Leicester
City Council

MEETING OF THE HEALTH AND WELLBEING SCRUTINY COMMISSION

DATE: **WEDNESDAY, 4 OCTOBER 2017**
TIME: **5:30 pm**
PLACE: **Meeting Room G.01, Ground Floor, City Hall, 115 Charles Street, Leicester, LE1 1FZ**

Members of the Commission

Councillor Cutkelvin (Chair)
Councillor Fonseca (Vice-Chair)

Councillors Chaplin, Corrall, Dempster, Myers and Sangster.

I unallocated Non-Group place.

Members of the Commission are invited to attend the above meeting to consider the items of business listed overleaf.

Standing Invitee (Non-voting)

Representative of Healthwatch Leicester

G. J. Carey

For Monitoring Officer

Officer contacts:
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Leicester City Council, City Hall, 115 Charles Street, Leicester, LE1 1FZ

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Further information
If you have any queries about any of the above or the business to be discussed, please contact Graham Carey**, Democratic Support on (0116) 454 6356 or email graham.carey@leicester.gov.uk** or call in at City Hall, 115 Charles Street, Leicester, LE1 1FZ.

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PUBLIC SESSION

AGENDA

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1. APOLOGIES FOR ABSENCE

2. DECLARATIONS OF INTEREST

Members are asked to declare any interests they may have in the business on the agenda.

3. MINUTES OF PREVIOUS MEETING

The minutes of the meeting held on 23 August 2017 have been circulated and the Commission will be asked to confirm them as a correct record.

The minutes can be found on the Council's website at the following link:-

http://www.cabinet.leicester.gov.uk:8071/ieListMeetings.aspx?CId=737&Year=0

4. CHAIR'S ANNOUNCEMENTS AND UPDATE ON PROGRESS WITH MATTERS CONSIDERED AT A PREVIOUS MEETINGS

To receive any Chair's announcements and verbal updates on any matters that were considered at previous meetings of the Commission.

5. PETITIONS

The Monitoring Officer to report on the receipt of any petitions submitted in accordance with the Council's procedures.

6. QUESTIONS, REPRESENTATIONS, STATEMENTS OF CASE

The Monitoring Officer to report on the receipt of any questions, representations and statements of case submitted in accordance with the Council's procedures.

7. SUSTAINABILITY AND TRANSFORMATION PLAN - MENTAL HEALTH **Appendix A (Pages 1 - 16)**

To receive an update on the Mental Health STP Workstream from Dr Peter Miller, Chief Executive, Leicestershire Partnership Trust and Jim Bosworth, Associate Director Commissioning & Contracting, East Leicestershire & Rutland Clinical Commissioning Group.

8. EMAS AMBULANCE RESPONSE PROGRAMME AND HANOVER TO THE LRI **Appendix B (Pages 17 - 32)**

Will Legge, EMAS Director of Strategy and Transformation and Richard Lyne, EMAS LLR Service Delivery Manager will attend the meeting to present a briefing paper on the Ambulance Response Programme and Handovers to the Emergency Department at Leicester Royal Infirmary.

9. EMERGENCY DEPARTMENT AT UNIVERSITY HOSPITALS OF LEICESTER **Appendix C (Pages 33 - 40)**

To receive a report from the University Hospitals of Leicester providing an update on the current state of play since the move to the new Emergency Department.

10. DE-COMMISSIONING OF NON-EVIDENCED BASED TREATMENTS FOR LOWER BACK PAIN WITH OR WITHOUT SCIATICA **Appendix D (Pages 41 - 66)**

To receive a joint report from Leicester City CCG, East Leicestershire & Rutland CCG and West Leicestershire CCG of plans to de-commission a number of interventions for lower back pain, with or without sciatica, in line with National Institute for Health and Care Excellence (NICE) guidance published in November 2016. Dr Umesh Roy Leicester City CCG, Lead Planned Care, Helen Mather, Implementation Lead Planned Care and Danah Cadman, Project Manager Planned Care will be in attendance at the meeting.

11. WORK PROGRAMME **Appendix E (Pages 67 - 70)**

The Chair submits a document that outlines the Health and Wellbeing Scrutiny Commission's Work Programme for 2017/18. The Commission is asked to consider the Programme and make comments and/or amendments as it considers necessary.

12. ANY OTHER URGENT BUSINESS

'It's about our life, our health, our care, our family and our community'

Better care together
Leicester, Leicestershire & Rutland health and social care

Update on the Mental Health STP workstream

Dr Peter Miller

Jim Bosworth

Rutland County Council · healthwatch · Leicester City Council · Leicestershire County Council · NHS

Introduction

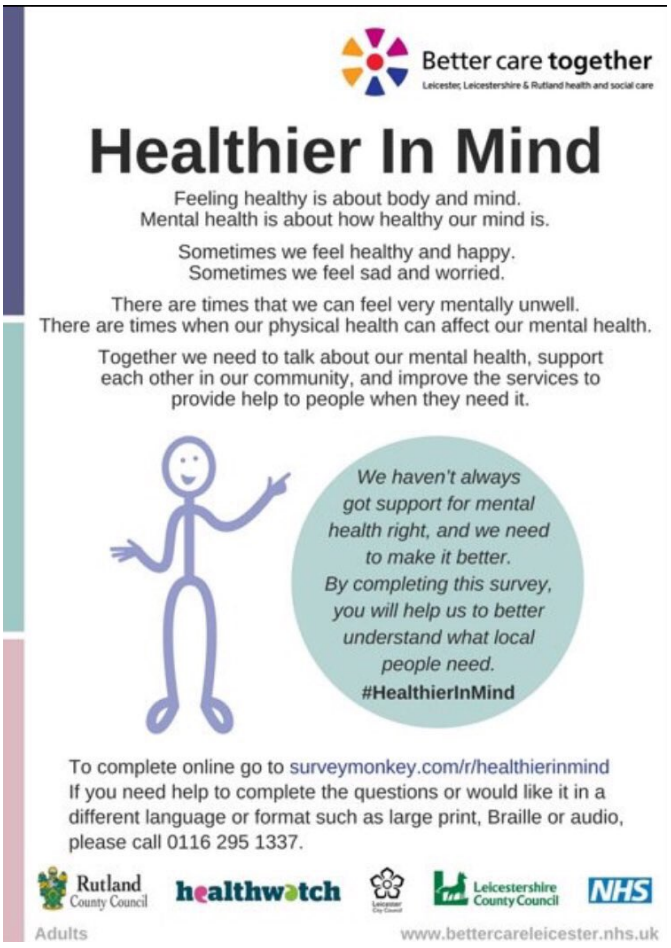
The paper provides an overview of the progress made with the Mental Health workstream of the STP the current activities, future challenges and expectations over the next 12 months.

The STP is focused on achieving quality, workforce and financial sustainability. The key underpinning principles that cross all STP workstreams are of service integration (based around families, communities and neighbourhoods) and home first (supporting and treating people in or near their home with extended community and primary care provision). Within the mental health workstream there has therefore been a focus on recovery, prevention and ensuring that our care pathways can support people at earlier stages, manage crisis periods effectively, and avoid hospital admission where possible.

Understanding the priorities for the people of Leicester, Leicestershire and Rutland

There is a national expectation that each Sustainable and Transformation Partnership will deliver the recommendations from the Five Year Forward View for Mental Health. It is important that this is undertaken with a clear understanding of what is important to the residents of Leicester, Leicestershire and Rutland (LLR) so that all change initiatives can be responding to local need. It is also important that there is a collective action across communities, statutory organisations and workplaces to support de-stigmitisation and wide spread improvement of mental health within LLR.

We therefore started the Healthier In Mind campaign to seek the views from the public on what would make the biggest difference if having poor mental health, what they would want from statutory services and what would help the mental health of their wider community.



We had **794** individuals respond to our survey and further engagement through established service user groups and within voluntary sector.

A thematic analysis was undertaken on the responses provided and the themes generated are summarised below.

Themes from #HealthierInMind

Q1. Thinking about your mental health, if you were to feel unwell, what would make the biggest difference to you?

- I am able to easily find out what help is available and access services quickly and that are convenient to me.
- When I need it, I want someone to talk to who listens to me and does not judge me.
- Having support from friends, family and people in my community for me and my family.
- I want people to understand me and my mental health and not judge me.
- I need a flexible understanding work place that supports me to get the help that I need.

Q2. Thinking about your mental health, if you felt unwell, what would you need most from local services like the NHS, Council, or Voluntary Sector?

Statement	**No. ticked**	**%**
When I need it, I can get support quickly	487	61.6%
I want to see someone who cares and not feel patronised or judged	457	57.8%
I know what help I can get and where	356	45.1%
Services work together and I only need to tell my story once	296	37.5%
I have support near to where I live	258	32.7%
I get supported to stay well	252	31.9%
I feel encouraged to talk about my needs	205	25.9%
There is support for my family	169	21.4%
I want support to be able to work	75	9.5%

Q3. What would help the mental health of your community?

- Knowing where to and getting timely and easier access to support.
- Activities and opportunities that bring people together to interact with one another.
- Things to do and places to go nearby that are safe and affordable.
- I want to be understood and not judged

An event on the 27th September 2017 has been designed to seek greater understanding on what these themes mean and the stories that sit behind them. The outputs from this work will then be used to refresh the overall Mental Health STP strategy with these shared priorities and to encourage collective action across statutory organisations, voluntary sector and communities to improve mental health within LLR.

Update on Five Year Forward View for Mental Health

Perinatal

One in five mothers have mental health illness within a year of childbirth. Therefore it is a key priority within the five-year forward view for mental health to increase the number of mothers supported through perinatal mental health services (30,000 more nationally by 2020/21). There has been investment in the community perinatal services to ensure provision of assessment, intensive support and treatment for childbearing women with serious mental illness who cannot be managed effectively by primary care services. Further investment is being sought to expand the service further to meet the national expectations leading up to the 2020/21 target.

The care pathway is being reviewed to ensure optimum outcomes and efficiency. There is also development of a bid, in partnership with the East Midland Perinatal Network to further expand this provision to ensure it meet national standards.

Early access to psychological therapies

Open Mind
Let's Talk-Wellbeing across Leicester City

There has been a significant expansion in access to psychological therapies, following the introduction of the national IAPT programme (Improving Access to Psychological Therapies). The Five Year Forward View for mental health provides a focus on helping people who are living with long-term physical health conditions, or are unemployed in particular. There is an expectation that at least 25% of people (1.5 million nationally) with common mental health conditions, such as anxiety and depression, access services by 2020/21. Local services are not meeting the current national access targets and therefore a review of the programme has been put in place to remodel the referral pathway.

A review of the IAPT clinical pathways is going to be undertaken to look at alternative models to increase access.

Local workshops have been set up for October.

