMR<75) as a robust indicator of the whole population’s health status, and hence need for public health services. It should not be interpreted as meaning that the allocation should not reflect the needs of those aged over 75, or that morbidity is not important. ACRA’s analysis showed that the SMR<75 is highly correlated with other measures of population health, such as disability free life expectancy and healthy life expectancy.

More details are available at https://www.gov.uk/government/publications/ring-fenced-public-health-grants-to-local-authorities-2013-14-and-2014-15.

Summary of equality analysis of the public health grant distribution:

Characteristic	Considerations in the ACRA formula
Age	For younger people aged 19 or under, substance misuse and sexual health services have a formula component adjustment.
Sex	Adjustments, or weights, for sex are applied to the same functions as age.
Race	Race may be correlated with the SMR<75. ACRA explored the Health Survey for England data on smoking, alcohol, and fruit and vegetable consumption by ethnicity and age, but the sample numbers were too small to provide robust data by ethnicity for allocations purposes.
Disability	ACRA considered using Disability Free Life Expectancy (DFLE), and the Healthy Life Expectancy (HLE) which more explicitly measure morbidity and disability than the SMR<75. However, SMR<75, DFLE and HLE are very highly correlated so the use of the SMR<75 does capture morbidity.
Gender reassignment	Gender reassignment data within the healthcare context is complex and incomplete. There was a lack of data on the group's public health needs suitable for use in an allocations formula.
Sexual orientation	The 2007 Citizenship Survey showed no difference in self-reported good health between heterosexual and gay/lesbian people. The Lesbian and Gay Foundation highlighted that LGB&T people are more likely than heterosexual people to smoke and drink alcohol and so could potentially have a higher need for public health services. Due to the lack of robust data available on sexual orientation within LA areas that are suitable for allocations purposes no adjustment was made for this factor.
Religion and belief	There is a lack of robust data suitable for allocations purposes on the public health needs of groups with different

	beliefs. No adjustment was made.
Pregnancy and maternity	Care through pregnancy and the early years impacts upon health and healthcare needs throughout life, but LAs are not directly responsible for pregnancy and maternity services. ACRA recognised that a good start in life can influence future health, educational and social outcomes, and recommended an age weight for children under five years old. The weight is approximated from the behaviour of the parental age group, as an indicator of likely future public health need.
Carers	Carers play a vital role in supporting the healthcare system, but often have poorer health outcomes. Allocations indirectly account for carers through the SMR as this is correlated with, for example, DFLE.
Other identified groups	<u>Seasonal workers</u> ACRA considered seasonal workers, who may be at risk of inequity of opportunity to access public health services. ACRA considered data from the ONS on the estimates of short-term migrants which were mapped to administrative sources provided by other government departments in order to accurately allocate short-term migrants to local authorities. In the majority of LAs the number of short-term residents is very small in comparison with the usually resident population (less than 0.5%). Those with a proportion higher than 0.5% are predominantly in London but without data on the intention of length of stay we cannot predict their pattern of public health demand. For this reason no adjustment is made. <u>Deprived populations within affluent areas</u> Deprivation impacts heavily upon public health need and more affluent areas, all else being equal, are less likely to need the same level of public health services. The SMR is highly correlated with deprivation and as the SMR is applied at ward level it takes account of the relative deprivation between and within LAs. Higher deprivation is therefore associated with higher allocations per head. <u>Travellers</u> Travellers may not have full access to public health services because of their non-permanent status. Public health allocations can help promote equity of access by ensuring LAs with relatively higher populations of travellers receive a higher share of available resources. Analysis was undertaken to calculate the traveller population as a proportion of each LA's total population. This was shown to be very low, as was

	the variation across local authorities. In addition, the Office for National Statistics undertook a special exercise to ensure that the 2011 population census included travellers, who are therefore included in the population base for public health grants. For these reasons, no adjustment was recommended by ACRA.

Consultation responses

Twenty-seven LAs and other respondents commented directly on the potential impact of the saving on health inequalities or on people with protected characteristics. All believed that removing £200 million from the grant in 2015/16 by any of the four options that DH suggested would have some level of negative impact on inequalities in health. Some suggested that the saving would have a substantial, disproportionate and unavoidable adverse impact on people who share a protected characteristic under the Equality Act 2010. Several argued that implementing the reduction at all is incompatible with the Secretary of State's duties under both the NHS Act 2006 and the Equality Act 2010 (DH does not accept these arguments, for the reasons described below). Others were disappointed that DH had not completed an equality analysis before publishing the consultation document.

A number of respondents made points about the impact on health inequalities or protected characteristics of the four specific options for making the saving suggested in the consultation document. Others suggested a different option. These responses are summarised below.

Option	**Responses**
A. Take a larger proportion of the saving from LAs that are significantly above their ACRA target allocation.	ACRA allocations do not take into account cost pressures in commissioning service in rural areas, creating disadvantages in the way allocations are calculated that option A would exacerbate. Fairer, creates equality.
B. Take a larger proportion of the saving from LAs that carried forward unspent reserves into 2015/16.	Reserves are earmarked for programmes that would reduce inequalities in health.

C. Take a standard rate of 6.2% from every LA's allocation.	There are difficulties in cancelling contracts which will affect front line services, leading to increased health inequalities in key areas.
D. Take a standard rate unless any LA can demonstrate that doing so would cause it particular hardship or would contravene DH's PSED or its health inequalities duty.	The saving will have an unavoidable adverse impact on people who share a protected characteristic within the meaning of Section 149 of the Equality Act 2010. Aging population or levels of child poverty are greater in some LAs; other significant health inequalities within others.
New option – a standard, cash per capita reduction from every LA.	This was suggested by LAs who argued that it would have the least detrimental impact on areas with the highest levels of economic deprivation. .

Analysis

The Government believes that taking action to reduce the deficit is vital to the long-term health of our economy and to all of the public services that it supports. A reduction (or, indeed, increase) in the size of the available national budget for the public health grant need not in itself affect relative inequalities. Far more influential are the formula by which resources are divided between LAs and the decisions that LAs themselves make on how to use their grants. This applies now, to the decision on how to implement savings, as much as it does to the original distribution of the grant. For these reasons, DH does not accept that the decision to make the saving is inconsistent with its equality duties and has taken account of the impact on health inequalities.

Each of the five options for making the saving that this analysis considers has merits and drawbacks in terms of their impact on health equalities and the PSED.

Option A would accelerate the pace of change of LAs towards the 'fair share' target allocations determined by the ACRA formula. It would, though, do so in a negative way, without increasing any LA's grant and by decreasing others' by a larger amount than they might be planning for, with consequent disruption to services used by people with protected characteristics or who experience health inequalities (especially when the time available to implement savings is so limited). It would also

pre-empt the current review of the ACRA formula. This review will make the formula more reflective of local need and is highly likely to affect the distance from target of many LAs, possibly moving some from above target to below and vice versa.

Option B might seem to minimise the impact on services by simply collecting unspent money. However DH does not have accurate figures for all LAs' carry-forward into 2015/16, nor does it have any quick or reliable way to obtain that information. As the responses to the consultation show, 'unspent' is not the same as 'uncommitted' – LAs carry forward resources for good reasons, and some intend the reserves to be used in ways that address inequalities in health or for long term projects.

Option C – the Department's initial preference – was seen by some respondents as a blunt instrument that does not adequately reflect local health inequalities or other circumstances. Nevertheless, as other respondents acknowledged, it remains the quickest and simplest option to implement, giving LAs the maximum clarity as quickly as possible about what is required and so minimising disruption to services (a priority for DH from the outset). The importance of rapid clarity was emphasised by a number of respondents, including the Local Government Association (LGA). Reducing each LA's grant by the same percentage is consistent with the ACRA formula and the approach taken to distribute the original allocations (itself based on an equality analysis and reflecting health inequalities through using standardised mortality ratio as a proxy for need) in that it leaves unchanged LAs' funding relative to each other.

Option D offers a mechanism for adjusting some LAs' required savings to mitigate potential adverse impact on equalities or on health inequalities, but that could only work at the expense of other LAs – the imperative to save a total of £200 million nationally would remain. The evidence that 20 LAs submitted would not allow DH to calculate adjustments that were demonstrably fair to the large majority of LAs that chose not to submit evidence. Nor does the evidence enable us to determine with confidence that the impacts these LAs cited are significantly different from those described by a number of other respondents who neither favoured this option nor submitted evidence.

The respondents putting forward the **new option** of a fixed per capita cash reduction argue that it would be fairer by taking less from areas of higher deprivation – and deprivation is associated with health inequalities. The savings required from LAs under this option would range from 1.7 per cent to 12.2 per cent. It would be inconsistent with the ACRA formula, which is designed to reflect local public health needs and has broad support. Just as with options A, B and D, the option would mean that some LAs would have to make larger savings within the current financial year (up to double the average of 6.2 per cent) and at very short notice. Again, as with options A, B and D, DH believes that there is a high risk that the effects of the

disruption that this would cause, to health inequalities and services in those areas for people with protected characteristics or who experience health inequalities, would outweigh the potential benefits for other areas.

In conclusion, DH has considered carefully both the existing evidence and the responses to its consultation document. In the light of this, and while it accepts that the decision is not straightforward, it believes that option C remains preferable to any other identified option and is fully consistent with its duties under section 1C of the NHS Act 2006 and section 149 of the Equalities Act 2010.

Impact on services

The factors that DH has taken into account when considering impact on services are very similar to those it considered in relation to equalities and health inequalities, and lead to the same conclusion: that option C remains the most viable and overall the least disruptive way of delivering this saving. The arguments that respondents expressed in favour of options A, B and D reflected points that the Department had considered before publishing its consultation document and expressing a preference.

Given that **option A** was the preference of the largest number of respondents, the Department gave it very careful consideration. While it understands the arguments in the option's favour, DH remains concerned about the likely impact on the planning of services of the uncertainty that would inevitably continue while DH arrived at an appropriate formula. For option A to produce a materially different outcome to option C it would also require some LAs to find savings significantly greater than 6.2 per cent, and with significantly less time to manage the effects. Finally, the review of the ACRA formula is very likely to change many LAs' target allocations for 2016/17 and beyond, meaning that making adjustments now on the basis of the current targets would risk producing avoidable anomalies.

Option B received the least support and DH believes it is the least practical, for the reasons it describes in the equality analysis. It too would prolong the uncertainty for LAs to an unacceptable degree.

DH has considered the evidence of hardship submitted by 20 LAs under **option D** but is not satisfied that the evidence described exceptional hardship or could support a robustly calculated adjustment that would be fair to the LAs whose contribution would have to increase. The Equality Analysis section of this document sets out why DH believes its preferred option C complies with the PSED and its health inequality duty.

The **new option** that a number of respondents proposed attempts to relate individual authorities' contribution to the overall saving more closely to the local need for public health interventions. Although some LAs mentioned disadvantages in the current

ACRA formula, it is the established and broadly accepted mechanism for bringing target resources into line with need. Adopting a per capita approach now would be inconsistent with that, and would produce a wide disparity in the proportion of their grant that LAs were required to save – from 1.7 percent to 12.2 per cent. DH is currently consulting on proposed refinements to the ACRA formula that should make it more reflective of local circumstances.

On balance, **option C** – a flat rate reduction of 6.2 per cent – remains DH's preference. It is the option most consistent with the underpinning principles for managing the saving that the Department has set out: it delivers the £200 million, it is the least disruptive to services and it is compliant with the PSED and the health inequality duty. The Annex (A) sets out revised 2015/16 allocations, subject to final technical checks.

Questions 2 and 3

The responses to questions 2 and 3 in the consultation will help DH to facilitate the saving and understand its consequences.

The government will address questions about the 2016/17 grant and the future of the ring-fence later this autumn, at the conclusion of the current spending review. DH will also consider the prescription in regulations of certain functions and the future of the Health Premium Incentive Scheme in the same light.

To assist LAs in managing the saving in the current year DH will bring forward the January instalment of the grant and make it available to LAs shortly, net of the £200 million saving.

PHE will continue to develop the advice it can offer to LAs on the cost effectiveness of specific public health interventions. PHE will also work with the LGA, the Association of Directors of Public Health, individual LAs and clinical commissioning groups to both mitigate and monitor the effect of the saving on public health outcomes. DH fully accepts the need for a process that makes optimum use of existing sources of information and does not place additional burdens on LAs.

Conclusion

The Department will save £200 million from the 2015/16 public health grant by reducing each LA's grant by an equal percentage – option C in its consultation document. The saving will be implemented through a reduction in the fourth quarterly instalment of the grant, which will be brought forward from January 2016. DH will continue working with its partners in PHE, NHS England, and the local government and public health sectors to support LAs and monitor the impact of the saving.

Annex A

Public Health Allocations to local authorities: total in-year savings for each LA in 2015/16 including 0-5 children's budget (£'000s)

ONS LA Name	Total PH allocation for 2015/16	0-5 allocation transferred in October 2015	Overall PH allocation for 2015-16	LA share of £200m savings	2015-16 allocation after reduction
Barking and Dagenham	14,213	2,512	16,725	1,035	15,690
Barnet	14,335	2,592	16,927	1,048	15,879
Barnsley	14,243	2,549	16,792	1,039	15,752
Bath and North East Somerset	7,384	1,387	8,771	543	8,228
Bedford	7,343	1,291	8,634	534	8,100
Bexley	7,574	1,720	9,294	575	8,719
Birmingham	80,838	11,210	92,048	5,697	86,351
Blackburn with Darwen	13,134	1,880	15,014	929	14,084
Blackpool	17,946	1,551	19,497	1,207	18,290
Bolton	18,790	2,835	21,625	1,339	20,287
Bournemouth	8,296	1,818	10,114	626	9,488
Bracknell Forest	3,049	774	3,823	237	3,586
Bradford	35,333	6,133	41,466	2,567	38,900
Brent	18,848	2,763	21,611	1,338	20,274
Brighton and Hove	18,695	2,111	20,806	1,288	19,518
Bristol, City of	29,122	3,799	32,921	2,038	30,884
Bromley	12,954	1,901	14,855	919	13,935
Buckinghamshire	17,249	3,061	20,310	1,257	19,053
Bury	9,619	1,806	11,425	707	10,718
Calderdale	10,679	2,190	12,869	797	12,072
Cambridgeshire	22,155	3,861	26,016	1,610	24,405
Camden	26,368	2,121	28,489	1,763	26,725
Central Bedfordshire	10,149	1,902	12,051	746	11,306
Cheshire East	14,274	2,353	16,627	1,029	15,598
Cheshire West and Chester	13,889	2,107	15,996	990	15,006
City of London	1,698	75	1,773	110	1,663
Cornwall	20,749	3,673	24,422	1,512	22,910
County Durham	45,780	4,894	50,674	3,137	47,538
Coventry	19,415	2,807	22,222	1,375	20,846
Croydon	18,825	2,748	21,573	1,335	20,237
Cumbria	15,594	2,599	18,193	1,126	17,067
Darlington	7,184	1,215	8,399	520	7,879
Derby	15,710	3,094	18,804	1,164	17,640
Derbyshire	35,562	5,140	40,702	2,519	38,183

Devon	22,060	4,513	26,573	1,645	24,928
Doncaster	20,198	3,450	23,648	1,464	22,184

ONS LA Name	Total PH allocation for 2015/16	0-5 allocation transferred in October 2015	Overall PH allocation for 2015-16	LA share of £200m savings	2015-16 allocation after reduction
Dorset	12,889	2,267	15,156	938	14,218
Dudley	18,974	2,453	21,427	1,326	20,100
Ealing	21,974	2,863	24,837	1,537	23,300
Essex	48,192	10,981	59,173	3,663	55,511
Gateshead	14,850	1,987	16,837	1,042	15,795
Gloucestershire	21,793	3,141	24,934	1,543	23,391
Greenwich	19,061	3,574	22,635	1,401	21,234
Hackney	29,818	4,009	33,827	2,094	31,733
Halton	8,776	1,410	10,186	630	9,556
Hammersmith and Fulham	20,855	1,996	22,851	1,414	21,437
Hampshire	40,363	8,843	49,206	3,046	46,160
Haringey	18,189	2,422	20,611	1,276	19,336
Harrow	9,146	1,577	10,723	664	10,059
Hartlepool	8,486	761	9,247	572	8,675
Havering	9,717	1,372	11,089	686	10,402
Herefordshire, County of	7,970	1,266	9,236	572	8,664
Hertfordshire	37,642	8,200	45,842	2,837	43,004
Hillingdon	15,709	2,137	17,846	1,105	16,742
Hounslow	14,084	1,935	16,019	992	15,028
Isle of Wight	6,088	1,226	7,314	453	6,861
Isles of Scilly	73	37	110	7	103
Islington	25,429	2,092	27,521	1,703	25,818
Kensington and Chelsea	21,214	1,342	22,556	1,396	21,160
Kent	53,264	11,894	65,158	4,033	61,125
Kingston upon Hull, City of	22,559	2,682	25,241	1,562	23,679
Kingston upon Thames	9,302	1,112	10,414	645	9,770
Kirklees	23,527	3,049	26,576	1,645	24,931
Knowsley	16,419	1,593	18,012	1,115	16,897
Lambeth	26,437	4,652	31,089	1,924	29,165
Lancashire	59,801	9,034	68,835	4,261	64,574
Leeds	40,540	4,993	45,533	2,818	42,715
Leicester	21,912	4,288	26,200	1,622	24,578
Leicestershire	21,930	3,202	25,132	1,556	23,576
Lewisham	20,088	3,790	23,878	1,478	22,400
Lincolnshire	28,506	4,166	32,672	2,022	30,650
Liverpool	41,436	4,845	46,281	2,865	43,417

Luton	13,286	2,114	15,400	953	14,447
Manchester	48,303	5,441	53,744	3,327	50,418

ONS LA Name	Total PH allocation for 2015/16	0-5 allocation transferred in October 2015	Overall PH allocation for 2015-16	LA share of £200m savings	2015-16 allocation after reduction
Medway	14,280	2,522	16,802	1,040	15,762
Merton	9,236	1,476	10,712	663	10,049
Middlesbrough	16,378	1,398	17,776	1,100	16,676
Norfolk	30,590	6,893	37,483	2,320	35,163
North East Lincolnshire	9,971	1,299	11,270	698	10,573
North Lincolnshire	8,464	1,078	9,542	591	8,951
North Somerset	7,593	1,636	9,229	571	8,658
North Tyneside	10,807	1,674	12,481	773	11,709
North Yorkshire	19,732	2,535	22,267	1,378	20,889
Northamptonshire	29,523	5,033	34,556	2,139	32,417
Northumberland	13,361	2,547	15,908	985	14,923
Nottingham	27,839	5,319	33,158	2,052	31,106
Nottinghamshire	36,119	5,815	41,934	2,596	39,338
Oldham	14,915	2,164	17,079	1,057	16,022
Oxfordshire	26,086	4,333	30,419	1,883	28,536
Peterborough	9,291	1,563	10,854	672	10,182
Plymouth	12,276	2,575	14,851	919	13,932
Poole	6,057	1,287	7,344	455	6,889
Portsmouth	16,178	2,013	18,191	1,126	17,065
Reading	8,212	1,446	9,658	598	9,060
Redbridge	11,411	2,112	13,523	837	12,686
Redcar and Cleveland	10,917	1,117	12,034	745	11,289
Richmond upon Thames	7,891	1,334	9,225	571	8,654
Rochdale	14,777	2,299	17,076	1,057	16,019
Rotherham	14,176	2,150	16,326	1,011	15,316
Rutland	1,080	195	1,275	79	1,196
Salford	18,777	2,444	21,221	1,313	19,907
Sandwell	21,805	3,175	24,980	1,546	23,433
Sefton	19,952	2,216	22,168	1,372	20,796
Sheffield	30,748	3,724	34,472	2,134	32,338
Shropshire	9,843	1,474	11,317	700	10,617
Slough	5,487	1,546	7,033	435	6,597
Solihull	9,644	1,407	11,051	684	10,367
Somerset	15,513	3,843	19,356	1,198	18,158
South Gloucestershire	7,345	1,655	9,000	557	8,443
South Tyneside	12,917	1,392	14,309	886	13,424

Southampton	15,049	2,103	17,152	1,062	16,090
Southend-on-Sea	8,060	1,355	9,415	583	8,832

ONS LA Name	Total PH allocation for 2015/16	0-5 allocation transferred in October 2015	Overall PH allocation for 2015-16	LA share of £200m savings	2015-16 allocation after reduction
Southwark	22,946	3,464	26,410	1,635	24,775
St. Helens	13,099	1,582	14,681	909	13,773
Staffordshire	33,313	5,330	38,643	2,392	36,251
Suffolk	25,742	4,206	29,948	1,854	28,095
Sunderland	21,036	2,750	23,786	1,472	22,314
Surrey	28,977	6,528	35,505	2,198	33,307
Sutton	8,619	1,280	9,899	613	9,286
Swindon	8,558	1,472	10,030	621	9,409
Tameside	13,463	1,771	15,234	943	14,291
Telford and Wrekin	10,913	1,572	12,485	773	11,712
Thurrock	8,631	1,956	10,587	655	9,932
Torbay	7,396	1,494	8,890	550	8,339
Tower Hamlets	32,261	3,855	36,116	2,235	33,881
Trafford	10,829	1,642	12,471	772	11,699
Wakefield	21,105	3,267	24,372	1,509	22,863
Walsall	15,827	2,146	17,973	1,112	16,861
Waltham Forest	12,277	2,908	15,185	940	14,245
Wandsworth	25,431	2,871	28,302	1,752	26,550
Warrington	10,439	1,467	11,906	737	11,170
Warwickshire	19,477	3,326	22,803	1,411	21,392
West Berkshire	4,819	919	5,738	355	5,383
West Sussex	27,445	5,582	33,027	2,044	30,983
Westminster	31,235	2,242	33,477	2,072	31,405
Wigan	23,665	2,761	26,426	1,636	24,790
Wiltshire	14,587	2,584	17,171	1,063	16,108
Windsor and Maidenhead	3,511	957	4,468	277	4,191
Wirral	28,164	2,522	30,686	1,899	28,787
Wokingham	4,223	930	5,153	319	4,834
Wolverhampton	19,296	2,198	21,494	1,330	20,164
Worcestershire	26,528	3,342	29,870	1,849	28,021
York	7,305	916	8,221	509	7,712
England	**2,801,473**	**429,763**	**3,231,236**	**200,000**	**3,031,236**

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Report author: Steven Courtney
Tel: 247 4707

Report of Head of Scrutiny and Member Development

Report to Scrutiny Board (Adult Social Services, Public Health, NHS)

Date: 24 November 2015

Subject: Primary Care

Are specific electoral Wards affected? If relevant, name(s) of Ward(s):	☐ Yes	☒ No
Are there implications for equality and diversity and cohesion and integration?	☐ Yes	☒ No
Is the decision eligible for Call-In?	☐ Yes	☒ No
Does the report contain confidential or exempt information? If relevant, Access to Information Procedure Rule number: Appendix number:	☐ Yes	☒ No

1 Purpose of this report

1.1 The purpose of this report is to introduce further information relating to the Scrutiny Board's inquiry around Primary Care and specifically various developments relating to general practice (GP services).

2 Summary of main issues

2.1 In June 2015, the Scrutiny Board identified Primary Care as a specific area for inquiry during 2015/16. At its meeting in September, the Board considered details around the general provision of primary care services in Leeds and potential areas of development.

2.2 Building on the information previously provided, a further report setting out some of the specific developments of general practice (GP services) is attached.

2.3 Appropriate representatives have been invited to attend the meeting to present the attached information, address any questions from the Board and generally contribute to the discussion.

3. Recommendations

3.1 That the Scrutiny Board considers the report, including details presented at the meeting, and determines any future scrutiny actions or activity.

4. Background papers[1]

4.1 None used.

[1] The background documents listed in this section are available to download from the Council's website, unless they contain confidential or exempt information. The list of background documents does not include published works.

Report author: Gina Davy, Deborah McCartney and Kirsty Turner

Tel: 0113 8435532

Report of: CCG Clinical Chairs

Report to: Scrutiny Board (Adult Social Services, Public Health, NHS)

Date: 24 November 2015

Subject: **Development of Primary Care Services (General Practice)**

2 Sentence Strap line: This report informs members of the developments taking place in General Practice across Leeds within the context of improving access and developing 7 day services. It also provides an overview of the local and national evaluation of schemes supporting improvements in access.

Are there implications for equality and diversity and cohesion and integration?	☐ Yes	☒ No
Is the decision eligible for Call-In?	☐ Yes	☒ No
Does the report contain confidential or exempt information?	☐ Yes	☒ No

Summary of main issues

NHS England has signalled an intention to develop seven day working across the NHS including primary care. This is within the context of a drive to transform primary care services in order to both meet the increasingly complex needs of an ageing population and improve quality and outcomes for patients.

This report provides an overview of how NHS Leeds North CCG, NHS Leeds South and East CCG and Leeds West CCG are working to improve access to **general practice services** and the challenges faced by general practices in reconfiguring both teams and infrastructure to achieve this.

1 Purpose of this report

1.1 The purpose of this report is to provide the Scrutiny Board (Adult Social Services, Public Health, NHS) with an overview of work underway to improve access and quality within primary care, specifically general practices, including the citywide response to the national drive to develop 7 day working.

1.2 Around 90% of healthcare contacts take place within primary care (including general practices, dental practices, community pharmacies and high street optometrists); often these contacts will be the first or only interaction a patient may have with the healthcare system.

Primary care therefore has a unique opportunity to treat patients but also to support patients to lead healthier lifestyles and improve their health outcomes.

1.3 The Leeds Joint Health and Wellbeing Strategy 2013-2015 sets out five outcomes for Leeds. Primary Care is clearly integral to achieving these outcomes and improvements in access will further strengthen the position of primary care to contribute to improving the health and wellbeing for the Leeds population.

2 Background information

2.1 The NHS Five Year Forward Plan, supported by 'The NHS England Business Plan 2015-2016' and 10 point General Practitioner (GP) workforce action plan recognises the strengths and achievements of the NHS. It also strongly communicates a case for change in order to keep up with not just the increasing needs of an ageing population but with patient preferences, technology and the need to embrace new models of care. A resilient NHS must break down barriers between providers, communities and patients to respond effectively and deliver best possible health outcomes.

2.2 List based general practice is still recognised as the cornerstone of the healthcare system however, there is much that can be learned from innovative emerging models of care nationally and beyond.

2.3 General practice services are currently commissioned by NHS England. Nationally, all general practices are contracted to provide primary medical care to registered patients between 08.00-18.30.

2.4 General practices can choose to be commissioned by NHS England to provide, through an optional (National) Enhanced Service agreement, a number of extended hours appointments before 08:00hrs, after 18:30hrs or during the weekend. The numbers of hours of extended opening is determined by the practice list size and practices are required to consider patient survey responses before finalising the extended hours provision.

Out of the 108 practices in Leeds, this is currently provided by 20 practices in NHS Leeds North CCG, 30 practices in NHS Leeds South and East CCG and 37 practices in NHS Leeds West CCG. It should be noted that an additional 4 practices in Leeds South and East CCG and 2 in Leeds North CCG hold an alternative primary care medical services (APMS) contract and are required to provide extended hours opening as part of their core contract provision. Appendix A provides the details of all practices extended opening arrangements.

2.5 In terms of access to other primary care contractors the current position is as follows:

NHS dental practices opening hours are dependent on individual practice contracts and therefore vary across the area. Access to out of hours dental care is provided by Local Care Direct based at Lexicon House and accessed via 111. There are no current national plans to support 7 day working with regard to dental practices.

Pharmacies and optometrists open a variety of hours, some covering 7 days, especially those in high foot fall areas such as city centres and those based in supermarkets. In Leeds we already have 73 pharmacies open on Saturdays, and 38 open on Sundays. There are no current plans to try to enforce 7 day opening as pharmacies and optometrists are predominantly business led; it is likely that if GP practices open 7 days then local pharmacies will look to mirror their opening times to support the primary care provision in the local area.

2.6 For the purpose of this paper, we are focussing on the access of routine general practice services. This includes an element of urgent care but could also include long term

conditions management and pro-active care, as opposed to access to urgent care services which patients can currently access 7 days per week via the out of hours service.

3 Policy and National Context

3.1 National policy has indicated that general practice should be identified as "*Wider Primary Care, provided at Scale".* This includes the expectation that general practices will be commissioned to offer extended opening hours and move towards the NHS providing access to all services 7 days a week.

3.2 On 4 October 2015, David Cameron announced a development of a voluntary GP contract for groups of practices with a combined population of 30,000 patients. The contract, to be available from April 2017, would allow groups of general practices to work together to deliver better integrated care and work more closely alongside community nurses, hospital specialists, pharmacists and other health and care professionals. The voluntary contract will also enable participating groups of practices to provide 7 day access to general practice services by 2020.

3.3 For general practices, the development of extended access has most recently been reflected in initiatives such as the 'Prime Minister's Challenge Fund' which has now been renamed as the Prime Ministers GP Access Fund which has previously been available for practices to bid for monies to work towards and pilot seven day, 8am until 8pm access to services.

3.4 At the time of writing, the initial evaluation report of wave one of the Prime Minister's Challenge Fund had just been published. A full copy of the report is provided at Appendix B and key conclusions drawn from the 20 pilot sites participating in the pilot are as follows:

- The pilots have been successful at providing additional GP appointment time as well as more hours for patients to access other clinicians.
- Low reported utilisation of appointments on Sunday would suggest additional hours are more likely to be well utilised if provided during the week or on Saturdays, particularly Saturday mornings.
- Where pilots did choose to make appointment hours available over the weekend, evidence suggests these might be reserved for urgent care rather than pre-bookable slots.
- Telephone-based GP consultations models proved most popular and successful. Other contact modes such as video or e-consultations have yet to prove significant benefits.
- Across the 20 pilot sites, there has been a 15% reduction in in minor self-presenting A&E attendances compared to a 7% reduction nationally. There was no discernable change in emergency admissions or out of hours services.

3.5 Whilst general practice services are commissioned and performance managed by NHS England; CCGs have a statutory duty for improving the quality of primary care services. It is through this statutory duty that CCGs have a responsibility to improve access and patient experience as a recognised marker of quality.

3.6 Co-commissioning of general practice services between CCGs and NHS England is offering more scope for CCGs to have influence and delegated responsibility for the commissioning of general practice services. To date, the Leeds CCGs have opted to work with NHS England as Level 1 co-commissioners, which allow CCGs to have more influence over decision making. All three Leeds CCGs have recently submitted an

application to NHS England for full delegated responsibility for the commissioning of general practice services. Feedback from NHS England is expected later this year.

3.7 NHS England have previously shared eight high impact interventions for system resilience that every System Resilience Group (SRG) is responsible for delivering. The first of these eight interventions states that "No patient should have to attend A&E as a walk in because they have been unable to secure an urgent appointment with a GP. This means having robust services from GP surgeries in hours, in conjunction with comprehensive out of hours services".

3.8 Representatives from the three Leeds CCGs are working closely with the citywide Urgent Care Team to ensure that clear and responsive arrangements are in place between general practices and the Out of Hours (OOHs) provider at known times of system demand. In order to achieve the transformational change required across the whole system to deliver new models of care outlined in the Five Year Forward View it is clear that CCGs will need to ensure primary care is at the heart of these developments through additional primary care commissioning.

4 Patient Experience

4.1 The most recent national GP survey was published in July 2015 covering the periods July – September 2014 and January – March 2015. The survey demonstrates results for Leeds that are fairly consistent with the national results however; there is wide variation across GP practices as demonstrated in Figure 1.

Figure 1	% patients giving a positive response					
	LNCCG	LSECCG	LWCCG	National	*Highest Leeds Value*	*Lowest Leeds Value*
Able to get an appointment to see or speak to someone	86%	83%	86%	85%	*100%*	*56%*
Ease of getting through to someone at GP surgery on the phone	76%	69%	72%	71%	*98%*	*40%*
Frequency of seeing preferred GP	60%	56%	59%	60%	*93%*	*22%*
Convenience of appointment	92%	91%	92%	92%	*100%*	*72%*
Rating of GP involving you in decisions about your care	77%	74%	76%	74%	*91%*	*51%*
Satisfaction with opening hours	74%	74%	77%	75%	*100%*	*51%*

4.2 All three CCGs will continue to work with individual general practices to address the variation highlighted which does indicate some specific areas of focus such as the ability to contact the surgery by telephone and the ability to see a preferred GP.

4.3 A number of workstreams and specific projects are already underway within Leeds, which supports the wider definition of improving access to general practice services and ensures sustainable high quality services for patients.

Some examples of the initiatives being progressed across all three CCGs in collaboration with NHS England that will help support improvements in patient experience are:

Initiative	**LNCCG**	**LSECCG**	**LWCCG**
Increase usage of online services to support self-	✓	✓	✓

management and access to appointments			
Development of **pharmacy first** services to support self-management and improved access to services	✓	✓	✓
Roll out of 'house of care' approach to long term conditions to support patients being involved in their care, led by Public Health	✓	✓	✓
Workforce development initiatives to support recruitment and retention in primary care including testing out new workforce models • clinical pharmacists in practice, • Health Care Assistant apprenticeships, • Physician associates • Nurse leadership initiatives	✓	✓	✓
Ensure all practice complete the Health Education England workforce tool to understand the risks relating to workforce and prioritise initiatives to those areas of greatest need	✓	✓	✓
Development of social prescribing models to support people to access non-medical sources of support and activities in the community reducing the need to access primary and urgent care services and therefore creating more capacity and improved access to these services	✓	✓	✓
Development of medicines optimisation initiatives to improve the quality and efficiency of prescribing	✓	✓	✓
Reviewing Friends and Family test data to understand real time patient experience	✓	✓	✓
Supporting practices to tackle people who Do Not Attend (DNAs) through various initiatives such the use of technology to support patients to receive reminders for appointments and complete surveys etc.	✓	✓	✓
Identifying scope for productivity and efficiencies through Quality Improvement Programmes such as General Practice Improvement Programme (GPIP) or Productive General Practice (PGP). A module of these programmes support capacity and demand modelling to support improving internal systems for appointments	✓	✓	✓
CCG quality improvement schemes in place to support improvements through the identification of key actions that will help to address local priorities	✓	✓	✓
Utilise the Primary Care Webtool to understand variation across general practice by highlighting where practices are a statistical outlier against local and national benchmarks.	✓	✓	✓

4.4 In addition to the national GP survey, the citywide urgent care team have recently undertaken extensive public and patient engagement in relation to urgent care services across the city, which has also provided some insight relating to general practice services. The engagement demonstrated high levels of patient satisfaction with urgent care across Leeds with 84% of patients satisfied with urgent care services (including urgent primary care). Other feedback was that older patients generally valued the "traditional" relationship

with GPs, whilst our younger population increasingly want to access advice in different ways (including telephone and Skype consultations).

5.0 Approach to 7-day working across Leeds

5.1 Evidence shows that the limited availability of some hospital services at weekends can have a detrimental impact on outcomes for patients, including raising the risk of mortality. NHS England is committed to offering a much more patient-focused service. Part of this commitment will be fulfilled by moving towards routine NHS services being made available seven days a week. Led by Leeds Teaching Hospital Trust (LTHT), a 7-day service forum/task group has been established within Leeds.

5.2 The focus to date has been on acute services, with LTHT establishing their own internal 7 day services working group. It is however important that we ensure community services are also available to support flow of services through the 'system' 7 days a week especially to facilitate weekend discharge of patients.

5.3 Earlier this year, a system wide workshop was held to review the development of 7 day services across Leeds with all Health and Social Care providers.

5.4 One of the key findings from the workshop was an analysis of the data relating to admissions and activity across the week; the busiest day for the majority of services is Monday. In planning for seven days we need to be able to address and manage this peak demand for activity and admissions throughout the week and across weekends. It may be that additional in hours capacity can prevent patients from accessing services out of hours.

5.5 The overall recommendation from the workshop was that organisations be aware that seven day services cannot be developed in isolation or without consideration of system wide impact.

The following points were also highlighted as part of the workshop:

1. Leeds is making good progress on seven day service provision but it is clear that staff across organisations do not know what is available.
2. A newsletter will be developed to share the availability of services and consider other ways of communicating what services are available.
3. Capacity, resources and workforce constraints are a consistent theme. Workforce includes additional staff requirements/ recruitment and management cover and need to consider change to contracts / union liaison in development of 7-day services.
4. Patients and service users and carers need clear communication on what is available and the services they can expect to receive out of hours and at a weekend.

5.6 The three Leeds CCGs are all working with members to develop and commission approaches to extended access to primary care. Leads from the three Leeds CCGs meet regularly to share the developing approaches and also work in close partnership with the citywide urgent care team.

5.7 A summary of the approaches being progressed across the three Leeds CCGs in relation to providing extended access to primary care is provided below.

NHS Leeds West CCG

I. In September 2014, the NHS Leeds West CCG Governing Body approved a proposal to pilot increased access to GP services in response to a growing interest in testing out 7 day services to meet the increasing demands being placed on primary care.

The 37 member practices of NHS Leeds West CCG are therefore now implementing an ambitious and transformative business case, which was co-produced by the CCG and its member practices to deliver extensive improvements to accessing primary care, which responds to:

- National drive for seven day working in the NHS
- Current capacity of primary care and growing patient demand
- Feedback from patients regarding access to general practice services
- Local appetite from GP practices to improve services

II. The proposal ultimately aims to transform local GP services. By extending the opening hours of member practices and supporting increased collaboration between practices in local neighbourhoods we aimed to improve the quality of care provided to local residents and improve their health and well-being while contributing to a resilient and financially sustainable health and care system.

Currently we have 15 practices covering a population of 148,000 providing services 7 days a week and 18 practices covering a population of 194,000 delivering extended services 5 days per week (7-7 or 8-8). With the remaining practices delivering the national enhanced service (commissioned via NHS England)

III. Leeds West CCG has recently undertaken an initial evaluation of the Enhanced Access Scheme so far. This evaluation has shown the proposal to be deliverable and early indications suggest it is popular with patients and may be showing positive impact on the wider healthcare system.

A mid-term report was presented to the CCG Governing Body in September 2015 and early indications are showing:

- Increased primary care availability
- Increased patient satisfaction
- Reduction in Accident & Emergency(A&E) and Out of Hours services

A copy of the report can be found at Appendix C.

IV. Since the introduction of the scheme, the appetite from member practices for further development of 7-day services and neighbourhood collaboration has increased, with more groups of practices wishing to explore further roll-out across the whole population of Leeds West.

This development would continue to test the local viability and impact of the national drive towards 7-day general practice and support the effort towards making the whole system a 7-day service. It would also act as a focus for local practice collaboration within neighbourhoods as a foundation to create the new models of community health and care provision set out in the NHS Five Year Forward View.

V. Developing the project has, at times been challenging; with members highlighting the potential de-stabilising effect this could have on neighbouring practices. The CCG has continued to work with practices and listen to feedback and reflect those concerns in the development of the specification. Discussions have actually helped develop relationships locally with practices now working much more closely together to support each and find ways of delivering services effectively.

VI. Feedback has been extremely positive from both staff and patients: patients are reporting feeling more engaged in their care and finding appointments easier to

obtain.

Engagement of member practices has been unprecedented with member practices actively involved in the design, implementation and on-going evaluation; everyone is committed to ensuring the scheme is a success so that we ensure the service can continue post the 18 month pilot.

VII. To complement this increased access, the 37 member practices of Leeds West CCG submitted a further *successful* bid to the **Prime Ministers Challenge Fund** (now GP Access fund) **Wave 2** to implement further initiatives which support the broader aspects of accessing services.

The proposal focusses on:

- Promotion and increased use of online services; many patients comment on the experience of accessing services such as difficulty getting through on the telephone so we wish to encourage those patients that can access online services to do so
- Testing out alternative ways of delivering services through video and e-consultations
- Developing self-management tools including the Pharmacy First Scheme (launched 1st July 2015) which is showing a steady increase in utilisation by patients.
- Comprehensive and consistent sign posting to services through practice websites
- Developing a locality leadership team to ensure that primary care is represented in locality and neighbourhood developments

NHS Leeds North CCG

I. NHS Leeds North Clinical Commissioning Group is currently working with member practices to improve access to GP services for the local population. Overall, levels of patient satisfaction with access to primary care are positive; 86% of patients responding to the latest GP survey reported that they were able to get an appointment when needed.

II. 20 of 28 practices within the CCG already provide some form of extended hours as per the enhanced service commissioned by NHS England [See appendix A]

III. However, we know that not all of our patients have a positive experience in accessing primary care and this can be affected by which population a patient belongs to and/or when they want to access primary care. Our approach to improving patient experience builds on a raft of existing initiatives to improve access to GP services and wider primary care.

IV. To inform our medium to longer term approach, we have commenced work to understand the underlying demand for primary care and the associated 7-day service need. We are working with member practices to shape our approach to developing extended access to primary care and engaging with patients through practice reference groups to understand local views and experience. Another key input into the development of our local approach is the review of the evidence and learning emerging from areas already implementing different approaches to extended access to primary care. In particular, the recently published learning and evaluation from the national Challenge Fund pilots as well as from NHS Leeds West CCG in developing extended access to primary care, is of key importance in the local shaping of our response within NHS Leeds North CCG.

V. A number of the existing interventions being implemented by NHS Leeds North CCG to improve primary care access are:

- **Commissioning additional GP capacity at times of known system pressure:** High-levels of system pressure across acute, community and primary care in April 2015 resulted in Leeds North working with 111 and the OOHs provider to commission member practices to provide additional GP capacity over the four day Easter 2015 period.

  Four Leeds North practices provided appointments which were booked by the GP Out of hours (OOHs) provider. Appointments were utilised by any Leeds (or-non Leeds) patient triaged by 111 as needing an urgent primary care appointment in Leeds. The initiative therefore had a significant whole-system impact, alleviating pressure on the citywide GP OOHs service over Easter weekend and improving access to primary care services for patients across the city during this period.

  Following the success of this initiative, the three Leeds CCGs are already working together with the GP OOHs provider to replicate this model for the Christmas 15 and Easter 16 periods. Beyond Leeds, other West Yorkshire CCGs are also planning to replicate this initiative.

- **Piloting new technologies to increase capacity within primary care:** we are working with member practices to trial new technologies which both improve the patient experience of accessing general practice and also free-up capacity within practice teams. Examples include the piloting of surgery pods (which enable key health checks to be undertaken at the convenience of patients) and the development of 'skype-like telephone consultations for specific populations such as care home patients and the working population.

- **Support for specific, newer migrant groups in accessing primary care:** Work is being undertaken by Public Health and member practices within the Chapeltown locality to provide support, advocacy and signposting support to Eastern European communities. This includes support to member practices from an Eastern European Migrant Community Networker worker who is working with communities in relation to the appropriate use of primary and urgent care services.

VI. **<u>Medium to Long-term Approach</u>**

- In June 2015, we held a workshop with member practices regarding the CCG's approach to extended access to primary care. The workshop provided detailed analysis on the known data and information relating to current activity, patient and members feedback to date, learning from elsewhere and national policy. The key themes emerging from the workshop were as follows:

  - Acknowledgement that through the existing GP OOHs service provided by 111 and Local Care Direct, patients living in Leeds can already see a GP 7 days a week.
  - Consensus that at times of system pressure it makes real sense to commission additional urgent, routine general practice services. However, this is not about every practice opening but about matching the total number of appointments made available with actual demand (across the CCG or city).

- Member practices fed back that the focus of additional opening after 6pm and/or weekends should be to provide urgent as opposed to routine care.
- Members felt that practices' opening for longer does not currently have the evidence, workforce capacity or sustainable funding. Once published, there is a need to understand the evidence of impact emerging from the evaluation of local and national extended hours pilots.
- If a model of extended primary care does become mandated, member practices would wish to deliver this through collaborative working possibly with CCG-wide organisation.

- NHS Leeds North CCG is taking forward these themes by engaging with patients within general practice patient participation groups with a view to understanding patient views and experience in relation to primary care. This will further inform our approach to extended access to primary care in Autumn 2015.

- At present, no additional workforce or recurrent finance is being made available nationally to deliver extended primary care. NHS Leeds North CCG is acutely aware of the current demands within primary care. We will continue to work with member practices to improve the experience of patients access to GP services in-hours and shape a locally appropriate and sustainable approach to the provision of extended primary care that maximises the effectiveness of the Leeds £.

- The current GP OOHs contract ends in March 2018 and NHS Leeds North CCG is working with the other Leeds CCGs and Urgent Care Team to align developing plans around extended primary care into decisions about future commissioning options.

NHS Leeds South and East CCG

I. In October 2014, the CCG approved a proposal to support extended access throughout the winter period that was categorised as December 2014- 31 March 2015. Engagement with the public in NHS Leeds South and East was conducted as part of the development of the scheme and took place through surveys, discussion at the CCG Patient Representative Group and small focus groups.

II. The scheme resulted in 23 practices participating to provide extended access to approximately 70% of the population. Practices worked collaboratively with other practices across eight hubs to deliver an additional 6000 appointments, including GP and Practice nurse availability. The scheme was supported by an extensive communication campaign including personalised letters to those households registered with the participating practices and bus stop advertising close to participating practices.

III. Evaluation of the scheme in relation to impact on urgent care services has shown the following:
- Reduction of A/E attendances in comparison to the same period in 2013/14
- Reduction of unplanned admissions in comparison to the same period in 2013/14
- Reduction of readmission, as measured by the 30 day readmission rates.
- Patients who provided feedback responded positively to the increased opening hours, although some practices reported an increase in the non-attendance rates.

This evaluation is positive however, it should be noted that several initiatives across the health and social care systems in Leeds South and East will have contributed to the above findings and it cannot solely be attributed to the scheme.

IV. The CCG developed a Quality Improvement initiative to commence throughout 2015, which would support the enhancement of improving access and extended hours across collaborative practice populations with a footprint of 30,000 registered patients, building on the work during December and March 2014/15. However, following feedback from member practices, clinical leads and colleagues within the CCG, consultation workshops were held in September and October 2015. This resulted in the redevelopment of the scheme and a new framework that incorporates four enablers which Practices should consider; these are collaboration between practices on a 30,000 minimum population footprint, access to services, long-term conditions and innovative local population needs approach.

V. The CCG released the revised scheme to Practices on 10th November 2015, and it will provide an increase in collaborative working between practices, improve access through a variety of mechanisms and increase the workforce within primary care. The CCG will be offering support to Practices during the development and implementation phase, which will include learning from previous work such as the Challenge fund and successful business proposal writing.

VI. However, due to the delay in implementing the above scheme, the CCG has re-released the winter scheme offered in 2014-15 to Practices. The rationale for this is to enable primary care to support a resilient health system in Leeds during periods of high demand, re-establish elements of collaborative working across Practices and provide transitional, learning approach to developing a wider service from April 2016. To date 30 Practices have signed up to deliver an extended hours service between November 2015 and 31 March 2016, covering a population of 217, 300 population. In the majority of cases, Practice collaborative groups will provide the extended hours on a Saturday. There is an increase in provision from last years' service.

VII. Other initiatives within NHS Leeds South and East CCG to support improving access:

- **Use of technologies to increase capacity within primary care:** The CCG has commissioned a patient messaging system for 39 practices from June 2015 which is able to send messages linked to appointments, reminders and targeted health messages such as book your flu vaccination. This sophisticated system enables patients to cancel their appointment through the messaging system whilst also removing the appointment from the GP clinical system. It is expected that this will have a significant impact on reducing the number of do not attenders (DNAs) within the practice. Initial feedback from one of the largest practices has suggested it has reduced DNA rates by 50%

- **Improving access for specific populations**: Practices with 10 or more residents residing in a non-nursing home have been offered a scheme to support the delivery of high quality care through a weekly ward round, post hospital discharge assessment and annual review approach since 2013. Since October 2014 we have also offered a similar scheme to people living in nursing homes. This scheme is a proactive approach to support the needs of a defined cohort of the population which increases access to primary care. The scheme is delivered by 17 practices, across 26 non-nursing homes and 10 nursing homes and provides a service to 735 patients of the care home population.

- Evaluation to date from the non-nursing home scheme is positive and demonstrates a 20% reduction in A&E attendances and a reduction in admissions of 11% compared to 11/12 data. The stakeholder evaluation showed a high level of satisfaction from patient/carers along with care home managers.

- **Developments within primary care:** The CCG has supported practices to explore opportunities to work together to share resources including back office functions, staff and skills to enable primary care to become more resilient and can respond to the 5 Year Forward View. This has resulted in the formation of the Leeds South and East Group Federation, in which 27 practices are committed to working within this framework for specific aspects of primary care. The initial work from the Group has led to bids being developed for improving access, utilisation of technology within primary care and exploring the role of Clinical Pharmacist within primary care. If successful these initiatives collectively will contribute to improving access in primary care.

6 Governance

6.1 Consultation and Engagement

6.1.1 This paper aims to demonstrate the progress on seven day services across general practices and the current plans for development. Each individual organisation has undertaken its own specific consultation and engagement process in the development of the individual schemes identified. It also reports on the existing patient engagement processes already underway such as the GP Patient Survey and Friends and Family Test etc.

6.2 Equality and Diversity / Cohesion and Integration

6.2.1 As there is no national mandated specification for 7-day GP services there is the potential for differential service models across the City. Each CCG will be responsible for undertaking an equality impact assessment for the individual schemes commissioned locally.

6.3 Resources and value for money

6.3.1 As detailed, each CCG is working within their member organisations and collectively across the system to ensure that the development of any 7-day service contributes to a sustainable health and social care system in Leeds.

6.4 Risk Management

6.4.1 Nationally, all CCGs face similar challenges in working with member practices to develop and commission extended access to primary care. These relate to primary care workforce, finance, clarity for patients and are described in greater detail below.

Risk	**Mitigation**
Workforce – The recruiting and retention of GPs and Practice Nurses is an increasing challenge on both a local and national	CCGs are developing individual and collective workforce recruitment and retention initiatives that will support

scale. A recent survey undertaken by the General Practitioners Committee (GPC) in May 2015 highlighted a third of GPs planning to leave the health service in the next five years and a significant number considering a reduction in their working hours. The poll also highlighted that whilst there is willingness from GPs to consider offering extended hours, "however, almost all GPs (94%) do not feel practices should offer seven day opening in their own practices". Extending the hours of existing primary care provision has been highlighted as a key risk by member practices across the three Leeds CCG of the sustainable delivery of primary care services. A recent survey by Leeds Local Medical Committee (LMC) of GP Practices relating to recruitment and retention of GP staff found that of the three quarters of GP Practices who responded to the survey had GP vacancies in the last year, up 25% from 2014. More than a fifth of the vacancies had been unfilled for the past 12 months or `more.	the GP workforce for the future. NHS England and Health Education England have recently announced a number of new models to support a transformed primary care workforce. This includes moving away from a traditional workforce to use of more skill mix initiatives such as the employment of pharmacists, physios and physician associates. CCGs are supporting practices to collaborate to deliver services to support efficient and effective use of the existing workforce.
Finance No additional recurrent funding has yet to be made available nationally to support extended access to primary care. Additional investment to improve extended primary care access has been through national Prime Ministers Challenge Fund Monies and/or through CCG non-recurrent investment.	The Leeds CCGs will work with the Urgent care team to evaluate the evidence emerging from local and national pilot sites to shape local commissioning approaches to extended primary care access. We will need to ensure we maximise the impact of our collective spend of the Leeds £ to ensure that primary care and urgent care contracts are aligned to prevent duplication of funding and to maximise the utilisation of all capacity commissioned within primary care. CCGs need to utilise new opportunities for investment in primary care such as the national Infrastructure fund; this is 'new' money that can support wider access and delivery of CCG services that keep people out of hospital. Leeds already has two schemes that are supported in principle (St Martins and Windmill)
Engagement of Member Practices – The development of 7-day services is a further	Each CCG has indicated how it has engaged with its member practices in

pressure on an already stretched service. Imposing a scheme will be detrimental to the on-going relationship with member practices which will be required in order to engage practices in wider service transformation.	the development of plans in relation to 7-day service. Locally, the Leeds West scheme has been successful because of the level of interest and engagement from member practices who have been able to co-produce the specification.
Consistent Communications for Patients- As there is currently a difference in the approach of the 3 CCGs it is difficult to provide a consistent message for patients with regard to accessing their GP.	All CCGs have committed to the use of 111 as a service to support patients accessing urgent healthcare needs. As demonstrated in figure 2, there are also a number of consistent services that are available across the City that support patients in accessing GP services: • Online services • Pharmacy First • Social Prescribing

Conclusions

6.5 The policy for delivering 7 day GP services is still evolving with a number of pilots underway as part of the Prime Ministers Challenge Fund and also local schemes such as the NHS Leeds West CCG scheme. The NHS Leeds West scheme is one of only a small number of large-scale schemes involving primary care and therefore the learning arising from NHS Leeds West should continue to be shared both locally and nationally to inform future plans.

6.6 There are varying views from patients and clinicians with regard to the policy development and ability to deliver within the context of limited workforce and infrastructure; there are significant resource implications to consider within a constrained financial envelope.

6.7 Overall, there is a willingness to test out new models of delivery to support the overall system resilience whilst continuing to learn from the existing schemes in operation.

6.8 CCGs should continue to work together to share learning and support overall system transformation and collaborations of practices to test out new models of care.

CCG	Practice	Signing up	Monday (am)	Monday (pm)	Tuesday (am)	Tuesday (pm)	Wednesday (am)	Wednesday (pm)	Thursday (am)	Thursday (pm)	Friday (am)	Friday (pm)	Saturday
Lds North	Nursery Lane	YES	7:00-8:30				7:30-8:30						
Lds North	North Leeds Medical Practice	YES		6:30-8:00		6:30-8:00		6:30-8:00		6:30-8:00			
Lds North	Rutland Lodge	YES								6:30-7:00			
Lds North	Oakwood Lane MP	YES	07:00 - 8:00		7:00-8:00		07:00-8:00		7:00		07:00-8:00		
Lds North	The Avenue	YES			7:30-8:00		7:30-8:00			6:30-7:30			
Lds North	Westagate Surgery	YES			7:00-8:00		7:00-8:00		7:00-8:00		7:00-8:00		
Lds North	Westfield	YES								6:30-7:00			10:15-12:15
Lds North	Chevin MP	YES	7:00-8:00	6:30-8:00	7:00-8:00	6.30-8:00	7:30-8:00		7:00-8:00				
Lds North	Allerton Medical Centre	YES			7:00		7:00				7:00		
Lds North	Woodhouse	YES		6:30-8:30									
Lds North	Shadwell	YES								6:30-9:00			
Lds North	Meanwood HC	YES	7:30-8:00	6:30-8:00			7:30-8:00	6:30-8:00		6:30-8:00			
Lds North	Street Lane	YES						6:30-8:00		6:30-9:00			
Lds North	Aireborough Family Practice	YES			7:30-8:00			6:30-7:30					
Lds North	St Martin's Practice	YES				6:30-7:30							
Lds North	Moorcroft Surgery	YES		6:30-8:00									
Lds North	Oakwood Practice	YES		6.30-8.30									
Lds North	Newton Surgery	YES	7:00-8:00				7:00-8:00						
Lds North	Bramham MC	YES		6:30-8:30									
Lds North	Church View Surgery	NO											
Lds North	Crossley Street S	NO											
Lds North	Spa	NO											
Lds North	Foundry Lane	NO											
Lds North	Chapeltown FS	NO											
Lds North	Wetherby Surgery	NO											
Lds North	Onemedicare & Hilton Road	NO	Provided as part of APMS contract										
Lds North	Onemedicare & the Light	NO	Provided as part of APMS contract										
LDS West	Morley HC	YES						6:30-7:30					
LDS West	Armley Medical Practice	YES		6:30-8:00	7:00-8:00		7:00-8:00						
LDS West	High Field Surgery	YES		6:30-7:30		6:30-7:30		6:30-7:30		6:30-7:30		6:30-7:30	
LDS West	Hillfoot Surgery	YES	7:30-8:00	6:30-7:30	7:30-8:00	6:30-7:30	7:30-8:00	6:30-7:30	7:30-8:00	6:30-7:30	7:30-8:00	6:30-7:30	
LDS West	Robin Lane MC	YES				6:30-8:00	7:00-8:00	6:30-8:00		6:30-8:00			12:00-4:00
LDS West	Manor Park	YES		6:30-7:30	7:00-8:00		7:00-8:00						
LDS West	Craven Road	YES	7:00-8:00	6:30-7:00	7:00-8:00	6:30-7:00	7:00-8:00	6:30-7:00	7:00-8:00	6:30-7:00	7:00-8:00	6:30-7:00	8:30-11:30
LDS West	Pudsey	YES	7:00	7:00	7:00	7:00	7:00	7:00	7:00	7:00	7:00		
LDS West	Priory View MC	YES	7:00-8:00	6:30-07:00	7:00-8:00	6:30-07:00	7:00-8:00	6:30-07:00	7:00-8:00	6:30-07:00	7:00-8:00		9:00-12:00
LDS West	Hyde Park	YES		6:30-8:00		6:30-8:00		6:30-8:00		6:30-8:00		6:30-8:00	
LDS West	The Surgery Morley	YES						6:30-8:00					
LDS West	Burton Croft	YES		6:30-7:00						6:30-7:00			8:30-11:30
LDS West	Guiseley & Yeadon Health Centre	YES		6:30-9:00									
LDS West	Vesper Road	YES		6:30-8:00		6:30-8:00		6:30-8:00	7:30-8:00	6:30-8:00	7:30-8:00	6:30-7:00	8:00-4:00
LDS West	Ireland Wood & Horsforth MP	YES	7:00-8:00	6:30-7:00	7:00-8:00	6:30-7:00	7:00-8:00	6:30-7:00	7:00-8:00	6:30-7:00	7:00-8:00	6:30-7:00	8:00-4:00
LDS West	Rawdon	YES		6:30-8:00									
LDS West	West Lodge	YES	7:00	7:00	7:00	7:00	7:00	7:00	7:00	7:00	7:00	7:00	
LDS West	Yeadon Tarn MP	YES		6:30-8:00		6:30-8:00		6:30-8:00		6:30-8:00		6:30-8:00	8:00-4:00
LDS West	Menston and Guiseley	YES		6:30-8:00				6:30-8:00					
LDS West	Windsor House Group	YES	7:30-8:00			6:30-8:00	7:30-8:00	6:30-8:00					8:00-12:00
LDS West	Sunfield	YES		6:30-8:00		6:30-8:00				6:30-8:00		6:30-8:00	
LDS West	Thornton MC	YES		6:30-8:00		6:30-8:00		6:30-8:00		6:30-8:00		6:30-7:00	
LDS West	Leigh View	YES		6:30-8:00		6:30-8:00		6:30-8:00	7:30-8:00	6:30-7:.30		6:30-8:00	
LDS West	The Fountain MC	YES	7:00-8:00	6:30-7:00	7:00-8:00	6:30-7:00	7:00-8:00	6:30-7:00	7:00-8:00	6:30-7:00	7:00-8:00	6:30-7:00	
LDS West	Abbey MC	YES	7:00-8:00	6:30-7:00	7:00-8:00	6:30-7:00	7:00-8:00	6:30-7:00	7:00-8:00	6:30-7:00	7:00-8:00	6:30-7:00	
LDS West	Burley Park	YES		8:00		8:00		8:00		8:00		8:00	
LDS West	Whitehall Surgery	YES	7:00	7:00	7:00	7:00	7:00	7:00	7:00	7:00	7:00	7:00	
LDS West	Fieldhead Surgery	YES	7:00-8:00		7:00-8:00			6:30-9:00					
LDS West	Laurel Bank	YES						6:30-8:00					
LDS West	The Gables	YES		6.30-8:00		6.30-8:00		6.30-8:00					
LDS West	Gildersome	YES		6:30-8:00			7:00 – 8:00	6:30-7:00		6:30-7:00			
LDS West	The Highfield S	YES	8:00-8:30	6:30-8:00	8:00-8:30	6:30-8:00	8:00-8:30	6:30-8:00					
LDS West	Kirkstall	YES		6:30-8:00									
LDS West	LSMP	YES	07:00-8:00	6:30-07:00	07:00-8:00	6:30-07:00	07:00-8:00	6:30-07:00	07:00-8:00	6:30-07:00	07:00-8:00	6:30-07:00	
LDS West	Beechtree MC	YES			7:00-8:00								
LDS West	Hawthorn Surgery	YES		6:30-8:30									
LDS West	Drighlington MC	YES		6:30-7:00				6:30-7:00				6:30-7:00	9:45-12:45
LSE	City View MP	YES		6:30-8:00						6:30-8:00			
LSE	Marsh Street	YES		6:30-8:00	7:00-8:00						7:15-8:00		
LSE	Windmill	YES			7:00-8:00	6:30-8:00			7:00-8:00				
LSE	Manston Surgery	YES											8:00-11:00
LSE	Leeds City & Parkside	YES		6:30-8:30					7:30-8:00				
LSE	Shaftesbury	YES	7:00-8:00			6:30-7:30	7:00-8:00						8:30-10:30
LSE	Lofthouse Surgery	YES			7:00-8:00		7:00-8:00		7:00-8:00				
LSE	The Whitfield Practice	YES				6:30-7:00			7:00-8:00				
LSE	Gibson Lane	YES		6:30-8:00									8:00-11:00
LSE	The Practice @ Radshan	YES		6:30-7:30									
LSE	Lingwell Croft S	YES		6:30-8:00		6:30-8:00							
LSE	Halton MP	YES	7:00-8:00	6:30-8:00									
LSE	Garforth	YES		6:30-8:00	7:15-8:00								8:30-11:30
LSE	Ashfield MC	YES			7:00-8:00				7:00-8:00				
LSE	The Practice @ Harehills Corner	YES								6:30-7:30	7:30-8:00		
LSE	Colton Mill MC	YES		6:30-8:30				6:30-8:00					
LSE	Bellbrooke Surgery	YES		6:30-8:30				6:30-8:30					
LSE	Nova Scotia	YES		6:30-9:00									
LSE	Kippax Hall Surgery	YES			7:30-8:00		7:30-8:00		7:30-8:00				
LSE	Park Edge	YES						6:30-8:00					
LSE	Shafton Lane	YES		6:30-8:00									
LSE	Arthington MC	YES		6:30-7:30	7:30-8:00		7:30-8:00						
LSE	Conway MC	YES		6:30-7:30									
LSE	Hunslet HC	YES							7:00				
LSE	York Road	YES								6:30-7:30			
LSE	Church Street Surgy	0											
LSE	Roundhay Road	YES				6.30-7:00							
LSE	Moorfield House Surgery	YES	7:30-8:00				7:30-8:00		7:30-8:00				
LSE	Beeston Village	YES	7:00-8:00				7:00-8:00						
LSE	The Practice @ Lincoln Green	YES		6:30-8:00				6:30-7:30					10:00-2:00
LSE	Cottingley	YES					6:45-8:00						
LSE	Oakley MP	NO											
LSE	The Garden	NO											
LSE	846 York Road	NO											
LSE	Grange: New Cross	NO	Provided as part of APMS contract										
LSE	Richmond Medical Centre	NO											
LSE	Ashton View	NO											
LSE	Family Doctors	NO											
LSE	Whinmoor Surgery	NO											
LSE	Grange: Middleton Park	NO	Provided as part of APMS contract										
LSE	Grange: Swillington	NO	Provided as part of APMS contract										
LSE	Shakespeare	NO	Provided as part of APMS contract										

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Prime Minister's Challenge Fund: Improving Access to General Practice

First Evaluation Report: October 2015

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SQW

Mott MacDonald

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Contents

Mott MacDonald

EXECUTIVE SUMMARY

In October 2013, the Prime Minister announced a new £50 million Challenge Fund[1] to help improve access to general practice and stimulate innovative ways of providing primary care services. 20 pilot sites were selected to participate in the Challenge Fund, covering 1,100 general practices and 7.5 million patients. Each scheme chose its own specific objectives, innovations and ways of organising services.

The independent national evaluation of the Challenge Fund (wave one[2])

These pilots are now over a year into delivery of their plans. This first evaluation report reviews their progress to date and assesses the extent to which the PMCF core programme objectives are being met. There will be another evaluation report at the end of 2015.

The evaluation focuses on three key national programme objectives:

- To provide additional hours of GP appointment time
- To improve patient and staff satisfaction with access to general practice
- To increase the range of contact modes

It also features several other lines of enquiry including looking at the Challenge Fund's contribution to reducing demand elsewhere in the system; facilitating learning; tackling health inequalities; identifying replicable delivery models; delivering value for money; and establishing sustainable and transformational change in the primary care sector.

In undertaking the evaluation, a multi-methods approach has been adopted incorporating both qualitative and quantitative assessment. This has comprised:

- Interviews with pilot leaders and those involved in implementation at multiple points during the programme
- Interviews with pilot partners and stakeholders involved in delivery
- Engagement with practices and other implementation staff through an online survey (to date, released at two points over the pilot implementation period)
- Collection and analysis of monthly data on key services and innovations being delivered as part of PMCF measured against a basket of nine metrics
- Assessment of the impacts and outcomes and identifying return on investment and value for money, through looking at how pilots have allocated their resources
- Identifying, examining and sharing good practice
- Showcasing innovation good practice through regular thematic papers

Metric data has been collected for pilots as they have become operational with their initiatives, although data remains patchy for a few pilots which has affected the ability to assess impacts and quantify savings in some cases. It is also essential to bear in mind the assumptions and limitations listed on page 7 of this interim report.

The nine national data metrics:

A. Patient contact, as a direct result of the change in access:

- The change in hours offered for patient contact
- The change in modes of contact
- The utilisation of additional hours offered

B. Patient experience/satisfaction:

- Satisfaction with access arrangements
- Satisfaction with modes of contact available

C. Staff experience/satisfaction:

- Satisfaction with new arrangements

D. Wider system impacts:

- Impact on the A&E attendances
- Impact on emergency admissions
- Impact on the 'out of hours' service[3].

1. The Prime Minister's Challenge Fund is hereafter referred to as PMCF or the Challenge Fund.
2. In September 2014 further funding of £100m was announced by the Prime Minister for 37 wave two pilots.
3. Out of hours primary medical care services are defined as those services required to be provided in all or part of the out of hours period which would be essential or additional services provided by a primary medical care contractor (i.e. a GP practice) to its patients during 'core hours'.

Some key achievements to date

The 20 sites have been ambitious in implementing their Challenge Fund programmes. Their definition of improving GP access has been very wide and their innovations have extended far beyond increasing the number of hours that general practice is available for. Pilot schemes have included improvements aimed at providing patients with differing needs with access to the right care from the right professional at a time which is convenient for them. They have also used the opportunity to kick start or build upon collaborative working and embark upon transformational change of primary care delivery. Their innovations have been very broad in nature as indicated opposite.

Key achievements to date include[4]:

Over **7 million patients** have access to a new or enhanced primary care service due to new projects or different approaches to service delivery.

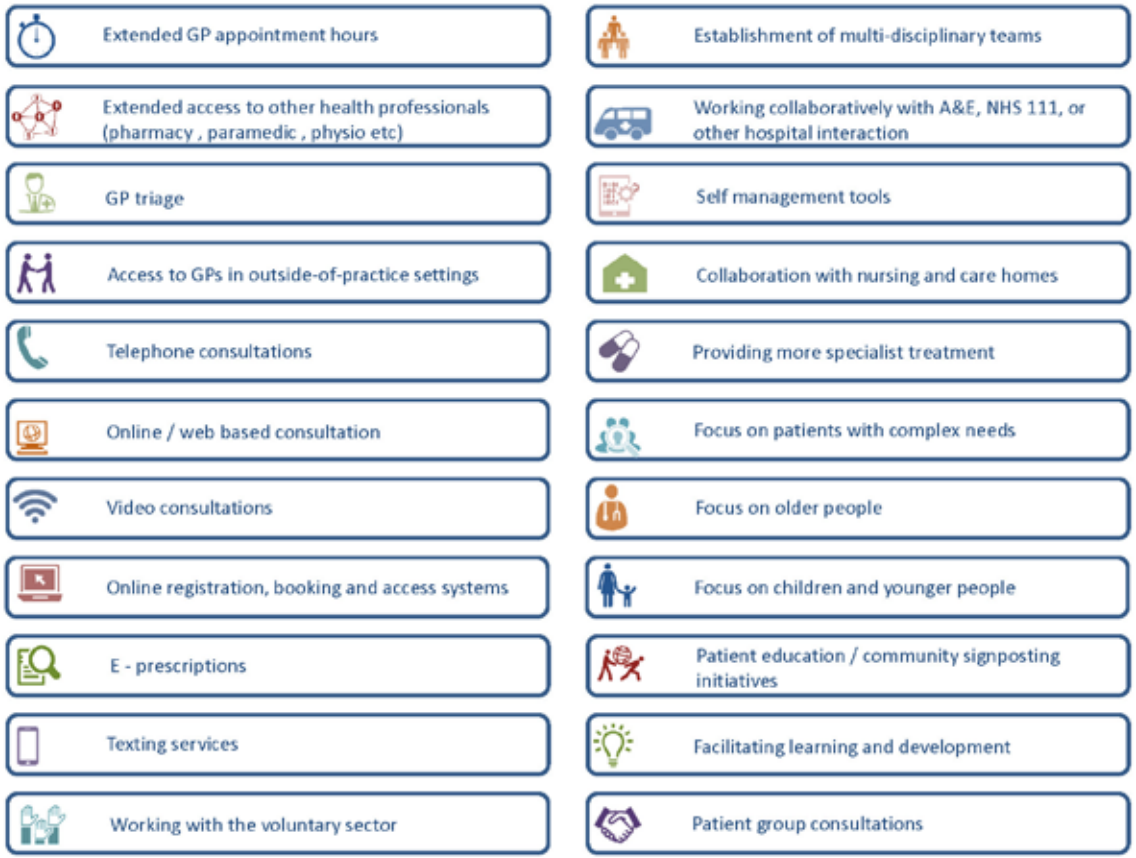
During the week **4.9 million patients** have access to a new or enhanced GP appointment service after core working hours during the week due to Challenge Fund investment[5]

At the weekend **5.4 million patients** now have access to a new or enhanced GP appointment service due to Challenge Fund investment[6]

Approximately **400,000** additional appointments have been provided in extended hours to patients across the pilot schemes

Approximately **520,000** additional appointments have been provided in core hours to patients across the pilot schemes[7]

At May 2015, there had been a **15% reduction** in minor self-presenting A&E attendances across the pilot schemes compared with the same period in the previous year; representing 29,000 attendances.



4 It is important to recognise that these figures reflect a point in time and pilot initiatives are ongoing
5 Core hours: 8am – 6.30pm, Monday – Friday. This is in addition to extended services that were already available during the week.
6 This is in addition to extended services that were already available at the weekend.
7 This is across 16 pilot schemes

To what extent have the national Challenge Fund programme objectives been met?

1. To provide additional hours of GP appointment time

As part of the analysis of progress against this objective, the evaluation has considered additional hours of appointment time provided by GPs and other practitioners.

Extended hours

From data collected to date, we estimate that the number of additional appointments being during extended working hours across the whole Challenge Fund Programme up to the end of May 2015 was potentially around 400,000 across all practitioners.

Based on data received from 16 out of the 20 pilot schemes 38,000 additional extended hours have been offered; an increase of over 100% from the baseline[8]. This is from the time that the pilots went live with their initiatives until May 2015. Of these additional 38,000 hours, over 70% have been provided by GPs. This translates into around 238,000 additional available appointments during extended hours, 184,000 of which were provided by GPs. Extrapolating this for the remaining four pilot sites[9], then derives the estimate of 400,000 additional appointments.

There has been an increase in the number of available appointments per extended hour by 33% as a result of new ways of working.

Since the introduction of the Challenge Fund, average utilisation of appointments during extended working hours has been 75%. Whilst this is slightly lower than the baseline position of 80%, it should be recognised that this represents a revised position where there has been a significant increase in appointments being provided over seven days compared to the baseline. The vast majority of pilots suggest that utilisation of the extended hours appointments is generally high in the week. There is also evident demand on Saturdays (mornings more so than afternoons) but there is typically very low utilisation of Sunday GP appointments. A number of pilots adjusted staff capacity to better match demand during the course of the programme.

Core hours

Pilots have also offered additional appointment hours during the normal working day. From the time that individual pilots went live with their initiatives until May 2015, a total of 66,000 additional hours have been provided, of which 26,000 have been provided by GPs. Also, as a consequence of introducing new modes of contact, the average number of available appointments has increased by 6%. In total, an additional 520,000 available appointments have been made available, of which 162,000 were provided by GPs.

Since the introduction of the Challenge Fund, the average utilisation of available appointments during core working hours across the whole programme is 94%. This is consistent with the baseline.

2. To improve patient satisfaction

Patient experience and satisfaction

Patient satisfaction with appointment times at practices involved in the Challenge Fund is high. 90% of patients that responded to the national GP patient survey consider that appointments are either very or fairly convenient and around 60% of patients are able to see their preferred GP. As may be expected given the short length of time that the pilots have been implementing their initiatives, at a programme level, there has been little change in patients' levels of satisfaction and experience since the introduction of Challenge Fund initiatives[10].

Staff experience and satisfaction

An online survey has been undertaken twice to assess the impact on satisfaction amongst staff involved in delivering Challenge Fund activities. This shows that:

- Over 60% of respondents from both surveys rated their experience of extending access in primary care as either very good or good compared with between 12% and 15% who rated this as either poor or very poor.
- Just over half of respondents in both surveys have rated the impact of the Challenge Fund on staff as either very positive or positive within the second survey.

3. Increasing the range of contact modes

Using technology

The majority of pilots (15 out of 20) have increased the variety of modes by which patients can access GP services.

- Ten pilots have extended or introduced GP telephone consultation facilities, providing telephone access to 1.9 million patients.
- Five pilots have introduced GP-led telephone triage systems in order to manage patient demand and match patients with a service appropriate to their needs. This is operating at over 120 practices, serving over 860,000 patients.
- Across these pilots, the percentage increase in telephone consultations and GP led telephone triage being offered in March 2015 compared with the baseline is 28% during core working hours and 220% during extended working hours.
- Six pilots have trialled GP e-consultations. This mode of access is currently available to over 250,000 patients across four pilots.
- Six pilots have introduced online diagnostic and/or video consultation tools to enhance patient access. These tools are available to over 270,000 patients.
- Five pilots have developed texting services, providing this facility to nearly 1.6 million patients across 265 practices.

8 North West London has not participated in the national metric data collection because the focus of the pilot was to progress with organisational change and network development rather than the immediate delivery of services. Barking & Dagenham and Havering and Redbridge; Bristol and partners; and Derbyshire & Nottinghamshire pilot schemes were unable to submit baseline data so it has not been possible to derive the additionality.

9 Please note the Assumptions and Limitations detailed in Section Two of the report.

10 Note that the national GPs patient survey does not specifically focus on PMCF and is more generally reflective of patient's experience and satisfaction with primary care services.

- Eight practices have also introduced online access features, typically online registration and booking systems, as part of their pilot programmes.

Introducing a wider range of practitioners

Another way in which pilots have increased the range of primary care contact modes is through integrating other service providers into their Challenge Fund programmes. This shows an appetite to collaborate and offer a more holistic package of primary care. Some examples include:

- Eight pilots have made more use of specialist nurses or Advanced Nurse Practitioners (ANPs). Despite some recruitment challenges, these initiatives have been a success in reducing pressures on GP time and adding more capacity in core and extended hours.
- Five pilots have integrated pharmacy into delivery of primary care services. There has been good buy-in from pharmacists and pilots report that these projects have been a success, helping to release GP time.
- Four of the pilots have undertaken targeted work with nursing and care homes in order to provide more proactive care to these patients and also reduce the number of care home visits by GPs. These initiatives are considered to be delivering benefits, releasing GP time and achieving patient satisfaction.
- Six pilots have engaged with the voluntary sector to offer a wider package of patient support and direct patients to community resources which can support them. Individual pilot examples show that these schemes are working well locally, releasing GP time and proving popular with patients.

Wider learnings and achievements

The evaluation of PMCF has also pursued some other lines of enquiry to identify wider learnings from the programme:

Stimulating transformational and sustainable change

The Challenge Fund has been successful in initiating a culture change amongst the primary care community. The injection of investment into primary care has had a catalytic effect, encouraging practices to move away from operating as independent small businesses and, instead, work collectively. This has been evidenced by the development of new networks, federations and legal entities, which applies to around half of the Wave One pilot schemes. Even in locations where there had been prior progress towards collaborative delivery, PMCF has boosted momentum and helped to mobilise federated working.

It should also be acknowledged that culture change and transformation are not easy to achieve; there have been some challenges along the way and pilots have often needed to proceed cautiously and work hard to engage GPs and secure buy in. Given this the degree of structural change across the programme marks a significant achievement, particularly because of the short amount of time that this has been achieved in.

The creation and development of collaborative arrangements and infrastructure represents an important legacy of this programme. Where federations with established governance structures and staff are in place, there is considerable confidence that they will continue to exist beyond the lifetime of PMCF. Federations are becoming a ‘cog’ in the system and the network approach or hub and spoke system are generally seen to work as delivery models.

Ultimately the sustainability of specific pilot initiatives is largely reliant on CCG funding going forward. It will be down to their discretion to continue with initiatives that have been shown to be locally popular and have demonstrated positive results.