Early intervention for psychosis

The early intervention with assessment and NICE approved treatment for individuals with first episode psychosis has been prioritised nationally. There is a national target for 50% of individuals with a first episode psychosis to be assessed and NICE approved treatment commenced within 2 weeks. The Clinical Commissioning Groups (CCGs) have therefore invested £450k (across 3 years) in the expansion of the existing Psychosis and Early Intervention and Recovery (PIER) service in Leicester, Leicestershire and Rutland to meet this target and to expand its support people form up to 35 year olds to people up to 65 years of age. This expansion commenced in November 2016. The service is meeting the national target currently, although the demand for assessment has increased significantly. The target itself will increase to 60% by 2020/21 and will require further review over the next 2 years to ensure that it has sufficient capacity to meet these needs.

Ongoing monitoring of target will be undertaken by NHS England and CCGs.

A review of the PIER service will be undertaken as part of the wider MHLD Transformation programme including a review of changes in demand and the requirements to meet the increased target.

Mental Health Wellbeing and Recovery Services

The Five Year Forward View for Mental Health describes the importance of developing partnerships between local public, private and voluntary sector organisations to improve mental health and wellbeing across communities. Leicester, Leicestershire and Rutland (LLR) Clinical Commissioning Groups and Local Authorities have jointly commissioned innovative locality based services, to develop supportive mental wellbeing communities and help individuals with mental health needs to stay well and live full lives.

The new services will start on the 2nd October 2017 and will work with individuals with mental health difficulties to help them to stay well or to recover if they have been or become unwell. They are expected to help people to identify what works for them, and to manage their lives.

The new mental health and wellbeing and recovery services will provide:

a. **Information:** Information for everyone, advice and support which could be provided via drop-ins, or a website, or the telephone;

b. **Advice and navigation:** Help to navigate other systems and link people to the right places (e.g. the right health service or housing service, social groups or leisure activities);

c. **Community recovery support:** Support for small groups or individuals to regain and sustain confidence to engage in everyday activities.

The new provider, Richmond Fellowship in the City, is currently mobilising and plan to provide the service in a number of community based venues across the city. There will also be work to ensure close connection with statutory community mental health services and community based organisations.

Liaison services

People with mental ill health are three times more likely to end up in the emergency department than the general population and five times more likely to be admitted to general hospital wards in an emergency.

During 2016-17 LLR was an urgent and emergency care Vanguard region. This included the development of mental heath practitioner assessment and triage support 24 hours 7 days a week within the emergency department to deliver 1-hour response to emergencies in the department. This has moved the services closer to the National plan called the 'Core 24 standards'. The Vanguard has now completed and non-recurrent monies of £430k have been made available by the CCGs to continue this provision in 2017-19. An LLR bid was made to NHS England for further funding to widen the 24 hour mental health support to other wards and clinical areas within hospitals (the full delivery of the 'Core 24 standards). This first bid was unfortunately not successful.

It is expected that NHS England will invite further opportunities to secure monies for Liaison services. Therefore another bid will be submitted by LLR to fully deliver the 'Core 24' liaison services.

Zero out of area admissions and reductions in Delayed Transfers of Care

During 2016/17 a successful programme was implemented, across acute adult mental health inpatient services, to reduce out of area care. However service users are still being sent out of area regularly due to unavailability of acute mental health beds.

Current Plans

There is a focus on keeping the instances of service users sent out of area as low as possible through:

- Initiatives to reduce length of time people need to stay in acute beds
- Initiatives to address the delays to discharge; most commonly the need for housing
- Collaborative working across housing social care and different health services
- Improved clinical leadership and learning from the acute sector on issues including patient choice and people with no recourse to public funds.

There is ongoing collaboration across agencies to constantly re-adjust plans and implement new initiatives.

There is a new housing initiative, 'moving on' beds commencing in November 2017 with action homeless to support short-term housing placements for patients who are ready for discharge.

Suicide reduction

Suicide is the leading cause of death for men aged 15-49 in the UK. LLR has a Suicide Prevention Strategy and Action Plan 2017-2020, which has been signed off in the city and county. The latest data on suicide for the period 2012-14, show that LLR rates were in line with the national average. There have been various actions undertaken to support reducing incidence of suicide. The LLR Suicide Audit and Prevention Group have worked with Leicestershire Police to produce the first local Real Time surveillance data report

The Suicide Audit and Prevention Group are examining ways to use Real Time data effectively, so that it triggers effective and necessary responses to protect people at risk of death by suicide.

in January 2016 and resources such as the Finding Hope Leicester suicide prevention films.

Parity of Esteem

Parity of esteem is the principle by which mental health must be given equal priority to physical health. It was enshrined in law by the Health and Social Care Act 2012.

Our local plans to tackle parity of esteem issues are still under consideration. They require collaboration across health and social care, and

The need for Parity of Esteem:

- Mental illness reduces life expectancy
- Mental ill health is also associated with increased chances of physical illness,
- Poor physical health increases the risk of mental illness.
- Children experiencing a serious or chronic illness are also twice as likely to develop emotional disorders.
- 54% of mental health service users arriving at A&E came by ambulance or helicopter compared to 26% of non-mental health service users.
- They also stay 30% longer
- They also had more outpatient appointments.

- Increased access to services - Appropriate waiting times will be established;
- Delivery of improved Liaison psychiatry (Core 24 standards)
- Tackling medically unexplained symptoms;
- Smoking cessation and other prevention services targeted at tackling premature mortality experienced by people with severe mental health problems;

There is an immediate focus on finalising the local plan and implementing first wave of changes.

- Regular physical health checks and for people with chronic physical health care problems to get regular mental health checks.

Future In Mind

The Future in Mind was released nationally three years ago focused on improving services supporting children and young people with their mental health and wellbeing. The local Transformation plan has set out to develop a whole system Children and Young People's emotional and mental health pathway, covering a full range of mental health needs, problems and illness that can be met through a range of services and organisations. This is in the context of a system that currently has significant capacity and demand pressures within the specialist CAMHS services that has led to long waits for treatment. Across the system there have been investment in:

- A new service to support resilience in schools (planned to start in September 2017)
- Enhanced early intervention (currently under procurement)
- Online counselling support (operational since June 2017)
- Expanded community eating disorders service to meet some of the new national targets and expectations (operational since 2015/16)
- Improved access model for specialist CAMHS (operational from June 2016)
- A new Crisis Intervention and Home Treatment service (operational from April 2017)
- Development of workforce and marketing/communication of future in mind.

There is focus on completing the mobilisation and procurement of the new services (resilience and early intervention respectively).

There is a recovery, improvement and transformation plan underway within the specialist CAMHS services to increase the quality and improve the flow through the services.

There is a key event planned for November/December to promote the different elements of the Future in Mind pathway.

Crisis Care Concordat

The Mental Health Crisis Care Concordat is a national agreement between services and agencies involved in the care and support of people in crisis. It sets out how organisations will work together to make sure that people get the help they need when they are having a mental health crisis. The Leicester, Leicestershire and Rutland Crisis Care Concordat action plan,agreed in 2014, is now into year three and has become part of the wider Mental Health STP plan.

Crisis Care Concordat has been incorporated into overall STP plan.

Update on the Mental Health Acute Care Pathway

There are an array of services that support the mental health acute care pathway ranging from the community mental health teams to the inpatient units. We recognise that these mental health services are not working the way they need to. There is more demand than they can manage, there is long waiting lists for service users to get the support they need and too many people having to go out of area for inpatient support due to unavailability of beds locally. This is similar to other mental health services nationally and this state cannot continue. Therefore we have committed to a transformation of the mental health acute care pathway within Leicestershire Partnership NHS Trust. This is focused on all ages from Children Adolescent Mental Health Services to Mental Health Services for Older People and also includes for individuals with Learning Disabilities. It is expected to take 5 years with a progressive increase in improvement across that time.

The MHLD Transformation Programme

This Mental Health and Learning Disabilities (MHLD) Transformation is learning from programmes that have been successful in other centres in the country, in particular from Northumberland Tyne and Wear (NTW). NTW transformed their services from being viewed as some of the worst within the north to outstanding CQC rated organisation. We are receiving support from NTW to design and undertake our transformation to maximise the likelihood of succeeding in our change. Whilst we cannot move its model of care directly across to LLR (due to differences in the configuration of services and needs between the different geographies), we can follow the same change methodology to achieve similar outcomes locally (further details of NTW's change are included in Appendix A). The methodology we are using involves careful **analysis** of what is going on, **co-design** (the direct involvement in the change of service users, carers, staff and stakeholders) and **trying and testing** new solutions quickly. All the changes are driven by focusing on:

Value	Focused on providing **value** for service users from all we do and look to stop things that don't
Respect	Respect our front-line staff by giving them the things they need to add the most **value** to the service users and their families
System	Focus on improving the entire pathways of service users care to provide a much better overall experience from our services

It is expected that through our redesign we will

- demonstrate good quality and experience and have addressed the key problems seen currently,
- have the whole acute care pathway to work as one system and redistribute **resources** across this system to best match skills and personnel to the demands on the different parts of the system.

Vision for Primary Care

The 5 year forward view for General Practice within Leicester envisions development of Multi-Specialty Community providers [MSCPs] to integrate a variety of services within primary care settings. The offer of integrated Primary Care services includes mental health in the form of IAPT and the community and voluntary sector as a mirror to developments in physical health care. There is the ambition for wider integration through drawing together local assets including social care, criminal justice and other stakeholders, facilitated through place-based commissioning. As a component of the reshaping of primary care there will be focus on achieving Parity of Esteem between physical and mental health.

Early intervention and prevention, as well as recovery and resilience, will overtake the traditional medical model of mental health and supplant it with a wellness agenda. In addition, pressure on General Practice and specialist services is expected to reduce allowing more accessible and focused services as well as mitigating workforce problems. Please see Appendix B for more information around the changes expected around primary care.

What this means for Leicester

Leicester has high rates of risk factors associated with mental health problems. There are high rates of emergency care for people with mental illness and poor rates of recovery. Moderate to severe perinatal maternal illness affects up to 250 women a year in Leicester, up to 5,000 children and young people have mental health problems, and somewhere between 30 and 40,000 working age adults have anxiety disorders. There is additional complexity around meeting the disproportionate impacts on people from minority ethnic backgrounds and people in lesbian, gay, bisexual and transgender communities.

The STP's focus on prevention and recovery is therefore essential to improve outcomes and experience within Leicester's population. This is expected to go hand in hand with improving access and usage of community providers (including social care) to be able to start the recovery journey earlier and better support individuals with enduring mental health conditions.