Reducing demand elsewhere in the system

Up to May 2015, at an programme level, there has been a statistically significant reduction in minor self-presenting A&E attendances by those patients registered to Challenge Fund GP practices. Overall, this has translated into a reduction of 29,000 minor self-presenting A&E attendances and represents a 15% reduction[11]. Nationally, there has been a 7% reduction in these minor A&E attendances.

Of the 20 pilot schemes, 13 have shown a statistical reduction in minor self-presenting A&E attendances, including, most notably, Barking & Dagenham and Havering & Redbridge, West Hertfordshire, Morecambe, and Brighton & Hove. These 13 pilots have seen a reduction of 34,000 minor self-presenting A&E attendances[12 13].

To date there is no discernible change in emergency admissions or out-of-hours services at a programme level.

Faciliting learning to better enable pilots to implement change

Sharing knowledge has been important at different stages throughout the lifecycle of the pilot schemes. Most pilots have developed their own locally appropriate mechanisms to do this. Approaches include engagement events (Brighton and Hove, HRW, Morecambe, Slough and Warrington); the establishment of action learning sets (Brighton and Hove); practice buddying (Slough and Warrington); and commissioning local evaluations (Care UK, DCIoS, Herefordshire and Morecambe).

Throughout the programme, the national team at NHS England and NHS Improving Quality have supported peer networking and knowledge exchange among pilot schemes. Some pilots have also undertaken their own dissemination activities. For wave two, NHS England is facilitating a buddying scheme, which pairs up wave two schemes with a wave one pilot.

Tackling health inequalities in the local health economy

Some pilot schemes (Morecambe, Warrington and West Wakefield) have targeted projects at hard-to-reach groups or areas of socio-economic deprivation. Another popular strategy has been to target patient groups amongst which there is a known high demand for primary care services, for example the frail and elderly (Darlington, DCIoS and Herefordshire), children and young people (DCIoS, Herefordshire and Slough) and those with complex or long term conditions (BHR and Workington).

The impact of these developments is yet to be proven so there is little collective learning that can be disseminated at this point. More work will be undertaken with selected pilots in the next three months to understand these projects' contribution to tackling health inequalities.

Identifying models which can be replicated for use in health economies elsewhere

The hub and spoke delivery model has the potential to be replicated across different health economies as a way in which to provide extended hours appointments through a number of designated locations, rather than at all practices. There is local variation in the detail of the model, however the common requirements are:

- Patients from all member practices need to be able to access extended hours appointments and wider services from the hub
- GPs providing the service need to have read and write access to patient records
- Integrated telephony, so that the hub can divert to practice systems and vice versa as necessary
- Hubs at an appropriate location and with sufficient capacity, based on robust modelling and planning

In addition, a large number of other innovations which improve access or other aspects of care have been shown to be feasible through this programme. More work will be done with pilots over the next three months to understand the transferability of these innovations.

Delivering value for money

Up until March 2015 pilot schemes have identified that they had spent a total of £45 million; this comprises both original PMCF funding and also any match funding.

Selecting the metric data and financial returns from those pilot schemes with more consistently reliable data returns, the typical average cost per total extended hour is in the range of £200 - £280. Of this, the average cost per hour for the GP is typically 50% or more of this. The remainder of the cost per hour is accounted for by other staff, overheads and other supporting activities, including premises and for some pilots, one-off technology costs. The average cost per available appointment in extended hours is typically in the range of £30 to £50.

11 Please note the Assumptions and Limitations detailed in Section Two of the report.
12 Comparing the weeks that pilot schemes have gone live with the same period in the previous year.
13 A&E minor attendances have been defined as those attendances coded to HRG VB11Z. Statistical significance has been measured at 95% confidence levels.

The cost per hour and the cost per appointment to support extended access is more expensive compared with the average GP hourly rate but more in line with locum GP rates and less expensive than an out-of-hours (OOH) contact. This is likely to be expected for a pilot scheme with economies of scale only taking effect over a longer period.

As detailed above, 13 of the pilot schemes have collectively seen a reduction in minor A&E attendances, the total reduction of which is 34,000 attendances to date. Assuming that these trends continue within these pilot schemes, the reduced number of attendances for a full financial year would be 56,000. This would generate a reduction in annual expenditure for commissioners in this service of £3.2 million.

For emergency admissions and out of hours services, there has been no demonstrable impact and, as such, there are unlikely to be any cost savings.

Conclusions to date

Extended hours

Collectively the pilots have been successful at providing additional appointment GP time as well as providing more hours for patients to access other clinicians. The feedback from across the wave one pilots is clear in that some extended hours slots have proved more successful than others. Whereas weekday slots have been well-utilised, patient demand for routine appointments on Sundays has been very low.

Based on the evidence on current provision and utilisation of extended hours it is suggested that 41-51 total extended hours per week are required per 100,000 registered population in order to meet the levels of demand experienced in these pilots[14]; of these 30-37 hours should be GP hours. Given reported low utilisation on Sundays in most locations, additional hours are most likely to be well utilised if provided during the week or on Saturdays (particularly Saturday mornings). Furthermore, where pilots do choose to make some appointment hours available at the weekend, evidence to date suggests that these might best be reserved for urgent care rather than pre-bookable slots.

Contact modes

The Challenge Fund has considerably increased the number of patients who have a choice of modes by which they can contact and have an appointment with their GP. To date telephone-based GP consultation models have proved most popular and successful. There is growing evidence to suggest that investment in telephony infrastructure can be cost effective due to the GP time savings that are being achieved. More work needs to be done to understand the appropriate pilot scale and model that will realise most savings (i.e. a central call centre or individual practice telephone systems) and also deliver optimum patient and staff satisfaction, particularly in view of the importance of continuity of care for some patients.

Other non-traditional modes of contact (for example video or e-consultations) have yet to prove any significant benefits and have had low patient take-up; this will continue to be monitored.

14 Given the uniqueness of its service model, this excludes Care UK.

Collaboration and skills mix

Integration of other practitioners into primary care provision has been successful in almost all cases. Joint working with ANPs, pharmacists, the voluntary sector, care homes, physiotherapists and paramedics has released local GP capacity and more appropriately matched the needs of patients with practitioners. Collaboration has proved most effective when established working relationships have been built upon, engagement happens early on and there is buy–in from GPs and provider partners to a shared vision. Practices report that it is also often necessary to redesign care processes or other working patterns to gain the full benefit of new roles.

Mobilisation and implementation

Effective mobilisation and implementation rely on a variety of factors. Most notably they require clinical leadership to secure and maintain GP buy-in; dedicated project management to drive change forward; sustained practice and patient engagement to ensure initiatives are positively received; and utilisation of existing resources (such as premises, staff and infrastructure) to minimise set-up and recruitment challenges. Successful pilot delivery teams need to be agile and responsive, adapting to lessons learned along the way. Phasing delivery also helps to manage implementation risks and workload during the resource intensive set-up stage.

Scale and scope

The wave one pilots are very different in terms of their size and coverage. From the analysis undertaken to date there does not seem to be a ‘perfect size’ but size is a factor in achieving different outcomes. For example evidence suggests that smaller pilots are quicker to mobilise and find it easier to engage and maintain exposure with both practices and patients. However, larger pilots have the benefits of economies of scale and are perhaps better placed to achieve system-wide change. Wave one pilots suggest that federations will be most successful when they are ‘naturally-forming’, based on pre-existing relationships rather than being driven only by size.

Also relevant to consider are the different approaches adopted. All pilots have been ambitious. However, some have focused their attention on a relatively discrete set of objectives or deliverables, whilst others have chosen to trial a wide menu of projects simultaneously. A very broad scope of work can in itself act as a barrier to rapid progress.

Understanding the local context and demand

Understanding the pattern of demand locally is important in order to provide the most relevant and value for money service for patients. The size of the local health economy, maturity of partner relationships, geographic profile and transport infrastructure are all key factors. An urban solution may not be appropriate for a rural local health economy for example. For any localities seeking to replicate wave one pilot models it will be critical to ensure that initiatives are locally tailored, bearing in mind these contextual factors.

Transformational change

The establishment of federations and networks and delivery via hub and spoke models marks a culture change in primary care and in most pilot areas provides or fortifies the platform for transformational change. Where there is clear alignment with other CCG strategies (such as urgent care, integration with social care or reconfiguration of acute provision) the contribution of these developments is maximised. This change programme has also prompted federations to build their capabilities in leadership, management, service redesign and business intelligence, providing a more solid foundation for future service transformation.

Learning and sharing knowledge

Sharing knowledge and lessons among participating practices has occurred at pilot level, with feedback loops and learning mechanisms established locally by the majority of pilots. Sharing between pilots and with the rest of the NHS has been facilitated by the national programme, with a few pilots undertaking their own dissemination as well. New lessons continue to emerge from wave one pilots' experience and it is important to retain flexibility in programme delivery in order to respond to them. It also remains imperative that this learning is constructively collated and shared with the wider primary care community to ensure that others are able to direct efforts into effective and proven initiatives.

Challenges

The achievements that pilots have made have not been without challenges. Many of these challenges have been process related and have caused mobilisation delays and had cost implications. IT interoperability, information governance, securing indemnity insurance and CQC registration are the most commonly cited process barriers. Acknowledging these issues, NHS England has established support for wave two pilots to ease and expedite mobilisation of their programmes and minimise duplication of effort in the resolution of common problems.

Sustainability

In order to sustain those initiatives that are demonstrating positive impacts, CCG support and buy-in is critical. Pilot programmes which are co-designed by CCGs or have engaged commissioners throughout implementation are better placed to secure future funding. This is especially the case given that the timescales of pilot delivery and commissioner planning have not necessarily aligned. As many pilots were not able to demonstrate impacts early enough to influence spending decisions; close working with commissioners as well as undertaking locally appropriate evaluation makes it easier to reassure them of anticipated benefits.

Capacity in the system

Wave one pilots did experience some capacity issues, which manifested themselves often as difficulties in recruiting or competing with OOH providers for GP time. The short term nature of the contracts of the pilot schemes also contributed to this. There remains some concern around the availability of ANPs in particular, which are likely to be exacerbated as more local health economies press ahead with seven day services and introducing skills mix. Similarly, to date some pilots have relied on incentivising GPs to resource PMCF initiatives and this may not be sustainable in the long term. These are issues likely to face all local health economies progressing towards extended access service models.

Equality of access

Some wave one pilots have reported inequalities to access whereby patients whose practice is a hub have benefited more from extended access initiatives than those whose practice is not. Rotation of hubs can be a way of overcoming this issue, although it may create other logistical issues. In addition, by the very nature of a pilot programme, there is potential to create some access inequities within local health economies because patients' access to new and enhanced services is dependent on whether their practice is a member of the pilot scheme or not. This issue could arise where not all practices within a CCG are participating in a pilot. However, this latter issue is unlikely to be a long term problem given the national agenda and move towards extended hours countrywide.

Benefits of working together

The hub and spoke models and federated delivery enable practices to deliver a wider range of services to patients over more hours in the week. Large and small pilots have also highlighted some wider benefits that can be achieved through collaboration. For example, working together has made it possible to share new specialist staff or resources and has created a 'critical mass' enabling them to negotiate better deals, attract additional support or assist in recruitment. However, as more federations are established nationwide in response to the Challenge Fund and the seven day services agenda, any competitive advantage, particularly with regard to recruitment might be short-lived.

Added value

Finally the Challenge Fund has provided a much-welcomed injection of investment into the primary care sector. This additional funding has provided the resource for local health economies to press ahead with collaborative working, create federations and extend patient access to GPs and other practitioners. Pilots are largely unanimous in their view that they could not have progressed with their agendas at the same pace if Challenge Fund resources had not been available. The considerable success achieved over the last year in moving away from independent working to delivering services at scale through joint working is added value in itself, even if some of the wider impacts and system outcomes are not yet fully tangible or measurable.

1 SECTION ONE: Background and context

Introduction: the national agenda

It is recognised that further significant improvements in service delivery are required to meet the future challenges faced by the NHS.

Over the last 15 years the NHS has achieved much success in improving how it provides patient care and in responding to the needs of a growing population, an ageing population[15], and a sicker population. However, notwithstanding these achievements, it also recognises that there are fundamental challenges facing the NHS now and over the coming years. These include:

- Changes in patients' health needs and personal preferences for involvement in their own care
- Changes in treatments and technologies which impact on how care is delivered
- Financial constraints and budgetary pressures

Primary care

A key enabler to support the trialling of new and innovative ways of working and improving access to primary care services has been through new funding sources such as the Prime Minister's Challenge Fund & Primary Care Infrastructure Fund

General practice and wider primary care services are facing increasingly unsustainable pressures. The current model of primary care delivery no longer fits with the changing lifestyle and needs of patients. However, there is recognition that primary care wants and needs to transform the way it has traditionally provided services and enhance the accessibility of services[16].

The Call to Action for general practice emphasised that with the highly systematic use of technology in primary care, the service was in a better position to consider the coordination of care across a practice network, seven days a week. This also then provided the opportunity to consider demands over the working week by for example, offering patients a wider range of appointment times, using skill mix and spreading the workload differently[17].

To facilitate this, the NHS Five Year Forward view has now set out a new deal for primary care with a commitment for more investment in resources and infrastructure. It recognises the need for more readily accessible GP and primary care services, reducing variation in access, reshaping care delivery and harnessing the use of technology to meet patients' changing needs.

15 Five Year Forward View, NHS England, October 2014
16 It's time to embrace seven day services, NHS England website, October 2013
17 Improving General Practice – A Call to Action, NHS England, 2013

The Prime Minister's Challenge Fund (PMCF[18]): Improving access to general practice

Wave one pilot schemes

In October 2013, the Prime Minister announced a £50 million Challenge Fund to help improve access to general practice. The Challenge Fund is designed to stimulate and test innovative ways of providing primary care services. A total of 254 expressions of interest were received from GP practices across the country to be part of this Challenge Fund. In April 2014 20 of these were selected to act as pilot sites, covering 1,100 general practices and 7.5 million patients.

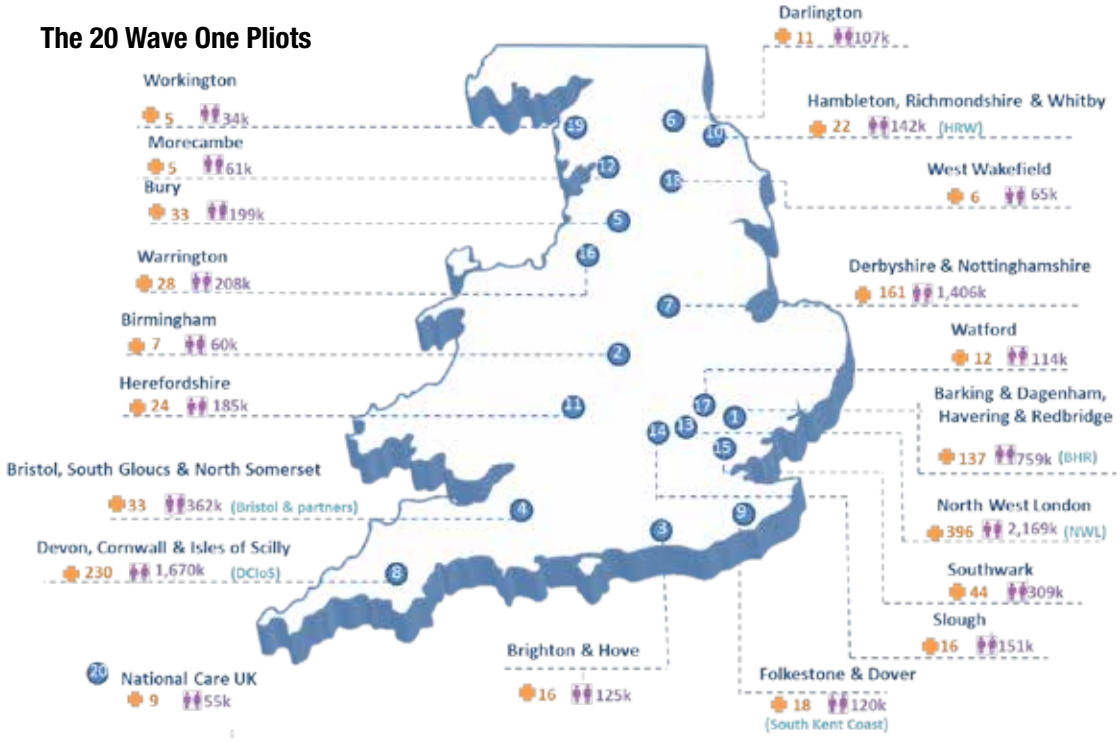
Pilots were selected based on their public and patient engagement; sustainability prospects; scale and ambition; leadership and commitment; links to local strategy; capacity for rapid implementation and their monitoring and evaluation plans. Following the selection of the 20 pilots, ten national objectives were agreed by which to measure their success.

Following the selection of the 20 pilots, three national objectives were agreed by which to measure their success in the evaluation.

The national Challenge Fund objectives:

1. To provide additional hours of GP appointment time
2. To improve patient and staff satisfaction with access
3. To increase the range of contact modes

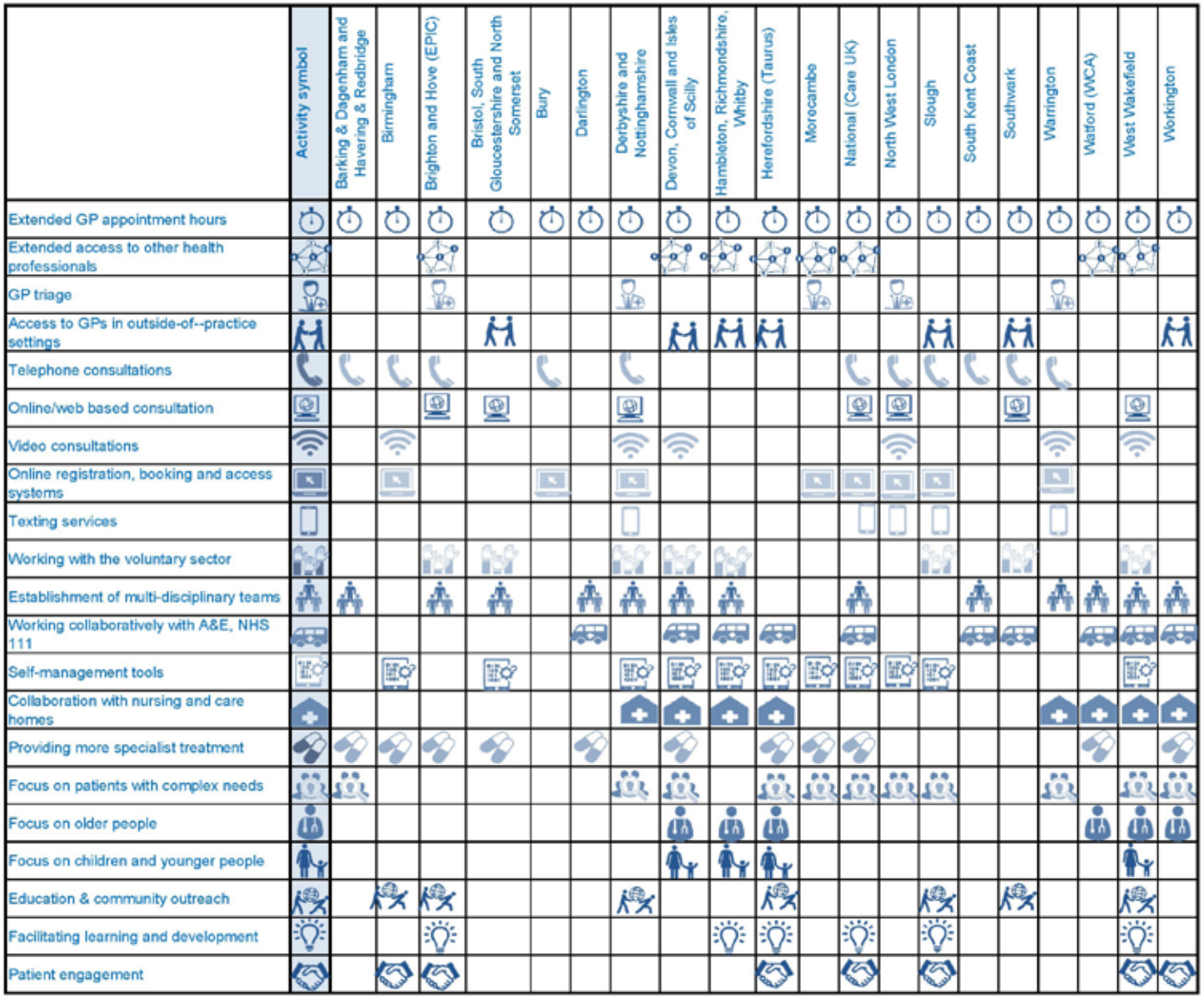
The 20 Wave One Pliots



Key	GP Practices Involved	Patient Population (to nearest 1000)	Pilot Location
1. Better Access, Better Care, Better Standards	8. Shaping Services to Meet Community Needs	15. Extending Access to Primary Care	
2. Health United	9. Integrated South Kent Coast	16. Primary Care Home	
3. Extended Primary Integrated Care	10. Together as One Community	17. Transformational Innovations for Primary Care in West Hertfordshire	
4. One Care Consortium	11. Improving Access, Supporting Primary Care Integration and Whole System Change	18. Moving Primary Care to a Wellbeing Approach	
5. Easy GP Project	12. Opening Doors- Aligning & Integrating Health & Care Services	19. Better Together	
6. Caring for Darlington Beyond Tomorrow	13. Transforming Access to General Practice	20. Transforming the Access Experience at Scale across England	
7. Transforming General Practice	14. Steps to the Future		

18 The Prime Minister's Challenge Fund is hereafter referred to as PMCF or the Challenge Fund

The size, scale, delivery models and intervention priorities vary significantly across the pilot schemes. They have all sought their own locally appropriate solutions to meet the objectives of the Challenge Fund. Common amongst the 20 schemes however, is the level of ambition that each pilot has demonstrated. All of the schemes have grasped the opportunity to go far beyond extending hours and traditional modes of access to GP services; there is an appetite to use this opportunity to transform primary care delivery more widely through integration with a range of delivery partners and redefining traditional ways of working and making access more convenient for patients.



The independent national evaluation of PMCF wave one

Putting in place an evaluation of the pilots is regarded by NHS England as central to the Challenge Fund programme.

At a local site level, evaluation provides a means by which pilots can test and refine their innovation ideas based on data that is gathered. At a strategic level, it provides NHS England with valuable knowledge and insight into models and innovations which are (and are not) yielding positive results. This helps inform wider policy planning in the primary care sector itself and the wider seven day services agenda.

In June 2014 following a competitive procurement process Mott MacDonald, working with SQW, was appointed by NHS England as the national evaluation partner for wave one. The evaluation is examining the models which are being put in place to deliver change; the extent to which impacts, outputs and outcomes are being achieve; the delivery barriers pilots are facing and how these challenges are being addressed; key factors which are enabling success and an assessment of value for money.

The four goals of the wave one evaluation process are to:

- **Support local progress:** inform rapid testing and implementation of changes within practices and across the pilot.
- **Demonstrate progress:** describe and measure the impact of the Challenge Fund programme in driving innovation and improvement within pilot sites.
- **Spread innovation:** produce 'rolling case studies' describing the innovations being used and critical success factors, to spread learning rapidly across the NHS.
- **Learn from innovation:** evaluate the innovations tested and the means of implementing them, sharing actionable learning about the conditions and methodologies for successful innovation and improvement in general practice.

As well as assessing progress against the three national programme objectives (GP appointment hours; satisfaction with access; and the range of contact modes) the evaluation has also featured several other lines of enquiry including looking at the Challenge Fund's contribution:

- establishing sustainable and transformational change in the primary care sector;
- reducing demand elsewhere in the system;
- facilitating learning;
- tackling health economies;
- identifying replicable delivery models; and
- delivering value for money.

About this first report

The wave one pilots are now over a year into delivery of their plans. This first evaluation report reviews their progress to date and assesses the extent to which the PMCF core programme objectives are being met. The report will be accompanied by 20 pilot evaluation papers which review the individual PMCF programmes, and how they meet the national objectives, in more detail.

As all 20 schemes were awarded some sustainability funding to continue with their initiatives beyond the original twelve month timetable, there will be a final evaluation report at the end of 2015, which will take on board further data.

Local evaluation

Many pilot schemes have undertaken their own evaluation activities at a local level in addition to participating in the national evaluation. This served service improvement needs as well as providing additional insights about specific innovations for practices and CCGs. Schemes made use of peer networking, workshops and masterclasses facilitated by the national programme to plan their approach. Four schemes commissioned or collaborated with external agencies.

Wave two pilot schemes and additional funding

In September 2014, further funding of £100m was announced by the Prime Minister for a second wave of pilot schemes of which 156 applications were received. Following the selection process, 37 pilot schemes were announced in March 2015. This second wave covers 1,417 practices, serving over 10.6 million patients. These pilot schemes are now in the process of mobilising although they are not the subject of this evaluation report. £25m has also been made available to the pilots via the Primary Care Infrastructure fund.

Part of the further funding has been used by NHS England to support wave one pilot schemes for a further six months. This additional 'sustainability funding' is in recognition of many mobilisation issues at the beginning of the programme (e.g. the set up of IT systems) and the detailed due diligence process, which was undertaken in order to gain reassurance of the robustness of implementation plans prior to the release of funding and needed to be completed before contracts could be signed and money released.

2 SECTION TWO: Methodology

Overview of approach

The evaluation has adopted a multi-methods approach incorporating both qualitative and quantitative assessment with an iterative and collaborative approach to interpretation and rolling publication of lessons and showcases

The methodology has comprised:

- Interviews with pilot leaders and those involved in implementation at multiple points during the programme
- Interviews with pilot partners and stakeholders involved in delivery
- Engagement with staff at practices and other implementation providers through an online survey released twice over the pilot implementation period to date
- Assessment of the impacts and outcomes measured against a basket of nine national metrics
- Identifying, examining and sharing good practice
- Identifying return on investment and value for money, through looking at how pilots have allocated their resources
- Showcasing innovation good practice through regular thematic papers
- Collection and analysis of monthly data on key services and innovations being delivered as part of PMCF

Quantitative evaluation

The national metrics

A basket of nine national metrics was developed in partnership with the pilots. These were distilled from over 280 metric indicators, as detailed in their original application submissions for Challenge Fund pilot status. The metrics were agreed by looking across the 20 pilot localities to identify the 'best fit' in terms of assessing activities being undertaken and also meeting the needs of NHS England in terms of understanding the impacts and outcomes of the Challenge Fund investment. This basket of national metrics have been organised under four categories.

A. Patient contact, as a direct result of the change in access:

- The change in hours offered for patient contact
- The change in modes of contact
- The utilisation of additional hours offered

B. Patient experience/satisfaction:

- Satisfaction with access arrangements
- Satisfaction with modes of contact available

C. Staff experience/satisfaction:

- Satisfaction with new arrangements

D. Wider system change:

- Impact on the wider system attendances
- Impact on emergency admissions
- Impact on the 'out of hours' service[19].

The data collection and analysis process

Pilots have taken responsibility for collating practice based data against those metrics under Category A (patient contact), as a direct result of the change in access. Each month, pilots have been requested to submit weekly practice level data of hours provided, contacts available and contacts used, broken down by staff practitioner type and mode of contact within both core and non-core working hours[20]. In addition pilots have provided monthly statistics on the use of GP out of hours services by their patient population.

Centralised support has coordinated the collection of the remaining five national metrics. Pilot-supplied data has been combined monthly with the metrics under Category D: Wider system change and periodically with the findings of the National GP Patient Survey to support Category B metrics and a bespoke staff survey managed by Mott MacDonald for the Category C metric. Each month data metric progress update briefings have been shared with the central NHS England team.

19 Out of hours primary medical care services are defined as those services required to be provided in all or part of the out of hours period which would be essential or additional services provided by a primary medical care contractor (i.e. a GP practice) to its patients during 'core hours'.

20 Core hours: 8am - 6:30pm Monday to Friday
Non-core hours: extended hours on Monday to Friday, anytime at weekends

A combination of centralised and local processes has been used to support the data collection.

The challenges encountered

The quantitative data collection and analytical processing has not been without its challenges. Chief amongst these has been the lack of facility for the extraction of routine appointment and contact data from practice level IT systems. Many pilots under-estimated the effort required to extract data from their GP systems. For example, some pilots were required to resort to manual data collection processes using practice appointment ledgers.

There have also been issues around data quality; variations in the completeness of data submissions; and a lack of standardised definitions being used across practices within pilots. For a few pilots, there has also been unease across their GP community about providing practice level data with concern about how this will be used and interpreted at a national level. Federations of practices within some pilots have struggled to gain out-of-hours data..

Since the end of March 2015, when all pilots were operational with delivery of their extended access and other initiatives, metric data has been collected for 19 out of the 20 pilots[21], although this still remains patchy for a few pilots.

Challenges with data collection have hampered some of the metric analysis undertaken by the evaluation team.

Qualitative evaluation

The evaluation has enabled the team to establish a detailed understanding of what that pilot was seeking to achieve; explore the full range of activities and why these are locally appropriate; what has been working well; where the challenges have been; the key success factors and; the lessons that are being learned. Interviews and visits have taken place at key points over the last year in order to develop these relationships and gather information to produce updates for NHS England.

Several pilots have also been invited to have discussions about services in which they are demonstrating good practice or noteworthy achievements.

The evaluation team has produced seven thematic innovation showcases as a way in which to spread learning. These showcases can be found on NHS England's website. The topics considered are:

- Delivering at pace
- Innovative use of technology
- Patient engagement
- Practice engagement
- Delivery at scale
- Collaborating with other providers
- Effective leadership

Future showcase topics planned over the next few months include: more use of specialist nursing; tackling health inequalities; and building sustainability.

The continuous iterative approach taken to gathering and analysing qualitative data has provided added value to the national programme. For example, it alerted NHS England to important areas requiring national support, such as IT, and has informed the ongoing development of the innovation support programme. Additionally, it facilitated the early publication of key lessons about success factors for implementation of at-scale primary care innovation for the benefit of the wider NHS[22].

An evaluation lead was assigned to each of the 20 wave one pilots to work with the scheme over the implementation period.

21 The exception is **North West London (NWL)** the funding received from the Challenge Fund was being used to support its infrastructure set-up for transformational change, and not specifically for service delivery. Therefore NWL was exempted from this process. This pilot has shared its survey findings and other qualitative evidence.

22 Prime Minister's Challenge Fund Wave Two: Learning from wave one, NHS England, December 2014 [hyperlink http://www.england.nhs.uk/wp-content/uploads/2014/12/pmcf-wave-2-lessons.pdf]

Assumptions and limitations

The evaluation is not designed to examine each of the pilot's local initiatives in detail

The report highlights examples of particular innovation, success and challenge and how these can be learned from, rather than naming every pilot that has delivered a certain initiatives.

There are some key considerations that are essential to bear in mind when reading this evaluation report:

- This is an independent national evaluation that is designed to assess pilots' collective progress against the national PMCF objectives and draw out key themes in terms of delivery. Figures presented in this report are at an aggregate programme level unless otherwise stated. Accompanying this main report are individual reports for each pilot.
- The national set of quantitative metrics looked to ensure consistency of data collection across the pilot schemes against some key indicators. It was recognised that most pilots were planning to implement a range of other initiatives against which the national set of metrics would not provide appropriate assessment.
- Metric data received from pilots has not been quality assured other than for obvious gaps and anomalies.
- Each pilot has been encouraged by NHS England to undertake local monitoring and evaluation activity to complement the national evaluation and support local decision making around sustainability.
- Given the range and complexity of initiatives being implemented across each of the pilot schemes and the context within which each is working, it has proved difficult to:
  - draw too many comparisons between pilot schemes; and
  - assign attribution of outcomes and impacts; particularly the impact of changes observed in the wider system metrics.
- In the 'reducing demand elsewhere in the system' section, hospitals may not record A&E attendances and emergency admissions consistently which could contribute to the observed variations.
- The report draws on many examples of pilot initiatives in order to illustrate key points. Given that there are twenty different pilot programmes, most of which have multiple project components, this evaluation cannot and is not intended to discuss every development or activity. However, there are 20 individual pilot reports discussing local issues in more detail, which accompany this overall report.
- The findings presented in this report, and the individual pilot are based on the information that has been provided to us by the pilots either through interviews, metric data submissions or monthly service data examples. These have been reviewed on receipt but the pilots themselves are responsible for the accuracy of the primary data.
- The most up-to-date metric data has been used for this report. For practice based data, A&E, emergency admissions and out-of-hours, this is May 2015. For the patient survey this is June 2015. The staff survey was run in January and July 2015.
- Figures on the number of practices providing, and the numbers of patients with access to, services has been taken from the monthly highlight templates which are collated by the evaluation team. The figures are from June 2015.
- It is acknowledged that upon publication of the report, there will be continuing data collection which will be reflected in later evaluation deliverables.
- Further work is obviously required to better refine the underpinning assumptions where there are gaps in the data. This programme of work will be undertaken over the next few months through close liaison with those particular pilots and will be reported as part of the final evaluation report.
- It has not been possible to collect data for NHS 111 contacts. Whilst this data is published nationally and broken down by regions, there is insufficient granularity within this source of data to match NHS 111 contacts with those particular GP practices included within the Challenge Fund pilot schemes.
- Finally, as has been identified earlier, attribution of impact to the Challenge Fund pilot schemes is inherently difficult to prove with many other initiatives, either as part of a national programme or as local drivers for change, being implemented.

SECTION THREE: Meeting the national programme objectives 3

This section of the report is dedicated to examining the progress towards the three national PMCF programme objectives.

Objective one: To provide additional hours of GP appointment time

Over 60% of respondents to the online staff survey consider there has been either a very positive or positive impact against this objective.

Prior to the Challenge Fund initiative, a number of GP practices were offering patients some access to appointments during extended working hours in the weekday and at the weekends largely through extended access Directed Enhanced Services (DES). As the Challenge Fund initiatives have been implemented by the pilot schemes, the number of GP practices offering access to a more comprehensive extending working hours service for their patients has dramatically increased. As at June 2015, it is estimated that net of the baseline service prior to the start of the Challenge Fund initiative, almost 5 million more patients now have access and a choice to a new or enhanced extended hours service during the week and almost 5.4 million more patients at the weekend.

Staff consider that the provision of additional GP hours to be the highest ranked impact of their pilot schemes

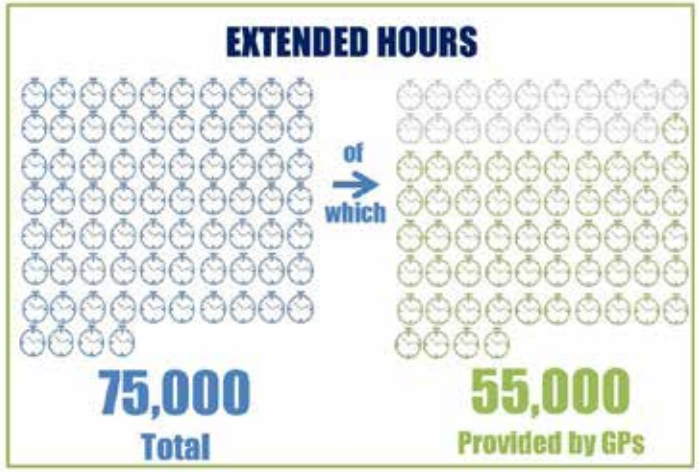
Hours and appointments

Across 16 out of the 20 pilot schemes, a total of 75,000 extended hours of access to primary care services have been provided between the time that individual pilot schemes went live with their initiatives to the of May 2015. Of this, 55,000 hours (73%) were provided by GPs. Net of the baseline, the additional extended hours being offered across these 16 pilot schemes was 38,000 hours of which 28,000 were provided by GPs.

The cumulative impact of additional core hours being provided over and above the baseline for the 16 pilot schemes up to May 2015 was 66,000 hours of which 26,000 (19%) were directly provided by GPs.

This increased service provision and the change in modes of contact (see objective three) has translated into additional appointment slots being offered to patients and from the time that individual pilot schemes went operational with their initiatives up to the end of May 2015, the combined impact of 16 out of the 20 pilot schemes was:

- Around 238,000 additional available appointments during non-core (extended working) hours of which 184,000 additional available appointments were provided by GPs; and
- Around 520,000 additional available appointments during core working hours of which 162,000 were provided by GPs.



In total, 758,000 additional appointments have been made available to date (as at May 2015).

On this basis, the number of additional extended working hours and appointments being offered up to May 2015 across the whole Challenge Fund Programme could potentially be around 70,000 hours and 400,000 appointments.

Data Caveats

It is important to note that:

- The analysis reflects the cumulative impact of the continued implementation of pilot scheme's extended working hours initiatives post June 2014 up to May 2015. It is important to recognise that pilots have phased their going live. Some pilots have been live since August 2014 whilst others have gone live later in the year or early 2015, with practices and hubs coming on stream at different times in some cases.
- The breakdown of additional hours and contacts provided masks how some pilot schemes are offering their services and, in particular, the implementation of new ways of working by GPs as part of a multidisciplinary team and therefore not recorded as a direct GP appointment but recorded as a 'mixed' appointment in the data returns.
- The change in service provision for some pilot schemes can result in identified reductions in hours and available appointments compared against the baseline. A reduction in available contacts may be due, for example, to longer appointment times being offered and a reduction in available hours may be due to possible recruitment and retention issues of clinical staff outside the influence of the Challenge Fund initiative.
- As stated, these headline figures reflect data for 16 out of the 20 pilots. The analysis does not include data for: **North West London (NWL); BHR; Bristol and partners; and Derbyshire & Nottinghamshire.**[23]

The four pilot schemes for which there are gaps in the data provided are some of the larger scale pilot schemes. Therefore, their likely contribution to the understanding of additional appointments being made through the Challenge Fund initiative is an important consideration.

As a crude approximation to estimate the potential scale of the additional appointments being offered across these four pilots, we have assumed the live pilot data received for Bristol and partners and BHR are all additional and then pro-rated additional appointments being offered across the pilot schemes in line with the proportional split of patients who now have access to extended hours services for the remaining two pilot schemes compared to the other pilot schemes.

On this basis, the number of additional appointments being offered across the Challenge Fund programme is estimated at around 400,000 across all practitioners.

23 These are pilot schemes where either no data has been provided or no baseline data has been provided against which to derive the additionality. As illustration of the data which has been provided, in Bristol between August 2014 and March 2015 3,362 hours of extended access has been provided and within the Barking pilot 23,283 planned appointments have been made available between Sept 2014 and May 2015.

Utilisation

Whilst the provision of additional hours and available contacts is a key objective of the Challenge Fund Programme, a key consideration is how well primary care services are being utilised. Comparing the total available and used appointments from the time that pilot schemes went operational up the end of May 2015, the average utilisation of available appointments during core working hours was 94% and 75% during extended working (non-core) hours. This latter figure compares with a baseline utilisation of extended hours appointments of 80%. There is no change in core working hours.

This analysis may overstate utilisation slightly given that in some pilot schemes not all used contacts have an assigned per-booked appointment slot e.g. time set aside for urgent same day appointments.

The lower utilisation of appointments during extended working (non-core) hours resonates with pilot schemes' own experience of lower take-up rates for weekend appointments; particularly on Sundays.

This aggregate utilisation analysis also masks the variation that exists between pilot schemes in the take-up rate of additional appointments. For example, **Care UK** provide extended access via their 24/7 call centre service and typically utilisation has been seen to be quite low compared to almost complete utilisation of hours within the **Slough** pilot scheme which undertook significant patient engagement from the outset.

This pattern of low demand on Sundays has been evident nationwide. There are exceptions (for example, **Bury, Morecambe** and **South Kent Coast** do not report any utilisation problems at weekends) but the vast majority of pilots have highlighted this in their feedback including **Derbyshire and Nottinghamshire, Darlington, DCIoS, BHR, Care UK, Herefordshire, Birmingham, HRW, Warrington, Workington and Watford**. Often these pilots are reporting that low take-up on Sundays and some (although far fewer) also highlighting low demand on Saturday afternoons and evenings. For example, across Darlington, local analysis of its pre-bookable appointments between October 2014 and March 2015 identified that on a Saturday 54% of appointments were booked compared to 12% on a Sunday. Several pilots have suggested that very low weekend utilisation figures mask success of the weekday non-core slots.

As a result of Sunday trends, many pilots have begun reducing their weekend service offer to fewer hours, with some ceasing provision on Sundays completely (**Watford, HRW, Darlington**) or are monitoring the situation with a view to potential discontinuation (**BHR, Brighton and Hove, Warrington**).

The wave one pilots have recognised that there are critical success factors with regard to provision and use of extended hours appointments. These include securing GP buy-in, raising patient awareness and adequate receptionist training. However, there is general agreement that the lack of success with certain weekend extended hours slots is not necessarily attributable to the delivery and design of projects or an ineffective communications strategy; rather it as a result of entrenched patient behaviours.

Rate per population of extended hours

A comparative analysis has been undertaken to assess the current range of extended hours per registered population being offered across pilot schemes in March 2015. This analysis includes the totality of extended hours provision and not simply the additional capacity being provided.

This analysis shows a range of extended working hours per week per 1,000 registered practice population. For illustration, the rate per 1,000 population in **Bristol, North Somerset and South Gloucestershire** is 0.11 (reflecting weekend extended access) and across Care UK practices is 14.1. **Slough** and **Warrington** pilot schemes offer around 1.9 and 2.0 extended working hours per week per 1,000 registered practice population respectively.

Smaller scale pilot schemes are offering an average of 0.55 extended hours per week per 1,000 practice population[24] and those medium scale pilot schemes are offering an average of 0.68 extended working hours per week per 1,000 practice population.

Therefore, for a pilot scheme covering 100,000 patients, this analysis would translate into the provision of around 55-68 hours for extended access per week. However, this does not factor in utilisation which has shown that, to date, 75% of extended working hours contacts are being utilised.

Taking account of this it suggests that the number of extended working hours per week which could be considered to maximise utilisation should be 41-51 hours per 100,000 patient population pilot scheme. For extended working hours provided specifically by GPs, this would translate to between 30-37 hours per week per 100,000 registered population (once utilisation has been accounted for).

Whilst this analysis provides a reasonable estimation it still remains too simplistic to define a “recommended” rate without reference to current service levels and pressures. There is known to be wide variation of patient experience with GP access, and local needs assessments should guide any new or additional services. The wider features of the innovations and models must also be taken into consideration. In particular, it should be noted that schemes varied widely in their use of innovations which promote self care and improve productivity. It will also be critical to consider when these additional hours are provided. Evidence to date indicates that it would be more sensible to allocate additional hours to weekday slots or possibly Saturday, rather than trying to establish a Sunday service.

B**irmingham** has concluded that their most effective delivery model lies not exclusively in providing additional hours, but in using core hours more effectively. In **HRW** overall low utilisation (between 50-60%) has suggested that extended hours is not a suitable or sustainable solution across the region. In fact, the initial focus on the extended hours element of delivery served to disengage some local GPs, later creating challenges with securing buy-in for some of the pilot’s other projects. The pilot has now ceased extended hours provision and is directing further investment towards other PMCF projects which are more aligned with local need. In turn the Alliance and the broader network of GPs are now more positive about the future.

24 Given the uniqueness of the Care UK service model, this has been excluded from the analysis.

Objective two: Improving satisfaction with access to primary care

Overall 84% of patients rated their experience of their GP surgery as either very good or fairly good.

Patient experience and satisfaction

To assess the extent to which the PMCF pilot schemes have improved levels of patient satisfaction, findings from the National GP Patient Survey have been used. The latest survey results published in July 2015 combine the survey responses collected over the previous 12 months at two periods, July 2014 to September 2014 and January 2015 to March 2015. This represents the time period during which the pilot schemes have been up and running[25].

Comparative analysis with previous survey findings has been undertaken to assess the extent to which there have been changes in patients' perceptions about access to primary care services.

Findings from the national GP Patient Survey

Given the limited time that pilots have gone live with their initiatives, it is still too early to make an impact and, at a programme level, there has been little change in patients' levels of satisfaction and experience. Seventy five per cent of patients who responded to the most recent survey are satisfied with their GP practice's opening times and consider that opening times are convenient for them. Of those patients who considered that additional opening times would make it easier to see or speak to someone, there was a 70% response rate for additional opening times on a Saturday, 65% after 6.30pm and 38% on a Sunday. Over 90% of patients across the Challenge Fund GP practices consider that appointments are either very or fairly convenient and around 60% of patients are able to see their preferred GP. Three quarters of respondents consider that their experience of making an appointment is either very good or fairly good. These findings are very similar to the national profile.

Notable pilot scheme exceptions to the overall Programme level trend include:

- A greater than 4% increase in the positive response to the convenience of appointments at the **Morecambe and Birmingham** pilot schemes.
- A 9% increase in the patient's experience in making an appointment but a 7% reduction in the convenience of opening times at the **Workington** pilot scheme.
- A 3% increase in patients' who state that they either always or a lot of the time get to see their preferred GP at the **Brighton and Hove** pilot scheme.
- A 12% reduction in those satisfied with surgery opening times at the **Birmingham** pilot scheme. This may reflect the removal of the extended hours services at the end of March 2015.

Findings from local data

Most pilots have undertaken local patient satisfaction surveys and other patient engagement activities to support their Challenge Fund initiatives. Without exception, feedback reported by the pilot schemes has been positive with the majority of patients asked stating that they would recommend the service to their friends and family. For example, in Herefordshire 93% of patients surveyed described the Taurus Healthcare Hub as excellent or very good and in Slough 97% are very satisfied or satisfied with the extended hours service. To support the promotion and feedback of local Challenge Fund initiatives, some pilot schemes have provided patient engagement activities, including patient educational support sessions and open days.

Findings from the staff survey

Findings from the two staff surveys have identified over 70% of respondents rate the Challenge Fund initiative as having had either a very significant or significant improvement in their patients' experience with:

- Between 62% and 64% of respondents within the surveys either strongly agreeing or agreeing that there has been a change in how the needs of patients are being met.
- 56% of respondents either strongly agreeing or agreeing that they are now providing care which more appropriately meets the needs of patients in terms of access.
- 45% of respondents either strongly agreeing or agreeing that they are now providing care which more appropriately meets the treatment needs of patients.

25 Note that the national GP patient survey does not specifically focus on PMCF and is more generally reflective of patient's experience and satisfaction with primary care services.

Staff experience and satisfaction

The national evaluation team has sought to understand and assess changes in staff satisfaction in pilot schemes through their experience of the Challenge Fund and their perceptions of the pilot's impact on patients, other staff colleagues and the overall primary care system. To do this an online staff survey which to date has been run twice, has been facilitated by Mott MacDonald.

Almost 1,000 responses were received to these two initial surveys. They include GPs, practice administration staff, nurses, and other clinical professional staff and practice management staff all of whom have had involvement in their pilot's Challenge Fund initiative. All pilots have participated in the online survey with the exception of one, **Warrington,** which intends to undertake its own staff survey in September 2015.

Across both surveys, findings have been consistent with:

Around 70% of respondents feeling either very satisfied or satisfied with the pilot's arrangements of how primary care services are being offered. Fourteen per cent of respondents rated either dissatisfaction or very dissatisfied with current arrangements.

Over 60% of respondents from both surveys rating their experience of extending access in primary care as either very good or good compared with between 12% and 15% who rated this as either poor or very poor.

Just over half of respondents in both surveys have rated the impact of the Challenge Fund on staff as either very positive or positive.

Respondents rating their current job satisfaction compared with that before the Challenge Fund showed a 3% improvement in job satisfaction within the initial survey findings. Findings from the second survey have shown that this has increased with respondents rating their current job satisfaction 6% higher than prior to the Challenge Fund. However, the second survey findings have shown that 20% of respondents are either dissatisfied or very dissatisfied; a marginal increase from the initial survey findings. This is predominantly GP and administrative staff and may be due to wider issues at a time of considerable pressure on general practice across England.

Pilots have also highlighted some of the increased staff engagement activities which have taken place to increase and maintain interest and participation in the pilot scheme. This has included videos and guides on new ways of working for members of staff in **Herefordshire**; establishment of a steering group for doctors and practice managers and IT training for receptionists in **West Hertfordshire**; using a range of media and a staff survey in **Darlington**; assignment of project managers to develop relationships with practices in **NWL**; and events and working groups to co-design initiatives in **Southwark** and **Workington**.

Whilst much of the feedback from staff has been positive, the staff survey has also received many additional comments from respondents which have been more critical and provide an opportunity to learn lessons for potential future waves of pilot schemes. These comments suggest the need to:

- Ensure patient accessibility and use of extended hours hubs in more rural locations.
- Ensure equitable access to additional appointment slots for non-host GP practices.
- Take into account the differing needs of patients, some of whom prefer to see their own GP rather than attend an extended hours appointment with another GP.
- Achieve improved alignment with other urgent care services, particularly out of hours services.
- Focus additional funding on core hour services.

Objective three: Increasing the range of contact modes

Using technology

The pilots have demonstrated considerable ambition

The majority of pilots (15 out of 20) have increased the modes of contact, usually with the aim of reducing face-to-face appointments (which take longer than some other contact modes) and/or making access more convenient for patients.

Telephone-based GP contact

Prior to the Challenge Fund initiative, the dominant mode of GP contacts in both core and non-core hours was face-to-face, with a comparatively small amount of telephone consultation hours:

- Core hours: 80% of appointments were face-to-face; of the remaining, 17% were telephone consultations and 2% were home based appointments[26].
- Extended hours: 91% of appointments were face-to-face and 8% were telephone consultations.
- Just over 450 practices were providing some level of telephone consultation.

The introduction or expansion of telephone access has been a popular component of the wave one pilot programmes, with two thirds of the pilots introducing schemes to expand this type of access. PMCF has increased the scale of provision considerably, supporting the development of telephone consultation facilities[27] at nearly 400 practices (serving over 2.5 million patients).

Despite this uplift of telephone access, March 2015 metric data suggests that the overall profile of patient appointments during core hours had not changed. However, there has been variation to the contact profile during extended working (non-core hours), which is characterised as:

15 out of 20 pilots have increased the variety of modes by which patients can access GP services.

- 87% face to face clinic appointments (compared to the 91% baseline)
- 11% telephone appointments (compared to the 8% baseline)
- 2% other

Some of the pilots are evidencing considerable success with this service development, as evidenced below.

Birmingham

In **Birmingham** the provision of telephone based consultations has been a major part of its offer; it has established a central telephony hub which books patients into an appointment or routes calls to patients' own practices for local matters (e.g. nurse appointments or test results). On average its telephony hub takes around 1,300 calls on a Monday, and around 800 on other weekdays. The metric data collected for the national evaluation indicates the investment in the hub system has been a success at re-balancing the appointment profile. During core hours 60% of appointments are now over the telephone compared to Birmingham's baseline position of 35%. GPs have reported increased capacity and greater control over their own workloads, as a direct result of the telephony offer. Local data from practices participating in the pilot are reporting consulting approximately 10% more patients without taking any additional hours into account.

"As well as making it easier to make contact, to book appointments and get support from the surgery, these new systems offer new routes to rapid and excellent professional advice and reassurance"

Birmingham patient

The Birmingham pilot suggests that to maximise the effectiveness of a telephone based model, it is important to ensure that the consultation procedure itself is an integral part of service design rather than focusing only on the telephony infrastructure. Patients need to speak to a practice doctor (ideally their own GP) with full access to the patient's notes. The effectiveness of the process is reduced where there is a mixture of staff involved in dealing with the patient, and where locums are used.

The proportion of telephone appointments in con-core hours has grown

26 1% use "other"

27 The pilots have introduced a range of telephone models by different names (e.g. telephone consultations; telephone triage; call centres)

Brighton and Hove
In **Brighton and Hove** local data suggests that the majority of practices implementing the telephone triage model are noticing some positive impacts, particularly in terms of GP time saved. In addition, this model has helped to shift the profile of GP appointments so that now 34% of core hours appointments are over the telephone, compared to a baseline of 10%. The pilot has found that the success of its telephone model is dependent on how GPs use it; some are reluctant to deal with patients entirely over the phone and ask patients to visit the surgery anyway.

Nottingham North East (Derbyshire and Nottinghamshire)
Nottingham North East (NNE) has enjoyed success with an ANP & GP telephone triage trial in one of its practices. The model was designed to better match the practitioner to the patient, allowing GPs to focus on patients with more complex care needs. Local data suggests that it has led to a reduction in the number of face-to-face GP appointments. The local patient survey recorded a 100% satisfaction rate with the service.

"We are now seeing more appropriate patients and we can clinically prioritise who we see when and decide the length of the appointment. We are therefore able to provide improved quality of care."

GP

Care UK has seen some significant shifts towards telephone consultations in its contact profile in both core hours (from 10% to 27%) and extended hours (from 20% to 42%). Its offer is based around a central telephony hub. This national pilot was able to make use of existing 111 telephone infrastructure to implement this service.

"I was very impressed with such a quick turnaround; this was the best experience [of general practice] I've had yet."

Care UK patient

Morecambe
Similarly in **Morecambe**, local patient feedback suggests that its telephone triage service is perceived as more responsive to need that NHS 111. 72% of the Morecambe pilot scheme's extended hours appointments are telephone based, via its triage model.

Video consultations

Six pilots have experimented with video consultations, using video technology. 20 practices are trying this contact mode with potential access for over 250,000 patients. There have been challenges with this mode of consultation. **Herefordshire** attempted to introduce care home videolink activities but found that there was inadequate on-premise broadband provision to support mobile devices. In **Birmingham** video appointments were launched at all of its participating practices in September 2014 but they have not yet proved to be popular with patients. The pilot feels that intensive marketing would be required to increase take-up of this offer. **DCIoS** trialled, and has since discontinued, video appointments in Devon. It also found there to be a lack of patient demand, pointing towards the patient demographic as the possible reason behind low take-up.

Video consultations have been challenging to implement

Online patient diagnostic and e-consultations

Six pilots have introduced online patient diagnostic tools. These include self-help content, sign posting options, symptom checkers, access to 111 clinicians and ultimately the ability to consult remotely with a GP via e-consultations (e.g. WebGP, SystmOnline, MyGP24/7).

To date these have met with a mixed reception from both GPs and patients. In **Bristol** 13 practices adopted e-consultations and, despite some technological set up issues, the trial was seen as a success. Elsewhere, prior to implementation, (**Brighton and Hove** and **Southwark**) some GPs had concerns that patients might not fully understand the front end advice process and were also apprehensive about being inundated with e-consultation requests. This led to some reluctance to implement the system. **Care UK** implemented a diagnostic and e-consultation system at all eight of its practices but experience suggests that it has a limited appeal for patients; they tend to prefer the pilot's telephone access offer, which provides patients with a GP response more quickly. Since going live, the pilot has provided 470 on-line consultations up to the end of May 2015.

Eight practices have also introduced online access features, typically online registration and booking systems, as part of their pilot programmes. Approximately 250 practices have provided these facilities across **Birmingham, Bury, Care UK, Derbyshire and Nottinghamshire, NWL, Slough** and **Warrington**.

Few pilots have implemented e-consultations and reception has been mixed

Introducing a wider range of practitioners

Wave one pilots have invested considerable resource and effort in engaging with the wider healthcare community to deliver services in partnership and more appropriately match patients to need, reduce exacerbations of conditions and free up GP time.

Making more of nursing staff

The evidence to date suggests that the strategy of making more use of nursing staff, particularly Advanced Nurse Practitioners (ANPs), is resulting in benefits including releasing GP capacity.

A few pilots have chosen to employ specialist nurses. For example, **Workington** appointed three specialist nurses (one for each of chronic obstructive pulmonary disease (COPD), diabetes and liaison with care home patients). **Herefordshire** has implemented a link nurse initiative to facilitate the discharge of patients in order to reduce the likelihood of miscommunication between primary and hospital care, avoid prolonged stays in hospital and the associated exacerbation of health issues. The pilot's local evaluation highlights that the project has avoided the need for post-hospital GP intervention in 25 cases and Taurus has secured further funding from the CCG to continue it.

"The link nurse has been acting as a link between my Father, our family, the GP surgery in Belmont and Hereford County Hospital. It has been really helpful to have someone who appears to be thinking about the whole picture concerning my father and his cancer as well as my mother and her difficulties"

Patient's son

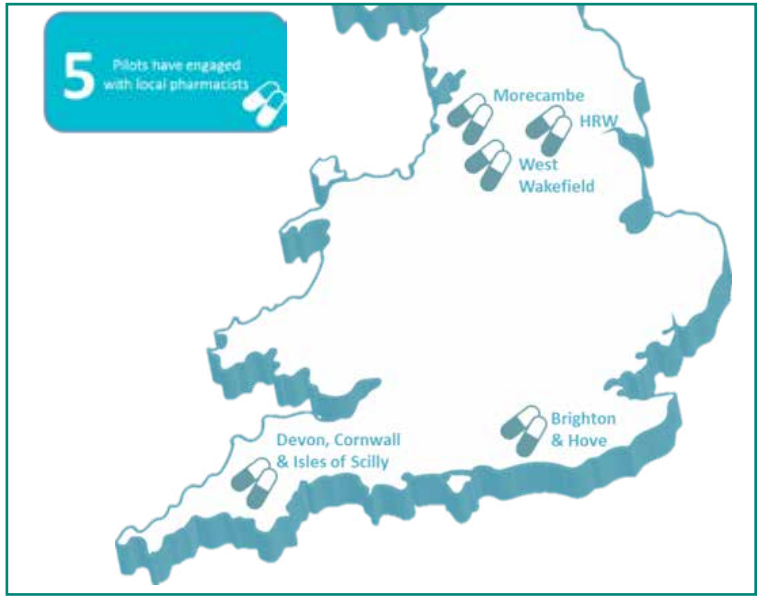
That there have been several hurdles to overcome in order to introduce wider roles for nurses

The use of ANPs has been a key strategy to try to release GP capacity. Models vary, with ANP capacity being provided in both core and extended hours, delivered from practices, hubs or working remotely. By and large these initiatives have demonstrated success. In Erewash (in **Derbyshire and Nottinghamshire**), local data for the first quarter of 2015 suggests that their ANP care home work stream has resulted in the avoidance of 118 unplanned admissions as well as freeing up GP time; of 136 urgent visit requests from care homes 23 were attended by GPs and 113 were attended by ANPs. In **Brighton and Hove**, data shows that an additional 2,000 hours of nursing time (net of baseline) have been provided during core working hours. Utilisation of ANP appointments has been very high, particularly during extended hours.

However there have been key issues around ANP recruitment and other nursing staff (community and district nurses) (see section 6), which have been exacerbated by the short-term nature of contracts. Pilots have also found it necessary to ensure the right balance between giving nurses sufficient additional hours to make the change in shifts worth their while, but also not overburdening them. **Slough** found it important to spread the extended hours load across the workforce, but also give nursing staff regular shifts to make it easier for them to manage. There have also been technological challenges, particularly for nurses working outside of practices. In Herefordshire, EMIS restrictions meant that the link nurse was unable to input directly to primary care records, meaning the project had to be flexed accordingly.

Making more use of nursing staff, both in terms of extra capacity and also enhancing their roles, has been a popular wave one intervention.

Pharmacy



Various pharmacy models have been chosen, some more successful than others.

"Collaborating in this way has helped us to build strong relationships with GP practices; we work together to mutually help each other. PMCF has been really helpful in changing the nature of the relationships between pharmacy and GPs in practices."
DCIoS pharmacist

DCIoS piloted a Pharmacy First scheme, originally launched in NEW Devon with services later extended to South Devon and Torbay. Local data suggests that this scheme saved nearly 3,000 GP appointments, over 1,000 OOH appointments and 150 A&E appointments over its first five months of operation, resulting in potential saving of nearly £165,000. Key to the success of this initiative has been the strong working relationships between GP practices and pharmacies, which for the most part preceded PMCF. A business case for the further integration of pharmacies and GP practices had previously been prepared and PMCF was used to further develop this. Local pharmacists have been fully supportive of the opportunity to further integrate with primary care and visited GP practices to build momentum and advertise the service. The pilot has found that the service is a particularly good access point for people in rural or remote communities.

"Absolutely invaluable service to our patients and us. Very useful also for temporary residents."
DCIoS

HRW introduced the use of clinical pharmacists to support primary care in the community in five of its practices. Most of the HRW practices have used the pharmacist for home visits to help ensure that patients are following their medication advice. Local data suggests that nearly 140 patients have benefited from this service; each receiving between four and five interventions. The success of the initiative has led to one practice identifying a second cohort of patients for pharmacist visits and the pilot suggests that 14 out of its 22 practices have expressed an interest in benefiting from this initiative in the future.

The experience of **Brighton and Hove's** pharmacy initiative has been more mixed. Part of its scheme has involved using independent pharmacists to work in three GP practices to treat common conditions and work with some patients with long term condition. This has shown to be a success, with local data showing that utilisation rates remain consistently high for these services (averaging between 80-100%) and patient feedback for these services is also good. However, the community pharmacy element of this work stream has been a significant challenge. Whilst there has been good buy-in from local pharmacists and good local satisfaction data from patients who have used the service, utilisation of appointments has been typically less than 5%.

Working with care homes

Recognising that older people are a key GP patient group, four pilots have undertaken targeted activity with nursing and care homes. In **Workington** a specific frail and elderly multi-disciplinary team has been established to improve care of people aged over 75 with a specialist care homes nurse to lead it. Local data suggests that in its first month in operation the team had seen over 85 patients and had saved over 100 GP visits.

Herefordshire also experimented with a range of work to enhance access to primary care within nursing homes in order to reduce pressures on GP time; it experienced mixed success. For example, it investigated using videolink technology to allow virtual access to GPs from residential homes but this was hampered by the limited on-site broadband capacity. More successfully, it implemented carer support packages to enable more confident identification of early signs of Ambulatory Care Sensitive conditions together with advice on instigating appropriate care to help prevent unnecessary hospital admissions. Local patient feedback has been 100% positive and more carers feel confident in testing for key conditions.

Voluntary sector / Community navigation

Marking another shift away from the traditional suite of services, six of the wave one pilots opted to partner with the voluntary sector in order to offer a wider package of patient support, often with the objective of reducing pressure on GP time.

Perhaps the best example of this is in **Brighton and Hove** which has been working collaboratively with Age UK and a local charity, recruiting 18 'community navigators' to work with patients with complex needs (usually low-level mental health conditions or older people who suffer from social isolation) to signpost them to third sector resources as necessary. Working with the voluntary sector has brought with it some challenges. There were issues around using the 'right language'; the time taken to recruit and train volunteers; and also ensuring the collection of appropriate monitoring data. Such challenges have been overcome through effective partnership working and through including the voluntary organisations on the programme board. At a GP level, the initiative has worked best where practices are inclusive, fully involving their volunteers and ensuring they are visible.

"I have never spoken to anyone about this. I love talking it through with you, this has been really useful"
Service user community navigation

"Why haven't we done this before? It's simple and I can see it really helps some of our patients"
GP

"I am feeling really valued and appreciated and the support given is fantastic"
Community Navigator

West Wakefield has undertaken in-practice activities to encourage patients to access wider self-care and community resources. It has trained 73 practice staff as Care Navigators so that they can provide guidance and support to patients as the first point of call. This has been complemented by the launch of the West Wakefield Health and Wellbeing website, which provides a directory of services to allow patients to manage their care more independently as well as in-practice self-service kiosks at two practices to improve accessibility to the information. Local data suggests that up to 400 GP appointments were saved per month.

A&E

Aware of both national and local agendas to reduce pressure in the A&E system, some pilots have experimented with closer working with A&E providers. Both **BHR** and **Darlington** linked with their local A&Es so that patients can be referred into extended hours slots.

Herefordshire attempted to place an emergency care doctor into the A&E waiting room to investigate the referral process from A&E into primary care. The eventual aim was to facilitate access to EMIS via an EMIS electronic patient record (EPR) viewer and train A&E staff to book patients directly into PMCF seven-day service appointments. However these projects have been slow to deliver with technical issues inhibiting interoperability. There is a resistance to having the EPR viewer installed in the A&E department (particularly because they could not book directly into the Hubs) and a lack of understanding of the Hub service offer. A&E staff made it clear that they intended to continue directing patients requiring primary care towards the OOH provider. Whilst interoperability issues have now been resolved the considerable delays have reduced the effectiveness of this intervention.

Targeted clinical specialists

Two other pilots are worth mentioning due to the local impact that they are having.

South Kent

In South Kent, they have deployed paramedic practitioners to work seven days a week (10am – 7pm) providing home visits and who are specially trained to provide primary care and dispense certain medications (such as emergency antibiotics). GPs refer cases to the service and the paramedic reports back with details of any treatment and medication given. Local data estimates that in a three month period (November 2014 and January 2015) the paramedic practitioner service saved around 720 GP appointments at the Folkestone hub alone[28] This pilot has also appointed two mental health specialists (one full time, one part time) based at its Folkestone hub five days a week so that a GP can make an immediate referral to this specialist rather than needing to escalate the case to mental health services. Feedback from patients, practitioners and especially GPs suggests that both the paramedic practitioner and mental health specialist have been very well received and have reduced pressure in the practices.

West Wakefield

West Wakefield introduced a scheme involving direct referrals to a physiotherapist, via their trained Care Navigators, rather than patients being required to see a GP first. The pilot is confident its PhysioFirst, which was designed to save GP time and provide patients with quicker access to the service they needed, has achieved its objectives. Local evaluation data suggest that it has saved nearly 100 hours of GP time since the start of the project. Although West Wakefield has noted that perhaps the service has not reached its full potential, this could be achieved through more advertisement of PhysioFirst as well as awareness-raising with Care Navigators so they can better signpost this service. Feedback from patients[29] has been positive, with all those who responded saying they are extremely likely or likely to recommend the service to a friend or a family member.

28 Data for Dover has not been analysed at the time of writing this report. In Dover the paramedic practitioner service is expected to address a formerly unmet need, and therefore the data will not directly translate into GP hours saved.
29 Collected using the Family & Friends survey.

Mott MacDonald

4 SECTION FOUR: Wider learnings and lines of enquiry

As well as exploring progress against the three national programme objectives, the evaluation has also taken some additional lines of enquiry to identify the wider impacts and outcomes of the Challenge Fund. The main findings are presented in this chapter.

Across the programme as a whole, PMCF has been successful in initiating a culture change amongst the primary care community.

Stimulating transformational and sustainable change

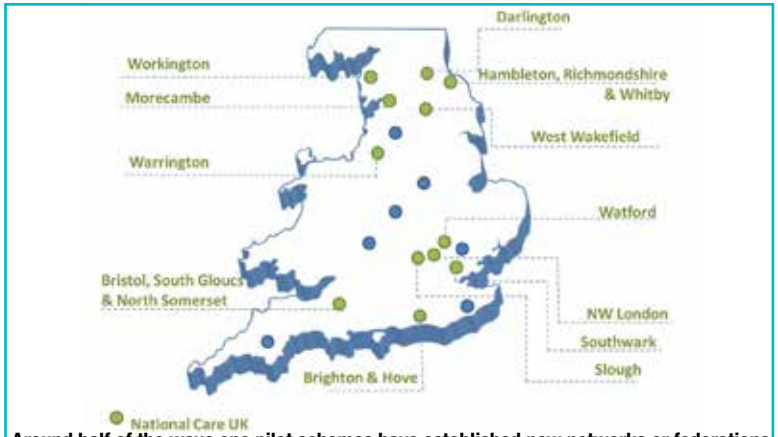
Service delivery is transforming

In some pilot locations there was already evidence of GPs collaborating in order to deliver greater access or an enhanced service to patients. For example, federations or networks were already present in **BHR, Bury, Herefordshire, Warrington, Southwark** and some of the CCGs in **NWL**. For all of the participating localities the Challenge Fund has had a catalytic effect. It has provided the cause, confidence, resource and created some 'headspace' to encourage practices to move away from operating as independent small businesses and, instead, work collectively. Even in locations where there had been prior progress towards collaborative delivery, PMCF has boosted momentum and helped to mobilise federated working. Across the programme as a whole this marks a significant departure, not least because of the short amount of time that this has been achieved in.

"One Care is the most exciting and engaging thing that practices have been involved in across the whole of the NHS locally for the last few years. It's because we have the opportunity to drive and lead the programme."
Practice Manager, Bristol and partners

This change in ways of working has been characterised in several ways. Most common has been the development of new networks, federations and legal entities. For example federations are now present in **Bristol, Darlington, Workington** and **West Wakefield** as a result of PMCF involvement, whilst **Brighton and Hove, Care UK** and **Slough** established new practice networks to deliver their programmes. For those pilot areas with federations already in place, they have used PMCF to build on their existing working relationships and move forward into service delivery. PMCF, through providing the investment to help localities move forward with innovative primary care plans, has helped to highlight that practices cannot provide extended hours, or many other initiatives, by working on their own.

As a result even the biggest pilot, NWL, has achieved full coverage in terms of structural, organisational change; it has tangible networks in each of its eight CCG areas, which is a considerable achievement given that it covers nearly 400 practices which serve around 2 million patients. For West Wakefield and Birmingham PMCF has helped create a platform for securing Vanguard status.



Around half of the wave one pilot schemes have established new networks or federations

A commitment has grown to working together in order to provide additional hours, capacity, flexibility and economies of scale.

The formal establishment of federations and networks over the last year in many pilot areas has set up a legacy of PMCF. Networks and federations are becoming a 'cog' in the system and the network approach or hub and spoke system are generally seen to work as delivery models. Some federations and alliances are also looking to expand their portfolios through further integration with other services and bidding for other community contracts.

At the same time as collaborating with each other, a shift in working behaviours has also been evidenced by the widespread introduction of new modes of contact as well as considerable ambitious cross-system collaboration plans to deliver services in a more innovative way and reduce pressures on GP time (see Section Two above for more details on these different initiatives).

Some wave one pilots have also pointed to specific interventions which they feel will be self-sustaining, rather than needing any significant future investment. These include **Brighton and Hove's** redirection of workflow initiative; the urgent care model and Pharmacy First in **DCIoS**; and patient self-help groups in **Slough**. These will be further explored with the pilots over the next few months.

"Delivering PMCF weekend access has brought us together as practices and had made the Federation 'real' for the first time"
GP, DCIoSs

Shifting trends and behaviours has required dedicated effort by pilot teams to ensure that buy-in has been maintained.

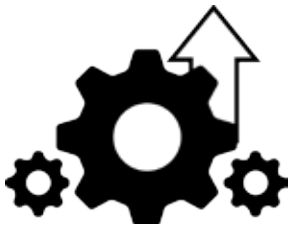
Shifts in working culture take time

Whilst the Challenge Fund has certainly helped to initiate transformational and sustainable change, this has not necessarily been easy to achieve as reflected in the staff survey which indicated that less than 50% of respondents consider that there has been a positive impact towards achieving a culture change amongst staff involved in the delivery of general practice. Moving towards cluster-based delivery, with services offered from new hubs or non-traditional settings represents a significant change for the many GPs that have never collaborated or provided joint services before. As such, there have been some challenges along the way.

Achieving wholesale culture change, and the associated impacts and outcomes, cannot be expected in a short implementation period.

Certain elements of some pilot programmes still face resistance and there is still not universal buy-in to the principle of 8am – 8pm seven days a week access. Some practices have struggled to move away from an independent mind-set whilst a couple of pilots have reported concern from GPs that 'competing' services are being established. In **BHR**, for example, there has been some anxiety around the potential of the Health1000[30] complex care initiative to affect practice lists. These issues have affected buy-in and in some places have stalled the progress towards a new working culture.

To build continued buy-in from GPs there has been a need to proceed with caution rather than rush forward with initiatives. **Bury, Herefordshire** and other pilots report that it has taken time to build GP confidence about the safety and reliability of the new extended hours services. It is important to accommodate this time in project implementation plans. Given this context, one year is considered insufficient to fully instil (or measure) permanent behaviour and mind-set change amongst both patients and GPs, especially given the process barriers that were faced in the first few months.



Looking ahead

Findings from the online staff survey undertaken to support the evaluation show that 41% of respondents consider that there has been either a very positive or positive impact towards establishing models which will be sustainable beyond the lifetime of the Challenge Fund. Some pilots have already made deliberate decisions to discontinue with projects that have been exhibiting low impact or lack of demand (e.g. **Darlington, HRW, Herefordshire** have scaled back their extended hours offer) to suit local demand.

The Challenge Fund was not established to launch permanent programmes in every pilot locality; it was acknowledged that some projects would be more successful than others. It will ultimately be down to the discretion of CCGs to continue with initiatives that have been shown to be locally popular and have demonstrated positive results.

Some pilots have highlighted that the relatively short implementation of the Challenge Fund programme has made it difficult to sufficiently demonstrate the impact of their projects; for some this has limited the ability to influence CCG commissioning decisions. This has emphasised the need for close working with the CCG throughout the implementation period. This is critical in terms of sustainability, as is alignment with other local strategies so the initiatives established through PMCF are embedded within wider transformation and future delivery models.

In **Bristol, North Somerset and South Gloucestershire** the One Care Consortium directly involves the CCGs in all three areas. The team considers it a positive sign that CCGs want to collaborate with One Care and a sign of recognition that this project is part of a new solution. CCG involvement has also meant that sustainability has been a consideration and on the agenda from the outset of the project.

In **Derbyshire and Nottinghamshire** PMCF coincided with the development of the Derbyshire & Nottinghamshire Strategy for Primary Care Transformation. The synergies between PMCF and the Strategy have given momentum to the pilot projects.

In **Slough** the PMCF project is embedded in the work of the CCG which has been particularly beneficial for governance and decision making. It has enabled there to be non-clinical challenge and managerial support and has been beneficial for the longer term strategy and direction of primary care.

In **Workington** the pilot has worked closely throughout with the CCG. The CCG has been happy to share the pilot's achievements and has encouraged the pilot to bid for additional work and other contracts to become more sustainable.

Where federations with established governance structures and staff are in place, there is considerable confidence that they will continue to exist beyond the lifetime of PMCF

30 Health1000 is an initiative set up to move patients with complex needs from a standard GP practice into an organisation specifically set up to manage this type of patient. It is located in the King George Hospital and staffed by several GPs (who are part-time in order to maintain their ability to do standard GP practice), a geriatrician, a nurse, an occupational therapist and a physiotherapist.

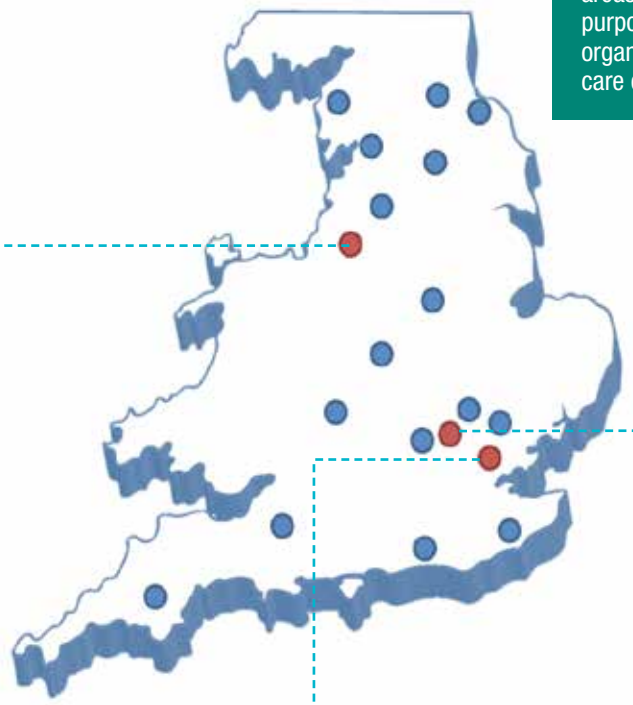
NWL, Southwark and Warrington have used PMCF resources to establish sustainable models for future delivery.

Building for sustainability from the outset

Three models deserve mention due to the deliberate ambition to use the Challenge Fund to create sustainable systems for the future of primary care delivery. These pilots saw PMCF as part of wider or more long-term transformational change rather than an opportunity to increase GP transactions or experiment with new access modes. Therefore they have purposefully used Challenge Fund investment to set up structures that will outlive the official lifetime of the pilot.

Across **NWL**, **Southwark** and **Warrington** there has been close cooperation with and buy-in from their respective CCGs as well as a strong foundation of previous joint-working.

Warrington
Warrington's pilot has been focused on sustainably transforming primary care. Its model is based on seven Primary Care Home (PCH) clusters which have been established through collaborative clinical leadership; relational working and whole system engagement; and actions to further integrate wider health and care services. Local commissioning intentions from the CCG and local authority have been aligned to the cluster model, supporting this as a sustainable model.



NWL
In **NWL** the Challenge Fund investment was used to advance the formation of networks and federations across the eight constituent CCGs as part of its Whole Systems Transformation Strategy. NWL CCGs have always seen networks and federations as new providers from which primary care services should be contracted from. Many of the CCGs have already contracted federations to deliver services – for example Brent CCG has commissioned the 4 GP networks to deliver extended access "hubs" services, whilst the five inner London CCGs have let a range of out of hospital service contracts (including extended access) to federations in their areas. This approach gives federations income and common purpose – and it is expected that this will help to maintain organisational form and collaborative approaches to primary care delivery, leading to long term change.