Key Challenges

There is a national mental health workforce plan issued by Health Education England describing an expected growth in the number of mental health workers by 300-350 within LLR, by 2021. This was split between professional roles (nursing, medical, therapies) and support workers. This increase is expected to go hand in hand with a large increase in demand for services. However, it will be extremely difficult to achieve this increase in new staff, due to the high number of vacancies that are currently in mental health services within LLR and ongoing difficulties in recruitment. Therefore this poses a notable risk of extended waits for treatment from unfilled vacancies.

Delivery of the overall STP will continue to be challenging within the socio-economic climate and will need ongoing openness across agencies to understand where resource is required to achieve these aims and redistribute appropriately. Therefore the joint working across NHS and local authorities alongside voluntary sector and local communities will be essential. This will clearly be significantly challenged if full commitment to understand, plan and deliver services together cannot be achieved across statutory agencies.

Next Steps

Five-Year Forward View for Mental Health

To deliver on the various elements of the Five Year Forward View for Mental Health outlined in the section above.

The MHLD Transformation Programme

It is expected that the key system analysis will be completed by March 2018 and the commencement of redesign workshops will have commenced into 2018/19 financial year.

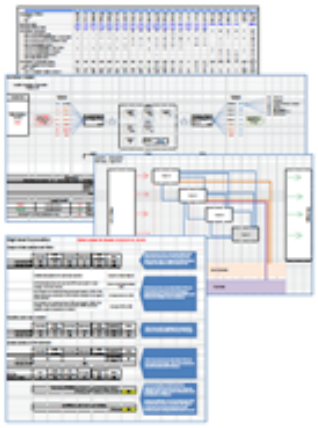
#HealthierInMind

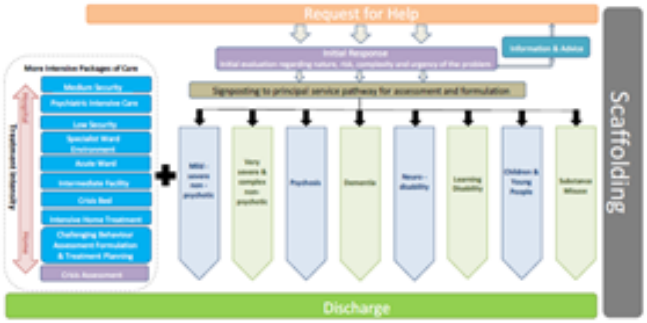
It is expected that there will be refreshed set of Mental Health strategic priorities for the STP that will have come from the contribution to the Healthier In Mind campaign.

Appendix A: Information for STP

Art of the Possible - Learning from the North

- Northumberland, Tyne and Wear Started from a similar state as LLR / LPT
- They delivered a long-term transformation programme:
  - Strong and detailed analysis
  - Co-design staff and service users
  - Cultural shift
- Created new Principal Care Pathways across boundaries





Strategic Driver	Improve **QUALITY** for the patient	**Improved outcomes and effectiveness**: *Substantially more* evidence-based interventions; recovery focus; care pathways and packages; time well spent with patients **Improved experience**: patient and carer-centred services; care closer to home in the community; partnership approach; service user and carer involvement in design, collaborative ways of working, easy access and re-access of services **Improved environments:** good quality venues, accessible locations
PCP Benefits	Improved outcomes and experience Improved safety	
Strategic Driver	Reduce **COST**	**Improved flow:** Alignment of the pathway across community and inpatient services; fewer admissions; reduced length of stay; better discharge planning; better transitions & partner working; balanced flow of access and discharge **Efficient clinical services:** New systems and processes; IT revolution; reduced bureaucracy and waste
PCP Benefits	Reduced reliance on inpatient beds Efficient services	
Strategic Driver	**SUSTAINABLE** services	**Improved skills:** Clinical skills development programme; evidence-based interventions **Improved teams and team-working:** Aligned to patient need; new systems and processes; MDT working; team resources aligned to demand **Willing partners and integrators:** This can only work well as part of an aligned whole system
PCP Benefits	Skilled workforce Partnership and integration	

Appendix B: Overarching plan around Primary Care Plan

Where we are now	What are we going to do	Where we want to be in 5 years
• Wellbeing inequalities and low life expectancy: we need to support parity of esteem • Crisis and home treatment services can be difficult to access: we need to make more responsive • Lack of primary and community outreach services including drug and alcohol: we need to expand the support available within local areas • Waits for some services are too long: we need to ensure people receive timely care • Focus on treatment: we need to increase focus on person centred recovery and prevention services • Difficulties in finding long term accommodation for people discharged from mental health inpatients and rehabilitation units	• Increasing general mental health well-being and resilience through targeted prevention initiatives • Redefining the meaning of recovery with stakeholders to develop person centred approaches • Reviewing the role of the Third sector to strengthen and integrate their role in supporting both recovery and resilience • Increasing the capability and capacity of primary care to manage people with severe and enduring illness in the community. • Increase life opportunities through the use of personal budgets and direct payments • Promote mental health and resilience and develop early help services for children's, young people and those that care for them • Ensure that housing needs are considered and met in both planning and provision, so reducing the use of residential care	• Reduced stigma related to mental health and greater awareness within population of promoting good mental health • Improved health Increased life expectancy for people with severe and enduring mental health needs • Reduce incidence of mental health conditions • Reduced crisis escalation episodes, with quicker response times when required which is responsive to individual need • Reduced delays in discharge and length of stay • Reduced reliance on acute services and increased capability and capacity within primary and community settings. • Increased level of community accommodation to support mental health rehabilitation and discharge from hospital

Where we are now	What are we going to do	Where we want to be in 5 years
• Limited collection of patient experience feedback and co-production with user and carers to improve mainstream services.	• Ensure that carers get the right level of support and breaks	

East Midlands Ambulance Service NHS Trust

Date: 15 September 2017

Report Title:	Ambulance Response Programme & Handover
Author	Richard Lyne, EMAS LL&R Service Delivery Manager
Presented by:	*tbc*

- **What are the current barriers with handovers at LRI?**
  The handovers with LRI are improving following the opening of the new emergency department and the new flow within department. However, the main barrier is when demand and attendances at the department and calls into EMAS are at higher levels. This means that A&E staff are focused on dealing with unwell patients, resulting in crews having to sometimes wait to handover to a clinician in department. The overall average turnaround for July/August 2017 was 30 minutes 25 seconds compared to 41 minutes 23 seconds in the same period last year (July/August 0216), we have seen the percentage of handovers over 15 minutes reduce by 19% over these same periods.

- **What is the impact of these handovers having on the rest of the region?**
  The impact outside of Leicestershire on these handovers has significantly decreased over the past 12 months, other county resources brought into Leicestershire due to handover delays and the resultant lack of county resources is now very rare and since April has only occurred once during a period of extreme demand in May. County resources do continue to be shared across county borders to support patient care and ensuring the right resource to the right patient in the quickest time.

- **Has the new fleet made a difference to issues suffered by EMAS?** The new fleet has improved the clinical care and environment for the staff. Staff where closely involved with the design of the new fleet, and it has been highlighted nationally as a marker of good ambulance design and other Trusts are also trialing EMAS fleet design. This new design means it is easier and quicker to access lifesaving equipment, provides a more accessible treatment area ensuring key equipment and supplies are in easy reach for crews in the back of ambulances, allowing for crews to treat more effectively on route rather than on scene.

- **What are the changes to the way EMAS priorities calls for ambulances in terms of severity? Have they made a difference?**
  The Ambulance Response Programme was introduced in EMAS from July and is a national change form next year. I attach a briefing that I have prepared which covers the changes and background. It is still very early to quantify the benefits as the system is still evolving, however speaking with frontline staff and reviewing dispatch

patterns positive trends are merging around the reduction in numbers of resources being dispatched to patients, i.e. the most right resource to the right patient in the right time, and our FRV being freed up to respond to the most time critical patients and not being held on scene awaiting ambulance backup. For example pre-APR implementation the divisional deployed on average 1.35 resources per incident, this has now dropped to 1.15 post introduction resulting in more resources being available to respond to calls rather than being tied up on scene awaiting backup.

- **What are the plans for both LRI and EMAS to make improvements?**
  EMAs and LRI are working closely together on improvements and working through a plan which includes opening up Emergency Consultant access to crews who are scene for clinical advice, looking at new pathways into emergency department such the GP Assessment Unit, undertaking bedside handovers between EMAS and LRI allowing for quicker time for crews to clear the hospital and looking at new opportunities to move clinicians from hospital into the community e.g. mental health cars and mobile treatment centre deployment in city centre and high demand areas such as universities. These actions are monitored and held to account via the A&E Delivery Board which is a statutory Board reporting through to NHS England and NHS Improvement.

- **Are the hospitals the right place to drop off the patients? As such, are the assessments making sure that patients are going to the right place for care?**
  This is an area of focus for EMAS, we are working across the health & social care system to ensure we are part of developments such the clinical navigation hub, undoubtedly hospital is not the right place for every patient, and as such EMAS ensure we work across the system to develop and identify pathways to ensure we don't have to admit into a hospital if this isn't the right place of care. All staff use a tool called 'Paramedic Pathfinder' which outlines all the different pathway available and contact details, in addition control host the CAT (Clinical Assessment & Triage) team who are a team of nurses and paramedic who can support crews in utilising other pathways

- **What is the relationship with NHS 111**?
  EMAS work closely with 111 as a key feed into the 999 service, we jointly review calls where crews may have felt different pathways would have been more suitable, and look at implementing any learning from these, additionally we work closely on projects such as the clinical navigation hub. We are also now starting a series of joint audits, called 'The 6A audit', which will review actual patient pathways, how the patients have worked through 111, 999 and into hospital and identify learning where this could have been avoided or other alternative care setting would have been more appropriate.

Ambulance Response Programme: EMAS Pilot

Stakeholder Briefing

Background

Response times as a performance indicator for ambulance service has been in place since 1974, with the most recent revision in 1996 introducing variable standards for differing clinical needs and urgency. The rationale for this is based upon the relationship between time and clinical outcomes/survival for conditions such as community cardiac arrest or myocardial infarction.

However the 'Red' calls cover a much broader range of conditions within the 8 minutes response time. None of the available research demonstrates any significant positive relationship between shorter response times and a decrease in mortality for those with life threatening conditions other than out of hospital cardiac arrest.

This has led to a dichotomy of matching the right response to clinical need at the time of calling for help versus a need to also meet response time targets. This is often summarised as:

"An ambulance can arrive at the scene of cardiac arrest in 7.59 minutes but the patient does not survive and is considered a success but arriving after 8 minutes and the patient survives is considered a failure."

In response to this NHS England commissioned the Ambulance Response programme (ARP) with formal trial commencing in October 2015 to address these opposing priorities to improve the clinical response and outcomes.

East Midlands Ambulance Service were identified as a phase 2.3 pilot Trust prior to national adoption during Winter 2017. EMAS went live with ARP at 0230 on 19th July 2017.