Southwark
Finally, in **Southwark**, the CCG has allocated funding for activity for three years, and is committed to the long term viability of the extended access and increased collaborative working. This up-front CCG commitment has enabled the pilot team to develop the pilot and its new networks without the immediate pressure of demonstrating impact.

Reducing demand elsewhere in the system

There has been a statistically significant reduction in minor self-presenting A&E attendances.

Wider system metrics for A&E minor attendances and emergency admissions have regularly been analysed. In addition to this, pilots were requested to submit out of hours contact data as part of their monthly data submissions.

A&E attendances

Up to May 2015, comparing the weeks that pilot schemes have been live with the same period in the previous year, at an overall programme level, there has been a statistically significant reduction in minor self-presenting A&E attendances[31] by those patients registered to GP practices within Challenge Fund pilot schemes (see Figure 1).

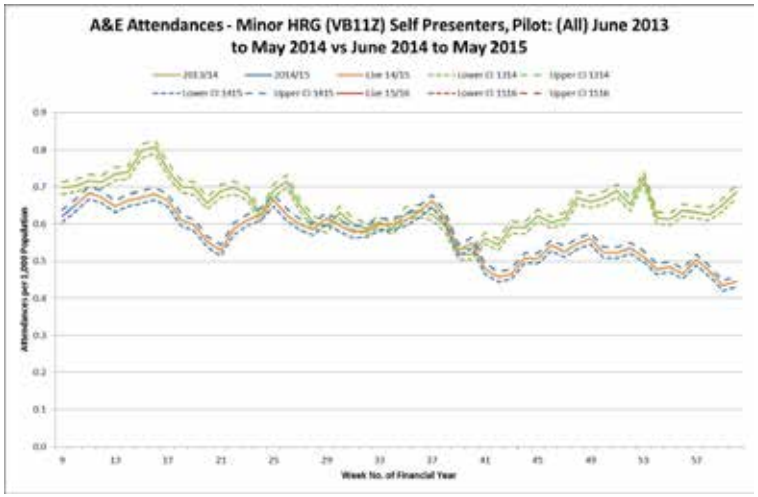


Figure 1: Profile of A&E Attendances 2014/15 versus 2013/14

Overall, this has translated into a reduction of 29,000 minor self- presenting A&E attendances equivalent to a reduction of 15% or 3.0 attendances per 1,000 registered patients[32]. In comparison, using the same data source, nationally there has been a reduction of 7% in minor self-presenting A&E attendances.

13 pilot schemes have shown a reduction in minor self-presenting A&E attendances with the most notable reductions experienced in **BHR, West Hertfordshire, North West London, Morecambe**, and **Brighton and Hove.** Seven pilot schemes have seen no reduction in minor self-presenting A&E attendances.

In terms of any defining characteristics between pilot schemes which may help explain why some pilot schemes have seen a reduction in the use of A&E departments, it is interesting to note that all four of the largest pilots achieved a positive impact compared with around 50% of both the small and medium size schemes. Identifying the key factors for this will be an area of further work over the coming months.

Of the 20 pilot schemes, 13 have shown a statistical reduction in minor self-presenting A&E attendances.

Emergency admissions

Similar analysis as that above in relation to the change in emergency admissions to hospital has shown that up to May 2015, the overall programme rate of emergency admissions per population during the live weeks in 2014/15 has been greater than the profile of emergency admissions during the same period in 2013/14 (see Figure 2).

Only five pilot schemes have seen a reduction in emergency admissions during the same time in the preceding year; ranging from a reduction of 1% to over 7%. These pilot schemes are Southwark, Bury, Darlington, Brighton and Hove and Care UK. Most of these pilot schemes are medium sized schemes[33].

Only five pilot schemes have shown a marginal reduction in emergency admissions compared to the same time in the preceding year

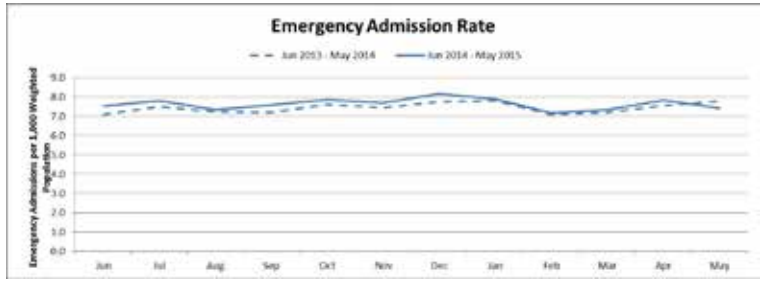


Figure 2: Profile of emergency admissions Between June 2013 and May 2014 compared with June 2014 and May 2015

31 These have been defined using HRG code VB11Z. Note also that data for 2015/16 may be subject to amendment through the financial year
32 Note the issue of attribution detailed in the Assumptions and Limitations in Section Two.
33 as above

Over 40% of respondents to the online staff survey considered that their Challenge Fund pilot was having either a very positive or positive impact for A&E and out of hours service but only 33% of respondents considered that there was a similar impact with regard to NHS 111 services. There is a correlation between the A&E data analysis and those pilots where the staff response has been more positive to the wider system impacts.

Out of hours contacts

Contact data to support an assessment of the change in the Challenge Fund pilot schemes on local out of hours services has proved difficult to access for some pilot schemes. To date, data related to 15 out of the 20 pilot schemes has been assessed.

Assessing the overall trend in the number of contacts per 1,000 registered patients shows that there has been no discernible change in the use of this service and that the monthly profile is quite variable. This pattern is also evidenced within the majority of individual pilot schemes, with one or two exceptions e.g. Slough.

This may be a product of latent demand and the balance between urgent and bookable appointments being offered during extended working hours by the pilots.

Findings from local data

Some pilots have undertaken local surveys with patients attending their extended hours services. Whilst findings from these surveys vary, some have shown that if the service had not been available, more than 50% of patients would have waited to see their own GP. The next largest proportion stated that they would have attended their local walk-in centre, urgent care centre or contacted their GP out of hours service. Only a small proportion of patients stated that they would have attended their local A&E department[34]. However, this evidence is not conclusive and one pilot (**BHR**) has reported that between 60-70% of patients using their hubs would have attended A&E if they had not been able to get an appointment at one of the hubs.

Data Caveats

It is still quite early to be definitive about impacts and for many pilot schemes an impact on the wider system was not set as a primary objective. It would therefore be misleading to interpret those findings of less change as a failure of the pilot schemes.

34 These findings are reasonably consistent with the national findings of the GP Patient Survey.

"Critical to the success of any programme or project is effective knowledge management - how you gather, create, organise, share, analyse and action knowledge"[35]

NHS IQ

Facilitating learning to better enable pilots to implement change

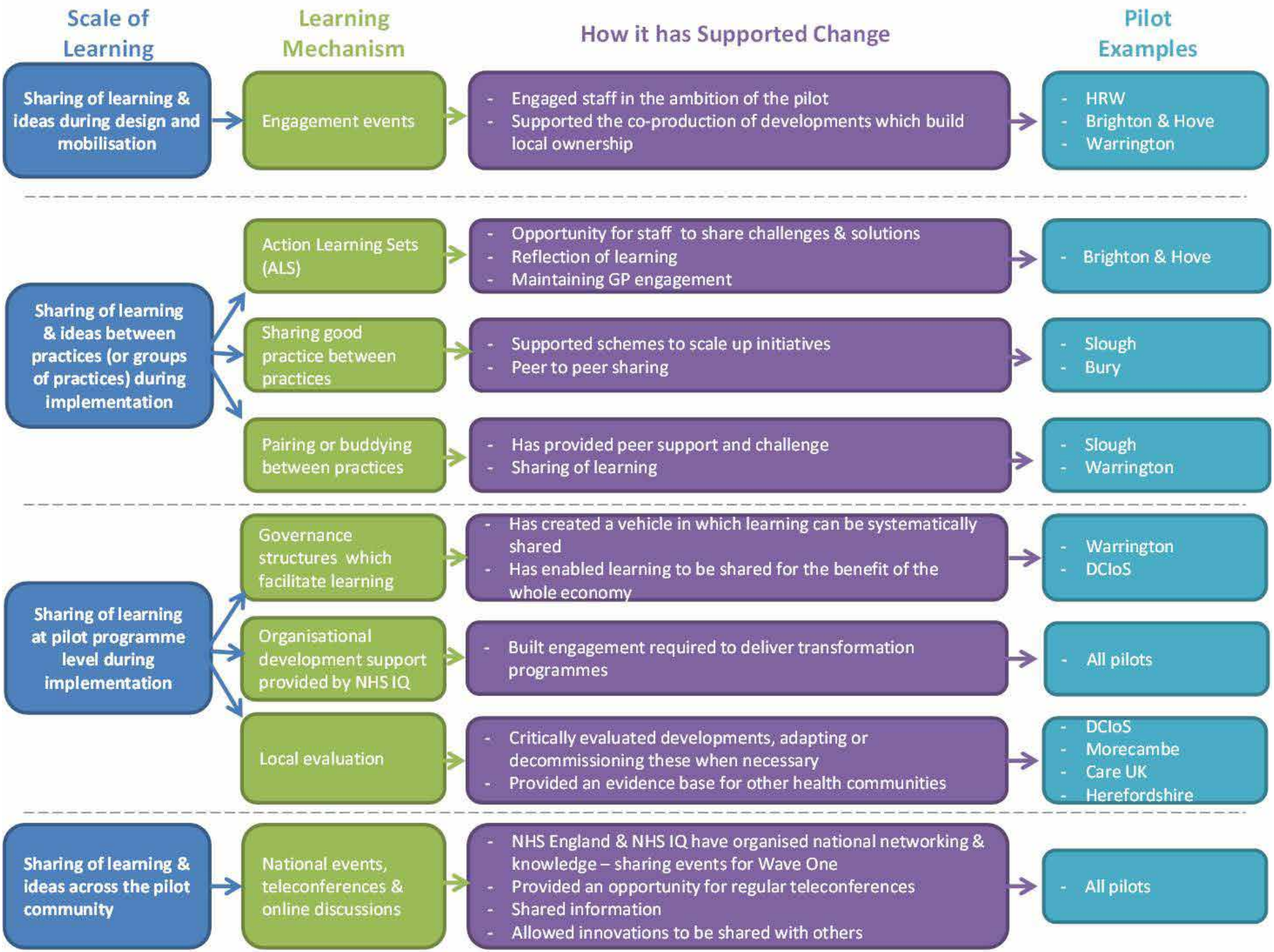
Sharing knowledge has been important at different stages throughout the lifecycle of the pilot schemes:

- **Initiation and mobilisation:** for many pilots there was a strong focus on the internal sharing of knowledge and ideas as they designed their programmes. This often included a wide range of primary care professionals including, clinical leads and GPs, practice staff, as well as input from local commissioners and providers.
- **Implementation:** throughout the delivery phase, several pilots established mechanisms to continue the process of learning between practices. In addition, some pilots have been participating in more external facing activities such as liaising with other pilot areas or third parties, as well as utilising the experience and expertise of NHS IQ.
- **Sustainability planning:** the focus in later stages of delivery has been on working with commissioners and undertaking local evaluations to understand the lessons from implementation.

There are many examples of pilot schemes sharing knowledge and learning between their own member practices and local PMCF programme partners. However whilst pilot schemes have been committed to sharing this knowledge internally, evidence of pilots sharing beyond their immediate health economy, are more limited. This may be because pilots are hesitant to share until they understand their local learning.

In addition to this, mechanisms have been established by the national programme and NHSIQ, which have supported exchange of knowledge and ideas and these are generally welcomed by the pilots. Every pilot engaged in this innovation support programme. NHS England recognised the need to share learning between wave one and wave two schemes and established a funded buddying programme to help facilitate this. The intention of this scheme is for self-nominated wave one schemes to share their experiences of challenges faced and learnings from progress to date. Pairings have been made either by geographical location or by matching of themes. Additionally, wave one representatives have led table sessions at national wave two events to encourage a culture of sharing learning. The programme offers to cover backfill costs and travel expenses for the wave one colleagues who are participating in this.

35 http://www.nhsiq.nhs.uk/capacity-capability/knowledge-and-intelligence.aspx


Scale of Learning
Learning Mechanism
How it has Supported Change
Pilot Examples
Sharing of learning & ideas during design and mobilisation
Engagement events
- Engaged staff in the ambition of the pilot
- Supported the co-production of developments which build local ownership
- HRW
- Brighton & Hove
- Warrington
Sharing of learning & ideas between practices (or groups of practices) during implementation
Action Learning Sets (ALS)
- Opportunity for staff to share challenges & solutions
- Reflection of learning
- Maintaining GP engagement
- Brighton & Hove
Sharing good practice between practices
- Supported schemes to scale up initiatives
- Peer to peer sharing
- Slough
- Bury
Pairing or buddying between practices
- Has provided peer support and challenge
- Sharing of learning
- Slough
- Warrington
Sharing of learning at pilot programme level during implementation
Governance structures which facilitate learning
- Has created a vehicle in which learning can be systematically shared
- Has enabled learning to be shared for the benefit of the whole economy
- Warrington
- DCIoS
Organisational development support provided by NHS IQ
- Built engagement required to deliver transformation programmes
- All pilots
Local evaluation
- Critically evaluated developments, adapting or decommissioning these when necessary
- Provided an evidence base for other health communities
- DCIoS
- Morecambe
- Care UK
- Herefordshire
Sharing of learning & ideas across the pilot community
National events, teleconferences & online discussions
- NHS England & NHS IQ have organised national networking & knowledge – sharing events for Wave One
- Provided an opportunity for regular teleconferences
- Shared information
- Allowed innovations to be shared with others
- All pilots

Tackling health inequalities in the local health economy

Health inequalities can be defined as differences in health status or in the distribution of health determinants between different population groups. Several of the pilot schemes have used the opportunity presented by the Challenge Fund to target projects at geographical areas or population groups where there are known health disparities. This page features some examples:

Morecambe
In **Morecambe,** a minor ailments scheme is increasing access for patients from certain vulnerable groups (such as those who may be socio-economically deprived) to medications which they might otherwise have to source via a prescription from the GP. As well as ensuring that GP appointments are used appropriately, this initiative is supporting this patient cohort to seek medication earlier, before their condition potentially exacerbates.

Warrington
In **Warrington,** as well as seeking to create equitable provision of primary care and access across all GP providers, paediatric ambulatory care and integrated services including social care are being prioritised in electoral wards of greatest economic deprivation

West Wakefield
In **West Wakefield,** the 'HealthPod', a mobile health and social care outreach service has been established for deprived and hard to reach communities. The HealthPod provides health promotion advice, blood pressure tests and access to the Citizens Advice Bureau. As a mobile facility it can be moved to different locations to target the most remote communities. The pilot has reported that this service has managed to reach vulnerable communities such as Gypsy-Roma populations who would have otherwise struggled to access primary care.

Children and young people

Slough has established a programme of health education with children in ten primary schools and the pilot is working with the local authority to develop this project further.

In **Herefordshire**, young people have been targeted via GP outreach interventions into education providers and a community facing app targeted to this audience. Anecdotally, this project is reported to have been successful with both young people and with schools/ colleges.

In **NEW Devon,** a children's walk in clinic has been introduced at a practice situated in an urban deprived area. Staffed by a triage practitioner nurse, its opening hours allowed parents to attend after school. The pilot reports that this has improved speed of access for this patient cohort and has offered a more effective approach than telephone assessment.

Other pilot schemes, whilst not addressing health inequalities explicitly, have used Challenge Fund investment to target specific patient groups which are known to be existing high users of primary care services or patient groups who are less engaged with general practice. Some examples are provided below and further detail is provided in the individual pilot reports.

The impact of these developments is yet to be proven and given that they are very area-specific or discrete in their coverage, there is little collective learning that can be disseminated at this stage. More work will be done with these pilots over the next few months to gather evidence on these initiatives.

Older people and those with long term conditions

Darlington, the frail elderly population have been targeted through proactive management to assessments and care planning, undertaken by a new MDT support team.

Within T**orbay and South Devon**, a Proactive Care Team (PACT) has been established which is a multi-agency initiative. This MDT team provides proactive, preventative support to patients identified as being at risk of admission to hospital, and is improving discharge planning for patients in community and acute hospitals to enhance patient flow.

In **Workington**, there has been a focus to standardise care for patients with certain long term conditions. This is being achieved through the recruitment of specialist nurses and the implementation of the 'Year of Care' approach.

Identifying models that can be replicated in similar health economies elsewhere

Replicating hub and spoke models

The main model which has been highlighted as having the potential to be replicable across different health economies is in providing extended hours appointments through a number of designated hubs, rather than at all practices. Whilst there is variation in the detail, common features of an effective hub and spoke model include:

- Patients from all member practices can access extended hours appointments and wider services from the hub.
- GPs providing the service have read and write access to patient records.
- Phone systems may also be diverted during extended hours to promote use.
- Modelling has been an important feature in determining the capacity and location of hubs.

Deriving maximum benefit and value from the Challenge Fund is reliant on the transferability of learning and effective service models to other local health economies.

Replicable interventions

Some are already rolling out initiatives beyond the pilot scheme boundary. For example, in **Morecambe**, conversations are underway with the CCG about the replication of their 8am - 8pm '828' GP telephone triage service across the CCG footprint. In addition, both Morecambe and Workington have been trialling local responses to the NWAS (North West Ambulance Service) Pathfinder Scheme which aims to deflect patients away from A&E by providing support and access to the patients care record to paramedics. This learning is being applied to other areas applying the Pathfinder across Cumbria and Lancashire.

Other pilots have highlighted initiatives which have the potential to be replicated across different health economies. For example:

The hub and spoke delivery model is regarded as a replicable model

- GP group consultations where a GP will typically see 15 patients with similar needs together i.e. diabetes patients. This approach has been implemented in **Slough**.
- Multi-disciplinary primary or community nursing teams based around groups or clusters of GP practices. Teams are targeted to specific patient cohorts or nursing homes and focus on delivering proactive care. This is being implemented in **DCIoS** and **Warrington**.
- The proactive management of complex patients through multi-disciplinary assessments and care plans. This is being implemented in **Morecambe** and **Warrington**.
- Educational support sessions which are group sessions focused on certain long term conditions such as diabetes. This has been implemented in the EPiC pilot in **Brighton and Hove**.
- The implementation of a Community Specialist Paramedic who reviews patients in A&E to determine whether they could have been more appropriately treated in Primary Care Centre. This has been implemented in **Workington**.

Detailed evaluation of the replicability of these initiatives and those models which are indicating success will be undertaken over the next three months, although pilot schemes themselves are already reflecting on this.

Conditions for success

Whilst detailed evaluation of the potential for replicability will continue to be undertaken as pilot schemes further develop, it is already apparent that for transferability to be achieved effectively, there are a number of contextual factors which must be carefully assessed by organisations looking to replicate others' service models locally. Early findings suggest these include:

The geographic profile and transport infrastructure of a locality is important in terms of the replicability of the model. In some areas, the use of hubs to provide extended access appointments may not be suitable if patients are required to travel long distances to access these sites. **DCIoS** found this to be an issue. Similarly infrastructure such as broadband connectivity is not of the same standard across the country and this needs to be reflected upon when seeking to copy across schemes which rely on mobile working.

Local ownership is essential. Models need to be tailored to local context and pathways through stakeholder input and from design through to implementation. Key stakeholders will include patients and GP practice staff, as well as commissioners and other providers in the local health and care system.

Pilot schemes have commented that they consider models would be replicable in "similar sized" health economies although some have also commented that they consider these to be 'scalable' with the appropriate programme management support. For example some have indicated that a sufficient critical mass is required to sustain extended hours service model. A scale which is able to justify the affordability of roles such as extended hours operations managers is required.

The relationships and culture between system partners is also likely to impact the ability of areas to replicate successful models. Commissioner involvement has also been an important feature of the pilots in **West Wakefield, Bristol, NWL, Warrington** and other pilots. In many pilots, PMCF developments have built on a long history of collaboration and engagement and this may be an important prerequisite in successfully replicating one of the Challenge Fund service models.

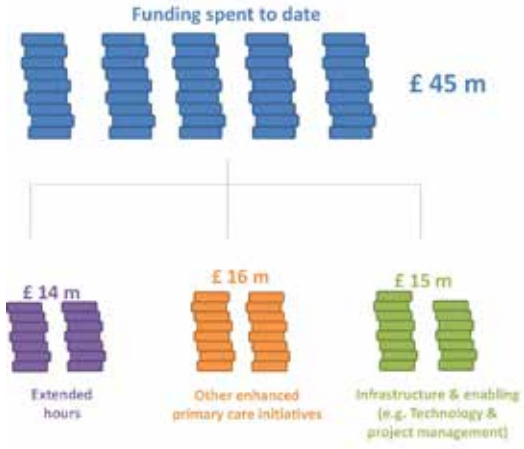
5 SECTION FIVE: Financial evaluation

Demonstrating value for money and a return on investment is a key requisite for the sustainability of any new initiative.

Overall, pilot schemes have indicated that they have spent a total of £45 million up to the end of March 2015 as part of their original Challenge Fund and matched funding. Beyond this, pilot schemes have identified a further £3.7 million funding as part of their ongoing sustainability for a further 6 months. Of the original funds spent to date, almost £14 million (31%) has been identified as funding for extended access schemes (£10 million on staffing costs and £4 million on non-staff costs including, for some pilots, one-off technology costs) with a further £16 million (36%) used to support other clinical initiatives being implemented by the pilot schemes. The remaining £15 million (33%) has been used to support infrastructure and enabling activities such as technology developments and programme management.

Extended access

As set out in Objective 1, extrapolating the metric data to include all pilot schemes, then potentially an additional 70,000 hours and 400,000 appointments had been provided through extended access hours up to May 2015. If we assumed that the additional estimated extended hours across all pilot schemes up to March 2015 were funded through the Challenge Fund monies spent on extended access up to the end of March 2015, then the average cost per extended hour is £233 and the cost per available appointment is £43.



However, given the limitations with some of the activity metric data, in terms of refining the assessment on the value for money of extended access services, the analysis can only be properly conducted using a subset of the pilot schemes. Further caveats to this assessment also centre on the need for further clarity from some pilot schemes of the extent to which funds up to the end of March 2015 were all spent or whether some of this original funding has been vired and used in combination with the further funding for sustainability post March 2015.

Analysing schemes with complete and clear data, the cost per additional hour to support extended hours working within a hub and spoke model is typically in the range of £200 - £280 of which the hourly cost of the GP may represent 50% or more of this. The remainder of the cost is accounted for by other staff, overheads and other supporting activity costs, including premises and technology. It is important to note that depending on how pilot schemes have recorded their metric data some of the cost per hour of 'Other' staff may include GP staff time. The average cost per available appointment in extended hours is typically in the range of £30 to £50.

On the assumption that this analysis provides a reasonable estimate then, even given that this work is undertaken during unsocial hours, the cost per hour and appointment to support extended access is more expensive compared with the average GP hourly rate[36] but not out of line with the cost of locum GPs. This is likely to be expected for a pilot scheme with economies of scale, such as permanent contracts, only making an impact over a longer time period. The value for money is further negatively influenced when utilisation of the extended access service is factored in. A number of respondents to the staff survey have drawn a similar conclusion and questioned the cost effectiveness and value for money of extended hours access; particularly at the weekend, most notably Sundays.

In comparison with Out of Hours[37] the cost per additional appointment used during extended hours is less expensive.

36 Based on average GP salary cost only. This assumes an average salary of £92,900 and is taken from GP Earnings and Expenses 2012/13, Health and Social Care Information Centre, September 2014. A 46 week working year and a 40 hour working week are also assumed.

37 Out of hours GP services in England, National Audit Office, September 2014.

In **Brighton & Hove** introducing more telephone contacts resulted in an average monthly increase in hours and appointments during core working hours of 8% and 17% respectively.

In **Birmingham**. The mode of contact by telephone during core working hours has changed from 38% in the baseline to around 50%.

NWL, Southwark and **Warrrington** have used PMCF resources to establish sustainable models for future delivery

However, there is variation across the pilot schemes and more work is required to tease out the subtleties of individual pilot scheme data returns to ensure that we can match more closely the profile of financial spend with the metric analysis. This will then provide a more accurate assessment of the cost effectiveness of providing extended access services.

New modes of contact

As a product of some of the other supporting activities being implemented and, in particular, the introduction of new modes of contacts and new staff practitioner types, pilot schemes have been successful in reducing the length of the appointment time. In particular, many pilot schemes have been piloting advanced nursing and other clinical support staff appointments, and telephone and online consultations. At an overall level, the number of available appointments per core working hour has increased by 6% and during extended working hours by 33% .

In relation to alternative staff practitioners to free up GP staff time which the Challenge Fund initiative has supported includes:

- **Bristol, North Somerset and South Gloucestershire** pilot scheme which up to March 2015 has invested £477,000 in its channel shift initiative to divert work from GPs to appropriately qualified clinical staff such as nurses and allied health professionals. Fifty per cent of available hours are supported by these staff who have provided around 460,000 available contacts between August 2014 and March 2015.
- **Brighton & Hove** pilot scheme where the investment of £43,000 to date has supported an additional 1,500 hours of pharmacist time; an average cost per hour of £29.
- Social prescribing at the **West Wakefield** pilot scheme. Since going live, this scheme has provided almost 3,600 additional hours at the end of March 2015. This scheme provides health and social care advice and is designed as an outreach service for deprived and hard to reach communities. The cost of this initiative has been almost £80,000, an average cost of £22 per hour.
- **South Kent Coast** pilot scheme's investment of £135,000 in paramedic practitioners and releasing GP time.

Typically, the use of these alternative clinical practitioners to support primary care services cost less than the cost of the GP's time; typically 50% of an average GP salary. Hence, on the assumption that these clinical practitioners are providing a direct substitution of services which would have traditionally been provided by a GP and are achieving similar outcomes, then this represents a significant cost saving.

In relation to new modes of patient contacts, a number of pilot schemes have implemented telephone triage and consultation and online appointment services. These telephone appointments typically are half the length of face to face consultations and hence for every face to face consultation a GP could have undertaken two telephone consultations. This has therefore helped to support the growing demand for access to primary care services; either unmet need or latent demand. However, it is acknowledged that some consultations cannot be dealt with entirely over the phone. In terms of assessing the return on investment in the telephony systems being implemented by pilot schemes, it is possible to assess the extra patient consultations being offered or used by telephone which, if not available, would have required a face to face appointment, and hence a saving in GP time[38] against the investment in technology being made.

Examples of these include:

Pilot	Investment in Technology	Additional Telephone Appointments	Return on Investment
Brighton & Hove (telephone based triage)	£186,000	More than 77,000 additional used telephone appointments	Assuming a saving of 6,400 hours of GP face to face time with patients to date, this has achieved an opportunity cost saving of £324,000. This has more than offset the cost of the investment in new technology
Herefordshire	£48,000	23,000 additional telephone appointments have been provided to patients during core working hours	Assuming a saving of 1,900 hours of GP face to face time with patients to date, this has achieved an opportunity cost saving of £97,000; more than offsetting its investment in new technology
Birmingham	£222,000[39]	26,000 core hour telephone appointments have been made available	Assuming a saving of 13,000 face-to-face consultations, the saving in GP time to date is £108,000. Running this scheme for a further 7 months would result in a positive return on investment
Morecambe (telephone based triage)	£30,000	10,600 telephone appointments available during extended working hours	Assuming a saving of 880 hours of GP face to face time with patients to date, this has achieved an opportunity cost saving of £45,000; again more than offsetting its investment

38 Based on average GP salary cost only. This assumes an average salary of £92,900 and is taken from GP Earnings and Expenses 2012/13, Health and Social Care Information Centre, September 2014. A 46 week working year and a 40 working week are also assumed.
39 This represents a total spend in technology and may overstate the expenditure in telephony infrastructure.

This is an encouraging outcome to date.

Further work is required to understand the impact of these new ways of consulting, including issues of continuity, equality and supply induced utilisation.

Impact on the wider system

As was highlighted in Objective 2, across all pilot schemes a reduction of 29,500 minor self-presenting A&E attendances had been observed up to the end of May 2015. Notwithstanding the complexity of attributing cause and effect between the Challenge Fund Programme and the reduction in A&E attendances, it nonetheless represents an impact on A&E Departments both in terms of staffing and financial resources.

Focussing on those 13 pilot schemes with a reduction in minor A&E attendances observed during the time that each pilot scheme has gone live with implementing its initiatives compared with the same time period in the previous year, the overall reduction is 34,000 attendances. Assuming that these levels of reduction continue to be observed within each of these pilot schemes, then extrapolation for a full financial year would yield an overall reduction in minor A&E attendances of 56,000. In terms of financial savings, this would generate a reduction in expenditure for commissioners of £3.2 million. This saving would, of course, need to be offset against the investment in primary care. Whilst further work and data points are needed to justify this estimate and understand better the key factors influencing the effectiveness of different models of care on the use of A&E services, for simple illustrative purposes only at this stage, if this change was seen at a national level then the savings could be between £17 million to £24 million. As above, savings would be offset against the investment in primary care.

For emergency admissions and out of hours, to date there has been no observed change at a programme level. For the former, this may not be entirely unexpected.

SECTION SIX: What has enabled innovation and change? 6

Pilots have highlighted some key conditions for success that have enabled them to introduce innovation and change. There has been considerable consensus around the factors which have been instrumental to their achievements. Other local health economies seeking to introduce collaborative working would do well to consider these enablers as they design and implement their own primary care programmes.

Pre-existing relationships

The importance of building on existing relationships has been stressed by many of the pilots; these relationships provide a useful platform from which to build more formalised collaborative working.

For example, **Brighton and Hove,** the pilot is managed by the Brighton and Hove Integrated Care Service (BICS), a pre-existing organisation with experience in delivering primary care. In addition, the networks formed as part of this pilot were determined by practices with a history of working collaboratively. In **West Wakefield,** the six GP practices have a track record of working together on their Health Care Integration Board, which has been in place for two years. This provided a strong platform for creating a federation of GPs that ultimately supported the pilot's delivery of extended access to primary care and supported its successful application to be a Vanguard site.

Effective leadership and project management have been central to successful implementation and managing risks.

Effective leadership and project management

The importance of specific individuals in developing buy-in and recognition has been key. Articulation of a clear vision allows buy-in at all levels. In terms of project management, making additional dedicated resource available and using the different skills in teams appropriately have been crucial elements.

A clear vision that allows for staff to understand and buy in to the goals of the change is important.

In both **Darlington and Watford** specific individuals leading the pilots were seen as pivotal in developing recognition and buy-in locally. **Morecambe** ensured that implementation was supported by a small project team with defined roles. As the project manager led on actions which did not require clinical input, decisions could be made in a timely manner and momentum was maintained. This allowed the service to be rapidly designed and implemented, with the 8am - 8pm service live from August 2014.

Remaining flexible to change

As is to be expected with a programme focused on piloting innovative primary care approaches there have been unanticipated challenges. In order to succeed, pilots have had to be responsive to emerging lessons, adapt to patterns of demand and supply, and overcome process delays. Demonstrating this flexibility has been essential in order to provide solutions which are aligned to the needs of the local health economy.

Where significant service changes have been deemed necessary to maximise the efficient use of resources, pilots have consulted with NHS England.

Morecambe: funding has been diverted away from the weekend X-Ray service (due to low patient demand) and app (as an appropriate app platform to meet the pilot's scope could not be found). Instead, this portion of funding has been used to fund the Community Deep Vein Thrombosis service, the minor ailments scheme, as well as additional investment for Florence, a self-management app for registered patients with long term conditions.

West Wakefield: whilst many GPs were positive about implementing video consultations, there were not enough resources locally for GPs to staff this. Responding to this challenge, the pilot is trialling the service with nurse consultations, making the most of available resources and utilising a multi-disciplinary model, rather than abandoning the initiative.

An enabler cited by many pilots is the importance of remaining open to change

Phased implementation

Phased implementation, whereby mobilisation is split up into more manageable stages and staggered over a stretch of weeks or months, has seen a number of benefits. These include the opportunity to share learning between each stage of implementation, increased efficiencies in later stages of implementation, the facility to adapt to the changing needs of the local pilot.

Consultation and engagement with member practices, both early on and throughout, has been critical in shaping pilots and developing buy-in.

In **Warrington,** for example, practices have had the flexibility to focus on projects which are most relevant to them and their local population. For example, the Central West cluster has focused care co-ordination on their elderly population and household population, whereas the paediatric ambulatory care project is being developed by the Central North cluster. Projects are designed and tested ahead of rolling out throughout the clusters more widely. This approach also allows for evaluation and learning to be embedded.

More than half of pilots anticipated change to their initial plans and subsequently chose to adopt a 'phased approach' to delivery

The phased approaches to implementation in **Brighton and Hove** and **Care UK** were intentional. The pilots considered that implementing extended access across all practices at once would have been too much of a risk. Care UK invested considerable effort in recording lessons learnt, logging conversations at the central hub and auditing each process for future reference. Whilst this effort was labour intensive at the start of the project, it enabled initiatives such as enhanced WebGP and interactive texting to be brought forward ahead of schedule. In Brighton and Hove's case, the phased approach meant that those practices going live later could learn from the lessons of the faster starters, increasing efficiency in their own implementation.

Engaging with practices

Engagement during mobilisation

Many pilots undertook extensive practice engagement at the start of their schemes. For very large pilots this was quite a challenge due to their coverage. In **NHS NWL**, the pilot's central transformation team visited each practice at the outset, to explain the aims and objectives of the PMCF and listen to questions and concerns. A dedicated project manager has been assigned to each CCG allowing relationships and buy-in to develop through a single point of contact. **Workington's** experience of early engagement to capture staff and patients' local knowledge to inform primary care projects benefited them. The pilot ran an event for all staff, both clinical and non-clinical, to outline the programme and staff suggested ideas for initiatives; it was a bottom-up development process. For **Southwark,** engagement with both clinical and non-clinical practice staff has been central to successful implementation; receptionists are particularly critical as they are often involved in booking patients into new appointment slots or services.

Ongoing engagement

Beyond initial implementation, some pilots put in considerable effort to maintain regular channels of communication between the project leadership and practice staff. **Warrington** and **Brighton and Hove** both circulate a newsletter. Brighton and Hove has also developed two 'action learning sets', with bi-monthly meetings to provide the opportunity for practice staff to share challenges and solutions. These sessions have allowed the programme to be more agile and responsive to concerns, injecting flexibility and also keeping GPs on board.

Engaging with patients

Patient engagement has been achieved in various ways across the pilots. Some pilots have focused on this more than others and it has been less of a consistent feature than practice engagement.

Slough has implemented a number of initiatives surrounding patient engagement and communication. The pilot has set up a Patient Representative Group (PRG) as part of pilot governance, which comprises patient representatives from across Slough's practices and is the primary channel to engage and communicate with patients. Slough has engaged the local authority and voluntary sector to help reach wider groups of people. This enabled views of those from wider age groups and those who are not part of the PRG, to be captured. In addition to this, two waves of patient surveys have been undertaken to capture real-time patient feedback (October and December 2014).The pilot also has a number of patient-led projects which involve patients and front-line staff in the co-design, such as:

- The 'Simple Words' project, which sets out to improve communications between GPs and patients.
- Self-help groups focused on peer support and self-management.
- Action learning groups which focus on patient representative experience and in developing personal leadership skills.
- A wellbeing programme involving voluntary patient navigators, supporting an online sign-posting portal to local sources of information and support.

Slough considers that successful patient engagement has helped to secure a high take up of the extended access appointments by securing patient buy-in and raising awareness of the pilot across Slough. Clinicians have also benefitted from learning about patient experiences of primary care and that this is leading to service improvements at practices.

Engaging with patients is an essential part of developing buy-in maximising utilisation and gathering feedback to inform ongoing improvement.

Brighton and Hove created a 'Citizen's Board' to gather patient and community viewpoints on programme development and implementation. The Citizen's Board holds the programme to account and has provided useful input around communication and how to tackle low utilisation issues. **Care UK** has put in place a number of channels to capture patient views (such as a complaints options on the Care UK website, paper comment slips in practices and text surveys to those who have used the extended hours service). The outputs of these feedback channels have informed delivery of the service, and supported business cases to amend delivery to better suit the needs of patients.

It is recognised that changing patient behaviours, however, does take time and this will not be achieved after a year of implementation.

Close working with the CCG

The involvement of commissioners in PMCF pilot working is essential for adopting sustainable and more dynamic primary care provision. Those pilots which have secured funding to maintain their initiatives beyond the lifetime of PMCF have cited working closely with their CCG as one of the key enablers.

In **Warrington** both the CCG and Local Authority Commissioners have a place on the CIC Board. Aligned to this, the cluster based model is reflected in the commissioning intentions of these organisations.

In **Bristol**, the current Consortium directly involves the CCGs in all three areas (Bristol, North Somerset and South Gloucestershire). The team considers it a good sign that CCGs want to collaborate with One Care and a sign of recognition that this project is part of the solution, not a new problem to overcome. Involvement of the CCG throughout the design and implementation phases of the project has meant that sustainability was a key consideration from the onset.

Alignment with and buy-in from CCGs as a key enabler to the success and progress of PMCF schemes

West Wakefield has stated that regular contact with the CCG fostered a strong working relationship and provided a forum to have open and constructive discussions about pilot design and delivery; this ultimately led to faster mobilisation when implementing schemes and better outcomes. The pilot went live with extended hours across all practices in November 2014.

A number of pilots (such as **Slough, NWL, Southwark and Derbyshire and Nottinghamshire)** have reported that close alignment between PMCF objectives and the wider CCG strategies have provided impetus for the delivery of the project. In the case of NWL, its PMCF model was designed to specifically align with existing initiatives taking place within the eight CCGs in the pilot area (Whole Systems Integrated Care and Shaping a Healthier Future). In Southwark, the alignment with its urgent care commissioning strategy and, particularly, the primary and community care strategy provided momentum and a context for championing improvements to GP and primary care as practices have seen this as part of a much wider context. Similarly Kernow CCG in **DCIoS** used its share of PMCF investment to support its wider objectives on urgent care and transformational change. This gave PMCF credibility and momentum early on and has also helped to ensure the legacy and sustainability of PMCF.

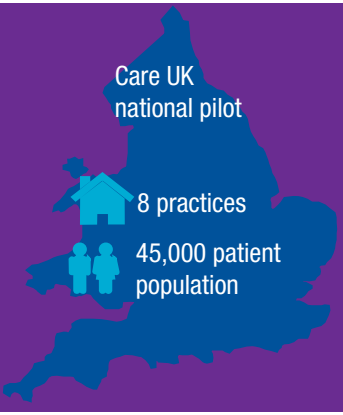
Use of existing resources and infrastructure

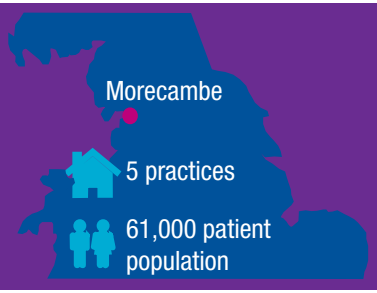
Using existing resources and infrastructure to deliver PMCF services has helped pilots to reduce the amount of time and investment needed to implement new services.

The most common use of existing resources is GP surgery locations to facilitate extended hours and additional interventions. Nine pilots are utilising GP surgeries to host PMCF initiatives. Other pilots are using hospitals, out of hours facilities and walk in centres.

It is not necessary to reinvent the wheel. Take opportunities to build on existing success.

Care UK
Care UK has utilised its existing NHS 111 central telephony infrastructure to offer clinical telephone treatment beyond 8am-8pm to registered patients. Many of the call handlers employed by the pilot already had prior experience of this type of offer through 111 and the pilot was able to use its existing 111 call centre location.





Morecambe
The **Morecambe** pilot implemented a community Deep Vein Thrombosis (DVT) service by utilising clinical expertise and availability of the existing same day service (SDS) team. PMCF funding was used to procure testing equipment needed to diagnose DVT. By utilising this existing resource the pilot has been able to provide patients with access to care in a more convenient location.

SECTION SEVEN: What barriers and challenges have been faced? 7

Pilots have experienced barriers in the implementation of their Challenge Fund initiatives. Again there has been considerable agreement over which issues have been most challenging.

GP capacity

There have been issues in terms of GPs lacking the capacity to deliver additional services and GPs being reluctant to deliver additional sessions outside of core hours. Two pilots reported both GP capacity and GP willingness to participate constraints; an additional eight pilots recorded GP reluctance to staff extended hours, with Friday evening and weekend appointments fairing the worst.

A number of pilots have experienced difficulties sourcing the GP capacity needed to deliver their PMCF services

Some pilots have sought to overcome these challenges by offering a financial incentive to deliver extended hours services. Both **Darlington** and **Morecambe** pilots offered financial incentives in the form of slightly higher rates of pay for weekend sessions; Morecambe also attempted to attract GPs by limiting appointments delivered at the weekend to patients from the GPs' own practices.

Some pilots cite that GPs simply do not have the capacity to deliver PMCF services. For example **Bristol and partners** reported difficulties implementing additional hours of GP time particularly at weekends, with GPs feeding back that they already work long hours. **Bury** has found resourcing GPs during weekday evening sessions to be a challenge. The pilot reports that this has been due to the inconvenience for GPs of having to travel to a different location to deliver the service after work and because many GPs have other commitments such as practice management, CCG meetings and professional development. It has sought to address this by offering financial incentives, contacting GPs working in neighbouring CCGs, and writing to local GPs who do not currently deliver extended working hours to promote the service.

The use of locum doctors to fill gaps in GP shortages has been recorded in six of the 20 pilots.

Recruitment

The challenge that many pilots have experienced around recruitment is linked to capacity issues.

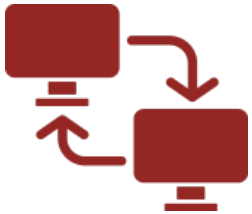
Warrington has found recruiting GPs to be a key challenge; as has **DCIoS,** which knew that filling GP posts was problematic prior to PMCF. Therefore, it developed projects which involved the use of other health practitioners (such as nurses and occupational therapists).

Perhaps even more than GPs, attracting nurses, particularly ANPs and other nursing staff has proved to be very challenging. A critical shortage of ANPs, limited timeframes within the lifetime of the pilots to train ANPs and temporary contracts have meant that several pilots (such as **Brighton and Hove, Care UK, Morecambe** and **Derbyshire and Nottinghamshire**) have struggled to recruit sufficient numbers. **Slough,** and other pilots have struggled to recruit other specialist nurses and healthcare assistants.

At least seven pilots cite difficulty in recruiting ANPs or specialist nurses

Nottingham North East CCG in the **Derbyshire and Nottinghamshire** pilot report that they were unable to fully implement their pilot due to limited ANP capacity to support their proposed hub. **Morecambe** also reported difficulty in employing nursing staff for its specialist cancer nursing team and as a result, had to decommission the initiative and divert funding into other areas.

The issue around short-term contracts associated with the pilot schemes are likely to have exacerbated the recruitment challenges experienced in delivering PMCF initiatives. Whilst this issue may affect wave two Challenge Fund schemes, it may not be as problematic if ANP use becomes commissioned as a long-term approach.



Configuring usable and reliable IT systems to support joint primary care initiatives and shared working arrangements has been one of the primary barriers facing pilots.

1 out of 20 pilots had practices using different IT systems

IT systems

As a result of the IT challenges NHS England has introduced a specific programme of support for wave two pilots.

Interoperability

There are numerous IT service providers that practices and other health providers can use to record appointments and patient records (EMIS Web, SystmOne, INPS Vision, Adastra and Microtest to name a few). Creating a solution that allows IT interoperability across these varying systems, so that GPs, clinicians and receptionist staff can access and update patient notes, has proven particularly challenging to the wave one pilots.

Some pilots (**HRW** and **Watford**) trialled a Medical Interoperability Gateway (MIG) between systems. This forms a bridge between two systems. However, the MIG can only provide access to a limited amount of patient data, so is not necessarily a sustainable solution.

Both Erewash CCG in **Derbyshire and Nottinghamshire** and **BHR** encountered issues with sharing patient records. As a medium term solution these pilots resorted to using Adastra, which facilitates automatic forwarding of details and notes from an extended access appointment to the patient's practice for addition to the patient's record, rather than allowing the extended hours GP to access or amend patient records directly.

Limitations of IT providers

In some cases the limited flexibility of the IT providers has restricted PMCF related initiatives.

Workington
Currently all five practices in **Workington** use INPS Vision. This system prevents nurses working in Workington using a single tablet iPad that works across all five practices; instead, they would need a tablet per practice and the costs of this are deemed prohibitive. Nurses are therefore required to complete their visits, take manual notes and return to the office to transfer them onto the system, which is not as efficient. Also poor or no wireless internet connection in local care homes meant that the frail elderly assessment team and care homes nurses were unable to utilise mobile working technology, and had to return to their practice to write up their patient notes.

Bury
Bury highlighted limited IT provider capacity to prioritise their development, highlighting that GPs in extended working hours cannot print prescriptions electronically which is limiting the pilots' ability to reach full capacity of appointments.

Herefordshire
In **Herefordshire**, a pitfall was encountered because of limited broadband capacity in local care homes, which prevented the implementation of remote appointments with GPs via videolink.

Watford
Watford originally commissioned BT to deliver its telemedicine solution however it emerged that they were unable to meet requirements and the pilot had to procure an alternative provider. This caused considerable delays to the project.

Contractual, procurement and legal issues

Most pilots have encountered contractual, procurement or legal issues in establishing their primary care models.

Indemnity insurance

There has been a lack of understanding about the difference between out-of-hours services and extended access and there is a current lack of suitable insurance products to cover new ways of working. Issues with indemnity insurance have led not only to increased costs but also to delays or the need to scale back original plans. For **Brighton and Hove** the considerable unforeseen cost prevented them pursuing other initiatives; for example, they wanted to target patients who were house bound by involving paramedics, but indemnity insurance challenges prevented this. **HRW** had hoped to utilise nurses more in staffing PMCF services but the prohibitive cost of indemnity insurance meant that this has not been possible. It has also meant that certain nurse-provided services cannot be offered in extended hours services (e.g. ear syringing, taking blood).

At least half of the pilots encountered difficulties securing affordable indemnity insurance for professionals delivering extended hours services.

Other pilots have been able to overcome insurance issues; **Workington** was advised by their provider that individual indemnity cover would be quicker to obtain than the cheaper group scheme. As such the pilot secured individual indemnity cover initially and intends to transfer to the cheaper group scheme and receive a reimbursement for the costs in the near future. In **Slough** the pilot came to an agreement with the insurance provider and an annual charge was agreed to enable nurses to see patients from different practices.

Care Quality Commission registration

The need for Care Quality Commission (CQC) registration for hubs and federations was an unexpected additional cost and has acted as a barrier to implementation for some pilots. In **Herefordshire** the host site for the hub already had CQC registration, however, because patients from other practices needed to access the hub for treatment, it was necessary to seek CQC registration again as a separate additional practice. Rushcliffe CCG in **Derbyshire and Nottinghamshire** reported that its main barrier was obtaining CQC registration; as a result their hub opened two months later than planned. **Southwark** struggled to acquire CQC registration within the timeframe required and had to escalate the issue to NHS England for support. Recent guidance has since been developed.

Many pilots have sought NHS England central support to help overcome CQC registration delays

Information governance (IG)

It is recognised by NHS England that the legal framework governing the use of personal confidential data in health care is complex. It includes the NHS Act 2006, the Health and Social Care Act 2012, the Data Protection Act, and the Human Rights Act. The law is intended to allow personal data to be shared between those offering care directly to patients but it protects patients' confidentiality when data about them are used for other purposes. As a result, some of the pilots have encountered considerable issues in this area.

Warrington and **Herefordshire** are two examples of pilots which have come up against complex legal inter-practice agreements to enable cluster-based working across practice boundaries. In **Warrington's** case, both legal and data sharing agreements have had to incorporate clauses which reflect that care delivered will incorporate both reactive primary care but also proactive care.

Herefordshire found there to be significant value in commissioning an independent IG consultant to develop a data sharing agreement.

Although the physical development of the data sharing agreement in **Herefordshire** was completed over two months, getting to a point where the practices were in a position to sign up to the agreement took significantly longer. The biggest delays were caused by:

- Waiting for the IG and legal reviews of the data sharing agreement to be completed and the final version to be available for signing.
- Waiting for all 24 practices to be IG Level 2 compliant before they could legally sign the Data Sharing Agreement.

Collection of data

As mentioned above practices involved in the wave one pilot programme use various different clinical systems. This fragmentation and lack of consistency has had an impact on the collection and accuracy of data and the monitoring of trends. **Bristol and partners** have reported that requests for information have at times been confusing and the sheer volume of requests has meant that the pilot team are often too busy to manage these effectively.

A few pilots (such as **Brighton and Hove, Bury** and **Southwark**) have found the data monitoring process to be burdensome and resource intensive. Brighton and Hove has recognised that the task of extracting the relevant data and the capacity required was underestimated and that even the most experienced practice managers struggled with this aspect of the project.

Some pilots had to employ dedicated resource to support member practices in gathering the data required for evaluation

Several pilots have stated that additional central support from NHS England would have been beneficial as well as best practice on collection methods. For wave two, in acknowledgement of these challenges, NHS England are looking to develop a more systematic data extraction system to help pilots.

8 SECTION EIGHT: Conclusions to date

Conclusions to date

Extended hours

Collectively the pilots have been successful at providing additional appointment GP time as well as providing more hours for patients to access other clinicians. The feedback from across the wave one pilots is clear in that some extended hours slots have proved more successful than others. Whereas weekday slots have been well-utilised, patient demand for routine appointments on Sundays has been very low.

Over half of the pilots have reported very low utilisation on Sundays

Based on the evidence on current provision and utilisation of extended hours it is suggested that 41-51 total extended hours per week are required per 100,000 registered population in order to meet the levels of demand experienced in these pilots; of these 30-37 hours should be GP hours. Given reported low utilisation on Sundays in most locations, additional hours are most likely to be well utilised if provided during the week or on Saturdays (particularly Saturday mornings). Furthermore, where pilots do choose to make some appointment hours available at the weekend, evidence to date suggests that these might best be reserved for urgent care rather that pre-bookable slots

Contact modes

The Challenge Fund has considerably increased the number of patients who have a choice of modes by which they can contact and have an appointment with their GP. To date telephone-based GP consultation models have proved most popular and successful. There is growing evidence to suggest that investment in telephony infrastructure can be cost effective due to the GP time savings that are being achieved. More work needs to be done to understand the appropriate pilot scale and model that will realise most savings (i.e. a central call centre or individual practice telephone systems) and also deliver optimum patient and staff satisfaction, particularly in view of the importance of continuity of care for some patients.

Other non-traditional modes of contact (for example video or e-consultations) have yet to prove any significant benefits and have had low patient take-up; this will continue to be monitored.

Collaboration and skills mix

Integration of other practitioners into primary care provision has been successful in almost all cases. Joint working with ANPs, pharmacists, the voluntary sector, care homes, physiotherapists and paramedics has released local GP capacity and more appropriately matched the needs of patients with practitioners. Collaboration has proved most effective when established working relationships have been built upon, engagement happens early on and there is buy–in from GPs and provider partners to a shared vision. Practices report that it is also often necessary to redesign care processes or other staff's working patterns to gain the full benefit of new roles.

Mobilisation and implementation

Effective mobilisation and implementation rely on a variety of factors. Most notably they require clinical leadership to secure and maintain GP buy-in; dedicated project management to drive change forward; sustained practice and patient engagement to ensure initiatives are positively received; and utilisation of existing resources (such as premises, staff and infrastructure) to minimise set-up and recruitment challenges. Successful pilot delivery teams need to be agile and responsive, adapting to lessons learned along the way. Phasing delivery also helps to manage implementation risks and workload during the resource intensive set-up stage.

Scale and scope

The wave one pilots are very different in terms of their size and coverage. From the analysis undertaken to date there does not seem to be a 'perfect size' but size is a factor in achieving different outcomes. For example evidence suggests that smaller pilots are quicker to mobilise and find it easier to engage and maintain exposure with both practices and patients. However, larger pilots have the benefits of economies of scale and are perhaps better placed to achieve system-wide change. Wave one pilots suggest that federations will be most successful when they are 'naturally-forming', based on pre-existing relationships rather than being driven only by size.

Also relevant to consider are the different approaches adopted. All pilots have been ambitious. However, some have focused their attention on a relatively discrete set of objectives or deliverables, whilst others have chosen to trial a wide menu of projects simultaneously. A very broad scope of work can in itself act as a barrier to rapid progress.

Understanding the local context and demand

Understanding the pattern of demand locally is important in order to provide the most relevant and value for money service for patients. The size of the local health economy, maturity of partner relationships, geographic profile and transport infrastructure are all key factors. An urban solution may not be appropriate for a rural local health economy for example. For any localities seeking to replicate wave one pilot models it will be critical to ensure that initiatives are locally tailored, bearing in mind these contextual factors.

Transformational change

The establishment of federations and networks and delivery via hub and spoke models marks a culture change in primary care and in most pilot areas provides or fortifies the platform for transformational change. Where there is clear alignment with other CCG strategies (such as urgent care, integration with social care or reconfiguration of acute provision) the contribution of these developments is maximised. This change programme has also prompted federations to build their capabilities in leadership, management, service redesign and business intelligence, providing a more solid foundation for future service transformation.

Learning and sharing knowledge

Sharing knowledge and lessons among participating practices has occurred at pilot level, with feedback loops and learning mechanisms established locally by the majority of pilots.

Sharing between pilots and with the rest of the NHS has been facilitated by the national programme, with a few pilots undertaking their own dissemination as well. New lessons continue to emerge from wave one pilots' experience and it is important to retain flexibility in programme delivery in order to respond to them. It also remains imperative that this learning is constructively collated and shared with the wider primary care community to ensure that others are able to direct efforts into effective and proven initiatives.

Challenges

The achievements that pilots have made have not been without challenges. Many of these challenges have been process related and have caused mobilisation delays and had cost implications. IT interoperability, information governance, securing indemnity insurance and CQC registration are the most commonly cited process barriers. Acknowledging these issues, NHS England has established support for wave two pilots to ease and expedite mobilisation of their programmes and minimise duplication of effort in resolving common problems.

Sustainability

In order to sustain those initiatives that are demonstrating positive impacts, CCG support and buy-in is critical. Pilot programmes which are co-designed by CCGs or have engaged commissioners throughout implementation are better placed to secure future funding. This is especially the case given that the timescales of pilot delivery and commissioner planning have not necessarily aligned. As pilots were not able to demonstrate impacts early enough to influence spending decisions; close working with commissioners as well as undertaking locally appropriate evaluation makes it easier to reassure them of anticipated benefits.

Capacity in the system

Wave one pilots did experience some capacity issues, which often manifested as difficulties in recruiting or competing with OOH providers for GP time. The short term nature of the contracts of the pilot schemes also contributed to this. There remains some concerns around the availability of ANPs in particular, which are likely to be exacerbated as more local health economies press ahead with seven day services and introduce skills mix. Similarly, to date some pilots have relied on incentivising GPs to resource PMCF initiatives and this may not be sustainable in the long term. These are issues likely to face all local health economies progressing towards extended access service models.

Equality of access

Some wave one pilots have reported inequalities to access whereby patients whose practice is a hub have benefitted more from extended access initiatives than those whose practice is not. Rotation of hubs can be a way of overcoming this issue, although it may create other logistical issues. In addition, by the very nature of a pilot programme, there is potential to create some access inequities within local health economies because patients' access to new and enhanced services is dependent on whether their practice is a member of the pilot scheme or not. This issue could arise where not all practices within a CCG are participating in a pilot. However, this latter issue is unlikely to be a long term problem given the national agenda and move towards extended hours countrywide.

Benefits of working together

The hub and spoke models and federated delivery enable practices to deliver a wider range of services to patients over more hours in the week. Large and small pilots have also highlighted some wider benefits that can be achieved through collaboration. For example, working together has made it possible to share new specialist staff or resources and has created a 'critical mass' enabling them to negotiate better deals, attract additional support or assist in recruitment. However, as more federations are established nationwide in response to the Challenge Fund and the seven day services agenda, any competitive advantage, particularly with regard to recruitment, might be short-lived.

Added value

The Challenge Fund has provided a much-welcomed injection of investment into the primary care sector. This additional funding has provided the resource for local health economies to press ahead with collaborative working, create federations and extend patient access to GPs and other practitioners. Pilots are largely unanimous in their view that they could not have progressed with their agendas at the same pace if Challenge Fund resources had not been available. The considerable success achieved over the last year in moving away from independent working to delivering services at scale through joint working is added value in itself, even if some of the wider impacts and system outcomes are not yet fully tangible or measurable.

NHS
Leeds West
Clinical Commissioning Group

NHS Leeds West CCG

Enhancing Primary Care Access Scheme

Assurance Monitoring & Evaluation Update,

July 2015

Purpose

The purpose of this paper is to provide assurance on the NHS Leeds West CCG (LWCCG) enhancing primary care access scheme and report emerging key findings from the evaluation.

Introduction

A Primary Care Enhanced Access business case was approved in September 2014. It was agreed that this pilot scheme would run for a period of 18 months from November 2014 until March 2016.

A significant non-recurrent investment of £9M was secured to enable the scheme to be offered to all 38 member practices and implemented. The approval was made with conflicts of interest well managed during the decision making process. To date £4.5M has been invested.

The funding supported the delivery of increased access by extending opening hours and increasing clinical capacity in Primary Care. Clearly defined outputs were not established at this stage in order to allow the scheme to develop. It was expected that the evaluation of system wide impact would produce data regarding sustainability of the project once the pilot period had ended.

Background

There is a clear National context and drive towards extending patient access to NHS services over seven days. We have worked with the National Team and facilitated a seven day services workshop in Leeds to gain the wider picture. Work in Leeds Teaching Hospitals and the community services are progressing towards seven day services.

In 2014 the CCG supported an application by a group of practices to the Prime Minsters Challenge Fund- the bid was unsuccessful but the Enhanced Primary Care Access Scheme (a local scheme) was then co-produced with member practices, and funded by the CCG.

Monitoring and Assurance

A Monitoring & Evaluation sub-group was established in October 2014 and a strategy developed in consultation with member practices. A data model has been developed and refined over the last nine months using an iterative process. This data model enables monthly monitoring of primary care activity and impact on secondary care at practice, scheme level, locality or network level as well as CGG level.

What has the investment supported?

In October 2014, all LWCCG member practices were invited to participate in the enhanced access scheme. Practice applications were reviewed by a panel and approved in tranches. The first group of applications were approved in November 2014; others were subsequently approved between December 2014 and March 2015. This resulted in varied start dates; in addition, Level 3 (see below) practices adopted a phased implementation in that they provided Level 2 services initially until the hub infrastructure was put in place.

The scheme offers three levels of enhanced access:

Level 1 – Increased capacity through extended hours (current Enhanced Service requirement)

Additional clinical time per week in minutes = practice population ÷ 1,000 × 30

Level 1 is practice based and mirrors the enhanced service that is commissioned by NHS England. The expected outcomes for Level 1 are to continue to provide the level of service as agreed with NHS England and in addition:

- To participate in demand and capacity modelling to help practices match number of appointments to patient demand and share information on practice appointments
- To participate in peer review and monitoring of the overall project outcomes as part of Locality Development Sessions.

Level 2 – Increased capacity through extended access (5 days)

Additional clinical time per week in minutes = practice population ÷ 1,000 × 30 × 5

Access to clinicians is spread throughout the week (Monday-Sunday) at times determined by practices in consultation with their patient groups.

Level 3 – Increased capacity through extended access (7 days) (practice populations over 35,000 only).

Additional clinical time per week in minutes = practice population ÷ 1,000 × 30 × 8

At level 3, practices are required to offer access to clinicians across 7 days with an expectation that they will provide a service for 8hrs on a Saturday and Sunday and on bank holidays.

The major benefit of L3 is that Practices would be supported to collaborate and work more closely together for their combined local population.

The scheme is funded as below:

- Level 1 – Increased Capacity through Extended Hours (£3 per patient)
- Level 2 – Increased Capacity through Extended Access (5 days) (£15 per patient)
- Level 3 – Increased Capacity through Extended Access (7 days) (£30 per patient)

Safeguarding the diversity of general practice:
A key principle of the scheme put forward by practices and agreed was to safeguard the diversity of general practice in west Leeds and was overt in not disadvantaging smaller practices who may not have the capacity to run the per-head funded scheme singlehandedly. To this end a minimum population size of 35,000 was agreed to be eligible to apply for level three funding. With the exception of one member practice (Leeds Student Medical Practice) no member practice had a list size of 35,000 or above. This meant that practices could only deliver level three if they worked in collaboration with other neighbouring (and possibly smaller) practices.

This had the additional benefit of developing new relationships between practices in localities and in several cases has led to further collaborations around other pieces of work.

Equity of funding:
Participation was voluntary for practices and all members were invited to participate at any level subject to meeting the necessary criteria. As this is a pilot scheme with little evidence from similar schemes it is important that the effectiveness of the different levels is evaluated and compared.

All 38 practices[1] signed up to the scheme. Four practices were approved at Level 1, eighteen at Level 2, and sixteen at L3 services.

Table 1 below shows the financial split by scheme level[2]:

	Amount allocated
Level 1	£22,600
Level 2	£3,336,700
Level 3	£5,675,900
TOTAL[3]	**£9,035,200**

Table 1

Hubs
A number of practices have organised themselves into hubs to provide Level 3 services. Hubs are groups of local practices working together to provide extended access services. One practice in the group acts as the hub and patients from the other practices will access their weekend (and some weekday evening) appointments there.

There are four hubs in operation in LWCCG providing Level 3 services consisting of between 2 and 5 practices.

[1] As of 1st April 2015 there are 37 practices due to Abbey Medical Centre, Holt Pak Health Centre and Moor Grange Surgery merger. This practice is now known as Abbey Grange Medical Practice.
[2] Financial information provided by Leeds West CCG Finance team.
[3] This figure does not include two L1 practices (Beech Tree Medical Centre and South Queen Street Surgery as no payment has been made to these practices to date

SECTION ONE

What has the investment bought?

Application forms submitted by practices detail the additional clinical capacity bought with the investment. Aggregated data at CCG and scheme level is provided below.

Additional time

Based on the practice application forms, the total additional clinical time bought with the investment equates to 1,055 hours clinical time purchased per week. Table 2 below shows the split at scheme level:

	Additional time funded under the local enhanced scheme (hours/week)
Level 1	8[4]
Level 2	470
Level 3	577
TOTAL	**1,055**

Table 2

Better access to general practice through enhanced practice opening times

Based on the proposed new opening hours stated in the application forms and subsequent development of the hub sites, the Leeds West practice population has access to over 420 more hours per week than they had pre-scheme.

	Practice opening hours pre-scheme (hours/week)	**Practice opening hours post-scheme (hours/week)**	**Additional practice opening hours (hours/week)**
Level 1	205[5]	213	8[6]
Level 2	970	1,081	111
Level 3	872	1,174	303
TOTAL	**2,047**	**2,468**	**422**

Table 3

Increased number of appointments

Based on the practice application forms the total number of additional appointments bought with the investment is 7,925 per week.

[4] No additional hours/week are required as part of the CCG enhanced access scheme, L1 practices are expected to continue to provide the level of enhanced service as agreed with NHS England. Two practices (Windsor House Group Practice and Beech tree Medical Centre) indicated on their application forms that they intended to increase their hours (7 hours and 1 hour respectively) as part of the local enhanced scheme.

[5] Based on data supplied by 2 practices; Morley Health Centre and Windsor House Group did not include this information in their application form

[6] No additional hours/week are required as part of the CCG enhanced access scheme; Level 1 practices are expected to continue to provide the level of enhanced service as agreed with NHS England

	Number of appointments/week pre-scheme	Number of appointments/week post-scheme	Additional appointments/week
GP	20,121	24,174	4,053
Nurse Practitioner	697	2,157	1,460
Nurse	9,316	10,754	1,438
HCA/Phlebotomist	4,850	5,824	974
TOTAL	**34,984**	**42,909**	**7,925**

Table 4

Many practices proposed to increase capacity within regular opening hours based on feedback from their Patient Reference Groups, for example extra clinics on a Monday.

Increased appointments per thousand population

Practice application forms suggest an increase in total appointments from 98 appointments per 1,000 population pre-scheme to 121 appointments per 1,000 population post-scheme. Table 5 below shows the split by scheme level.

	List size	Total appointments /week pre-scheme	Total appointments /week post-scheme	Total appointments /week pre-scheme per 1,000 population	Total appointments /week post-scheme per 1,000 population
Level 1*	23,219	1,001	1,033	43	45
Level 2	188,117	17,662	21,798	94	116
Level 3	144,208	16,321	20,011	113	139
Leeds West	**355,544**	**34,984**	**42,842**	**98**	**121**

*Based on data supplied by 3 practices; Windsor House Group did not include this information in their application form

Table 5

What is being delivered?

In order to capture the data needed for monitoring and assurance (as well as impact) of the scheme a data model has been developed internally. This model extracts data on activity from member practices via EMIS and SystmOne and is enabled by a data-sharing agreement with practices. Its development was supported by the Data Quality Team of the Yorkshire and Humber Commissioning Support Unit.

The aim of the data model is to capture monitoring, assurance, impact and evaluation information to support measurement of the scheme in a standardised way and to minimise variation in data collection techniques, which may occur through returns being collected from multiple sources.

The development of the data model was ambitious and, as far as is understood, has not been replicated to such an extent in any other health care system nationally, certainly with regards to the capturing of primary care activity. It has also been beset with many challenges during development including how to best capture activity delivered within the 'hubs' described above, and a solution to this issue has not yet been fully identified. Another challenge has been standardising the information captured from the two different clinical systems used by the practices, with many different users.

It has therefore taken time to build confidence in the primary care activity data captured in the LWCCG data model. Validation of this data has taken place with colleagues at the Leeds Intelligence Hub, plus with the monthly returns made by the practices themselves. Although in some cases there are very close similarities between the three data sources, in many cases there were significant differences (see Chart 1 below). Following detailed inquiries into the reasons for the differences, the Monitoring and Evaluation Group has agreed that the data captured in the LWCCG data model (seen as 'JI model' on Chart 1 below) is the most valid and reliable.

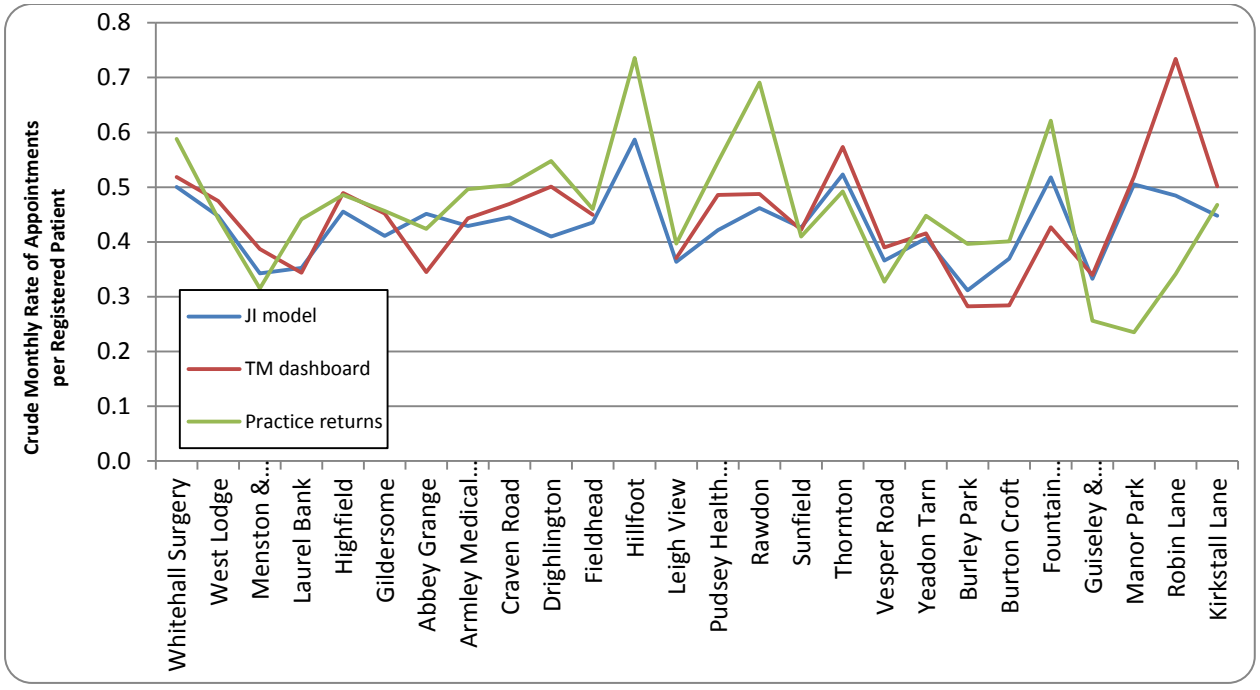


Chart 1

Chart 1 demonstrates that data from three sources may produce differing results

Whilst many of the practices started to introduce enhanced hours from December 2014, in reality implementation has varied across practices depending on practice plans for delivering the additional hours. Although most practices have extended working hours for existing practice staff, some practices have been required to supplement staff with additional locum cover. In terms of primary care activity, the data model is showing:

It is important to note in the following charts that the data demonstrates emerging trends and not statistically significant results.

Appointment slots available

The total number of appointment slots available per month has increased since December 2014. The monthly figures are higher for the period December 2014-May 2015 when compared with the same month in the previous year (see Table 6 below).

There was a marked increase in total appointment slots available in December 2014 and March 2015. This reflects the start date for a large number of Level 2 practices (December 2014) and the subsequent offering of Level 3 services (March 2015).

Please note the appointment slot figures included in Table 6 below are for SystmOne practices only, as EMIS figures are still to be added to the model (however the number of attendances includes SystmOne and EMIS practices).

														Change from Previous Year						
Summary of Change from Previous Year	Latest Data	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Dec	Jan	Feb	Mar	Apr	May	Latest Month % Change
GP Practice Data - Number of Attendances	May-15	115,274	132,766	120,757	128,633	120,962	114,189	128,569	129,099	122,541	139,005	122,898	118,388	13,295	-3,667	1,784	10,372	1,936	4,199	3.7%
Total Slots		91,629	103,050	92,411	96,298	92,558	86,077	105,714	107,661	101,035	114,054	102,120	97,882	14,085	4,611	8,624	17,756	9,562	11,805	12.8%

Table 6

Number of attendances

For this evaluation update, primary care activity is defined as all attendances in general practice and includes –

- Face to face consultations
- Telephone consultations
- Home visits
- Walk-ins

The total number of attendances per month has increased since December 2014. The monthly figures are generally higher for the period December 2014-May 2015 (with the exception of January and April 2015), when compared with the same month in the previous year. This may be due to the historic winter planning schemes / Easter arrangements that have previously been in place.

Again, there was a marked increase in the number of attendances for the months of December 2014 and March 2015. This reflects the start date for a large number of Level 2 practices (December 2014) and the subsequent offering of Level 3 services (March 2015).

In total there were approximately 28,500 more attendances in primary care for the six months from December 2014 to May 2015 when compared with total attendances from December 2013 to May 2014.

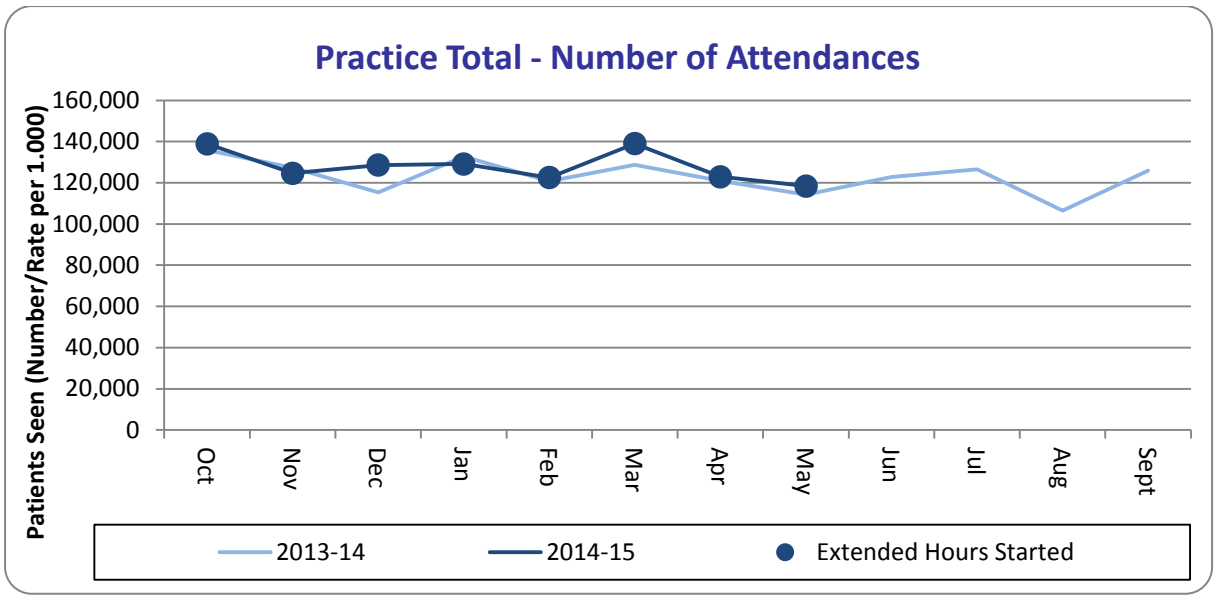


Chart 2

Total and unused slots

The trend in unused slots since December 2014 mirrors the trend in total slots available.

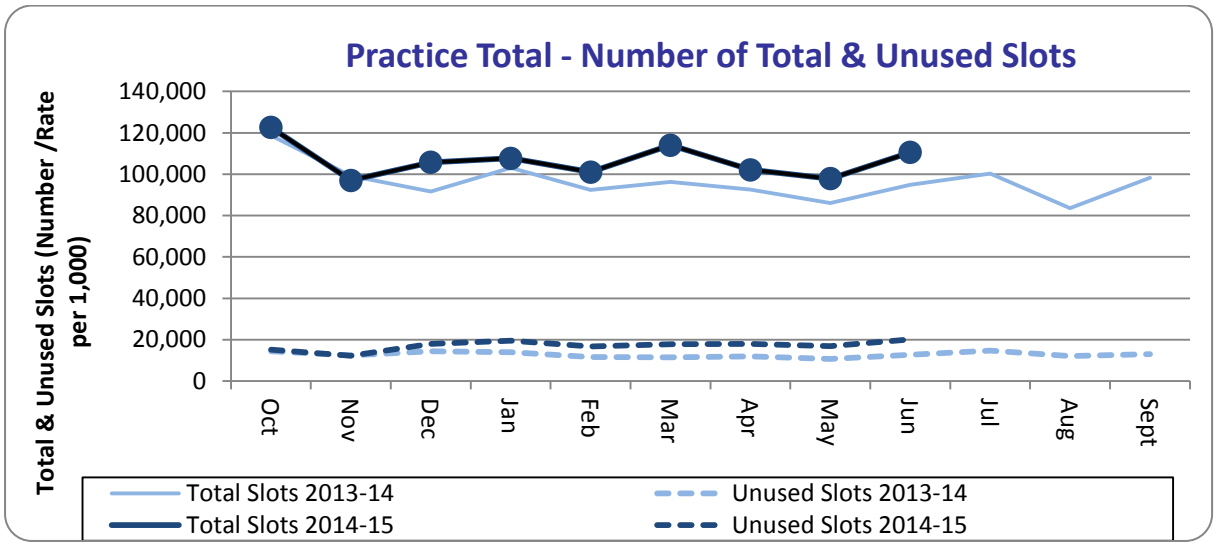


Chart 3

Did not attend (DNA) rate

The DNA rate has remained fairly static at approximately 4,000 per month since the scheme was introduced. This will be monitored.

Telephone appointments

There is an upward trend in telephone appointments, with approximately 11,000 telephone appointments per month pre-scheme compared to 13,000 appointments per month post-scheme.