Principles of the Ambulance Response Programme

ARP introduces 3 main changes to the current call coding, allocation and performance monitoring:

1. Introduction of new a new set of call categories replacing the current RED/GREEN, with new categories which will align clinical and resource requirements with AMPDS codes.
2. Further enhancement of despatch on disposition, incorporation of questions to immediately identify life threatening condition and for other conditions, allow longer for clinical triage to occur in order to ensure right resource is sent to the right patient in the right time.
3. Review of Ambulance Quality Indicators (AQI) to further drive clinical outcomes for patients.

NHS England have suggested that once these changes are fully adopted nationally:

- "Early recognition of life-threatening conditions, particularly cardiac arrest, will increase. Based on figures from London Ambulance Service, it is estimated that up to 250 additional lives could be saved in England every year."
- "Up to 750,000 patients every year would receive an immediate ambulance response, rather than joining a queue."
- "The differences in response time between patients living in rural areas and those in cities would be significantly reduced."

Changes to National Standards

Clinical Indicators:

- For serious heart attack patients, who have specific ECG changes, a measure the proportion of patients that receive definitive treatment balloon inflation during angioplasty at a specialist heart attack centre) within 150 minutes of making a 999 call. It is expected that 90% of patients to meet this standard by 2022.

- For stroke patients, we will measure the proportion of patients that complete their pathway of care (thrombolysis where appropriate, or first CT scan for those where it is not) within 180 minutes of making a 999 call – again with an expectation that 90% of patients will meet this standard by 2022, up from an estimated 75% of stroke patients currently completing their pathway of care within that timeframe.

Despatch Standards From:

Category	Percentage of calls in this category	National Standard	How long does the ambulance service have to make a decision?	What stops the clock?
Red 1	3%	75% within 8 minutes	The clock starts at the point the call is connected to the ambulance service	The first ambulance service-dispatched emergency responder arriving at the scene of the incident
Red 2	47%	75% within 8 minutes	The earliest of: •The problem being identified •An ambulance being dispatched •60 seconds from the call being connected	The first ambulance service-dispatched emergency responder arriving at the scene of the incident
Green	50%	No national standard	The earliest of: •The problem being identified •An ambulance response being dispatched •60 seconds from the call being connected	The first ambulance service-dispatched emergency responder arriving at the scene of the incident

To:

Category	Percentage of calls in this category	National Standard	How long does the ambulance service have to make a decision?	What stops the clock?
Category 1	8%	7 minutes mean response time 15 minutes 90th centile response time	The earliest of: •The problem being identified •An ambulance response being dispatched •30 seconds from the call being connected	The first ambulance service-dispatched emergency responder arriving at the scene of the incident (There is an additional Category 1 transport standard to ensure that these patients also receive early ambulance transportation)
Category 2	48%	18 minutes mean response time 40 minutes 90th centile response time	The earliest of: •The problem being identified •An ambulance response being dispatched •240 seconds from the call being connected	If a patient is transported by an emergency vehicle, only the arrival of the transporting vehicle stops the clock. If the patient does not need transport, the first ambulance service-dispatched emergency responder arriving at the scene of the incident stops the clock.
Category 3	34%	120 minutes 90th centile response time	The earliest of: •The problem being identified •An ambulance response being dispatched •240 seconds from the call being connected	If a patient is transported by an emergency vehicle, only the arrival of the transporting vehicle stops the clock. If the patient does not need transport the first ambulance, service-dispatched emergency responder arriving at the scene of the incident stops the clock.
Category 4	10%	180 minutes 90th centile response time	The earliest of: •The problem being identified •An ambulance response being dispatched •240 seconds from the call being connected	Category 4T: If a patient is transported by an emergency vehicle, only the arrival of the transporting vehicle stops the clock.

Prepared By: Richard Lyne – Service Delivery Manager for Leicester, Leicestershire & Rutland.
8th August 2017.

East Midlands Ambulance Service NHS Trust

East Midlands Health Scrutiny Network

Will Legge, Director of Strategy & Transformation

Background

CQC inspected EMAS November 2015 and published its report May 2016.

- Requires improvement overall
- Inadequate safety
- Warning notice (response times, number of staff and vehicles, and need to improve training and appraisals)

We progressed our Quality Improvement Plan, and the CQC came back to EMAS February 2017.

Overall CQC rating – requires improvement

- **Safe:** improved from 'inadequate' to 'requires improvement'
- **Effective:** remained 'requires improvement'
- **Well-led:** remained 'requires improvement'
- **Caring** and **Responsive:** remained 'good'

Summary of CQC findings

- Significant improvements made
- No new areas of concern
- Areas of outstanding practice
- Response times need to improve

- Hospital handover times need to improve
- Patients overwhelmingly positive about caring and compassionate staff, delivering patient focussed care in challenging circumstances

Our response:

We are sorry that some patients have experienced unacceptable waits.

To improve services, we've:

- invested in new ambulance vehicles
- invested in our electronic patient record system
- recruited more staff to our frontline
- improved the clinical outcome for many of our patients

Challenges:

We were not commissioned or resourced to meet the 2016/17 national standards which is the reason why, together, we undertook an independent demand and capacity review.

However, we got to more people faster than ever before

- over 10,000 more 'red' patients within eight minutes compared to previous year…

… despite hospital handover delays during the year:

- over 100,000 delays over 15 minute
- over 20,000 delays over 30 minutes

Our improvement plans continue to address CQC concerns

We're embedding the Plan, Do, Study, Act (PDSA) Quality Improvement Methodology into our Clinical and Quality Strategy and work plans.

- Quality Improvement Plan
- Ambulance Response Programme pilot
- Partnerships addressing impact handover delays have on EMAS and patients waiting in the community
- Ensure our incident reporting is robust and staff know the process
- Embed Duty of Candour requirements across EMAS
- All staff receive the training they need for their role
- Improving our Fit and Proper Persons process
- Ensure staff are fitted with protective masks

Playing our part

Strains on the health and social care system directly impact on our ability to address all the concerns highlighted by the CQC.

It is not within our control alone to fix:

- Achievement of national and local performance standards
- Reduction of hospital handover delays
- Impact NHS111 has on our activity

However we continue to play our part.

Next steps

- EMAS continued progression of Improvement Plans
- Ambulance Response Programme
- Independent strategic demand, capacity and price review – more staff and resources needed
- Significant improvement and change in the wider health and social care system

In summary

Through our Quality Improvement Plan and PDSA approach we will continue to progress and develop services for the benefit of our patients and staff.

Questions welcome.

NHS
University Hospitals of Leicester
NHS Trust

Report to: Leicester City Health and Wellbeing Scrutiny Commission
Date: 4 October 2017

Author: Lisa Gowan, Head of Operations

Emergency Department at University Hospitals of Leicester

What is the current state of play since the changes have been introduced?
The move into the new Emergency Department, (ED) on 26 April 2017 went as planned. Council colleagues will recall that a principle reason for the development of the new ED was that the previous facility was built to accommodate circa 100,000 attendances a year but the exponential growth in attendances had pushed that figure to closer to 200,000 attendances. As a consequence the 'old' ED at times of high demand was cramped, overcrowded and offered a poor patient experience.

Immediately following the opening there was deterioration in both the four-hour performance and speed of ambulance handovers. There key reasons for this were:-

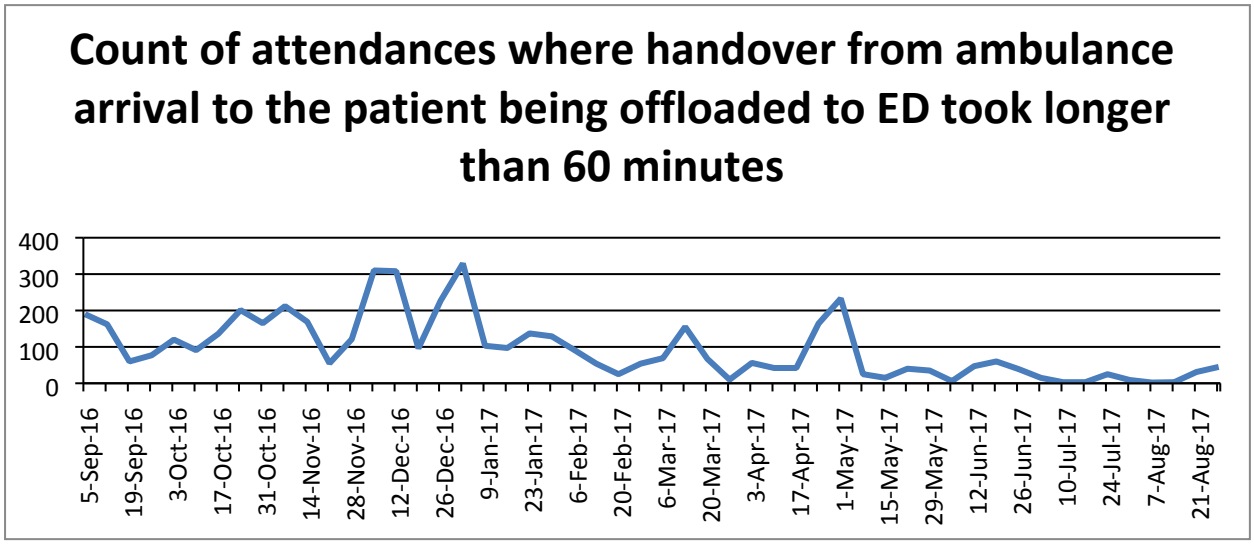
- Embedding the new Standard Operating Procedures (SOPs) and ways of working for the 450+ staff across the new department
- Staff adjusting to their new environment meaning slower processing than normal
- Staffing in the primary care component of ED
- Sustaining meaningful flow out of the Emergency Department to the wards… largely as a consequence of bed availability.

Since April, there have been improvements to our four-hour performance, despite continued high demand on our emergency care pathway, but this has not been sustained at a level we are in any way happy with and as such though patients are seen and treated in an environment that is far superior to that which was previously available, the fact remains that still too many patients wait too long.

Despite marked improvements during the day, i.e. between 8am and 6pm, performance has been poorer overnight. This is largely due to the limited availability of senior clinical decision makers later in the evening, nurse staffing issues across the department, and having sustainable and meaningful outflow from the emergency department. In essence the new department works well when we have the right staff in the right place at the right time, (and access to beds) which combined allow us to deal with peaks in demand, but the ED still 'silts up' if either staffing or beds are in short supply.

On the subject of bed availability there continues to be insufficient capacity for the number of patients we are admitting (baseline shows we are 105 short).

All that said a key measure that caused the Trust, our partners in EMAS and local government colleagues serious concern, i.e. ambulance handover times, have improved dramatically. The department has moved from being the worst performer in the region to one of the best and this improvement is now sustained. (See chart below)



The long-standing problem of ED performance deteriorating overnight, largely because medical and nursing resources do not match our demand, and the continued struggle to ensure flow along the whole emergency care pathway, have led to the Trust-wide 'September Surge' which began on September 1st.

What is 'September surge'? How will it help and what will change? Has it made a difference?

The 'September Surge' began on 1 September, and ran for 14 days, with the aim of increasing focus on getting the basics right and also testing a range of new ideas to improve the care provided for all emergency patients. The underlying principle of the surge was to try out new approaches to managing demand ahead of the inevitable winter pressures.

A number of actions were put in place in ED and across the whole Trust, in recognition that emergency care performance is not just an ED issue.

The actions included:

- More senior doctors in the Emergency Department overnight
- Increasing the number of patients discharged before noon each day
- Doctors from specialties across the hospital coming into ED to see patients, thereby ensuring patients have quicker treatment plans in place. (Known as 'in reach')

The aim of the Surge was to ascertain which specific targeted actions could make a marked difference to ED performance

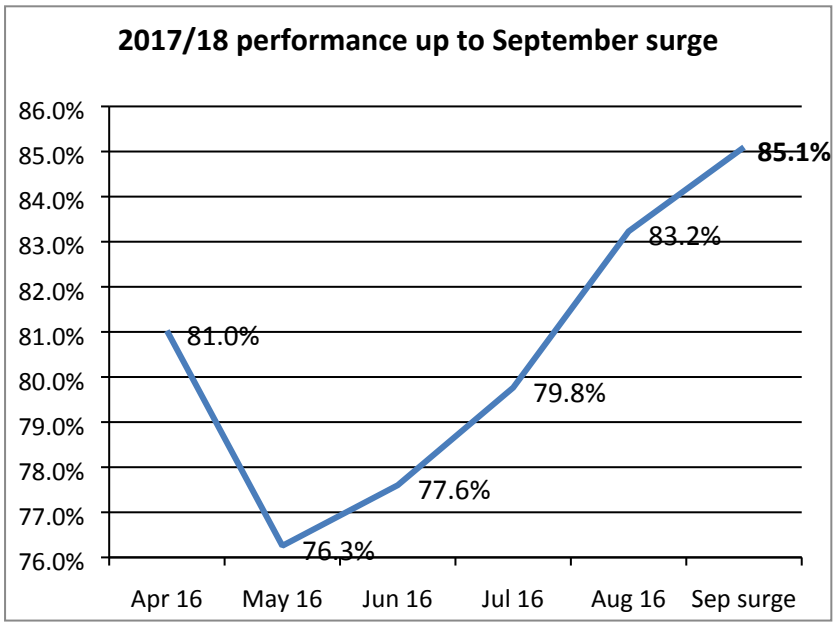
During the two-week period, performance improved, with really excellent performance on several days. This was essentially the result of good bed availability and good performance by ED itself. The additional senior doctor presence in ED made a difference between 6pm and 6am, maintaining our processing power and rapid clinical decision making as well as supporting the overnight team beyond 1am. The 'bad days' were generally being driven by a lack of bed capacity with a particular problem around

the lack of discharges at the weekend and the 'Monday spike' in attendance. (The table below shows this by day)

Daily Performance during Surge

	Arrival Date	Attendance Count	4 Hour Breaches	Performance
Fri	01/09/2017	571	100	**82.5%**
Sat	02/09/2017	597	44	**92.6%**
Sun	03/09/2017	628	28	**95.5%**
Mon	04/09/2017	719	115	**84.0%**
Tue	05/09/2017	643	151	**76.5%**
Wed	06/09/2017	569	109	**80.8%**
Thu	07/09/2017	640	134	**79.1%**
Fri	08/09/2017	628	105	**83.3%**
Sat	09/09/2017	540	76	**85.9%**
Sun	10/09/2017	621	97	**84.4%**
Mon	11/09/2017	701	132	**81.2%**
Tue	12/09/2017	623	111	**82.2%**
Wed	13/09/2017	577	46	**92.0%**
Thu	14/09/2017	605	43	**92.9%**
	Surge Period	**8662**	**1291**	**85.1%**

Overall, the surge improved ED 4 hour performance from 83.2%% in August prior to 85.1% during the surge. (The graph below shows the month on month improvement). The next steps are therefore to take those interventions that made the greatest difference to performance and seek to make them sustainable during the coming winter months and beyond.



These key actions are listed below:

PRE-ED

- Ensure GP extended access roll-out plan matches target
- Ensure minimum 36% 111 calls handled by a clinician
- Actions to address Monday attendance spike

ED

- Continue additional Registrar/Consultant shifts x 3 evening/overnight
- Develop medium-term plan for sufficient medical resources evening/overnight
- Maintain focus on 4 hour segments
- Embed new front door frailty model

ACUTE MEDICINE/AMU

- Continue additional Acute Med ED in-reach shifts
- Review working of AMU/ specialty ownership (L&D)
- GP referrals to by-pass ED (L&D)
- Maximise ambulatory care (L&D)
- Speed up mechanics of flow from ED to assessment units

SPECIALTIES

Continue daily inter-specialty huddles
Continue surgical in-reach into ED (Gen Surg/ENT) or convert to hot clinics
Improve speciality ownership of patients in ED (L&D)

WARD FLOW

- Further embed SAFER/R2G on LRI medical wards (St Helier approach)
- Ensure job plans match SAFER/R2G requirements
- Ensure reliable dedicated discharge role on every medical ward
- Physician of the week (not daily changes)

DISCHARGE

- All CHC assessments to be outside an acute setting
- Fully implement trusted assessment
- Discharge to assess (no assessment for long term care in acute setting)

COMMUNICATIONS

- Continue weekly organisational update
- Staff flu vaccination campaign

INFRASTRUCTURE/COMMAND/PROGRAMME MANAGEMENT

- Accelerate implementation of real-time e-bed management
- Implement daily “scrum” meetings to drive key actions
- Recalibrate Whole Hospital Response policy to reflect speciality ownership of ED situation

What is involved in phase 2 following the move?
As councillor colleagues may recall the new ED design and build was always in two phases. Phase 1 being the ED itself and phase 2 the ‘co-location’ of our assessment units next to the new ED (Previously the assessment units were floors apart accessed by lifts, causing inevitable delays)
The next and final phase of the Emergency Floor is therefore the relocation of the medical assessment and frailty assessment units next door to the new ED. Hence, the space of the old Accident and Emergency Department is currently a busy building site, and will become home to the assessment units from May 2018.

The assessment units are currently located on levels 3 and 5 of the Balmoral and Windsor buildings, meaning it takes time and more resources to move the patients from ED. This co-location will create a ‘hot-floor’ meaning that patients will flow quickly from ED to the assessment units for further investigation and treatment.

The new purpose built space will, like the new ED, be frailty-friendly; it will improve privacy and dignity for all patients, and provides a state-of-the-art environment for staff to provide care for some of the most vulnerable patients who visit UHL.

As part of this plan, the ambulatory service will also move into a dedicated space on the 'hot floor'. Meaning that more patients who are referred from their GP to the hospital will now be able to bypass ED by going directly to the ambulatory service.

What unexpected barriers have you come across? How have they been resolved?
Change is not easy; and moving into a new environment has not been simple. This has required lots of work by the teams to adopt new ways of working appropriate to a modern emergency department. There has been on the ground training, familiarisation sessions in each area, and coaching with teams to support the move. The staff have worked tirelessly to support each other to embed those changes.

Across the Trust, there has been a focus on the whole hospital response to our current poor performance; ensuring that everyone plays their part in improving the experience patients receive in hospital. This has been particularly positive for patients who need geriatrician and/or medical physician care. Specialty doctors have been working within the ED footprint, seeing patients as they come through the 'front door', often reducing the need for patients to be admitted to a bed, and starting a treatment plan almost immediately.

Ensuring there are enough staff remains a challenge; Staff are being asked to do more, and continue to rise to the challenge in often very difficult circumstances. Intensive recruitment continues across all areas of the hospital, as well as workforce reviews to look at varied roles and creating a flexible workforce to meet the current demands.

What would you have done differently?
Of the actions and ideas that were tested over the two week Surge, taken from national best practice and learning from other Trusts, some had more impact than others. The increase in senior doctors overnight is a good example of where marked improvements were seen in performance as a direct result of this action. Further work over the next four weeks will focus on tailoring other actions to the Trust, to ensure they have an impact on processes and flow of patients.

What is the relationship with GP's and other health professionals making referrals to A&E?
The Trust continues to work with local GPs and Clinical Commissioning Groups to reduce the number of people coming to the ED.

The GPs who work at the ED 'front door' provide a valuable primary care service to those patients who need it.

We are working closely with our GP colleagues to look at inappropriate referrals, making best use of hub availability across both the City and the County. We are also trialling in October having some primary care coordinator support at ED reception to help 'deflect' patients to alternative providers of care.

We also recognise that we see a regular spike in attendances on Mondays and this reflects a national picture. The increase is most pronounced in 'walk in' ambulatory patients so we are working with CCG and GP colleagues to look at how this can be

mitigated by extending hub access over the weekend to ensure patients are not waiting until a Monday morning to seek treatment.

Feedback from users

In summer 2017 the Trust welcomed colleagues from Healthwatch who spent time in the new ED talking to patients about their experience of our service. As ever the HW findings were incisive and contributed to our understanding of the services we provide. Since then we have acted upon a number of the recommendations from the report, including increased signage both in and outside of the ED, and putting a hot drinks machine into the main waiting area.

As regards direct patient feedback, the recent Friends and Family Test scores show UHL as the top rated acute hospital within the region with 95% of patients recommending the care that they received. This is a huge achievement and one that the team ED is rightly very proud of. Nonetheless, all Trust colleagues who daily work in, or with, our emergency department recognise that our current performance as measured by the 4 hour target is unacceptable and are therefore committed to resolving this issue for the benefit of our patients.

HEALTH AND WELLBEING SCRUTINY COMMISSION
3RD OCTOBER 2017

REPORT OF:-
LEICESTER CITY CCG,
EAST LEICESTERSHIRE & RUTLAND CCG AND
WEST LEICESTERSHIRE CCG

Decommissioning of non-evidenced based treatments for lower back pain, with or without sciatica

Purpose of report

1. The purpose of this report is to inform the Health and Wellbeing Scrutiny Commission of joint plans from the three clinical commissioning groups across Leicester, Leicestershire and Rutland to decommission a number of interventions for the treatment of lower back pain, with or without sciatica, in line with National Institute for Health and Care Excellence (NICE) guidance published in November 2016.

2. To share with the Health and Wellbeing Scrutiny Commission the plan for public engagement supporting this piece of work.