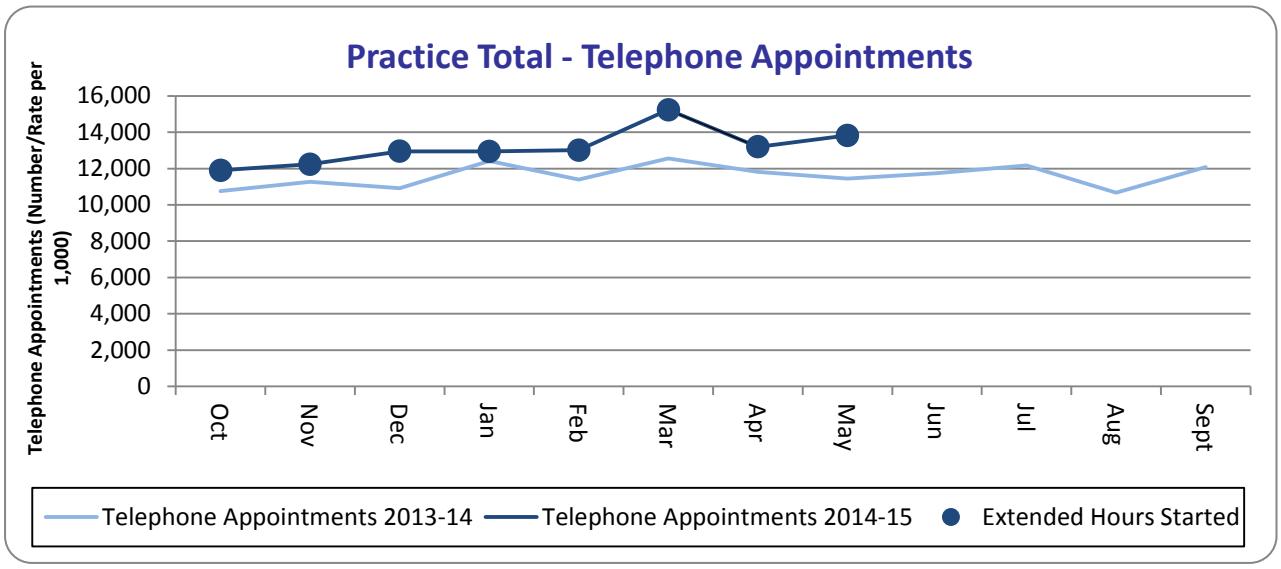


Chart 4

Time of day

Additional activity in March, April and May 2015 is evident throughout the day when compared with the same months in 2014. Despite evidence of early morning and late evening activity, take-up of these appointments appears to be relatively low at this stage.

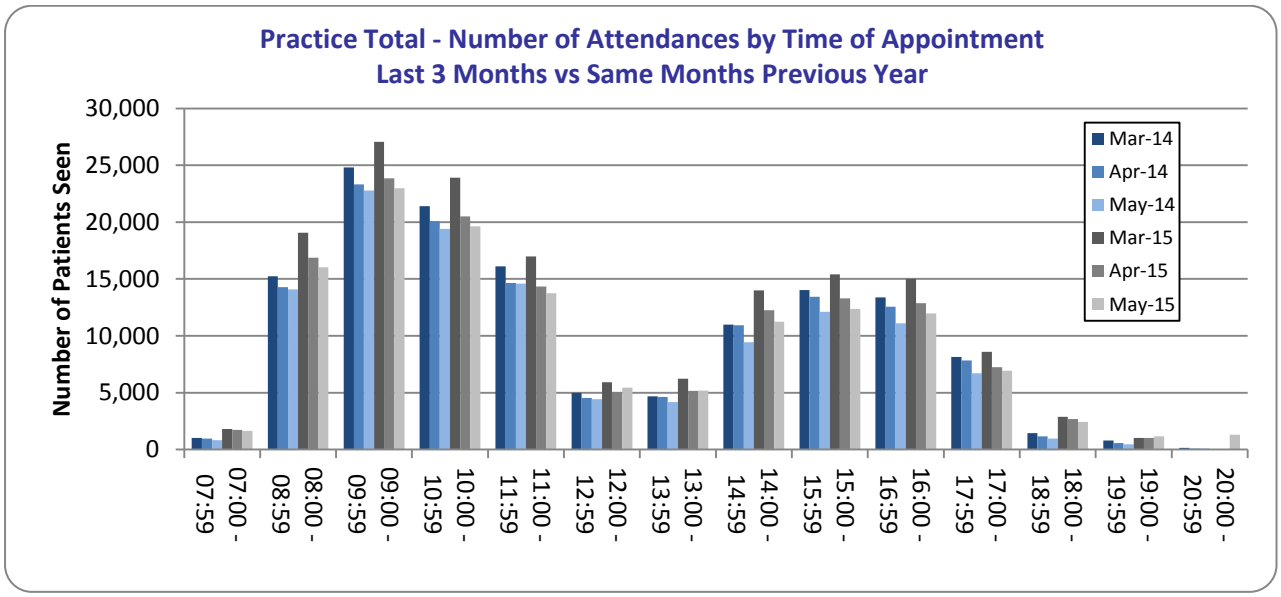


Chart 5

Day of the week

The total number of patients who attend appointments during the week has remained fairly static at approximately 125,000 per month since the scheme was introduced. The number of patients attending appointments at the weekend has steadily increased in the period December 2014-May 2015 as the hubs have become operational. This increase in weekend attendances also reflects that a number of Level 2 practices open on a Saturday morning (in lieu of a Friday evening), which has been particularly helpful during bank holiday times such as Easter.

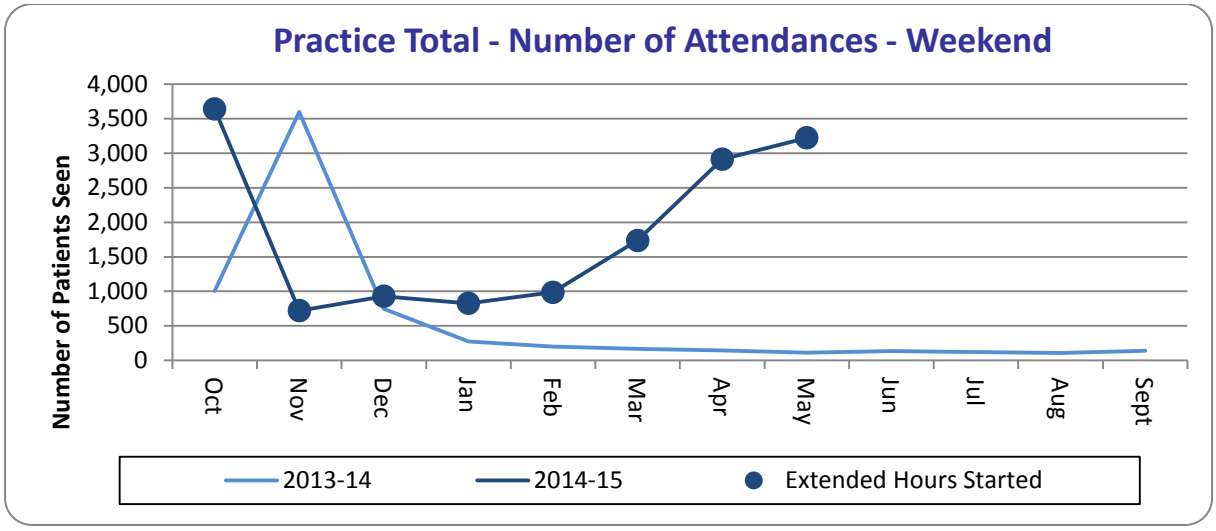


Chart 6

Please note the peaks in weekend appointments in November 2013 and October 2014 were due to additional clinics for 'flu' vaccinations.

SECTION TWO

Impact on the wider health care system

The impact on other services in the health care system is captured and monitored in the LWCCG data model using data sources already in regular use throughout the health economy. For example, impact on secondary care activity is captured via the Secondary Uses Service (SUS) system. This is a well-established data source that is robust and that colleagues are experienced in using. There is therefore a high degree of confidence in the data used to assess impact on the wider health care system. However the data demonstrates emerging trends only and cannot be seen as statistically significant at this mid-point evaluation stage.

For the GP Out-of-Hours service, the data source is regular contract monitoring information which is widely available.

Among the caveats when monitoring impact on the wider health care system is that there are many improvement schemes underway citywide, all with similar objectives, that is to reduce demand on secondary care and enable people to remain in their own homes for longer, avoid hospital admission where possible and facilitate earlier discharge. Whilst none of the evidence below can be directly attributed to the LWCCG enhanced access to primary care scheme as a causal link, it cannot be denied that the increase in access to primary care does support these overarching aims and therefore it is reasonable to assume an association with the scheme.

Comparisons with the other two Leeds CCGs have been included below to add context to the data.

Economic and statistical analysis has been applied to the data by the Health Evidence, Economics and Evaluation (HEEES) team of the Yorkshire and Humber Commissioning Support Unit. However, there are insufficient data points at this stage in the project to enable

any notable observations and none of the analysis undertaken to date or indeed any of the differences in the data reported below can be deemed statistically significant. These processes will continue to be developed and a full economic and statistical analysis will be reported in due course.

Impact on A&E (selected treatments[7])

Chart 7 below shows the activity in A&E (selected treatments and investigations) for the three Leeds CCGs. A slight downward trend in demand for this type of A&E activity can be noted for all three CCGs.

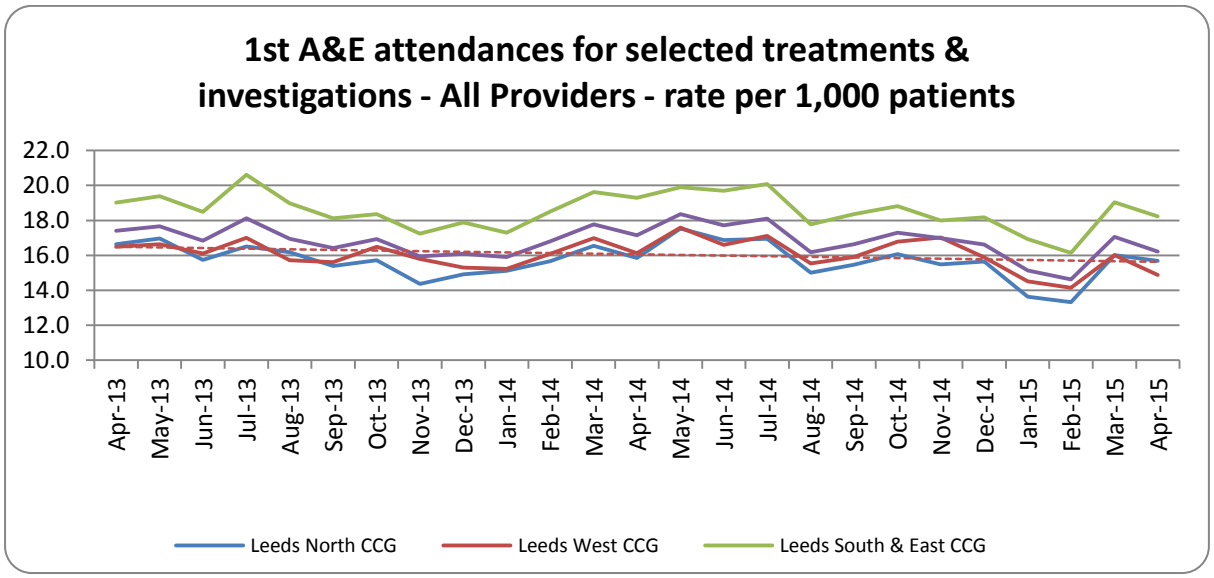


Chart 7

When this type of A&E activity is compared across the three Leeds CCGs and with the same period (December-April) in 2013/14, the Leeds West rate per 1,000 patients has dipped below the Leeds North rate (see Chart 7) – however the reduction in Leeds West (5.4%) for this period is only marginally greater than the other two CCGs, where this type of A&E activity has also decreased. This is shown in Table 7 below.

	Dec13-Apr14	Dec 14-Apr15	Var.	Var. %
LNCCG	15,893	15,122	-771	-4.9%
LWCCG	**27,105**	**25,644**	**-1,461**	**-5.4%**
LSECCG	26,250	25,099	-1,151	-4.4%
Leeds totals	69,248	65,865	-3,383	-4.9%

Table 7

[7] Treatments

Dressing, Bandage/support, Sutures, Wound closure (excluding sutures), Removal foreign body, Physiotherapy, Minor surgery, Observation/electrocardiogram, pulse oximetry/head injury/trends, Guidance/advice only, Tetanus, Recording vital signs, Wound cleaning, Dressing/wound review, Sling/collar cuff/broad arm sling, Joint aspiration, Active rewarming of the hypothermic patient, Medication administered, Occupational Therapy, Loan of walking aid (crutches), Social work intervention, Eye, Prescription/medicines prepared to take away and None (consider guidance/advice option).

Investigations

Bacteriology, Biochemistry, Clotting Studies, Haematology, Immunology, None, Pregnancy Test, Ultrasound, Urinalysis, X-Ray plain film.

Impact on Emergency Admissions (selected specialties[8])

Chart 8 below shows emergency admissions for selected specialties for the three Leeds CCGs. LWCCG have had a small decrease in emergency admissions for these specialties since the implementation of the scheme, compared with the same period in the previous year.

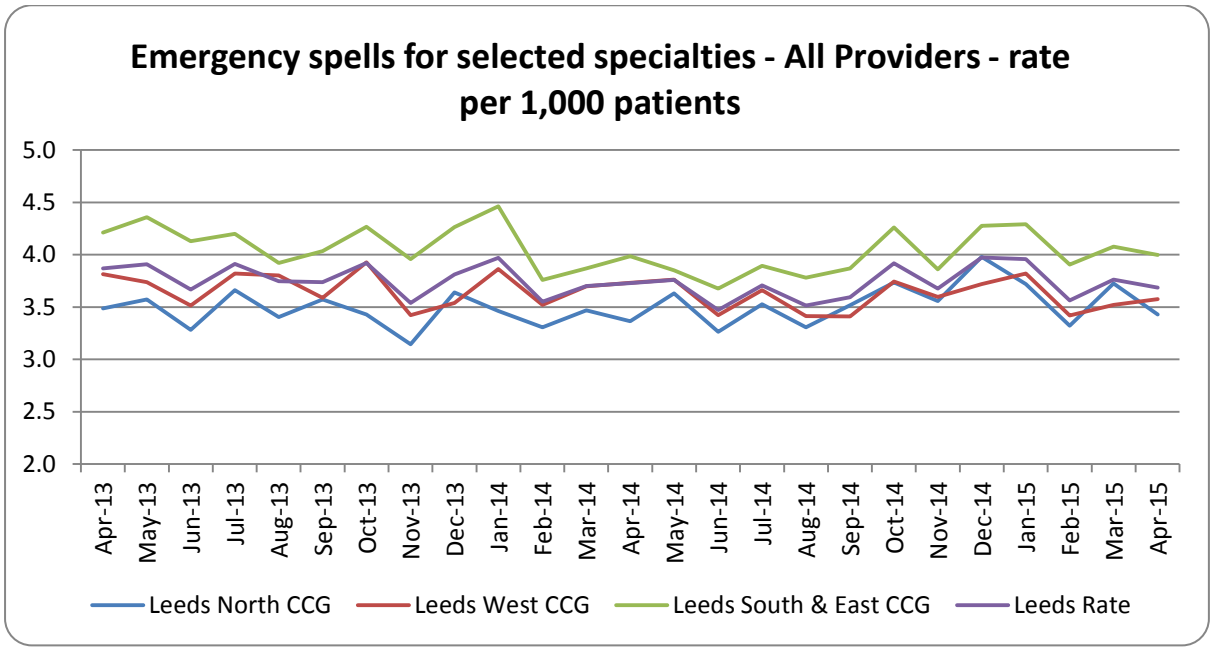


Chart 8

It is notable that the Leeds West year on year reduction of 1.6% for the period December 2014-April 2015 compares with increases in activity for Leeds North and Leeds South and East CCGs. Table 8 below shows the year on year variance of the three Leeds CCGs.

	Dec13-Apr14	Dec 14-Apr15	Var.	Var. %
LNCCG	3,510	3,699	189	5.4%
LWCCG	**6,239**	**6,139**	**-100**	**-1.6%**
LSECCG	5,767	5,825	58	1.0%
Leeds totals	15,516	15,663	147	0.9%

Table 8

Please note that the above information on emergency admissions does not include direct GP admissions to assessment units. This is being assessed and will form part of the final report. Due to the nature of the 2015-16 contract between the Leeds CCGs and Leeds Teaching Hospitals NHS Trust it is not currently possible to monitor and include assessment unit activity, however a solution to this is being sought.

[8] General Surgery, Urology, General Medicine, Cardiology, Respiratory Medicine, Geriatric Medicine.

Impact on GP Out-of-Hours service

Chart 9 below shows activity for the GP Out-of-Hours service for the three Leeds CCGs. It shows that since February 2015, LWCCG have the fewest attendances per 1,000 patients. It is notable that prior to that time LWCCG often had the most attendances per 1,000 patients. This is possibly associated with the fact that weekend hub appointments started to become available in January/February 2015.

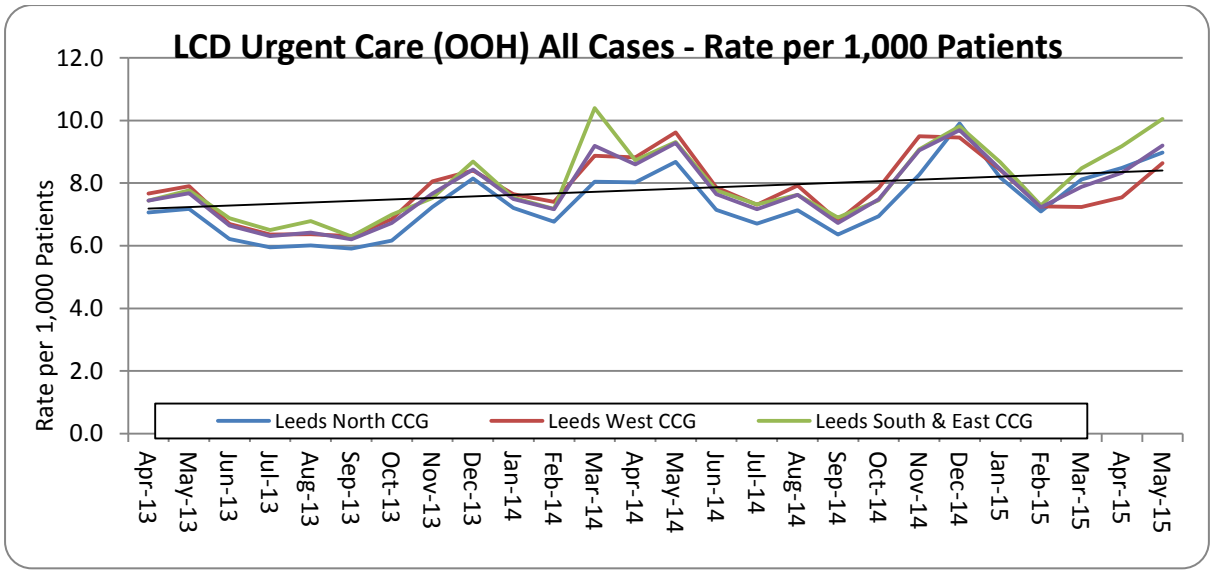


Chart 9

When comparing this activity with Leeds North and Leeds South and East CCGs for the period December 2014 to May 2015 it is important to note that whilst Leeds West have seen a decrease in attendances of 4.3% compared with the same period in the previous year, the other two Leeds CCGs have both seen an increase in attendances. LNCCG's increase was 8.3% for the same period. This variance is shown in Table 9 below.

	Dec13-May14	Dec 14-May15	Var.	Var. %
LNCCG	9,538	10,331	793	8.3%
LWCCG	**17,255**	**16,505**	**-750**	**-4.3%**
LSECCG	14,696	15,160	464	3.2%
Leeds totals	41,489	41,996	507	1.2%

Table 9

LWCCG activity for GP Out-of Hours service is therefore 12.6% lower than Leeds North CCG and 7.5% lower than Leeds South and East CCG for the period.

Whilst this difference is not currently statistically significant, this indicator is of particular interest going forwards and could develop into a significant outcome by March 2016.

Impact on Minor Injury Unit (MIU) activity and NHS 111

Activity for MIU has remained relatively static and no impact of the scheme can yet be seen in the data.

Activity for the NHS 111 service has increased slightly since the scheme was implemented. This will be further assessed.

Financial impact

The tables below set out the financial impact of the enhanced access scheme split by scheme level, month and service.

With regard to potential savings identified from secondary care services, because the Leeds CCGs currently have a fixed income agreement with Leeds Teaching Hospitals NHS Trust the majority of savings from A&E and emergency admissions will not be cash releasing in 2015/16, but may reduce the income agreement in future years.

A major caveat in this data is that there are several transformation schemes running across services in Leeds currently- all of which will be claiming any service , financial or activity improvements, it will therefore be extremely difficult to assess direct and absolute impact of any individual scheme on for example reduced emergency admissions.
The data below therefore needs to be read as- ''it would appear that a L2 practice will see a reduction in spend'', rather than ''the reduction in spend is directly attributable to the L2 work'' No correlation between Level of activity and projected savings can be made at this stage, again, it is an emerging theme.

(Reduction)/Increase in spend by Point of Delivery

CCG	ENHANCED ACCESS LEVEL	A&E	111	MIU	LCD - OOH	Shakespeare WIC	Emergency Admissions	Total
Leeds West CCG	1	-£9,308	£1,620	£689	£3,429	-£139	£42,622	**£38,912**
	2	-£33,297	£9,662	-£4,060	-£8,773	-£5,841	-£449,852	**-£492,160**
	3	-£74,628	£247	£2,211	-£60,849	-£5,239	-£11,867	**-£150,125**
	TOTAL	**-£117,233**	**£11,529**	**-£1,160**	**-£66,193**	**-£11,219**	**-£419,097**	**-£603,373**

Table 10

CCG	ENHANCED ACCESS LEVEL	A&E	111	MIU	LCD - OOH	Shakespeare WIC	Emergency Admissions	Total	Total List Size	£ saving per patient
Leeds West CCG	1	-£9,308	£1,620	£689	£3,429	-£139	£42,622	**£38,912**	**22,740**	**£1.71**
	2	-£33,297	£9,662	-£4,060	-£8,773	-£5,841	-£449,852	**-£492,160**	**182,450**	**-£2.70**
	3	-£74,628	£247	£2,211	-£60,849	-£5,239	-£11,867	**-£150,125**	**134,614**	**-£1.12**
	TOTAL	**-£117,233**	**£11,529**	**-£1,160**	**-£66,193**	**-£11,219**	**-£419,097**	**-£603,373**	**339,804**	**-£1.78**

Table 11

(Reduction)/Increase in spend by Month

CCG	ENHANCED ACCESS LEVEL	Dec	Jan	Feb	Mar	Apr	May	Total
Leeds West CCG	1	-£18,608	-£5,275	-£50,996	£43,858	£63,235	£6,700	**£38,913**
	2	£122,220	-£68,058	-£128,874	-£174,250	-£131,102	-£112,098	**-£492,162**
	3	£91,094	£28,444	£3,780	-£102,540	-£109,955	-£60,948	**-£150,125**
	TOTAL	**£194,706**	**-£44,889**	**-£176,090**	**-£232,932**	**-£177,822**	**-£166,346**	**-£603,373**

Table 12

CCG	ENHANCED ACCESS LEVEL	Dec	Jan	Feb	Mar	Apr	May	Total	Total List Size	£ saving per patient
Leeds West CCG	1	-£18,608	-£5,275	-£50,996	£43,858	£63,235	£6,700	**£38,913**	**22,740**	**£1.71**
	2	£122,220	-£68,058	-£128,874	-£174,250	-£131,102	-£112,098	**-£492,162**	**182,450**	**-£2.70**
	3	£91,094	£28,444	£3,780	-£102,540	-£109,955	-£60,948	**-£150,125**	**134,614**	**-£1.12**
	TOTAL	**£194,706**	**-£44,889**	**-£176,090**	**-£232,932**	**-£177,822**	**-£166,346**	**-£603,373**	**339,804**	**-£1.78**

Table 13

As emergency admissions data for April and May 2015 is not yet available a monthly average has been taken and extrapolated over the full period to provide a projected estimate of total savings. Over 18 months the scheme has the potential to generate savings of over £1.8m based on current data with 'flat line' progression (pro-rata'd over the total period of the scheme). Clearly if impact on the wider health care economy increases over the duration of the scheme the financial savings generated would be greater.

It is notable that currently Level 2 practices appear to be generating greater cost savings than Level 3. This could be due to the fact that there are fewer patients in total registered at Level 3 practices. In addition it could be noted that L2 practices are based in the more deprived areas of the CCG, which impacts on activity and spend, particularly for emergency admissions. The majority of the hubs did not begin to be operational until January or February 2015 and therefore the impact may yet to be seen in the data.

Also of note is that one Level 3 practice is showing an almost £100,000 increase in spend on emergency admissions for the period December 2014 – May 2015, which is bringing the savings per patient down significantly. This may be a data anomaly and needs to be further investigated. However, whilst excluding this practice's data from the calculations does increase the savings per patient it is still lower than Level 2.

SECTION THREE

Impact on patient experience

General Practice Patient Survey

Findings from the General Practice Patient Survey (GPPS) published in January 2015 provide baseline data against which to measure changes in patient experience following introduction of the enhanced access scheme. These findings relate to questionnaires completed in January-March 2014 and July-September 2014.

Findings published more recently (July 2015), which relate to questionnaires completed in July-September 2014 and January-March 2015, provide some early comparative data;

however, as this report includes responses dating back to July 2014, any comparisons should be interpreted with caution.

Later GPPS survey reports due to be published in January 2016 and July 2016 (relating to questionnaires completed in the periods January-March 2015 and July-September 2015, and July-September 2015 and January-March 2016 respectively) will provide more valuable comparative data.

Friends & Family Test (FFT)

GP practices are required to provide the opportunity for patients to provide feedback through the FFT since December 2014, and to submit monthly data to NHS England. The GP FFT and submission of local data is in its infancy with practices still getting used to the monthly collection and submission of data. The number of returns submitted by Leeds West practices since January 2015 has varied each month, however the percentage of patients who would be either 'extremely likely' or 'likely' to recommend their practice has remained static at 89-90%.

	LW practices returning data to NHS England	Total returns	Number of returns – range (practice level)	% recommended (extremely likely/likely)
Jan 2015	36 practices	3,190	0-394	90%
Feb 2015	25 practices	1,589	0-183	90%
March 2015	25 practices	1,748	0-212	90%
April 2015	30 practices	2,330	4-481	89%

Table 14

Healthwatch Leeds Patient Survey

In May/June 2015, Leeds Healthwatch visited Leeds West practices to conduct a patient experience survey focusing on access to GP appointments. Four hundred and six patients were interviewed between 11th May and 7th June; patients from 22 practices were involved in the survey, and17 patients were attending an appointment in a hub practice.

The aim of the survey was to identify if the enhanced opening hours had impacted on patient access to their GP surgery, and to identify any early improvements in patient experience.

Some of the key observations are summarised below:

- Patients were very willing and happy to speak to Healthwatch representatives
- The impact of the extended opening hours didn't seem to have really filtered through to patients. The majority of people either felt it had not changed anything or they had not had the need to make an appointment so could not comment.
- There were low levels of awareness amongst patients from many of the surgeries about the enhanced opening hours. This was even more so with the weekend surgeries where many people had only found out about them when they had requested an appointment or had called their own surgery at the weekend.
- There was general consensus once people were told about the enhanced hours that this was a good idea.

- Some concerns were expressed from patients at surgeries who were part of the hubs about accessibility to the weekend surgeries. These were when the location of the weekend surgery was considered to be not very accessible or patients didn't know where it was.
- There were a lot of comments made about problems when phoning surgeries to make an appointment. This included problems getting through to the practice, especially when having to ring at a certain time and then not being able to get an appointment when they did eventually get through to the surgery. People also commented that they did not like complicated phone systems and just wanted to speak to someone directly.
- The issue of receptionists was mentioned by some people. Whilst in some surgeries very positive comments were made about receptionists, many patients were quite negative about receptionist attitudes. In some surgeries, patients told us that there was one very nice receptionist and one unhelpful one and the service they received was dependant on which one they spoke to on the day. Others commented that they had no issue with the GPs and surgeries, but the challenge was 'getting past' the receptionist.
- In some of the surgeries concerns were raised about the difficulties in making routine appointments where patients were having to wait weeks, but yet could get an appointment on the same day if it was an emergency. Patients felt that they then had to say it was an emergency in order to get an appointment.
- There were mixed views about the 'walk-in' and 'sit-and-wait' services. Some people felt this was a good system and were happy to sit and wait, whilst others felt they had to wait too long and preferred to have an appointment.
- One surgery received some negative feedback in relation to issues with language and interpreters.

Findings from the Healthwatch survey can be compared with those reported in the General Practice Patient Survey, to give a more current picture. This suggests that whilst getting through to someone at the GP surgery on the phone continues to be an issue for more than a quarter of patients, their overall experience of making an appointment is improving. Similarly, the data suggests that the number of patients who are satisfied with the hours that their GP surgery is open improved from 77.3% in January 2015 to 88.0% in June 2015.

Table 15: General Practice Patient Survey, July 2014 and January 2015 reports relative to Healthwatch Leeds Patient Experience Survey, June 2015 – key questions[9]

Accessing your GP services			
GPPS Q3 - Generally, how easy is it to get through to someone at your GP surgery on the phone?	Easy (very, fairly)	July 2014	75.3%
		Jan 2015	73.4%
		June 2015	72.0%
Making an appointment			
GPPS Q18 - Overall, how would you describe your experience of making an appointment?	Good (very, fairly)	July 2014	74.6%
		Jan 2015	74.1%
		June 2015	78.0%
Opening hours			
GPPS Q25 - How satisfied are you with the hours that your GP surgery is open?	Satisfied (very,	July 2014	77.7%
		Jan 2015	77.3%

[9] Healthwatch Leeds/Leeds West CCG Patient Experience Survey, June 2015 – Overall Report

	fairly)	June 2015	88.0%

The table below compares the findings for Level 2 and Level 3 practices.

Table 16: Healthwatch Leeds Patient Experience Survey, June 2015 – Level 2 responses relative to Level 3[10].

		Level 2 practices	Level 3 practices
Number of practices visited		6	15
Number of patients surveyed		119	279
Q2 - In your experience, since January 2015, has it been easier to get an appointment?	Yes	47%	55%
Q4 - Overall, how would you describe your experience of making an appointment?	Good (very, fairly)	64%	83%
Q5 - Generally how easy is it to get through to someone at your GP surgery on the phone?	Easy (very, fairly)	63%	76%
Q6 - How important is it to you to see a particular GP?	Important (very, fairly)	62%	59%
Q7 - For today's appointment - how long ago did you contact the surgery to book?	Today	30%	32%
Q8 - Were you able to get an appointment on the day you wanted?	Yes	62%	67%
Q9 - How satisfied are you with the hours that your GP surgery is open?	Satisfied (very, fairly)	85%	89%
Q10 - Are you attending a 'walk-in' or 'sit and wait' surgery today?	Yes	18%	9%
Q11 - If yes, how satisfied are you with the 'walk-in' or 'sit and wait' system at your surgery?	Satisfied (very, fairly)	62%	79%
Q14 - Where else would you have gone for advice or treatment if you were not able to access an appointment?	A&E	8%	6%
	GP Out of Hours service	13%	10%
	Minor Injuries Unit	8%	3%
	Pharmacy	20%	20%
	Walk-in-centre	19%	9%
	Waited for next appointment	43%	55%
	Other	12%	9%

Two free text questions were included in the survey:

[10] Healthwatch Leeds/Leeds West CCG Patient Experience Survey, June 2015 – Scheme Level Reports

1. What could your surgery do to improve your experience of making an appointment?
2. Is there anything else you would like to say about your GP surgery opening hours?

Over 200 comments were received for each question. A sample of comments is included below:

> *"I was surprised to be given an appointment on a Sunday was lucky to get one today. I don't use online services."*
>
> *"Make it easier to get non urgent appointments. You have to wait weeks for an appointment that is routine. It is difficult to see the doctor of your choice, you just have to see who is available or wait a long time."*
>
> *"They should open on weekends as this is the only practice in this area. Seeing a particular doctor depends on if you have a long term condition."*
>
> *"Skype would interest me. Today was about reassurance and this could have been done quite easily over phone. Sometimes we can feel so poorly we might have to cancel. I would like to be able cancel by text or email."*
>
> *"Pretty good now hours have been extended. I'm not an online person so wouldn't take up opportunity to have online consultation or book online."*
>
> *"Change the phone system, it is long and drawn out and you have to wait ages to get through and sometimes get phone put down on you so have to start all over again. Last time I rang it took 20 minutes to get an appointment on the phone so I just come in person now to make an appointment."*
>
> *"Ideally you would want to see a particular doctor but they are sometimes fully booked."*
>
> *"Good idea. I did not know about the extended hours and good that you have the option to go elsewhere. I prefer to see my own GP as I have a long term condition and feel it is better to see the same GP for continuity of care."*
>
> *"Weekend opening times will further be useful. Don't mind attending any other surgery as long as I get seen."*
>
> *"Weekend appointments are good and I would use if needed but not sure where Ireland Wood is."*

All patient comments and suggestions for improvement will be analysed and key themes identified at CCG, scheme (Level 1, 2 & 3) and practice level. CCG and scheme level findings will be shared with members via the Locality Development Sessions. Practice level findings will be fed back to Locality Development Managers and Practice Managers and discussions held locally.

Case Studies

In addition to the Healthwatch survey, three focused interviews were undertaken by the CCG Patient Engagement Officer.

Burton Croft Surgery (Level 3)

"I contacted the surgery to make an appointment and gave staff some dates that I'd be free on. We agreed a date and time and I only had a few days to wait. It's not particularly important to me that I see a named GP but it's important that my wait to see a GP is fairly short.

My practice contacted me by email to let me know about the change to the practice hours, and I feel they're very good at keeping me up to date with any changes that are happening in the practice. I know that not everyone uses the internet and maybe the practice could contact people by telephone, although that would probably be quite time consuming.

I'm very happy with the extended hours that the surgery has introduced."

Leigh View Medical Practice (Level 2)

"When I contacted the surgery I had no idea about the extended hours and think that these should be advertised more as it'll have a big impact on how appointments are now made. I'd use post, text and posters in the surgery, but when I sit in the waiting room I always watch the information on the TV screens and I know that other people watch it too so you could use that.

I've a number of long-term conditions and I want to continue to see my own GP as it works better for me, because then I won't need to keep repeating my symptoms to another GP. If I want to see my named GP I sometimes have to wait for two weeks and occasionally this means that I've had to go to A&E.

The practice explained about hub and spoke and I'd have to say that I don't feel that would work for me with my long-term conditions. But if I needed a day-to-day appointment I'd be happy to take one of the first available appointments and would be happy to travel to a local practice. The model would work very well for my husband who works full time and is 30 miles away from the surgery - evenings and weekends would be really beneficial.

LS6 practice (Level 3)

"As I only visit the practice every six months I didn't know about the extended hours until I rang to make an appointment. The new system was briefly explained to me and I was given an appointment for that day.

Having a named GP isn't important to me but it's very important that I can access appointments quickly and with minimum disruption to my working day. My practice mentioned the hub and spoke model, which I wasn't aware of. Once they explained to me how it works and its benefits, I'd be very happy to visit another GP practice as long as it's only walking distance from mine. I work from 8am to 6pm and hopefully it will be much easier to make an appointment, and I'll definitely use evening and weekend appointments."

Staff Experience

General practice staff are key to the delivery of the enhanced access scheme. It is therefore important to measure the impact of the scheme on staff pre- and post-implementation of the enhanced hours.

What do we know about staff experience?

There are approximately 1,000 staff working in our 37 member practices. One of the key drivers for the scheme is that staff were reporting working under increasing stress and pressure. It is therefore important to measure and report any changes in staff morale and wellbeing at work post-implementation of the scheme.

A staff survey was developed and conducted in November/December 2014. All practice staff were invited to complete the baseline survey as practice applications were approved. Four hundred and fifty two completed surveys were received, which represents a response rate of approximately 45%.

Overall staff reported that they felt reasonably confident about achieving future change. The staff survey will be repeated at the end of the project and the findings compared.

Whilst the launch of the enhanced access scheme was met with mixed feelings with a large number of practices disengaged from the scheme, there has been a marked difference in how practices are now viewing the scheme and we have seen a significant shift in the way member practices are engaging with the CCG and their appetite for change.

There has been an increase in practice involvement in a range of schemes, including those practices that have not necessarily engaged in previous projects. It is clear from this increased engagement that member practices are continuously striving to improve the patient experience and to identify new ways of delivering services, such as using technology to support integrated working and to enable patients to access services from their own homes.

This is reflected in verbatim comments made by members as part of the 2015 national 360 Degree Stakeholder Survey:

"We feel the CCG has tried to involve all practices in discussions about future of general practice and ongoing changes. we have a good working relationship with the CCG".

“The past year has marked a milestone in engagement, consultation and involvement with the membership. I am really impressed with progress and achievement”.

“CCG has encouraged and created opportunities for forming links with the neighbouring practices which has resulted in potential collaborative work in the future”.

“The support of the recently formed "Enhanced Access Schemes" which will improve access to Primary Care Services, now from 8am to 8pm weekdays and 8am to 4pm weekend days.”

Also, comments from a recent Locality Development Session with members (June 2015) suggests further staff benefits:

“Our practice is really feeling the benefit of extended hours, the extra capacity makes a real difference at key pressure points during the week”

“Staff are enjoying the ability to say yes to patients more often”

“Reception staff report a lot less stress since the introduction of extended hours. They have to say no to people asking for a same day appointment so much less”

“Extended hours has increased the capacity and level 3 is proving useful”

“Staff feel that it helps to be able to give an appointment to a patient for the weekend”

“Clinicians finding it hard to cover the early/late surgeries particularly at holiday times”

“Helps the reception team to offer patients an appointment at the weekend”

What is the learning from this scheme to date?

This paper provides an update from the monitoring and evaluation work to date and highlights some early headlines. **None of the analysis reported in this paper is statistically significant at this point in time and it is important to recognise that there are insufficient data points to be able to draw any conclusions around the effectiveness of the scheme at this mid-point.**

The monitoring and evaluation group will continue to provide updates and a final report will be produced in 2016.

The Evaluation team and the primary care team have been very impressed with the level of clinical engagement in this project - this is a key strength of this work. Practices remain enthusiastic and indeed several practices wish to progress from L2 to L3 and full weekend service provision.

There are some very encouraging emerging trends developing in the data and support is ongoing from the Leeds Data analysts.

Conclusions:

From **November 2014 to May 2015** the following emerging findings have been highlighted (in comparison to the same period in the previous year):

- Significant progress made in collaboration and joint working between practices, many of the examples unprecedented. These developments are directly attributable to the implementation of this scheme. This provides a platform for future transformation and is one of the key achievements of the scheme to date
- Early implementation of national direction of travel to provide 7 day working giving an opportunity to test the local approach before national mandate
- Approximately 32,000 additional attendances in member practices
- Potentially significant decrease in GP OOH attendances compared with increases at Leeds North and Leeds South and East CCGs
- Greater decrease in A&E attendances for selected treatments than Leeds North and Leeds South and East CCGs
- Small decrease in emergency admissions (selected specialties) compared with increases at Leeds North and Leeds South and East CCGs
- Over 18 months of the scheme this has the potential to generate savings of over £1.8m based on current data with ‘flat line’ progression. This is expected to increase over time.
- Emerging positive and improving patient experience about the new opening times

- Some patient feedback that they were not aware of the new opening times and they still find it hard to get through on the telephone
- Emerging evidence from colleagues at Leeds Community Healthcare Trust that community staff are finding it easier to deliver care at weekends because of the availability of GPs and practices

One of the key learnings from the evaluation to date is around working with the primary care activity data. This is a completely new area for the CCG and the level of achievement is unprecedented nationally and should not be underestimated.