Link to the local Health and Care System

3. Clinical Commissioning Groups (CCGs) are responsible for the commissioning of the majority of health services on behalf of their local population and have a statutory duty to ensure that:
    - The services they commission meet the NHS Policy Mandate from NHS England and the health needs of their local population(s)
    - The resources utilised and prioritised to deliver healthcare within LLR, provide services with proven benefit, and demonstrate value for money.

Recommendation

4. The Health and Wellbeing Scrutiny Commission is asked to:

    a) **NOTE** the change to the NHS funded treatments that will be offered to patients with lower back pain, in line with NICE guidance.
    b) **NOTE** the timeline for public engagement, and how patients will be informed of the implications.

Policy Framework and Previous Decisions

5. The following NHS Boards and Committees have approved, in principle, the decommissioning of three specific interventions (namely acupuncture, electrotherapies and spinal injections) in line with the NICE guidance.

    - East Leicestershire and Rutland CCG (ELRCCG) Integrated Governance Committee
    - Leicester City CCG (LCCCG) Governing Body
    - West Leicestershire CCG (WLCCG) Finance and Planning Committee
    - University Hospitals of Leicester (UHL) Executive Strategy Board

Background

NICE Guidance

6. The National Institute for Health and Care Excellence (NICE) is an executive non-departmental public body responsible for providing evidence-based guidance on health and social care. It is accountable to the Department of Health, but operationally independent of government.

7. It was established in 1999 to provide and independent, systematic source of evidence to support commissioning decisions about drugs and treatments, in particular to reduce variations in the availability and quality of treatments and care across the country (for example the so-called 'postcode lottery').

8. NICE aims to improve outcomes for people using the NHS and public health and social care services, by producing guidance setting out the evidence base and recommendations that should be referenced across the country in order to assess the efficacy of drugs and treatment.

9. In November 2016, NICE published guidance for low back pain and sciatica in the over 16s.

    The NICE guidance sets out specific recommendations for the assessment of back pain, its initial and ongoing treatment and the management of chronic or recurrent back pain:-

    - Initial treatment should be focused on self-management advice and information to promote an early return to normal activities (unless red flags are present).
    - Assessment should be undertaken using the STarT Back Risk Stratification tool which uses a short questionnaire to determine further intervention based on modifiable prognostic indicators.
    - StarT Back then allocates patients to different pathways depending whether their risk of persistent disability is low, medium or high.
    - Those triaged to low or medium risk (around 75% of non-specific back pain presenting in the community) should be managed by a combination of ongoing self-management, community based physiotherapy and lifestyle advice, including exercise referral.

- The 25% identified at high risk of a poor prognosis and persistent disability should be offered early intervention with a combined physical and psychological programme.

11. The table below summarises what the evidence shows for each type of intervention and whether these interventions should be commissioned and offered by NHS commissioners in the future.

Treatment	**Offer/ Do not offer**	**Supporting Information on the Rationale & Evidence Base**
Self-Management	Offer	There is some evidence that self-management (advice and education) improves quality of life and reduces use of health services. NICE supports giving information to all patients and recommends they continue with their normal activities.
Exercise	Offer	Exercise of all types is beneficial to reduce longer term functional disability. NICE supports group exercise programmes for people with a specific episode, or flare-up, of low back pain with or without sciatica.
Orthotics • Belts or corsets • Foot orthotics • Rocker sole shoes	Do not offer	NICE reviewed all the trial data and found no benefit between those using orthotics (or any other appliance) and usual care.
Manual therapies • Traction • Manual therapy e.g. massage, spinal manipulation and mobilisation carried out by chiropractors, osteopaths and physiotherapists	Do not offer Offer as part of a treatment package	There is no evidence from trials that traction adds benefit for back pain. Manual therapies in isolation are not cost-effective but NICE supports their use as part of a treatment package including exercise, with or without psychological therapy.
Acupuncture	Do not offer	NICE reviewed 29 randomised controlled trials including those that compared 'sham' treatment (needles are placed but in the "wrong" locations or not deep enough), and a real acupuncture group. No clinically important benefit was identified. NICE concluded that are benefit perceived by patients was likely to be to the context of the treatment, rather than acupuncture itself, and it should not be offered for patients with back pain or sciatica.
Electrotherapies • Ultrasound • Percutaneous electrical nerve stimulation (PENS) • Transcutaneous electrical	Do not offer	NICE reviewed trials for all the major modalities used to treat back pain - (ultrasound, percutaneous electrical nerve simulation (PENS) , transcutaneous electrical nerve

nerve simulation (TENS) • Interferential therapy		simulation (TENS) - and interferential therapy and decided there was insufficient evidence of their benefit for managing low back pain with or without sciatica.
Psychological therapy	Offer as part of a treatment package	Behavioural, mindfulness and cognitive-behavioural (CBT) approaches have all been studied in trials and do not offer clinical benefit in isolation.
Combined physical and psychological programmes (multidisciplinary biopsychosocial "functional" rehabilitation)	Offer especially for people with persistent low back pain	Combining a physical component (exercise, mobilisation) with a biopsychosocial component (CBT) has been shown to be cost effective in improving quality of life, but not reducing pain, based on a course delivered by experienced physiotherapists with additional psychological training. Initial risk stratification helps to identify those patients who will benefit (those at most risk of developing long term disability) by focusing on significant psychosocial obstacles to recovery.
Return to work programmes	Offer	NICE recommends promoting return to work or normal activities of daily living for people with low back pain with or without sciatica.
Pharmacological interventions	Guidance provided for the various options	NICE offers recommendations to reduce medication use for chronic back pain including not offering opioids.
Spinal injections (facet joint injections, trigger point injections, prolotherapy)	Do not offer	The studies show minimal evidence of benefit compared with the potential harms and NICE recommends they should not be part of the management of low back pain.
Radiofrequency denervation	Offer and provides criteria for when	NICE recommends that this should only be offered for chronic pain that has not responded to alternative non-surgical therapies after a positive response to a diagnostic medial branch block.
Epidural	Offer and provides criteria for when	Trial indicate a clinical benefit after epidural injections of local anaesthetic and steroid in people with acute and severe sciatica
Spinal decompression	Offer and provides criteria for when	Surgical decompression may be an option for people with sciatica when non-surgical treatment has not improved pain/function and radiological findings are consistent with sciatic symptoms.
Spinal fusion	Do not offer	Not supported by NICE unless part of research trial

Current Position

12. Within the local NHS, the Pain Management Service at UHL currently provides the following treatments which NICE now no longer supports as evidence based:-

    - Acupuncture
    - Electrotherapies (TENS and PENS)
    - Spinal injections

13. Around 360 patients per year will be affected by the change. The cost of these treatments would have equated to £42,000 per annum for patients in Leicester, Leicestershire and Rutland.

14. In LLR, some of the services that NICE does recommend already exist for the treatment of back pain.

15. Most back pain gets better by itself without the need for intervention the guidance recommends self-care as a key component of the treatment options for back pain. Where this is not successful, physiotherapy, functional rehabilitation and lifestyle advice and exercise programmes are already available for patients, as well as services for higher risk patients within UHL.

16. In Leicester, Leicestershire and Rutland the existing services are currently being developed into a new integrated back pain service along with other NICE recommended services.

17. The model will utilise existing community services more cost-effectively (reducing referrals and imaging for low/medium risk patients) and also focus the activity of specialist services, including Musculoskeletal (MSK) extended scope practitioners, on those at high risk of a poor outcome who require more intensive input.

Next steps including engagement plans

18. LCCCG Governing Body, ELRCCG's Integrated Governance Committee, WLCCG's Finance and Planning Committee and UHL's Executive Strategy Board have all agreed in principle to the decommissioning of the above treatments, in line with the NICE guidance.

19. As NICE has made a clear decision not to support certain treatments based on the clinical evidence of the treatment, the CCGs are not required to enter into a period of formal consultation with patients and other stakeholders.

20. However, the CCGs would wish to engage with patients, particularly those who are or have been in receipt of these services, or may be in receipt in the future, to inform them of the proposals and proposed future treatment options. It will also allow their views to inform the development of future services for the treatment of back pain.

21. The CCGS have agreed to undertake an eight week period of public and clinical engagement which will be led by Leicester City CCG Communications and

Engagement Department on behalf of all three CCGs in LLR. This will commence on 28th September 2017.

22. Engagement with primary care is also planned to commence on 21st September 2017.

23. The purpose of the engagement is to:

    - inform the public and clinical staff of the outcome and implications of the NICE guidance
    - confirm that acupuncture, electrotherapies and spinal injections will no longer be carried out for the treatment of lower back pain within the NHS in LLR
    - provide clear advice and information about the options that are available to people with lower back pain, and how NHS resources will be prioritised to the NICE approved interventions in the future

24. The risks of continuing to provide non-evidence-based treatments will also be explained, along with how the evidence demonstrates that exercise, increasing the person's mobility and physiotherapy are the best interventions for the management of lower back pain.

25. The engagement plan will include targeted communications for those patients waiting for the treatments that are to be decommissioned, and for those who have already commenced treatment, as well as a set of general messages and advice for the public at large and clinicians.

26. This will include clear information on the process to access services for lower back pain, which will include (but not be limited to) self-care, information online, exercise and self-referral to physiotherapy.

27. Patients currently waiting for appointments for acupuncture, electrotherapy or spinal injections will receive specific information to advise them that, as a result of these changes, patients will no longer be referred for such treatments within the NHS or be added to waiting lists, with effect from 1st November 2017.

28. Their options will be clearly explained, along with education on the recommended treatment options in the future. These patients will have the option to continue with their planned treatment or choose to receive physiotherapy instead, which is a NICE recommended treatment.

29. Patients who have already commenced their treatment will be advised they are able to complete their current treatment cycle, but they will also be informed of the implications of the NICE guidance, the timing of the cessation of these services within the NHS in LLR, and the options available to them in the future, along with who to contact for further advice.

30. Some Patient Public Partnership Group representatives have already been involved in the decision making process, through:-

    - The Pain Management Service
    - The Planned Care Work stream

- The Alliance Clinical Reference Group

33. Their input will continue to be used to finalise the communications and engagement plan and products

Timetable for Decisions

34. Key dates for the decommissioning of acupuncture, electrotherapies and spinal injections for the treatment of back pain are as follows:-

Date	Activity
21th September	Engagement with Primary Care commences
21st September	Leicestershire Health and Wellbeing Board
25th September	Engagement with public commences
26th September	Rutland Health and Wellbeing Board
4th October	Leicester City OSC
1st November	Date that patients will no longer be added to the waiting list for acupuncture, electrotherapies and injections (subject to final confirmation by CCGs).
19th November	Engagement with the public ends
12th December	CCG Governing Bodies will review engagement feedback.

Officer to Contact

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List of Appendices

NICE guidance

Relevant Impact Assessments

On request

Partnership Working and associated issues

The proposals within this report have been produced jointly by University Hospitals Leicester, the 3 CCGs across Leicester, Leicestershire and Rutland, Public Health departments across LLR, with engagement from the patient representatives noted in para 32.

NICE National Institute for Health and Care Excellence

NICE guideline

Low back pain and sciatica in over 16s: assessment and management

NICE guideline

Published: 30 November 2016
nice.org.uk/guidance/ng59

Your responsibility

The recommendations in this guideline represent the view of NICE, arrived at after careful consideration of the evidence available. When exercising their judgement, professionals and practitioners are expected to take this guideline fully into account, alongside the individual needs, preferences and values of their patients or the people using their service. It is not mandatory to apply the recommendations, and the guideline does not override the responsibility to make decisions appropriate to the circumstances of the individual, in consultation with them and their families and carers or guardian.

Local commissioners and providers of healthcare have a responsibility to enable the guideline to be applied when individual professionals and people using services wish to use it. They should do so in the context of local and national priorities for funding and developing services, and in light of their duties to have due regard to the need to eliminate unlawful discrimination, to advance equality of opportunity and to reduce health inequalities. Nothing in this guideline should be interpreted in a way that would be inconsistent with complying with those duties.

Commissioners and providers have a responsibility to promote an environmentally sustainable health and care system and should assess and reduce the environmental impact of implementing NICE recommendations wherever possible.

Contents

This guideline replaces CG88.

This guideline is the basis of QS155.

Overview

This guideline covers assessing and managing low back pain and sciatica in people aged 16 and over. It outlines physical, psychological, pharmacological and surgical treatments to help people manage their low back pain and sciatica in their daily life. The guideline aims to improve people's quality of life by promoting the most effective forms of care for low back pain and sciatica.

Who is it for?

- Healthcare professionals
- Commissioners and providers of healthcare
- People with low back pain or sciatica, and their families and carers

Recommendations

People have the right to be involved in discussions and make informed decisions about their care, as described in your care.

Making decisions using NICE guidelines explains how we use words to show the strength (or certainty) of our recommendations, and has information about prescribing medicines (including off-label use), professional guidelines, standards and laws (including on consent and mental capacity), and safeguarding.

1.1 Assessment of low back pain and sciatica

Alternative diagnoses

1.1.1 Think about alternative diagnoses when examining or reviewing people with low back pain, particularly if they develop new or changed symptoms. Exclude specific causes of low back pain, for example, cancer, infection, trauma or inflammatory disease such as spondyloarthritis. If serious underlying pathology is suspected, refer to relevant NICE guidance on:

- Metastatic spinal cord compression in adults
- Spinal injury
- Spondyloarthritis
- Suspected cancer

Risk assessment and risk stratification tools

1.1.2 Consider using risk stratification (for example, the STarT Back risk assessment tool) at first point of contact with a healthcare professional for each new episode of low back pain with or without sciatica to inform shared decision-making about stratified management.

1.1.3 Based on risk stratification, consider:

- simpler and less intensive support for people with low back pain with or without sciatica likely to improve quickly and have a good outcome (for example, reassurance, advice to keep active and guidance on self-management)

- more complex and intensive support for people with low back pain with or without sciatica at higher risk of a poor outcome (for example, exercise programmes with or without manual therapy or using a psychological approach).

Imaging

1.1.4 Do not routinely offer imaging in a non-specialist setting for people with low back pain with or without sciatica.

1.1.5 Explain to people with low back pain with or without sciatica that if they are being referred for specialist opinion, they may not need imaging.

1.1.6 Consider imaging in specialist settings of care (for example, a musculoskeletal interface clinic or hospital) for people with low back pain with or without sciatica only if the result is likely to change management.

1.2 Non-invasive treatments for low back pain and sciatica

Non-pharmacological interventions

Self-management

1.2.1 Provide people with advice and information, tailored to their needs and capabilities, to help them self-manage their low back pain with or without sciatica, at all steps of the treatment pathway. Include:

- information on the nature of low back pain and sciatica
- encouragement to continue with normal activities.

Exercise

1.2.2 Consider a group exercise programme (biomechanical, aerobic, mind–body or a combination of approaches) within the NHS for people with a specific episode or flare-up of low back pain with or without sciatica. Take people's specific needs, preferences and capabilities into account when choosing the type of exercise.

Orthotics

1.2.3 Do not offer belts or corsets for managing low back pain with or without sciatica.

1.2.4 Do not offer foot orthotics for managing low back pain with or without sciatica.

1.2.5 Do not offer rocker sole shoes for managing low back pain with or without sciatica.

Manual therapies

1.2.6 Do not offer traction for managing low back pain with or without sciatica.

1.2.7 Consider manual therapy (spinal manipulation, mobilisation or soft tissue techniques such as massage) for managing low back pain with or without sciatica, but only as part of a treatment package including exercise, with or without psychological therapy.

Acupuncture

1.2.8 Do not offer acupuncture for managing low back pain with or without sciatica.

Electrotherapies

1.2.9 Do not offer ultrasound for managing low back pain with or without sciatica.

1.2.10 Do not offer percutaneous electrical nerve simulation (PENS) for managing low back pain with or without sciatica.

1.2.11 Do not offer transcutaneous electrical nerve simulation (TENS) for managing low back pain with or without sciatica.

1.2.12 Do not offer interferential therapy for managing low back pain with or without sciatica.

Psychological therapy

1.2.13 Consider psychological therapies using a cognitive behavioural approach for managing low back pain with or without sciatica but only as part of a treatment package including exercise, with or without manual therapy (spinal manipulation, mobilisation or soft tissue techniques such as massage).

Combined physical and psychological programmes

1.2.14 Consider a combined physical and psychological programme, incorporating a cognitive behavioural approach (preferably in a group context that takes into account a person's specific needs and capabilities), for people with persistent low back pain or sciatica:

- when they have significant psychosocial obstacles to recovery (for example, avoiding normal activities based on inappropriate beliefs about their condition) **or**
- when previous treatments have not been effective.

Return-to-work programmes

1.2.15 Promote and facilitate return to work or normal activities of daily living for people with low back pain with or without sciatica.

Pharmacological interventions

1.2.16 For recommendations on pharmacological management of sciatica, see NICE's guideline on neuropathic pain in adults.

1.2.17 Consider oral non-steroidal anti-inflammatory drugs (NSAIDs) for managing low back pain, taking into account potential differences in gastrointestinal, liver and cardio-renal toxicity, and the person's risk factors, including age.

1.2.18 When prescribing oral NSAIDs for low back pain, think about appropriate clinical assessment, ongoing monitoring of risk factors, and the use of gastroprotective treatment.

1.2.19 Prescribe oral NSAIDs for low back pain at the lowest effective dose for the shortest possible period of time.

1.2.20 Consider weak opioids (with or without paracetamol) for managing acute low back pain only if an NSAID is contraindicated, not tolerated or has been ineffective.

1.2.21 Do not offer paracetamol alone for managing low back pain.

1.2.22 Do not routinely offer opioids for managing acute low back pain (see recommendation 1.2.20).

1.2.23 Do not offer opioids for managing chronic low back pain.

1.2.24 Do not offer selective serotonin reuptake inhibitors, serotonin–norepinephrine reuptake inhibitors or tricyclic antidepressants for managing low back pain.

1.2.25 Do not offer anticonvulsants for managing low back pain.

1.3 Invasive treatments for low back pain and sciatica

Non-surgical interventions

Spinal injections

1.3.1 Do not offer spinal injections for managing low back pain.

Radiofrequency denervation

1.3.2 Consider referral for assessment for radiofrequency denervation for people with chronic low back pain when:

- non-surgical treatment has not worked for them **and**
- the main source of pain is thought to come from structures supplied by the medial branch nerve **and**
- they have moderate or severe levels of localised back pain (rated as 5 or more on a visual analogue scale, or equivalent) at the time of referral.

1.3.3 Only perform radiofrequency denervation in people with chronic low back pain after a positive response to a diagnostic medial branch block.

1.3.4 Do not offer imaging for people with low back pain with specific facet join pain as a prerequisite for radiofrequency denervation.

Epidurals

1.3.5 Consider epidural injections of local anaesthetic and steroid in people with acute and severe sciatica.

1.3.6 Do not use epidural injections for neurogenic claudication in people who have central spinal canal stenosis.

Surgical interventions

Surgery and prognostic factors

1.3.7 Do not allow a person's BMI, smoking status or psychological distress to influence the decision to refer them for a surgical opinion for sciatica.

Spinal decompression

1.3.8 Consider spinal decompression for people with sciatica when non-surgical treatment has not improved pain or function and their radiological findings are consistent with sciatic symptoms.

Spinal fusion

1.3.9 Do not offer spinal fusion for people with low back pain unless as part of a randomised controlled trial.

Disc replacement

1.3.10 Do not offer disc replacement in people with low back pain.

Putting this guideline into practice

NICE has produced tools and resources to help you put this guideline into practice.

Putting recommendations into practice can take time. How long may vary from guideline to guideline, and depends on how much change in practice or services is needed. Implementing change is most effective when aligned with local priorities.

Changes recommended for clinical practice that can be done quickly – like changes in prescribing practice – should be shared quickly. This is because healthcare professionals should use guidelines to guide their work – as is required by professional regulating bodies such as the General Medical and Nursing and Midwifery Councils.

Changes should be implemented as soon as possible, unless there is a good reason for not doing so (for example, if it would be better value for money if a package of recommendations were all implemented at once).

Different organisations may need different approaches to implementation, depending on their size and function. Sometimes individual practitioners may be able to respond to recommendations to improve their practice more quickly than large organisations.

Here are some pointers to help organisations put NICE guidelines into practice:

1. **Raise awareness** through routine communication channels, such as email or newsletters, regular meetings, internal staff briefings and other communications with all relevant partner organisations. Identify things staff can include in their own practice straight away.

2. **Identify a lead** with an interest in the topic to champion the guideline and motivate others to support its use and make service changes, and to find out any significant issues locally.

3. **Carry out a baseline assessment** against the recommendations to find out whether there are gaps in current service provision.

4. **Think about what data you need to measure improvement** and plan how you will collect it. You may want to work with other health and social care organisations and specialist groups to compare current practice with the recommendations. This may also help identify local issues that will slow or prevent implementation.

5. **Develop an action plan**, with the steps needed to put the guideline into practice, and make sure it is ready as soon as possible. Big, complex changes may take longer to implement, but some may be quick and easy to do. An action plan will help in both cases.

6. **For very big changes** include milestones and a business case, which will set out additional costs, savings and possible areas for disinvestment. A small project group could develop the action plan. The group might include the guideline champion, a senior organisational sponsor, staff involved in the associated services, finance and information professionals.

7. **Implement the action plan** with oversight from the lead and the project group. Big projects may also need project management support.