Nevertheless it is recognised that we do not yet have this right. There is still progress to be made to ensure full confidence in the LWCCG data model – there is confidence that this will be achieved.

It has been highlighted that practices would benefit from more detailed analysis of their activity data in order to facilitate quality improvement. The resource for such a function has yet to be identified.

Programme next steps:

1. There is anecdotal evidence of some unfilled capacity in hubs, particularly on Sundays. Practices should address this as a priority by marketing awareness of the new arrangements or by exploring how this capacity could be used differently.
2. In response to comments made by patients during the Healthwatch Survey practices should further advertise their opening hours and raise awareness of the extended opening times they are offering. Local patients should be well informed about what is happening in their local practice and the responsibility for this lies with each practice. The CCG Communications team will assist in this re marketing of the project and will be asked to develop a further patient engagement plan. We must not underestimate the required culture and behavioural change by staff and patients.
3. In response to comments made by patients during the Healthwatch survey the culture of having to telephone a practice at 8am for an appointment is still very unpopular with patients. Practices should consider alternative processes and self-assess their ease of telephone access.
4. There is a need for practices to develop robust plans for the forthcoming Winter 2015/16 and in particular the Christmas / winter period 2015.
5. There is a need to further assess whether the scheme is most benefitting those from the least deprived / most affluent backgrounds in our area. This analysis will be carried out over the coming months.
6. There is some evidence that prescribing spend has increased since this scheme was implemented. There is a need to further understand the data and to assess whether this is an appropriate increase.

7. The challenges experienced in developing the LWCCG data model highlights the need to secure further resource to understand, analyse and use this data effectively. The CCG should contribute to national learning on practice data returns as requested and continue to refine the model.

8. Data analysis and feedback should continue to be shared regularly with practices to enable local schemes to be further developed.

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NHS
Leeds West
Clinical Commissioning Group

TRANSFORMING GENERAL PRACTICE

SEVEN DAY WORKING

OCTOBER 2015

2015 has been an unprecedented year for innovation and activity in NHS Leeds West CCG. All its 37 member practices have been engaged in co-designing, implementing and evaluating an ambitious and transformative enhanced access scheme to improve their patients' access to primary care services.

CURRENTLY WE HAVE...

15 practices

covering a **population** of **148,000**

providing services **7 DAYS A WEEK**

and a further **18** practices

covering a **population** of **194,000**

delivering extended services **5 DAYS PER WEEK** (7am-7pm or 8am-8pm)

= **33** practices

covering a **total population** of **342,000**

This scheme responds to:

- national drive for seven day working in the NHS
- current capacity of primary care and growing patient demand
- feedback from patients regarding access to general practice services
- local appetite from GP practices to improve services

How the scheme was developed

Practices have been able to develop their own approach, and use information from their practice profile/demographics to help inform service delivery, to meet the needs of their patients with the overall aim of:

- improving patient outcomes;
- enhancing patient and staff satisfaction;
- reducing demand for other services; and
- increasing cost-effectiveness across the local health economy.

Practices are being innovative in service delivery, producing benefits beyond those that might be gained simply by increasing capacity. These include:

- looking at opportunities for further skill mixing (using physiotherapists and pharmacists);
- redesigning their day to do early home visiting, which allows more efficient flow of patients in and out of hospital; and
- participating in modelling demand and capacity as a key part of our scheme.

Delivering most five day schemes began in November 2014 with the majority of the seven day schemes beginning in February 2015.

Criteria for approving the seven day schemes set delivery for populations of a minimum of 35,000. This both safeguarded the smaller practices and also encouraged practices to work together to deliver the schemes. Four hub systems made up of two or more practices emerged between the practices delivering seven day access to general practice.

Since the scheme was introduced, the appetite from member practices to further develop seven day services and neighbourhood collaboration has increased, with more groups of practices wishing to explore further roll-out across the whole Leeds west population. The CCG has committed funding within the life of the scheme to continue the roll out, and so the remaining 22 practices are developing their proposals to support winter resilience.

Investment

Practices were paid £15 per head of registered population to deliver the five day scheme and £30 per head to deliver the seven day scheme. Funding was provided by the CCG and agreed in the first instance for eighteen months until March 2016.

Evaluation and data

The evaluation strategy was developed during the scheme's early implementation and was designed to evaluate four domains:

1. Activity in primary care
2. Impact on the wider system and activity
3. Patient experience
4. Staff experience

Finding a solution to measuring activity in member practices proved to be the greatest challenge in terms of data collection. Practices use either SystmOne or EMIS which added further complexity to the task. However a solution has been found and is now working well.

A detailed independent patient experience survey was undertaken by Healthwatch Leeds as part of the evaluation work. 406 patients were interviewed in 22 practices in May and June 2015. The results were extremely positive as a whole, however it highlighted the need to further market the scheme to raise awareness and also to explore ways to address some patients' concerns around being able to see a preferred GP.

A baseline practice staff survey was undertaken in October 2014 and 452 responses were received (45% response rate). The survey is due to be repeated in October 2015.

Headlines

Evaluation data has been analysed for the first six months of the scheme. From **November 2014 to May 2015** the following emerging findings have been highlighted (data analysed in comparison to the same period in the previous year):

- Significant progress made in collaboration and joint working between practices, many of the examples unprecedented. These developments are directly attributable to implementing this scheme. This provides a robust platform for future transformation and is one of the scheme's key achievements to date. As a result, new models of care are already beginning to be piloted.
- Early implementation of national direction of travel to provide seven day working giving an opportunity to test the local 'bottom-up' approach before national mandate.
- Approximately 32,000 additional attendances in member practices.
- Potentially significant decrease in GP OOH attendances compared with increases at NHS Leeds North CCG and NHS Leeds South and East CCG equating to a comparative decrease of around 8% (4.3% decrease for Leeds West compared to increases of 8.3% and 3.2% respectively).
- Marginally greater decrease in A&E attendances (selected treatments and investigations[1]) than NHS Leeds North CCG and NHS Leeds South and East CCG equating to around 0.5 - 1% (5.4% decrease for Leeds West compared to decreases of 4.4% and 4.9% respectively).
- Decrease in emergency admissions (selected specialties[2]) compared with increases at NHS Leeds North CCG and NHS Leeds South and East CCG, equating to a comparative decrease of around 4% for LWCCG (1.6% decrease for Leeds West compared to increases of 5.4% and 1% respectively).
- Over 18 months of the scheme this has the potential to generate savings of over £1.8m based on current data with 'flat line' progression. This is expected to increase over time.
- Emerging positive and improving patient experience about the new opening times

[1] Selected treatments and investigations that could have been carried out in general practice

[2] Selected specialties where general practice could have affected admission

What our patients have told us

Mr GG – Burton Croft Surgery

"My practice contacted me by email to let me know about the change to the practice hours, and I feel they're very good at keeping me up to date with any changes that are happening in the practice. I'm very happy with the extended hours that the surgery has introduced"

Ms NM – LS6 practice

"As I only visit the practice every six months I didn't know about the extended hours until I rang to make an appointment. The new system was briefly explained to me and I was given an appointment for that day.

"My practice mentioned the hub and spoke model and once they explained to me it how it works and its benefits, I'd be very happy to visit another GP practice as long as it's only walking distance from mine. I work from 8am to 6pm and hopefully it will be much easier to make an appointment, and I'll definitely use evening and weekend appointments."

Mrs TR – Leigh View Medical Centre

"I've a number of long term conditions and I want to continue to see my own GP as it works better for me, because then I won't need to keep repeating my symptoms to another GP

"The practice explained about hub and spoke and I'd have to say that I don't feel that would work for me with my long term conditions. But if I needed a day to day appointment I'd be happy to take one of the first available appointments and would be happy to travel to a local practice. The model would work very well for my husband who works full time and is 30 miles away from the surgery - evenings and weekends would be really beneficial.

"I'm very happy with both the staff and services at my surgery, the longer hours and access to other local surgeries would make access to appointments easier and stop people going to A&E"

> "Additional hours have made it easier. I work in Harrogate so have to compromise between times and seeing a doctor. It needed to improve." (Ireland Wood & Horsforth Medical Practice)

> "Good idea. I did not know about the extended hours and good that you have the option to go elsewhere. I prefer to see my own GP as I have a long term condition and feel it is better to see the same GP for continuity of care." (Burton Croft Surgery)

NHS Leeds West CCG

NHS LEEDS WEST CCG

BUDGET
£407
Million

OUR POPULATION
50,176
Aged over 65

NUMBER OF MEMBER PRACTICES
37

POPULATION WE SERVE
367,390
Registered patients

OUR POPULATION
60,739
Aged 16 and under

LIFE EXPECTANCY
79
Years for men

LIFE EXPECTANCY
81
Years

LIFE EXPECTANCY
83
Years for women

NB life expectancy figures for 2010-2012

IN 2014-2015

5,870
Patients had chronic obstructive pulmonary disease (COPD)

14,324
Patients had diabetes

92,520
Patients from west Leeds attended A&E

IN A TYPICAL MONTH APPROXIMATELY...

6,714
People from our area call NHS 111

3,555
Ambulances are called out to addresses in our area

1,600
People from our area make use of a minor injury unit

IN MARCH 2015...

23,402
Patients registered as being obese

19,655
Patients with asthma

10,873
Patients with coronary heart disease

Please note figures were the latest available at the time of publication

For further information, please contact:

Dr Simon Stockill
Director of Primary Care and Medical Director

Kirsty Turner
Associate Director of Primary Care

Dr Christopher Mills
Lead GP for Primary Care Transformation

NHS Leeds West CCG, Suite 2-4, WIRA House, West Park Ring Road, Leeds, LS16 6EB

Tel: 0113 84 35470

Leeds CITY COUNCIL

Report author: Steven Courtney
Tel: 247 4707

Report of Head of Scrutiny and Member Development

Report to Scrutiny Board (Adult Social Services, Public Health, NHS)

Date: 24 November 2015

Subject: Cancer Waiting Times

Are specific electoral Wards affected? If relevant, name(s) of Ward(s):	☐ Yes	☒ No
Are there implications for equality and diversity and cohesion and integration?	☐ Yes	☒ No
Is the decision eligible for Call-In?	☐ Yes	☒ No
Does the report contain confidential or exempt information? If relevant, Access to Information Procedure Rule number: Appendix number:	☐ Yes	☒ No

1 Purpose of this report

1.1 The purpose of this report is to introduce a report around Cancer Waiting Times and associated performance across Leeds' Clinical Commissioning Groups and Leeds Teaching Hospitals NHS Trust.

2 Summary of main issues

2.1 In June 2015, the Scrutiny Board identified Cancer Waiting Times as a specific area for inquiry during 2015/16. This is the first meeting where such details have been presented for consideration.

2.2 Attached is a joint report from Leeds' Clinical Commissioning Groups and Leeds Teaching Hospitals NHS Trust around Cancer Waiting Times and associated levels of performance against national targets.

2.3 Appropriate representatives have been invited to attend the meeting to present the attached information, address any questions from the Board and generally contribute to the discussion.

3. Recommendations

3.1 That the Scrutiny Board considers the report, including details presented at the meeting, and determines any future scrutiny actions or activity.

4. Background papers[1]

4.1 None used.

[1] The background documents listed in this section are available to download from the Council's website, unless they contain confidential or exempt information. The list of background documents does not include published works.

NHS Leeds West Clinical Commissioning Group
NHS Leeds South and East Clinical Commissioning Group
NHS Leeds North Clinical Commissioning Group
The Leeds Teaching Hospitals NHS Trust

REPORT TO SCRUTINY BOARD (ADULT SOCIAL SERVICES, PUBLIC HEALTH, NHS) **24 November 2015**

Report prepared by: Helen Lewis, Head of Acute Provider Commissioning, Leeds Clinical Commissioning Groups, and Catherine Foster, Head of Cancer Commissioning, Leeds Clinical Commissioning Groups, with input from Angie Craig, Head of Performance, Leeds Teaching Hospitals NHS Trust

EXECUTIVE SUMMARY

This paper outlines the current performance at Leeds Teaching Hospitals (LTHT) and for the local Leeds population against the 62 day GP referral to treatment time for suspected cancer; the approach being taken to improve cancer outcomes for local people; and the way in which the national Cancer Strategy will be delivered in Leeds.

1.0 Background

Cancer performance at LTHT is closely monitored as one of the key national waiting time standards within the NHS Constitution. There is a monthly subgroup of the LTHT Contract Management Board where cancer performance is discussed in detail. LTHT also has an internal cancer board which reports to the Trust Board and there is a system wide network of meetings including a group working on the Leeds Integrated Cancer Services model.

In addition to a focus on performance, the health economy has recognised the need for a forum that takes a system wide and population overview, looking at impact and outcomes for the patients of Leeds. This new cancer strategy group has been established to steer the implementation of the new Cancer National Strategy locally. We wish to ensure that we maintain a strategic overview of service delivery, early diagnosis, patient experience and outcomes as well as on the nationally reported waiting time standards.

This paper is intended to provide the assurance that all possible actions are underway to deliver national cancer performance for the Leeds CCGs' patients and at LTHT where NHS Leeds West CCG is the lead commissioner. It also highlights the difference between the LTHT Trust total performance and that for individual CCG patients and the reasons for this.

2.0 Outcomes for cancer patients

A new cancer outcomes group has been recently established to look at cancer outcomes for the city, led by the Public Health Consultant lead for Cancer. It has been presented at the Health and Wellbeing Board Chair's weekly briefing and will

be brought to the Health and Wellbeing Board in January 2016 for wider discussion. There is a focus locally on improving breast, bowel and lung cancer outcomes and reducing health inequalities and this is the basis for the forward workplan.

Areas for improvement:

- To ensure annual review of population outcomes for cancer in Leeds including staging and routes to diagnosis
- Understand why Leeds mortality and survival is not improving as fast as the England and Yorkshire and Humber average and take appropriate action
- To develop and test patient relevant outcome measures
- Focus on reducing health inequalities across the system but especially NHS Leeds West CCG and NHS Leeds South and East CCG
- For each CCG to consider the need for local action as part of a citywide approach
- Ensure there is robust and sufficient system capacity to diagnose and treat new presentations of cancer in a timely manner including closer working between primary and secondary care, increasing open access diagnostics, and working with specialised services
- To agree strategic priorities for prevention and early diagnosis work in Leeds including:
    - Continue to maintain primary focus on breast, bowel and lung cancers early diagnosis
    - To work across the system to reduce health inequalities through awareness campaigns and commissioning the third sector
    - To understand and monitor routes to diagnosis and staging
    - Continued investment in smoking prevention and treatment, obesity reduction, and alcohol prevention and treatment
    - Promote bowel screening in vulnerable populations
    - Addressing BME specific cancers e.g. Black men and prostate cancer

3.0 Performance

There are a number of national waiting time standards for cancer. This paper outlines performance against the major standards; the 'two week wait' standards and the 62 day GP referral to treatment time standard.

3.1 2 Week Wait and 2 Week Wait breast symptoms performance and risks at Leeds Teaching Hospital Trust (LTHT)

Overall, LTHT delivered the 2 week wait GP referral to first seen standard by the end of quarter 2 (Sept 15) with 93.5% of patients being seen within 2 weeks of GP referral against the 93% standard. However, it under-achieved the two week wait standard for all patients with breast symptoms for quarter 2 (85.2% against the 93% standard). The difficulties in seeing all patients with breast symptoms within two weeks is due to very substantial growth in demand not yet sustainably matched with capacity, despite every effort from existing staff. Two new Advanced Nurse practitioners are now in post and being trained to provide a resilient service from February 2016. We are also working with the Trust on developing new models of care.

The total numbers of patients GPs referred to LTHT as suspected cancer has grown extremely rapidly over the past few years – up by over 60% since 2012/13. In 2013/14 there were 19,107 referrals, rising to 23,190 in 14/15 and we expect at least 26,160 by the end of 15/16.

So while the overall 93% standard is not always met each month, the total number of patients being seen within 2 weeks continues to increase monthly.

The national drive to increase the numbers of patients referred on all pathways to improve outcomes presents an on-going risk to meeting waiting time targets, given the lag times required to increase capacity for some services. Those pathways involving endoscopy are particularly at risk given national recruitment issues in these services, and there are also pressures in radiology services. All partners are working jointly to model demand for 2016/17 as well as possible, but workforce remains a local as well as a national risk. The national cancer strategy is now looking towards a target of 4 weeks from referral to diagnosis which will have an impact on pathways and future performance reporting.

3.2 62 day urgent GP/GDP Referral to Treatment Time Target

LTHT have not achieved the overall national standard for 62 day urgent GP/GDP referral to treatment for some months. The most recent performance for Quarter 2 2015/16 is 81.3% compared to national performance of 81.9% and the required standard of 85%. However, LTHT treated 87.5% of those patients referred to Leeds originally or referred to the Trust by day 38 of their pathway within 62 days of their original referrals. The discrepancy between these two figures relates to the experience of patients referred from other hospitals into Leeds as a tertiary centre. The national performance data requires LTHT to report a 'half breach' for patients who originate in another centre but are treated beyond 62 days in Leeds, even if the patient was not seen in the Leeds team until after day 62.

LTHT has worked hard to tackle internal performance constraints, including some staffing and capacity shortages in gynaecology, urology and lung and has created additional theatre capacity for these specialties. Particular improvements have been made in delivering capacity for robotic prostatectomies and capacity and demand for this service is now back in balance. Improvements have also been made in the lung surgery service. Work is on-going to increase the speed of turn round for diagnostic tests and results to help improve earlier decision making.

The key issue constraint for delivering the 85% target for the Trust as a whole remains late referrals from the District General Hospitals where around 50% of patients are transferred to LTHT after day 38 of a 62 day pathway. Actions are in place to review joint breaches with referring Trusts. There are some encouraging signs that the patients referred in October are being referred earlier which are helping to contribute to improved performance.
The national cancer team are now reviewing the ways in breaches of the target for patients treated across two or more hospitals are reported. Modelling demonstrates that LTHT would achieve the target if there was a different way of allocating responsibility for patients transferred late to the tertiary centre who can then not be

treated in target. Medical Directors to Medical Director letters have been refreshed as have letters to lead cancer managers and LTHT's Chair, has written to Chairs of other providers. The NHS Leeds West CCG Chief Executive has also written to all of local CCGs' Chief Executives to remind them of their role in ensuring their local hospital refers patients prior to day 38.

The attached Appendix 1 performance data demonstrates the difference between the performance for Leeds CCGs at all providers, compared to the performance for LTHT in total. The difference between the two figures demonstrates the impact on the LTHT total position of late referrals and breach sharing for patients originating at other providers.

4. Meeting structures for cancer strategy

An established network of cancer meetings is in place with appropriate governance. Leeds has now established an overarching Cancer Strategy Group, in addition to the operational meetings, to take the overview across the city on cancer delivery and impact on population outcomes. This has representation from all statutory partners and key voluntary organisations. This will ensure we have an integrated approach to delivery of improvements for patients, from public awareness and early diagnosis through to aftercare and 'living with cancer'

5. Current commissioning actions

a) Arrangements are now in place for the System Resilience Group (SRG) to take the overview for cancer. Core work will still be undertaken by the acute care commissioning team and reports passed to SRG as required. A dashboard for SRG is in development.

b) Trust and system wide response to *Improving and sustaining cancer performance* – Monitor/TDA tripartite letters 14 July 2015 and 4 August, LTHT were required to submit a plan addressing the eight key priorities noted in the letter by end of August, most of which are already being covered. LTHT confirmed they have reviewed all pathways and will publish them on Leeds Health Pathways. All the NICE guidance for 2 week wait referrals has been updated, and each referral form is being reviewed.

c) Leeds has been successful with a bid for national Accelerated Coordinated and Evaluated 2 (ACE 2) funding. The ACE bid will focus primarily on the scoping and set up of a 'Straight to Test pathway for patients with unexplained weight loss.' The funding for the pilot is not confirmed yet.

d) The CCGs continue to work with the regional 10CC Cancer group and ensure that our Leeds views are fed into the regional work programme. We are also working closely with NHS England specialised commissioners as cancer commissioning is a shared responsibility for most pathways

e) The CCGs have agreed to fund two clinical sessions to support a half time LTHT lead cancer clinical post that will work across LTHT and primary care to ensure integration of approaches for the whole population.

NEXT STEPS

The NHS Leeds West CCG acute commissioning team continues to closely monitor the overall LTHT cancer performance and that achieved for local patients and those referred by day 38, and to retain an overview of the performance for Leeds patients at all providers. The LTHT Cancer Board has a continued work programme to further improve the timeliness of diagnosis and treatment and develop follow up protocols. Joint work is ongoing to encourage patients to seek early advice on symptoms, to encourage appropriate early referral and improve patient experience and outcomes at all stages of a cancer pathway. .

RECOMMENDATION:

The Scrutiny Board (Adult Social Services, Public Health, NHS) is asked to note

(a) **Note** the current situation with regard to cancer performance and monitoring and the progress being made to deliver better outcomes and shorter wait times for both Leeds patients and other patients treated at LTHT.

Appendix:

1. *Cancer performance data* : Performance data for each of the Leeds CCGs against the National Waiting Times Standards, across all providers, and LTHT's performance across all commissioners

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Appendix 1

Cancer Waiting Times Performance Report

National Standards

Leeds West CCG (All Providers)

	Target	Sep	Q2	Oct	Nov	Dec	Q3	Jan	Feb	Mar	Q4	2014-15 Q1 + Q2 + Q3 + Q4	2015-16 Apr'15	May'15	Jun'15	Q1	Jul'15	Aug'15	Current month Seen within target	Current month Referrals	Current month Breaches	Aug'15 Breaches
2 week GP referral to 1st outpatient (suspected cancer)	93.0%	94.3%	93.8%	96.0%	96.8%	96.6%	96.5%	93.2%	97.9%	93.7%	94.9%	94.8%	90.2%	93.5%	92.6%	92.0%	94.7%	91.4%	903	988	85	85
2 week GP referral to 1st outpatient (breast symptoms)	93.0%	92.9%	91.9%	93.7%	96.9%	97.9%	96.1%	97.3%	95.3%	96.2%	96.2%	92.6%	88.4%	89.9%	95.1%	91.9%	91.7%	73.3%	126	172	46	46
31 day diagnosis to treatment for all cancers	96.0%	97.7%	97.9%	97.4%	99.2%	99.1%	98.6%	90.5%	96.9%	97.9%	95.5%	97.3%	97.2%	97.5%	98.6%	97.9%	99.3%	99.1%	114	115	1	1
31 day second or subsequent treatment- surgery	94.0%	94.6%	96.4%	92.5%	86.2%	96.4%	93.9%	84.4%	96.7%	100.0%	97.3%	96.5%	96.3%	100.0%	95.5%	97.1%	93.9%	100.0%	29	29	0	0
31 day second or subsequent treatment- drug	98.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	98.3%	100.0%	100.0%	100.0%	100.0%	72	72	0	0
31 day second or subsequent treatment- radiotherapy	94.0%	97.8%	98.5%	98.3%	100.0%	100.0%	99.4%	100.0%	100.0%	98.0%	99.3%	99.3%	98.1%	100.0%	100.0%	99.3%	100.0%	100.0%	28	28	0	0
62 days urgent GP referral to treatment of all cancers	85.0%	79.3%	84.2%	80.0%	78.2%	89.1%	82.9%	78.8%	73.9%	86.2%	80.1%	83.8%	91.1%	76.9%	84.9%	84.2%	84.4%	90.6%	58	64	6	6
62 day referral to treatment from consultant screening	90.0%	100.0%	97.2%	100.0%	100.0%	92.9%	97.3%	100.0%	100.0%	100.0%	100.0%	98.3%	100.0%	90.0%	100.0%	96.2%	75.0%	100.0%	1	1	0	0
62 day referral to treatment consultant upgrade	85.0%	100.0%	86.7%	40.0%	100.0%	60.0%	58.3%	40.0%	66.7%	85.7%	66.7%	76.4%	100.0%	100.0%	100.0%	100.0%	100.0%	83.3%	5	6	1	1

Leeds North CCG (All Providers)

	Target	Sep	Q2	Oct	Nov	Dec	Q3	Jan	Feb	Mar	Q4	2014-15 Q1 + Q2 + Q3 + Q4	2015-16 Apr'15	May'15	Jun'15	Q1	Jul'15	Aug'15	Current month Seen within target	Current month Referrals	Current month Breaches	Aug'15 Breaches
2 week GP referral to 1st outpatient (suspected cancer)	**93.0%**	95.3%	95.9%	96.2%	96.2%	95.6%	96.1%	95.7%	95.1%	93.9%	94.8%	95.3%	90.4%	94.1%	93.2%	92.5%	94.7%	94.5%	497	526	29	29
2 week GP referral to 1st outpatient (breast symptoms)	**93.0%**	94.1%	95.6%	96.9%	98.8%	97.3%	97.7%	96.4%	92.5%	96.5%	95.3%	94.1%	94.2%	91.1%	98.9%	95.4%	93.9%	83.0%	73	88	15	15
31 day diagnosis to treatment for all cancers	**96.0%**	95.8%	96.4%	100.0%	97.8%	98.4%	99.1%	98.9%	97.1%	98.5%	98.3%	98.2%	98.9%	98.7%	96.9%	98.2%	98.0%	100.0%	70	70	0	0
31 day second or subsequent treatment- surgery	**94.0%**	92.3%	95.3%	100.0%	92.3%	100.0%	100.0%	94.7%	75.0%	100.0%	92.2%	95.9%	90.9%	89.5%	100.0%	95.2%	100.0%	95.0%	19	20	1	1
31 day second or subsequent treatment- drug	**98.0%**	97.4%	99.1%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	99.8%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	39	39	0	0
31 day second or subsequent treatment- radiotherapy	**94.0%**	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	96.8%	98.8%	99.4%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	21	21	0	0
62 days urgent GP referral to treatment of all cancers	**85.0%**	80.0%	77.2%	80.0%	84.8%	75.0%	80.4%	87.5%	79.3%	75.9%	81.9%	81.7%	85.7%	80.5%	75.7%	80.8%	88.9%	80.0%	24	30	6	6
62 day referral to treatment from consultant screening	**90.0%**	100.0%	87.5%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	98.0%	100.0%	100.0%	100.0%	100.0%	94.4%	93.8%	15	16	1	1
62 day referral to treatment consultant upgrade	**85.0%**	100.0%	90.9%	66.7%	100.0%	100.0%	80.0%	100.0%	-	100.0%	100.0%	91.7%	100.0%	50.0%	100.0%	83.3%	100.0%	50.0%	1	2	1	1

Leeds S&E CCG (All Providers)

	Target	Sep	Q2	Oct	Nov	Dec	Q3	Jan	Feb	Mar	Q4	2014-15 Q1 + Q2 + Q3 + Q4	2015-16 Apr'15	May'15	Jun'15	Q1	Jul'15	Aug'15	Current month Seen within target	Current month Referrals	Current month Breaches	Aug'15 Breaches
2 week GP referral to 1st outpatient (suspected cancer)	**93.0%**	94.9%	93.4%	95.8%	94.4%	95.3%	95.2%	95.0%	96.3%	94.3%	95.2%	94.4%	90.5%	94.9%	92.9%	92.7%	93.8%	92.9%	624	672	48	48
2 week GP referral to 1st outpatient (breast symptoms)	**93.0%**	96.1%	94.6%	98.1%	97.3%	98.9%	98.1%	94.2%	97.2%	97.4%	96.3%	93.7%	92.5%	91.3%	97.9%	94.3%	93.2%	79.2%	114	144	30	30
31 day diagnosis to treatment for all cancers	**96.0%**	97.8%	97.3%	93.8%	97.8%	95.1%	95.7%	97.6%	95.2%	96.1%	96.7%	96.8%	97.9%	98.6%	97.9%	97.8%	99.2%	98.9%	93	94	1	1
31 day second or subsequent treatment- surgery	**94.0%**	86.7%	92.2%	100.0%	94.1%	93.9%	95.3%	90.0%	95.5%	94.1%	93.2%	94.3%	100.0%	100.0%	100.0%	100.0%	92.9%	95.5%	21	22	1	1
31 day second or subsequent treatment- drug	**98.0%**	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	98.3%	100.0%	99.4%	100.0%	100.0%	55	55	0	0
31 day second or subsequent treatment- radiotherapy	**94.0%**	100.0%	100.0%	95.3%	100.0%	100.0%	98.0%	100.0%	100.0%	100.0%	100.0%	99.5%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	35	35	0	0
62 days urgent GP referral to treatment of all cancers	**85.0%**	63.9%	77.8%	84.0%	84.6%	76.2%	82.1%	72.7%	78.9%	83.9%	79.1%	80.0%	91.7%	93.1%	87.2%	89.7%	87.0%	91.3%	42	46	4	4
62 day referral to treatment from consultant screening	**90.0%**	75.0%	88.9%	100.0%	60.0%	100.0%	77.8%	100.0%	60.0%	100.0%	100.0%	93.0%	100.0%	100.0%	100.0%	100.0%	85.7%	100.0%	4	4	0	0
62 day referral to treatment consultant upgrade	**85.0%**	100.0%	87.5%	66.7%	50.0%	100.0%	71.4%	100.0%	100.0%	100.0%	100.0%	86.0%	100.0%	66.7%	50.0%	70.0%	85.7%	100.0%	10	10	0	0

Cancer Waiting Times performance

LTHT Trust Total

	Target	Sep	Q2	Oct	Nov	Dec	Q3	Jan	Feb	Mar	Q4	2014-15 Q1 + Q2 + Q3 + Q4	2015-16 Apr'15	May'15	Jun'15	Q1	Jul'15	Aug'15	Current month Seen within target	Current month Referrals	Current month Breaches	Aug'15 Breaches
2 week GP referral to 1st outpatient (suspected cancer)	**93.0%**	94.5%	94.3%	95.7%	95.4%	96.0%	95.7%	93.9%	96.4%	93.6%	94.6%	94.6%	90.6%	93.6%	92.5%	92.2%	94.3%	91.8%	1819	1982	163	163
2 week GP referral to 1st outpatient (breast symptoms)	**93.0%**	93.6%	93.4%	94.5%	97.4%	98.3%	96.6%	96.0%	94.9%	96.0%	95.6%	92.7%	90.8%	91.3%	96.8%	93.5%	91.9%	73.7%	269	365	96	96
31 day diagnosis to treatment for all cancers	**96.0%**	95.7%	96.2%	95.6%	96.4%	97.0%	96.5%	94.0%	94.8%	**97.5%**	**96.0%**	**96.5%**	**96.6%**	97.1%	97.4%	97.0%	97.7%	99.3%	428	431	3	3
31 day second or subsequent treatment- surgery	**94.0%**	92.1%	94.4%	94.9%	89.4%	94.5%	94.3%	89.0%	93.5%	98.4%	95.7%	94.8%	95.4%	98.6%	98.3%	97.6%	95.8%	97.0%	160	165	5	5
31 day second or subsequent treatment- drug	**98.0%**	99.6%	99.9%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	99.2%	100.0%	99.9%	100.0%	100.0%	221	221	0	0
31 day second or subsequent treatment- radiotherapy	**94.0%**	99.3%	99.4%	98.4%	100.0%	99.3%	99.3%	100.0%	99.1%	99.7%	99.9%	99.5%	98.9%	98.9%	99.8%	99.2%	100.0%	99.1%	347	350	3	3
62 days urgent GP referral to treatment of all cancers	**85.0%**	71.5%	76.2%	72.1%	77.1%	74.1%	74.8%	74.4%	67.2%	78.9%	73.9%	76.0%	83.2%	74.2%	79.4%	79.0%	81.3%	82.5%	130	158	28	28
62 day referral to treatment from consultant screening	**90.0%**	91.4%	92.1%	93.9%	92.9%	94.7%	93.9%	97.3%	94.3%	100.0%	97.5%	94.8%	100.0%	94.9%	97.8%	97.7%	91.7%	96.6%	28	29	1	1
62 day referral to treatment consultant upgrade	**85.0%**	93.3%	83.2%	57.6%	63.6%	69.6%	63.6%	75.0%	59.1%	82.9%	74.7%	77.2%	89.7%	59.4%	75.0%	75.2%	91.2%	90.2%	19	21	2	2

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Leeds CITY COUNCIL

Report author: Steven Courtney
Tel: 247 4707

Report of Head of Scrutiny and Member Development

Report to Scrutiny Board (Adult Social Services, Public Health, NHS)

Date: 24 November 2015

Subject: Work Schedule (November)

Are specific electoral Wards affected? If relevant, name(s) of Ward(s):	☐ Yes	☒ No
Are there implications for equality and diversity and cohesion and integration?	☐ Yes	☒ No
Is the decision eligible for Call-In?	☐ Yes	☒ No
Does the report contain confidential or exempt information? If relevant, Access to Information Procedure Rule number: Appendix number:	☐ Yes	☒ No

1 Purpose of this report

1.1 The purpose of this report is to consider the progress and development of the Scrutiny Board's work schedule for the current municipal year.

2 Summary of main issues

2.1 The Board's outline work schedule, which reflects discussions at the Board's previous meetings, is attached at Appendix 1. It is important to retain sufficient flexibility in the Board's work programme in order to react to any specific matters that may arise during the course of the year, therefore the work schedule may be subject to change and should be considered to be indicative rather than definitive.

2.2 In order to deliver the work schedule, it is likely that the Board will need to take a flexible approach and may need to undertake some activities outside the formal schedule of meetings. Adopting a flexible approach may also require additional formal meetings of the Scrutiny Board.

3. Recommendations

3.1 The Scrutiny Board (Adult Social Services, Public Health, NHS) is asked to:

a) Note the content of this report and its attachments.
b) Identify any specific matters to be incorporated into the work schedule for the remainder of the current municipal year.
c) Prioritise any competing demands where necessary and agree the work schedule for the remainder of the current municipal year.

4. Background papers[1]

4.1 None used.

[1] The background documents listed in this section are available to download from the Council's website, unless they contain confidential or exempt information. The list of background documents does not include published works.

APPENDIX 1

SCRUTINY BOARD
(ADULT SOCIAL SERVICES, PUBLIC HEALTH, NHS)

2015/16 WORK SCHEDULE

Title	Nov.	Dec.	Jan.	Feb.	March
Integrated Health & Social Care Teams		Working Group meeting to conisder progress and determine any specifc scrutiny activity.	Possible visits		Scrutiny Board report / statement for agreement
Air Quality			Evidence session 2 - working group meeting		
Primary Care	Evidence session 2		Evidence session 3		
* Access to GPs/ dentists					
* Workforce planning					
* Future plans for primary care					
* Some aspects of health inequalities					
Cancer Wait Times	Service commissioners & provider reports (inc. performance)		Scrutiny Board report/ statement for agreement		

APPENDIX 1

SCRUTINY BOARD
(ADULT SOCIAL SERVICES, PUBLIC HEALTH, NHS)

2015/16 WORK SCHEDULE

Title	Nov.	Dec.	Jan.	Feb.	March
Involvement of 3rd Sector		Service commissioners & provider reports		Scrutiny Board report / statement for agreement	
Co-commissioning - specialised commissioning		Update to HSDWG		Update to HSDWG	
Integrated performance reports		To be determined			
CQC Inspection outcome	Standing item	Standing item Waterloo Manor lessons learned Progress from providers	Standing item	Standing item Visits with HWL	Standing item LCH - progress LYPFT - progress LTHT - progress
Care Act Implementation					Progress report from Dir ASC

APPENDIX 1

SCRUTINY BOARD
(ADULT SOCIAL SERVICES, PUBLIC HEALTH, NHS)

2015/16 WORK SCHEDULE

Title	Nov.	Dec.	Jan.	Feb.	March
Adult Safeguarding - Annual Report		Annual Adult Safeguarding Report			
Health Protection Board					
Director of Public Health - Annual Report					
Quality Accounts - monitoring / development			Joint working group with HWL (proposed)		
CAMHS & TaMHS			Follow-up report. Content & timing to be determined		
Future provision of homecare					Progress report from Dir ASC

APPENDIX 1

SCRUTINY BOARD
(ADULT SOCIAL SERVICES, PUBLIC HEALTH, NHS)

2015/16 WORK SCHEDULE

Title	Nov.	Dec.	Jan.	Feb.	March
Children's Epilepsy		Update to HSDWG		Update to HSDWG	
Maternity Strategy					
Children's Oral Health Plan					
Budget performance/ proposals		Director Reports: ASC & PH			
Public Health Budget Reduction	Update report	Future activity to be determined			
Health Service Developments		W/G meeting		W/G meeting	

APPENDIX 1

SCRUTINY BOARD
(ADULT SOCIAL SERVICES, PUBLIC HEALTH, NHS)

2015/16 WORK SCHEDULE

Title	April
Integrated Health & Social Care Teams	
Air Quality	Scrutiny Board report / statement for agreement
Primary Care	Scrutiny Board report / statement
* Access to GPs/ dentists	for agreement
* Workforce planning	
* Future plans for primary care	
* Some aspects of health inequalities	
Cancer Wait Times	

APPENDIX 1

SCRUTINY BOARD
(ADULT SOCIAL SERVICES, PUBLIC HEALTH, NHS)

2015/16 WORK SCHEDULE

Title	April
Involvement of 3rd Sector	
Co-commissioning - specialised commissioning	Update to HSDWG
Integrated performance reports	
CQC Inspection outcome	Standing item
Care Act Implementation	

APPENDIX 1

SCRUTINY BOARD
(ADULT SOCIAL SERVICES, PUBLIC HEALTH, NHS)

2015/16 WORK SCHEDULE

Title	April
Adult Safeguarding - Annual Report	
Health Protection Board	
Director of Public Health - Annual Report	
Quality Accounts - monitoring / development	Joint working group with HWL (proposed for May 2016)
CAMHS & TaMHS	Follow-up report. Content & timing to be determined
Future provision of homecare	

APPENDIX 1

SCRUTINY BOARD
(ADULT SOCIAL SERVICES, PUBLIC HEALTH, NHS)

2015/16 WORK SCHEDULE

Title	April
Children's Epilepsy	Update to HSDWG
Maternity Strategy	CCG progress report
Children's Oral Health Plan	DPH progress report
Budget performance/ proposals	
Public Health Budget Reduction	
Health Service Developments	W/G meeting