8. **Review and monitor** how well the guideline is being implemented through the project group. Share progress with those involved in making improvements, as well as relevant boards and local partners.

NICE provides a comprehensive programme of support and resources to maximise uptake and use of evidence and guidance. See our into practice pages for more information.

Also see Leng G, Moore V, Abraham S, editors (2014) Achieving high quality care – practical experience from NICE. Chichester: Wiley.

Context

Low back pain that is not associated with serious or potentially serious causes has been described in the literature as 'non-specific', 'mechanical', 'musculoskeletal' or 'simple' low back pain. For consistency, we have used the term 'low back pain' throughout this guideline. However, 'non-specific low back pain' was used when creating the review questions. Worldwide, low back pain causes more disability than any other condition. Episodes of back pain usually do not last long, with rapid improvements in pain and disability seen within a few weeks to a few months. Although most back pain episodes get better with initial primary care management, without the need for investigations or referral to specialist services, up to one-third of people say they have persistent back pain of at least moderate intensity a year after an acute episode needing care, and episodes of back pain often recur.

One of the greatest challenges with low back pain is identifying risk factors that may predict when a single back pain episode will become a long-term, persistent pain condition. When this happens, quality of life is often very low and healthcare resource use high.

Unlike the previous NICE guidance on the management of persistent low back pain between 6 weeks and 12 months, we have moved away from the traditional duration-based classification of low back pain (acute, sub-acute and chronic) and have looked at low back pain as a whole where risk of poor outcome at any time point is almost always more important than the duration of symptoms.

This guideline gives guidance on the assessment and management of both low back pain and sciatica from first presentation onwards in people aged 16 years and over.

We use 'sciatica' to describe leg pain secondary to lumbosacral nerve root pathology rather than the terms 'radicular pain' or 'radiculopathy', although they are more accurate. This is because 'sciatica' is a term that patients and clinicians understand, and it is widely used in the literature to describe neuropathic leg pain secondary to compressive spinal pathology.

This guideline does not cover the evaluation or care of people with sciatica with progressive neurological deficit or cauda equina syndrome. All clinicians involved in the management of sciatica should be aware of these potential neurological emergencies and know when to refer to an appropriate specialist.

We hope to address the inconsistent provision and implementation of the previous guidance and provide patients, carers and healthcare professionals with sensible, practical and evidence-based advice for managing this important and common problem.

More information

You can also see this guideline in the NICE pathway on low back pain and sciatica.

To find out what NICE has said on topics related to this guideline, see our web page on low back pain.

Recommendations for research

The guideline committee has made the following recommendations for research. The committee's full set of research recommendations is detailed in the full guideline.

1 Pharmacological therapies

What is the clinical and cost effectiveness of benzodiazepines for the acute management of low back pain?

Why this is important

Guidelines from many countries have said that muscle relaxants should be considered for short-term use in people with low back pain when the paraspinal muscles are in spasm. The evidence for this mainly comes from studies on medications that are not licensed for this use in the UK. The 2009 NICE guideline on low back pain recommends to consider prescribing diazepam as a muscle relaxant in this situation, but the evidence base to support this particular medicine is extremely small. Benzodiazepines are not without risk of harm, even for short-term use. Because of this, there is a need to find out if diazepam is clinically and cost effective in the management of acute low back pain.

2 Pharmacological therapies

What is the clinical and cost effectiveness of codeine with and without paracetamol for the acute management of low back pain?

Why this is important

Codeine, often together with paracetamol, is commonly prescribed in primary care to people presenting with acute low back pain. This often happens with people who cannot tolerate non-steroidal anti-inflammatory drugs (NSAIDs) or when a person has contraindications to these medications. Although there is evidence that opioids are not effective in chronic low back pain, there are relatively few studies that look at their use for acute low back pain (a problem commonly seen in primary care). Also, it is not known if using paracetamol and codeine together has a synergistic effect in the treatment of back pain.

3 Radiofrequency denervation

What is the clinical and cost effectiveness of radiofrequency denervation for chronic low back pain in the long term?

Why this is important

Radiofrequency denervation is a minimally invasive and percutaneous procedure performed under local anaesthesia or light intravenous sedation. Radiofrequency energy is delivered along an insulated needle in contact with the target nerves. This focused electrical energy heats and denatures the nerve. This may allow axons to regenerate with time, requiring the repetition of the radiofrequency procedure.

The length of pain relief after radiofrequency denervation is uncertain. Data from randomised controlled trials suggest relief is at least 6–12 months but no study has reported longer-term outcomes. Pain relief for more than 2 years would not be an unreasonable clinical expectation. The economic model presented in this guideline suggested that radiofrequency denervation is likely to be cost effective if pain relief is above 16 months.

If radiofrequency denervation is repeated, we do not know whether the outcomes and duration of these outcomes are similar to the initial treatment. If repeated radiofrequency denervation is to be offered, we need to be more certain that this intervention is both effective and cost effective.

4 Epidurals

What is the clinical and cost effectiveness of image-guided compared with non-image-guided epidural injections for people with acute sciatica?

Why this is important

Epidural injection of treatments, including corticosteroids, is commonly offered to people with sciatica. Epidural injection might improve symptoms, reduce disability and speed up return to normal activities. Several different procedures have been developed for epidural delivery of corticosteroids. Some practitioners inject through the caudal opening to the spinal canal in the sacrum (caudal epidural), but others inject through the foraminal space at the presumed level of nerve root irritation (transforaminal epidural).

Some people believe transforaminal epidurals might be most effective because they deliver corticosteroids directly to the region where the nerve root might be compromised. But because

transforaminal epidural injection needs imaging, usually within a specialist setting, this potentially limits treatment access and increases costs. Caudal epidural injection can be done without imaging, or with ultrasound guidance in a non-specialist setting. But it has been argued the treatment might not reach the affected nerve root, meaning this method might not be as effective as transforaminal injection.

Evidence that one method is clearly better than the other is currently lacking. Use of the 2 methods varies between healthcare providers, and people whose sciatica does not respond to caudal corticosteroid injection might go on to have image-guided epidural injection. This means people with sciatica might currently experience unnecessary symptoms at unnecessary cost to the NHS than they would if the most clinically and cost-effective way of delivering epidural corticosteroid injections was always used.

5 Spinal fusion

Should people with low back pain be offered spinal fusion as a surgical option?

Why this is important

An increasing number of procedures have been proposed for surgically managing low back pain. One of these procedures is surgical fixation with internal metalwork applied from the back, front, side, or any combination of the 3 routes. The cost of these operations has risen, and now that minimally invasive approaches are used, more of these operations are done with uncertain benefit.

As well as the cost, surgery can lead to complications – some studies report around a 20% complication rate in the short to medium term. There have been several studies (both randomised and cohort) looking at the clinical effectiveness of spinal fusion versus usual care, no surgery, different surgeries, and other treatments. Overall, the studies do not show a clear advantage of fusion but do show some modest benefit for some elements of pain, function and quality of life. The studies also show healthcare use was lower. It is not known what treatments should be tried before surgery is considered. The evidence from the studies was weak because of low numbers of patients, large crossover and in-case selection bias. This means there is a need for a large, multicentre randomised trial with sufficient power to answer these important questions.

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Accreditation

Health and Wellbeing Scrutiny Commission

Work Programme 2017 – 2018

Meeting Date	Topic	Actions arising	Progress
21st Jun 17	1. Lifestyle Services Review 2. Infant Mortality Rates	1. Information on workshops to be circulated to Members.	
23rd Aug 17	1. Sexual Health Review 2. Settings of Care Policy – Verbal Update 3. STP – Primary Care	1. A letter highlighting concerns about the lack of engagement of schools to be sent to Strategic Director, Children's Services 2. Further update to come to a future meeting. 3. Questions/comments to be sent to the CCG.	
4th Oct 17	1. STP – Mental Health 2. EMAS – Handovers with LRI 3. Accident & Emergency Services at UHL – progress report on new facilities and phase 2 4. Services for Lower Back Pain		
29th Nov 17	1. CQC Inspection of LPT – Update 2. Settings of Care Policy 3. Sexual Health Review 4. Oral Health Update 5. Repeat Prescriptions and Pharmacies 6. Drugs & Alcohol Services – CQC Inspection		
11th Jan 18	1. Lifestyle Services Review – Update 2. STP – Acute Hospital Sites 3. STP – Maternity Services		
7th Mar 18	1. Anchor recovery hub – Update on how it is progressing following a move to the new site		

APPENDIX E

Leicestershire, Leicester and Rutland Joint Health Scrutiny Committee

Meeting Date	Topic	Actions arising	Progress
29th Sep 16	1) NHS England's Proposals for Congenital Heart Disease Services at UHL NHS Trust 2) UHL NHS Trust's View on NHS England's Proposals for Congenital Heart Disease Services 3) Other Viewpoints on NHS England's Proposals	Contact NHS England to inform them that the committee would like the review process to be stopped but if it is to go ahead then they will need to attend another joint meeting once the consultation is announced.	
14th Dec 16	1) Sustainability and Transformation Plan	All three council scrutiny committees agreed to consider elements of the STP separately based on local concerns. Another joint meeting will convene when each council has had separate consideration.	
14th Mar 17	1) NHS England's Proposals for Congenital Heart Disease Services at UHL NHS Trust	It was agreed to have a further meeting of the committee before the consultation ends to hear views from Members of the public and other stakeholders.	
27th Jun 17	1) NHS England's Proposals for Congenital Heart Disease Services at UHL NHS Trust	It was agreed for the committee response to be collated following information heard at the meeting and submitted to NHS England. It was also agreed to write to the Secretary of State to request he looks at the process and reconsiders the review and drop proposals to close the CHD centre at Glenfield Hospital.	

Forward Plan Items

Topic	Detail	Proposed Date
Dementia, Dental Care, Diabetes, GPs, Obesity, Smoking, COPD and Substance Misuse	Progress to individual strategies/services	
Patient experience of the system	Work with Healthwatch to gain an understanding of how patients feel about health services	
Public Health Performance Report	Annual/Six monthly?	
CQC Inspection of LPT including CAMHS – Joint with CYPS Scrutiny	Update since the last meeting and an updated action plan to improve performance	Oct/Nov 2017
CQC Review of Health Services for LAC and Safeguarding – Joint with CYPS Scrutiny	Updated action plan and indicators that suggest the current performance.	Oct/Nov 2017
Children Young People Joint Strategic Needs Assessment (JSNA) – Joint with CYPS Scrutiny		Oct/Nov 2017
CCG Annual Report		
LPT Annual Report		
Air Quality Action Plan	Update to be considered jointly with EDTT Scrutiny	Oct 2017
Impacts of Brexit on staffing in NHS	What has the immediate impact been? What will continue to happen when we exit the EU? What contingencies are being put in place? Where will the biggest impacts be?	